"Porque tienen mucho derecho" : parteras, biomedical training and the vernacularization of human rights in Chiapas

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"PORQUE TIENEN MUCHO DERECHO:"

PARTERAS, BIOMEDICAL TRAINING AND
THE VERNACULARIZATION OF
HUMAN RIGHTS IN CHIAPAS

by

Mounia El Kotni

A Dissertation
Submitted to the University at Albany, State University of New York
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2016
"Porque Tienen Mucho Derecho:"

Parteras, Biomedical Training and
the Vernacularization of
Human Rights in Chiapas

by

Mounia El Kotni

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To my *compadres*, Evi and Victor, who opened their door to a complete stranger seven years ago.

To my *ahijado* Ik Balam, who fills our spirits with joy.
Abstract

This doctoral research stems from thirteen months of ethnographic fieldwork in the Mexican State of Chiapas. Chiapas is one of the regions with the highest maternal mortality rates in the country. To comply with international development goals to lower maternal mortality rates, indigenous midwives are trained in detecting risk factors in pregnancy and birth, while women are encouraged to give birth in hospitals. This dissertation sheds light on the impact of such policies on poor women's access to reproductive health care and Mayan midwives' practices. Over the course of my research, I utilized the methodology of participant-observation and conducted in-depth interviews with traditional Mayan midwives and professional midwives within and outside the public health system, mothers living in urban and rural areas, workers from the public health sector, and Non Governmental Organizations activists working in the field of reproductive health. In particular, this dissertation stems from my collaboration with the Organization of Indigenous Doctors of Chiapas (OMIECH), in San Cristóbal de las Casas.

At the intersection of medical anthropology, institutional anthropology and the anthropology of human rights, this dissertation makes three major contributions. First, it documents the consequences of socioeconomic stratification, structural racism, and the marginalization of traditional medical knowledge on indigenous women's reproductive health. This triple oppression marks women in their bodies, as illustrated through cases of obstetric violence endemic in the country. Second, these social forces, combined with government trainings, lead to a displacement of traditional midwives towards the margins of the health sector and of the Mexican society. Their marginalization is reinforced by the push for professionalization, positioning Mayan midwives without any formal education at the very bottom of the medical hierarchy. Finally, this dissertation offers a nuanced understanding of
human rights, as understood and brought forward by women, midwives and activists in their critique of public health policies. For OMIECH activists, indigenous rights provide a powerful framework to push their political agenda forward. For indigenous women, their local interpretations of human rights, coined vernacularization (Levitt and Merry 2009), allow them to call out the obstetric and structural violence these policies reproduce.
Acknowledgements

"In that Empire, the Art of Cartography attained such Perfection that the map of a single Province occupied the entirety of a City, and the map of the Empire, the entirety of a Province. In time, those Unconscionable Maps no longer satisfied, and the Cartographers Guilds struck a Map of the Empire whose size was that of the Empire, and which coincided point for point with it. (...) In the Deserts of the West, still today, there are Tattered Ruins of that Map, inhabited by Animals and Beggars; in all the Land there is no other Relic of the Disciplines of Geography."

Jorge Luis Borges 1998. "On exactitude in science"

Like the cartographers of the Empire, I was tempted to share each and every step of my journey in this dissertation. Thanks to Jaime de las Heras for mentioning this Borges story, and open my eyes to the fact that I could not put everything in the dissertation, because everything would be life itself.

Many people participated in the making of this dissertation, each in their own way. Those lines are my modest retribution for the brief instants, long hours, multiple days or countless months you shared with me. Writing might feel like a solitary journey, but research is definitely a collective endeavor. Thanks to each and every one of you who contributed to this incredible experience; I take full credit for the inaccuracies you might encounter.

In Albany, I am deeply grateful to my wonderful dissertation committee; who followed the development of this research step by step, provided guidance in navigating this language that is not mine, and who fully supported me when I decided to write from home. To my advisor, Jennifer Burrell, thank you. During my four years at UAlbany, your precious advice informed many of my decisions. When I shared my doubts about 'studying over' my friends of the Association MÂ, you encouraged me to cultivate this friendship into something bigger. When I was nervous about summer funding, you provided me with much appreciated employment
opportunities. Thank you for helping me grow from a shy graduate student into a "real anthropologist."

I am very much indebted to Elise Andaya, who introduced me to the fascinating world of medical anthropology. You handed me Brigitte Jordan's *Birth in Four Cultures*; no amount of reading has yet been able to quench my thirst and curiosity for the field of birth. Thank you for helping me find "my people" in the jungle of the AAAs, and for the insightful conversations; your eloquence is inspiring.

To Walter Little, I extend my deepest gratitude. You treated me like a colleague since my first day as a student, and were always ready to lend an ear to my questions. Your patience and kindness are remarkable, and I appreciate our collaborations in Albany and Mexico. You never failed to lift my spirit up in moments of doubts; I fondly remember our conversations in Frenglish and long for many more.

The University at Albany provided constant support with my research projects. I would like to acknowledge the DeCormier family, the Institute for Mesoamerican Studies, the Benevolent Association, the Initiative for Women and the UAlbany Dissertation Fellowship Award for supporting my fieldwork. The Anthropology Department funded my years at Albany (2012-2014), a crucial support for international students. In the Department, I would like to thank the Faculty members for building an inclusive community. I also take this opportunity to thank Jaime Moore for all her help while I was in Mexico and in France. Thank you also to my fellow graduate students and friends, Elizabeth, Aaron, Logan, Jim, Yahaira, Yuliya, for the study hours, the coffee breaks, and dealing with my mail when I was in the field. Isabelle and Lucila: the "writing challenge" and your encouragements helped me get through this, seriously.
As French anthropologist Jeanne Favret-Saada wrote, "being affected is central to the ethnographic experience." Part of my ch’ulel is trapped in the foggy mountains of Chiapas, on the muddy roads, in the smoky kitchens, in the tears and joys of birth. Countless peoples have opened their hearts to me. On the personal level, I would like to thank Evi and Victor and their families, who made Chiapas feel like home; without forgetting Israel, for his indefectible optimism and cheerful presence. Alice, for constantly updating me while I was not in Chiapas; thank you for your dedication to this project. Susannah, thanks for the numerous Skype support sessions. Alba and Irazú: thank you for the moments of collaborative research. I am also indebted to my Tzeltal professors at the Bats'il K'op language school, Xuno and Carlos, who made every effort to answer my endless questions. Kolawal to Mari, for her precious help in transcription and translation, and introducing me to her family.

The heart of this research lies in the lives of the women and men who opened their doors to me. Thank you to the parteras in the Intercultural Hospital who keep providing care despite difficult working conditions; to the parteras in birth centers who make every effort to humanize birth; to the parteras and tam-alaletik in San Cristóbal, Oxcuch, las Margaritas and Yajalón, who provide care to women despite the rain and the distance and; to the OMIECH ones in Carmen Yal Cuc, Simojovel, Chenalhó and C'ancuc, who shared their lucha with me. Your real names are not in these pages but your spirit is behind every word.

To the mothers who shared the joys and pains of giving birth in contemporary Mexico, thank you for letting me intrude into this intimate space. To the medical staff in SSA and IMSS clinics and hospitals in San Cristóbal, Oxcuch, Coapilla, Comitán, Palenque and Mexico City, who try to change the system from within, thank you for letting me see the other side.
to the NGOs and activists in San Cristóbal, Mexico City and Palenque, for sharing your valuable time with me.

In San Cristóbal, my dissertation would not have existed without the collaboration with OMIECH. Thank you to the Mesa Directiva for letting me hang out in offices and inviting me to various events. Thank you to all OMIECH staff members, and in particular Agripino. Rafael, thank you for your guidance, incisive questioning, and availability to discuss my work; your tireless commitment to the parteras is an inspiration. Last but not least, thank you to Micaela, who insisted memorizing my real name when all others went with my nickname Moni. I hope this work will help you in your lucha, and that we will work together for many years to come. I will not let you leave for "Estados Unidos" quite yet.

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<tr>
<td>A.C.</td>
<td>Asociación Civil (Nonprofit)</td>
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<tr>
<td>ACAS, A.C.</td>
<td>Asesoría, Capacitación y Asistencia en Salud (Consultancy, Training and Assistance in Health)</td>
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<tr>
<td>CASA</td>
<td>Centro para Adolescentes de San Miguel Allende (Center for Adolescents of San Miguel Allende)</td>
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<tr>
<td>CeDeMM</td>
<td>Centro de Desarrollo de la Medicina Maya (Center for the Development of Mayan Medicine)</td>
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<tr>
<td>CIAM, A.C.</td>
<td>Centro de Investigación y Acción de la Mujer Latinoamericana (Research and Action Center of the Latin American Woman)</td>
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<tr>
<td>CNDH</td>
<td>Comisión Nacional de Derechos Humanos (National Human Rights Commission)</td>
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<tr>
<td>COMPITCH</td>
<td>Consejo de Organizaciones de Médicos y Parteras Indígenas Tradicionales de Chiapas (Council of Organizations of Indigenous Traditional Doctors and Midwives of Chiapas)</td>
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<tr>
<td>CONAVIM</td>
<td>Comisión Nacional para Prevenir y Erradicar la Violencia contra las Mujeres (National Commission to Prevent and Eradicate Violence Against Women)</td>
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<tr>
<td>DIF</td>
<td>Desarrollo Integral de la Familia (Integral Development of the Family)</td>
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<td>ECOSUR</td>
<td>El Colegio de la Frontera Sur (College of the Southern Border)</td>
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<td>GIRE</td>
<td>Grupo de Información en Reproducción Elegida (Information Group on Reproductive Choice)</td>
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<tr>
<td>ICBG</td>
<td>International Cooperation Group for Biodiversity</td>
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<td>ICM</td>
<td>International Confederation of Midwives</td>
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<td>ILO</td>
<td>International Labour Office</td>
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<tr>
<td>IMSS</td>
<td>Instituto Mexicano del Seguro Social (Mexican Institute of Social Security)</td>
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<td>INEGI</td>
<td>Instituto Nacional de Estadística, Geografía, e Informática (Institute of Statistics, Geography, and Informatics).</td>
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<tr>
<td>INI</td>
<td>Instituto Nacional Indigenista (National Indigenist Institute)</td>
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ISSTE  Instituto de Seguridad Social de los Trabajadores del Estado (Social Security Institute for State Workers)
MANA  Midwives Alliance of North America
MDG  Millennium Development Goals
NAFTA  North American Free Trade Agreement
NGO  Non-Governmental Organization
OMIECH  Organización de Médicos Indígenas del Estado de Chiapas (Organization of Indigenous Doctors of the State of Chiapas)
OMM  Observatorio de Mortalidad Materna en México (Observatory of Maternal Mortality in Mexico)
PROIMMSE  Programa de Investigaciones Multidisciplinarias sobre Mesoamérica y el Sureste (Multidisciplinary Research Program on Mesoamerica and the Southwest)
SADEC, A.C.  Salud y Desarrollo Comunitario (Health and Community Development)
SBA  Skilled Birth Attendant
SIPAZ  Servicio Internacional para la Paz (International Service for Peace)
SEDESOL  Secretaría de Desarrollo Social (Secretary of Social Development)
SSA  Secretaría de Salud (Ministry of Health)
TBA  Traditional Birth Attendant
TMA  Traditional Medicine Area (Área de Medicina Tradicional)
UNICH  Universidad Intercultural de Chiapas (Intercultural University of Chiapas)
WHO  World Health Organization
WMS  Women and Midwives Section (Área de Mujeres y Parteras)
Chapter 1. Introduction.

Indigenous Health and Human Rights in Mexico

"They asked me: If there are so many revolutionary movements in the world, how come the movement in Chiapas has had so much impact? And I told them: Because the movement in Chiapas is for universal values. For the value of justice, for the value of dignity, for the value of peace, (...) and these values speak to everyone. (...) So, this is the most beautiful, and I think it is Mexico's path right now. We need to have faith [confianza], this confianza that Don Samuel [Ruiz García] placed in his people. (...) This is the most important, that we look at one another like important subjects in the construction of history, and not as objects; not like the indigenous law that señor Fox finally approved, in which our brothers are not subjects of right, but are treated as objects. This is the barbarity that we have in this country."

Raul Vera, Bishop of Saltillo and President of the Center for Human Rights Fray Bartolomé de las Casas (Frayba) during the change of director, San Cristóbal de Las Casas, Chiapas, August 18, 2015 (Koman Ilel 2015).

"At a global, national, and regional levels, the Every Newborn Action Plan is supporting developments in health programs, for pregnant women, mothers, and their newborns. (...) Now there is good evidence that these investments in self-help groups are also paying off: as women encourage and support one another to adopt both pre and postnatal care routines. And what I'm excited about about [sic] self-help groups, is [that] we're learning how to really measure the results they are getting, and I think we're only going to get better at that as a world, and that's going to help us with the supply and demand issues that we have to get women really using the services provided."


These two quotes are drawn from events belonging to two parallel yet increasingly entangled universes: on the one hand, local organizations defending indigenous peoples' rights, and the argument for their positioning as subjects of rights instead of objects of history and on the other; international programs aiming to improve poor peoples' health, while fashioning them
into modern world citizens. Taken together, these two discourses illustrate the various aspects of life in contemporary Mexico: a country where people die from poverty-related illnesses yet one that is eager to become Latin America's next leader. In order to achieve this goal, Mexico measures its progress through statistics, and maternal and child health indicators in particular. As anthropologists working in the field of birth have pointed out, at the global level, these indicators serve as a scale to measure nations' economic development and their progress towards achieving modernity (Andaya 2014; Georges 2008). Countries like Mexico invest in hospital-based birth so as to become modern and credible in the eyes of international institutions. In the USA today, 99 percent of babies are delivered in hospitals (Gálvez 2011:87), while in Japan the numbers reach 99.8 percent (Ivry 2009:20). Mexico follows in the footsteps of these nations: in 1990, 76.7 percent of births happened in health institutions; in 2013, 96.1. The changes are even more significant in Chiapas, one of the states where a large number of women still give birth at home; in the last twenty-five years, numbers increased form 22.4 percent to 72.9 percent (Observatorio de Mortalidad Materna en México [OMM] 2013:28).

In 2000, the United Nations' Millennium Development Goals (MDG) merged concerns for maternal health and the need for development by relying on health statistics to measure progress in universal access to reproductive health. Through MDG number 5, developing countries were urged to diminish by three quarters rates of maternal mortality. In Mexico, the proportion of maternal deaths (per 100,000 live births) has moved from 77 in 2002 to 54.7 in 2013 (OMM 2013), before increasing again to 68.1 in 2014. A closer look at the numbers reveals that rural indigenous women are the ones who still die in childbirth1. In Chiapas, the maternal mortality rate of women in reproductive age (between 15 and 49 years old) has actually increased between

1 Those numbers reflect deaths that have been reported and registered as maternal deaths. Research has indicated a severe underreporting of such deaths, partly due to the pressure to comply with MDGs (Freyermuth Enciso and Cárdenas Elizalde 2009).
2010 and 2013, and that of indigenous women has almost doubled (1.7 times) over the time period (ibid).

This dissertation explores the many paradoxes of the modernization of Mexico’s health system by analyzing how it impacts a population that is at the heart of international and national health campaigns, while also being the most marginalized: poor, indigenous women. Throughout my work, I analyze how the construction of indigenous peoples as objects of history in national and international development programs influences the kind of care women receive. I also argue that positioning indigenous women as subjects of rights is precisely what local Non-Governmental Organizations are committed to in Chiapas. The shift from perceiving indigenous women as objects of history, which is the approach taken by the Mexican government, to women as subjects of rights is embedded in different visions of health, and in practice leads to different types of policies. In this first chapter, I present an overview of Mexican health policies and how these are tied to international concerns about maternal mortality and family planning. I also discuss what an intersectional feminist lens brings to the discussion of reproductive rights.

**Traditional Birth Attendants in the New World Order**

In their landmark volume *Conceiving the New World Order*, Ginsburg and Rapp highlight the changing faces of reproduction in a post-Gulf War world, in which distant populations are entangled together on a globalized labor market and face increasingly similar reproductive challenges (Ginsburg and Rapp 1995a). Twenty years later, health inequalities and health policies are more globalized than ever, and statistics measure and compare the socio-demographic profiles of populations living distant realities. When it comes to childbirth, a "biosocial phenomena" (Jordan 1993) par excellence, the challenges women face are deeply rooted in the social constructions surrounding reproduction. The one-size-fit-all solutions
promoted by international organizations homogenize the historical, political and social factors that underlie women's lives. International campaigns, such as the United Nation's Millennium Development Goals (MDGs), prioritize the biological aspect of reproduction over the social one, in order to generate measurable quantitative data. These numbers then "position development institutions as the locus of authoritative knowledge while devaluing other, local form of knowledge" (Pigg 1997:233). In this process, the social aspect of reproduction is limited to acknowledgement of local tradition, which is in all cases meant to change through the training of midwives (Lang and Elkin 1997; Pigg 1997). International campaigns aiming at reducing maternal mortality rates, such as the Safe Motherhood Initiative, are constructed by crunching data from different social and economic settings. When the sole focus is the medical problem to be solved, a specific case becomes a statistical anomaly, and Mayan women's health problems become comparable to that of any other poor women in the world, with the belief that "whoever you are, wherever you are, a shot of Pitocin should make your uterus cramp" (Berry 2010:12).

In her pioneering work comparing Birth in Four Cultures, Jordan describes how certain types of knowledge "[carry] more weight than others, either because they explain the state of the world better for the purposes at hand ('efficacy') or because they are associated with a stronger power base ('structural superiority'), and usually both" (1993:152). What she coins "authoritative knowledge" then is not a matter of correctly or incorrectly assessing a situation, but the legitimacy of one way of knowing over another. In the case of pregnancy and birth, biomedical authoritative knowledge is the authority of physicians' diagnostics over women and midwives' bodily knowledge and experiences. Doctors' authoritative knowledge relies on technology while extending beyond it:
"Authoritative knowledge isn't produced simply by access to technology, or an abstract will to hierarchy. It is a way of organizing power relations in a room that makes them seem literally unthinkable in any other way." (Rapp 1997:xii)

Throughout this dissertation, I will examine how the authoritative knowledge of obstetricians and state workers overrides and reshapes indigenous midwives' own knowledge, and how midwives resist such changes. While the New World Order contributes to reinforcing global authoritative knowledge, the same globalizing forces also provide indigenous midwives with transnational connections and discourses to resist their marginalization (Davis-Floyd 2005).

Since the 1970s, international policies aiming at improving mother and child health have focused on the training of "Traditional Birth Attendants" (TBAs). From Malawi to Mexico, the stereotypical TBA is an older woman who has not received formal schooling and relies on her empirical knowledge to help women deliver their children at home (Berer and Sundari Ravindran 2000). Anthropologists have questioned the shift in the World Health Organization's (WHO) policies regarding traditional midwives, who moved from allies in diminishing international maternal mortality rates in the 1970s and 1980s, to antagonists in the 1990s after the rates did not decrease (Berry 2010; Pigg 1997). In parallel to this rejection of TBAs, international guidelines pushed for the training of Skilled Birth Attendants (SBAs). In contrast to TBAs, SBAs are personnel who have undergone formal training and are able to navigate the hospital environment. Still today, SBAs are seen as the key element to improving poor mothers' health (United Nations 2014), as illustrated in another part of Melinda Gates' speech, referred to at the opening of this chapter:

"Quality care at facilities is one of the absolute keys to saving mothers and newborns. So we need to continue to insure that we are satisfied and that those Skilled Birth Attendants are staffed at all clinics for women. That the clinics themselves are well-supplied and well-trained, so that we can make childbirth even safer." (GMNHC 2015)
Gates' quote illustrates the contemporary face of maternal mortality reduction policies. The presence of SBAs in health centers and clinics is proportionate to the absence of TBAs, who deliver babies in homes. The former are integrated in the health system and provide quality care, while the latter work outside of the system and are implicitly associated with maternal deaths. Universal categories like TBAs and SBAs blend different types of midwives and erase their particularities, by grouping them under generic terms: "Tradition" and its opposite, (biomedical) "Skills". As Pigg underlines in her discussion of TBAs in Nepal, "the words 'Traditional Birth Attendant' serve as a placeholder, a blank waiting to be filled in at the local level where primary health care is to be carried out" (1997:239). Medical anthropologists working in Mesoamerica share similar critiques towards this terminology. Some have pointed out that the term TBA is both ethnocentric and "medicocentric" (Cosmimksy 2012:187), while others critique the "technoscientific bias" (Gálvez 2011) of the SBA category. The exclusion of TBAs from maternal mortality reduction positions biomedicine as the only way to reduce maternal deaths, and thus achieve modernity. Such discriminatory policies dismiss the various forms of learning traditional midwives experience, including self-attending their own birth and/or attending the births of family members. By creating TBAs and SBAs as mutually exclusive categories, this classification does not take into account the skills that midwives who attend births outside of medical institutions might possess (Freyermuth 2010). The distinction between Traditional and Skilled Birth Attendants places international organizations and state agents as the locus of global authoritative knowledge and morality, and contributes to reinforcing global power inequalities (Pinto 2008). Categorizations such as that of TBAs are neither natural nor neutral, and in each country, the relationship between the public health sector and TBAs often depend on local politics. The type of training offered to TBAs will also vary from region to region depending on
the political and material means, and the historical relations between doctors and midwives, among others. In this dissertation, and like other anthropologists working in Chiapas (Speed 2002; Speed, Hernández Castillo, and Stephen 2006), I invite readers to rethink the hierarchies between global and local, as I share examples about how local women and midwives’ actions have an impact beyond their daily routine.

In order to comply with international goals such as the MDGs, and prove its commitment to the global concern that women's health has become, Mexico has undertaken a major reform of its public health system through Seguro Popular (People's Health Insurance). Since 2004, Seguro Popular aims to reduce families' out-of-pocket health-related costs and provides free health care services to those without health insurance (see Chapter 5). In a country with a long history of medical pluralism — the coexistence of multiple healing systems — Seguro Popular stems from the Western model of healthcare, ignoring the country's historical multiplicity of health systems (Parra 1989). In regions like Chiapas, located at the crossroads of commercial, touristic and migratory routes, several medical models coexist and ideas about health circulate at local, regional and global scales. People living in metropolitan areas mix and match several medical systems for their diagnoses and treatment (Ayora Diaz 2002) including when it comes to reproductive health (Ramírez Pérez forthcoming; Sánchez-Pérez et al. 1998). As in Guatemala, recent public health reforms, combined with the rising number of NGOs working in the field of health have reconfigured the definition of medical pluralism; now patients not only choose between various health systems (Menéndez 2003): for the same health problem, they have several biomedical practitioners to select from (Chary and Rohloff 2015).

Policies specifically directed towards women made their way into Mexican society during the 1970s. The International Conference on Primary Health Care (Alma Alta, 1978)
which targeted "health for all, by 2000" recognized the value of all medicines, including indigenous medical knowledge. This conference focused on health in general, and women's reproduction was not a specific concern. In fact, during the first half of the 20th century, population growth was not considered a problem; on the contrary, pronatalist policies encouraged it (Freyermuth Enciso 2003:45; Parra 1989). However, following the oil crisis of the 1970s, national reproduction became an economic issue. In particular, the control of poor people's reproduction fell under national scrutiny. Such changes coincided with international concerns about overpopulation and women's rights, framing modern nations as those where women have fewer children. In Mexico, like in other modernizing countries, poor women became the target of programs aiming to control their reproductive behaviors and model them into modern subjects (Gálvez 2011; Ram and Jolly 1998; Smith-Oka 2013c; Van Hollen 2003). Still today, "women who have more than three children are seen as overtly fertile and marked as problematic, while those who follow the population policies and have fewer children are hailed as paragons of modernity" (Smith-Oka 2013c:103). As a consequence of repetitive political and media discourses, Mexican men and women interiorize the morality of such policies and worry that they are "so many" (Braff 2013). In this context, family planning becomes a tool for reproductive governance (Morgan and Roberts 2012).

In contemporary Mexico, family planning is still a central concern as government programs focus on poor, indigenous women's reproduction — a topic I discuss at length in Chapters 4 and 6. In Chiapas, indigenous peoples' health became the government's hobby horse after the Zapatista uprising; over 55 million pesos (about US$7 million at the time) were transferred from the federal to the state level between 1995 and 1997 (Freyermuth Enciso 2003:349). The message conveyed by the Zapatistas underscored the structural violence in
indigenous peoples' lives and framed their demands in terms of human rights. In particular, Zapatista women's Revolutionary Law received international attention, echoing international discourse about women's health and rights. Non Governmental Organizations from all over the world gathered in Chiapas, some collaborating with local NGOs and feminist groups defending indigenous peoples' rights. Maternal mortality, the issue local activists had been trying to put on the international agenda for over a decade, finally received attention (Freyermuth Enciso and Manca 2002:5) — even though family planning never ceased to be a priority.

The same year as the Zapatista uprising, the International Conference on Population and Development in Cairo in 1994 framed for the first time women's reproductive health as a human right. The following year, the Fourth World Conference on Women in Beijing implemented the Gender and Development approach, which tied economic empowerment to women's reproductive choices. The logic behind the Gender and Development approach is that women can only be empowered if they participate in the public sphere, which is intimately connected to their reproductive behaviors. Policies created under the Gender and Development approach overlook the fact that choices are "inseparable from the economic and physical hardships [women] endure under global conditions" (Ginsburg and Rapp 1995:14). The emphasis on individual choice does not necessarily lead to improving women's care or diminishing maternal mortality rates, which are never "entirely matters of private, individual, and moral concerns" (Pinto 2008:221). Even in a context of a socialist state providing free childcare like Cuba, women struggled to balance work and family life (Andaya 2014). Launched in 1987, the Safe Motherhood Initiative (joined

\[\text{Galtung (1969) identifies structural violence as violence that cannot be traced directly to an actor or institution. Structural violence is intimately linked to social injustice, which was at the heart of the Zapatista demands.}

\[\text{3 For example, the third article reads: “Women have the right to decide on the number of children they will have and care for” (Speed, Hernández Castillo, and Stephen 2006).}]}\]
by Mexico in 1993) relies on a rhetoric of modernity to encourage women to give birth in hospitals, and to push the TBAs to transfer their patients from home to clinics (Berry 2010). Following the Safe Motherhood Initiative, and the funding the program channeled, maternal mortality and maternal and child health became major concerns in every developing country (Berer and Sundari Ravindran 2000).

Under the New World Order, women are perceived as rational individuals who can make decisions over their bodies. This notion of choice does not take into account the multiple networks in which women are entangled — familial, communal, and religious — and which influence their decisions. In the ever-evolving market of medical care, not all choices are equal, and "traditions of the past come to be seen as constraints on the individual's freedom to make rational choices from an ever-expanding field of options" (Georges 2008:158). Under structural adjustment programs, choice and consumption are intertwined as public health policies generate "citizens who have the 'right to choose' (that is, to consume) privatized medical services" (Morgan and Roberts 2012:249). The right to access healthcare becomes the right to choose between services. The measuring unit for a good or bad choice is not the quality of care provided but the logics of the choice made by what Morgan and Roberts call "rational citizens." These citizens are "those that embody and reproduce state-supported priorities in their values, conduct, and comportment" (2012:244). In Mexico, Seguro Popular has implemented free hospital birth for all women, with the goal of diminishing maternal deaths, for which indigenous midwives (the "Traditional Birth Attendants") are overtly blamed (Mills and Davis-Floyd 2009; Smith-Oka 2013a). Women are expected to act as rational citizens and make the choice of birthing with an SBA rather than a TBA. When their actions don't follow international guidelines, and they decide to give birth at home, women's behaviors are explained by factors such as gender
dynamics or poverty, equating their choice as making no choice at all (Berry 2010; Pinto 2008:228).

In this dissertation, I argue that the Mexican state's fraught relationship with indigenous peoples is captured in its behavior towards indigenous midwives. This is particularly salient in Chiapas, one of the states with the highest portion of indigenous population and that has come to stand for — along with other indigenous states like Oaxaca and Guerrero — the past that needs to be modernized. Historical paternalistic relations between the Mexican state and indigenous peoples has pushed them towards the margins of the system, portraying them as second-class citizens who need to be guided into making the right choice (Joseph and Nugent 1994; Das and Poole 2004). Up until the Zapatista uprising, indigenous people were invisible to mestizos, only portrayed in celebrations of the nation's indigenous past (Brown 2003; Nash 2001a). In Highlands Chiapas, in the city of San Cristóbal de las Casas where I conducted fieldwork, until the late 1940s indigenous peoples had to get off the sidewalk when their path crossed that of a non-indigenous person. Decades later, some Coletos (historically powerful mestizo families from San Cristóbal) are openly racist towards indigenous peoples, blaming them for being dirty, backwards, and having too many children. Like in the 1960s, kaxlanes (Tseltal and Tsotsil word to refer to non-indigenous people) address Mayans with the familiar tú, while indigenous men and women who speak Castilla (Spanish) will respond with the polite usted (Guiteras Holmes 1961:23)⁴. Institutionalized racism and the criminalization of poverty impedes indigenous peoples from exerting many rights, including access to justice (Hernández 2013; Speed 2014)⁵.

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⁴ The tú/usted reflects the same symmetry of power as in the French tu/vous (Scott 1990:31).
⁵ There are many examples of blatant racism towards indigenous people in Chiapas: "Even after the triumph of the revolution, when slavery was abolished, in Chiapas Indians were still bought, sold, and offered during land selling" (Page Pliego 2011:41).
"Feminist theory, (...) is always explicitly tied to political struggle — the struggle for gender justice" (Speed, Hernández Castillo, and Stephen 2006:48). This struggle includes shedding light on the social mechanisms positioning certain knowledge as objective, thus more legitimate than others, that are situated (Haraway 1988). When it comes to medical knowledge, indigenous midwives' expertise is dismissed, and relegated to "cultural practices" or "traditions," while biomedicine is "modern" and "objective" (similar to the emphasis on cultural explanations of cholera in Venezuela (Briggs and Mantini-Briggs 2004)). The differentiation of the value attached to knowledge is reinforced through the government trainings, which position midwives on the receiving end, while medical personnel are on the giving end. The modes of production of their socially and structurally situated medical knowledge are held against them, in the face of the Hegemonic Medical Model (*Modelo Médico Hegemónico*, MMH (Menéndez 1994; Menéndez 2003)). Analyzing this power relationship through a Foucauldian lens, we will see how despite its historical construction, the naturalness of the MMH makes it invisible and thus difficult to contest (Foucault 2004).

In Latin America, the exclusion of indigenous midwives from skilled personnel is permeated by the historical and structural exclusion of indigenous peoples from governing bodies. At best, indigenous midwives' knowledge is admired as a relic of the past, and perceived as a "culture" rather than "real knowledge" (Smith-Oka 2013c:183; Briggs and Mantini-Briggs 2004). In Mexico, the control over midwives' practices served as one of the many tools of oppression during the Colonial period (Zolla and Carrillo 1998). As in other countries, midwives were accused of being witches and prohibited from practicing (Ehrenreich and English 2010), and midwifery slowly but consistently moved from a women's profession to a male domain. In 1833, midwifery was institutionalized within the Mexican National School of Medicine but very
few midwives met the requirements to pass the examination (which included presenting a certificate of purity of blood, de facto excluding indigenous people) (Carrillo 1999:168). Midwives' scope of practice steadily declined; in 2009, the number of births attended by physicians was of 93 percent (Walker et al. 2013).

In the early 2000s, to encourage indigenous people to go to hospitals, the Mexican government launched three "intercultural hospitals" in the country, in the states of Nayarit, Puebla and Chiapas. In Chapter 5, I describe my fieldwork in Chiapas' Intercultural Hospital and discuss the moderate success of this initiative aiming to integrate traditional and modern medicines, which, in practice comes down to translating the name of the different rooms into two Mayan languages, Tsotsil and Tseltal. The push for intercultural policies are part of what anthropologists have coined neoliberal multiculturalism, a process through which states promote indigenous peoples' cultural rights while maintaining socioeconomic inequalities (Hale 2002; Postero 2007). In addition to the construction of Intercultural Hospitals, in Mexico neoliberal multiculturalism is illustrated through government training programs for midwives (capacitación). In an effort to curb maternal mortality rates, the Mexican government has designed trainings for indigenous midwives, which they must attend if they want to be able to register newborns (a conditionality I further discuss in Chapter 4). The trained midwife (partera capacitada), whose indigeneity and traditional knowledge are valued while her practices are strictly monitored, becomes the only form of authorized midwife. The figure of the partera capacitada is then comparable to the Indio permitido, the "authorized Indian" constructed and constrained by neoliberal multiculturalism (Hale 2004). Navigating these constraints, indigenous actors still exert agency, and perform indigeneity when interacting with the state, journalists and tourists (Burrell 2013; Little 2000).
Finally, neoliberal policies also take the shape of cash-conditional transfer programs, which promote the right to health as an individual reward rather than a state prerogative (Freyermuth and Sesia 2009; Harvey 2005), which I detail in Chapter 3. Launched in 1997, the Mexican program changed names several times (Murray de López 2015), the latest in 2015 when it went from being called Oportunidades (Opportunities) to Prospera (Prosper). Funded through the World Bank, Oportunidades has been praised for its success and duplicated in fifty-two countries around the world⁶, and is now part of the political landscape in countries like Brazil (Rasella et al. 2013) and Niger (Olivier de Sardan et al. 2014). In Mexico, the maternal branch of Prospera focuses on the "co-responsibility" of the beneficiaries. In order to keep receiving their stipends, pregnant women have to attend monthly talks at their local clinic (often focused on family planning) and comply with their prenatal appointments (Freyermuth 2010; Smith-Oka 2013c). Born out of the 1990s' vision tying development to economic empowerment, the program's individualistic focus has had dramatic consequences on social networks in villages (Olivera 2012). In addition, the program reinforces gender stereotypes by tying families' income to women's compliance with a set of rules aiming to craft them as good mothers (Molyneux 2006; Smith-Oka 2013c; Vizcarra Bordi 2002). Women's compliance with the program has an impact on the income of poor families, in regions where the subsidies represent their main cash income. On their end, indigenous midwives are doubly affected by this program: as mothers, they are often enrolled in Prospera, and need to participate in events in which their knowledge is depreciated. As midwives, the care they provide to women is not considered in the program requisites. Mothers often seek midwives in addition to their mandatory clinic appointments, and the midwife's discourse about pregnancy then competes with the doctors'.

Despite such policies aiming to increase the medicalization of birth, in indigenous communities of Chiapas, midwives still attend 70 per cent of births (Gómez Mena 2012). Government programs targeting mothers and trainings aimed at midwives influence the type of care women have access to, indirectly differentiating their reproductive capabilities. However, even with the dismissal of their knowledge, women still exert agency in their reproductive decisions. Throughout this dissertation, I draw attention to the mechanisms that constrain indigenous women's reproductive choices, but also analyze how these women navigate and resist them. Resistance happens through actions that are not overtly political, embodying what Scott has coined infrapolitics (1990). Infrapolitics constitute the "weapons of the weak" (Scott 1987): forms of resistance that are concealed from those in power. In the case of Mayan midwives, publicly confronting government policies or doctors' authoritative knowledge can be dangerous. Over the next chapters, I present strategies that fall under infrapolitics, such as non-compliance with medical instructions (Chapter 6); and other more public forms of resistance, like community organizing (Chapter 7).

Efforts to draw women in to hospitals, whether by building Intercultural Hospitals, training midwives, or through cash-conditional transfer programs like Prospera, reinforce the marginalization of the very population they seek to help, and alter the relationship of trust between women and their midwives, or confianza. "The women, they are looking for confianza" is a sentence that I have heard many times during fieldwork. Indeed, the women feel they can trust their local midwives, who will provide culturally appropriate medical care. Another aspect of confianza lies in the shared belief women and midwives have in the body's ability to give birth, one that is at the heart of the midwifery model of care (Rothman 1979). In Highlands Chiapas, the confianza between a woman and her partera is an important element preventing
complications (Freyermuth Enciso 2006). The efficiency, both symbolic (Lévi-Strauss 1949) and material, emerges from the confianza between two people sharing the same social and linguistic background. On the other end of the scale of trust, the expression "no nos hacen caso (they don't take us into account)" has come to represent the distrust in governmental institutions, whether in the medical staff (Chapter 5 and 6) or in government official and their promises (Chapter 7). Throughout this research, I explore the many layers of confianza (and this desconfianza), as well as the mechanisms that might impede its proper functioning. I use confianza as a lens to analyze the relations between women, and the different ways in which the medicalization of birth affects them. Theorizing confianza allows going beyond the individual trust between practitioners and patient and framing it as a social contract, essential to the reproduction of society. The situations I describe in this dissertation illustrate the changes in and challenges to confianza, due to internal and external factors. In particular, in Chapter 3, I analyze how the monetarization of birth impacts confianza. In Chapter 4, I explore how government trainings push some parteras out of the trust range of women in their communities. Certification becomes an additional requirement for parteras to gain women's confianza. In other cases, confianza also serves as a response to the marginalization of indigenous women. This resistance is represented through the Organization of Indigenous Doctors' (OMIECH) struggle, which I examine in Chapters 4 and 7. By valorizing indigenous medical knowledge, OMIECH workshops aim at consolidating confianza in communities, a factor they believe is important in preventing maternal deaths.

Finally, like any ethnographic encounter, this dissertation emerges from the confianza between my informants and myself. In a context of highly deceptive relations between mestizos and indigenous, and amid cases of biopiracy (Chapter 7), my informants trust me to tell them the truth about my research project. And in return, I trusted that they would not lie, and share with
me more than the public transcript. Confianza also has ethical implications for the researcher that I further discuss in the Methods section (Chapter 2).

**An Intersectional Approach to Health and Human Rights**

In Latin America, ethnicity and gender are key factors to analyzing indigenous women's relations to the state, and their experiences of (in)justice (Sieder and Sierra 2010). In Mexico, the violation of women's bodies as a tool of domination goes back to the colonial period, during which landlords would rape all virgin women working in their plantation (Marcos 1992:165). In this dissertation, I argue that because of its status as a historically marginalized state, later propelled to the center of the international movement for indigenous rights, Chiapas is a place where the politics of birth can be best observed. As *campesinas* (peasants), indigenous women are impacted more harshly by globalization and economic reforms (Nash 2001b). The triple discrimination of ethnicity, poverty and gender impact the fate of indigenous midwives and the women they care for. In turn, women build on these gendered, ethnic and socioeconomic experiences to craft their own feminist demands (Marcos and Waller 2008; Masson 2008). Through this research, I take an intersectional approach to examine the transforming field of indigenous midwives' practices in Chiapas and how some midwives build on international discourses of human rights as a response to such changes. Using an intersectional lens brings forward the multiple factors of oppression women face and how they reinforce one another (Collins 1986; Crenshaw 1991), making indigenous women more vulnerable to gender-based violence than any other women in society (Speed 2014:80). When reflecting on the articulation between these different factors of oppression, which produce violence, social scientists have used the metaphor of a continuum (Schepic-Hughes and Bourgois 2003a), with domestic violence on one end and state violence on the other. However, Speed suggests that these relationship are
better understood as a "mosaic" of individual trajectories that account for women's experiences beyond their common gender, and which, articulated together, tell a collective story (Speed 2014). In a context of alarming levels of feminicides (Falquet 2014; SIPAZ 2014), the murder of women because of their gender and ethnicity become additional factors of violence in indigenous women's lives. In the various settings in which I conducted research, machismo and paternalism were always present, whether in the government programs for women (Chapter 3); trainings for midwives (Chapter 4); the relationship between midwives and doctors (Chapter 5) or women and doctors (Chapter 6) and; inside NGOs (Chapter 7).

Using an intersectional approach to health means acknowledging that analyzing indigenous women's reproductive trajectories needs to take into account more than their gender. In Mexico, historical inequalities put indigenous women more at risk of dying in childbirth (Chopel 2014; Freyermuth Enciso and Argüello Avendaño 2010). In Chiapas, indigenous women represent less than a third of the female population (Gobierno del Estado de Chiapas 2014) but almost half of the overall maternal deaths (OMM 2013). Depending on women's socioeconomic status and ethnicity, they do not have the same power to make decisions over their reproductive health — what Colen coined "stratified reproduction" (Colen 1995; Ginsburg and Rapp 1995b). In her work with West Indian care providers in New York City, Colen highlights how immigrant women give up their own reproductive life, often leaving children in the hands of family networks in their home countries, to nurture the children of wealthier women in the United States (1995). Stratified reproduction is rooted in social inequalities and often mirrors social stratification. The desirability of one's reproduction is tied to idea(is) of citizenship, making reproductive futures easier for some groups and more difficult for others, and is intimately tied to hierarchies of nationality, class, and ethnicity. Structural factors such as poverty and
marginalization also count as risk factors in health (Farmer 2005; Rylko-Bauer, Whiteford, and Farmer 2009). As a tool of analysis, stratified reproduction is useful to analyze structural and global factors constraining poor women's reproductive choices (Browner and Sargent 2011). In Chiapas, indigenous midwives' social positioning affects how their knowledge is perceived, and reinforces stratified reproduction by discouraging mothers to seek their services. As a response to these structural factors, indigenous peoples and NGOs have appealed to human rights to highlight midwives' cultural right to practice; while on its end the Mexican state has presented access to biomedical care and pregnancy as a human right (Gálvez 2011:77).

In Mesoamerica, "the concept of human rights at the end of the twentieth century is intimately bound up with questions of indigenous rights and indigenous rights movements" (Pitarch, Speed, and Leyva Solano 2008:7). In his analysis of land rights and the Zapatista uprising, Collier traces the emergence of the human rights movement in Mexico to the 1980s. This movement, drawing on the spaces opened by neoliberal reforms following the oil crisis, paralleled the shift from class-based identity (peasants) to ethnic identity (indigenous). The Zapatista uprising completes the shift from individual rights to collective ones, "[moving] away from popular and class-based demands and towards those based on identity and right" (2005:180). In both Chiapas and Guatemala, human rights discourses emerge in a context of war and state repression. As anthropologists and human rights defenders have argued, the same global forces which allow the expansion of neoliberalism and consolidate the New World Order also pave the way for the circulation of human rights discourses (Goodale and Merry 2007).

"Poverty, exacerbated by this dominant system, triggers collective awareness about the globalization of human rights. While above, power is globalized, down below human rights are globalized and social movements are constructed" Ruiz García (2014[2004])
Bishop Ruiz García, an emblematic religious figure in Chiapas, was also one of the most prominent defenders of human rights and Liberation theology. Liberation theology and its central tenet, the "preferential option for the poor" (Binford 2004; Engler 2000) is "based on a strong valorization of indigenous culture and, notably, on the understanding that human beings of all cultures are equal before God" (Pitarch, Speed, and Leyva Solano 2008:210). Liberation theology emphasizes the structural factors that lead to poverty, and in Chiapas has provided a space for the exercise of democracy, for indigenous women in particular (Freyermuth Enciso 2003:34; Masson 2008). Using the rhetoric that rights are given by God, the preferential option for the poor integrates human rights into poor people's daily struggle (Kovic 2005; López Intzín 2011). Since rights are given by God, then all human beings should enjoy the same rights. Its attention to daily living conditions echoes poor peasants' concerns: "How are we supposed to live happy (in Heaven) if we live a sad and poor life or one filled with injustice here?" wonders Me' tik Rosa, a 77 year old Tseltal woman (López Intzin 2011:13).

The process of appropriation of global discourses at local levels is what Levitt and Merry coined "vernacularization" (2009). The vernacularization of human rights constitutes powerful tools to contest marginalization. When indigenous peoples adopt the vocabulary of human rights, they challenge the association between rights and modernity on one side, and pre-modern and indigenous on the other. They also call out to the hypocrisy of the Mexican government that, despite signing international treaties protecting indigenous peoples' rights, does not respect them in practice. Indigenous organizations resort to human rights to criticize this double-standard and

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7 Marginalized by the Catholic Church, Liberation Theology was acknowledged by Pope Francis during his visit to Chiapas, on February 15, 2016 (Mandujano 2016).
8 Speed lists that Mexico has ratified most of international human rights agreements such as the “Universal Declaration of Human Rights, the International Covenant on Economic, Social, and Cultural Rights, the International Covenant on Civil and Political Rights, and the Interamerican Convention on Human Rights” (Speed 2002:210), as well as the Indigenous and Tribal Convention 169 (ILO 169).
the "absent presence" of the state (Goldstein 2012:57). In Chiapas, the absent presence of the Mexican state is illustrated through the militarization of the region since the Zapatista uprising and the requirements of cash-transfer programs on one side (Barmeyer 2009; Collier 2005; Freyermuth 2010), and the lack of infrastructures and access to justice on the other (GIRE 2015a; Sieder and Sierra 2010). Recently, Mexican NGOs have raised their concern about poor women's lack of access to reproductive justice and the violation of women's reproductive rights happening during childbirth (GIRE 2015a).

At the heart of reproductive justice lays the belief that rights are not only written in the law but mostly exist in their everyday practice. Limited by definitions of human rights that are perceived as ephemeral, "here today, gone tomorrow; available for some and not for others, workable is some spaces and not in others" (Burrell 2010:95), indigenous communities in Chiapas, as in Guatemala, root rights in their everyday practice rather than in texts (Speed and Collier 2000). Like the preferential option for the poor, OMIECH and other indigenous organizations contrast the theoretical framing of human rights to their everyday exercise. Many indigenous organizations, including the Zapatistas, promote a "rights in practice" approach, in which one "doesn't need permission from the government" to exert their rights (Speed 2005:30). This approach to human rights is a response to the government's use of human rights discourse, which in Mexico is used to subordinate and circumscribe indigenous peoples' actions (Speed 2005; Speed and Collier 2000).

Rights in practice can be seen as one form of vernacularization, but other forms do not necessarily include an explicit reference to rights, which are transformed in the "labyrinth of translation" (Pitarch 2008). In Chapter 3, I describe how indigenous midwives put forward the notion of respect (and the lack of it) to talk about their relations with doctors and the changes
government trainings and the neoliberal regime have caused in their lives. In Spanish, the Tseltal and Tsotsil concept *ich'el ta muk'* is used in official documents as a translation for rights (*derechos*), and in the Universal Declaration of Human Rights. In an attempt at diffusing knowledge about key international documents, and raising awareness about indigenous peoples' rights in their own language, international organizations and the Mexican state rely on *ich'el ta muk'* without trying to incorporate the essence of *ich'el ta muk'* in the spirit of Western law. Already a polysemous concept, *ich'el ta muk'* takes on a new meaning when associated with *derechos*. But in the translation of rights as *ich'el ta muk'* something is lost, and it is the notion of respect, that any state should have towards its citizens (mirroring the *ich'el ta muk'* that community leaders have towards community members) (López Intzín, personal communication). The phonetic translation of *derechos* as *rerecho* used in the Universal Declaration of Human Rights further indicates the separation between *ich'el ta muk'* and *derechos* (United Nations Information Centre, Mexico 1998). When moving away from their communities, young men and women learn about their rights and forget *ich'el ta muk'*, as a former community leader laments:

"[Young people who go to school], they don't know how to receive others with greatness, because they say that now they have rights. (...) They talk about their rights and they do about everything except for that, the *ich'el ta muk'*." (López Intzin 2013)

Throughout the dissertation, the many approaches to health, reproduction, indigenous midwifery and human rights that the state, NGOs and indigenous citizens promote or resist reflect the complexity and the significance of such topics in contemporary Mexico. I discuss their interrelations and contradictions over the next seven chapters.

**Organization of the Dissertation**

At the heart of this work lays the tension between the marginalization of indigenous midwives in Chiapas, and the pivotal role such sidinglining plays in illustrating the fraught
relationship between the Mexican state and indigenous peoples. In the next Chapter, I discuss why it is important to put Chiapas at the heart of analysis, and introduce my research site(s). Some of the methods I have used, such as engaged research, stem from this will to center Chiapas and historically marginalized actors.

In Chapter 3, I take a closer look at how global economic policies under the New World Order impact indigenous women and midwives. One such policy is the cash-conditional transfer program Prospera. When analyzing the impact of Prospera on indigenous midwives' practices, I highlight how the program makes the marginalization of poor women one of its central elements. Another impact of the program includes a shift in confianza between women and midwives, which also shakes the roots of ich'e'l ta muk', the respect, in favor of a rights discourse.

Chapter 4 focuses on the different training programs for parteras, the unintended consequences of international politics, and the not so unexpected results of local politics. Under the guise of diminishing maternal deaths, these trainings reinforce the doctor/midwife hierarchy and contribute to the stratification of midwifery, creating a separation between the good midwife who attends trainings and refers women to hospitals, and the bad one who does not. Like other government programs, midwifery trainings erode the confianza women have in their midwives, also affecting the trust midwives have in their own practices. While they frame indigenous midwives as their main concern, in practice trainings further marginalize these women, and once again illustrate the tension between the center and the margins that is inherent to Chiapas.

In San Cristóbal, a group of trained midwives (parteras capacitadas) were invited to participate in a government-sponsored Intercultural Hospital. In Chapter 5, I analyze the relationship between these midwives and other staff members of this entity to illuminate how national policies claiming to integrate midwives rely on the same logic of neoliberal
multiculturalism and ultimately exclude them. In this chapter, I also contextualize the changes happening in the Mexican public health sector and how the understaffing and lack of funding of hospitals reinforce the lack of confianza indigenous peoples have in medical institutions.

The trainings of midwives and their pseudo-integration into the medical health system are two faces of a same policy directed towards TBAs. What consequences do they have on pregnant and birthing women? The combination of the medicalization of reproductive care, through structural adjustment programs, and of trainings insisting on transferring to hospitals, contribute to overcrowding public health facilities. Chapter 6 highlights how hospitals then become a site where women's reproductive rights are routinely violated. I argue that obstetric violence is symptomatic of the structural violence in the country and feeds into to the mosaic of violence indigenous women experience throughout their lives.

Women and midwives elaborate several strategies to avoid and respond to this violence. Following the case of one organization, OMIECH, Chapter 7 dives into the complexity of defending human rights when confianza in the state is missing, and the trust in one's own organization is weakening. The chapter also explores the financial difficulties and internal struggles OMIECH faces, and in particular the challenge of being funded while publicly criticizing local, national and global policies.

The Conclusion provides the opportunity to discuss a few initiatives aiming at improving indigenous women's treatment in medical institutions. I also update the reader on the changes that have occurred in the various research sites since the end of my fieldwork, and discuss the uncertain future of parteras.
Chapter 2. Chiapas at the Center.\(^9\)

Research Settings & Methodology

Reflecting on the epidemic of violence plaguing Mexico, Bishop Vera, quoted in the opening of this dissertation, adds, "and this [the violence] happens everywhere. All of Mexico is Chiapas: it is not true that this only happens in Chiapas. But what is for sure is that then we knew who the enemy was, whereas now we do not" (Koman Illel 2015). In many ways, the events that have happened and are unfolding in Chiapas inform what is happening in the rest of the country. The Zapatista movement attracted international support, while the human trafficking, especially of migrants, has also become a concern in other states. I argue that putting Chiapas "at the center" contributes to decentering the hierarchical relationship between North and South, and makes the region's connections to national issues and international transformations even more salient. To do so, I build on a growing body of literature that puts Chiapas at the center of analysis, rather than portraying it as a marginal state (Ayora Diaz 2002; Collier 2005; Nash 2001a; Speed 2002; Speed, Hernández Castillo, and Stephen 2006). In particular, I follow anthropologist Nash's call to social scientists to cultivate their "peripheral vision:" she argues that putting Chiapas in perspective reveals both its uniqueness and its intimate connections to globalized reforms (Nash 2001a). In my work, I explore the tension created when putting Chiapas at the center, due to the historical treatment of the region by the Mexican state as a marginal place.

Chiapas often makes the news for its high rates of poverty and maternal mortality yet the same characteristics that mark it as a marginal place are also presented as central to its identity.

\(^9\) I thank Alyshia Gálvez for a heartfelt conversation about the particular place that is Chiapas, and why it is important to put it back at the center of my analysis. My theoretical framing stems from our discussion.
Recently, during the visit of Pope Francis to the region, which centered the cameras of the world on Chiapas twenty years after the Zapatista uprising, the constant marginalization indigenous peoples have been facing since the Conquest dominated the conversation (Mandujano 2016). Similarly, development campaigns led by international institutions or the Mexican state rely on similar statistics to launch crusades aiming at fighting hunger, educating children and medicalizing health. Centering on the same, recurrent, topics inevitably sidelines other issues such as human rights, traditional medicine and structural violence, which are then left for local NGOs to care for (Servicio Internacional para la Paz 2014). Despite their marginalization (or sometimes because of it), they claim public spaces and create unique processes in the country.

It is in this interstitial space created by the tension between centering and marginalizing that the processes I describe in this dissertation take place. My research presents fragments of lives of the many actors involved in reproductive health and rights in Chiapas; put together they have the potential to illuminate the fate of many more women in the region and in the country. In this chapter, I present my research sites: the city of San Cristóbal de las Casas mostly, but also the different places to which my research interests have led me. After situating Chiapas for the reader, I map out the different kinds of midwives I have met and the difficulties of classifying, raising the question "are we all midwives"? Finally, I detail my research methodology that stems from my commitment to put Chiapas at the center; this includes multi-sited ethnography and engaged and collaborative ethnography.

Location(s) of research

For the visitor traveling to San Cristóbal for the first time, the town emerges like a green hollow in the midst of a valley\textsuperscript{10}: a valley 2200 meters high, above the clouds, the morning

\begin{footnotesize}
\textsuperscript{10} To paraphrase Rimbaud (1998).
\end{footnotesize}
neblina (fog) vividly described by writer Rosario Castellanos (1960). Coming from the airport of Tuxtla Gutiérrez, the state's capital, the drive is relatively short (an hour and half) but one cannot escape the inevitable curves in this mountainous region (Figure 1). The Tuxtla-San Cristóbal curves, on a highway, retrospectively appear gentle to the anthropologist and her motion sickness. "But you... you have traveled the world. It is very strange for you to be sick. That the gringos may not used to this... but you, you have traveled a lot here" my colleague Micaela once told me while holding my hands on our way to a workshop in Simojovel. Ni modo\textsuperscript{11}, the dizziness disappears as San Cristóbal appears below the last curve.

"How cold are the mornings in Ciudad Real! The neblina covers it all" (Castellanos 1960). How many times I have thought of this as I closed the house on our vividly colored house surrounded by the morning fog. Founded in 1528, four years after the Conquest, by Diego de Mazariegos, Ciudad Real (Royal City), the historical capital, still enchants international tourists and government campaigns alike for its colorful house facades, paved streets and indigenous culture. In 2003, the Ministry of Tourism classified the historical capital, a rising touristic spot since the 1970s (Berghe 1994)\textsuperscript{12}, as one of the pueblos mágicos\textsuperscript{13} (magic towns) of the state (see Taylor (2012:188) for a discussion on the impact of being a pueblo mágico on a Mayan village). Much like Antigua in Guatemala, San Cristóbal's indigenous population has become part of its cultural heritage (Little 2008), and in the two cities, street vendors offer their merchandise – shawls, bracelets, blouses – to passersby. Like in Guatemala and in other indigenous regions of

\textsuperscript{11} Ni modo can translate as "oh well," implying that if we cannot do anything to change some aspects of our lives then we should accept these as they are.

\textsuperscript{12} The French traveler Désiré de Charnay travels to San Cristóbal during his Mexican travel of 1858-60, and remarks that there are no hotels in this town "in which the foreign traveller is just an exception" (Charnay 1987:278). Today, the traveler is the rule.

\textsuperscript{13} "A Pueblo Mágico is a locality which displays symbolic attributes, legends, history, transcendent events, everyday life, in sum magic which emanates from each and every one of its sociocultural manifestations, and that marks it nowadays as a great opportunity for touristic development." http://www.sectur.gob.mx/pueblos-magicos/ Accessed March 2, 2016.
Mexico, the local government takes great pride in the colonial past and developing ethnic tourism (van Den Berghe 1994), but cautiously controls the performance of its present indigenous population.

While the town changed names several times since its foundation, moving back and forth between various combinations of Ciudad Real and San Cristóbal de las Casas, in Tzeltal and Tzotzil, it is called Jobel, after the name of the valley in which it is located. The current name refers to Fray Bartolomé de Las Casas, the Dominican friar who was only briefly Bishop of San

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14 I use the reformed orthography of Tzeltal and Tzotzil, which means I write "b" and not "v", "s" and not "z", "w" and not "v"; and do not use the standalone "h." For more information see (Polian 2013)
Cristóbal (1543-1545), and known for his compelling description of the exploitation of indigenous peoples by the Spaniards (Las Casas 1966). Today, one quarter of the population of the state is of indigenous descent (Maya and Zoque), and the proportion reaches 68 per cent in the Highlands region (Gobierno del Estado de Chiapas 2014). The two major ethnic groups are Tseltals and Tsotsils, making 37.9 and 33 per cent of the indigenous population of the state, respectively (INEGI 2015). The Popol Vuh, the book of origins of the Maya, describes how the Tsotsils (Zotztil) seized the fire from other Maya groups, and later separated into Tsotsils and Tseltals (Page Pliego 2011:31). This common Maya origin between Guatemalan and Chiapas can be seen today in several features, including in shared medical practices. However, the pan-Maya identity, which gained momentum in Guatemala in the post-war years, did not reach Chiapas, where local identities are still strong (Breton and Arnauld 1991; Page Pliego 2011).

In Chiapas, 76.8 percent of the population lives in poverty and extreme poverty, compared to the national 43 percent rate\(^{15}\) (Enciso L. 2014). In the Highlands, 65 percent of the municipios (municipalities) are classified with the highest rate of marginalization (Consejo Nacional de Población 2010:88). Ethnicity and poverty often conflate, and the indigenous population of the state is also the poorest (Nash 2001b; O'Donnell 2010). Out of the 18 municipios\(^{16}\) of the Highlands jurisdiction, San Cristóbal is the only one that is not considered with ‘high' or ‘very high' marginalization. In indigenous communities, Maya women and their families experience poverty-related illnesses such as malnutrition and infant and maternal mortality (O'Donnell 2010:18). In the last national census (2010), Chiapas had the highest fertility rate (3.07), while the national average was 2.39; women had experienced the loss of 9.4

\(^{15}\) Disparities are even stronger for extreme poverty: 38 per cent for Chiapas, 7.9 per cent at the national level.

\(^{16}\) The municipios define both the principal town and its zone of political influence. Page Pliego uses the municipio as the identity limit (Page Pliego 2011:14).
per cent of their children — almost one out of ten (INEGI 2010). The fertility rate is much higher in rural areas. During my fieldwork, half of the total of midwives I interviewed (22) had carried over 4 pregnancies or more. Among these, more than half (13) had given birth to over eight children (between eight and twenty) but not all had survived.

Despite a rich literature depicting indigenous life, early ethnographies of Chiapas barely mentioned maternal health. Pozas' ethnofiction, which describes the life trajectory of a Chamula man gives a vivid description of life in the Highlands from a male perspective (1962). The Harvard Chiapas Project, led by Vogt, beginning in 1957 and for the next 35 years (Vogt 1994), documented many aspects of the daily life of Tsotsil peasants (Bricker and Gossen 1989), including religious cargos (Cancian 1965; Vogt 1993), gossip and humor (Bricker 1973; Haviland 1977), and the economic structure of peasant society (Cancian 1972). In the wake of the Harvard Research Project, research in the early 1970s some monographs also included research on material culture, in particular weaving techniques (Guiteras Holmes 1961; Nash 1970; Vogt 1969), the ritual use of textiles (Breton and Becquelin-Monod 1989; Cancian 1965; Gossen 1974; Morris and Meza 1987; Turok 1976), and pottery-making (Nash 1970).

Most of these monograph do not focus on health, and none mention pregnancy and birth beyond daily life (Freyermuth Enciso 2003:265; Guiteras Holmes 1961:102). This reflects a broader trend in anthropology, where women and maternity were not studied, or only in passing, and when maternal death was not yet a concern of public policy. The work of female anthropologists in the 1980s and 1990s gave ethnology a less androcentric tone (Freyermuth Enciso 2003:16; Nash and Safa 1985). In the 1990s and early 2000s, feminist research focusing on gender relations in indigenous communities highlights both the marginalization of indigenous
and the changes induced by tourism and globalization on the other — notably through weaving cooperatives (Eber 1995; Eber and Kovic 2003; Eber and Rosenbaum 1993; Rosenbaum 1993).

My research draws on these previous detailed ethnographies of Mayan women's lives and struggles, through narratives of their gendered experiences of care in a rapidly transforming environment. To access these narratives I have interviewed them and their midwives. The continuous governmental trainings midwives have undergone for decades in Chiapas made me fear that I would not encounter any midwife to talk to anymore (Araya Morales 2008; Freyermuth, Cadena, and Icó 1989). However, when I arrived in Chiapas, people I discussed my research with almost always exclaimed "You want me to introduce you to a midwife? My aunt/mother/grandmother/neighbor attends births!" One interview after another, I realized the complexity of the field I had dived into. In the next section, I discuss the terminology I use in this dissertation.

"We Are All Midwives"? A tentative classification of parteras

In a 2006 op-ed, Díaz-Ortiz, a US Certified Professional Midwife, criticizes the differentiation that international organizations like the WHO or the International Confederation of Midwives (ICM) distinguish between traditional midwives and skilled midwives, the former relegated to being assistants of the latter (2006). She argues for a more inclusive definition, one that would recognize traditional midwives as "true midwives." The anthropological and medical literature refers to Mexican midwives as parteras, grouping under a single word women living under very different conditions. Partera can be used to refer to those women who are only sought at the moment of birth (Fernández Guerrero 2002). Alternatively it also refers to women

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17 While I was conducting fieldwork I participated in a seminar bringing together researchers working in the field of midwifery. I would like to thank the PROIMMSE for their space, and the seminar participants for their contributions. This section builds on discussions developed during our sessions.
who provide prenatal care and attend births in villages (Freyermuth Enciso 2003) and in cities (Ramírez Pérez forthcoming). In the public discourse, *parteras'* different backgrounds are homogenized through their socioeconomic conditions: *parteras* are associated with poverty and ancient times, while doctors and nurses working in state clinics and hospitals embody a desirable modernity (Gálvez 2011; Howes-Mischel 2012).

With these discussions in mind, I have elaborated a classification of the midwives that are the focus of this study (Figure 2). In the multiplicity of ethnic, social and cultural backgrounds, the different contexts and techniques of practice, I chose to focus on their learning process as the determining factor. In most cases, midwives' possibilities of learning are not dictated by international recommendations but by the material conditions under which these women and their families live. In order to keep the categories to a manageable size, I had to favor some characteristics (urban or rural environment, ethnicity, forms of payment) over others (religion, gender18).

i. Tam-alal and jtamol

I use *tam-alal*19 (plural *tam-alaletik*) when referring to indigenous midwives in Tseltal villages. A similar word exists in Tsotsil, *jtamol* (Freyermuth Enciso 2003:211; Page Pliego 2011:325)20. These rural midwives acquire their knowledge through various processes, including dreams and personal birth experience. In WHO language, they would be categorized as "Traditional Birth Attendants." Midwifery is not these women's main source of income, and it is

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18 Gender plays an important part, but it impacts the relation with the government and doctors more than the practice per se. Out of a total of 42 *parteras* I have interviewed, only 4 were men.
19 A Tseltal *partero* distinguished between *yil-alal* (the person who sees the baby) and *tam-alal* (the person who catches the baby). According to him, the *tam-alal* only attends the birth while the *yil-alal* cares during pregnancy and birth. He was the only person to bring up this distinction, and defines himself as *yil alal.*
20 Guiteras Holmes uses an orthography closer to Tseltal, *tam-olol* "she who picks up the infant" (1961:104).
practiced as community service; some tam-alaletik are community leaders and fulfill religious duties. I will discuss the changes occurring in these women's lives in Chapter 3.

My collaborators at the Organization of Indigenous Doctors of Chiapas (OMIECH) translate *tam-alal* and *jtamol* as *parteras indígenas tradicionales* in Spanish — "traditional indigenous midwives." This both refers to women's' ethnicity (indigenous), and their way of learning (traditional), two aspects I have tried to keep with the choice of *tam-alal*.21 The use of the word traditional relates concurrently to the midwives' empirical training, to their spiritual calling and to their self-description. It does not mean that these women do not integrate some biomedical elements in their practices, as pointed out by other scholars working in Mesoamerica (Chary and Rohloff 2015; Cosmimksy 2001a; Davis-Floyd 2005).

The Mexican Ministry of Health (*Secretaría de Salud, SSA*) differentiates between the women who are recognized *tam-alaletik* in their communities (and that the government calls *parteras tradicionales*) and *parteras eventuales*, accidental midwives. Accidental midwives are the people who happen to be present at a birth when no one else is, and who provide assistance to the mother (usually it is the husband, family member, neighbor). These occasional midwives are not the targets of government trainings, while *tam-alaletik* are, as I discuss in Chapter 4. Some of the *tam-alaletik* I have interviewed started as *parteras eventuales*. OMIECH does not specifically mention these occasional midwives, but during interviews colleagues and I have discussed the case of *parteras familiales*, family midwives, who only care for women in their immediate family and do not publicly come out as *tam-alaletik*.

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21 To avoid confusion for the reader, I will use *jtamol* when referring to a specific Tsotsil midwife but use *tam-alal* as the generic for both *tam-alal* and *jtamol*. 

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As I discuss in this dissertation, some of the most famous tam-alal started as parteras eventuales, and continued learning through numerous births (theirs and others'). Other tam-alaletik initially received their knowledge through their dreams. Both of these paths rely on empirical knowledge and oral transmission from an older midwife. In urban settings, the term "empirical midwife" can refer to mestizas who have learned through their embodied knowledge (through their own birth experience), or to indigenous midwives who do not see their work as community service but as their main source of income. In WHO categorization, these women, who do not have a formal education in midwifery (except for a handful who are also nurses) are, like tam-alaletik, TBAs that need to be trained.

A particular category of empirical midwives includes midwives of higher social status (foreigners or mestizas) who have had formal schooling (not usually in midwifery), and learned

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22 This categorization changes across regions. In the Northern state of Chihuahua, the government trained parteras are called parteras empíricas (Chopel 2014).
midwifery through apprenticeship. These midwives' path is similar to that of homebirth midwives (or Direct-Entry Midwives) in Upstate New York and Canada (Davis-Floyd and Johnson 2006a; MacDonald 2008). Their empirical training shares similarities with that of indigenous parteras empíricas, but their social connections give them opportunities to attend additional formal trainings in midwifery/nursing and connect internationally, which impacts the price they charge for their services (not a service to the community like tam-alaletik). Even though they don't always have formal training in midwifery, their social and cultural capital place them in the "Skilled Birth Attendants" category.

iii. Partera capacitada

Parteras capacitadas (indigenous or mestiza) are those who receive regular government training and collaborate with the health sector, either by attending monthly talks or by working in a public clinic/hospital. In Chapter 5, we will meet a tam-alal who, after attending many training sessions in San Cristóbal is now officially recognized as partera tradicional capacitada, trained traditional midwife. Some mestizas who live and practice in San Cristóbal as parteras empíricas also attend government trainings. Others (indigenous and mestiza) have received trainings in the past but now distance themselves from the public health sector. Thinking with WHO categories, parteras capacitadas who receive continuous training could be considered SBAs, but the current trend positions them below SBAs. Because their training is mostly sporadic, they are considered "trained TBAs" i.e. unskilled birth attendants, (Sibley and Sipe 2006; Walker et al. 2013).

iv. Partera profesional

The parteras profesionales are midwives who have gone through formal midwifery schooling, in one of Mexico's two midwifery schools, abroad, or in other non-officially recognized schools (Davis-Floyd 2001; Dixon 2015; Mills and Davis-Floyd 2009). Even though
professional midwives share a similar vision about what a midwife should be, there are disagreements about the type or content of their training (Dixon 2015). Parteras profesionales who studied in the accredited Mexican institutions can work in the public health sector. Those who have gone through non-officially recognized training work in private birth centers or independently. Even if not officially recognized, their training positions them as SBAs (Walker et al. 2013).

Another category of personnel who attend births "professionally" are enfermeras obstetras, nurses with a specialization in obstetrics, who work alongside physicians in hospitals (Walker, Suárez, et al. 2011). We meet one of them in Chapter 4.

v. We are all parteras

Throughout my dissertation, I use the generic term parteras when talking about measures that impact midwives across the spectrum. In particular, these measures include monitoring the practices of tam-alaletik and empirical midwives, while professional midwives are relatively exempted from government scrutiny. I detail this difference in treatment in Chapters 3 and 4. But before turning to the practical impacts of the categories of parteras, I first detail the methods I have used to conduct this research.

Research Methods

i. Positionality

Among my informants, there was a shared belief that pregnancy and birth are topics that are more easily spoken about to women. One of my Tseltal professors, who helped me preparing interviews, confessed that despite being a native speaker some of the words pertaining to the field of female reproduction were unknown to him, and we had to turn to his mother for clarifications. Among the parteras I interviewed, over 90 per cent were women. Out of the four
men I met, all had undergone previous training as health promoters and at least three of them worked in collaboration with their wives. Even at OMIECH, all the advisers of the Women and Midwives' Section have always been females, and it is an essential criterion in the hiring process. This research would have been more difficult to carry, but not impossible, if I were a man (Hinojosa 2004:639); and I was still able to gain crucial information despite my status as a childless woman.

My own approach to the field, and to OMIECH, is informed by my personal trajectory. My involvement with OMIECH's French partner (Association MÂ) and my personal connections to Chiapas situate my knowledge (Haraway 1988) and my positioning in the different fields I accessed. While researching NGOs in Peru, Markowitz highlights the difficulty of positionality for anthropologists "studying over" their colleagues (2001). Having been involved with the Association MÂ before OMIECH, I also had to face the unsettling position of studying over an organization for which I had much empathy.

My positionality, or the ways in which socio-economic, education and gender characteristics influence research, and also shape how others have approached me. The parteras I was closest to, and Micaela, treated me like a daughter. However, my inability to perform all the duties expected from a daughter (in addition to my phenotype and shaky Tzeltal) reminded everyone, if needed, that I was an outsider. This "outsider within" position (Collins 1986) allowed me to spend time with men23, and contrast their descriptions and actions to those of women. When navigating the bureaucracy, my position as a student was not seen as threatening, while my status as a foreigner helped me gain access to information that I would never have been granted as a woman from the community. Acknowledging my position of privilege within a

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23 One of the male parteros I interviewed said he had already hosted a French student who also "wanted to learn Tzeltal" for her dissertation. I think being woman outsider did not prevent me from building confianza with the parteros as well, as I did with Yametik Catalina’s husband, Don Manuel (Chapter 3).
stratified Mexican society helped me work towards the building of confianza with my research partners, who had been deceived on several occasions by people sharing some ethnic and socio-economic attributes with me. At the same time, my status as a female student (in school, and as they perceived it, also learning midwifery) and soon-to-be-married woman also positioned me at the fringes of familial organizing (Freyermuth Enciso 2003).

The data I was able to collect is the product of the articulation of these two positions – of power and of fragility – and of my attempt at leveling them. This effort is also part of my ethical commitment to my collaborators. Keeping in mind the classic anthropological examples of the terrible consequences stemming from deceitful confianza on one end (Chagnon 1984; Humphreys 1975), and the utmost confianza which leads to destroying fieldnotes before having to turn them in on the other (McNabb 1995), I tried to make my research statement and the potential implications as clear as possible to my collaborators. In a region where the difficulties of obtaining prior informed consent have led to the cancellation of projects with my same research partners (Rosenthal 2006), I was worried that my dissertation goal would be misunderstood; or worse, that my research would be used to defend policies paying lip service to parteras while actively seeking to transform their practices. By putting Chiapas and parteras back at the center, I try not to reproduce hierarchies of knowledge, and observe the mutual confianza my partners and I have created, which emerges partly from my position as an activist researcher.

ii. Acting: on activist research

"You know, a lot of researchers have come here. We gave them all the information, we talked to them, and then, they never came back," Micaela told me during the weeks following our first encounter. What she and her colleagues were upset about was not the absence of the
physical return of the researcher, but never being acknowledged in the research nor receiving a copy of the book. The complaint about researchers' lack of reciprocity, as if they were the only creators of knowledge, is one that is expressed in many research settings, whether in the NGO field (O'Donnell 2010) or from the formally organized residents of a barrio (Paley 2001:201). In the first decade of its foundation, OMIECH has collaborated with the CIESAS research center (Freyermuth Enciso 1993; Freyermuth, Cadena, and Icó 1989). Later, other researchers wrote about OMIECH (Ayora Diaz 2000), particularly in the wake of a biopiracy controversy (Araya Morales 2008; Pitarch 2007) (see Chapter 4). The Women and Midwives Section shared with me the work of students who interned with them (Weidner 2007), but, according to Micaela and her colleagues, more had come who never shared their work. In this context, we spent our very first meeting, during which I presented my research interests to OMIECH, discussing common grounds between the organization's goal and my academic skills.

Since this first meeting, the relationship between Micaela, who is in charge of the Women and Midwives Section, and myself only grew stronger. I consider her to be not only one of my main informants; she has also acted a cultural broker in many occasions. Since this first encounter, we became colleagues and friends. In many ways, activist research is a lesson of humility, as we adapt our methods of research to our collaborators' needs. Being an engaged researcher has led me to write grant proposals and come in contact with midwives across the globe, which I would probably not have done if I had not taken a commitment towards the Women and Midwives' Section. It also taught me to balance between "doing" and "writing" (Green 2009), and engage in non-academic writing. For Micaela, our collaboration has also meant participating in academic conferences, and sharing her story with this specific audience. Finally, my engagement to OMIECH's political goal also taught me to reframe my projects for a
different kind of Review Board, where the criteria for acceptance are the good ethics and positive impacts, and not only the good intentions or potential harm (McNabb 1995). As Hale observes, "activist research is justified (...) by the data and understanding that result when research subjects themselves perceive the research as aiming to produce "good" or "useful" results, in a project at least partly of their own conception" (2006a:38).

Anthropologists documenting human rights have used their work to raise awareness of social conflict and war (Binford 1996), and the impact of neoliberal policies (Nash 2001b; O'Donnell 2010), and to participate as experts in courts (Hale 2006b; Sawyer 2004). Advocates or activists, anthropologists' work is often a call for social justice, "grounding intellectual work in practical struggle" (Engler 2000:360). Binford (2004) reflects on the different existing options for anthropologists engaged on the human rights terrain. In the field, researchers can collaborate with grassroots organizations and investigate human rights abuses. From anywhere in the world, anthropologists can also scrutinize the work of international organizations and translate and diffuse materials. In our homes, Binford incites anthropologists to work actively within our own communities and contribute to politicizing our discipline (Binford 2004:422–3; see also Simonelli 2007); a position also encouraged by grassroots organizations like the Zapatistas. At home, anthropologists can also contribute to raising awareness on human rights and human rights violation through their roles as teachers (O'Donnell 2010; Odham and Frank 2008).

Ultimately, activist-research relies on the belief that political engagement is a continuation of anthropological training, and that anthropology can "contribute something to [their] struggle through one's research and analysis" (Speed 2006:71), what Speed calls doing "critically engaged activist research." Politicizing our discipline also has consequences in the practice of anthropology. In Latin America, anthropologists can find themselves under scrutiny.
After the Zapatista uprising in Chiapas, Simonelli recalls the difficulties writing about human rights and being an activist anthropologist: any writings focusing on other than an essentialized Maya culture was viewed as "human rights related, and, therefore, political" (Simonelli 2007:161). This position brings forward the public role of anthropologists, highlighting that our research is by essence political — a martial art (Carles 2001).

Initially, I thought conducting fieldwork away from home would preserve me from the struggles "halfies" face (Abu-Lughod 1991). However, the activist side of my research also positioned me as an outsider within, providing a vantage point to auto-analyze my own interactions within OMIECH and note the differences in opinion and experience that might arise between my colleagues and myself. Simultaneously approaching OMIECH as a doctoral student and as a member of their French partner organization (Association MÂ) has placed me in uncomfortable situations at times, but allowed me to fully live participant-observation, and gain authoritative knowledge myself, the kind that allows me to talk about the politics of indigenous organizing "from the gut" (Bernard 2006:342). Of course, I was not able to provide the same level of commitment to all the people and organizations I met over the course of my research. For the people outside of OMIECH, I was just another researcher24. Still, this has not prevented the building of confianza with several of the parteras, who always welcomed me with a variant of "Estas en tu casa, con toda la confianza (Treat this as your own house, in all confidence)."

iii. On multi-sited ethnography

In total, I conducted thirteen months of physical fieldwork in Chiapas, spread over a period lasting from May 2013 to July 2015. Despite our various geographical locations, members

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24 There is only one instance in which another NGO refused an interview, because of the deceptive experience with previous researchers and the staff’s very busy schedule. I did not want to commit to more than I could and was honest about it. After an initial meeting, they told me that they would not have time to meet with me again.
of OMIECH and I have been able to write projects together, present our work in academic settings (El Kotni, Icó Bautista, and Bafoin 2015), and organize local events (OMIECH 2014). This interdisciplinary and transnational collaboration is very much characteristic of what has come to be known as "multi-sited ethnography" (Marcus 1995). When the researcher and the participants work together from different countries, in a deterritorialized context (Markowitz 2001) this research can be renamed long-distance ethnography. The use of technology is crucial to conduct such ethnography and collect data without being physically in the field (Wilson 1998). Maintaining regular contact with OMIECH while in the United States has been essential for my research and even more crucial in developing confianza. In my research, I consider having conducted long-distance ethnography over a specific period of time (February to May 2014); and it comprises more than occasional phone calls I now make. During the spring 2014, long-distance ethnography has included the video recording of bi-monthly meetings of the Women and Midwives' Section, and my response through email and/or video messages. In the same way that good participant-observation erases the disturbance created by the presence of the researcher, I was able to notice how the technology, at first odd, then became integrated into the meetings, so far as having questions directed towards myself while the speaker is looking at the camera. On both OMIECH and my side, technology has reinforced the co-evalness (Fabian 1983) between us, allowing both my colleagues to update me with important news from the organization, and myself to keep them updated about my dissertation work. Co-evalness also maintains the anthropologist's ego under control, keeping away the false feeling that my colleagues rely on my presence to trigger projects. Looking back, I realize that it is almost the opposite: the two meetings of tam-alaletik happened in February 2014 and 2016, respectively one month and six months after I had left the field.
While in the field, I also carried another type of multi-sited ethnography. OMIECH's headquarters are located in San Cristóbal, but the Women and Midwives Section's activities take place in the member communities. With Micaela, we would visit the midwives, and when funding was available, conduct workshops in the villages. The contrast between the infrastructures midwives had access to in the city and the lack of it in villages led me to undertake fieldwork in the communities as well, expanding my field sites. Additionally, to underscore the uniqueness of OMIECH's project, I also conducted ethnographic research with midwives who were not related to the organization. These considerations led me to conduct fieldwork in various settings (Figure 3), which also meant that I put forward different parts of my identity in each of them. Or rather, people interpreted my being in their space in different ways (Little 2004:21): for the hospital staff, I was a midwifery apprentice. For the tam-alaletik in their...
villages, I was both an apprentice and a student who was learning Tseltal. These men and women incorporated my incongruous self into their world, while I tried to adapt my methods to the complex and multi-sited connections of their own lives (Marcus 1995).

iv. Talking: trust building through conversations

Most of trust building, "rapport" in anthropological jargon, happens through seemingly non-research activities: making tortillas, attending a religious ceremony, learning how to greet strangers, chatting on Whatsapp. As anthropologists have shown, these actions help members of the community judge the research and integrate her/him in their social network, which then leads to agreeing to share their personal story (Bernard 2006; Eber 1995; Little 2004). When listening to life stories, or to conversations around the fire, I was often reminded of Hurston's ethnography, *Mules and Men* (Hurston 1990). Indeed, Mayan women often express themselves using a rhetoric that interweaves metaphor, fragmentation and oneiric narratives. Like in Hurston's writings, indigenous women's narratives revealed the complex relationship between ethnicity, gender, and marginalization. These forms of expression which were overlooked in research until the postmodern shift (Behar 1990) revealed hidden transcripts in powerful ways (Scott 1990). Listening to jokes, complaints and hopes provide a counter discourse to government policies and everyday relationships between patients and doctors, in ways that observing interactions would not.

Informal conversations – this includes gossiping – during tortilla making (Eber 2000; Taylor 2012), when learning how to weave (Little 2004), or while waiting for patients in the hospital (Howes-Mischel 2012) allow for words to flow more freely than during an interview. Such conversations made me realize for example that my informants happened to be related to various degrees (for example: one of the tam-alal I interviewed used to live in the same village
than one of OMIECH's *partero*. I would then integrate this data in my research, to build new questions about the people's relations, or to illuminate some part of their past that was previously unknown to me. The informal conversations with *parteras* have also helped me separate OMIECH's discourse and positioning about midwifery, what can be seen as its "public transcript" (Scott 1990), from that of *parteras*. The different people member of OMIECH did not necessarily express diverging views about midwifery, and I do not consider their transcript as a "hidden" one, but the words they used and the goal they pursued by organizing were presented differently. In my writing, I distinguish it by referring to OMIECH to talk about the public transcript, and name the *parteras* when indicating their own view.

Adapting informal conversations to rapidly developing technologies, I also started to integrate text messaging as a means of building rapport. In the middle of my fieldwork period, I changed my basic flip phone to one that would integrate mobile apps, and in particular *Whatsapp*. This decision allowed me to build relationships in ways I never could have imagined. All of a sudden, doctors and researchers whom I had been trying to contact for months – over the phone, by email and in-person – were making arrangements for an interview. Others whom I had interviewed forwarded me information about meetings or important news via text messages, or even comments on cases of obstetric violence. In a multi-sited research, these new technologies are becoming unavoidable, even in the most remote locations. They provide free texting options for sons and daughters of *parteras* traveling to the nearest Wi-Fi-equipped town, and allows migrants to keep communicating with their families, even from afar.

v. *Observing and writing: where/when does research end?*

The technologies that keep us connected to our research participants also raise the question of the spatiotemporal location of our research. For example, does a Whatsapp message

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25 This was also probably amplified by the realization that I would be living the field soon.
weigh as much as a recorded response in a formal setting? After trying so hard to fit in the landscape, we still have to remind our hosts of our researcher status when having a conversation after a meal. Even with Micaela, my closest informant, I have felt uncomfortable writing notes as she was sharing with me the organization's internal struggles. But we both knew her words were important, and that I needed to write them down. The confianza we have built authorized me to keep writing, and her to stop when she wanted – anthropologists are never the only ones setting the temporal limits of research. At times, my collaborators caught me off-guard. For example, when entering the temazcal (steam bath) to bathe, as I tried to accustom my inexperienced body to the burning air and the narrow space, the tam-alal addressed me: "look, this is how you massage the woman postpartum," and she made sure I recorded it in my hands and mind.

vi. Asking: semi-structured interviews

In addition to informal conversations, I also conducted more formal interviews with the participants. The latter took place in the parteras' home, and I was assisted either by a translator or by a family member. The interviews focused on the parteras' lives, how they learned to become parteras, and the changes in their practice. The interviews lasted an average of 45 minutes (and spanned from fifteen minutes to three hours), and were often interrupted at the whim of family life and visitors. The table below (Figure 4) summarizes the number of participants, and gives gender and ethnic characteristics. In some situations, I spent more time discussing the interview topics informally (what Bernard (2006:210) classifies as unstructured interviews), while walking in the garden or cooking, than sitting down and recording information – what is typically imagined as an interview setting.
During semi-structured interviews, I followed a set of topics prepared beforehand. When working with a translator, volunteer or professional, I made sure to cover all the themes with them beforehand, so that they knew when to redirect the conversation. When I was staying at the partera's home, I reviewed my interview notes before asking more questions. When the interviews were "one time only," I tried to cover all the topics in the allotted time, but was not always able to do so. This is particularly true for doctors or Ministry of Health employees, who were on very tight schedules.

<table>
<thead>
<tr>
<th>Participants</th>
<th>Number</th>
<th>% women</th>
<th>% indigenous</th>
</tr>
</thead>
<tbody>
<tr>
<td>PARTERAS</td>
<td>42</td>
<td>90.5</td>
<td>52.4</td>
</tr>
<tr>
<td>Tam-alaletik(^{26})</td>
<td>11</td>
<td>90.9</td>
<td>100</td>
</tr>
<tr>
<td>Parteras capacitadas(^{27})</td>
<td>18</td>
<td>83.3</td>
<td>66.7</td>
</tr>
<tr>
<td>Parteras profesionales</td>
<td>9</td>
<td>100</td>
<td>33.3(^{28})</td>
</tr>
<tr>
<td>Apprentices</td>
<td>4</td>
<td>100</td>
<td>25.0</td>
</tr>
<tr>
<td>MEDICAL STAFF</td>
<td>27</td>
<td>51.9</td>
<td>7.4</td>
</tr>
<tr>
<td>Doctors</td>
<td>19</td>
<td>52.4</td>
<td>4.8</td>
</tr>
<tr>
<td>Nurses</td>
<td>5</td>
<td>60.0</td>
<td>20.0</td>
</tr>
<tr>
<td>Interns</td>
<td>2</td>
<td>50.0</td>
<td>0</td>
</tr>
<tr>
<td>MOTHERS(^{29})</td>
<td>25</td>
<td>100</td>
<td>56.0</td>
</tr>
<tr>
<td>hospital birth only</td>
<td>9</td>
<td>100</td>
<td>55.6</td>
</tr>
<tr>
<td>partera only(^{30})</td>
<td>7</td>
<td>100</td>
<td>57.1</td>
</tr>
<tr>
<td>both</td>
<td>9</td>
<td>100</td>
<td>66.7</td>
</tr>
<tr>
<td>NGOs(^{31})</td>
<td>26</td>
<td>57.7</td>
<td>42.3</td>
</tr>
<tr>
<td>GOV. EMPLOYEES</td>
<td>10</td>
<td>63.6</td>
<td>27.3</td>
</tr>
<tr>
<td>RESEARCHERS</td>
<td>7</td>
<td>57.1</td>
<td>16.7</td>
</tr>
</tbody>
</table>

Figure 4: Overview of research participants.

\(^{26}\) Includes one hierbera who participated in an interview with her mother, a tam-alaletik.
\(^{27}\) Includes two nurses who later started to work as parteras.
\(^{28}\) Among the indigenous parteras profesionales, two of them also underwent traditional training in their communities, before or after midwifery school.
\(^{29}\) At times the husband was present during interviews of parteras and mothers but that was rather infrequent.
\(^{30}\) Includes birth in the Intercultural Hospital with a partera, and birth centers.
\(^{31}\) Eight of the interviewees had been involved with OMIECH at some point in their professional trajectory.
Most of the participants in this research are women (about three to one), the lowest proportion being in the medical profession, where the number of men and women interviewed is almost equal (14, for 13 men). However, the lives of all these women differ greatly, from the Tseltal woman in an Oxchuc village pregnant with her sixth child, to the mestiza doctor in the Comitán hospital who is preparing for her specialty examination. These socioeconomic differences cumulate with ethnicity to push the common denominator – gender – to the background. The proportion of indigenous informants also drastically changes between categories. They are lowest in the medical profession and in research settings, while they represent half of the mothers and parteras I interviewed.

vii. Doing: (collective) participant-observation

Medical anthropologists have highlighted the difficulty of conducting participant-observation in the context of public clinics. How much participation is allowed and what type of knowledge is accessible varies depending on hospital and university regulations but also on very down-to-earth criteria such as the friendliness of the staff (Andaya 2014; Gálvez 2011; Howes-Mischel 2012). In my case, I gained "experiential knowledge" (Bernard 2006:342) by conducting participant-observation in three different spaces. First, I met some of the parteras while conducting participant-observation at OMIECH and was later able to interview them. I followed another approach of participant observation when I stayed with parteras in their homes, where I tried to participate in their daily activities, and observed their interactions with other family or community members (Eber 2000; Little 2004). As I explained earlier, my participant-observation was multi-sited, as I did not only stay in one community but with four different parteras in four different villages, and visited one in San Cristóbal several times.
Second, I conducted participant observation as a volunteer at OMIECH, by participating in the activities that were available to me as a Women and Midwives Section volunteer. This meant that I did not engage in activities of other sections, such as drying plants — which Micaela does for example. Usually, anthropologists who have written on NGOs and organized groups have either conducted interviews (Calles Romo 2009) or collaborated through engaged research, as mentioned earlier (Colloredo-Mansfeld 2007; Sawyer 2004; Speed 2006). I consider my participant-observation at OMIECH as a collective project, because I also integrated observations and reports on the organization's activities from other members and volunteers while I was away. These people knew my research well enough to notice traits, actions, and events that were of interest to me. This applied to activities at OMIECH but also during the workshops or external events.32

Finally, the third space where I conducted participant observation was at the Intercultural Hospital, where I served as an assistant for a partera tradicional capacitada. The first person I met in the hospital was actually a partera profesional from the CASA midwifery school who warned me "I have seen many colleagues of yours when doing my training. They just show up during appointments and births and take notes and pictures. I will not allow you to do that with me." After this warning, I was prepared to conduct other types of observations, which I did for a couple of months, talking with mothers after their appointment, or with the parteras. Then I met Doña Gabriela and she brought me in. Still, I was very cautious about my participation and note taking, even if the lines between assistant and researchers blurred as anthropologists have described (Dixon 2015; Gálvez 2011) and on which I reflect in Chapter 5.

32 See Chapter 4 for data on the workshops observed.
viii. Triangulating

Participant observation, combined with conversations and interviews complement each other and facilitate the cross-analysis of data, what in qualitative research is called triangulation: "A process of using multiple perceptions to clarify meaning, verifying the repeatability of an observation or interpretation" (Stake 2000:443). I relied on triangulation when, for example, asking the same question to the same person at different moments, or when contrasting what parteras said they do with what happened during the interactions with their patients. Likewise, by spending enough time at OMIECH, the same topics were covered several times, and their redundancy in my fieldnotes highlights the importance of certain issues over others.

To put in perspective and correlate the data from my fieldnotes, I use statistics from the Observatory of Maternal Mortality in Mexico (OMM 2013) and the Mexican website dedicated to the Millennium Development Goal (Objetivos de Desarrollo del Milenio n.d.), and official database such as the National Census (INEGI 2015) and National Council on the Evaluation of Social Development Policy (Consejo Nacional de Evaluación de la Política de Desarrollo Social 2012). I rely on these numbers as a background for the data collected at OMIECH on the number of births attended by parteras, and to contextualize the work of the other parteras I met. In addition to these statistics, I also draw on reports from the World Health Organization (2015) and the United Nations (2014) which both make recommendations to mothers and midwives. I contrast the advice presented in those reports to the recommendations that the parteras shared with me, and to the publications of OMIECH regarding partera care (Chapter 7). OMIECH, and the Women and Midwives Section in particular have been prolific in creating videos and publishing booklets promoting parteras' medical knowledge. I have had access to a variety of boletines — small booklets on knowledge about plants (Área de Mujeres y Parteras 2004; Área
ix. Analyzing: on grounded theory

The general themes of this dissertation, which I grouped to form the different chapters, emerged while I was conducting fieldwork. Typing notes, first on a daily and later on a weekly basis, help me to process the data in the quietness of my room. For the interviews conducted in Tseltal or Tsotsil, the translator and I would first listen together to the interviews and discuss their broad meaning. Then, she would transcribe and translate either all or specific parts of the interview. In the last three months of fieldwork, I noticed that the interviews started to echo one another, and the events recorded to complement or contradict observations I had previously made. It was exciting to witness the dialogue between the data, and I started thinking about overarching themes that would make the stories fit together. This "gut feeling" was the first step of analysis, the point of departure of the grounded theory methodology (Glaser and Strauss 1967). The formal process of coding came next, and the months of writing and analysis reminded me the most important quality of grounded theory, flexibility (Bernard 2006:492).

The coding process was threefold. First, I went through the Outline of Cultural Material or OCM codes (Bernard 2006:400), created a list of those related to my research topics, and used this modified version as a guideline when going through my research material. While manually going through my notes, I also paid attention to words, concepts, or stories that were recurrent in fieldnotes and interviews, and proceeded to manually code them. Then, I used the qualitative data analysis software Nvivo to code the modified OCM and search for the list of recurring terms I had prepared. Nvivo allowed me to see how the terms were related, and made the data analysis less messy: I could have several codes for the same chunk of text and still be able to read through...
my document. I relied on memos, one of the key tools of grounded theory (Bernard 2006:493), to analyze different concepts (ex: confianza) and themes (ex: difficult birth) from various sources of data. In the analysis, I also used diagrams (Lofland et al. 2004) to visualize how people or key concepts (for example hospital and human rights) were related to one another. I also found Nvivo's "word trees" generator useful; the tool visually maps and groups the sentences in which similar words appear after and before key words. Of course, the analysis process included trial-and-error: for example, elaborating too many codes, and then realizing they carried the same meaning under different names. But constant revision is also an important part of grounded theory (Lofland et al. 2004).

I present the results of these research and analysis processes in the following chapters. In the next chapter (Chapter 3), I take a closer look at the global and national economic changes impacting tam-alaletik. One such change is illustrated by the governmental cash-conditional transfer program Prospera, which encourages women to get prenatal care at their local clinic, gradually transforming women's reproductive habitus, their "modes of living their reproductive body [and] their bodily practices" (Smith-Oka 2013c:16). Government programs also impact the confianza between women and their partera and bring out alternative definitions of rights, which include respect (ich'el ta muk').
Interlude: Plant knowledge as *lekil kuxlejal*. Doña Margarita's story

Doña Margarita, a fifty-four year old mestiza, is a *partera* and *hierbera* living in the town of Las Margaritas, close to the Guatemalan border. Although her grandmother was a *partera*, she never formally passed her knowledge on to her. It is only as an adult, after having had three of her six children, that Doña Margarita started attending births and curing with plants. She places her personal experience as the center of her knowledge, and recognizes the trial-and-error process at the beginning of her practice:

"At first, I was trying the plants to cure my kids and my family. But then one day a neighbor came and asked me if I knew how to cure her. I said I didn't. But she came back, and so I gave her a treatment, "I will give you for your pain and that's it" I told her. I prayed to God, I was so scared that she would die because of me. But she healed, and so the word spread, and more and more people came to me. I had about a hundred people a day waiting at of my door for their treatment."

Doña Margarita's reputation grew throughout the town and beyond, and since this first patient twenty-one years ago, not a day has passed without someone seeking her.

Testing plants and remedies on oneself and the close family is a way of validating the midwives' intuition, the principal component of their authoritative knowledge (Davis-Floyd and Davis 1996). During my fieldwork with OMIECH, my colleague Micaela Icó Bautista and I spent months elaborating a *recetario*, a recipe book of natural remedies shared by the *parteras* during their 2014 meeting (OMIECH 2014). The criteria to include the recipes were that their efficiency needed to have been proven; if Micaela had not tried it herself, she would make sure to explain, "I have not tried it, but this is what such midwife told me. She tried it and it worked."

The *recetario* elaborated by Micaela plays a triple role. First, it fits the OMIECH' goal to "preserve, strengthen and develop traditional medicine" (OMIECH n.d.). Second, the *recetario* is to bring attention to the shrinking numbers of *parteras* and other medical specialists in the
Highlands. Every year, there are fewer of them, and some of the recipes only relied on the knowledge of a single person. Printing this knowledge is a way to preserve it for the communities, and aims to stimulate pride in younger generations. Finally, the recetario intimately links knowledge preservation, natural remedies, and awareness about one's environment. The introduction of the most recent recetario reads, "We have to use the plants and the knowledge of our ancestors, because they are natural and healthy (without chemical) and because they are part of our lekil kuxlejal" (OMIECH and Área de Mujeres y Parteras 2015:2).

The link between the environment and parteras' knowledge might seem obvious, however this relationship takes a particular connotation in the Mayan region. Indeed, Tseltals and Tsotsils think of plants and animals as elements in the continuum of humans (a worldview Descola classifies as analogism (2005)). In particular, the Madre Tierra, Mother Earth, is an essential actor that also can take on a religious significance (Page Pliego 2011). Protecting one's environment is thus similar to caring for one's family member, and the role of Mayan men and women is to care for the Madre Tierra. To Micaela and OMIECH, caring for the environment is a duty that is part of the lekil kuxlejal, translated in Spanish as buen vivir (the good way of life). In an interview with a Swedish student (Prage 2015:23), Micaela contrasted lekil kuxlejal to what she calls mal kuxlejal. Mal kuxlejal is the state in which we are currently living, and can be translated as the bad way of life. The latter includes attitudes that are hurtful to the Madre Tierra, such as using fertilizers, and inappropriate actions in one's community, like disrespecting the ancestors. But Micaela also includes government programs in which the majority of poor indigenous women are enrolled under mal kuxlejal. As I discuss in the next chapter, these programs constrain women's reproductive choices and interfere with parteras' work, disturbing their responsibility towards their community.
Chapter 3. "No da tiempo de soñar."

Challenges Facing Indigenous Midwifery in the Highlands

"Aprendí sola." Empirical and oneiric learning of tam-alaletik

The first time I arrived in the village near Oxchuc to meet Yametik\textsuperscript{33} Catalina, she was not home. Her husband greeted my colleague, who works as a translator, and I, and told us to look for her by the school: "hay junta," he explains, there is a meeting. We walk towards the school's covered playground that has bleachers on one side, making the construction look like a little stadium. On the basketball court across the road from the school, a small market popped up. Some women sell boiled corn. The ambiance feels like a holiday: everyone in the pueblo seems to be outside, and children are freed from classes. Under the covered playground, women of all ages wearing red and white striped huipils (blouses) line-up. The men stand just outside of the school, waiting. As we enter the stadium, all eyes are on me, and my notebook. My colleague asks around for her Yametik Catalina, and I stare at the women moving through the S-shaped line. Today is a day of payment from the government program Oportunidades\textsuperscript{34}. As soon as women get their stipend from the office located in one of the school's classrooms, they leave the school.

A few months later, the daughter of Yametik Catalina, a thirty-year old woman who lives and works in San Cristóbal, calls me to ask if I would like to go with her and visit her mother for mothers' day the following week, to which I happily agree. Mothers' day is a Sunday (May 10\textsuperscript{th} in 2015), but each village decides on a weekday to celebrate it, which then becomes a holiday.

\textsuperscript{33} In Oxchuc, Yametik is used to address an older woman. It conveys the same respect as the prefix Doña in Spanish.

\textsuperscript{34} The program changed from Oportunidades to Prospera in September 2014, but most of the people still referred to it as Oportunidades during my fieldwork.
After an early morning cab ride, we arrive a little before 9 am to greet Yametik Catalina and her husband. We learn that in addition to the Mothers' Day fiesta, there is also a junta at the clinic, for women to update their Oportunidades card and get a new one (in the transition to Prospera). "People here, they are not nice; they see that it is [the women's] special holiday and they make them go to a meeting," her daughter criticizes. She stays in the house while I ask to accompany Yametik Catalina to the clinic. In the clinic's internal patio, I am an entertainment opportunity for the thirty or so women waiting. The pharmacy and one of the screening rooms have been converted into offices and each woman has been given a number. Staff members call out numbers without any logical order, and every time it creates a movement within the group of women who frantically ask each other which number they heard. Staff shouts the numbers in Spanish, a language most of the women do not speak. At almost each call the women shout back their own number, full of hope: "Sixteen! - Sixty? That's me"! If the person with the correct number does not come forward, the staff then precedes to calling her by name, and the crowd searches for her "she is over there doctor, she is on her way! – and to the child in Tseltal: 'Go and get your mother, quick!' " At first I am entertained by the movement, and see the wait as an opportunity to practice my Tseltal skills. But after thirty minutes under the morning sun, I too am eager for the doctor to call Yametik Catalina's number.

In this chapter, I describe the life and work of tam-alaletik who live in rural communities in Highlands Chiapas. While the focus has often been on the historical and cultural roots of Mayan healers' practices (Icó Bautista 1999; Paul and Paul 1979; Hinojosa 2015), contemporary Mayan people actively interact with biomedicine. Over the next pages I show how tam-alaletik swiftly combine various medical skills when caring for women (Chary and Rohloff 2015; 35 In Spanish, setenta (sixty) and sesenta (seventy) sound very much alike – I have used other numbers in English to transmit the resemblance.)
Cosmimksy 2001a). I also examine the intrusion of government programs like Oportunidades/Prospera in their lives and how it constrains their work. By constraining women to seek biomedical care, Prospera impacts the lekil kuxlejal (the good way of life) and the respect (ich'el ta muk') between people — a key component of the confianza between women and their midwives. But Prospera is only one of the many socioeconomic changes rapidly transforming Mexico's midwifery landscape. In the next pages, I discuss how tam-alaletik in particular and indigenous people in general are affected by structural adjustments program, threatening the transmission of their knowledge and leaving "no time for dreaming," when dreams are a crucial part in the learning process. Tam-alaletik's activities are central to the biological, social and cultural reproduction of their communities. However, not all women embrace this calling, and those who do so find it every day more difficult to transmit their skills to their daughters and granddaughters. This reluctance is in part due to the lack of financial retributions for tam-alaletik's services, even though this is changing. Through Micaela's story, I discuss the philosophical and practical consequences of such change.

In the second half of the 20th century, the privatization of health in many countries reshaped older forms of colonial domination into new forms of inequality. In his work in an Aboriginal town of the Northern Territory in Australia, Saethre refers to "welfare colonialism" (2013) to describe the shaping of poor people's health care options through monetary incentives. Global welfare policies encouraged by international organizations in the 1970s envision development as a linear process, allowing to move from tradition to modernity, indexed on industrial Western countries (Bähr Caballero and Degavre 2006). Poor women become the main targets of such programs, which are built on a sexist bias that only portrays them through the lens of their role as caregivers. In Mexico, the maternal branch of Prospera conditions women's
subsidies to certain practices, such as coming to their local clinic for prenatal care and attending monthly meetings (*pláticas*). The meetings' themes vary from clinic to clinic but are mostly focused on family planning. The maternalist bias of the program (similar in Guatemala, (Chary and Rohloff 2015)) is intimately linked to the fear that Mexicans are "so many" (Braff 2013) and that in order to become a modern nation, Mexico needs to curb its fertility rate, which is highest in rural areas (INEGI 2015) Programs like Prospera are based on the neoliberal focus on personal responsibility (Harvey 2005), aiming at "breaking the intergenerational transmission of poverty" (SEDESOL 2008:9). This focus makes individuals increasingly responsible for their own health. Prospera encourages women to have fewer children, a behavior that is often explained as a cultural practice.

"Cultural changes made in the name of modernity can reinforce inequalities or create new ones, can push out sound traditional practices and their practitioners as relics. These processes can also contribute to neoliberal subject formations in which the state is absolved of responsibility for its citizen and noncitizen members, and self-formation becomes an act of citizenship" (Gálvez 2011:8).

In order to become good citizens, poor women need to be good beneficiaries. This chapter's opening vignette about Yametik Catalina illustrates the conditionalities attached to enrollment in government program. The waiting, which happens systematically, sends the message that poor peoples' time is not valuable (Auyero 2012). This is why some women like Micaela decide to quit the program: "I used to have [Prospera] but now I don't want to anymore. I got mad: meetings, that's all there is! Meetings and appointments. No, I don't want to; I don't like it, it makes me mad."

The program is particularly successful in rural areas, for which it has been designed (SEDESOL 2008). But because it is not possible to open government offices in all rural villages, the state needs to rely on schoolteachers and clinic staff to distribute its stipends. These decisions
lead to unplanned consequences: when medical personnel take on government responsibility, it blurs the categories: women come to associate clinics with the government program, and need to obey doctors even outside of the pláticas. In her evaluation of the first generation of this cash-conditional transfer program (then called Progresa) in the State of Mexico, Vizcarra Bordi analyzes how instead of improving women's living conditions, the obligation to attend various activities at the clinic becomes an additional stress for them, "as they worry constantly about poor attendance, have to get up earlier to make tortillas or otherwise stop cooking on Wednesdays" (2002:218). Such programs also extend the clinic staff's authority beyond the medical sphere, as they are in charge of checking women's attendance of the pláticas and are able to coerce them into coming to their appointments. Despite such studies, the same program persists under new names, and the observations Smith-Oka makes in Veracruz ten years later highlight similar techniques to force women's compliance (Smith-Oka 2013c).

In Chiapas, I have noticed comparable power dynamics. If women do not come to their gynecological appointments or to prenatal care, they are penalized economically. What motivates women to attend is then the fear of loosing their income. In Tzeltal and Tzotsil communities, women worry about the program's requirements, which are reminiscent of old colonialist practices. They shared their anxieties in a meeting organized by OMIECH, "It feels as if they are paying us to see our body" (Área de Mujeres y Parteras 2007:1). Women cannot openly share these concerns because they fear that it would lead to their removal from the program.

Since the Conquest, indigenous women's bodies are used as the battlefields for the control of the nation (Marcos 1992). Building on Bourdieu's habitus (1982), Smith-Oka offers a "reproductive habitus" framework to highlight the interconnections between individual actions (the number of children one has, or the type of prenatal care one goes to) and international
politics (control of overpopulation). The notion of habitus deconstructs the ideal discourse about choices, very much present in global discussions about poor women's reproductive health:

"The reproductive habitus model I proposed allows one to frame how the women's bodily micropractices are shaped by larger forces. All these forces – the class and social structures, gender roles, and government policies, become even more pronounced when the women are part of Oportunidades. Once a woman is enrolled, there are only a few set paths she can take to actually be seen as a good mother" (Smith-Oka 2013c:153).

The possibility for "choice" is only available to middle-class women, and the women enrolled in programs like Oportunidades are poor women. Organizations in San Cristóbal working with Mayan women share their concerns with the program, which violates women's right to decide over their own bodies, and is an intrusion of state policies in the most intimate spheres of their lives (CIAM, AC. 2008). The prenatal appointments that women have to go to at the clinic marginalizes indigenous midwives' role, creating a physical separation between the care provided inside the clinic by a medical doctor and that provided at home by a tam-alal. In the next section, I describe the empirical training that tam-alaletik experience, a training that is deemed to have no value in the biomedical setting.

When Yametik Catalina and I are back home from the clinic, one of her neighbors stops by. She knows me, and her daughters never fail to greet me: "Mónica Kotniiii!" they scream. María is twenty-eight years old and seven months pregnant. This is her seventh pregnancy; her first two children were born with the help of her own mother live in another village. However, for the last three, she could not afford the time to travel away and leave her husband, so she sought the help of her neighbor, Yametik Catalina. Today, María stops by for Yametik Catalina to check the baby's position: she fell, and the baby moved into a breeched position – it is now in

36 Because of my unusual first name for Mexicans, in Chiapas I go by the surname Moni, which is the nickname for Mónica. People never remembered my full last name, abbreviating it to Kotni. Fieldwork is transformative indeed.
a seated position, instead of being head down. Since she fell, María regularly visits Yametik Catalina who turns the baby around with her hands. This maneuver, called external cephalic version or sobada (massage) in Spanish, represents one of the most common reasons women seek parteras throughout Mesoamerica (Greenberg 1982; Hinojosa 2015; Jenkins 2003; Miranda 2015). This repositioning has to be done over several visits, and it is best to seek the partera before the third trimester. When they massage the pregnant woman's abdomen, parteras are also able to determine the baby's sex. Hurtado (1977) reports that if the baby is located on the mother's right side, with the placenta to the left, then it is a girl; boys would tend to go in the other direction. This is consistent with my fieldnotes from Yametik Catalina and other indigenous midwives (Figure 5).

Like many other women, Mayan women interpret amenorrhea, nausea, and weight gain as signs indicating pregnancy (Freyermuth Enciso 2003). A visit to the partera, usually after the first trimester, confirms the pregnancy diagnosis. Women are expected to visit their partera every month, and she treats the discomforts they might experience (nausea, back or body pain) with teas and sobadas. This continuity of care contributes to building confianza between the

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37 OMIECH parteras do not refer to such positioning, but insist that baby girls are born boca abajo, face down, while boys are born boca arriba, face up. Consequently, the placenta is buried with the maternal side facing upward or downward depending on the parents’ desire for a future boy or girl (Icó Bautista 1999). In determining the sex, Doña Margarita relies on another technique, similar to the popular knowledge in France: if the shape of the mother’s abdomen is pointing forward, then she is expecting a girl; if it is spread out to the sides, then it is a boy (which is the opposite in the Caribbean and US (Elise Andaya, personal communication).
woman and her midwife, and one of the reasons women keep going to parteras despite having mandatory prenatal care appointments at their local clinic (Hinojosa 2015:95). More than a physical massage, the sobada is an encounter between the mother and her midwife (Hinojosa 2015:85). Both nonverbal and verbal communication are important in Mayan healing (Waldrum 2015); during the sobada, the partera talks with the mother and detects any physical discomfort or any trouble she might be experiencing in her family. It is crucial to build such rapport before the birth process, and non-indigenous and professional midwives also take the time to talk with the mothers during prenatal appointments (Davis-Floyd and Davis 1996; Dixon 2015). I argue that such regular encounters contribute to building the "pact of confianza" between the mother and her partera, an element crucial in the success of a birth (Parra 1989:67)\(^{38}\). This confianza starkly contrasts with the relationship that women might have with doctors and nurses in the clinic, where there is little or no trust (Berry 2008; Smith-Oka 2013c). Parteras from all backgrounds, living in San Cristóbal or in villages, described the importance of taking their time during prenatal consults, answering the mother's questions and sharing advice with her and her family.

"Most of the time we spend in prenatal consults is dedicated to working around the fears (...) We go over all of these things, and try our best to care for anything that could be prevented before [the birth]" (Partera working in a birth center).

In rural areas, the sobada represents one of the ways to overcome the uncertainties of birth. Catholic tam-alaletik will also perform ritual prayers, or suggest the family finds someone who can pray on their behalf. These prayers are another element of prevención, to avoid any bad

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\(^{38}\) Midwives across the spectrum know that fear inhibits labor (DeMaria et al. 2012).
outcome during the birth (Área de Mujeres y Parteras 2005:15; Freyermuth Enciso 2006; Guiteras Holmes 1961:103)\(^\text{39}\).

Pregnancy is a vulnerable state for Mayan women, and acts of *prevención* aim at protecting them from a wide-range of risks, including: gender-based violence and alcoholism, bad positioning of the fetus in the womb, and *embarazo del mono* (monkey pregnancy)\(^\text{40}\). The *embarazo del mono* (where the monkey stands for the devil) can happen during the first trimester of pregnancy and occurs when one woman's pregnancy transfers to another woman (Freyermuth Enciso 2003:269; Guiteras Holmes 1961:104; Hurtado 1977:179). The devil/monkey takes the fetus out of a woman's womb (she will then hemorrhage), and places it into another women's womb (who will then wake up to a pregnancy of several weeks). Both parents are involved in preventing this from happening: the mother needs to be protected through prayers and the father asked to embark in ritual fasting (Freyermuth Enciso 2003:269). In a context where abortion is a tabooed topic, a hemorrhage during the first trimester and leading to the termination of pregnancy might then be explained by the *embarazo del mono*. On the other end, a woman suddenly showing signs of a two or three-month pregnancy can invoke sorcery. This is similar to the *ragued* in North African societies — a child that suddenly wakes up in the womb after years of sleeping (Lazali 2010)\(^\text{41}\).

In Mesoamerica, birth is a family event: the woman labors in fully dressed with the help of her husband (who sustains her while she is squatting, as in Picture 1): the *tam-alal* massages her, performs prayers, and catches the baby, while family and in-laws are in charge of warming the room, heating water, and among other (Berry 2010; Cadenas Gordillo 2002; Freyermuth

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\(^{39}\) Among healers too, prayers are used to heal, even when patients do not understand the words spoken (Waldran 2015).

\(^{40}\) For a more complete list, refer to Freyermuth Enciso (2003:269–271) and Área de Mujeres y Parteras (2004).

\(^{41}\) In both contexts, such unusual pregnancies are said to only happen to married women.
Enciso 2003; Guiteras Holmes 2010; Jordan 1993). When labor begins, most women know who their tam-alal is and the husband or another family member go and search for her. However, in some cases the tam-alal is sought after only at the moment of birth, or when the birth gets complicated (Freyermuth 2003). This can happen when the father is not involved (or has migrated) or when the woman does not know she is pregnant (Falla 2010)). When such is the case, the father-in-law — or any other person, at times an anthropologist (Eber 2000) — will take the husband's position at birth (Freyermuth 2003)\textsuperscript{42}. Freyermuth analyzes the masculine presence of the husband or father-in-law during childbirth as an element that reflects patriarchal control over women's reproductive decisions (2003). Contrary to this analysis, OMIECH sees the future father's presence as an important emotional support, which is an element of prevención that facilitates the birthing process. Women also express that the father's presence makes his bonding with the child easier (Miranda 2015). This situation is in stark contrast with what happens to women in the hospital, where the loneliness they experience is perceived by their families and parteras as an element of complication during birth (Berry 2008).

During the immediate postpartum\textsuperscript{43}, the tam-alal works in team with the rest of the family, making sure that both the mother and the baby are cared for. Tam-alaleletik do not cut the umbilical cord until the placenta (sme' alal, "the mother of the baby" in Tzeltal) is delivered. Practices regarding the disposal of placenta vary throughout the region, but most of the women and parteras bury it (Cadenas Gordillo 2002; Icó Bautista 1999; Freyermuth Enciso 2003)\textsuperscript{44}.

\textsuperscript{42} I have also seen a father helping his daughter give birth, because the husband was in a different city. In Agripino Icó Bautista’s video of a birth (1999), which is displayed for tourists at the Museum of Mayan Medicine ran by OMIECH (see Chapter 7), the husband is played by one of OMIECH’s staff members. In some communities however, the husband does not participate in the birth (Nash 1970).

\textsuperscript{43} The postpartum is divided into the first or acute phase (the first 6 to 12 hours), the second or subacute phase (2 to 6 weeks) and the third or delayed postpartum period (up to six months) (Romano et al. 2010).

\textsuperscript{44} The practice of burying the placenta expands to mestiza population, who will often plant a tree over it (interviews with non-indigenous mothers in San Cristóbal).
Similarly, the father buries the cord (inside the home for a girl, outside for a boy (Asturias de Barrios 1997)) or attach it to the highest branch of a tree, so that the child will be fearless (Cadenas Gordillo 2002). The tam-alal bandages the abdomen of the baby on the navel, and also tightly bandages the mother (fajar) to help her body "close up" after being open during birth. The family prepares chicken soup that will be shared by all after birth.

![Picture 1: Home birth in the Highlands. Courtesy of OMIECH. Panel used during community workshop to illustrate breeched birth (feet coming out first).](image)

As we can see, the tam-alal's role extends far beyond being just an "attendant" of the birth. In Oxchuc, young girls call Yametik Catalina "jibikil," literally "my cord," because she is the one who brought them into the world. The social role of tam-alaletik, who women and their families can visit in their home before and after birth, is a crucial element in the confianza between them, and contrasts with the relationship with doctors, who belong to different (geographical, ethnic, gender) spaces. The confianza that the mother and the family place in the midwife (which might also be influenced by the midwife's reputation) becomes the locus of the tam-alal's authoritative knowledge. Such knowledge might transcend gender hierarchies at times. For example, during pregnancy, the tam-alal explains to the husband the appropriate conduct he
should have with his wife, helping her with household chores and seeing her well\textsuperscript{45}. The \textit{partera} has authority to scold him if he does not follow the appropriate behavior (Icó Bautista 2008; Manca 1999:372). In some contexts, the \textit{tam alal}'s religious powers (if she is also a healer) help her maintain her authoritative knowledge (Cosmimksy 2001a:358)\textsuperscript{46}.

![Picture 2: Prenatal consult in Oxchuc. May 2015.](image)

With her striped \textit{huipil} and navy skirt, held tight by a \textit{faja} (sash), speaking only Tzeltal, Yametik Catalina could fit romantic descriptions of indigenous women untouched by modernity. But Yametik Catalina eagerly combines her expert knowledge of \textit{sobada} with the use of a stethoscope to listen to the baby's heartbeat (Picture 2)\textsuperscript{47}. Within Mayan medicine, the landscape is rapidly transforming, due to religious changes and government programs constraining the mothers' reproductive choices. Across Mesoamerica, those labeled Traditional Birth Attendants

\textsuperscript{45} See Freyermuth 2003:282 and Guiteras Holmes (2010) for a detailed list of husband’s expected and prohibited behaviors

\textsuperscript{46} In the case of \textit{parteras profesionales} or \textit{parteras capacitadas}, they, like midwives in the United States, rely on their intuition more than divine help. Intuition becomes part of their authoritative knowledge and allows them to make important decisions, like when to transfer from home to the hospital (Davis-Floyd and Davis 1996).

\textsuperscript{47} I have not seen Yametik count the beats, or pass the stethoscope to the mother to listen to her baby’s heartbeat, as professional midwives or other parteras in the city do.
(TBAs) like Yametik Catalina actively engage with biomedical practitioners and have been using tools of allopathic medicine for decades (Chary and Rohloff 2015; Cosmimksy 2001a; Davis-Floyd 2005). In countries with long standing traditions of medical pluralism, parteras and mothers choose the elements they want from the clinic (vitamins and folic acid), and combine them with elements from Mayan medicine (sobada and prayers). In the next chapter (Chapter 4) I come back to Yametik Catalina's story, and how it is interwoven with government programs training parteras. But in order to understand tam-alaledik's relationship with government trainings, I will first describe the empirical and spiritual path to becoming a tam-alal.

In the vast domain of health, several Tzeltal and Tsotsil specialists are in charge of caring for the wellbeing of the community (Figure 6). In the Museum of Mayan Medicine run by OMIECH in San Cristóbal (see Chapter 7), five categories of medical specialists are displayed, all belonging to the category of jpoxtawanej in Tzeltal / j'ac'poxil in Tsotsil ("the person with the medicine (pox)"). The j'ilot (priest-doctor) is "the person who sees" the illness by listening to the circulation of the blood pulse in the body (OMIECH 2005:5-6). The k'oponej witz (Tsotsil) or mountain priest (Ayora Diaz 2000) intercedes for the community by praying to sacred caves, mountains and water sources (OMIECH 2005:5). The tzac' bak (Tsotsil), is a Mayan bonesetter, and manipulates the body to heal (Hinojosa 2002). The ac' vomol (Tsotsil; hierbero/a

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48 Despite their ability to combine allopathic and traditional medical knowledge, and even in cases where relations with the clinic staff are good, the globalization of medical knowledge and the availability of allopathic medicine decreases the use of plants by indigenous women (Smith-Oka 2008).

49 Page Pliego translates j'ilol (plural j'ilolletik) as priest-doctors and refutes the Spanish translation of curanderos, healers, as a pejorative term used by the dominant group (2011:283). Such a term subordinates j'ilolletik to biomedical doctors. Ayora-Diaz uses pulse taker (2000).

50 In Tzeltal and Tsotsil, as in other Mayan languages, bak is the word for bone (Page Pliego 2011:19).
in Spanish) or herbalist masters the medical properties of plants and administer treatments.\textsuperscript{51} Finally, the \textit{jve'tome}\textsuperscript{52} (Tsotsil), \textit{tam-alal} (Tseltal) is the birth specialist (OMIECH 2005:200). Specialties are not exclusive to one another, and \textit{jpoxtawanetik} often cumulate several. In my research, \textit{parteras} across the spectrum used herbal remedies (including homeopathy among the \textit{parteras profesionales}) with three of them recognized as \textit{hierberas}. Freyermuth estimates that in 1993, 20 per cent of OMIECH \textit{jtamol} are also \textit{j'ilol} (ibid:324)\textsuperscript{53}.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{Figure6.png}
\caption{Medical Specialists in Highlands Chiapas (OMIECH 2010).}
\end{figure}

Drawing on Van Gennep's classification of separation, transition and incorporation (1981), Nájera Coronado identifies three ritual stages in the formation of \textit{tam-alaletik} (1999:390). First, the \textit{partera} experiences a separation from her former social position. Among

\begin{itemize}
  \item \textsuperscript{51} Because of their position in the family, women are more aware of the illnesses of their children and how to treat them, and are frequently hierberas, even if most of them only treat their families (fieldnotes, OMIECH workshop, April 2015).
  \item \textsuperscript{52} Page Pliego uses \textit{jvetom} or \textit{jtamol} for Tsotsil (2011:19)
  \item \textsuperscript{53} OMIECH only refers to these five specialties, but in her work on maternal mortality in Chenalhó, Freyermuth also mentions \textit{me'santo} (Tsotsil), \textit{él que habla al cofre} (Freyermuth Enciso 1993) — the person who talks to the chest. This has been documented mostly in Zinacantán (Guiteras Holmes 1961:18), and is more difficult to identify in other Tsotsil communities (Page Pliego 2011:123,227).
\end{itemize}
the Tsotsils, one's unique destiny as a *jpoxtawanej* is announced through a *señal*, a sign that will trigger the transformation (Page Pliego 2011)\(^{54}\). The *señal* can be a dream that the person has or it can take the shape of a severe illness affecting the future healer. The *j'ílol* is called, and s/he diagnoses the illness as the *señal* that the person has a special gift, a *don* (Ayora Diaz 2010:17; Page Pliego 2011:240)\(^{55}\). Once the *don* is detected, the family guides their son or daughter in their apprenticeship, as was the case for one of OMIECH's *tam-alaletik*, who is also a *j'ílol*:

"So my mother told me: 'Ay, this is good my little girl, so you are going to be a *j'ílol* like me, you will be a *j'ílol* like your grandmother. How good that someone is going to inherit the knowledge and power of the *j'ílol* when we die. Look, your grandmother passed away already, and it stayed with me, so when I will die, it will stay with you. All my knowledge I have, all the prayers I know, they will lay in you.' " (Page Pliego 2011:243)

If the woman accepts the *don*, she enters into the second stage of the transformation (I discuss later what happens when the person rejects their *don*). During this phase, the *tam-alal* transitions into her new social status and is in a liminal state, no longer her former self but not yet a *partera*. It is during this second stage that dreaming occurs. Dreams are a mode of transmission of sacred knowledge in Mesoamerica (Jenkins 2003; Paul and Paul 1979) and across the world (Eliade 1964). In his work with thirteen *j'íloletik* in Highlands Chiapas, Page Pliego estimates that the number of dream is of three at minimum (per specialty), and can add up to twenty-three. Even though most of the knowledge is revealed through dreams, the *tam-alaletik* I interviewed seemed to agree that the person could also trigger the initiation by "praying to God with all their heart."

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\(^{54}\) Even non-indigenous *parteras* and midwives in other settings, such as home birth midwives in the United States refer to a "calling" that triggered their learning of midwifery (Davis-Floyd and Johnson 2006a).

\(^{55}\) Similarly, Page Pliego and Hinojosa (2002) describe how Mayan bonesettters learn through their fractured body how to heal others: "The deities indicate them that in order to learn about diseases, the illness needs to go through the [future healer]'s body, so that s/he knows them by feeling the pain and learning how to "fix them""(Page Pliego 2011:289).
Today, dreams are losing their pivotal place in the formation process. Among the parteras I interviewed, only one jtamol – the same who worked with Page Pliego – mentioned her dreams as the primary source of her knowledge. For tam-alaletik and bone setters, empirical learning is foregrounded (Hinojosa 2002) as they can acquire prestige through successful practice — unlike j’iloletik who cannot pretend to be j’iloteletik until they have received their oneiric formation (Page Pliego 2011:254). This successful practice constitutes the third phase of parteras' training, and marks their reincorporation in the community under a new status. For all jpoxtawanej, a successful practice and regular dreaming are means to update their knowledge, which enables them to keep up with changing diseases (Page Pliego 2011:328).

The recognition of one's empirical experience in becoming a tam-alal is illustrated through the recurrent affirmation aprendí sola, "I learned by myself." In the eponymous documentary produced by OMIECH, a Tsotsil jtamol explains:

"I learned by myself. And I asked myself: 'how is the massage done?' Then I remembered how my midwife had done it to me before, and so, following my memories, I could feel if [the baby] was in the normal position, or if it was breeched." (Icó Bautista 2011)

In the case of tam-alaletik, "Aprendí sola" also refers to learning out of necessity, after these women gave birth on their own. Birthing alone is often a defining moment, and for some future parteras it sparks the desire to help other women in the same situation (García Delgadillo and Potts 2015:182). For others (including those who are not parteras), this previous embodied experience becomes useful when they unexpectedly find themselves confronted with a laboring woman. A teacher in her late forties, whose mother is a jtamol (Tsotsil partera), had to attend several births in the communities where she worked, "I am not a partera, but as a teacher this is also part of my commitment to the community. (...) The teachers in the communities, they act also as lawyers, doctors…." Reflecting on the treatment that teachers now receive from the
government, in a context of massive strikes against educational reforms, she added, "But now they have lost respect; they don't respect the teachers anymore." This notion of respect is central to the work of teachers and parteras: mutual respect is essential between teachers and their students, women and their midwives, and also between government and the people. In Tseltal and Tsotsil, this mutual respect is called ich'el ta muk'.

The word ich'el means both "to receive" and "to be received," and muk' is the root of "grand, grandeur" also understood as "dignity." The preposition ta links the two words, and so ich'el ta muk' can be translated as "to recognize, recognition, respect, honor," or, as Xuno López Intzin, a researcher and my Tseltal professor, eloquently put it, ich'el ta muk' is "an interpellation towards the Other." For Xuno, ich'el ta muk' is an attitude towards other living and non-living beings to recognize their greatness, "it is everything, absolutely everything. [That] the little like the great has its own greatness." Following my conversation with Xuno, I started asking my Tseltal and Tsotsil informants and friends about the translation of ich'el ta muk' in Spanish, and their response would invariably be the same, "it means respect." Don Manuel, Yametik Catalina's husband described it this way:

"Don Manuel: It's respect, from the young towards the elder. It's like someone who is in High School now; well, he used to be a kid [and learn to respect]. But now these kids they don't even say 'goodbye' anymore to the elder men, to the elder women. There are no more goodbyes. This means that they don't have respect, mayuk ich'el ta muk'. Because you have to respect those who are older.
Mounia: And from an adult towards a child, is there also ich'el ta muk' or is it something else?
Don Manuel: No, it's the same. We too know how to respect children: 'Goodbye children, goodbye little children, [we say]'. So this means that it is among both, not only from the adults, also from the children. But they don't know how to behave anymore."

Ich'el ta muk' is respecting the other by maintaining harmonious relationships between all members of the community. First, Don Manuel elaborates that younger children must show ich'el
"ich'el ta muk" towards elders, which is something that they learn to do (Pitarch 2001:133). But then he explains that adults must also behave correctly with children and teach them "ich'el ta muk'.

If "ich'el ta muk" is unequivocally translated as respect, when I asked how rights (derechos) would be translated in Tzeltal, the definite answer was... "ich'el ta muk". The Universal Declaration of Human Rights translates derechos, rights, as "ich'el ta muk". In an attempt at diffusing knowledge about key international documents, and raising awareness about indigenous peoples' rights in their own language, international organizations and the Mexican state rely on "ich'el ta muk" without trying to incorporate the essence of "ich'el ta muk" in the spirit of Western law. Already a polysemous concept, "ich'el ta muk" takes on an additional meaning when associated with derechos. But in the translation of rights as "ich'el ta muk" something is lost, and it is the notion of respect, that any State should have towards its citizens — mirroring the "ich'el ta muk" that community leaders have towards community members (Xuno López Intzín, personal communication). The phonetic translation of derechos as rerecho found in the Universal Declaration of Human Rights further separates "ich'el ta muk" from derechos (United Nations Information Centre, Mexico 1998).

The difference between "ich'el ta muk" and derechos can be analyzed in relation to socioeconomic changes, as a former local leader remarked, "[young people who go to school], they don't know how to receive others with greatness anymore, because they say that now they have rights (...) They talk about their rights and they do about everything except this, the "ich'el ta muk""). When moving away from their communities, young men and women learn about their rights and forget "ich'el ta muk". Derechos take away "ich'el ta muk", and

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56 I now understand that the many times Yametik Catalina and Don Manuel corrected me for not using the correct salutation for people passing on the road that borders their house, they were treating me like a child and teaching me "ich'el ta muk". Again and again they would correct me, encouraging me to greet strangers, and scold me when I did not.
young people "don't know how to receive others with greatness, because they say that now they have rights" (López Intzin 2011:10).57

In this framework, how are *parteras'* *derechos* understood? How do they exert *ich'el ta muk'* in their practice—and can it be translated to *derechos*? When I tried to ask about the rights of *parteras* it sparked confusion among my listeners (besides OMIECH). They mentioned the duties of the *parteras*: such as the *partera* needs to care for women, or the *partera* needs to call the doctor if something goes wrong. When they respect their patient and attend births successfully, *parteras* gain respect and women keep coming to them. Because of their knowledge of plants and of the body, *parteras* interact with a wide range of beings (especially those who are also *j'iloletik*). It is by showing *ich'el ta muk*, understood as recognizing the other, that *parteras* maintain their ability to attend births. This ability to attend births moves onto the human rights terrain when the relationship is not longer between midwives and their patients but between government and citizens (a point I further discuss in Chapter 4). The relationships to rights (granted or not by the state) then differs from *ich'el ta muk'* which is reciprocal by nature: in order to receive *ich'el ta muk'* from others, one needs to give it; this is how the *lekil kuxlejal*, the "ideal of humanity" (López Intzin 2011) can be achieved. From my conversations with Xuno and Micaela, there seems to be an agreement that this ideal has been achieved in the past, but that it has been lost, and that if indigenous peoples are able to achieve *ich'el ta muk'*; then the *lekil kuxlejal* becomes a possible future. *Tam-alaletik* and *j'iloletik* are key actors in the construction for this harmonious future. However, despite receiving the *señal* some women refuse to fulfill their destiny. Why and what happens to them is the topic of my next section.

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57 This starkly contrasts with Foxen’s findings among K’iche’ in Guatemala, where elders encourage young people to fight for their rights, a prolongation of notions of authority and respect (2010:78).
"Yo no soy partera:" going against one's calling

When I first heard the word *tulan*, I was confused. It was one of my first interviews and my Tseltal was still shaky. Realizing that *tulan* means difficult, I started to pay closer attention to this word, and realized that it appeared in almost all of my Tseltal transcripts (as did *difícil* (difficult) in Spanish ones). In this section I explore what makes the *parteras'* work *tulanix* (difficult indeed), and how recent socioeconomic reforms add on to an already demanding profession, impeding the transmission of their knowledge.

In the 1980s, the financial crises opened the continent to neoliberal reforms in Latin America, based on financial austerity and decentralization. Reflecting on her fieldwork in Chiapas, June Nash noticed that neoliberal reforms led to the "reversal of social contract" between indigenous communities and the nation (Nash 2001a:78): the state's withdrawal transfers the responsibilities of education and health on the shoulders of citizens (similar in Bolivia (Escobar 1998; Postero 2007)). This New World Order (Nash 2001a) emerges under the auspice of what Collier (2007) refers to as "bourgeois law:" a world where capitalism, the legal system and patriarchy are intertwined. More than economic reforms, neoliberalism carries a political project, reshaping subject formation and meanings of citizenship (Gledhill 2007; Harvey 2005; Marcos and Waller 2008), which impacts more strongly already vulnerable populations. Chiapas has been a site of particularly devastating structural reforms like the North American Free Trade Agreement (NAFTA) in 1994, and the Plan Puebla-Panamá (PPP) in 2001 (in 2008, the PPP was renamed the Mesoamerica Project with a substantial portion focusing on health (see Chapter 4).

Doña Emilia is a seventy-seven-year-old *partera* who lives in the *municipio* of Oxchuc, in a village near Yametik Catalina's. She did not learn through dreams, but was trained by two
nuns from the Presbyterian Church who taught her to use plants and how to give injections. In this region, Presbyterians have a long history of demonizing traditional healers, which contributed to their disappearance (Freyermuth Enciso 2003:57; see Page Pliego 2010 for a detailed history of religion in Oxchuc). Doña Emilia went through empirical training, attending one birth after another. She became famous beyond her village and in the neighboring municipios. When the clinic of the Mexican Institute of Social Security (IMSS) in Oxchuc formed a group of parteras, she joined in. Her daughter Daniela, now in her late fifties, started to attend the group meetings with her mother, and to represent her when she was sick. Her mother is now very tired and has almost stopped attending births, although she has been carried on a chair from her house to the birthing woman's to care for her. This is the reason why Daniela moved back (from San Cristóbal) to live with her parents, and brought her fourteen-year-old daughter along with her. Daniela and her daughter take care of the house, and have a little tienda, shop, where they sell basic supplies and some medication. Daniela's daughter goes to school in the village. When I went to the parteras' meeting in Oxchuc with both of them, Daniela said that she might stop attending: it is taking time out from her duties and neither she nor her mother deliver babies anymore. The bimonthly stipend her mother receives (1,500 pesos; about US$125) is not a strong enough incentive for them to keep participating. When I ask Daniela's daughter if she is going to be a partera, she shakes her head and tells me that she is not really interested. She has been to the trainings with her mother and grandmother, but she always falls asleep. I ask her what she wants to study; "I want to be a doctora (doctor)," she replies with a large smile on her face\textsuperscript{58}.

\textsuperscript{58} Gálvez shares a similar story in Oaxaca, where she interviewed a partera empírica and her daughter, an obstetrician (2011).
The story of Daniela, her mother and her daughter, illustrates the changes impacting the transmission of indigenous midwives' knowledge in the Highlands. While older tam-alaletik still engage in new and innovative ways with their practices (Chary and Rohloff 2015; Cosmimksy 2001a), their daughters and granddaughters, who are less committed to village life, look for more profitable alternatives. These changes in partería (midwifery) are symptomatic of broader changes in the social organization of indigenous communities. The reasons these young women invoke for rejecting their grandmothers' calling are related to the high commitment the profession requires. Even those who have attended births occasionally shared their fear of blood and the discomfort they feel when seeing another woman in pain as reasons why they shy away from becoming parteras. On their end, the tam-alaletik all complained about the difficulties of their lives, which includes leaving their family at any time of the day or night, traveling long distances in the rain, the scarce payment, and the physical weariness. "Me buscan," they are looking for me, they often repeat. Tam-alaletik use this euphemism to refer to the inexorable nature that of their don: at any time of the day or night, women seek them. Because of the peculiarities of parteras' work, who "live at the margins of some of the socially established rules for women, in a liminal space beyond sexual and gendered differences" (Manca 1999:372), family and marital support is crucial. Women who are allowed to go out at night to distant houses either have the support of their husband, are widows, or live in a household where other women can take on domestic duties (Page Pliego 2011; Paul 1975; Paul and Paul 1979). In cases where her husband has also been trained in health, the couple attends births together. Being together reinforces the bond of trust between husband and wife, and also avoids jealousy and discontent among spouses. On the mother's side, having two tam-alaletik, with one who is a

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59Women who are indisposed by blood can be dangerous for the newborn: "Unwilling parteras (disgust) can provoke diseases of the newborn’s soul" (Page Pliego 2011:287).
male, helps in negotiating in case of transfer. As studies have shown, the female tam-alal, even if experienced, is rarely the only one deciding of a transfer (Berry 2006; Freyermuth Enciso 2003), which is different in the setting of homebirths of middle-class women where midwives' authoritative knowledge is the determining element for transfer (Davis-Floyd and Davis 1996).

Tam-alalek's authoritative knowledge has come under increased scrutiny from the government, medical personnel and even some families, who question their practices. Migration, mass communication and conditional cash-transfer programs distort the confianza between parteras and their patients. The combined effects of: the economic crises impacting tam-alalek as campesinas (farmers); government programs aiming to eradicate poverty, lower fertility rates and increase school attendance that target them as mothers and; television shows and telenovelas (soap operas) that make their ways into Tseltal and Tsotsil homes, leave no time for dreaming. When I interviewed Tania, an activist who formerly worked with politically organized parteras, she poignantly described the difficulties of transmission of women's knowledge,

"There is no time for dreaming: women are over-occupied, all of their time is filled up, and women are violated and marginalized in their political activities. They all have their television now; this does not leave any time for organizing... We are in another moment of capitalism in Mexico, a very savage moment"

Not only do younger women like Doña Emilia's granddaughter show little interest in their mothers and grandmothers' occupations, they also claim that they do not have partera dreams. Perhaps it is that young women do not have tam-alalek dreams, or perhaps they do not report their dreams — voluntarily or involuntarily, as the spaces for dream sharing are disappearing due to the same factors (television, wage labor). In both cases, not being able to dream is in a strong indicator of the structural changes happening in indigenous communities. Dreaming is associated with traditional medical knowledge, and young men and women do not see it as a desirable future for them. "It indicates a disdain for their own culture. Poverty is assumed and the
perception of campesina class is lost," Tania adds. Indeed, young women come to associate their mothers' and grandmothers' don with poverty and underdevelopment – a discourse fueled by government campaigns (Dixon 2015; Gálvez 2011). This pushes some of them to refuse their calling, a decision not without consequences.

What happens to those who refuse to follow their destiny and listen to their dreams? Whether j'iloletik or tam-alaletik, the consequences are the same: the person gets sick, has bad luck, and can eventually die (Page Pliego 2011:274). Their untimely death does not generate much empathy from the community (Paul and Paul 1979:710). In Guatemala, Walter Little reported the story of a young woman who, despite her many dreams, at first pushing her to fulfill her destiny and then warning her about her faith, refused to become a partera and studied to become a teacher. Her early death in a truck accident was interpreted under the light of her refusal to fulfill her calling (personal communication). In this section, I share my colleague Micaela's story to illuminate the dilemmas women who receive the calling face.

Micaela Icó Bautista is a Tsotsil woman in her mid-fifties, and one of the founders of the Organization of Indigenous Doctors of Chiapas (OMIECH), where she is in charge of the Women and Midwives Section (Área de Mujeres y Parteras). The goal of the Section is to revive local knowledge about medicinal plants and therapeutic techniques (such as massages) used by tam-alaletik during pregnancy, birth and postpartum. An activist working alongside parteras for over three decades, Micaela has witnessed the decline in traditional midwives' activity, and the lack of transmission of their knowledge to younger generations. A couple of months into fieldwork, I arrived at OMIECH to find the door of the Women and Midwives Section office closed (it is always open when Micaela is in). After knocking, I heard Micaela's voice:
"Mounia? I am with my patient
- Can I come in? I ask, hearing voices behind the door.
- Yes, pásale, come in. As I open the door I see a woman sitting on a chair gesturing for me to come in. Come in! You are a woman, there is no reason [for you not to]."

I pushed the door and noticed a second woman laying face down on a mat and blankets on the floor, and Micaela on her knees next to her, massaging her back. I sit down, wondering, "How often has Micaela done this? Why? How do people find her?" and most important, "How come I was not aware of this?" I knew that Micaela had a vast knowledge of the human body, and had learned acupressure\(^\text{60}\), but I somewhat dissociated her massaging me on a bus ride to counteract my carsickness from the formalized session I was now witnessing.

The woman had come to Micaela because of pain in her lower back, what Micaela diagnosed as aire or reuma, a common condition of pregnant women (Área de Mujeres y Parteras 2004): the baby's changing positions press on different parts of the woman's body and cause her pain. Whatever the condition her patient presents, Micaela's massages follow a roughly identical script. First, the woman lays on her back (boca arriba) while Micaela warms the body to by touching the shoulders; second, she moves her patient to her sides, massaging the neck, arms and back; finally she massages the back while the woman is on her stomach boca abajo (in the case of pregnant women, she skips this phase). Micaela then asks her patient to come on her back again, and proceeds to the closing, by massaging the whole body once again, from head to toes. The final closing gesture consists of an imaginary cross that she draws on the lower abdomen, with a little saliva on her index while she recites the Trinitarian formula, "in the name of the father, the son, and the holy spirit"\(^\text{61}\). While she is massaging her (Picture 3), Micaela asks her patient how she is feeling, if it hurts, and as she massages over the same spot, if she is feeling

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\(^{60}\) digitopresión is detailed in one of OMIECH’s publications as "the pressure applied with the fingers on a part of our body (…). This form of healing was invented by traditional Chinese doctors; this practice is good, simple, and does not cost any money" (Área de Mujeres y Parteras 2001:30).

\(^{61}\) Micaela follows the same script of Mayan parteras in Guatemala (Hinojosa 2015:86).
better now than earlier. She then tells her patient to rest a little, and to be careful when getting up. While she is massaging them, Micaela tells the patients about remedies they can take, names of plants to drink and use in the temazcal (steambath, see Chapter 5). Women stay fully clothed during the massage, rolling up their shirts when necessary. Micaela asks pregnant women to loosen their pants or skirts. During the whole massage, Micaela uses baby oil on her hands. After the consult, she directs them to the organization's herbalist shop and/or garden to collect the plants needed. When the patient has left, we roll up the blankets and Micaela washes her hands with rubbing alcohol.

![Picture 3: Micaela showing how to massage the uterus. June 2015. Courtesy of Alice Bafoin.](image)

Micaela was introduced to acupressure through health workshops in the 1990s. She then reinforced her skills by massaging her own body and those of her family members. Like other indigenous peoples in Mesoamerica, Tsotsils and Tseltals use a hot-cold dichotomy to categorize illnesses, plants and food (Messer 1981; Page Pliego 2011). The oil Micaela uses cannot be hot nor cold or it will hurt the patient. Micaela particularly enjoys argan oil I bring her from Morocco.

In Guatemala, massage became better known around the same time. During the 90s, there was a Japanese massage therapist living in Todos Santos and many women regularly visited him in order to address issues in their bodies. Weavers were especially enamored, for dealing with the aches of working on the backstrap loom for many hours each day (Jennifer Burrell, personal communication).

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and even OMIECH parteras recognize her massaging skills and often seek her when they are sick. The problem Micaela points out is that after she gives a massage, she gets very tired — she often sweats in the process. This is similar to the j’ilolletik, fighting the disease of her patient passes on to her and so she needs to protect herself (Page Pliego 2011:284). Micaela complains that when she is herself tired and sick, she is not able to find anyone who can massage her. She would mimic on my body other peoples' attempts, which are either too soft and have no effects, or too strong and painful.

Micaela's knowledge about plants and the diseases of the body and the ch'ule mark her as a hybrid specialist — a mix of huesera, hierbera and partera. She attends more than just pregnant women, sharing the fate of the jpoxtawanetik who "have to attend to all people, without distinction of age or sex" (Page Pliego 2011:261) and cannot charge for their practice. Mayan medical specialists rely on their patients' voluntary cooperation; if they start to charge, then they cannot fulfill their mandate of attending people without distinction. However, Micaela does not define herself as a jpoxtawanej. The only way she positions herself is through what she is not: a partera. When she massages pregnant women, Micaela is very cautious of talking to them about their partera: Have they found one? Is she good? Does she massage them the same way she does? When women answer that their partera is not as good as Micaela, she is at the same time happy and cautious to explain that she is not a partera. I have also seen Micaela negate service, sometimes because she was tired or did not have time, "I don't like the idea to charge people" she explains. This is part of the reasons Micaela does not want to have a signboard (letrero) up at the

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64 The concept of ch’ule has been translated as “soul” (Freyermuth Enciso 2003), or “the other of the body” (Pitarch 1996:32). A person has several ch’ule, the healthy Tsotsil person possesses thirteen of them (Page Pliego 2011:173; Hinojosa 2015:7).

65 In the case of j’ilolletik their mandado obligates them to attend people outside of their family circle, under the threat of being subject to the same treatment as those who refuse the cargo. This requisite does not seem to apply to parteras.
entrance of the organization, as friends and colleagues suggested to her by. During a conversation with a collaborator from Germany, whom she has known for years, Micaela explained that if she had a sign advertising her work, she would then be obligated to provide services, which would constrain her own schedule: What if she was not able to be in the office that day? What if the person thought the price was too high and was not satisfied with Micaela's service? They would not be happy, and neither would Micaela.

Why does Micaela massage under such sporadic conditions? And what does it have to do with *parteria*? For Micaela, massages are a way to fulfill part of her calling as a *partera*. In her autobiography she describes how she received the calling, through her dreams (Icó Bautista 2008). She attributes part of the hardship she has suffered in life to her unwillingness to fulfill her calling as a *partera*. Several people have warned her about the consequences of her refusal, consequences she has endured up to a certain point. In her story, she retrospectively analyses many of her illness and the problems she has faced with her children through the lens of her refusal to become a *partera*. Bargaining with her destiny, it is only recently that she has started to perform *sobada*. This change in her attitude took place after she was invited to Guatemala to participate in a women's encounter in 2013. During this meeting that lasted a couple of days, one of the Guatemalan women, who was a *partera*, approached Micaela and told her "you are a *partera*, aren't you?" Micaela started by denying the fact, as I have seen her do many times, vehemently. But the woman insisted, "I don't believe what your mouth is saying. I see you: they gave you [the don] but you do not want to fulfill it." Micaela got scared and finally gave in, "yes I have had the dreams, but I have refused to do it." The Guatemalan midwife proceeded to confirm to Micaela what she already suspected: that her misfortunes were due to her refusal. After hearing Micaela's reasons for not fulfilling her calling – the same reasons I describe earlier
the Guatemalan woman convinced Micaela to at least accept part of the work and help heal others who needed her, even if she did not attend births. From that moment on, Micaela started to provide massages to strangers, accepting the donations they would give her.

Refusing one's calling is not only about challenging one's destiny. I analyze it as a failure to comply with the imperative of reciprocity that guides communal relationships (Mauss 1923). If the community provides the individual with security, food, rituals etc., then anyone who has received a special gift must share it with others in return. Refusing to comply with this rule breaks the reciprocity and puts the health of the community at risk. Micaela's dilemma about her calling and her decision not to charge for her services echoes the choice of other parteras, however, in a context of increased monetarization of health, more and more tam-alaletik ask for financial compensations. This is precisely why Micaela does not want to have a letrero indicating that she gives massages. It would imply that she charges, which might discourage some of the people to seek her – the very population that she feels she has to help. The patients Micaela attends range from a mestiza woman visiting from the Northern part of the country (Monterrey) who is experiencing back pain, to indigenous pregnant women living in San Cristóbal, and a sick young boy from the Selva. Often, Micaela's patients would come back, and depending on their condition she would herself ask them to do so to follow-up on their treatment. She does not have a fixed price for her services, and relies on her patients' cooperation, explaining that it helps her buy oil and alcohol. During my fieldwork, Micaela cared for about ten patients, with an average number of visits of two per person. While I have seen Micaela return money to her patients for what she perceives as overpayment, I have never witnessed her ask for more money than what she was given. When we were alone, we would comment on the amount; I would prompt her most of the time, "So, how much did they give you?" and she would
show me, adding "Está bien (it's good, it's enough)." In one case only did she spontaneously tell me the amount she had received. As I arrive in the office on a January morning, she tells me that a sick child came with his father for a sobada the day before. "Do you know how much he paid me? " she asks. "A treasure," she adds with a tender smile while showing me three pesos. "Because I told him it was voluntario, voluntary contribution. This is why I don't set a price, she explains to me. It's like me, even though I am sick, I will not go to the doctor because of the price of the consult. I don't want my patients to feel this way." A few days later, the little boy and his father came back. He gave her 5 pesos (US$ 0.40) this time, almost enough for a kilo of tortillas we calculated.

The low pay that parteras receive for heir work is one of the challenges that come with their calling. Some parteras say they are ashamed to charge (Parteras, Promotoras y Promotores del CCES 2002). Another explanation for not charging is that money is cold, and so when the j’iloletik receive it in the right hand (that they use to cure), they lose heat, and so lose the power to cure. Some healers avoid this curse by receiving money in their left hand (Page Pliego 2011:296). In an interview, Micaela gives her own analysis about why a good j’ilol or tam-alal cannot charge for their services:

"They told me that [j’iloletik] cannot charge, because they can loose their right to be healers or to be parteras (...). The sick woman, sometimes she does not have money. And so she starts to think "oh God — because this is how they talk — oh my dear God, look at how much s/he charges. I hope that s/he cures me, s/he heals me. They charge so much. Just because they are j’iloletik." Well this is why they diminish their power. [If they charge money] they loose their power, they block it out."

Micaela makes a strong case against the monetarization of health, framing healing as a service to the community, and to the poor in particular. When health is tainted with money, it excludes certain persons from accessing it, usually those who most need it. In our conversation, Micaela switches back and forth between derecho (rights) and poder (power) to characterize the
"j’iloletik's actions, making the two words synonyms. If a *jpoxtawanej* charges, s/he loses the right/power (given by God) to cure. Just like God has given the right/power to become a *j’ilol* through dreams, it can take it back if it is not used properly. As we will see in the next chapter, Micaela and OMIECH defend the right to practice traditional medicine in the face of government programs limiting them. However, in this particular conversation, Micaela is talking about the right of people to have good health (part of the *lekil kuxlejal*), which counterbalances the right of *jpoxtawanej* to practice. The punishment for charging for a *don* serves as a control mechanism to ensure that those entrusted with such powers do not abuse it by accumulating money and dispossessing other members of the community (Harvey 2005).

Reciprocity is the central act of communal economy, in which social relations and economic (not necessarily monetary) relations are intertwined (Gudeman 2001). When seeking a *partera* or asking for a *sobada*, indigenous women will ask them if they would *hacer favor*, do them a favor. This euphemism illustrates the non-monetary value of the service: if the gift is a favor, then the counter-gift can be a "thank you." It can go beyond this and turn into a material counter-gift or a monetary one, but not necessarily (Jenkins 2003:1905; Hunt, Glantz, and Halperin 2002:105). The *parteras*, like other Mayan medical specialists, are supposed to take what the family gives them in exchange for their care: food, clothes, small animals, and wood, among other. The payment is not always immediate and *parteras* never know how much they will receive. Doña Margarita, the mestiza *partera empírica* who lives in Las Margaritas, explained,

"There is this family, I caught all of their babies. After the first birth, they did not pay me, so I just let it go, because sometimes people just don't pay you [as a *partera*]. At the following harvest, the father came and brought me big sacks of corn and beans. It has been like this every year since then."
Of her work as a *partera*, Doña Margarita says "It does not make us rich, but at least we always had food on our table." Even if she lives in a town, Doña Margarita does not set fixed price, which contrasts to the *parteras* I interviewed in San Cristóbal, who tend to have a fixed price for prenatal care and birth (see Chapter 4). A mestiza *partera empírica* in her seventies who lives in San Cristóbal repeated several times during our interview "Me, I don't work for free," positioning *partería* not as *don* or a duty but as paid labor.

Throughout this chapter, I mapped out the transformations occurring in *tam-alaletik*'s lives. Their vast knowledge, a gift from God, is conditioned to them serving women in their communities. However, due to the government program Prospera, pregnant women are increasingly seeking prenatal care at their local clinic, for which they receive a monthly stipend. Another consequence of the program is that it pushes *tam-alaletik*, once central actors in their communities, towards the margin of the health system. Prospera is just one example of the changes happening to the Mayan health system. The loss of the centrality of respect, *ich'el ta muk*, affects community relations altogether: in a context of cash economy, some *tam-alaletik* have started to charge for their services, particular in urban areas. I discussed the complex impact of such decision: if charging can be a way for midwives to assure a minimal retribution for their work, it can also prevent some families from accessing their services at all. I argue that the changes in charging for services is not a small shift in individual practices but rather, central to the broader changes in health policies that are happening in Mexico. In the end, this economic retribution is not a strong enough incentive to attract younger women in the profession, who associate it with the past while biomedical careers are seen as the only desirable option. To free themselves from their calling and its concurrent obligations which arrive through dreams, young women claim that they do not have dreams. "There is not time for dreaming," an activist
deplored, referring to poor women's increasingly monitored schedule. They have "all of their time occupied" through their various commitments to government programs, she added. Such commitments illustrate once again the tensions between the margins and the center: because they are central figures of the fight against poverty and maternal mortality, women have to regularly attend various meetings and events. In return, this mandatory attendance only marginalizes them further, leaving no time for their own organizing and driving them and their communities a little further each day from the lekil kuxlejal.

In the following chapters, I describe other facets of this decomposition of community health. One of the contributing factors to it are government trainings for parteras. These trainings, like the fact of charging for a sobada, erode the roots of confianza between women and parteras, and create competition among parteras. I contrast these government trainings to OMIECH workshops, which stem from the confianza between Micaela and the parteras. While the first ones use a discourse of right to health to circumscribe parteras' actions, the second rely on a discourse of respect to defend tam-alaletik's rights to practice.
Chapter 4. Behind the Smokescreen.

*Capacitaciones and the Molding of Future Parteras*

In 2014, Mexico was the deadliest country for journalists in the Western hemisphere (Reporters Without Borders 2015). In their report, Reporters Without Borders point out to the vulnerability of human rights defenders, journalists and activists (2015). On the Global Peace Index, Mexico ranks 144 (out of 162), behind countries with very violent histories, such as Rwanda, and just before Lebanon and Colombia (Institute for Economics and Peace 2015). In a context of violence and insecurity, already vulnerable populations are even more at risk. Particularly, in the past decade, there has been an increase in feminicides – crimes targeting women specifically because of their gender. In November 2015, over a period of ten days, six women were killed in different localities of the Chiapas (SIPAZ 2015); in the whole country, seven women are killed each day (Muñoz Ramírez 2016). Anthropologists analyze the context of impunity and the militarization of the country as a direct consequence of government policies, making the state itself a perpetrator of violence (Hernández Castillo and Mora 2008). The impact of violence against women affects every aspect of society, as gender-based violence is inextricably linked to structural violence, itself rooted in social injustice (Galtung 1969). As the national state fails to act upon those cases, indigenous women's social and structural positioning puts them more at risk for violence and is a barrier in their access to justice (Sieder and Sierra 2010). At the margins of the state (Das and Poole 2004), indigenous women suffer a wide range of discriminations, which impact their reproductive health, ultimately leading them to die more in childbirth. In Chiapas, indigenous women represent less than a third of the female population.

66 "The living conditions of the victims of feminicides are part of a social dynamic in which violence is propagated because, in one way or the other, [violence] is assimilated in everyday life" (Arteaga Botello and Valdes Figueroa 2010:33).
(Gobierno del Estado de Chiapas 2014) but almost half of the overall maternal deaths (OMM, 2013). Government efforts to improve indigenous women's living conditions and better their reproductive health have relied on cash-conditional transfer programs on one hand (Chapter 3), and on the training of indigenous midwives on the other. As we have seen in Chapter 3, women at the heart of such programs are highly critical of their consequences, which disrespect heir bodies and their way of life. In this chapter, I analyze the impacts of trainings specifically targeting empirical midwives (capacitación, plural capacitaciones). I also discuss how local activists rely on human rights to criticize the physical and structural violence indigenous women live and which state programs perpetuate. In particular, OMIECH argues that tam-alaletik and physicians have a differentiated access to rights. This difference is what allows doctors to get away with acts of obstetric violence, such as routine episiotomies on laboring women, which have become endemic in the country (GIRE 2015; Zacher Dixon 2015) and that I describe more in depth in Chapter 6. In contrast, parteras do not have as "much" rights, and are systematically blamed for unfavorable birth outcomes. This message is conveyed during the capacitaciones for parteras, which exhort them to refer their patients to higher levels of care. I argue that these state-promoted trainings are yet another instance of the little confianza between the Mexican state and indigenous midwives and contrast to OMIECH workshops, which take an opposite direction and draw on community knowledge to preserve tam-alaletik's practices.

In this chapter I analyze several impacts capacitaciones have on the work of parteras; first, only parteras who regularly attend trainings can register newborns, which disrupts the confianza between women and their parteras; second, the mandatory meetings devaluate parteras' authoritative knowledge, subordinating it to the public health system; third, capacitaciones contribute to the stratification of midwifery by differentiating between the good
partera who goes to trainings and the bad ones who does not, which generates competition between parteras and finally; the trainings are part of the global strategy of professionalizing midwifery, which further marginalizes tam-alaletik who are not included in the modernization project. To analyze capacitaciones and their consequences, I rely on a rights in practice approach, which incorporates the power differential between biomedical health practitioners and traditional midwives.

**Defining indigenous midwives' rights in the face of gendered structural violence.**

Since the Zapatista uprising in Chiapas, human rights have provided a powerful framework for NGOs and civil society to call attention to the structural violence in indigenous peoples' lives (Speed 2002). Similarly, organizations working in the field of indigenous health rely on human rights to reframe maternal deaths not as the consequence of partera care but as the outcome of a series of state neglect: "Maternal mortality might be one of the most serious expressions of a series of omissions and violations of the economic, social, and cultural rights of the woman and her whole community" (Arana 2002:47). A human rights approach to maternal mortality allows framing maternal deaths as a violation of women's rights. It also highlights how blaming indigenous midwives is a violation of their rights as indigenous peoples. This blame happens in everyday discourses and is implicit during government trainings for parteras. In its critique of capacitaciones, Micaela points out is to the complex entanglement between rights, culture and blame,

"But they die, they do. They say 'neverrrr, ever;' they never admit that babies die, that mothers die over there [in the hospital]. They put the blame on the women, on the parteras, because they are indigenous…They say that this is why parteras must go to capacitación. If mothers or babies die (with the partera) they are quick to condemn them (...) [They say] that the midwife is worth nothing, that it is the pregnant woman's fault, that it's because of this, because of that… The government workers go "Well, babies never die [in the hospital], never..."No. It is not true that they don't die, that they don't
die in their hands... But they never admit this, because [the doctors] have mucho derecho [much right]. Yes, this is why: they have much right. Because… it is legal, it is within the law, because they have their degrees, their doctorates and whatnot… everything." (El Kotni and Icó Bautista 2014)

For Micaela and OMIECH, there is an uneven reaction to maternal mortality depending on where it occurs. Indigenous midwives are systematically blamed while doctors are hardly ever held to account because of the social prestige their profession carries (their "titles" and "doctorates"). Parteras might have their rights inscribed in the Constitution, but in practice they are the ones blamed in case of a bad birth outcome. Other conversations with Micaela and colleagues at OMIECH indicate that, like in the case of the cholera outbreak in Venezuela, indigenous peoples are blamed for their culture (Briggs and Mantini-Briggs 2004). This culture of blame stems from parteras' situated knowledge, that of poor, not formally educated, Tseltal/Tsotsil, women. How can their knowledge compare with that of rich(er), educated, mestizo, masculine (or masculinized) professionals? When calling out the difference in rights between doctors and parteras, Micaela and OMIECH analyze human rights through the lens of these material conditions. By positioning indigenous peoples as historical actors who are also subjects of rights (and not just as objects of history), Micaela follows the "preferential option for the poor" which challenges the opposition between culture and rights, (Kovic 2005; Steigenga et al. 2004). When indigenous people take on the vocabulary of human rights, they challenge the association between rights and modernity on one side, and traditional and indigenous on the other. Micaela's quote captures this challenge, by contrasting modern doctors (who have rights) to traditional parteras (who don't have rights, or have fewer rights).

For some people, claiming rights brings very concrete advantages (land, stipends), which can lead to more prestige or power. When discussing j'iloletik's practices, Micaela uses the words rights and power interchangeably ("they have rights, they have power"). But like rights, power
can be taken away if misused – as discussed in the previous chapter about the consequences on j’iloletik of charging for their service. If rights are translated on the basis of their power potential, they replicate the power stratification in society, leading to some people (j’iloletik, doctors) having more rights than others (the sick, the poor). Building on the j’iloletik analogy, power/rights embrace both the rigidity of social capital (a don that one does not choose) and the flexibility of social status (upward mobility by acquiring more practice, downward mobility if one does not comply with their destiny). Micaela's statement that doctors have "mucho derecho" highlights the differentiated distribution of rights: not everyone is granted rights, and some people, by birth or through acquisition, have more rights than others. They have more rights (quantitatively) but also their rights weight more (qualitatively), which is illustrated by Micaela's choice of word "mucho derecho" (much right) rather than "muchos derechos" (many rights). This phrasing mirrors the English construction of "much right" which also relates to power. In other interviews, Micaela uses a slightly different phrasing but refers to the same idea of power when discussing the government's view on tam-alaletik, "if they don't go to capacitación, then they don't have tanto derecho (as much right) to be a partera". Micaela is the only person I interviewed to use this wording, and it is always articulated to capacitación. By making it harder for parteras to practice, capacitaciones illustrate the lack of respect (another form of talking about rights) of the government towards parteras and indigenous families.

The changing and localized definitions of human rights, as illustrated by Micaela's alternate use of "power" and "derecho," is a process that Merry has coined "vernacularization" (2006), also defined as "the process of appropriation and local adoption of globally generated

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67 Thank you to Vanessa Céspedes for sharing her interview transcript with me.
68 In other interviews, Micaela uses a similar wording when discussing the consequences of capacitaciones, which creates "mucho susto, mucha competencia (much fear, much competition)" among parteras.
ideas and strategies" (Levitt and Merry 2009:441). As in the case of ich'el ta muk', if the translation of concepts only focuses on words, then it takes the risk of getting lost in the "labyrinth of translation" (Pitarch 2008) and erases the social use behind words like ich'el ta muk' and rights. The use of vernacularization, as developed by Merry, is more ambitious: it suggests an active use of the concept from the people in their daily lives, as they see it fit. While translation is perceived as being two-way, vernacularization implies a top-down relationship, which mirrors the way human rights are channeled, from international institutions to states to local organizations. However, vernacularization is not always about western concepts needing to find the correct indigenous translation but rather a hybrid process. In the case of parteras, human rights embrace indigenous ways of relating to one another (ich'el ta muk') and women's claim to the state (for equity). In doing so, parteras load human rights with new meanings that, in turn, are channeled back to institutions, through a process of institutionalization (Speed, Hernández Castillo, and Stephen 2006). Such institutionalization allows activists, who often take over the process of translation, to place their local struggles on a global agenda (Levitt and Merry 2009; Unnithan and Heitmeyer 2014), which is also what OMIECH has done (see Chapter 7). For parteras, human rights become a tool to contest government policies that further marginalize their knowledge, as capacitación best illustrates.

In search of capacitaciones.

After six months of hearing about capacitaciones, asking around about them, and establishing connections, I am finally there. It is eleven a.m. on a Wednesday and I am in the room where every month Doña Gabriela, a Tseltal partera I met in one of San Cristóbal's public hospitals (see Chapter 5), and her colleagues turn in their informe (report): the number of births they attended, the number of pregnant women they have in control (prenatal care). My colleague
Irazú, who is conducting preliminary fieldwork for her Masters' research, is with me. The nurse is busy when we arrive so we wait in the room and chat with the parteras. Suddenly, the nurse appears in the doorframe: "I see new faces here, may I know who you are?" The chitchat suddenly stops and the room gets quiet. Like schoolgirls who know they are in trouble, Irazú and I look at the nurse. I explain my research; that the parteras told us about this capacitación they have every month and that we would like to observe it. The nurse replies: "You can stay but this is not a capacitación. We can talk after the meeting (reunión)."

When I was conducting fieldwork, I had the feeling that capacitación, a word translated from international guidelines requiring Traditional Birth Attendants to be "trained" (World Health Organization 1997:2), kept vanishing before my eyes. The NGO workers I interviewed were organizing talleres (workshops), the parteras were talking about the juntas (meeting) they had to attend, and Micaela was meeting the parteras for pláticas (talks). It seemed that the only actor still referring to capacitación was the public health sector. So I was more than surprised when the nurse explicitly rejected the term.

Before I describe the meetings at the health clinic, I would like to address the criticism that capacitaciones have faced in Mesoamerica. Since the 1980s, these critiques focus on three aspects: first, the content of the training programs, based on Western obstetrics (Freyermuth Enciso 1988:355; Greenberg 1982; Jordan 1993; Parra 1993); second, the dynamic of the training, which assumes that parteras have schooling experience69 (Jordan 1993; Parra 1989), and; finally, the dismissal of parteras' knowledge, the disdain for local practices and the blame put on indigenous culture to explain maternal deaths (Cosmimksy 2001b; Greenberg 1982; Parra 1991). The latter assumptions can have dramatic consequences, negating therapeutic practices

69 Few of these women finished high school. Nationwide, only about half of Mexican women between 16-19 years old are still in school, and in places like Chiapas, only about 40 percent are. Further, nearly a quarter of women age 15 and older in Chiapas are not literate (INEGI 2010).
which help prevent complications, such as prayers (Freyermuth Enciso 2006). For government workers and medical personnel, *parteras'* empirical knowledge is at best seen as helpful, but most of the time it is perceived as "largely obsolete and irrelevant to the outcome of birth" (Gálvez 2011:79). The recurring criticism of *capacitación* from anthropologists, the *parteras* and civil societies probably led to an abandonment of this loaded term in favor of a more neutral one. In practice however, not much seems to have changed.

Back in San Cristóbal's health center, it is 11:15 and the meeting is starting. More than twenty *parteras* are gathered and chairs are missing. The nurse, an *enfermera obstetra*, reads a list with the *parteras'* names. For each one of them, she starts by verifying their address. She then writes down the number of births they attended, any complication that might have arisen, and the sex of the baby. The nurse then asks for the number of pregnant women each *partera* has in control; the *partera* then gets up and signs or thumbprints the register. The atmosphere is relaxed and the *parteras* chat among themselves, while keeping an ear out for their name and their colleagues' statistics (a source of gossip after the meeting). The *parteras* reporting in this health center live in the Southern half of San Cristóbal. While most of them are Tsotsil or Tseltal, there is occasionally a foreign *partera* working in one of the NGOs, as well as apprentices\(^\text{70}\).

Doña Gabriela, who is now 65 years old, started to attend births when she was already a married woman and had had her first child. One day, while she as working in the *milpa* a distressed neighbor called her for help because the *partera* was not arriving. "I only knew that you had to squat and the baby would get out," she recalls. When she came home after attending her neighbor's birth, she prepared dinner with the *caldo de pollo* she was given as a thank you.

\(^{70}\) However, others *parteras profesionales* working in the Casas Maternas (see Chapter 5) or birth centers (see later in this chapter) are not required attending these *capacitaciones*. 

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Her husband asked about the reason for the special meal, and when she told him that she had attended a birth, he reacted, "they are going to put you to jail, you are not a partera," to which she replied "I am a midwife now." Doña Gabriela has started attending capacitación since she moved to San Cristóbal some eighteen years ago. And even though she does not know how to read or write, it is very important that she keeps her booklet in order. Her daughter writes down the appointments that take place in her home or neighborhood, and her apprentice or the occasional anthropologist records those that take place in the hospital where she works (see Chapter 5). Many times I have heard Doña Gaby say, "please we have to write this down, otherwise the doctora (referring to the nurse) will not be happy." This control over parteras' productivity sometimes comes with a benefit for them: in some health centers, they are given supplies such as gloves and gauze (Freyermuth Enciso 2003:326). But in this particular health center there is no budget line for the parteras and the supplies given to them come from the staff's stock (Ramírez Pérez forthcoming).

The nurse who provides the training, a native Spanish speaker, does not speak Tsotsil, so some of the parteras need translation. One of them often comes with her husband who translates for her; other parteras rely on their colleagues for translation when sharing their informe. However, when it comes to the teaching part of capacitación, the nurse asks one of the parteras to translate out loud. Of the three times I have sat on the capacitación, the teaching part only happened once, and Doña Gabriela volunteered to translate.

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71 The report of parteras’ activity is described by anthropologists in Guatemala (Cosmimksy 2001a; Chary and Rohloff 2015)
72 The first time, the nurse needed to fill a report for the Ministry of Health with more detailed information than what she usually asks, such as the partera’s age, the number of monthly meetings attended since the beginning of the year and other demographics. This took over more than the time of the meeting. The second time, the parteras were given Vitamin K and A and another nurse explained to them how to use it. A group of health workers then had a meeting in the room so the parteras had to leave. Finally, the third time, the nurse was able to use the last fifteen minutes of the meeting to give her talk.
The nurse starts the session by asking the *parteras* the definition of *señales de alarma*, alarm signals, which *parteras* are supposed to check their patients for at every appointment (El Kotni 2016). One of the *parteras* answers, "light headed." "No, the nurse responds, this is not the definition of a *señal*, this *is* a *señal*. So what does *señal de alarma* mean?" The *parteras* are confused. As others start enumerating *señales* (Picture 4), the nurse repeats again and again "No, this *is* a *señal*, I am asking what *is* a *señal." Finally, one of the younger *parteras* who is also trained as a nurse responds, "A *señal* shows us that the woman is in danger." Relief spreads through the audience. The misunderstanding about *señales de alarma* between the nurse and the *parteras* reveals two things. First, the difficulties of working in a multilingual background: the confusion probably would not have happened in Tsotsil, or if the *parteras* were native Spanish speakers. Second, it also uncovers the consequences of policies insisting that *parteras* learn the
alarm signals. Alarm signals, or the detection of danger in pregnancy and childbirth is the most discussed themes during parteras trainings, whether governmental or non-governmental.73

After explaining the (subtle) difference between what alarm signals mean and what the alarm signals are, the nurse moves to reminding the parteras not to attend risky births: women who present risk factors during pregnancy should be channeled to the hospital. This includes twin pregnancies and breeched births. The nurse adds, "I know that some of you still attend them, and I know you have a lot of experience and that these births all turned out well. But I have to tell you that if something goes wrong then it will be your responsibility. Only parteras who are very, very experienced can take on such cases." The nurse then proceeds to a graphic description of a breeched birth, where the feet are born first (as in Picture 1, Chapter 3). She explains that women have espinas (espina in Spanish can mean both thorns and spine) in their pelvis and that these espinas can hurt the baby; because of these, the baby's head stays inside the woman and is detached from the rest of the body, which is delivered. The room grows silent as she talks. After this very graphic description, none of us ever want to be placed in this situation. I am deeply disturbed by the nurse's description and decide to further inquire. A couple of days later, I ask Micaela about the espinas. She laughs my fears out "if we had thorns inside our body, how would we be able to be alive"? I then realize later that what the nurse referred to as espinas are pelvic bones, that every baby goes through during birth (Qaasim 2011, 17min30).

While parteras are trained to detect and transfer, becoming 'alarm signal detectors', doctors are trained in obstetric emergencies.74 In this configuration, parteras and doctors do not

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73 In San Cristóbal, one of the organizations working with parteras opens each meeting with the parteras singing along the señales de alarma (Alba Ramírez Pérez, personal communication).
74 I also attended training for medical personnel on obstetric emergencies. Four of the five workshops were all centered on the risk of hemorrhage during birth and the necessity of acting quickly. Such framework positions doctors in a mindset of risk, where all births can potentially go wrong (Davis-Floyd 1992). When I asked, I was told that such emergencies occur in 1 percent of births, but in Chiapas’
work hand in hand (in "mutual accommodation" (Davis-Floyd et al. 2009; Jordan 1993)), but rather form the opposite links of a vertical chain. Indigenous parteras, in Mexico or Guatemala, "are expected to recognize and refer, but never to treat" (Chary and Rohloff 2015:7; O'Rourke 1995). The insistence that parteras learn alarm signals and transfer to higher levels of care is one of the strategies to reduce maternal mortality rates in Chiapas and in Guatemala (Berry 2006; El Kotni 2016; O’Rourke 1995), where the main causes of maternal deaths are hemorrhage and retention of placenta (Freyermuth Enciso 2003; Vázquez Vázquez 2002). Another initiative is illustrated by the Iniciativa Salud Mesoamericana (Mesoamerican Health Initiative, funded by the Interamerican Development Bank and the Bill and Melinda Gates Foundation, among others), a program aiming to decrease maternal and infant deaths in the region that remunerates parteras for each woman they transfer to the hospital (Ramírez Pérez forthcoming)75. As the (male) doctor in charge of the public clinic in the municipal center of Oxchuc explained to me,

"The parteras are the first contact. It is important. Women, they keep having trust in the parteras. While there is a good control, there are no problems; the midwife knows it. The problem is if she does not identify the alarm symptoms, when there are risks."

If parteras incorrectly perform their role of alarm signal detector, they put the mother's life in danger. Capacitaciones then become a way to control the greater risk parteras represent (Cosimbksy 2012). In this sense, I see capacitaciones as a tool for reproductive governance (Morgan and Roberts 2012), that rely on a discourse of risk to have women comply with government policies. Government capacitaciones follow a public transcript (Scott 1990), promoted by international organizations, which insist that Traditional Birth Attendants cannot attend risky births. As mentioned in Chapter 1, the 1990s saw a shift in policies related to maternal mortality, in which TBAs moved from allies to enemies. While the cultural skills of context, the lack of proper care in normal birth (i.e. not properly trained parteras) and of poor infrastructures increase the risk.

75 The program also reimburses the mother for her transport fees.
TBAs are recognized, the goal is to train Skilled Birth Attendants to "gradually replace [them]" (Berer and Sundari Ravindran 2000:5).

When they listen to the nurse's discourse, parteras in San Cristóbal's health center know that she is performing her role as government employee. And the parteras on their end perform (Butler 1988) what is expected from them, the role of the obedient indigenous women. Their performance of the india permitida, the "authorized Indian" (Hale 2004), is delimited by international discourses and local politics: a certain level of cultural knowledge is acceptable and encouraged, but not too much. The character of the india permitida can only be performed by indigenous peoples who are not subjects of rights, to recall Bishop Raúl Vera's quote from Chapter 1. Some of the parteras have known the nurse for almost a decade, and capacitaciones, despite their mandatory attendance, are also a space for laughter and chisme (gossiping)– on both the nurse and the midwives' side. Beyond the public transcript of señales de alarma, the nurse knows that the parteras care for women who have complicated pregnancies, and cannot always transfer in case of complication. Both parties acknowledge this in interviews, in what could be seen as a semi-hidden transcript (Scott 1990). However, they still need to perform their specific role when in the capacitaciones setting. In the capacitaciones situation, the mandatory performance leaves no room for confianza, which exists in the parallel hidden transcript (the interpersonal relation) but not the public one (the institutional relation). Acknowledging the semi-hidden transcript publicly could have dangerous consequences for the parteras, who will be scolded and at worse threatened with jail76, and for the nurse, who regularly reports parteras' statistics to the Ministry of Health77. Bringing the semi-hidden transcript to light would also

76 This is also the case in the state of Michoacán (Vargas Escamilla 2015) and in Guatemala (Edvalson et al. 2013).
77 After the conversation and questions about señales de alarma, the nurse told the parteras "All the questions I am asking you is so that you will have your credencial. If you don't answer, I will not give
mean recognizing that parteras are more than *india permitidas*, and are able to take on some prerogatives belonging to doctors, a challenge to gender, ethnic, and medical hierarchies.

"Currently, the strategy of the government health sector and of some NGOs relies on *capacitaciones* based out of the allopathic model, and that aim to transform *parteras* in 'little nurses.' *Capacitaciones* (...) are displacing and disappearing traditional indigenous midwifery; the *parteras* are told that what they know how to do is wrong, and that there is one and only way of attending births and caring for women and babies." (OMIECH 2010:13)

In Mexico, the institutionalization of midwifery knowledge goes back to the Colonial period (Carrillo 1999; Zolla and Carrillo 1998). In 1750, Spanish midwives started to become scrutinized by the medical profession and submitted to examinations. Requisites included having studied four years with a teacher, "purity of blood" (de facto excluding those of indigenous descent) and a cost of 63 pesos. These criteria nipped the reform in the bud: only two certificates were distributed until the removal of the policy in 1831 (Carrillo 1999). The regulation of midwifery led to a slow but consistent displacement of midwifery by hospital-based obstetrics. By the end of the 20th century, midwives' scope of practice was rapidly shrinking, such that between 1974 and 2009, the number of births attended by physicians increased from 74 percent to 93 percent (Walker et al. 2013).

In Chiapas, the first governmental health programs started in the 1940s, and were tied to the control of tropical diseases (Freyermuth Enciso 1993:29; Page Pliego 2002). In the 1970s and 1980s, Chiapas was at the center of the state's indigenist policies, and the programs developed there were replicated in other parts of the country. The first program related to traditional medicine, *Medicinas Paralelas* (Parallel Medicines) was launched by the National...
Indigenist Institute's (INI) Tseltal-Tsotsil Center in San Cristóbal in 1979. It focused on training bilingual health promoters and the construction of medicinal gardens in rural communities (Argüello-Avendaño and Mateo-González 2014; Freyermuth Enciso 1993; Page Pliego 2002)\(^79\).

Regarding \textit{parteras}, Cosmimksy reports trainings as early as 1888 in the State of Yucatan (Cosmimksy 2001b). In Mexico, the Ministry of Health starts training midwives sin the 1920s (Freyermuth, Cadena, and Icó 1989). Under the aegis of international policies, such programs expanded in the 1970s, the "decade of the midwives" (Parra 1989:59) in both Mexico and Guatemala (Cosmimksy 2001a). In Mexico, with the goal of expanding healthcare services to rural areas, between 1974 and 1981, more than 15,000 \textit{parteras} were trained (Sesia 1982:7). The general direction of national and international health policies in Mexico (and in Guatemala) since the late 1970s has been to incorporate \textit{parteras} into the public health system, based on the premise that "midwives and their practice need to be controlled" (Cosmimksy 2001a:362) by the state (Maupin 2008). In 2009, the Mexican Health Law, \textit{Ley General de Salud}, was modified, with the addition of a paragraph to article 64 determining the actions of the sanitary authorities in relation to maternal and child health. It includes actions such as \textit{capacitación} to "strengthen the technical competencies of traditional midwives"\(^80\). However, the inconsistency of international funding directly impacted the length and format of such trainings (Cosmimksy 2001a).

To evaluate the success of \textit{capacitaciones}, the Ministry of Health (SSA) and NGOs use quantifiable metrics such as the number of \textit{parteras} participating in the meetings, the number of births they attend and the birth outcome. It seems more difficult to measure the skills that \textit{parteras} have learned, and their usefulness, especially when the \textit{parteras} are not given space to express themselves. Today, there is no specific program for \textit{parteras} neither in the SSA nor at

\(^79\) In 1982, a similar project was launched in another region of Chiapas (INI, Centro Coordinador de la Selva Lacandona 1982) but ceased due to the lack of subsequent funding (Page Pliego 2002:55).

\(^80\) \url{http://dof.gob.mx/nota_detalle.php?codigo=5092132&fecha=31/05/2009}
the state level, which means that there is no specific budget either. Dra. Eva, who works for the SSA and has been in close relation with the parteras, highlighted the incongruity of the situation: because of the lack of official directive, every time there is a political change (elections) and/or an internal reorganization in the SSA, programs change as well, making continuity difficult.

"The problem is precisely this one, [the SSA] doesn't want to be associated with a personnel that is not trained [capacitado], that does not have a certain educational level, or… let's say that could be "useful" for the institution. They [the parteras] do have knowledge, but the institutional part does not recognize it precisely for that, because they belong to a personnel that they [the institution] do not consider to be useful."

Because of the lack of official guidelines, each municipio develops its own strategy for parteras. In the Tsotsil municipio of Huixtán, some (but not all) of the parteras receive about 200 pesos a month; in Oxchuc, they receive 500 pesos a month (Nazar Beutelpacher 2011:18). Local politics shape parteras' practice by funding certain groups affiliated with the political party in power, and not others. For Dra. Eva, the political goal is the same as in the 1970s: to link the parteras to the health system. In order to do so, the institution first needs to "recognize that out of eight thousand births, me, the institution, I barely attend four thousand, so that means that the parteras attend [four thousand]… And for me this is important. And because it is important, I will at least recognize them." But this step depends largely on who is in power. The rise and decline of the parteras' training mirrors the interest of those in charge of the institutions.

In Chiapas, the diversity of NGOs working with parteras reflects the lack of a consistent political strategy of the State. During my fieldwork, I met fifteen organizations actively working with parteras, and five others who collaborated with them through health or women's empowerment programs. In a public health system that is more oriented towards curative rather than preventative medicine, the incorporation of midwives represents an exception (Parra 1993), and springs from three concerns: avoiding the cost of implementing health care in rural regions,

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81 Even within the same municipio (Oxchuc), I had trouble gathering consistent data.
promoting family planning, and the low use of public clinics by rural populations (Parra 1989). Does this proliferation of NGOs illustrate the weakness of the Mexican state in terms of health (like in Guatemala (Chary and Rohloff 2015))? Rather, I analyze it as a consequence of the lack of coherent policy towards _parteras_. In Mexico like in the United States, when the state is absent, marginal populations need to rely on informal and semi-formal networks of care (González, Burrell, and Collins 2012). In Chiapas, NGOs and state institutions seem to work in complement: NGOs cover regions where the SSA is absent. The diversity of terms used to describe activities with _parteras_ (capacitación, juntas, pláticas, talleres) highlight that the state does not have the monopoly of naming. The public health sector is not the only source of training and funding, and organizational processes generated in the 1980s keep functioning today. The verticality of the state-organization relationship is replaced with horizontal relations between NGOs and with public clinics. Most of the organizations have contacts with partners in the global North and therefore do not need to rely on regional or national organizations for support. However, these multilateral interactions do not erase state authority. In their recent work on medical pluralism in neighboring Guatemala, Chary and Rohloff analyze the multiplication of NGOs as a factor reinforcing state authority: "even when the state is removed from the actual delivery of services and provides very limited infrastructure, it defines agendas and significantly shapes ideologies about how and to whom to provide health care" (2015:13). In contrast to other configurations, like in Egypt (Elyachar 2005), neoliberal policies in Guatemala do not reduce state authority but give birth to other forms of governance, through NGO contracting, which reinforces surveillance and bureaucratic procedures. In Chiapas, OMIECH resists the state's

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82 In 2013, a proposition to amend the Ley General de Salud to integrate professional midwives was submitted (http://gaceta.diputados.gob.mx/Black/Gaceta/Anteriores/62/2013/feb/20130226-II/DecDictamen-5.html). The amendment includes capacitación for professional midwives and also calls for an integration of professional midwives in the Mexican health system, to guarantee their placement (see Chapter 5).
pressure to training midwives in biomedicine. Opposing the individual framework of modern health policies, Micaela and her colleagues rely on community knowledge to strengthen indigenous midwives' practices.

During a meeting with Alba, a colleague who is writing her thesis on urban midwifery (Ramírez Pérez forthcoming), she asks me about the workshops at OMIECH. "So the capacitaciones that Micaela gives..." I immediately stop her, "don't you go out asking Mica about her work that way or she will shut down. She does not give capacitaciones, she gives talleres (workshops)." How has capacitación become such a loaded term in civil society? The only actor to whom I could talk about capacitación without fearing the backlash was the Ministry of Health, and even so, the nurse at the health center rejected the word. The official discourse has coopted this concept so strongly that any other actors working with parteras and willing to distance themselves from the official discourse will not use the word, even if in substance they are training (capacitar) the parteras.

Over the course of my fieldwork, I participated in five workshops with Micaela, in Tsotsil and Tzeltal villages. Contrasting this experience to the meeting at San Cristóbal's health center, I see several differences, which I briefly describe below. First, the workshops are not mandatory for the parteras. Rather, it is the parteras who ask Micaela when she will come and visit them, which is contingent on the organization's funding (Chapter 7).

Second, the workshops are open to everyone. When the date is confirmed, the partera lets her family and other people in the area know about the workshop. In all but one of the workshops I participated in, there were men and children in addition to parteras and young women. In the case where it was only women, we learned when we arrived that another event at the local school was happening on the same day, which accounted for the low turnout of our
workshop, and the shortened session. The participation of men is an important element, as it promotes the dialogue between men and women about women's health.

Third, it is the organizer (the WMS) who travels to the community, and the participants can walk from their home to the place of the workshops, usually a larger house (this is not an exclusivity of OMIECH, it is also a characteristic of other NGOs).

Fourth, another important difference is the language in which the activities take place. Micaela speaks Tsotsil and understands Tseltal. During the workshop in C'ancuc (Tseltal), the partera could understand her in Tsotsil, other women in the audience were not able to, so the partera's son translated her Tsotsil to Tseltal (Picture 6).

A fifth difference lies in the workshops' methodology. In contrast to state capacitaciones that dismiss local knowledge, the workshops organized by Micaela take tam-alal's practices as the starting point of the conversation. Workshops always open with an icebreaker, what Micaela calls a dinámica, which vary from throwing a ball to another participant while introducing oneself or drawing one's face on a piece of paper (Picture 5). After the icebreaker, participants
form a half-circle with Micaela at the center. She then uses a set of images (carefully picked in the office according to the theme discussed) to spark the conversation. Micaela holds the pictures and asks, "What do you see? Is the woman happy? Why? What would you give her?" (Picture 6). Prompted by the questions, participants share their opinion with Micaela and interact with one another. Similar to popular education (Freire and Macedo 2000), Micaela's philosophy is that every woman has some knowledge to share, even when she thinks she does not. This contrasts radically with the verticality of capacitaciones, where the nurse waits for a correct answer from the participants. OMIECH workshops are based on the confianza that emerges between peers, where tam aletaikan express themselves in their native language, and without the fear of sanction. Placing women's voices at the center of the workshop is Micaela's way of going against the marginalization indigenous women experience in their daily lives, inside their families and in relation to the government.

The sixth difference I encountered resides in the material produced/given during the workshops. During workshops, I write down the recipes participants share on large sheets of paper: a copy stays for the parteras and we keep one for the minutes and the edition of the future boletín (booklet), which is then redistributed in the next series of workshops. In the past, material distributed has included gauze, cotton, umbilical strips and flashlights. However, there is a significant budgetary difference between planning a workshop only (a few hundred pesos) and planning to buy material (a few thousands), so during my fieldwork Micaela only distributed boletines.
Finally, a major difference lays in capacitaciones and workshops' overarching goal. While the first one aims to incorporate parteras into the medical system (even from afar), the WMS' goal is to strengthen parteras' autonomy and revive indigenous medical knowledge to transmit it to younger generations. This approach positions parteras as subjects of rights who can act within their communities, reinventing new forms of confianza among themselves.

Official and OMIECH approaches to diminishing maternal deaths are radically different: while one focuses on emergency and risk, the other emphasizes normalcy and community work. Like other NGOs working on community health in Mexico and other Latin American countries, OMIECH believes that communities can improve their health if they are involved in the policies (Heredia Cuevas 2008; Paley 2001). OMIECH provides an opportunity for community organizing, reinforcing parteras' knowledge, and offering administrative support and transnational cooperation opportunities (Chapter 7). Through her workshops, Micaela acts like a
"catalyst" and sparks concientización (Freire and Macedo 2000) in her audience, who discuss their health in relation to their structural positioning in Mexican society. Challenging the hierarchy between biomedical and traditional, parteras of OMIECH defend their right to practice in the broader context of discriminations they suffer as indigenous and campesinas. Despite the fact that the "process of globalization has ensured the dominance of cosmopolitan medicine over other forms of local medicine knowledge and practice" (Ayora Diaz 1998:186), OMIECH workshops and boletines resist hegemonic definitions of health and criticize the structural violence reflected in the state's control of indigenous medicine. I have argued that capacitaciones are a privileged site to observe such control. In the next section, I explore the practical consequences of capacitaciones and how they impede the everyday practice of indigenous midwifery.

Unintended consequences? The stratification of midwifery in contemporary Mexico

Because she regularly attends trainings at her local clinic, Doña Gabriela is considered a partera tradicional capacitada (trained traditional midwife), which is specified on her credencial. This credencial allows her to deliver birth certificates, which are then used by parents to register their newborn. Women who give birth with parteras who do not possess such identification cannot register their babies: they either have to convince the clerk at the Registro Civil (Civil Registry) that the birth happened too quickly for them to go to the hospital, or buy a birth certificate from a partera capacitada. This policy is slowly weighing on women's decisions to seek one partera or another: if in Doña Gabriela's youth, women sought her because of her reputation as a good partera (and people from her community still seek her for this

83 I borrow this term from Rafael Alarcón Lavín, who used it during a conversation about the WMS workshops.
84 In Guatemala, the credencial is called carnet and operates in a similar way (Chary and Rohloff 2015; Cosmimksy 2001a; Greenberg 1982).
reason), now some women also select her because she is an officially certified partera. Doña Gabriela and her colleagues obtain blank birth certificates at the health center, and each is sealed at the bottom. The nurse hands parteras a new document for each birth they attend such as that each partera only has the exact number of certificates she need. The careful monitoring of these documents' distribution is presented as a part of the strategy to fight child trafficking. For those women who have given birth on their own, with a family member or a tam-alaletik not recognized by the Ministry of Health, registering one's child turns into an arduous process. Such was the case for Carlita, a twenty-year old mother from San Cristóbal. Carlita's son was born in her home with the help of her grandmother, a recognized jtamol in her Tsotsil community:

"When labor started I went to the hospital, but they wouldn't pay attention to me. Finally, a doctora checked me [performed a cervical exam]. She told me to go back home because I still had time. The doctora was nice, but I did not like how she touched me. So when I left [the hospital], I told my mother 'I don't want to give birth in this place, it's better to call my grandmother so that she can come and care for me at home.'"

A week after her son's birth, Carlita went to the Registro Civil, but the clerk refused to register the child because she did not have a birth certificate. 

"[My partner and I] had to go back a couple of times, and at one point the clerk asked for my grandmother to come with me, but she can't!" Faced with the state bureaucracy, Carlita and her partner sought a partera capacitada from their neighborhood so that she could forge a birth certificate for them, but they had to give up because of the price the partera was asking for, 5,000 pesos (over US$400). Carlita then decided to go back to the Registro Civil and slightly twisted her story, "In the end, I told them that as I soon as I came back home from the hospital labor started, and my grandmother, who happened to be here, helped me give birth." This was the only way Carlita could register her child. Like Carlita, women who have given birth neither in the hospital nor with a partera

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85 This is similar to the situation described by Cosmimksy in Guatemala, where parents who did not give birth with a partera certificada are left out of the system and unable to register their child (2001b:363).
capacitada face many obstacles in their registering of their child. These administrative difficulties become tools of biopolitics, a mode of governance through the monitoring of these women's bodies (Foucault 2004). In the previous story, biopolitics is illustrated in the state's differential treatment of women depending on where they gave birth. The bureaucratization of birth also illuminates the process of governmentality, which is the transformation of a state of justice to an administrative state (Foucault 2004).

In Chiapas, governmentality occurs in a context of increased control over parteras' practices by the state, through the mandatory capacitaciones on the one hand, and the requisites for newborns' registrations on the other. Responding to such control of parteras' practice, OMIECH uses the human rights register to draw attention to the "absent present" Mexican state. In his work in Bolivia, Goldstein alludes to the "absent present state" (Goldstein 2012) to highlight the contradiction between a state overwhelmingly present to monitor certain citizens' behaviors, but drastically absent when these same citizens need to access justice or infrastructures. The absent present state disconnects citizenship and rights while accentuating the link between citizenship and duties. As an organization, OMIECH has called out the state's numerous requirement towards women (Prospera program) and parteras (capacitaciones), which contrasts starkly with the lack of infrastructure or health personnel when these same women need to transfer to higher levels of care (Área de Mujeres y Parteras 2007). Collective organizing allows OMIECH parteras to exercise their rights and contest the marginalization of their practices, as illustrated in the following example.

While I was volunteering for the Women and Midwives Section of OMIECH, I noticed a group of parteras who would come regularly to ask for constancias from Micaela, to prove their belonging to the organization. Micaela had already been confronted by such demands from the
parteras in the past. However, in the past couple of years, the request for credenciales increased in certain regions. The group of three Tsotsil women found it more and more difficult to register the babies at the Registro Civil of the municipal town. The constancias, proving their affiliation with OMIECH, were not accepted anymore and the clerk was asking them for a credencial, with their picture. This requirement led the women to conduct several trips to San Cristóbal to visit Micaela, on the request of parents who were worried that they would not be able to register their children. The shift of Civil Register workers from accepting constancias to asking for credenciales shows the normalization of the latter in identifying ‘real' parteras and the loss of autonomy of parteras in their practice. "With the certification and the credencial [the partera] feels that she has a boss. If anything goes wrong, the mother or the child dies, then she has someone who defends her," Micaela analyzes. The credencial she receives from the government subordinates the partera to the doctor ("she has a boss"), while also protecting her in case of a bad outcome ("someone who defends her"). In addition to subordinating parteras' knowledge to that of nurses and doctors, capacitaciones contribute to creating a hierarchy between parteras empíricas (tam alaletik or urban ones), parteras capacitadas and parteras profesionales. Capacitaciones create competition between parteras. It is in this context that Micaela mentions that some parteras and doctors have more rights to practice than others. Capacitaciones' focus on parteras' individual responsibility is an extension of the neoliberal framework focusing on individual responsibility and of Mexico's indigenist policies, assimilating indigenous peoples as indios permitidos rather than recognizing their unique contributions to the nation.

For parteras who do not attend capacitación their moral and legal obligations are in tension: if they are not certified cannot legally practice, which is in contradiction with their moral obligation to their communities, where they are responsible for helping women who come to
them (Sesia 1997). Capacitaciones cleverly constrain parteras’ cultural rights and women's reproductive rights by focusing on a discourse of risks. In the medical setting, risk has become an umbrella term comprising alarm signals, women's medical history, and nonhospital birth, limiting women's autonomy (Davis-Floyd 1992; Fordyce and Maraes 2012; Ivry 2009). In Chiapas, one consequence of the risk discourse is that it limits parteras' decisions to care for women, by making parteras think in terms of risk (for their patient, for them) rather than normality. In the Selva region of Chiapas, the constant threats (of jail, of withholding their Prospera stipend) on parteras have led all the parteras from a village to stop attending births. They now only offer prenatal care (sobada), and refer all births to the clinic (organization SADEC, personal communication)^86.

In the contemporary field of birth in Mexico, there is one last type of partera that I have not explored yet, the partera profesional. Over the next pages, I analyze how the emergence of this hybrid figure, neither tam-alaletik nor nurse, is guided by the same global strategies pushing for capacitaciones. I also discuss how professionalizing this field also contributes to its stratification. The Asociación Mexicana de Partería (Mexican Association of Midwifery; thereafter Asociación) was launched in 2011, with the goal of "strengthening the midwifery profession in Mexico as a model of sexual and reproductive healthcare for women, which promotes their autonomy and their rights, is attentive to their needs and trusts in the knowledge of their body" (Asociación Mexicana de Partería n.d.). The organization seeks to represent midwifery in Mexico and to regulate the profession (with a certification process in preparation). A recent organization, the Asociación is active on the academic scene (they published an edited

^86 In the state of Morelos, where the capacitaciones have been ongoing since 1974, parteras’ roles are more and more constrained to that of prenatal care (Margarita Aviles, personal communication). The same process is described by Jenkins in Costa Rica (2003).
volume on midwifery in Mexico (Sánchez Ramírez 2015)) and the political scene, through its annual meetings which include discussions on burning issues like obstetric violence (Chapter 6).

For young women who want to become parteras profesionales, there are a few options, however few are officially accredited by the state (Dixon 2015). The CASA midwifery school (private) in the state of Guanajuato illustrates the institutionalized midwifery model and is the first midwifery accredited institution in the country (Davis-Floyd 2001; Dixon 2015; Mills and Davis-Floyd 2009). Thanks to an agreement with the Ministry of Education, CASA graduates obtain their cédula profesional (professional certification), which allows them to work in public hospitals. Since the opening of CASA, private birth centers and midwifery school have flourished in the country (Dixon 2015; Howes-Mischel 2012). However, the main problem these parteras confront after their training is certification by the state. In a context of a- legality (neither illegal nor legal, like in some US States (Davis-Floyd and Johnson 2006a)), their practice is tolerated, as long as it does not interfere with the state.87

In the midst of the medicalization of reproductive health in Mexico, parteras profesionales are in continuous tension between the preservation of knowledge on one hand, and the need for political organization and professionalization on the other (Davis-Floyd 2008). Not all of them agree on the criteria for licensing; some parteras profesionales feel that an examination based on the North American Registry of Midwives exam would exclude indigenous midwives (Davis-Floyd 2001). The US experience shows that "to professionalize is to accept a level of regulation and bureaucratic conformity that can compromise independence of practice" (Davis-Floyd and Johnson 2006b:7). Not only does regulation compromise parteras' autonomy; the lack of intersectionality in their activism might precipitate the disappearance of

87 Since most of the parteras working as liberal midwives or in birth centers attend a population that would otherwise go to private clinics, the competition for clientele is with private gynecologists rather than with public health services (Vargas Escamilla 2015).
The ambivalent relationship between *parteras profesionales* and *tam-alaletik* is also at stake in *partera profesionales'* self-presentation. While some of them are careful about distinguishing themselves and their work from that of indigenous midwives (Global Press Journal 2014), others have collaborated with them (Alonso, Banet Lucas, and Tryon 2015).

While I was conducting fieldwork, there were no relations between the *Asociación* and OMIECH. Obviously, *parteras* from OMIECH agree with the need for better treatment of women in the hospital, and the need for political representation through an organization. Nonetheless, OMIECH and other NGOs working with indigenous midwives perceive the movement as mostly one of and for mestiza women (who can afford to hire a professional midwife) and mestiza *parteras* (who have the educational and political capital to negotiate their legitimacy before the state). *Tam-alaletik* and urban mestiza midwives live in very different realities, and their practice of midwifery can never be separated from the material conditions under which they live. For example the cost to attend the annual meetings can be prohibitive for *tam-alaletik*, $2,000 (US$166) for members, $1,000 (US$83) for students, $2,500 (US$208) for non-members. For OMIECH, the *Asociación* participates in the increased stratification of midwifery and, like *capacitaciones*, contributes to the ‘war on parteras’ and feeds into the structural violence indigenous women face over their reproductive lives.

Based on her work on childbirth across cultures, and in Mexico and Brazil in particular, Davis-Floyd depicts the future midwife as a "postmodern midwife" able to transcend both biomedical codes and her cultural heritage to craft the future of women's care (Davis-Floyd 2007; Davis-Floyd and Davis 1996). The postmodern midwife can be either a professional midwife (who has gone through formal training and owns a degree) or an empirical or traditional

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88 As a reminder, *tam-alaletik* in the Highlands are seldom paid in cash for their services and if they are it is $500 (US$42) at most for a birth. In 2015, the *Asociación* launched a campaign to fund the participation of those parteras who could not afford the costs of the meeting.
midwife (who has learned empirically and whose skills are not recognized by a degree) (Davis-Floyd 2007, 2008). In either case, the postmodern midwife picks and chooses the practices that best suit her needs. While the postmodern midwife is an analytically useful tool (an ideal-type (Davis-Floyd, Pigg, and Cosmimksy 2001)) that disrupts the professional/traditional dichotomy and illustrates the mix and match practices happening for the various parteras in Mexico, it eludes important questions of intersectionality and cultural appropriation. During monthly meetings at OMIECH and over seminars at the PROIMMSE, collaborators of the WMS of OMIECH expressed over and over their concern about the appropriation of tam alaletik's medical and cultural knowledge by parteras profesionales or doulas (labor support providers) in Mexico and others countries. Some of the women who fit the category of Davis-Floyd's postmodern midwife market their "traditional knowledge" to future mothers of upper-middle class. Even when they recognize where this knowledge comes from, the monetary retribution rarely goes back to the partera/community who shared it 89. The question of cultural appropriation in midwifery needs to be addressed and poses important questions: Whose knowledge is it? Is knowledge about plants/massages still valid when disconnected from their cultural contexts? Can this knowledge be individualized? Without addressing these questions, the professionalization of midwifery in Mexico will lead to an increased stratification, and eventually to a point of rupture between indigenous and mestizas, mirroring the US scenario 90, in which the marginalization of midwives of color within the national organization Midwives Alliance of North America (MANA) resulted in a rupture (Peacock 2012a; Peacock 2012b) 91. In

89 The CASA program includes and recognizes the benefits of traditional midwives’ knowledge, but not the midwives themselves (Walker, Suárez, et al. 2011).
90 Thank you Alice Bafoin for pointing this parallel out to me and for the nurturing conversations.
91 In her dissertation, Lydia Zacher Dixon points out that Mexican midwives often refer to the process of professionalization of midwifery in Mexico as "the same as what happened in the US twenty years ago," but to her it is unlikely that Mexico will follow the same trajectory (Dixon 2015:7). I am not so certain.
Chapter 7, I describe how OMIECH fought against a bioprospection project, which raised similar ethical questions. Along with them, I argue that using *tam-alaletik*'s knowledge without contributing to improve their living conditions is a form of cultural appropriation. In the next chapter (Chapter 5), I introduce the broken *temazcal* metaphor to illustrate what happens when indigenous knowledge is essentialized into selected features, and disconnected from its social context.

In the face of obstetric violence (Chapter 6), urban women are turning away from public hospitals. Some of them remain at home and give birth with a family member, like Carlita who preferred giving birth in her home with her grandmother rather than in San Cristóbal's Family Hospital. Other, wealthier, women go to private clinics where they can have elective C-sections, a trend similar to other countries (Diniz and Chacham 2004; Epstein 2007). Finally, some women turn to private birth centers offering *parto humanizado* (humanized birth). In 2005, the first birth center of San Cristóbal opened its doors. Founded by a Certified Professional Midwife, the birth center aimed to provide an alternative to hospital birth, for indigenous women living in San Cristóbal (Alonso, Banet Lucas, and Tryon 2015). Quickly, the women-centered care appealed to mestiza women too. The center grew and has since attended over 400 women, with a clientele of mestizas, indigenous, and foreigners. The birth center promotes humanized birth, and offers a wide range of additional (paying) services such as prenatal yoga classes, homeopathy, and craniosacral therapy. In January 2015, the founder opened a new birth center in Mexico City. The cost of a birth varies depending on the family's resources. The average cost ranges

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92 In an interview with the founder of the birth center, she explained that during the first years, they attended a lot of women living in the outskirts of the city. I have interviewed a woman who gave birth with them six years ago for 1,500 pesos, equivalent to her monthly salary at the time. When her sister-in-law got pregnant in 2014, she suggested she asked the birth center for a discount, but she was told they could not go below 7,000 pesos, which the sister-in-law could not afford.
between ten to twelve thousands pesos (US$1,000) in San Cristóbal and 20,000 (US$1,600) in Mexico City.

The second birth center, founded in 2011 by a general doctor who became a midwife. Like the previous center, the space offers childbirth preparation classes, activities for parents and children, and various meetings around women's health. Women come from surrounding cities (and states) to give birth in the spacious home; they have the option of renting a room on the property for a couple of weeks around their birth date. This center employs two midwives and doulas. The cost of a birth is about 12,000 pesos (US$1,000). Given the small size of San Cristóbal, the fact that there are two birth centers reflects the diverse population of the town and highlights the particular place Chiapas occupies in the country; once again, what happens in Chiapas illuminates changes happening on a bigger scale.

Like any other product, the commodification of midwifery care (Davis-Floyd 2004) obeys the logic that "if you don't charge, your work is not worth it" (Micaela). But what can account for the immense difference between what a birth center charges and what a tam-alal does not charge: the quality of care? The knowledge? Even if urban parteras like Doña Gabriela increase what they charge for a birth to 2,000 pesos (US$166), it will still only represent a fraction of what birth centers charge. But for the people they serve, this might leave them without any care at all. The value of parteras' knowledge is linked to their different philosophy (a profession or a calling, don), but not only. Direct-Entry Midwives in the United States often charge very little (Davis-Floyd and Johnson 2006a)93, and some tam-alaletik I have met charge more than others. The costs of living in a city (and renting a space) also plays in the different costs of birth, and young women who have left their homes to study midwifery also need to

93 Midwives from the Albany region I have interviewed for a side project barely covered the costs of their practice, and were willing to discuss non-monetary exchanges with families that could not afford their services.
make a living. However, I argue that the variations in price also come from the type of clientele. The commodification of birth also carries the illusion that the best product is the more expensive, and women who can afford to pay 10,000 pesos (US$833) will probably feel more comfortable in a birth center. The mestizas and foreigners I have interviewed also highlighted that it would also not make much sense for them to hire a tam-alaletik. Because of all these factors, some of the researchers I interviewed are very pessimistic about the future of parteras tradicionales in the country, and based on some examples presented in this chapter, it is understandable; in other countries, the training of parteras has seriously limited their practice, like in Guatemala (Maupin 2008), Costa Rica (Jenkins 2003) and Peru (Guerra-Reyes 2015).

Despite the good intention behind capacitaciones — saving mothers' lives — and the good faith with which most of healthcare providers I met carry them, capacitaciones further marginalize parteras from the healthcare system and sometimes from women in their own communities. The monthly reports parteras have to make, the classroom-like atmosphere and the medical hierarchy infantilize these women, mostly mothers and grandmothers. Their knowledge is categorized as dangerous for the women they attend, and parteras have to subdue their own authoritative knowledge to the biomedical one (Cosmimksy 2001b; Jordan 1997). Capacitaciones contributes to the structural violence faced by tam alaletik, an abstract violence that cannot be traced directly to health institutions or individuals (Galtung 1969). Through the professionalization of midwifery, tam-alaletik who were once at the center of international policies, are pushed away from mainstream reproductive health care, towards the "margins of the state" (Das and Poole 2004). Swimming against the stream, Micaela and OMIECH put tam-alaletik and their knowledge back at the center and analyze health politics as a lack of respect towards parteras, and a violation of their cultural rights. In the next chapter, I introduce the
reader to the Intercultural Hospital, a state-led initiative aiming to make the hospital friendly to both indigenous women and their *parteras*. However, like with the *capacitaciones*, we will see that good intentions are not enough and structural and local factors come into play to further alienate *parteras*, restricting her to performing the *india permitida*. 
Interlude: Mixing and Matching. Doña Gabriela's Hybrid Practice

After Doña Gabriela successfully attended her neighbors' birth, and announced to her husband "I am a midwife now," more and more women started coming to her. "All the kids in the village, they were born with me, and now their children and grandchildren too." Thirty-five years later, Doña Gaby, as her apprentices fondly call her, has expanded her knowledge beyond birth and cures a wide range of illnesses, including aire (rheumatism) and mal de ojo (evil eye)\(^{94}\); and she also cures animals. Doña Gabriela has been living in San Cristóbal for almost twenty years, and was enrolled in capacitaciones as soon as she arrived:

"The Oportunidades representative in my neighborhood told me that since I was a partera I needed to go to the clinic and receive capacitación. I did not want to go, but she insisted. And there I learned that we need to use gloves, and they would give us materials… And the doctora said I should keep coming. So I kept going."

Being capacitada does not mean that Doña Gabriela shies away from attending home births; on the contrary, this is where she receives the majority of newborns (either in a separate room in her own home or at the mother's home). If the birth gets complicated, Doña Gabriela refers women to the hospital. Since she lives in San Cristóbal, women from the surrounding municipios (mestizas and indigenous alike) hear about her by word-of-mouth and seek her help. Following government training, Doña Gabriela has incorporated biomedical elements in her current practice. As we will see in the next chapter, her practice is similar to what is described among some Kaqchikel parteras, who "simultaneously [maintain] strong ties with traditional Kaqchikel life and actively [engage] biomedical resources, on [their] own terms, to craft [their] own style of practice" (Chary and Rohloff 2015:2). Like Josefa, the Guatemalan partera who

\(^{94}\)Mal de ojo is a common illness affecting adults and children, but with stronger effects on newborns. According to Page Pliego, the illness originates from the Virgin Mary, who had a very hot gaze, and as a consequence all the children that fell under it would start crying (2011:195). The characteristics of the disease include restlessness, diarrhea, vomiting, and fever.
experiments with technology and tries out a Doppler connected to a phone (King, Chary, and Rohloff 2015:10), Doña Gabriela is eager to use new technologies, such as the digital blood pressure monitor despite not being able to read the numbers. Participating in capacitaciones makes her a modern partera tradicional, two adjectives that she does not perceive in opposition but as complementary. In fact, Doña Gabriela is reproducing a model of traditional apprenticeship with the women coming to learn with her. Of the six apprentices she has had, only one is Mexican, the others come from the USA, Colombia, Germany, and myself, a French-Moroccan anthropologist. An active partera and a naturally curious woman, Doña Gabriela participates in many local midwifery-related events (organized by the government or by parteras profesionales) and is part of an organization of parteras with whom she has traveled to Mexico City. Living in the city, she had to adapt to living costs, which are different than in her community, and practices differential pricing. For example, in San Cristóbal she charges fifty to a hundred pesos for a consult (US$4 to US$8), while she does not charge for the women she visits on her regular trips to her village. Similarly, a birth in the city will cost between 1,000 and 1,500 pesos (US$83 to US$125), while she charges 500 for women in the village (US$42). A widow, Doña Gabriela supports two of her grandchildren studying in San Cristóbal, and shares her house with one of her daughters and her child. I attribute the rising prices of her services for her urban patients to the costs of living in the city, but also to the fact that she is aware that mestiza parteras working in birth centers charge much more than that for their services. Her involvement with various midwifery networks and students stem from her collaboration in a state project, the Intercultural Hospital, which I describe in depth in the next chapter.
Chapter 5. Multicultural Health Policies.

Where do Midwives Fit in the Hospital?

It is 9:15 am, and I am sitting in the waiting room of the Traditional Medicine Area (TMA) of the Intercultural Hospital in San Cristóbal, where I meet with Doña Gabriela every week. She is not here yet, and so I prepare a list of questions about the birth we attended together the week before. The labor and birth took place in the building's birthing room which is equipped with one double bed, a birthing chair, a crib and an infant scale. Inside the TMA, there is also a separate room for consults, with three single beds and a scale, where Doña Gabriela provides prenatal care consultations (consulta). The Intercultural Hospital is one of the two public hospitals ran by the Ministry of Health (SSA) in San Cristóbal. Even though the Constitution recognizes the pluricultural component of Mexican state since 1992, in practice it is not after the negotiations between the Zapatistas and the government in 2001 that the right of indigenous people to live a life without discrimination (Article 1) and their right to traditional medicine (Article 2) were added (Almaguer González, Vargas Vite, and García Ramírez 2014:21). It is in this context that intercultural hospitals were launched in the country.

In this chapter, I draw on fieldwork in San Cristóbal's Intercultural Hospital to discuss the local impacts of Mexico's multicultural policies. Like the capacitaciones I analyzed in Chapter 4, intercultural policies aim at linking indigenous peoples in general and traditional midwives in particular to the official healthcare system. The will to attract indigenous people into the hospital result from Mexico's global commitments to improving their disastrous health conditions (Physicians for Human Rights, ECOSUR, and CCESC 2006), and reducing maternal mortality.

To draw poor people in the hospital, intercultural policies are combined to free health care, granted since the implementation of Seguro Popular (People's Health Insurance) in 2004. Under
cover of integrating indigenous *parteras* in the official health system, Seguro Popular and intercultural policies symbiotically act to further marginalize them. In this chapter, I analyze the tension between intercultural policies and their application through the metaphor of the "broken *temazcal,*" the Mayan steambath that has been integrated in the hospital but will never properly function. I argue that the treatment *parteras* receive in the Intercultural Hospital reflects deeper roots of racism and sexism in the country, while the lack of government response shows the little interest the SSA has for indigenous midwives. Rising against the marginalization of their profession, Doña Gabriela and her colleagues publicly hold the state accountable for their poor working conditions.

The situation of empirical midwives in the hospital starkly contrasts with the promotion of *parteras profesionales,* which I have introduced in the previous chapter. Here, I contrast the Intercultural Hospital and the marginalization of indigenous midwives to initiatives specifically targeting *parteras profesionales,* the Casas Maternas (Maternity Homes). The differential treatment of *parteras profesionales* and *parteras capacitadas* reflects the increased stratification of midwifery in the country.

"Interculturality in health" in practice

The SSA started incorporating traditional elements in preventative medicine in the 1970s, to reduce institutional costs in the midst of the petroleum crisis (Parra 1991). For Parra, the inclusion of traditional midwives in the Mexican health system "is the result of the failure of the public health system in proportioning similar quality of care in rural areas and in urban areas" (85). The incorporation of *jpoxtawanetik* (indigenous doctors) into the health system first started with an informal collaboration at the regional level (1979-1981). In 1982, a pilot project was launched in Chiapas, later developed at the national level. In the 1990s, the relationship between
health institutions and healers shifted towards one with organizations of indigenous doctors (OMIECH in Chiapas) (Ríos Cortázar and Olivares González 2008:122). Today, the "interculturality in health" approach implemented in some regions is in continuity with such programs. In 2002, the Federal Ministry of Health launched a Direction of Traditional Medicine in Mexico City, in charge of creating a national strategy of "interculturality in health" (interculturalidad en salud) (Almaguer González, Vargas Vite, and García Ramírez 2014; Page Pliego 2011:78), which can be defined as "the package of policies and actions intended to recognize and incorporate the culture of users throughout the attention process" (Ríos Cortázar and Olivares González 2008:122). In the report giving directions to implement interculturality in Mexican hospitals, the SSA emphasizes the need to "tear down cultural barriers" for users (Dirección de Medicina Tradicional y Desarrollo Intercultural 2008). The various reports present interculturality as a model at the crossroad of "Scientific medicine" which is "evidence-based" and brings "safety"; "Culture" which provides "millennial knowledge" and conveys "physiological positions"; and "Gender perspective" which combines women's agency and "humanism" (Subsecretaría de Integración y Desarrollo del Sector Salud, Dirección General de Planeación y Desarrollo en Salud, and Dirección de Medicina Tradicional y Desarrollo Intercultural 2010). The birthing chair (Picture 7) is then designed to retain the "good" elements of traditional birth (verticality) and change the "bad" ones (uncomfortable position for the medical staff). Activists and researchers alike have harshly criticized this simplistic vision of interculturality; they argue,

"[In the Intercultural Hospital], biomedicine and traditional medicine supposedly coexist in a same physical space; however, this is still a utopia given that the management and health personnel share the same mercantilist orientation as other hospitals in the region, maintaining old working habits and racist views, turning the discourse of interculturality in health into a panacea ready for the opportunism of some health workers" (Tibaduiza Roa, Sánchez Ramírez, and Solana 2011:87).
In Mexico, medical anthropologists have been associated with intercultural health projects since the 1940s, but interculturality as a state project expanded under the indigenist State in the 1960s (Lerín Piñón 2004). While theses initiatives were set aside in the 1990s under neoliberal policies, and the diminution of inversions in health, the rise of neoliberal multiculturalism brought such questions back on the agenda. OMIECH members analyze the Health Law of the State of Chiapas (1990) through the lens of International Labor Organization's article 169, which institutes prior consultation of projects impacting indigenous peoples, and Article 4 of the Mexican constitution, which recognizes indigenous peoples' cultural rights. They point out how in the context of economic neoliberalism, putting the health within the hands of families and traditional healers represents monetary savings for the state. The notes from the meeting highlight the ambivalence of the state, which decides what practices should be promoted as cultural, but without consulting the affected population, "We are not very familiar with the health law, but we know that it is not ours because they never invited us to a meeting, neither have they come to our communities to ask us about our ideas, our thoughts" (Page Pliego,
Alarcón Lavín, and Juana María Ruiz Ortiz 1995:280). Indeed, even if the 1992 Constitution recognizes indigenous *usos y costumbres* (law and customs), indigenous law is subordinated to state law. In Chiapas, the two main laws intersecting with indigenous communities' *usos y costumbres* in Chiapas are the national 2001 law and the 1999 Chiapas law. In 2001, following five years of negotiation with the Zapatistas, the Mexican Congress adopted the Law on Indigenous Rights and Culture, which uses the "language of individual human rights (...) to directly reduce the parameters of indigenous rights as established in the law" (Speed 2005:37). Through this restrictive law (granting less liberties than the ILO 169 convention signed by Mexico), the Mexican state reaffirms its primacy over the communities, in defining indigeneity. Like in other Latin American countries, such as Bolivia (Goldstein 2007) human rights discourses are used to defend individual rights (neoliberal philosophy) while restricting collective ones (an essential component of the pluricultural nation). In Chiapas as in Bolivia, collective rights such as the one to administer justice are circumscribed because they interfere with human rights (Goldstein 2012; Speed and Collier 2000).

Neoliberal reforms influence multicultural health policies by shaping the good indigenous citizen, who accepts his/her indigeneity while properly fitting into state institutions (Colloredo-Mansfeld 2007). First coined by Hale to describe the double process of affirming cultural rights while maintaining economic inequalities under neoliberal reforms in Guatemala (2002), the term "neoliberal multiculturalism" has since been used in a wide range of contexts. By separating cultural rights from socioeconomic rights, the neoliberal package empowers on one side while disempowering on the other, taking away rights while promising others,

"Far from opening spaces for generalized empowerment of indigenous peoples, these reforms tend to empower some while marginalizing the majority. Far from eliminating
racial inequity, as the rhetoric of multiculturalism seems to promise, these reforms reconstitute racial hierarchies in more entrenched forms. " (Hale 2004:16)

Neoliberal multiculturalism encourages certain forms of being indigenous, while vilifying others as dangerous — what Hale has coined the *indio permitido* ("authorized Indian"). Neoliberal multiculturalism opens up "categories and spaces where indigenous actors and citizens are expected to remain. Some of these classifications include fiestas, touristic marketplaces, and national celebrations" (Burrell 2013:89). In Mexico, indigenous heritage is celebrated, but only in certain ways. Indigeneity is allowed only when if it means speaking an indigenous language (Speed 2002) or wearing *huipils* (Labrecque 2005), not to spark political participation or protests. In a similar way, under neoliberal multiculturalism, traditional medicine is accepted only under certain conditions; the *parteras* have to be trained (*capacitadas*) while women are offered a modernized version of homebirth (like the birthing chair). The authorized traditional birth is the one in the public hospital, while the only authorized midwife is the *partera capacitada*.

Neoliberal multiculturalism includes seemingly social reforms that in reality contribute to individualizing the costs of health. In April 2003, an amendment to the Mexican General Health Law implemented the Seguro Popular. Since January 1st 2004, the 45 million Mexicans (42 percent of the population at the time) who are not already affiliated through their employer, can access any public health facility. Before Seguro Popular, the Mexican health system had divided the population into three categories: the Mexican Institute of Social Security (IMSS) would attend those affiliated with it (private workers until the 1970s, and rural populations since the mid-1970s (Howes-Mischel 2012:182)), while public servants would go to the Social Security Institute for State Workers (ISSSTE). The Ministry of Health (SSA) would attend everyone else.
The goal of Seguro Popular is to reduce families' out-of-pocket health-related costs (such as labs, medication, surgeries). The level of contribution is determined annually according to the family's income (Boltivnik 2003; Domínguez, Ramírez, and Michel 2011). Affiliation with the Seguro Popular comes with a list of rights and obligations, among which right #8 "freely decide about your attention;" obligation #7, "inquire about the risks and alternatives of therapeutic and chirurgical operations that are indicated or carried" and; obligation #9 "treat with respect the medical, auxiliary and administrative personnel of the healthcare services, as well as other users and their company" (Seguro Popular 2015). As in the case of the cash-conditional transfer program Prospera (discussed in Chapter 3), access to information is individualized: it is the patient who has to undertake research in order to be able to choose "freely" the attention s/he wants, in relation to the risks, and find alternatives (that are not offered by the public health program). This opacity of information makes "choice" impossible for the population that Seguro Popular serves. Information is both a right, and an obligation. If it is an obligation, then the patient cannot complain if the treatment received is inadequate. Poor women giving birth in and around San Cristóbal do not really have a choice in terms of providers. One of the few free options provided under Seguro Popular includes the Family Hospital (Figure 7), and women have complained about the poor treatment they receive in the maternity ward (see Chapter 6). What about the parteras in the Intercultural Hospital? As I detail over the next pages, their care is not covered by Seguro Popular, so patients then have to bear the full cost of their services.

"Allà no atienden partos." Social and medical stratification in the hospital

Inaugurated a few years after the implementation of Seguro Popular (2007), as an "intercultural hospital with Traditional Medicine," the Intercultural Hospital integrates selected cultural features to be more "friendly" to indigenous peoples. In San Cristóbal, the Intercultural
Hospital's services complement the Family Hospital (SSA hospital specialized in obstetric care) Public Clinic (a Level II hospital of the Mexican Social Security Institute), a public hospital for the Chiapas State employees (Instituto de Seguridad Social de los Trabajadores del Estado, ISSTE), and two Level I health centers, one for the population living in the North half of the city, and the other for the South half of the town (Figure 7). The Traditional Medicine Area (TMA) of the hospital is an attempt at hybridization, between biomedicine and traditional medicine. In practice however, interculturality is often limited to signage in Spanish, Tseltal and Tsotsil (Picture 8).

![Laboratorio](image)

**Picture 8:** Laboratorio (Spanish), *Snail sk’elobil chamaletik* (Tsotsil), *Snail yilobil chamaletik* (Tseltal). Laboratory, used as a kitchen. Intercultural Hospital. November 2014.

<table>
<thead>
<tr>
<th>Name</th>
<th>Ran by</th>
<th>Birth?</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercultural Hospital</td>
<td>SSA</td>
<td>Yes (parteras)</td>
<td>II</td>
</tr>
<tr>
<td>Family Hospital</td>
<td>SSA</td>
<td>Yes (doctors)</td>
<td>II</td>
</tr>
<tr>
<td>Public Clinic</td>
<td>IMSS</td>
<td>Yes (doctors)</td>
<td>II</td>
</tr>
<tr>
<td>Public Clinic 2</td>
<td>ISSTE</td>
<td>Yes (doctors)</td>
<td>II</td>
</tr>
<tr>
<td>Health Center 1</td>
<td>SSA</td>
<td>No</td>
<td>I</td>
</tr>
<tr>
<td>Health Center 2</td>
<td>SSA</td>
<td>No</td>
<td>I</td>
</tr>
</tbody>
</table>

**Figure 7:** The different clinics in San Cristóbal.
Located at one of the city’s exits, the Intercultural Hospital hosts various specialties (epidemiology, endocrinology, among other), in addition to the Traditional Medicine Area. The hospital was built to alleviate overcrowding at the Main Hospital in the center of the city. After the opening of the Intercultural Hospital, the Main Hospital converted to the Family Hospital, specialized in obstetrics, while all the other specialties were sent to the Intercultural Hospital. According to physicians from the Family Hospital, the initial policy was quite the opposite: to move the gynecologic and obstetric service to the new hospital, with the TMA, and keep the other specialties in the old hospital. However, various doctors explained to me that for "political reasons" the original plan was never executed. Instead, the parteras stayed in the Intercultural Hospital, without any obstetrical team to back them up. When necessary, parteras have to transfer from the TMA to the Family Hospital either by ambulance or, if it is not available, by taxi or private transportation. On the other hand, women who enter the Family Hospital with a normal pregnancy and want to have a non-medicalized birth would need to transfer to the TMA. This, according to doctors and parteras, has never happened.

When I entered the Intercultural Hospital for the first time, I was convinced there was no birth happening there. Everyone I had spoken to, researchers, activists, parteras profesionales, had convinced me that the Traditional Medicine Area was just another white elephant clinic, which is not surprising in the Mexican context. As Smith-Oka encountered in Veracruz, "the use of the hospital as a political football is typical in Mexico of the way politicians build things to enhance their popularity without bothering to ensure that they are useful" (2013:113). However, during the eight months I spent with Doña Gaby, she attended at least seven births in the TMA. According to a physician from the Intercultural Hospital, in the past there years the TMA registered 250 births, an average of one per week. This makes the TMA definitely less busy than
a maternity ward, but nevertheless more active than the other two intercultural hospitals (also called hospitales mixtos or hospitales integrales, holistic hospitals⁹⁵) of the country – one in Cuetzalan, Puebla (Duarte-Gómez et al. 2004), and the other in Jesús María, Nayarit⁹⁶. Both were launched in the 1990s, but according to Jaime de las Heras, who conducted research in both hospitals in 2015, parteras attend births in neither location (personal communication).

Since its opening, San Cristóbal's Intercultural Hospital has suffered multiple criticism, including of medical negligence and discrimination. Among the problems related to the new hospital is the fact that it has been built over the ruins of the city's cemetery. The parteras told me that their patients do not want to come and give birth here because of the bad spirits that are around, testimonies also collected by other anthropologists (Maya 2015). Indeed, the municipal cemetery is facing the hospital, a relatively indelicate choice for an institution navigating between life and death. Another criticism addressed to the hospital is the lack of waiting area for the families of the patients. The only place protected from the sun or the rain is the area in front of the entrance of the Emergency room, a narrow strip of concrete where barely a dozen people fit (see Figure 8). As Tania, the activist I introduced in Chapter 3 commented, "This is a sad place. There is not even shade where the people can wait." Indeed, facing the main entrance, a large uncovered plaza stretches until the road, not offering any protection for the families who have to wait in the sun (Figure 8 and Picture 9). At night, family members who can find space in the emergency waiting room (the only aisle of the hospital opened 24 hours a day) sleep next to each other on the floor.

⁹⁵ I use Chopel’s translation, who works in the Northern state of Chihahua, and advocates for a holistic hospital in the region, to overcome the lack of trust between practitioners and patients (Chopel 2014).
⁹⁶ It seems that recently more hospitales integrales have opened, in particular in the state of Durango. One newspaper article promotes their use of the birthing chair as an example of interculturality (Maurer 2016).
The Traditional Medicine Area is promoted as a place where one can find *parteras tradicionales capacitadas*. However, the *parteras* are not the only ones to use the space; they...
share it with a wide range of people, some of them working in the TMA, others just passing through. In this section, I describe how the space sharing leads to conflicts and power struggles, which marginalize parteras in their own space. Figure 9 gives an overview of the spatial arrangement of the TMA. The parteras' working space include the Examination room, where they give prenatal consults; the Birthing room, which can accommodate one woman and her helpers during labor and delivery; the medicinal garden where they collect plants; and the kitchen, where parteras prepare herbal teas for their patients and where the family of the laboring woman can cook during and after birth. The TMA is also equipped with a temazcal (steambath used in Highlands Chiapas during prenatal care and birth) but parteras do not use it because it does not work (a fact I analyze later in this chapter). There is also a small office where parteras store some herbal remedies and their administrative documents, but not all have access to the key.

In addition to parteras, the TMA suffers from a constant flow of hospital employees and patients using the different rooms. Patients can be divided into two categories: those who come to see the speech therapist, whose office is placed within the TMA, and those who come to use the public facilities (restroom and altar). The speech therapist's patients, consisting mainly of one woman and her child(ren), use the transitory space of the television room to wait for their appointment. Their wait often lasts fifteen to twenty minutes, making them temporary inhabitants of the TMA. Temporary visitors and the speech therapist's patients do not occupy the TMA space for long periods of time, which for them is a non-place (Augé 1992). This is also the case for the speech therapist, who, although physically present in the TMA, is disconnected from it in various ways. First, she is part of the hospital's medical staff; and wears a white blouse, (most parteras don't). Second, she only uses her office space; her patients wait in the waiting room, but
she seldom leaves her office to greet them. They usually enter on their own as soon as the previous patients have left. During my time there, I never saw her use the kitchen space or any of the other shared spaces. For the speech therapist then, outside of her office, the TMA also constitutes a non-place. Other transitory occupiers of the TMA include nurse interns, who watch TV on their lunch break, nurses who use the shower (normally reserved for the laboring women), security guards (which the parteras refer to as policia, abbreviated poli) who heat their lunch and coffee in the kitchen and use the public restrooms, and the person in charge of cleaning the floors of the TMA. The TMA space thus serves as an annex for many of the hospital staff, who has nothing to do with Traditional Medicine. After an NGO conducted a free health campaign and donated medical material to the hospital in the spring, my colleague Irazú97 and I arrived in the TMA only to find the television room filled with boxes. Those remained several months, only diminishing in volume, which means that the staff was using it and had no intention of storing them elsewhere.

Another person who has an office in the TMA is a researcher, who occupies what was previously the Homeopathy office. When I first arrived at the hospital, the homeopath had just left. Her office was left vacant for several months, with the "Homeopathy" sign still on. In February 2015, a researcher from the SSA, who has been involved with parteras for many years, started using it as her research office. The Doctora knew all the parteras well, and would often chitchat with us. She would also make sure to be in the hospital during official visits, and made herself available for researchers. But, despite her being a general doctor, Doña Gaby never mentioned her as being a back-up option during births. In the last month of my fieldwork, July 2015, the Homeopathy sign was not up anymore, and instead a paper on the door said "Research

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97 My colleague Irazú who I mention in Chapter 4 also conducted fieldwork with Doña Gaby.
Area on Traditional Midwifery." The *Doctora* reclaimed the space, making it legitimate through a new sign\textsuperscript{98}.

Figure 9: The Traditional Medicine Area.

Finally, another important agent of the TMA is the *partera profesional*, Sofia. Sofia's status is an ambivalent one. She has been assigned to the TMA to complete her *servicio social* (medical internship). As a *partera profesional*, she belongs to the world of the *parteras*, but her formal education puts her in a different category from the *parteras tradicionales capacitadas*. As Doña Gaby once explained to one of her patients "Sofía, she is a *partera* but more like a physician, because she studied. Me, I am a *partera empírica.*" Sofia uses the same rooms as the *parteras*: kitchen, examination room, and birthing room. But contrary to the other *parteras* who

\textsuperscript{98} In contrast, as illustrated in Picture 8, the kitchen sign remained “Laboratory,” even if it was never used as such.
would spend their time in the kitchen or the television room chitchatting while there were no patients, Sofía spent hers in the small office at the entrance of the TMA. Specifically, the office serves as a storage place for drying medicinal plants, and the products that her and two other parteras started making with the goal of developing a brand of natural products for women (cream, teas, balms). The office also hosts, on a bottom shelf, seven binders, belonging to each of the seven parteras of the TMA. Each of the binders contains reports of the births they attended (informes). Because Sofía always spends most of her time in the office, either preparing the plants, filling her informes or reading, the space slowly became associated with her; another reason for that being that she is the only one to hold the key to it\footnote{The measure was taken after one of the (now ex-) parteras stole some of the office's documents. Since then, Doña Gaby explained, only Sofía is allowed to have the key.}. This means that, in order to fill their informes, parteras have to wait for Sofía to be there – she works the afternoon shift, while other parteras usually leave in the mid-afternoon.

Outside of the TMA, parteras mainly interact with three other zones in the hospital: the ultrasound office, the Seguro Popular office and the Emergency room. In each of these encounters, the partera's authoritative knowledge is subordinate to that of the technical or medical person in charge, while at the same time she acts as a guide and sometimes a translator for her patient. Around the world, ultrasounds have become one of the most widely adopted technologies during pregnancy, used to determine the position of the baby, know the sex, and detect any malformation (Andaya 2014; Georges 1996a; Ivry 2009; Mitchell 2001). In Mexico, enrollment in the Prospera program has led indigenous women to travel to nearby cities to be given ultrasounds. Such is the case for some of Doña Gaby's patients, who take advantage of their trip to San Cristóbal for a prenatal check to have her schedule their appointment at the Intercultural Hospital. In order to get an appointment for an ultrasound, the partera needs to
make sure that her patient is affiliated with Seguro Popular. Most of them are already, but if not she tells them which paper they need to bring and takes them to the office. The second step to get an appointment is to fill a form including the patient's name and the authorization of a physician. In this step, one of the main problems parteras are confronted to is the absence of gynecologists in the hospital. If the Doctora (researcher in the TMA) is here, then the parteras will ask her to sign the form and fill the patient's name (parteras do not know how to read or write). When the Doctora is not there, the parteras have to search for another doctor, any doctor, who is willing to sign off the authorization. Despite promoting "interculturality in health," in the Intercultural Hospital partera's knowledge is clearly subjected to the biomedical one. The exaggerated bureaucratic hierarchy generates incongruous situations, for example Doña Gaby asking an epidemiologist with whom she has no professional tie to sign an authorization for her patient to get an ultrasound.

The authorization system reflects the infantilization of parteras by the institution, and the lack of credibility they suffer in the hospital. Once the partera and her patient have the two documents (Seguro Popular and authorization sheet), the ultrasound office gives them an appointment, with very little flexibility. Doña Gabriela recommends her patient to arrive one to two hours prior to the appointment, because the schedule is sometimes shifted around and they might call her in earlier. The patient's right to an ultrasound generates the obligation for her to be there when she is called in, even if it is at a different time. Since the patient is only allowed one person in with her during the appointment, it is usually the partera who comes in, and not the husband. In contrast to Western women who use ultrasounds to bond with their baby (Mitchell 2001) or make sure they carry a perfect fetus (Ivry 2009), ultrasounds in the Intercultural Hospital are, like in Cuba (Andaya 2014), mainly directed towards the professional who
requested them (*partera* or doctor). Whatever the reason for ultrasounds, the setting always implies a relation of power between the person manipulating the technology and describing, almost translating, the images, and the mother listening (Georges 1996a; Mitchell 2001). After the appointment, I never heard Doña Gabriela comment on the image, but only on the doctor's comments, either about the baby's position or, in the weeks and days before birth, the quantity of amniotic fluid\(^\text{100}\).

Another area of the hospital that *parteras* interact with is the Emergency room. This only happens during labor and delivery, in case a transfer to the Family Hospital is needed. The emergency staff's response to *parteras'* request highly depends on the personality of the doctor on call. *Parteras* sometimes have to go (or send the husband, or the security guard) several times to the emergency room before a doctor comes to the TMA. Sometimes the doctor will stay and help attend the birth; at others the ambulance driver will be sent without any doctor coming. The previous examples illustrate how, outside of the TMA, *parteras* have little to no authority. In the next section, I focus on what happens inside the TMA, where *parteras* are also marginalized despite it being "their" area. I argue that *parteras'* treatment illustrates the use of interculturality as a façade for the little interest hospital staff, the SSA, and the state in general have in their activities.

When entering the hospital, visitors have to pass in front of several security posts (guarded by *polis* hired through a private company). There are several security posts in the hospital: in order to access the TMA, visitors need to pass in front of the *poli* of the main entrance, and then the *poli* in front of the TMA entrance. These security measures frame the hospital a place of hyper-surveillance (Foucault 1993), reminding visitors that they are entering a

\[^\text{100}\] It is more than likely that Doña Gaby is not sure how to read the paper imagery, and thus needs to rely on the doctor's interpretation.
state building and speaking to the local context of low-intensity warfare and national social unrest (Centro de Derechos Humanos Fray Bartolomé de las Casas 2015; Speed, Hernández Castillo, and Stephen 2006). Usually, when I arrive through the hospital's main entrance, the poli either ignores me or, if it is the one I know, she hugs me, "how are you my precious little girl, preciosa chulita" and asks me to visit more often. But today, the new poli asks me what brings me to the hospital. Perhaps it is the backpack, which gives me a very unique style, different from the doctors – many of the female doctors are wearing high heels – and the indigenous patients. I respond I am going to see the parteras in the TMA and with that I am allowed to get in. I pass through the large corridor in front of the Seguro Popular office and, leaving a waiting room on my right, I stop at the other poli post and fill in the visitors' form: Last and First names, Time of entrance, Purpose of visit. The last column, Time of exit, is filled by the poli when the visitor leaves. The purpose of visit ranges from "toilet" and "prayer room" to "partera" which both the parteras and their patients use, when the latter (and myself) should fill in "visit" 101.

The relationship between the poli and the parteras is not always a smooth one. Both have to look after the TMA: the poli by supervising the entries, and the parteras by keeping the space in order. However, when one or the other does not respect those boundaries, tensions arise. The sharing of space creates tensions and surveillance between actors that all share a non-medical status within the hospital. Surveillance often refers to the way the state apparatus slips into citizens' everyday life, to control their actions (Foucault 1984). Medical anthropologists have applied this concept to describe the mechanisms controlling women's bodies through routine medical practices (such as lab tests or ultrasounds) (Davis-Floyd 1992; Han 2013; Ivry 2009). In

101 On my end, I wrote down either of these two words (partera and visit) when filling the form. One day I had written "partera" on the form; Sofia came in after me and, when seeing me, exclaimed "Oh it’s you! I was looking at the form and was wondering who this new partera was!” I had forgotten I, too, was under surveillance.
the Traditional Medicina Area, I would like to analyze the surveillance that takes place among the different workers of the Area, indigenous and mestizos who roughly belong to the same socioeconomic category. The position of the different TMA's inhabitants is similar to that of Mayan street venders in Antigua, who internalize the top-down governmentality of the World Heritage rules, but exert horizontal surveillance among each other for the rules to be respected (Little 2015). While they enact surveillance, they also challenge it, as we will see is also the case with *parteras* in the TMA. Like street vendors, the *parteras* are not recognized as important by the hospital hierarchy, but they consider themselves and their work important. Horizontal surveillance becomes a tool of governmentality (Foucault 2004) that reinforce medical and social stratification in the hospital, and highlights state intervention in everyday life (Joseph and Nugent 1994). It is in the everyday that the governance emerges (Little 2015), creating tensions between global demands (here, applying "interculturality in health") and local pragmatics.

The main topic of disagreement between hospital workers is the cleaning; many actors use the space, but the ones in charge of maintaining it clean and neat are the *parteras*. The bone of contention resides in the cleanliness of the kitchen. For Doña Gaby, *parteras* have to keep the space clean no matter what, because the TMA is their space, and it can affect their reputation. For Doña Gaby, the workspace is an extension of the self, and as women, it is their responsibility to maintain it clean. Such discourse internalizes and reproduces more global social and gendered hierarchies: the kitchen is a place belonging to the home, making the *parteras' workplace less of an exterior office place, and more similar to a private one. This free labor is not considered as such because of the *parteras' gender*. As Irazú once commented in an exasperated tone "have you ever seen a doctor cleaning the emergency room, or worrying about the dishes?" In addition, the *poli* makes sure that the TMA is clean so as to not be unfairly blamed. This micro-war of

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102 Using midwives as free work is not uncommon in rural health centers (Chary and Rohloff 2015).
power and blame leads to irrational situations, such as when Irazú and I are asked by a young male *poli* to clean up the kitchen at one in the morning, as we are leaving with Doña Gaby to transfer a laboring mother to the Family Hospital. We try to point out to the emergency of the situation, and that in any case we will be back the next day with Doña Gaby. Our explanations are useless, the *poli* insists that the place needs to be left clean or the blame will fall on him. Irazú and I feel the weight of bureaucracy as we roughly tidy up the room and wash the dishes. The *poli*'s attitude stems from several factors, including that fact that he was new to his position. But even so, his gender (and ours) probably account for his attitude, which would have been different if Doña Gaby, Irazú and I had a different social status (doctors and not *parteras*/apprentices) or had been men.

Inside the TMA, another tool for surveillance, which operates both horizontally and vertically are the *informes*, reports that the *parteras* need to fill every time a new patient comes in; they use the same for subsequent visits, which are stored in "Sofia's office." The first page (Figure 10) relates to prenatal care: the woman's last date of menstruation, her age, number of children, dates of the visit. For each visit the *partera* needs to fill in the weight, pressure, measure of the uterine fund, and fetal heartbeat. The next page is about the baby's position (filled at each visit). On the third page, the *partera* notes any of the alarm symptoms the woman might present during pregnancy (dizziness, fatigue…), and which Doña Gaby makes sure to check at every prenatal appointment (El Kotni 2016). Finally the fourth page is filled after birth (did the placenta come out entirely? Any hemorrhage?). As shown on Figure 10, in an attempt to reach out to *parteras* who do not know how to read, the *informe* is not made of written questions but rather of drawings. But still, *parteras* need to enter numbers and comments, which they are unable to do on their own. The drawings represent women from various countries (one of them is
wearing a sari, another one a headscarf), and were adapted from the Hesperian Foundation's famous *A Book for Midwives* aiming at training Traditional Birth Attendants around the world (Klein, Miller, and Thomson 2007).

![Figure 10: TMA: First page of the informe for parteras.](image)

When *parteras* fail to fill in their *informes*, Sofía reminds them to do so verbally. In one instance, she left a handwritten note on Doña Gaby's file, which we read to her, "Do not forget to fill in *all* the information in your *informes." Another time, we also used this strategy and left a note on the office desk requesting more blank *informes* for Doña Gaby. In a school-like manner, Sofía responded "Here are the *informes* you requested Doña Gaby, I congratulate you for the excellent maintenance of your file." When it comes to the *informes*, the relationship between Sofía and the *parteras* is a vertical one: she knows how to read and write while they don't, and
she is the one who has access to the blank informes. In all logic, Doña Gaby thus refers to filling the informes as an action done "for Sofía." After a conversation Irazú and I had with her about the becoming of the informes, Doña Gaby realized that the informes were perhaps also a way for the hospital to know how many births she attended. With the idea that she could use this monitoring to her advantage, Doña Gaby started asking us to fill in informes for the women she attended in her home as well. Even if this did not impact the treatment her and the TMA in general received from the hospital, Doña Gaby saw filling the informes as a means to valorize her work as a partera, and combat the marginalization of the TMA within the hospital structure and the health system in general. In the next section, I analyze this marginalization of parteras and the TMA through the metaphor of the "broken temazcal."

The broken temazcal and the partera permitida

The temazcal (pus in Tseltal and Tsotsil) is a small rectangular mud or wood steambath that can be found in households in Highland Chiapas. For Mayans, the temazcal represents the maternal womb (OMIECH 2010) and is used as a therapeutic tool to "warm the flesh and the blood" (Groark 1997). In pregnancy and childbirth, some tam-alaletik use the pus when massaging the mother; the heat helps the fetus moving inside the belly and give strength to the future child (Groark 1997; Nájera Coronado 1999). In Oxchuc, some women and parteras reported that it was also used during labor and delivery for two reasons. First, it smoothenes the temperature transition from the womb to the outside for the infant. Second, during this phase, the mother's loss of blood puts her from a hot state (of pregnancy) to a cold state where she is vulnerable to illnesses. The pus restores the equilibrium. After birth, the mother and newborn

103 Childbirth, the culmination of pregnancy, is a very ‘hot’ stage because of the accumulation of blood of the mother (from the retained menstrual blood) (Freyermuth Enciso 2003; Groark 1997; Groark 2005; Guiteras Holmes 1961:105). As women loose blood, they loose heat and must be careful not to fall into a
are confined to the *pus* for several days (Groark 1997; 2005)\(^{104}\) or enter to bathe a few days after (sometimes with the father), depending on the region (Área de Mujeres y Parteras 1989a; Hunt, Glantz, and Halperin 2002). In the Intercultural Hospital, the TMA includes a *temazcal* for *parteras* to use. Perhaps because of its large size, or its unusual location in the hospital, the word "*temazcal*" has become a metaphor for the TMA among staff. The first time I heard the analogy was when one hospital employee said to another, "I am going to *temazcal*." Bewildered, I asked her what she meant, and she explained that *temazcal* is a shortcut the staff uses when referring to the TMA.

Describing a touristic tour of a Mayan village in Yucatán, Taylor refers to the "staged authenticity" of the houses that tourists visit during the tour (2012:177). Tourists enter a house to see one Mayan woman grinding the corn on the old *metate* — which she has in reality never used — and explaining to them its cultural significance. When tourists leave, she cleans and keeps the *metate*, and goes back to grinding her corn on the shiny metal one that none of them noticed. In Mexico and Guatemala, Mayan women, performing "traditional" household chores such as weaving or pottery making in their shiny blouses have been used on postcards and in tourist guidebooks (El Kotni 2010). In some highly tourist regions like Yucatán (Mexico) and around the Lake Atitlán (Guatemala), their homes have become a place of performance for tourist exhibits (Little 2000). In the TMA, the tours given to tourists, prospective clients, journalists, politicians, and anthropologists all include the *temazcal*, and highlight its cultural significance for Tzeltals and Tzotsils. It is only if one digs a little deeper and asks if the *parteras* use it, that the staged authenticity is revealed. Contrary to San Antonio Aguas Calientes, the performers are colder state. This is why sources of heat such as the kitchen fire, the *temazcal* and the various teas that a woman is given to drink are essential elements during childbirth (Nájera Coronado 1999).

\(^{104}\) Like Groark’s informants, my collaborators have shared that previously, women and newborns used to stay in the steambath for several days after birth, but this practice has been abandoned.
not afraid to reveal the fraud (Little 2000), "It's too big, way too big. We cannot use it. Those who built it probably never entered a *temazcal* in their life," one of the TMA's *parteras* commented during an interview. Thus, the *temazcal* functions as a double metaphor. First, as a metonymy, as it is an element of the TMA that stands for the area. Second, as a metaphor for the Hospital's failed attempt at interculturality: the Traditional Medicine Area's *temazcal* never functioned. Too large, it would need too much wood to heat, and becomes a cold place – which is dangerous for the pregnant woman's body that needs heat. When the staff jokes around about the *temazcal*, they focus on the oddness of such a traditional tool in a biomedical space. A *temazcal* in a hospital seems out of place and, by extension, so are the *parteras*.

Like the broken *temazcal*, policies designed by non-indigenous technocrats for indigenous peoples are rarely successful, and illustrate the ambivalent relationship between institutions and indigenous peoples. As Labrecque analyzed in relation to the use of the *huipil* by non-Mayas in Yucatán: "The supposed Indian ethnicity, which has a social existence, must be domesticated, made inoffensive, while maintaining the social stigma of the "Other"" (2005:100). The broken *temazcal* serves the same purpose; if the only *temazcal* allowed in the hospital is one that is broken, under what conditions can *parteras* be accepted? In the previous chapter, I described how *capacitaciones* aim not only at training *parteras* in biomedicine: they also serve to model them into obedient citizens, and build on discourses of risk to forge the image of the only authorized midwife, the *partera capacitada*. In the Intercultural Hospital the *partera capacitada* is also an *india permitida* (Hale 2004). Interculturality in health relies on certain specific traits of indigenous culture and, like the too big *temazcal*, *parteras* must perform a role imagined for them by the state and that does not always suit them. Tania, the local activist,

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105 Doña Gaby seldom uses the *temazcal*, but I have seen her bathe her patient in it using a tub — the bathroom is too small for the tub to enter in. Other than that, the *temazcal’s* main usage is performative.
poignantly analyze the TMA, "the Intercultural hospital would never exist without the
delegitimización of parteras' work." In the hospital, the only partera permitida is the partera
capacitada, and better, the partera profesional. Mirroring to the broken temazcal, the state's
attempts at interculturality keep failing indigenous peoples by not incorporating them in the
design of its projects. During my fieldwork, I witnessed many scenes of neglect of parteras'
work, as illustrated in my fieldnotes,

"I am invited to a rezo (religious prayer) in the Altar area of the TMA. After struggling
with transportation, I finally arrive by the polí at noon, where I run into Sofía. She does
not plan to attend — she has to finish typing the report of her servicio social. (…) Doña
Gaby and Doña Lupe are here; the rezo has not started yet. One of the polí is helping
them clean up the table, "Let's just change everything at once" they decide. We take off
the cloth, the plastic flowers, the saints' figures, and the two-meter high picture of the
Virgen de Guadalupe. (…) Doña Lupe complains that nobody ever changes the cloth; she
has to do it on her own once or twice a month. As we put a new cloth on she says she will
clean the old one in her home. (…) Doña Gaby takes out a new outfit for the Jesus
figurine from her bag. The polí asks her how much she paid: three hundred pesos
(US$25). We all agree it is a good price. (…) We are waiting for the director [to start the
ceremony]; "it's that they have things to do" Doña Gaby says, talking about the people on
the second floor. They remember how, for the installation of the Nativity scene, the time
kept being delayed and the ceremony ended up starting at 4pm instead of 2pm."

Crystallized over an event that never happens (at least not that day), this story illustrates
the social and medical stratification in the Intercultural Hospital. The staff works together to
prepare an event that is important to them for its religious significance. Even though they are not
in charge of the Altar, open to the public, because of its location in the TMA they feel it is their
responsibility to care for it. Therefore, the two parteras come on a day when neither of them is
on call, clean the space, and take on extra costs to care for the altar — one by washing the cloth
in her home, the other by paying for the figurine's special outfit. However, none of them
complain about these out-of-pocket costs. Later in the scene, parteras complain about the lack of
food and refrescos (sodas), which used to be provided by the management. The vignette
illustrates how, in the Intercultural Hospital, *parteras* are treated as second-class employees. Their personal schedule is not taken into consideration: to the busy management, the *parteras'* time is flexible, and so are they. As in other settings, when interacting with bureaucracy, the time of the poor (Paley 2001) and the unemployed (Auyero 2012) is perceived as free and flexible, ignoring these people's various other commitments. In a later scene, *parteras* make up for the absence of food and *refrescos* by seizing the opportunity of a charity stationed outside of the hospital and dispensing free coffee and snacks. Lining up with patients' families and some nurses, the *parteras* and *poli* eagerly wait for their turn. Like in other contexts, NGOs and citizen compensate for the lack of state involvement and take over governmental functions (Chary and Rohloff 2015; Elyachar 2005; Paley 2001). In the case of the Intercultural Hospital, even if *parteras* are now allowed to take their meal from the hospital's canteen (while the *polis* bring their own food), they do not completely belong to the hospital. It is this interstitial space that makes their position unique, and leads to their criticism of not being taken into account. The hospital plays on this double status of belonging to alternatively make requests to the *parteras* (to maintain the space) and ignore them (by not paying them).

Indeed, Doña Gabriela and her colleagues do not receive any pay for their work in the TMA, and thus represent cheap labor for the state. Although women who come to them are affiliated with Seguro Popular, traditional medicine is not included in it. The *parteras* in the hospital exclusively rely on women's cooperation, as they would do in the community. The price depends on the *partera* but a consult (prenatal care or *curación*) is about fifty pesos (US$4). The number of consults the *parteras* give varies across time and across *parteras*: from as much as six consults to as little as none a day. The *parteras* attribute the lack of work to the fact that women prefer to go to the hospital where they can use the benefit of the Seguro Popular coverage. When
there are no patients during the whole day, the *parteras* lose money since they have to pay for their transportation (only a couple minibus route serves the hospital, and a taxi ride is minimum 30 pesos (US$2.5) one way).

Doña Gaby and her colleagues regularly complain about their marginalization within the Intercultural Hospital, "*no nos hacen caso*" (they don't take us into account) they would often tell me or other visitors of the TMA. By saying "*no nos hacen caso" the parteras show that they are aware of the realities of their working conditions. When they make this statement publicly (in a newspaper, in a video for the day of the midwife), they denounce and resist their marginalization by the state. Their return, every week, to the hospital, and their participation in various events illustrate their attachment to the space. Despite all its dysfunctions, the Intercultural Hospital is also a place of power for the *partera*, who take pride in being publicly associated with a hospital, a place of doctors and technology. The political prestige outweighs the financial benefits; Doña Gaby, who is, according to doctors and some parteras, the one with the busiest schedule, makes more money attending from her home: in 2014, out of 93 births Doña Gaby registered in her booklet\(^{106}\), only three were marked as happening in the TMA\(^{107}\). During my fieldwork, out of seven births Doña Gaby attended in the TMA, four were brought to her randomly. The great majority of women who came to prenatal care already knew her and came to the TMA to seek her in particular. Doña Gaby's strong reputation had people willing to pay the cost of transportation to the hospital, in addition to the cost of consult, rather than going to a doctor, which would be free with their Seguro Popular. Most of the women who come to the

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\(^{106}\) This is an average of two per week, not including the random births Doña Gaby seems to always find on her way: a cabdriver calling her to the rescue of one of his passengers, a woman giving birth on the street, among many. Doña Gaby would regularly tell us such stories; I estimate these random births to one a month.

\(^{107}\) Most of the entrees do not specify the place of birth. Based on my fieldwork with Doña Gaby in 2014-2015, it is probable that there are a few other births registered in the hospital binders that she did not include in her booklet, but these would still not change the trend.
Intercultural Hospital do so because they trust (have *confianza* in) Doña Gaby, and do not trust the hospital (Family Hospital); I detail some of the reasons why in the next chapter. This contrast with the government's lack of trust in *parteras empíricas* which is illustrated through their marginalization in the hospital space that has been specifically designed for them. While Doña Gabriela and her colleagues are not "taken into account" by the government, mirroring the shift in global strategy from TBAs to SBAs, the Ministry of Health is building *Casas Maternas* (Maternity Homes) throughout Chiapas as part of a strategy to fight against maternal mortality. The new Casas Maternas are staffed with *parteras profesionales*, widening the gap between older *parteras empíricas* and younger, educated, *parteras profesionales*.

According to the Ministry of Health of Chiapas, there are thirteen Casas Maternas in the region (SSA n.d.). With a new one inaugurated in March 2015 in Chamula, there are now fourteen. Casas Maternas are part of the strategy to comply with the Millennium Development Goals, and result from the collaboration between the Chiapas SSA (that pays for the construction) and the municipality (that supplies it). The goal of the Casas Maternas is to provide women, their family and *partera tradicional* "a communal space close to the health unit, with the participation of qualified medical personnel to attend obstetric emergencies and timely transfer" (SSA n.d.). In practice however, the organization (and the naming) of the Casas Maternas vary according to local politics and budgets. Figure 11 summarizes the characteristics of the Casas Maternas, based on data collected during visits and/or interviews with employees. Technically, the TMA was designed as a *Posada de Nacimiento* (Birth House), but only one person referred to it by its official name, an SSA employee. Officially, in the Casas Maternas, the *parteras* don't attend the births: they only monitor labor and transfer women to the next-door hospital to deliver. I will briefly contrast the situation of the *parteras* in the Intercultural Hospital to that in two
other Casas Maternas in Chiapas, Comitán and Chamula. The nuances of these global reforms (Andaya 2014; Guerra-Reyes 2013; Wild et al. 2012) appear in the local usage of the Casas Maternas and illustrate once again the lack of coherent strategy of the state when it comes to the place of *parteras* in the health system.

<table>
<thead>
<tr>
<th>Place</th>
<th>Official name</th>
<th>Parteras...</th>
<th>Parteras paid by SSA?</th>
<th>Parteras deliver?</th>
<th>Medical staff?</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Andrés Larráinzar</td>
<td>Casa materna</td>
<td>Capacitadas</td>
<td>No</td>
<td>No birth registered</td>
<td>Yes</td>
</tr>
<tr>
<td>Chamula</td>
<td>Unidad de maternidad</td>
<td>Professionales</td>
<td>In process</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>San Cristóbal</td>
<td>Posada de nacimiento</td>
<td>Capacitadas</td>
<td>No (patient pays)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Comitán</td>
<td>Casa Materna</td>
<td>Capacitadas</td>
<td>500 pesos monthly (private)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Tenejapa</td>
<td>Casa Materna</td>
<td>No</td>
<td>NA</td>
<td>NA</td>
<td>Used as Centro de salud</td>
</tr>
</tbody>
</table>

*Figure 11:* Overview of some of the Casas Maternas.

Built to relieve the maternity ward of the hospital, which attend almost eight thousand births every year, Comitán's Casa Materna allows for women to be monitored without them occupying one of the hospital's ninety beds. The town's hospital has been working closely with the *parteras* since the 1970s, but the construction of the Casa Materna was funded by a private foundation (Cruz Estrada et al. 2015). When the hospital was relocated at the outskirts of the city, a new Casa Materna was built next to it. Before visiting Comitán, I had heard diverging opinions about it; while some people would praise the Casa Materna as a perfect example of collaboration between the *parteras* and doctors, others were more skeptical and warned me "the *parteras* don't attend births there." The familiarity of the sentence, which echoed the comments issued to me before I went to the Intercultural Hospital, caught my attention.
The *Doctora* giving me the tour is Dra. Laura, a thirty-year-old *Comiteca* (Comitán native) who I introduce more in depth in Chapter 6. Dra. Laura explains to me that in the Casa Materna, the laboring woman can spend the night with one family member. All the care (teas, *sobadas*) is provided free of charge for patients. As I later describe my visit to Doña Gaby, she is amazed, at first, "The *parteras* are paid? And they don't have to do the cleaning? There are thirteen beds? And two nurses to back them up?" But then I tell her the final point; that in reality the *parteras* don't attend births. They only support the woman in labor until she is six centimeters dilated, and then transfer her to the maternity ward of the hospital. Her enthusiasm wanes and she shrugs, "So then they are not really *parteras* then." In Comitán, *parteras* have become physicians' auxiliaries. They carry the prenatal care in the hospital, and when a woman arrives in labor, the physicians assess her before sending her to the Casa Materna. Comparing her situation with that of her *compañeras* in Comitán, Doña Gaby and I are faced with the impossible equation: would she rather work in a nice, clean, environment but not be allowed to practice; or rather be authorized to attend births, even under the unsatisfying conditions that are hers?

Comitán's Casa Materna is one of the strongest examples of the subordination of midwives' authoritative knowledge to that of physicians. Constrained in their practice, *parteras* become physicians' auxiliaries; their monthly salary of 500 pesos (US$42) is provided by a private foundation, making them once again cheap labor for the state. In Chamula, the situation is slightly different, and under cover of promoting midwifery, the Casa Materna represents yet another example of the stratification of midwifery, a process

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108 The Casa Materna of Las Margaritas, where I was not allowed in by the *poli* (there had been an incident a few weeks ago and only patients were now allowed in) functions like the one in Comitán. Doña Margarita recalls, "I met one of my *ahijadas* (goddaughters) there one night (...) and the *partera* was there, snoring. (...) They had asked me to join them [in the Casa Materna] but I don’t want to join these old *parteras* who sleep while their patient is in labor (...) And then [as I was making tea for my *ahijada*], the *partera* said we had to wait for the doctor, that they were just there to watch over the women."
happening across the country (Dixon 2015). Similar to American birth centers, in Chamula's Casa Materna the *parteras profesionales* and obstetric nurses provide a full scope of reproductive health care, and, in case of a complication, the staff transfers to the Chamula clinic or to the Family Hospital in San Cristóbal. In a region with a high incidence of home births, the Casa Materna provides an alternative to the hospital. The Casa Materna was funded through international funds (Inter-American Development Bank, through the Salud Mesoaméricana project (Ramírez Pérez forthcoming)) and, I was told, private funding from the CASA midwifery school. When asked if there were any *tam-alaletik*, one of the *parteras profesionales* working in the *casa materna* told Alba and I that there were none, since the original project was "that it would be only *parteras, parteras profesionales* that can work there. Because this is how the project was designed from the headquarters." At the time of the interview, a couple of months after its opening, there had not been any births at the Casa Materna. The *parteras* were focusing on family planning services and meetings (*pláticas*) for women. They were also about to start *capacitaciones* with *tam-alaletik*. During an interview with another *partera profesional* working at Chamula's Casa Materna, she confirmed not having attended any birth, but described she had faced a transfer: the woman had started labor at home with her *tam-alal*, but when the birth complicated she went to the Casa Materna for help. However, the latter is not equipped to handle high-risk births, and so the staff had no other option than transferring the woman immediately to Chamula's hospital.

Promoted under the Safe Motherhood initiative to overcome the "tyranny of distance" and the long journey pregnant women make to give birth in hospitals (Wild et al. 2012), maternity homes developed across continents. Originally designed as maternity waiting homes where women can stay in the days (or weeks) previous to their due date, these temporary
solutions do not solve the problem of distance and transportation, the main barriers for women to access hospital care (Wild et al. 2012). Maternity homes' design and use vary from country to country, or even within the same region as the Chiapas example illustrates. In Cuba, women can stay in maternity homes if complications arise during pregnancy; portrayed as ideal places to rest from housework while being provided free healthy food, maternity homes are also used as a threat by physicians to discipline pregnant women's behavior (Andaya 2014), echoing Peruvian women's feelings about these homes being like "little jails" (Guerra-Reyes 2013). Contrarily to Cuba, where maternity homes are part of the state's duty to ensure the nation's healthy reproduction, and are open to all women, in Chiapas (and Peru) Casas Maternas target those who are less likely to go to the hospital, poor indigenous women. In both cases, maternity homes serve as tools for reproductive governance. However, in Mexico, poverty and ethnicity conflate: by targeting a specific population (poor women), Casas Maternas maintain indigenous women's reproduction under surveillance.

In Chiapas, *parteras tradicionales capacitadas* like Doña Gaby have been used as propaganda for campaigns aiming to reduce maternal mortality. Wearing their traditional clothes, they are given medical briefcases and taken pictures of. However as I have discussed in this chapter, in practice *parteras* are in no case considered employees of the state. The social interactions at the TMA are an example on the micro-level of broader relationships between the state and indigenous peoples in Mexico. Interculturality, far from being an empowering experience for indigenous patients, becomes a bureaucratic requirement. In the hospital, *parteras* are offered a space to work, but they are also scolded if they do not maintain the space clean and are not offered any remuneration. Their incorporation into the state system relies on a precarious balance: only those who have been trained are authorized to continue practicing, but under the
medical gaze (Foucault 1976). Referring to their situation in the hospital and the government's attitude, the *parteras* I have met recurrently complain that the government does not take them into account (*"no nos hacen caso"). *Parteras* contrast the first years of operation of the hospital, which coincide with Juan Sabines' administration (2006-2012), to the following years and the deterioration of their working conditions. Doña Gabriela remembers fondly the ex-governor of Chiapas, who always invited the hospital's *parteras capacitadas* to different events. "Now this one does not care as much," she laments. The current period corresponds to a change in local government, and to a disinterest for the training of parteras. In line with the intercultural turn of health policies, the strategy of the current government is focused on the construction of Casas Maternas throughout the State, rather than the celebration of indigenous midwives. After years of insisting on TBA trainings, international agencies now focus on the need for Skilled Birth Attendants, like *parteras profesionales* (Berer and Sundari Ravindran 2000; United Nations 2014). In Chiapas, the diverse landscape of the Casas Maternas illustrate the lack of coherent government policy and the uncertain outcomes of global projects, tied to local politics and historical relations between the state and marginalized populations. Across the region, the general tendency is that while the *parteras profesionales* are encouraged to attend births in the Casa Materna, *tam-alaletik* (even the *capacitadas*) are not allowed to, losing all autonomy over their practice (Freyermuth 2010). In this context, the *parteras* of the TMA represent an exception that might not last for long.

The "interculturality in health" policy, the TMA and the various Casas Maternas across Chiapas illustrate the state's attempt at bringing hospital care closer to indigenous people. Still, most of indigenous women give birth in their home in rural villages. Even in San Cristóbal, some indigenous, mestiza and foreign women choose to give birth in their home or in one of the two
birth centers (Chapter 4), and complain, "The hospital is where women die." In the next chapter, I turn to women's reasons for avoiding hospital birth, despite its geographical proximity.
Chapter 6. Tales of (Obstetric) Violence.

Reproductive Governance in Modern Mexico

Estela is struggling to walk on her own as she makes her way into the Traditional Medicine Area's waiting room. Her husband is helping her, while her own mother is right behind her, carrying a baby wrapped in a fluffy yellow blanket. Estela is a mestiza woman in her early twenties. She gave birth a week ago with Doña Gabriela in the TMA's birthing room. Today, Estela comes to visit Doña Gaby again because she is feeling much pain when breastfeeding. She takes her shirt off, and shows us her swollen breasts and scratched nipples. She cannot breastfeed anymore, and has to pump her milk and bottle-feed her daughter. Doña Gabriela is alarmed, and asks me to collect the plants she names from the garden, and to prepare water to boil. We then make a tea that we mix with ampicillin (an antibiotic to prevent infection), and clean Estela's breasts with the help of her husband. Doña Gabriela keeps providing advice, and carefully explains to Estela's mother and her husband how to keep caring for her. Doña Gabriela then asks Estela why is it she is having trouble walking, and Estela says that it is because of the stitches from the hospital; ever since then, her lower abdomen has been hurting a lot and she has not been able to walk. I am a little confused, because I thought Estela had given birth in the TMA. Doña Gaby explains to me that even though the birth went well, after the baby and the placenta were born, Estela started to feel very dizzy, her pressure lowering, and kept saying that she was going to die. Despite Doña Gabriela reassuring her that she was fine, her family started to worry and decided it would be better if she went to the Family Hospital to get checked by a doctor. When Estela arrived to the Family Hospital, the personnel immediately gave her an IV (which bruised both her wrists) and performed a manual uterine revision – a very painful procedure which consists of introducing one's hand in the vaginal cavity in search for residual placenta (residual
placenta is a cause of postpartum hemorrhage). According to international guidelines, this procedure should not be routinely performed – and is categorized along with other practices as "practices that are clearly harmful and should be eliminated" (World Health Organization 1996a)\textsuperscript{109}. It is this act and the stitches performed on her later that were now causing Estela pain.

After hearing the story, Doña Gabriela asks me for a specific oil she always keeps in her purse, and starts massaging Estela's lower abdomen. Meanwhile, Estela continues her account: after the uterine revision and the stitches, two government workers entered the room where she and other women were recovering. "They were going from bed to bed, offering contraceptive implants, and they were telling those who refused the implant that they would not be allowed to leave the hospital." Estela refused at first, but the workers repeated their warning, so she finally agreed to have the implant put in her arm so that she could go back home. "One of the señoras there, she had just given birth to her eighth child, and she did not want the contraceptive… so they kept her in. I left, and she was still in there." According to Doña Gaby, still massaging Estela's abdomen, the pain that Estela is now feeling in her back, her stomach and her uterus is directly linked to the implant that was introduced in her arm. Doña Gabriela warns Estela: if she keeps the implant, it is going to make her sterile, "because it is very cold, and we don't want anything cold after the birth. It's better that you go to the doctor so they can take it out." Doña Gabriela insists; even if Estela has to go to a private doctor (particular), the most important is to get the implant out of her body; otherwise she will keep experiencing pain.

Estela's story raises several important questions: First, why did her family feel the need to go to the hospital if the partera, who is a family friend, was telling them everything was fine?

\textsuperscript{109} Since Estela had not given birth in the Family hospital, and Doña Gabriela, like other parteras, is not allowed inside, there was no way for the personnel to know the placenta had come out in its integrity. Even so, manual uterine revisions are performed routinely in Mexican hospitals (Smith-Oka 2013a; Zacher Dixon 2015).
Second, why did the staff at the Family Hospital perform unnecessary and painful procedures on Estela? And finally, what framework allows for government workers and medical staff to force contraception on women? In Chiapas as in other places of the world, the medicalization of reproductive health is slowly changing women and their families' perception of childbirth, sometimes leading them to challenge parteras' authoritative knowledge and overcome their fear of the hospital. The physical violence Estela experienced in the maternity ward is one of the reasons mestiza and indigenous women refuse to go to the hospital (Berry 2008; Smith-Oka 2013a; Zacher Dixon 2015). Women's fears stem from such stories of violence, in part linked to the poor working conditions of hospitals in Mexico, and which are reinforced by the medical, gender and ethnic stratification at play in the medical encounter; what Micaela alluded to in Chapter 4 when arguing that doctors have "mucho derecho."

In this chapter, I first explore how women's birth experiences are shaped by racism in the medical institution, which mirrors the Mexican state's historic marginalization of indigenous peoples. I then describe how, in the maternity ward, gendered hierarchies between women (including parteras) and obstetricians legitimates violence and further serves the devaluation of parteras' knowledge. Actions of violence are not always "the product of the acts of rogue individual practitioners, but rather of a systemic failure that reinforces outdated practices" (Zacher Dixon 2015:449); at the end of this chapter, I contextualize this "systematic failure" by analyzing the cost to health and physician's working conditions.

Throughout this chapter, I will talk about violence, "a slippery concept – nonlinear, productive, destructive, and reproductive. It is mimetic, like imitative magic or homeopathy" (Scheper-Hughes and Bourgois 2003:1, emphasis in original). Scheper-Hughes and Bourgois specify, "violence can never be understood solely in terms of its physicality – force, assault, or
the infliction of pain – alone. (…) The social and cultural dimensions of violence are what gives violence its power and meaning" (*ibid*). In the context of the hospital, violence is replicated among the staff, as the intern learns from the resident, who learned as an intern that this is how patients are treated. Power hierarchies between staff and patients, and among the staff, reproduce and maintain obstetric violence – the physical, verbal, psychological and structural violence women face within the structures of care over the course of their reproductive trajectory.

*Parteras profesionales* use the concept of *violencia obstétrica* not necessarily to refer to physical violence, but to wider patterns of inequality that resurface in the hospital (*Zacher Dixon 2015*). When it comes to women's reproduction, structural violence and social stratification reinforce one another, and, as women like Estela come to experience, the hospital shifts from a place of care to a place of pain.

"*Manipulada por partera.*" Everyday racism in the emergency room

If "human rights can and should be declared universal, [the] risk of having one's rights violated is not universal" (*Farmer 2005:231*). Rather than populations "sharing risks," *Farmer* points out how, in the case of AIDS as in that of human rights abuses, social stratification puts some individuals or categories of individuals more at risk than others. So is the case with obstetric violence. As I discussed in Chapter 1, in Chiapas, indigenous women account for 42.9 percent of maternal deaths (*Grupo de Información en Reproducción Elegida 2015a:161*), when indigenous people represent a quarter of the population of the state (*Gobierno del Estado de Chiapas 2014*). With the pressure of complying with the United Nations' Millennium Development Goal (MDG), the Mexican government has focused on lowering the maternal mortality rates, but rural indigenous women are the ones who still die in childbirth. In Chiapas, the maternal mortality rate of indigenous women has almost doubled (1.7 times) between 2010
and 2013 (OMM 2013). Through its construction as a multicultural nation, Mexico has successively glorified and marginalized the indigenous population within its borders (López 2010). One of the consequences of the construction of indigenous people outside of the nation is that the State does not reach out to them; and when it does, it is often through programs that poorly take into account their demands, as I discuss through the metaphor of the broken temazcal (Chapter 5). In many indigenous states like Chiapas, "justice institutions are often physically distant (they are usually based in municipal capitals), hardly any justice system employees speak indigenous languages, there are few interpreters\footnote{Access to an interpreter within the Mexican judicial system is a right, but it is not guaranteed in practice.} and employees may discriminate against indigenous people on the basis of racist attitudes" (Sieder and Sierra 2010:15). In rural areas, men and women need to walk sometimes for days to go to a hospital, and are not always attended to because of similar racist behaviors. In the absence of specialized clinics in the communities, and because of the lack of doctors and medicine in hospitals, men and women need to travel to urban areas when their case requires specialized medical attention. Frequently, they do so when they are already in a vulnerable state, aggravating their health problems (Hernández Sánchez, Soto Pizano, and Durán Mora 2008). The following scene in the Intercultural Hospital illustrates the everyday racism indigenous women are confronted to in public health structures.

Inés arrives in the TMA searching for Doña Gabriela, who cared for her throughout her pregnancy. Full term pregnant, she is feeling some pain — what could be the beginning of labor. Doña Gabriela gives her some tea and requests an ultrasound appointment to check the level of amniotic fluid. She is able to get one for the same afternoon, but Doña Gaby suggests they arrive two hours early, as they might get Inés in earlier if there is a cancellation. They follow her advice and indeed, Inés' name is called a few minutes after we sit in the waiting area. Doña Gabriela and
Inés get in while the husband and I wait. When they come out, we go back to the TMA where Doña Gabriela tells us that the level of liquid is fine, but that the doctor said that the baby's heartbeat is too high and Inés needs an *operación* (operation, euphemism for C-section). "Which doctor was it?" I ask. "The mean one, Doña Gaby mutters. He scolded me for always bothering him with my patients." Inés quietly adds "and as we came in, he said why do we need appointments if we are only wasting his time, and that us people just come here to dirty his floor (*solo vienen a ensuciar el piso*)." Doña Gaby directly correlates this racist comment to the subsequent diagnostics of fetal distress; she explains that Inés was upset after hearing this comment, which impacted her baby. The treatment Inés received in the emergency room not only highlights the racist hierarchy between a male mestizo doctor and the indigenous female patient; it also illustrates how technological encounters are used to discipline women's bodies and assert biomedical authoritative knowledge (Andaya 2014; Browner and Press 1996; Georges 2008). Derogatory attitudes of health staff like the ones described in the previous vignette reflect institutionalized racism and sexism in Mexico. In return, these institutionalized discrimination plays into people not being able to trust government or their health providers, and thus avoiding state institutions. Examining bureaucracy in India, Gupta analyzes "the production of arbitrariness" (2012:14) by state employees. This particular power leads to a disconnection not only between the government and the governed, but also splits the governed into categories: those who have rights and those whose rights are dangerous and should be suspended. In Mexico, as everywhere else, women don't come to birth equal; the place where the differential treatment is most prevalent is in the emergency room.

Women who arrive in the Family Hospital's emergency room first interact with the medical staff on call, who will assess their stage of labor, while the husband fill out forms in the...
office. In the case of transfer from an attempted home birth, the staff — doctor, intern and nurse — often uses the sentence "manipulada por partera (manipulated by a midwife)" to refer to what they assume happened in the home (Argüello Avendaño and Freyermuth Enciso 2004:36). The deprecating term "manipulada" refers to the sobada, the massage practiced by parteras who accommodate the baby (discussed in Chapter 3) perceived as an action that "manipulates" the woman's body. The sentence's vagueness, in the passive voice, portrays women in the hands of parteras, deprived of any agency. It also implies that parteras play around with women's bodies without a clear idea of the consequences of their actions. Like in other states such as Oaxaca (Sesia 1996), Veracruz (Smith-Oka 2013c) and Yucatán (Gautier and Labrecque 2013; Miranda 2015), Chiapas' health and government workers associate birthing at home with backwardness, while hospital-birth is promoted as a safer and more modern choice. This sentence also implies the superiority of biomedical knowledge over parteras' and is inscribed in historical asymmetric relationship between indigenous people and mestizos in Mesoamerica, "it is not hard to imagine the potential for double discrimination toward traditional midwives, for being Mayan and for being women, to be aggravated by their impoverished socioeconomic status" (Hurtado and Saenz de Tejada 2001:223). In the previous chapters, I discussed several instances in which parteras were marginalized because of their ethnicity, gender and socioeconomic status, like in the capacitaciones (Chapter 4) and the hierarchies inside the Intercultural Hospital (Chapter 5). In this chapter, I analyze how the biomedical bias towards parteras impacts the treatment women receive in hospitals.

111 Outside of the emergency room, I have heard this sentence used by nurses during a training organized by the NGO Helping Babies Breathe in San Cristóbal. Three nurses, working in different clinics across the state, were discussing the various obstetric emergencies they had had to handle. One of them exclaimed "it’s that they arrive manipuladas por parteras, and so it’s difficult for us to know what [the woman] really has, what has been done to her or not." Her two colleagues followed-up, each sharing cases of women who had been manipulada por una partera and the consequences it had on the woman and the baby.
In her 2003 article on home birth emergencies in the United States and Mexico, Davis-Floyd points out the "fractured articulation" between midwives and doctors, which complicates transfers (Davis-Floyd 2003). This fractured articulation consists of blaming the midwives for transport and emergencies, and dismissing their knowledge when they enter the hospital. It can have tragic outcomes as physicians might punish the mother from attempting a home birth by not attending her on time. In the emergency room of the Family Hospital, Doña Gabriela has alternately been blamed for not bringing the laboring woman in on time ("why did you wait until now to bring her?"), and for bringing her at all ("why did you bring her if she is fine?"). Experiences like these reinforce women and parteras' beliefs that, despite the government's Seguro Popular, access to the hospital is not guaranteed, and if one wants to be attended, they must negotiate (Berry 2008; sometimes a foreigner has more success negotiating the woman's entrance (Burrell, personal communication)). Like in other regions of Mesoamerica, only the laboring woman is allowed beyond the waiting room (Berry 2008; Smith-Oka 2013b) but Doña Gabriela and other parteras sometimes push themselves in to explain to the staff what happened. However, once they have provided the only information asked from them, i.e. the beginning of labor, they are sent back to the emergency waiting room, to wait with the woman's family. Any other precious information they might possess, such as the position of the baby, or their assessment of the mother's state, are not required from them. The parteras (tam-alaletik and parteras profesionales alike) and activists I met voiced their concern about the treatment they receive from hospital staff. In particular, OMIECH members vehemently criticize the devaluation of parteras' knowledge, and the racist attitude of the hospital staff, which nurtures the cycle of blame and distrust between parteras and doctors; "Women enter the emergency room and they are asked, 'Who attended you? - The partera… – Well then it's the partera's fault,
they don't know anything' and they don't even ask which partera or what happened". The "fractured articulation" fuels the lack of trust between parteras and doctors, and the feeling for some parteras that transferring to the hospital represents a failure of their own care (Dudgeon 2012; Freyermuth Enciso 2003). In the next section, I turn to women's treatment in the maternity ward, which is also fueled by racist prejudice (as Inés experienced) and reinforced by gender hierarchies between the masculine medical system and the female body (Andaya 2014; Davis-Floyd 1992; Martin 1987).

"Puje, mi hija:" ethnic and gender stratification in the hospital

Discourses of modernity imply that women "choose" the number of children they want to have, with the only rational choice being that of having fewer children. However, as medical anthropologists have pointed out, "Reproduction is not only enabled and constrained by policies explicitly conceived as regulating health or fertility, but also by policies around labor, housing, migration, and so forth, that often have uneven and contradictory consequences for decisions about bearing and nurturing children" (Andaya 2014:6). In Mexico, pregnant women enrolled in the cash-conditional transfer program Prospera have to attend mandatory prenatal care in their local clinic if they want to keep receiving their monthly stipend (see Chapter 3). In this context, the trust between patients and doctors is replaced by fear of losing ones' income. The doctors extend their medical roles and take on the duties of government social worker, encouraging compliance and thus consolidating their authority (Vizcarra Bordi 2002). Women who do not attend prenatal care at the clinic, but rather with their partera (or any non-institutionalized care) are not counted as having prenatal care. As I have witnessed, when a woman arrives to the

112 The prejudice against parteras is a nationwide phenomena, Smith-Oka reported that in Veracruz, "in 2011 the hospital certified midwives in a 12-week-long certification course with no intention of employing any of them. Ever. As one female obstetrician said, "We have bad experiences with midwives. [Their patients] are the ones who die" " (2013a:2).
emergency room and answers the question "where did you go for prenatal care?" with "with my partera," it effectively equates, in this model, to the woman not having received any prenatal care at all.

When women don't comply with the government programs (of giving birth at a clinic) or expectations of modernity (of having less children), they expose themselves to scolding, coercion and mistreatment from the health personnel. The various appointments women have to make at their clinic over the course of their pregnancy systematically place medical staff's authoritative knowledge over other forms of knowledge, such as their parteras' recommendations or their own embodied knowledge, defined as "subjective knowledge derived from a woman's perceptions of her body and its natural processes as these change throughout a pregnancy's course" (Browner and Press 1996:142). In the clinical setting, pregnant women's "embodied capital" does not carry weight against the technical, educational, and symbolic capital of the physicians (Bourdieu 1994). As pregnant women are socialized into the medical system, they trade embodied knowledge for compliance to the medical authority and scrutiny, what Foucault calls the "medical gaze" (1976). The medical gaze is often a male one; pregnancy and birth being "clearly located on a terrain which is irreducibly female, but the need to control its outcome, thus ensuring members for a collective future, often fuels the activities of male specialists" (Rapp 2000:106). This contrasts starkly with birth outside of the medical system, where the birth specialist is female, even though as researchers across the globe have pointed out, women (including the partera) are not always the ones determining to transfer to the hospital, their decision capacities being entangled in gender and family hierarchies (Berry 2010; Freyermuth Enciso 2003; Pinto 2008). In Chapter 3, I described the ideal home birth in the community, one where the family is present, and discussed the confianza that exists between women and their
partera, which is based on what women and their family perceive as appropriate respectful cultural care. This is also the case with the births I witnessed in the Intercultural Hospital with Doña Gabriela. In the TMA, the woman labors assisted by Doña Gabriela and her mother, father, or husband. Family members are allowed to come and visit, and use the kitchen space to cook or make coffee. The persons in charge – Doña Gabriela and the pregnant woman – are female, and they are the ones who make the decision to call a physician or to transfer. The home or TMA midwife-assisted births starkly contrasts with what women experience in public hospitals, experiences which feed into the reciprocal mistrust between the medical establishment and patients (Nazar Beutelpacher 2011; OMIECH 2014). In contrast, my experience at the Public Clinic (Figure 7) highlights the gendered hierarchies women experience when giving birth in the biomedical system.

July 7, 2015. Alba and I meet with a physician at the Public Clinic. After the interview, he asks us if we would like to enter into the labor room, to which we agree. He seeks the female head of nursery because the male director is nowhere to be found. The nurse agrees to us conducting observation in the maternity ward, an authorization which then needs to be corroborated by the male obstetrician on call that day. The physician who Alba and I interviewed takes us behind the swinging doors marked "Authorized Personnel only," and after granting permission from the obstetrician, explains, "Look, right now there is only one patient, and she is not cooperating. But it is good if you see her, because this is the reality." He hands us green pants, gowns (which we put backwards) and hat and leads us to the labor room. Nineteen-year-old Ana is lying on the single high-bed in a cubicle of the labor room, convulsing with pain. The green hospital gown is up to her pubis, revealing her skinny legs, and almost uncovering her

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113 The Public Clinic maternity ward has fifteen beds (Argüello Avendaño and Freyermuth Enciso 2004).
114 I read her name on a plastic hospital bracelet around her wrist.
stomach, to which a fetal monitor is strapped. With a grimace on her face, she is screaming, "I can't!" as we are entering the cubicle. The male nurse comments to my colleague Alba and I: "She is not listening. It would be much easier for her if she stopped moving around like this and just listened to us." As another contraction arrives, his eyes jump to the monitor screen, while Ana sits up to push.

Several elements put Ana in the category of noncompliant patient. First, she is a young mother. Teen pregnancies are far from uncommon in Chiapas and Mexico, but they are frowned upon by the medical staff (Smith-Oka 2016), in this case the nurse, who refers to Ana as "mi hija" (my daughter), even though, in his mid-twenties, he is too young to be her father. The patronizing tone of the nurse's "mi hija" creates a symbolic hierarchy which, combined with medical and gender hierarchy place him in a position to get Ana to comply. Second, even if Ana spoke Spanish, her physical traits associate her with an indigenous population, adding an ethnic dimension to the hierarchy between the mestizo nurse and herself. The many hierarchies between medical staff and young mothers like Ana can lead to harsh verbal aggressions from the medical personnel, which are justified through a moralized discourse about what good motherhood is – and young (indigenous) mothers do not fit the scheme (Smith-Oka 2015).

As the experience of the Intercultural Hospital's TMA illustrates, some elements from the midwifery model of care, such as women's ability to give birth in various positions, can be integrated in the hospital. However, in maternity wards like the Family Hospital or the Public Clinic, the supine position is still predominant (Davis-Floyd 1992; Gálvez 2011; Smith-Oka 2013a). Medical anthropologists have pointed out the many similarities between the treatment of women's bodies in hospital and that of objects (Jordan 1997) or assembly lines (Davis-Floyd 1992; Martin 1987). In The Woman and the Body, Martin (1987) explores the gendered
construction of science and the reification of women's bodies in hospitals in the 1980s in the United States. The different stages of labor parallel factory work, while women's bodies become machines and themselves laborers to produce a perfect product, the baby, which is the focus of all medical technologies (Ivry 2009) and health education campaigns (Oaks 2001). The focus on the "product" takes away the attention from the laboring mother, who are only valued as working bodies. Like in factories, male obstetricians supervise the female laborer; the medical scrutiny of a patient's body is also a male gaze on the female body (Davis-Floyd 1992; Smith-Oka 2013a).

In the birth I witnessed in the Public Clinic, Ana was forced to lie down; verbally by the nurse, and physically because of the monitor strapped on her. The physical position of the nurse, standing up on Ana's right, and of Ana, frantically laying down, provides a visual contrast which vividly illustrates Martin's metaphors in birth: in the production of new citizens, the physician acts as a supervisor, and the pregnant woman as the laborer (1987). The product to be made, Ana's child, needs to be produced under conditions determined by the supervisor, not by the laborer. Thus, what matters is the quick production in the most efficient position, not the one that is the most comfortable for Ana the laborer.

In the hospital setting, birth becomes a technical event, where the knowledge of the staff (nurse and doctors) is combined to the use of technologies, such as the fetal monitoring. Despite having assisted in five births, Ana's labor was the first time I was confronted with fetal monitoring, but I recognized at first glance. After a few minutes of Alba and I observing, the nurse asked me to come on his side of the bed, and began to explain how the monitor works, "Look, here on the screen are the product's cardiac frequencies. Let's wait a little... There! You see, now she is having a contraction, so the frequency decelerates, which is normal. Let's

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115 Most of the biomedical personnel I have met use the technical word "product" to refer to the fetus, making Martin's metaphor of the baby-as-product come to life. On their end, parteras use the word "baby" or sometimes "little angel."
wait until the end of the contraction…. [without a word to Ana]. There! See? It changes again.

With a complete indifference towards the laboring woman, the nurse focuses on the technology, which often stands for development and modernization (Castro, Heimburger, and Langer 2003; Davis-Floyd and Sargent 1997a; Georges 1996b; Ivry 2009). In a postcolonial context, medical knowledge and the use of new technologies are linked to status and power, which for indigenous women makes any kind of contestation difficult. The "over-medicalization of care" (Freyermuth and Sesia 2009:77) is conceptualized in Davis-Floyd's "technomedicine," which she defines as "a system of health care that objectifies the patient, mechanizes the body, and exalts practitioner over patient in a status hierarchy that attributes authoritative knowledge only to those who know how to manipulate the technology and decode the information it provides" (Davis-Floyd and Sargent 1997b:8). The technocratic model of care is embedded in gender hierarchies, reproducing "patriarchy by constructing women's bodies as weak and requiring male-controlled technologies" (Van Hollen 2003:505). In a national context of widespread gender-based violence, where women struggle to gain control over their own body (Arteaga Botello and Valdes Figueroa 2010; Muñoz Ramírez 2016), the hospital becomes a place where violence is reproduced, as women's intimate birth experiences are controlled by male professionals through technology. These gendered hierarchies of power are further maintained by the focus on risk.

Anthropologists have analyzed how medical discourse transforms a natural event into a risky one. In his research among K'iche in Guatemala, Dudgeon describes how pregnancy is perceived by the medical staff as a "condition of constant emergency" (2012:20). This state of emergency, or state of exception is, according to Agamben, a component of biopolitics. Under the state of exception, the "paradigm of security [becomes] the normal technique of government" (2005:14). If pregnancy and birth are categorized as states of exception, then the medical staff
can take exceptional measures; the monopoly on violence (Weber 2002) is no longer simply a prerogative of the state to control disobedient citizens, but is extended to hospital staff's handling of noncompliant patients. In the Mexican context, the complex interlocking of government politics, poverty and discrimination creates an environment in which giving birth easily slips into a subversive act if it does not follow the established guidelines. If they don't follow the recommendations of their doctors and the parameters of the government program, pregnant women and the parteras who attend them can be denied their rights as citizens (such as the right to choose how and where they want to give birth) – turning into what Auyero coined "denizens," citizens whose rights are not respected. By using risk to constrain women's choices, pregnant women ending up in hospitals are turned into denizens, agents without agency. And so, because they are citizens without rights, women's rights in childbirth are consistently violated.

Researchers and NGOs have been documenting obstetric violence in Mexico for more than a decade (Castro and Erviti 2003; Castro 2004; Freyermuth Enciso 2004; Kirsch and Arana 1999), but it is only after the picture of an indigenous Mazatec woman giving birth on the lawn of a Oaxacan hospital after being denied care went viral on the internet that Mexico that the world took measure of the breadth of the phenomenon (Gomez Licon 2013). Since then, actors from the civil society such as GIRE (Information Group on Reproductive Choice) have encourage women and their families to present demands to the National Commission of Human Rights (CNDH), and pushed for legislation on the matter. Currently, three states criminalize obstetric violence (Chiapas, Guerrero and Veracruz), and similar processes are underway in two others (Jalisco and Zacatecas) (Grupo de Información en Reproducción Elegida 2015b; Murray de López 2015). As I discuss in this chapter, obstetric violence derives from structural power differences between doctors and their patients, which cannot be analyzed as individual acts but
rather as symptomatic of deeper inequalities permitted by the state of exception that is pregnancy. The violation of women's reproductive rights during childbirth takes the form of verbal insults (Castro and Erviti 2003), routine invasive procedures (cervical checks (Smith-Oka 2013a) and uterine revision (Zacher Dixon 2015)) and forced sterilization (Castro 2004), among other.

In line with international organizations, GIRE places obstetric violence on the human rights terrain, in contradiction with the WHO statement that "every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care". In particular, women of low socioeconomic status and minorities more likely to suffer obstetric violence. During an interview I conducted with a Tsotsil professional midwife, she recalled her own birthing experience at the hospital, before she had even thought of engaging partería: the intern who was supervising her birth performed an unnecessary and very large episiotomy, which later got infected, causing her pain for months, "This was the problem, I could not even sit, I stayed with the pain for over a month, I could not sit." She concludes with a poignant, "así fue cómo me lo hicieron a mí (this is how they did it to me)," anchoring her story in the collective experience of Mexican women. Routine episiotomies are categorized by the WHO as "practices which are frequently used inappropriately" (1996). However, these are five time more likely to occur in a hospital birth attended by a physician than at a home birth (Janssen et al. 2009) and are routinely practiced in many countries (Davis-Floyd 1992; Diniz and Chacham 2004). While I was unable to get the specific rates of episiotomy for the Family Hospital, according to the gynecologist who worked there for three years, it is interns, not doctors, who more frequently perform it, because they more unsecure about their practice. A French midwife who volunteered at the clinic of Altamirano in the Selva region had to leave after less than two months there
because she was not performing enough episiotomies, "the doctor would come in and say "why didn't you do an episio?" and I would answer 'well, this is not how I work; look, the mother and baby are fine, they did not need it,' but they would scold me" (Association MÂ 2015). The French midwife also added a list of other violent practices that decided her to leave the clinic such as, women confined to their beds during labor and delivery, taking babies away immediately after birth, and manual placenta removal without anesthesia.

In their 2015 report, Niñas y Mujeres sin justicia. Derechos Reproductivos en México, GIRE analyzes how criminalizing obstetric violence is not the solution to its ending; rather the state should recognize such violence as institutional violence and act to provide women with quality care (2015b). However, focusing on specific behaviors "would be limiting and could turn into an obstacle for the identification of such behavior and for victims' access to full reparation" (GIRE 2015b:134). The likely impossibility to apply such law will not serve women in practice. The Obstetric Violence law does not focus on the structural roots of such violence, such as the way medicine is taught, the lack of information given to women on their birth options, and the structural inequality between doctors and patients. Indigenous women's fear of the hospital does not just stem from horror stories. It builds on a greater mistrust of the state, and it is entangled with historical gender, ethnic, and class inequalities in Mexico (Hernández 2013). In a life marked by what Speed refers to as a "dreadful mosaic" of violence (2014), dying in the hands of kaxlanes (non-indigenous) doctors becomes the ultimate form of violence. The unequal power relationship between patients and physicians, at play in any medical encounter (Davis-Floyd and Sargent 1997a), is amplified by the social and ethnic stratification in Mexican society.

On their end, the medical professionals I have met have been generally very skeptical about such laws, which are impossible to implement. The reactions ranged from sexist disdain
"well, we will only have female obstetricians then, so we won't be charged with violating women" (from a male physician working in a rural clinic) to more pragmatic ones, "the Obstetric Violence law has a very noble purpose and very good concepts; the problem is that [politicians] they make such a law and [as a doctor] you think "and how am I going to implement this if I don't have any way of [implementing humanized birth]" (Dra. Carla, obstetrician and former Family Hospital employee). Another limitation of the law is the lack of legal recourse to denounce obstetric violence, and the little trust Mexicans have in their judicial institutions. If the complains do not go through, why file them? In November 2013 in Chiapas, a Tsotsil woman who came to the Family Hospital in labor died after an emergency C-section and an operation of the gallbladder for which she did not give her consent (Grupo de Información en Reproducción Elegida n.d.; Ramos 2014). The work of GIRE allowed her family to win the case in court against the State of Chiapas, and obtain reparation two years after the fact.

Obstetric violence does not only occur during childbirth, but also after birth, as in the case of Estela. As Estela's story illustrates, the biopolitics of birth in Mexico include limiting women's fertility, and for those in public hospitals, through forcible methods. In Latin America, forced sterilization and imposed contraception are part of government programs to reduce national birth rates – and indigenous women's fertility rates in particular (Castro 2004; Garcia 2016; Smith-Oka 2009). Even though she is mestiza, Estela, a twenty-year-old first-time mother still experienced the violence of forced contraception. Her story illustrates the moralities of maternal care in Chiapas and developing countries: young women are expected to want fewer children, and therefore should happily agree to take contraception, offered to them for free by the hospital staff. Global moralities that women should want and have fewer children who will have a better life directly lead to forced sterilizations on poor women. In the neoliberal regime,
children become something one should be able to afford (Van Hollen 2003). Cases of forced sterilization of minority women have been documented throughout the Americas, including Mexican-American women in the USA (Gutiérrez 2008), women with HIV in Mexico (Kendall 2009). In Mexico, cases of IUDs inserted without the woman's prior consent have been reported by apprentices of the CASA midwifery school to Dixon (2015), and in Chiapas by Kirsch and Arana (1999). In the neighboring state of Oaxaca, a report highlights that 80 percent of pregnant indigenous women suffer obstetric violence (Jimenez 2015). Across the country, a public report from the National Commission to Prevent and Eradicate Violence Against Women (CONAVIM) evaluates that at least 27 per cent of indigenous women who have been in contact with health services have been sterilized without their consent (Proceso 2013)\(^\text{116}\). Such procedures are at the core of what Morgan and Roberts coined as "reproductive governance," namely,

"The mechanisms through which different historical configurations of actors – such as state, religious, and international financial institutions, NGOs, and social movements – use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor, and control reproductive behaviors" (2012:243).

Across Mexico, researchers, journalists and midwives have embarked on a crusade against obstetric violence, relying on a discourse focusing on women's reproductive rights to call out for structural changes in the way women are treated in hospitals GIRE 2015a; Zacher Dixon 2015). Their critique of the Obstetric Violence law highlights that violence does not only stem from the practice of individual practitioners, or be reduced to a series of practice. Rather, the context of generalized violence in the country, and the lack of means of the public health sector need also to be considered.

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\(^{116}\) This is also the case in Guatemala (Garcia 2016)
Structural reforms and the cost to health

It is 6 am as the minibus from San Cristóbal to Tuxtla pulls over at the city's entrance. It is still dark outside, but already warm, so I take off some layers of clothes; the temperature difference between the two cities never stops surprising me. I see Israel's car on the supermarket's empty parking lot. As he does every morning, he is leaving the Chiapas capital, where he lives, for the north of the State, where he works as a generalist in a Centro de Salud – a two hour drive away, in the Zoque region. Israel works in the clinic from 8 am to 3 pm, Monday to Friday, and every other Saturday. Sometimes when he works Saturdays, he has to stay and sleep at the clinic. In the afternoons – that is from 5 to 8 pm – he works in Tuxtla, in a private health center which offers alternative medicine services, such as acupuncture and homeopathy. And when he finally gets back home at night, he often attends clients in his and his wife's private consult.

"So, when do you sleep? I ask, incredulous.
- Well for example last night I went to bed at 3 am.
- And you woke up at 5?
- Yes. I am very tired. Do you want to drive?"

Israel's case is not unique, and like him, the other doctors I have met juggle between several jobs and finding time for their family. There seem to be two reasons in-demand professionals take on several jobs simultaneously. The first one is the pay. As Israel explained to me, what the public clinic pays him is not enough for him and his family to live in Tuxtla (his wife is still a medical student), so having several jobs is a way for him to make ends meet. The second reason is that keeping a foot in the public system has some benefits for retirement and leaves. But working several jobs also means no holidays: the week previous to our meeting, Israel was on holiday from the public clinic, which meant he could work more hours at the private practice. It is not the first experience Israel has of working in a rural area; he spent his
servicio social (year of residency) living and working in the Selva, far from his family, as most of pasantes (medical interns) experience.

Since the late 1960s, when indigenist policies led to the construction of rural clinics, first in Chiapas and then across Mexico (Fenner and Palomo Infante 2008), most of the young doctors who staff rural clinics are unpaid pasantes. These young doctors "recently graduated from medical school and are doing their mandatory year of government service before entering residency or beginning general practice" (Molina and Pazuelos 2014:33). Pasantes, who are rarely Chiapas natives, are often unprepared for the cultural shock they will encounter, the complex health problem of campesinos, and despite having technical experience, lack the commitment to the community (Fenner and Palomo Infante 2008; Lewis 2012). They are left without any formal mentorship training, leading to a feeling of abandonment (Molina and Palazuelos 2014) reminiscent of the TMA parteras' claim that the SSA "does not care about them" (Chapter 5).

Currently, there are 1.3 doctors per one thousand inhabitants in Chiapas, which is lower than the national average (1.9), and less than half the ratio for the capital (3) (Aguilar 2014), which in practice means that communities are in charge of their own health. Despite this scarcity of doctors, I was surprised to see in many villages in the Altos the green and white building indicating a Centro de Salud. However, most of these, built after the Zapatista awakening, are white elephants, where pasantes struggle with the lack of material and medication (DeMaria et al. 2012; Hernández Sánchez, Soto Pizano, and Durán Mora 2008). The SSA provides pasantes them with certain medication, but not all, so patients often had to buy out-of-pocket their own medication in neighboring towns. In Yametik Catalina and Don Manuel's village in the Oxchuc region (see Chapter 3), the Centro de Salud is open Monday to Friday, from 8am to 3:30 pm. It is
staffed by one male generalist, one male pasante, two female nurses, and one male pharmacist. Women come to get their prenatal care at the clinic, but when I asked if they can give birth in the Centro de Salud, the doctor replied "we are not here in the evening, so we tell women to go with their partera." And when I inquired about transferring, he explained, "We don't have an ambulance; people need to go to Oxchuc or San Cristóbal by [private] car."

The center of investigation Fundar reveals that, since 2009, the Federal SSA has signed agreements with each of the State SSA, where each state is responsible for implementing "the prevention and promotion of health actions" (Díaz 2014). However, the way each State spends the allocated resources is not disclosed. In 2015, the Chamber of Deputies approved the SSA budget with a cut of 80.8 millions of pesos (US$6.7 million), which is equivalent to an average 10,380 vaginal births (Díaz 2015a). As analyzed by Fundar, the cut makes it even more difficult for Mexico to comply with the International Covenant on Economic and Cultural Rights, which recognizes health as a human right. Even though health is recognized as a human right for all since the Alma Alta conference of 1978, poor Mexicans still struggle to exercise this right, whether as migrants in the USA (Gálvez 2011; González, Burrell, and Collins 2012) or within their own country (Physicians for Human Rights, ECOSUR, and CCECS 2006). Macro decisions like cuts in the SSA budget impact rural health clinics such as the one in Oxchuc, but also bigger hospitals like the Intercultural Hospital and the Family Hospital.

The Family Hospital is a teaching hospital, meaning that pasantes should learn from senior physicians, while being supervised. In reality, the influx of patients and the shortage of obstetricians leave young doctors on their own. Paralleling Davis-Floyd's observations in the

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117 Even in clinics where doctors could attend births, Freyermuth reports that the doctors would rather send the women to give birth in the hospital, because they fear conflict with the local population in case of a problem. And for this very reason (being sent to the city), women do not want to go to the clinic (2010:58).
United States, Mexican residents internalize a pattern which works for them, and will then repeat it even if the procedures are not necessary. "The great majority of births attended by obstetrical residents are channeled through the same procedures, and most of these births turn out well. Thus, once the resident has internalized the pattern for performing those procedures, this learning (and the successful births that accompany it) become generalized" (Davis-Floyd 1992:260) – leaving little space for contestation and change, as in the case of episiotomies described earlier by the French midwife in Altamirano. As anthropologists have analyzed, the medical structure serves to discipline patients and socialize them into the norm (Ivry 2009; Lock and Schepers-Hughes 1990; Smith-Oka 2015). In Cuba, pregnant women are disciplined into the medical system, and doctors often remind them to be "disciplined" (Andaya 2014). Disciplining is also at the heart of the training of future doctors, becoming part of their habitus (Castro 2010), their internalization and reproduction or norms; "From the first semesters of their studies, medical students learn the centrality of punishment as a didactic resource through which they are formed" (ibid:64). The doctors I have met were aware of the repercussion of their training on their practice. Dra. Laura, the generalist working in Comitán, and who is preparing her specialty exam, recalls,

"When I was a pasante, once I heard a [male] doctor say [to a woman in labor]: "Really, you were screaming like this when you made it, cabrona, so now push!" and I thought it was rude and inappropriate, so I don't say this kind of thing, but what about the other pasantes? They might think this is how you treat your patients."

The reproduction of violence, the mimetism evoked by Scheper-Hughes and Bourgois (2003) is a difficult cycle to break, and individual attitudes like the one Dra. Laura witnessed are difficult to call out in a system where women have no choice but going to the hospital – because they do not want to loose their government stipend, because their parteras are threatened with jail if they keep attending them.
With twenty-six beds, the Family Hospital cannot possibly respond to the demand of all of the women seeking its services. The Family Hospital technically provides its services to the 204,654 women over 12 years old living the Highlands (Grupo de Información en Reproducción Elegida n.d.). In reality, women from all over Chiapas occupy the thirteen beds of the emergency room. The medical staff I have interviewed explained to me that most of the women who arrive at the Family Hospital are often referred from other hospitals because of the lack of space. When they arrive in the emergency room, the medical staff evaluates women's state; those with the most serious condition are taken in, while others await outside. This hierarchization of patients according to the gravity of their condition implies that a woman living in the Coastal region and has a complication first needs to go to the hospital in the main town of Tonalá (Figure 12). However, if her case is not deemed severe enough, she will either have to wait or be encouraged to go to a hospital in another town, where the scenario will repeat. The laboring woman physically moves along the referral chain, and in the meanwhile her state deteriorates. She then arrives at the Family Hospital, the final link, and there, as Dra. Carla, the female gynecologist and former Family Hospital employee, stated,

"And there is no space here either, but now she is dying so [we say] "come in come in" and now the one who is not as severe will wait for us while we will attend this patient who has seen… four hospitals and none of them have been able to receive her. So yes, we have patients who come from… far, very far, Yajalón, Ocosingo, even Comitán and Tuxtla when there is no space. They arrive here. They arrive here in San Cristóbal."

Like in Guatemala, for this reason physicians encourage women to go to the hospital before a complication emerges (Berry 2006). But these recommendations also contribute to overcrowding public hospitals. Women such as the one portrayed in this vignette do not have private health insurance, and cannot afford to pay for a private clinic at any stage of their journey. They face economic and social barriers that ultimately lead them to die. As stated
earlier, in Chiapas, the maternal mortality rate of women in reproductive age (between 15 and 49 years old) has increased between 2010 and 2013, and that of indigenous women has almost doubled (1.7 times) over the time period (OMM 2013).

<table>
<thead>
<tr>
<th>Town/ Distance [km]</th>
<th>San Cristóbal de las Casas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tonalá</td>
<td>200</td>
</tr>
<tr>
<td>Yajalón</td>
<td>149</td>
</tr>
<tr>
<td>Ocosingo</td>
<td>96</td>
</tr>
<tr>
<td>Comitán de Domínguez</td>
<td>93</td>
</tr>
<tr>
<td>Tuxtla Gutiérrez</td>
<td>60</td>
</tr>
</tbody>
</table>

Figure 12: Distances between the Family Hospital in San Cristóbal and other towns.

To lower maternal deaths, the strategy of sending virtually all women to give birth in hospitals has led to the saturation of public hospitals (like in Guatemala, Cosmimksy 2012). More women also go to the hospital because of programs such as Prospera, which aims to send them to give birth with Skilled Birth Attendants, but without the necessary infrastructures. The need to attend to many patients as possible contributes to the rising rates of Cesarean sections in Mexico (70 percent in private hospitals and 40 percent in public hospitals at the national level (Sánchez 2010))\(^\text{118}\). For the period January to April 2015, the Family Hospital registered a C-section rate of 51.4 percent.

"This was a strategy that the government initiated, not just here in Mexico, but in many countries, that was suggested to diminish infant mortality; hospitals are saturated and a C-section is a good way of programing who comes in, when they do, and when they come out. [We have] a failed health system that does not know how to care for pregnant women – C-sections are a clear example of that – and it is not possible that we keep having a C-section rate three times higher that that recommended by the World Health Organization" (Redacción AZ Noticias 2015)

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\(^{118}\) C-sections have become so common in Mexican hospitals, that women (and parteras) talk about “parto natural” (natural birth) to mean “not a C-section,” which does not exclude a vaginal birth with drugs, an episiotomy, a uterine revision.
There are many factors accounting for the high rate of C-sections in Mexico, which have become "a by-product of the medicalization of birth" (Castro, Heimburger, and Langer 2003). As described in the previous quote, C-sections are convenient because they are easier to time and to control, which feeds into the mechanization of birth and the control of women's bodies, as analyzed earlier in this chapter. Israel, the doctor who works in a public clinic two hours away from Tuxtla, agreed that Cesarean sections are convenient for physicians, "Because it saves time (... ) you need 15 or 20 minutes for a C-sections. And then [the doctor] goes to sleep." He also added another explanation for the high rates of C-sections: doctors want to practice. This echoed the words of members of OMIECH's Women and Midwives Sections, who explained that doctors doing their specialization in obstetrics want to "practice their skills" and that, like in the United States, it is more prestigious to perform a C-section than to deliver a vaginal birth (Davis-Floyd 1992; Epstein 2007). Finally, another parameter is the differential cost between a Cesarean section and a vaginal birth. The Women and families I interviewed feel that at times doctors "make up that you need a C-section, because they want money." In San Cristóbal's Family Hospital, a Cesarean section costs about 10,000 pesos (US$833). Those who do not have Seguro Popular have to pay the full cost. Women who are registered with Seguro Popular pay on a sliding scale, according to their income. In a private practice in Tuxtla, a mother delivered vaginally for 18,000 (US$1,500) pesos; a Cesarean section would have cost her 25,000 (US$2,000). Like in the United States, birth in Mexico has become a business (Epstein 2007).

The availability of free services does not mean that people will be able to and/or want to benefit from them. The reasons why people don't attend public health facilities are complex, and include the cost of attention and of transportation, as well as the trust potential patients have in the health care providers, a consistent barrier across the region (Berry 2008; Chopel 2014;
DeMaria et al. 2012). At the frontline of health, *pasantes* in health centers and nurses in the emergency room juggle between their goal (deliver health services to the poor) and their working conditions (lack of infrastructure). Making decisions on the spot, which can have important impact on their clients' health, medical staff embody "street-level bureaucracy." In his 1969 address to the Annual Meeting of the American Political Association, and later in his monograph, Lipsky theorizes the complex role of street-level bureaucrats, whose ability to carry on their professional script is jeopardized by the unavailability of personal and organization resources, the large number of clients they have to face and the quick decision-making that is required from them (1969, 1983). Such conditions make it difficult for these workers to deliver person-centered services, which is paradoxically what is expected from them. In the Family Hospital, the employee at the screening of the emergency room needs to decide rapidly about the level of attention needed by the woman in labor – if she requires immediate attention or not. Making people wait becomes part of the bureaucrats' "coping mechanisms" within a deficient system. The large number of clients the Family Hospital attends leads to institutionalizing invasive procedures such as episiotomies and Cesarean sections. The relative discretionary decision-making of street-level bureaucrats' in the hospital explains the perpetuation of such practices.

Street-level bureaucrats can also call out the deficiencies of a system that puts them at the forefront of complaints. In March 2015, the first time I entered the emergency room of the Family Hospital, there was a wall-sized canvas enumerating all the deficiencies of the hospital that were putting patients' lives at risk. Among these: working with outdated material, not enough beds, no proper work conditions (crowded operating rooms), which threatened the safety of patients. By doing so, the Family Hospital staff protests the structural conditions of their work, and the
impossibility to comply with their mission of treating patients with high standards of care\textsuperscript{119}. Their protest call out the health care under the neoliberal regime, which convinces women (through Prospera) and \textit{parteras} (in \textit{capacitaciones}) that birthing in a hospital is best, while at the same time cutting the funding of public health structures and not guaranteeing quality care. In practice, being affiliated with Seguro Popular does not mean that the treatment women will receive is of better quality. As Estela's story of forced contraception in the opening of this chapter shows, patients in public clinic are often treated as second-class citizens who should not only accept the treatments offered by the personnel, but also be grateful for them. Data from the Mexican Observatory of Maternal Mortality shows that there is no significant difference in maternal mortality rate for affiliated and non-affiliated women. In 2013, 51.6 percent of maternal deaths were those of women with Seguro Popular. In Chiapas, it is 56.5 percent (OMM 2013), which questions the quality of care the deceased affiliated women received (Díaz 2015b). For poor people, the free clinic becomes the last choice, and only when private care is unaffordable (Molina and Palazuelos 2014). Between public and private, \textit{parteras} in the urban setting have acquired a semi-private status; they charge for their services (1,000 pesos for a birth, about US$83), but not as much as private clinics.

Inés, introduced earlier in this chapter, and who experienced racism in the ultrasound office, came to the Intercultural Hospital through her cousin, who recommended Doña Gaby after she was able to change the position of her baby from breeched to head down. Inés and her husband are both in their mid-thirties, and live with their six-year-old son in one of the \textit{colonias} on the outskirts of San Cristóbal. They do not have any family support, as both their families live

\textsuperscript{119} In 2013, several clinic and hospital staff in San Cristóbal went on strike, among their demands, "even though there is Seguro Popular there are no supplies; there is no ink for the printer, we have to buy our own jugs of [drinkable] water, the punching clock card has the wrong hour and is out of ink (…)" (Herrera 2013).
in the Selva. Their first child was born in the Family Hospital through a Cesarean section. Inés was not planning to go to the hospital, but after a long and painful labor of two days and two nights, she started to hemorrhage and the baby was still not coming out, so she went to the hospital. Inés says she did not want to be "cut open," but in her critical situation there was no other option, as the baby boy was breeched. After the C-section, "I was in pain for weeks after that" she tells Doña Gabriela and I. Her husband remembers, "I was working at the time (as an employee in a meat shop), and they only allowed me a week off when the baby was born. I had to leave her alone and I was sad because she was suffering." Now in her second pregnancy, a long vertical scar on her stomach serves as a reminder of her first childbirth experience. After an ultrasound during which she learned that this baby, too, was breeched, Inés worried as she did not want another C-section. Following her cousin's advice, she came to the hospital seeking Doña Gabriela's services, and asked her if she could "adjust" (acomodar) the baby. After a couple of appointments at the hospital and at Doña Gabriela's home, the latter managed to position the baby's head down\textsuperscript{120}, and explained that if it stayed this way, Inés would be able to have a vaginal birth.

Since she already had a previous Cesarean section, Inés' second birth falls under the category of Vaginal Birth After Cesarean (VBAC). Both the American College of Obstetricians and Gynecologists and the Royal College of Obstetricians and Gynecologists agree on the conditions for VBACs, which most hospitals in Chiapas are unable to fulfill,

"Women with a history of one or two uncomplicated low transverse caesarean sections, in an otherwise uncomplicated pregnancy at term and with no contraindications to vaginal birth, which should be undertaken in a suitably staffed and equipped delivery suite at a facility capable of providing emergency care (most notably emergency cesarean

\textsuperscript{120} It is partly to this massage that doctors refer to when saying women are "manipulated" by the midwives (see earlier section). Doctors have an ambiguous relationship to sobada, acknowledging that it can help to decrease C-section rates, but at the same time seeing it as a dangerous practice that threatens the fetus, if the umbilical cord is too short or wrapped around the neck.
section deliveries), with obstetric, anesthetic, operating room, and neonatal/pediatric/midwifery staff support continuously available" (National Guideline Clearinghouse 2011)

Midwives across the spectrum have a different view on VBACs. A recent article comparing Trial of Labor After Cesarean (TOLAC) at home in the United States found a high success rate (87 percent). Most of the successful VBACs took place at home, some women were able to have a VBAC in the hospital, but as researcher and nurse Cheyney points out, most in the hospitals had cesareans for "failure to progress" (Cox et al. 2015; Muza 2015), a reason that relates to the close surveillance of time in hospitals (Davis-Floyd 1992; McCourt 2010). Most physicians discourage VBACs because of possibilities of the scar reopening. As discourses of risk are intertwined with medical authoritative knowledge, Cesarean-sections become tools of reproductive governance (Morgan and Roberts 2012) curbing poor women's reproductive choices (Castro, Heimburger, and Langer 2003; Good Maust 2000; Erten 2015; McCallum 2005). In this risk-focused discourse, the number three becomes the ideal number of C-sections and of children (Castro, Heimburger, and Langer 2003), as illustrated in this excerpt of my conversation with Israel.

"Mounia: And how many C-sections can a woman have?  
Israel: Up to three… Yes. But, I am telling you, the risk is augmenting (…). For example, a mother or a woman who will be having her first child, and for whatever complication she cannot have it normally, naturally, and it is decided to do a cesarean…Everything goes well, the cesarean, and that's it, it is resolved. But in three, four years, she decides to get pregnant again, yes? The ideal is that a cesarean [section] get done, so as to not take the risk. And scheduled.  
Mounia: 'And scheduled.' Why?  
Israel: It has to be programmed because you cannot wait until the risks present themselves. That is, if we already know that in her first pregnancy the birth was complicated, then I will not wait until the second pregnancy gets complicated. So I schedule her for a cesarean. When it has an appropriate fetal maturity.  
Now, if her first cesarean was for some problem where the life of the mother was at stake, and I know that her second pregnancy is going to be the same or worse… This patient preferably needs to… avoid becoming pregnant. You can operate on her once and for all. Why? Because her life is at risk."
As this conversation illustrates, birth is no longer a natural event where the woman is supported by her family, but becomes a risky practice performed by a technocrat, the obstetrician (Davis-Floyd 1992; Fordyce and Maraesa 2012). Like most doctors, Israel argues that women with multiple C-sections "the body of a woman is not capable of supporting various cesareans, due to the risk of uterine rupture; therefore, women who have undergone multiple [C-sections] should put a permanent end to their fertility" (Castro, Heimburger, and Langer 2003:18). However, this medical discourse walks the thin line between risk protection and forced sterilization – a recognized practice used to control the reproduction of Mexico's indigenous population (Castro 2004; Proceso 2013; Smith-Oka 2013a). Population control relies on a discourse of risk as instruments for controlling the body (Foucault 1976). Here, biopolitical measures, such as preventing pregnancy, are used in the name of risk: avoiding situations that put ones' self at risk (multiple births). What this discourse does not say is that such measures do not affect all women equally, but are targeted towards an already risky population (poor and indigenous). Later in the interview, I asked Israel to hypothesize about two situations: one woman living in the state capital, Tuxtla Gutiérrez, and who could afford a private clinic; and another woman living in a rural community hours from the capital. Both women would have the same clinical history he described: would he still recommend sterilizing both? After pondering about the cases, Israel agreed that if the women insisted on not being "operated," he would be more lenient with the one living in the capital. This response is directly linked to the difference in infrastructures between urban and rural settings in Chiapas: in case of complication, the highest level of care is accessible in the capital. For rural indigenous women with the same condition, distance and poor road conditions might lead to a tragic outcome. This differential
treatment is a crucial element of stratified reproduction (Colen 1995), making some women's reproductive capacities more difficult than others.

Despite medical discourse of risk and government programs controlling their reproduction, women like Inés or Estela are not deprived of agency. In their encounter with their physicians, women are

"active interpreters of medical information. They pick and choose, using and discarding advice according to internal and external constraints and considerations. In the case of our pregnant informants, embodied knowledge and everyday life exigencies proved to be pivotal in their selective designation of certain biomedical knowledge as authoritative." (Van Hollen 2003:152).

Across the world, other micropolitics of resistance include verbally acknowledge one's discontent with the social treatment of pregnancy, what Ivry calls "discursive criticism" (2009:166), birthing at home when it is not the norm (MacDonald 2008), and delaying the entry to the hospital at the moment of birth (Davis-Floyd 1992; Martin 1987). In their study with pregnant women in California, Browner and Press (1996) found that women were more likely to reject practitioners' authoritative knowledge if it contradicted their bodily experiences of previous pregnancies, if it wasn't compatible with their daily lives and if the problem was considered benign; this data was not influenced by ethnicity or social class of the women. Such embodied resistance is illustrated by Inés, who, because of her previous experience did not want to go back to the hospital where she knew she would be getting another Cesarean section.

If some women reject hospital birth and technology, others don't, or the same women might change their mind during labor. In her ethnography of birth in the United States, Davis-Floyd interviewed one hundred women on their birth experience. Seventy per cent of them "either desired, actively sought, or accepted as appropriate the technocratic treatment they experienced. Only 15 percent actually desired and achieved natural childbirth in the hospital, and
only 9 percent who desired natural childbirth but did not achieve it were seriously disturbed as a result. (The other 6 percent gave birth at home)" (1992:281). The reason for such high rate of satisfactory experiences lies in the coincidence between women's view of what childbirth should be like and the biomedical model of care. As emphasized by Davis-Floyd, the technocratic model only functions in synchrony with the values of American society, "American women do not rise up against technocratic birth because it is in fact what most of them want" (282). In fact, women are active consumers of scientific knowledge when it comes to their own bodies (Georges 2008; Ivry 2009; Mitchell 2001). By making decisions about their bodies, and the amount of technology they want, women are able to assess the quality of their own fetus and make decisions accordingly, whether on the use of additional technology or the decision to terminate a pregnancy (Ivry 2009; Rapp 2000).

If for some women giving birth in the hospital might seem "easier," parteras remind their patients that, in the long term, a Cesarean birth is more difficult to recover from than a natural birth. The nurse at Ana's birth in the Public Clinic shared this opinion, "they think they are going to come here and not suffer and get their C-section. But a C-section also has consequences," he warned, scolding Ana, who took the blame for previous patients' demands. The idea that women desire C-sections to avoid the pain of childbirth is widely shared among physicians (Castro, Heimburger, and Langer 2003; McCallum 2005). But the women I have interviewed, like Inés, complained about the pain they felt after the surgery, and the long recovery time – in addition to the fear of being forcibly sterilized. Parteras also used these arguments to inform women about the risks they faced in hospitals, and assert their own authoritative knowledge, which sometimes includes using some of the biomedical tools they decry.
In the conversations I had with medical personnel and parteras, they made no significant distinction between the natural hormone produced by the woman in labor, oxytocin (oxitocina), and the synthetic one injected to her, Pitocin (oxitocina sintética). The use of the synthetic hormone is widespread in Mexican hospitals (Smith-Oka 2013b), and in other countries such as India (Van Hollen 2003) and Greece (Georges 2008). Despite its wide availability in Chiapas, the use of oxitocina is prohibited by non-medical personnel and particularly during homebirth. However, because of the idea that oxitocina is able to speed up birth, parteras are eager to use it. An empirical partera living in San Cristóbal, who is also a nurse, remembers "I wanted to be a nurse in addition to being a midwife, because they forbade the use of injected oxitocina, now it is only allowed through intravenous [drip]." This prohibition of injecting oxitocina limits it to hospital use, and effectively excludes parteras. In general, parteras feel it is an unfair prohibition since doctors are allowed to use it, and one partera wants to learn how to insert an IV to be able to give serum to her patients, but also perhaps oxitocina.

The reason why the use of oxitocina is so widespread among urban and rural parteras is because of government campaigns in the 1980s promoting its use to prevent postpartum hemorrhage (Freyermuth Enciso 1993:95). Inappropriate use of oxitocina during childbirth can bring fetal distress. So when the policies changed and the parteras were not officially allowed to purchase oxitocina, families themselves started to pressure them to buy it because of its reputation of "speeding-up birth." The endemic use was so widespread that local organizations hosted several radio campaigns against the use of oxitocina (ACAS, A.C., personal communication). The problem with the current illegal status of oxitocina is that parteras are able

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121 In her study of midwives in rural Mexico, Parra notes that trained midwives added Pitocin to their practice and ask women to lie on their back (Parra 1989:70).
122 During fieldwork I did not encounter the use of oxitocina in postpartum (except for parteras profesionales); it seems to be used primarily to "speed up birth."
to purchase it, and learn how to inject it, but in the case of a transfer cannot tell the doctor (and make the woman and her family swear not to do so) that they have used it. This double standard in regard to who is allowed to use *oxitocina* stems from the exclusion of *parteras empíricas* from the Skilled Birth Attendant category. Their use of a forbidden tool, which carries the modernity of a hospital birth, can be read as a challenge to their outcast status and a practice of resistance. The law, while maintain them in illegality, unintentionally harms women.

Throughout this chapter, I have analyzed the complex relationship between indigenous women and the Mexican health system – a relationship fraught with racism and sexism. I connected the violence women suffer in hospitals to broader patterns of inequality and the climate of generalized violence in the country. Rather than blame all physicians for women's suffering, I foregrounded how an underfunded health system and overcrowded hospitals exacerbate their already stressful work conditions. Even though these conditions don't justify violating women's rights, they are important elements to take into account when analyzing Mexico's high C-section rate. In sync with programs focused on family planning (Prospera), trainings devaluing indigenous knowledge (*capacitaciones*) and failed intercultural policies, obstetric violence and the control of women's body in childbirth are tools for reproductive governance. In Mexico, reproductive governance is particularly exerted towards women at the margins of society: the poor and the indigenous, whose reproduction fuels fears of overpopulation. In public hospitals, free care through Seguro Popular excuses mistreatment and cultural blame from the medical personnel. This maintains the deceptive relations between poor women and doctors, who feel they will try to make them pay for unnecessary interventions. The discrepancy between these women and those who can afford to pay 10,000 pesos (US$833) for a
birth in a birth center, or choose to pay 25,000 pesos (US$2,000) for an elective C-section in a private hospital, further widens the gap between the rich and the poor in Mexico.

In the face of obstetric violence, I also showed that women and parteras are not deprived of agency. They negotiate with their providers, sometimes relying on the very same technology; Inés actively sought an ultrasound to know if her baby was breeched, which then led her to Doña Gaby. The partera was able to correctly position the baby and Inés delivered her second child vaginally. Building on these individual acts of resistance, in the next chapter I analyze collective organizing through OMIECH’s example. For over thirty years, OMIECH has fought against the medicalization of childbirth in the region, trying to rebuild the confianza between women and their partera. It is to their struggle that I now turn.
Interlude: Micaela's birth stories

During a conversation in the office with a colleague, Micaela was prompted to narrate her birth stories. I took advantage of having my computer at hand to transcribe the conversation as it happened.

"Micaela: No, I did not know if one dies or not [during birth]. [The partera and a doctor friend] were telling me that they would take me to the hospital if the baby was not out within ten minutes (...) I was with my partera, who was also pregnant. They did not give me the plant to break my water, and I couldn't... My strength left me, I laid down.

Santiago: Your husband was not there?

Micaela: No, he had left me. I was crying and preoccupied. I did not know what to do or where to go. I was renting a house because he had brought his other wife into our home. I wasn't well, there were many problems.

Santiago: Those are risk factors too...

Micaela: And so [the partera] did not tell me how to prevent, like I tell to women now. And pain, and pain... The partera's husband held me, all night long, and I couldn't [give birth]. And so the partera held my hand, and diagnosed envidia [she was also a j'ilol]. I thought I was going to die. "Be strong or I will take you [to the hospital]" the doctor said. I don't want to go, I did my training [as a health promoter] there and I know how hospitals are. (...) My God...(...) And I stayed.

Santiago: And the other births?

Micaela: When one takes birth control, then it is difficult again, like the first [child]. The second child, my contractions started around 9 or 10 pm, my husband went for the midwife. She gave me tea, and the pain arrived "Help me" I said, and they held me. My son was born at 12 am, it didn't cost me anything.

The third, it was six years later, so it hurt like the first child. My husband heated my stomach and the partera gave me tea. It was a different pain, because I was not so angry. Same for the fourth, just like that, normal, in 5-6 hours my son was born. I felt very little pain. Yes, I could [give birth]. That's it. Blessed be Jesus, they did not sow my skin.

Meeting Micaela for the first time, I was stroke by the strength radiating from her gestures and her words, despite (or perhaps, because of) the many years of suffering she has overcome. Her life story, which she shares in an edited volume (Icó Bautista 2008), is one of poverty and violence, a "mosaic of violence" (Speed 2014) she experienced through her

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123 The original conversation took place in Spanish.
124 Micaela refers to both episiotomies and C-sections, both requiring to cut and sow women's skin (Diniz and Chacham 2004).
childhood, adolescence and adulthood. But her story is also one of combativeness, for herself, her siblings, and her children. At the age of thirteen, Micaela was kidnapped (robada) on her way to school. The practice is common in Chiapas among young people whose parents are opposed to their union. In some municipios, this is also a strategy for young men to avoid paying the bride wealth to their in-laws (Collier 1968; Freyermuth Enciso 2003). However, kidnapping also happens when a young woman and her family turn down a suitor. This was Micaela's case.

Once the woman has been kidnapped, it is assumed that she has had sexual relations with the man who took her away so she is married to him to preserve her and her family's honor. In the aftermath of the robbery and forced marriage, however, Micaela managed to escape her suitor's house and return to her parents'. Despite being the oldest of ten children (seven living), Micaela's father had always insisted she attend school, but after the robada, she could not return to school anymore and people started to gossip about her kidnapping in the village. So Micaela left her community in the municipio of Huixtán for the city of San Cristóbal de las Casas, about 40 kilometers away, where she started working as a maid. She was treated badly by her employer so she decided to quit when she heard that the INI was looking for bilingual indigenous men and women to be trained as health promoters. It is during this training that she met the people who would become her colleagues at OMIECH, as well as the father of her four children.

Reflecting on her births in retrospect, Micaela realizes that the conditions in which she had her first child were not optimal, and far from the traditional birth. She identifies several factors contributing to the difficulties she faced during her labor. First, her husband had abandoned her for another woman, so she was angry. This anger, added to the jealousy (envidia) of the other woman, acted as risk factors. She now realizes she should have protected herself correctly during pregnancy, through prayers and fasting (Freyermuth Enciso 2006; Guiteras
Holmes 1961). Finally, Micaela also criticizes her partera for not giving her the correct plant to break her water and help with the birthing process. Being her first birth, and isolated from her family who were still all in Huixtán, Micaela did not know any better. Now that her four sons are all young adults, Micaela still uses her own birth experiences to counsel women during workshops, and insists on the importance of protección and prevención. Micaela is aware that women's experiences of birth and the complications they face stem from structural factors, including gender-based-violence and racism. For thirty years, she has drawn on her own experience to defend indigenous women and tam-alaletik's rights in the Women and Midwives Section of OMIECH.
Chapter 7. "La lucha es de todos."

Defending Partería in an Indigenous Organization

Micaela and I are on our way to a workshop in a Tsotsil village in the municipio of Huixtán. We are walking on the dirt road surrounded by milpas, under the glorious April sun. One of the socios was waiting for us at the combi stop, and now he and Micaela are reflecting on the recent political moves of the younger men living on the organization's land, a year from the e-board elections. I catch a few words from their Tsotsil-Spanish conversation. Micaela turns to me and translates in Spanish: one of these young men has apparently been bragging about putting more efforts in the organization than others. Micaela disagrees, and thinking out loud she says, "la lucha es de todos (it is everyone's struggle)." Addressing us, she adds "everyone participates; it is not a competition, we are all here for the lucha."

A few months earlier, in January 2015, I am in the office of the Women and Midwives Section, where Micaela and I are working on a recipe book of herbal remedies that parteras use during pregnancy, birth and postpartum. We hear a knock on the door, and Doña Magdalena, an 80-year-old Tsotsil jtamol and j’ilol, enters. At the beginning of my fieldwork, I would only see Doña Magdalena once a month, when she would come to town for business and stop by the office to visit Micaela, an old friend. While they talked and gossiped, Micaela would ask Doña Magdalena about the number of men and women she attended to since her last visit, and fill out an informe (statistical tracking of patients) for the archives, which justified refunding Doña Magdalena's pasaje (travel fee). However, since December 2014, I had been seeing Doña Magdalena more frequently; at first because of the threats of invasion OMIECH had been receiving, requiring socios and socias (members) to attend meetings in San Cristóbal; then during the invasion, when more meetings occurred; and now, after the socios kicked out the
invaders and settled on the land behind the offices (I discuss these events are later in this chapter). As the sleepless nights of vigil stretched into weeks and months, I saw my colleagues grow tired, but determined to defend their land at any cost, "The lucha is hard, they would say, but we are here and will not let them take it away from us." I soon realized that the meaning of lucha differed, depending on my interlocutor. While this word is highly associated as Marxist (class struggle translates as lucha de clase), my colleagues use it to refer to different types of luchas. When talking about the invasion, lucha can either mean the fight against the invaders, and/or the physical struggle against hunger and exhaustion. The word can also include the lucha to have the government listen to OMIECH and support the organization through financial and political means — a government that the activists feel does not care for them ("no nos hace caso"). And then, there is the lucha referring to the organization itself, the long way it has come and the struggle it is to maintain it alive. I heard this latter reference many times, from everyone involved in the organization: the founding members, socios and socias, the staff. But I of course heard it most from the person with whom I spent the most time, the only current staff member who is also a founding member of OMIECH, Micaela.

In the months following the invasion, I would often see Micaela with tired, red eyes. When I would arrive at the organization ad find Micaela outside of her office, inviting me to sit down in the sun with her, I knew she needed to talk. One day, by the end of my fieldwork, I arrive as an internal meeting ends. Micaela invites me to sit on the grass behind the Museum, under the July sun. She immediately starts talking. During the meeting, she once again confronted the Mesa Directiva (Executive Board). More than ever in disagreement with the board of directors and some of the socios of the organization regarding the land use, Micaela is torn. She knows that she would be happier if she started her own A.C. (nonprofit), with the
parteras, an organization where her work would be respected and valorized. However, she still hopes that she can change the current state of things within OMIECH and go back to the core values of the organization, "I don't want to do it completely outside [of the organization], because my struggle is here," she insists, pointing her index towards the ground, and poking it several times. As I listen to her, my mind wanders, and I imagine Micaela as a Don Quijota, fighting against giant windmills; carrying the illusions that the organization is the same as the one she nurtured, while intimately knowing it is just the shadow of what it used to be.

In this final chapter, I analyze the organizational changes at OMIECH, from its origins in the 1980s to the accelerating events that happened during my fieldwork. As one of the very few indigenous-led NGOs of San Cristóbal, the analysis of the difficulties the organization faces, and the changes in political register — moving from the defense of cultural collective rights to individual ones — illustrate wider changes impacting traditional medicine and indigenous peoples in the city. Because of its location between women and the state on the one hand, and between Mayan conceptions and global discourses of health and rights on the other, OMIECH is a particularly interesting research site. Placing OMIECH's Women and Midwives Section at the center, I analyze its trajectory inside the organization and its relation to the wider midwifery movement in Mexico. Like I have done in previous chapters (Chapter 4, Chapter 5), I question the increased stratification of midwifery in the country and the place of tam-alaletik in Mexico's future. I also describe how gender is a determining factor in the changes happening inside the organization, and plays into the marginalization of the Women and Midwives Section. In particular, in the last section of this chapter I describe how an external event (land invasion) impact internal decisions, highlighting two visions of the organization, a bureaucratic and a political one.
Defending *partería* from the margins: OMIECH's *Área de Mujeres*

Founded with the objective of "[retrieving], [valorizing], and [developing] indigenous medical knowledge" (OMIECH n.d.), OMIECH challenges the hierarchy between biomedical and indigenous medical knowledge. OMIECH's defense of traditional medical knowledge emerges from the marginalization suffered by indigenous peoples across the State and the country. Since OMIECH's foundation, the role of the Mexican State has been double-edged: while the National Indigenist Institute (INI) developed various projects in support of indigenous medicine, other segments of the state apparatus implemented modernization reforms in the health sector and neoliberal projects threatening the survival of the plants indigenous doctors rely on. Despite the state's alternating support and marginalization, OMIECH has managed to carry on its activities for over three decades; drawing strength from the same margins it was relegated to and from which it sprang.

Anthropologists Das and Poole have analyzed the creativity which takes place at the margins of the state. In their words,

"An anthropology of the margins offers a unique perspective to the understanding of the state, not because it captures exotic practices, but because it suggests that such margins are a necessary entailment of the state, much as the exception is a necessary component of the rule." (2004:4)

By taking a closer look at the relationship between OMIECH and the state, I aim to bring to light both the "ordering function of the state" (*ibid*: 6) and the reconfigurations it undergoes. In this first section, I explore the three margins from which OMIECH and the *parteras* act: at the margins society, at the margins of the formal midwifery movement, and, in the case of the Women and Midwives Section, at the margins of the organization itself.

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125 As a reminder: in 2012, in Chiapas, 76.8 per cent of indigenous peoples lived in poverty (38 per cent in extreme poverty), as opposed to 43 per cent of the general Mexican population (7.9 per cent in extreme poverty) (Enciso L. 2014).
In the 1950s, the INI started several development projects in the Highlands, including bilingual schools, medical clinics and cooperatives. In order to overcome the mistrust of the local population, several initiatives were launched, including that of a puppet theater, the Teatro Petul. Health represented the biggest bone of contention between INI and the local population; through the Teatro Petul's performances, the audience had the opportunity to discuss sensitive reproductive health issues such as birth control (Lewis 2011).

"And when the INI built health clinics in the highlands and staffed them with ladino doctors and nurses, the indigenous continued to prefer traditional healers, who spoke their language and treated them in their own homes where they were surrounded by family and loved ones. No dimension of the INI's development program more directly clashed with the spiritual underpinnings of Tzeltal and Tzotzil society than the health program." (Lewis 2012:67)

The Teatro Petul was successful for many years, however, over the next decade, the bureaucratized theater ended up as a means to convince populations of accepting vaccination campaigns (Lewis 2011). The difficulties of fighting against institutionalized racism led INI directors to focus on changing indigenous peoples' habits rather than the "overarching political and economic systems that exploited them" (Lewis 2012:77). This echoes the fate of other INI initiatives, such as the health promoters, who also became agents of vaccination campaigns, leading to the dissociation of some of them with the INI project (this is the case of some of the founders of OMIECH like Micaela). In the late 1960s, the Highlands Chiapas Development Program launched health campaigns, hospital constructions and medical assistance in marginalized communities (Tibaduiza Roa, Sánchez Ramírez, and Solana 2011). But it was under the presidency of Echeverría in the 1970s that the interest in indigenous policy skyrocketed, with many projects aiming to develop new indigenist policies implemented through INI. In 1974, the Indigenous National Congress of Chiapas, co-organized by the Highlands Chiapas Development Program and Bishop Ruiz, and attended by over a thousand people,
revealed the many necessities of indigenous peoples in Chiapas, including demand for medical attention (Muñoz 2009:173). The following year, the First National Congress of Indigenous Peoples set the agenda for two decades of indigenous policies (Muñoz 2009).

Micaela's *lucha* started in the effervescence of the late 1970s. In 1977, she was nineteen years old. Despite her young age, she had already been through many life-changing experiences, including running away from a forced marriage, working as a maid in San Cristóbal, and successfully undertaking the INI training to become a health promoter (Icó Bautista 2008). It was during the training, and the years of working in Tseltal and Tsotsil villages, that Micaela met other future members of the organization, including Sebastián Luna, also a health promoter, future founding member of OMIECH and father of her children. At first a diligent health promoter vaccinating children, Micaela slowly distanced herself from biomedicine, becoming more oriented toward indigenous modes of healthcare. Through conversations with the women and elders of the villages and with her colleagues, she took a fresh look at the medicinal plants, the prayers, and the role of *j’iloletik* and *tamalaletik*. Her commitment to indigenous medicine was strengthened by the changing political context: the INI's Teatro Petul had been coopted into a tool for the promotion of government health campaigns, while the Church's health programs demonized local healers (Freyermuth Enciso 1993; Page Pliego 1989; Pitarch 1999; Tibaduiza Roa, Sánchez Ramírez, and Solana 2011), "When OMIECH started, indigenous doctors were being killed, they were persecuted and killed… there are (sic) many threats" (Sebastián Luna, in Pitarch 1999:80).

In 1982, through the SSA project Program of Interrelation with Traditional Medicine, several organizations of indigenous doctors were launched (Freyermuth Enciso 1993; Page Pliego 2010). From 1983 to 1985, the Program was managed by the SSA and funded through
UNICEF. Micaela and her colleagues were contracted as health promoters for a project on plant identification and workshops with parteras (Freyermuth Enciso 2003). In 1985, financial problems as well as changes of direction in the two institutions led to resignation of the staff, and the end of the program (Freyermuth Enciso 1993:53; Page Pliego 2002:55).

"There was a fight with UNICEF, they wanted to exert their power, to be the boss. But we did not let them. They wanted to take the documents [of the organization], but I kept them hidden… We kept everything, even the three Jeeps. This is why at times I cry for this organization." (Micaela; see also Icó Bautista 2008:100)

After the separation from UNICEF, and taking advantage of the contacts they had made with local doctors through their work at INI, the political context favorable to indigenous projects, and the help of anthropologists and doctors collaborating with INI, a group of eleven (male) health promoters founded the Organization of Indigenous Doctors of Chiapas in 1985, the first of its kind in the country (Icó Bautista 2005). The organization first had an office in San Cristóbal, before one of the advisers, through contacts at the INI, was able to obtain a donation of two hectares in the outskirts of San Cristóbal de Las Casas (Pitarch 1999). On the property, OMIECH built the offices of the Center for the Development of Mayan Medicine (CeDeMM), where it is still located today.

In 1985, OMIECH's main political goal was to gain an equal recognition between indigenous medicine and biomedical/allopathic medicine. Its activities revolved around the organization of health workshops in indigenous communities, and the production of booklets about plant knowledge to cure common diseases (Área de Mujeres y Parteras 1989c). Since their first meeting, members of OMIECH called attention to the "persecution and lack of respect,  

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126 The 1980s and early 1990s were particularly favorable to indigenous organizations, like women’s weaving cooperatives (Eber and Rosenbaum 1993; Eber 1995; El Kotni 2010; Morris and Meza 1987).
127 In the late 1980s, INI launched several organizations across the country, including one in Nayarit in 1989 (Organización de Médicos Indígenas Tradicionales del Estado de Nayarit, A.C. 2006), and in Yucatán in 1988 (Güémez Pineda 2005).
coming from some institutions and social groups, related to [indigenous] medical practices" (Page Pliego 1995) — demands which still prevail today. In 1987, a specific section was created to address the needs of women and tam-alaletik, the Área de Mujeres y Parteras, Women and Midwives Section (WMS) (Freyermuth, Cadena, and Icó 1989). The first publications about OMIECH started in the 1990s, through collaboration between the WMS and the research center CIESAS (Freyermuth, Cadena, and Icó 1989). During the decade of the 1990s, OMIECH also moved away from its collaboration with the Ministry of Health, after realizing that the government programs did not consider allopathic and indigenous medicine as equal, in opposition to the organization's goal of strengthening and legitimizing traditional medicine. In 1992, the organization started collaborating with the IMSS, through the program Interrelation of Medicines, the precursor of the contemporary government project of "intercultural health" (see Chapter 5) (Page Pliego 2011:15). Members of the Interrelations of Medicines program recognized the discriminations and obstacles faced by indigenous peoples in their access to health, and developed an agreement with OMIECH aimed at facilitating the transfer of patients from the communities to the IMSS clinic (Cadenas Gordillo 2002).

The 1990s were also the start of a fifteen-year collaboration between OMIECH and the German Protestant Foundation, Bread for the World. During these years, the German organization provided institutional funding which covered salaries, workshops, and an annual meeting of all the socios (Calles Romo 2009:138). Thanks to this unconditional support and other governmental institutions, OMIECH developed its activities across the state, and built the Museum of Mayan Medicine, inaugurated in 1997. The goal of the Museum is to inform the public about indigenous medical practices (Ayora Diaz 2000; Ayora Diaz 2002; Pitarch 1999). The Museum and the Herbolario (pharmacy selling herbal medicine), where the staff processes
and sells herbal teas, syrups and remedies to locals and tourists, proved crucial to the survival of
the organization.

Born out of government initiative, OMIECH's trajectory illustrates the typical relation
between the Mexican government and Non-Governmental Organizations. The first years are
supported by political and financial will, but similar to a fashion trend and following changes in
the government, the interest declines and so does the funding. On the ground, members of local
organizations have not been trained to search for funding, and when the funding ceases, the
organization rarely survives and gets pushed back to the margins. Out of the many organizations
of indigenous doctors created in the 1980s in the Highlands, OMIECH is the only one still
carrying on activities. I argue that this does not come from a better 'quality' of the organization
or of the people managing it. Rather, I see the difference in fates as one of conjuncture: being
located in San Cristóbal, with advisers aware of the dynamics of the funding agencies, has given
OMIECH a non-negligible asset. The fifteen-years unconditional funding of Bread for the World
also allowed for the development of self-funded activities, which benefitted from the city's
growing population and tourism. Today, the organization is 825 members strong, mostly
j’ilolotik, bonesetters and parteras. These members are from and live in 38 communities of
Chiapas (OMIECH 2005:3). Since the beginning, the organization is based on membership from
the community: if a j’ilol wants to join OMIECH, then the whole community needs to approve it,
support the healer and provide a plot of land for a medicinal garden in the community. The j’ilol
will then become the representative of the community (socio) for events taking place in San
Cristóbal128.

128 This protocol raises the question of the definition of community, and does not address the case of
healers who live in cities (Ayora Diaz 2000). Ayora-Diaz (2002) argues that such model is based on the
romantic vision of a harmonious community, and instead of protecting local medicine, adversely affects it
by denying support to urban j’ilolotik.
Since the inauguration of the Museum in 1997 and to date, the CeDeMM is constituted of five areas or sections: the Museum of Mayan Medicine, the Medicinal Garden, the Herbolaria, the Women and Midwives, and the administrative offices. A project of building a healing hut was discussed but never completed (Pitarch 1999). The Herbolaria has been central to the relation between OMIECH and the communities (Icó Bautista 2005; Page Pliego 2011). In San Cristóbal, OMIECH staff workers and volunteers travel to member communities in order to organize workshops, and collect plants that are transformed and sold in the Herbolaria. Workshops are opened to all members of the community where it is organized and are based on the premise that the best way to improving health is through community capacity-building and participation. Health is framed not only as a right, but as a matter that communities have to take in their own hand, "Taking care of our health is not only a right everyone has, it is also everyone's responsibility" (Área de Mujeres y Parteras 2001:2).

On the political level, OMIECH is organized around a deciding body in San Cristóbal and members in the community (see Freyermuth Enciso 1993:59 for a detailed classification). This organization is supposed to prevent the concentration of decision-making power in the hands of a few. OMIECH's Mesa Directiva (Executive Board) is conferred legal authority (Weber 1978) through elections by the socios (one representative per community). On their end, staff members (técnicos), with the help of volunteers, manage daily activities and search for funding. So even though the socios are recognized indigenous doctors and have communal authority, in the urban context in which técnicos and advisers live, legal authority is slowly taking priority over traditional authority (Ayora-Diaz 2002). Some argue that OMIECH's jpoxtawanej have "formal authority but no effective power" (Pitarch 2007:190), because the power is concentrated among the hands of the técnicos and the advisers. This affirmation is
particularly true during crises, as I highlight later when describing the invasion of the organization's land. But first, I turn to the Section of OMIECH I know best, the Women and Midwives Section, where I volunteered during my fieldwork. In the following pages, I analyze the position of OMIECH's WMS in the Mexican midwifery movement.

A few days before the International Day of the Midwife\textsuperscript{129}, I am meeting with a \textit{partera} working in one of San Cristóbal's birth centers. In the past years, urban \textit{parteras} have organized gatherings, celebrations and even a small congress in 2010 (Dixon 2015). For the 2015 celebration, they are putting together a gathering on the main plaza. I ask who else is invited, and the \textit{partera} explains that it is open to everyone. We both wonder if OMIECH \textit{parteras} would come. The \textit{partera} searches for the right word, "the \textit{parteras} of OMIECH, they are more… \textit{clandestinas} (clandestine, secret)." Certainly, past experiences of organizing meetings with OMIECH have proven to be difficult. During the 2010 congress, the \textit{parteras} of OMIECH were invited at the last minute. The WMS did not respond to the invitation until after the congress, when they learned about the static vision of indigenous midwifery conferred during the meeting (Dixon 2015:151). Their response was an incisive email, "we are not circus freaks that you can display at your convenience." After this episode, the urban \textit{parteras} stopped inviting OMIECH to their events.

A few days after the interview, and despite my invitation to her, I do not see Micaela on the plaza (Picture 10). The next day, Micaela explains they had a last-minute meeting. "\textit{Son más clandestinas}..." I keep hearing the words of the \textit{partera} in my head. In the context of the low-intensity warfare, the word \textit{clandestino/a} echoes the Zapatista movement, whose governing body is the Clandestine Indigenous Revolutionary Committee. If the \textit{tam-alaletik} are clandestine, they

\textsuperscript{129} The International Day of the Midwife is celebrated on May 5 since 1992, on the initiative of several midwifery associations, including the International Confederation of Midwives.
represent the invisibilized majority, while the *parteras capacitadas* are recognized at some level by the state, and the politically savvy *parteras profesionales* are organizing (Zacher Dixon 2015). I argue that the difference between OMIECH and other *parteras* is not related to their technical capabilities, but rather stems from the different population they work with.

![Image](image.jpg)


Since its foundation, the WMS has published over twenty booklets (*boletines*) focusing on maternal and infant health. In the late 1980s and early 1990s, the WMS' community workshops were innovative because of their pedagogical techniques (drawings, theater performances) and their message (strengthening community health) (Cadenas Gordillo 2002). Popular education workshops involved indigenous men and women, who like the *campesinos* Freire conducted worked with, did not have a voice in the public scene (Freire and Macedo 2000). These workshops nurtured OMIECH's theoretical framework, focusing on indigenous healers' human rights. In the late 1990s, after the Zapatista uprising, many organizations started educational and health projects in Tseltal and Tsotsil communities. In the past few years, the discourse about *parteras'* rights has gained popularity, but the lack of public debate about the
definition of *partera* has further separated *tam-alaletik* from urban and professional *parteras*\(^{130}\). During a monthly Seminar co-organized by members of OMIECH and the research center PROIMMSE during my fieldwork, debates around the definition of *partera* were often divided between those working on the rights of *tam-alaletik* and those working with *parteras profesionales*. Are the two worlds incompatible? On which grounds can they meet?

An analysis of the WMS' publications highlights the importance of the living conditions on definitions of health, human rights, and how the two intersect. The first publications are focused on the role of the *tam-alaletik* in their communities (Área de Mujeres y Parteras 1988; Área de Mujeres y Parteras 1989a). The text is based on the staff's work in community workshops, but in the process of generalization, the *tam-alal* (*jtamol* or *jnet'um* in Tsotsil, which is the title of the series) moves closer to a Weberian ideal-type. While some have argued that such idealization might exclude other *parteras*, such as those living in the city (Ayora Diaz 2002), other elements of the *boletines* draw on specific context, giving the possibility to the audience to use the advice that pertains to their needs. The many drawings illustrating the recommendations (the pregnant woman should eat well, not carry heavy loads etc.) target an unschooled population (Figure 13). The specific needs of indigenous women in their communities emerges from their marginalization which (re)produces structural violence (Farmer 2005). Like other members of their village, they are confronted with diseases such as diarrhea (Área de Mujeres y Parteras 1989c), respiratory problems (Área de Mujeres y Parteras 1991), parasites (Área de Mujeres y Parteras 2001), and sexually transmitted diseases (STDs) (Área de Mujeres y Parteras 1993). Some of these diseases are linked to poverty, and urban *parteras* working with a wealthier population might not come into contact with them. Others, like STDs

\(^{130}\) Recently, the research center ECOSUR and the Mexican Association of Midwives have edited a volume on the "*parteras*" of Mexico, a term encompassing *tam-alaletik, parteras capacitadas, parteras profesionales*, without taking into account their different lived realities (Sánchez Ramírez 2015).
are more widespread across the rural/urban spectrum, but the lack of information and treatments about them in rural areas also shape the different realities of tam-alaletik and urban parteras.

Another dimension of the boletines, which anchors the tam-alal ideal-type in her sociocultural context, highlights the interrelation between gender and health. For example, the boletín on adolescence reiterates several time that boys and girls are both important to a family and should be valued equally (Área de Mujeres y Parteras 1992), while a whole boletín is
dedicated to discussing indigenous women's rights in law and in practice (Área de Mujeres y Parteras 2007). In a context of high rates of feminicides and of gender-based violence targeting indigenous women (Arteaga Botello and Valdes Figueroa 2010; Falquet 2014; Freyermuth Enciso and Argüello Avendaño 2010; Reyes Díaz n.d.), the WMS' boletines generate important discussion during workshops and reveal the social aspects of the tam-alaletik's role. This indigenous feminism is reminiscent of the Zapatista's Women Revolutionary Law (O'Donnell 2010; Speed, Hernández Castillo, and Stephen 2006). In the decade before the Zapatistas arose, indigenous women were already formulating similar demands,

"We want to talk and work in agreement with our husbands, our work to be valued, to not be hit, that when we talk in community assembles we are listened to, and to be taken into account when agreements are made" (Área de Mujeres y Parteras 1989d:10)

Despite changes that occurred in indigenous communities after the Zapatista uprising — the construction of roads, clinics and schools— indigenous women still live at the margins of Mexican society. Indigenous peoples are doubly castigated: by the structural violence under which they live and by the discredit their medicine endures. More than medical recipe books, the Area de Mujeres y Parteras' boletines allow for a space of contestation and community strengthening (El Kotni 2015). In an ecofeminist perspective not dissimilar to homebirth midwives in the United States (Davis-Floyd and Davis 1996), the boletines tie the defense of local medicine to women's rights and environmental concerns, with statements such as "We do NOT want [our] knowledge to be lost. We do NOT want it to be patented" (Área de Mujeres y Parteras 2006:1). Perhaps this radical positioning linking environment concerns and structural violence can account for the difficulties of finding a common ground with urban parteras, who indirectly benefit from tam-alaletik's knowledge when it is encapsulated in essential oil bottles or shared during modified temazcal rituals. So far, the voice of indigenous midwives in the
Mexican Association of Midwifery has been limited to attending some events. By the time I was leaving the field, there were discussions among WMS members about contacting the Asociación and proposing a task force committee to make sure that the interests of tam-alaletik are not forgotten in the movement of professionalizing midwifery. In San Cristóbal, the WMS has been conducting monthly seminars in different spaces of the city about midwifery, inviting other organizations and parteras, with the objective of fostering a dialogue. This seminar is also a means for the WMS to re-enter the political scene, a decade after the strong mobilization against the ICBG-Maya project, which I discuss next.

In 1994, thirteen communities and several organizations of indigenous doctors (including OMIECH) came together to form the Council of Organizations of Indigenous Traditional Doctors and Midwives of Chiapas (COMPITCH). COMPITCH's struggled for environmental justice, and the meetings emphasized the interrelation between tam-alaletik and j'iloletik's medical knowledge and their environment: in order to fulfill their calling, they need to maintain biodiversity (Harvey 2006:226). COMPITCH acted as a safeguard against projects that were perceived as stealing indigenous knowledge, as illustrated in the controversy around the ICBG-Maya project (Berlin and Berlin 2003). Several ICBG (International Cooperation Group for Biodiversity) projects were developed around the globe, with the objectives of creating natural medicine, while conserving biodiversity and contributing to economic development of local communities. For the Mexican project, the University of Georgia partnered with the Welsh company Molecular Nature Limited, and the Mexican research center ECOSUR (Castro Soto 2000). The ICBG-Maya project started in 1998 but relied on the Berlins' decades of work in Chiapas. The project aimed to give indigenous communities official control over some medicinal plants through a patenting process. Researchers obtained the agreement of 46 indigenous
However, some organizations, COMPITCH among them, questioned the impact of the project on non-participating communities. The social justice argument brought forward by COMPITCH interconnected international indigenous rights agreements (prior consultation), intellectual property rights (only a handful of communities would benefit financially from the patent) and indigenous customs (nature and its products cannot be owned) (Castro Soto 2000; Valadez 2000). When ECOSUR canceled its participation in 2001, the project ended (Harvey 2006). COMPITCH survived for a few years after this, but due to the lack of funding and internal disagreements, it slowly stopped its activities. When I first met OMIECH in May 2013, there was still one member of COMPITCH in the offices and the Museum, but when I came back the following January, he had left. In 2015, no one at OMIECH mentioned COMPITCH anymore, except in relation to the ICBG131. The parteras were key actors of COMPITCH, which served as a political experience of conscientización (Freire and Macedo 2000). After the ICBG-MAYA, which coincided with a decline in OMIECH funding, the political activity of the organization declined, strongly impacting the Women and Midwives Section. The WMS moved from a central actor to the periphery of the organization.

Physically, the Área de Mujeres y Parteras (Women and Midwives Section, WMS) exists in the form of an office, with two desks, a computer, a small library and the Section's archives, located behind Micaela's desk. The walls are covered with pictures of workshops and plants, and posters of the different events organized by the WMS or in which Micaela participated. The WMS' office is made for two people, a coordinator (Micaela) and an asesora (adviser). The last asesora left in 2010, and since then organization's adviser and the volunteers have filled in this role. Micaela has seen many volunteers come and go (all women), those she remembers are the

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131 A couple of informants still mentioned that in the communities, COMPITCH still exists. It is just no centralized anymore.
ones who have stayed longest: a German student writing her thesis on maternal mortality
(Weidner 2007), members of the Association MÂ (Alice and myself). Behind Micaela's desk, the
archives contain the statistics about the number of births attended by the tam-alaletik from the
organization. Micaela fills out the informe while conversing with the socia during the woman's
visit at her office, or copies the information a family member who is literate has written down on
a piece of paper or a notebook for her. The informes are used for statistical tracking, but also as
accounting evidence since she refunds the partera her travel expenses (from her home to the
office). Going back as far as 1988, the informes represent valuable information regarding the
activities and resources of the WMS. During this first year, there were 50 parteras in the
organization (Área de Mujeres y Parteras 1989a), who attended a total of 154 birth. The first
informes only mentioned where the birth happened, who attended it, the sex of the baby and if
the baby lived (Área de Mujeres y Parteras 1989b). The more recent informes I accessed in the
archives range from 2007 to the present, with a peak of activity between 2008 and 2011,
corresponding to the years the WMS was able to secure funding. These informes are more
detailed, and include women's and children's illnesses treated, as well as care not related to
reproductive health. Beyond the appeal for the public sector, which is interested in tracking the
number of parteras, the data is also a means for OMIECH to prove the interest of communities
for the workshops as well as the success of its projects.

So how are OMIECH's informes different from the ones of the SSA, or the parteras
capacitadas' monthly reports to the health center (Chapter 4)? Some noteworthy differences
include the fact that OMIECH parteras come to the workshops of their own will, and do not
share their data in public. The use of the data is different, too: the number of births are not used
as a way to measure the productivity of the parteras, but rather to keep an eye on the number of
parteras by community and the changes that occur in peoples' health habits (Área de Mujeres y Parteras 1989b:10). Figure 14 illustrates the number of parteras who registered their activities with Micaela, between 2007 and the first semester of 2015, as well as the number of communities they are from. The fluctuation in the numbers does not so much reflect parteras who would join and leave the organization: the informes were collected during the WMS workshops in communities, and, from one year to the other, the communities visited change. The variation in the number of parteras registered depends on the number of active parteras per community, and on the WMS' funding. The decrease in the number of parteras reporting to Mica mirrors the financial difficulties of the WMS, and the internal tensions in the organization, which lead to privileging some activities over others, as I detail in this chapter.

![Figure 14: Number of parteras who attended births, by year (based on WMS informes only).](image)

Ran by women and for women, the Área de Mujeres represents the feminine space within the organization. Micaela recalls the early days of the organization, "We were doing the lucha, and me, as a woman, I was [also] doing the lucha. (...) I feel happy because I am still a member of the organization, the only woman who stayed" (Icó Bautista 2008:257–259). Even though she
is a founding member, Micaela has been isolated from the decision-making process since her husband's passing fifteen years ago. Today, the distant relationship between the WMS and the organization's governing body is both an advantage and a drawback. On the one hand, the WMS can develop its projects autonomously. On the other, it depends on the Mesa's goodwill for everyday expenses and proceedings.\(^2\)

Micaela has always been vocal about her disagreement with the Mesa. I have not attended any of the meetings, but Micaela has interpreted the lack of respect shown towards her and her Área through gender issues. "They think that because I am a woman I will not speak," she regularly commented. Prior to the land invasion, to which I turn to in the next section, disagreements between Micaela and other members revolved around two issues: activities and funding. Most of the WMS' activities take place in the office, and involve computer work (grant writing, workshop planning, editing boletines) and talking, which are not valorized by the rest of the team, who is either working in the Museum or transforming the plants into remedies. This creates personal tensions between Micaela and other staff members. In addition, Micaela's salary is issued from the other Section's work (selling Museum tickets and herbal remedies) while a very little amount of the WMS' externally funded projects is dedicated to the organization. Most, if not all, goes into transportation to the communities, reimbursement of the parteras' travel fares and publishing. While the WMS absorbs internal money, it produces knowledge regarding the organization at large — tensions I explore at the end of this chapter. The gender stratification of the organization's Áreas reveals one of OMIECH's paradoxes: discourses conveyed during workshops about gender equality and women's equal participation in decision-making processes

\(^2\) While my relationship with Micaela and my long-term commitment as an activist-anthropologist, has opened many doors, it has also its downside: in a divided organization, my association with the WMS has prevented me from constructing deeper relationship with other Sections; other anthropologists have encountered similar barriers (Paley 2001).
do not hold internally. Micaela is, of course, aware of this, and this is why she keeps confronting "the men" (the Mesa). In this process, the development of closer ties with local feminist organizations in the last few years has helped her find the support and the female space she needed, while probably accelerating the separation from the men in the organization. One of the events which crystalized Micaela's isolation from the rest of the staff members is the invasion of the organization's land and its aftermath.

**Before Lynching. The invasion of OMIECH and the limits of activist-research**

In Chiapas in the 1990s, over 70 per cent of the population worked in the farming sector. Land is not only a means of subsistence but also a source of social conflicts, and *campesinos* have relied on land invasion to alert the government about their living conditions (Freyermuth Enciso 1993:15). Like in other Latin American countries, the 1990s were marked by the neoliberalization of the economy, which attaches more value to the land than to those who live on it (Paley 2001:70). In 1992, the Salinas de Gotari government modified Article 27 of the Constitution, a historical amendment issued from the Mexican Revolution. The modification amended collective ownership of the land and annulled all pending demands for communal land, paving the way towards the privatization of land. On January 1st, 1994, the Zapatista uprising in Chiapas coincided with the coming into effect of the North-American Free Trade Agreement (NAFTA), which will have devastating effects on Mexico's peasants (Collier 2005; Nuñez Rodríguez 2004). Because of its centrality for economical survival and cultural resonance, land was crucial to the Zapatista's demands of autonomy, at the heart of negotiations between the Zapatistas and the government (Nash 2001a). The EZLN's uprising was followed by land

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133 The reform also impacts indigenous women, who cannot inherit land. Since the 1992 land reform, decision to sell the land is not made by the family but by the community assembly in which women do not have a voice. Widows have the right to first refusal, but can often not gather sufficient funds to buy the land back (Stephen 2007:94).
recuperation and invasions, not only in the Zapatista municipalities but also beyond the conflict zone: 40 per cent of invaded land was located outside of the conflict zone (Nuñez Rodríguez 2004:74). Following the Zapatista rebellion, hundreds of new communal lands (ejidos) were formed in Chiapas; nowhere in the country was the creation so intense.\(^{134}\)

In Highlands Chiapas, the privatization of land and the lack of support for peasants accelerated the stratification of peasant communities, leading to the "proletarianization of the peasantry" (Olivera 2012). In San Cristóbal, this proletarianization has created landless peasants, who are contracted to invade unused land.\(^{135}\) This is what happened to OMIECH. Shortly after its creation, the organization was given two hectares from INI land. The first hectare hosts the offices and Museum, while the second hectare, meant to host a greenhouse and medicinal garden, turned out to be partly used as a milpa by the técnicos and partly left idle. "Since the land belong to the government, people see it as government space, which was unused" (Male activist).

On October 3, 2013, over a hectare of this idle land is invaded by a group of indigenous peasants, calling out the government about the need for land. During one month, one hundred and thirteen families live on the land. They leave on their own on November 2, after the government's promise to give them land. In an interview, a member of the Mesa and a staff member warn that if the government does not act quickly, they will take the matter into their own hands (Hernández Aguilar 2013). Following the departure of the invaders, members of the government visit OMIECH in December 2013. The mother of the Governor of Chiapas, who is the head of the state agency Integral Development of the Family (DIF) visits the organization, and, using a classic indigenist discourse, praises the indigenous people's culture and takes pride

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\(^{134}\) 725 new communal lands were registered between 1991 and 2007 in Chiapas, followed by 158 in the State of San Luis Potosí during the same time period (Nuñez Rodríguez 2004:74).

\(^{135}\) "There are people who do this for a living" was a recurrent affirmation since OMIECH’s first invasion, from OMIECH staff and non-OMIECH informants alike.
in Chiapas' traditional medicine (Henriquez 2013). Most of OMIECH staff on their end, perform the *indio permitido* (Hale 2004), because they are seeking help in the aftermath of the invasion. However, OMIECH's performance has limits: on this and subsequent visits, the DIF president tries to obtain the contact information of the *parteras* of the organization to invite them to *capacitación*\(^{136}\), but the staff members always managed to get out of this situation without sharing the information (they have lost the numbers, the parteras are not reachable etc.) Micaela in particular feels that she would betray the *parteras* and the organization's *lucha* if the shared such information. I arrive in San Cristóbal soon after the government visit, for a short fieldtrip. I ask Micaela to show me where the invasion happened. As we walk together, I notice remains of burned waste. She tells me how the *invasores* entered at night, and took all the corn, the beans, and the chickens. The well is dirty, there are soda labels floating in it. "Where are [the invaders] now?" I ask her. She doesn't know, the government gave them land. Despite this, the organization is receiving new threats of invasion.

On February 21, 2014, the organization's land is invaded for the second time. Once again, I am informed by a friend's email. She writes, "Last Monday, about forty *invasores* (invaders), the same as last time, took the land. The police came and they left pacifically." Even though this smaller group of invaders, formed after the division of the larger group, only stayed a couple of days, they were able to steal the water pump and cut the electrical cables, a few days before a meeting of OMIECH *parteras*. This time, there was less news coverage and no government representative visited the organization (Gómez 2014).

The third and most recent invasion happened in December 2014. The organization had been receiving threats since mid-December. To protect their land, the staff organized vigils at

\(^{136}\) In addition to illustrating complete ignorance about the organization’s goals, actions such as these demonstrate the scant attention paid to organizations' and peoples’ needs, only perceived as potential voters.
night, including during Christmas Eve. However, on the morning of December 28, I receive a call from Micaela "Hey Mounia I have bad news. The *invasores* came in again. At 4 a.m. when everyone was sleeping." The timing of the invasion, during the holiday break, made it difficult for OMIECH to gain the government's attention; the police informed that no intervention could be planned before January 2 (Rodríguez 2014a). The political climate, as elections approached, seemed to play in favor of the organization at first, with the government promising to settle the matter (Rodríguez 2014b). However, no actions were taken before January 16 (Herrera 2015), the day after the staff tried to evict the invaders by their own means\textsuperscript{137}. I describe the evening of January 15 in my fieldnotes, 

"I am at home (…) around seven pm, my phone rings. It's Micaela. I don't understand everything; she is speaking quickly. She says that she is locked in her office; the *invasores* are throwing stones at them. She mentions something burned. She says "I am telling you, if something happens to me, you know who it is." She tells me to stay at home. "There was a confrontation." I call a friend working at the human rights center Frayba. Later in the evening he and his colleagues go for a vigil. Everything is quiet. I call Micaela every hour. She asks me if there isn't someone I can call to pressure the police to show up, because they don't want to come. I don't. I feel powerless."

It is not until the next day, when I am able to talk to Micaela in person in the office, that I start making sense of what happened the previous night. In the afternoon of January 15, the police finally acted and peacefully evicted the invaders, under the eyes of journalists, who notice that most of them are women and children (Herrera 2015). A few hours later however, a handful of drunken men made their way back to the organization and started provoking OMIECH members. As one of the drunken young men was insulting those present, he found himself

\textsuperscript{137} One explanation I heard from several activists (non-OMIECH) is that the votes of the invaders (and those supporting them) weighted more than those of the few OMIECH members mobilized around the issue.
surrounded by OMIECH people, worn out by weeks of vigil and hunger\textsuperscript{138}. The men from OMIECH quickly grabbed him, some of them searching for gasoline with the plan of setting him on fire. "They were about to set him on fire," Mica recalls, but she and other women interfered. "We told them that if they did such a thing, then they would be the ones guilty and will have many problems." The men calmed down and released the drunk young man. It is during this process that Micaela called me and asked for help. OMIECH members had called the police many times, but the latter argued that the matter had already been taken care in the afternoon.

In her ethnography of postwar Guatemala, Burrell describes her reencounter with the town of Todos Santos Cuchumatán after the lynching of a Japanese tourist and his bus driver made it to the international news (2013). Lynching, she argues, cannot be understood solely as a "moment" but needs to be placed in perspective with its past and present. In the case of Todos Santos, the media treatment of the event portrayed the villagers as savages and backwards. The lack of co-evalness (Fabian 1983) serves as a way of spatial and social distancing between the perpetrators and those affected by lynching (the modern, the civilized). Far from analyzing the event, such commentaries focus on the spectacular, without examining the consequences for the future (what Todosanteros were most worried about). In his ethnography, \textit{The Spectacular City}, Goldstein underscores how acts of lynching cannot be separated from the communal tensions they emerge from, and the structural violence that perpetrators endure (2004). Lynching is both a reaction to and a consequence of the absent-present state in Latin America (Goldstein 2012) and needs to be understood in relation to underlying ethnic and political tensions, and a context of insecurity. As Green's analysis in Guatemala has demonstrated, in the Americas violence has

\textsuperscript{138} The organization enforced a strict rule and for weeks, the staff was not able to go back to their home more than a couple of hours a day, and had to prepare meals in the organization’s kitchen, which created tensions about the food distribution.
become part of the social (and geographical) landscape. Fear is not only an individual experience but a social and collective one, a "way of life" (Green 1994).

When judicial instance reproduces violence towards citizens (Sierra, Hernández, and Sieder 2013), alternative forms of justice emerge. Lynching provides the relief of immediate justice, in contexts where indigenous people rarely have access to official justice (Burrell 2013; Burrell 2010; Goldstein 2012; Sieder 2013). Under these circumstances, human rights organizations are second-choice solutions. Those affected by the thief/invader/deceiver, often perceive human rights as being on the side of the criminals, protecting them from communal justice (Burrell 2013; Goldstein 2004; Paley 2001). In Bolivia, like in Guatemala and Chiapas, those affected by violence feel that the law favors the human rights of thieves over their own right to security (Goldstein 2007; Burrell 2010; Speed and Collier 2000). Human rights suffer from the same bureaucratic slowness as administrative procedures, and investigate both parties' stories, making them suspicious of protecting alleged criminals. Despite these critics, human rights still provide a powerful framework for indigenous movements. On the night of January 15, during one of our phone calls, Micaela said, "llegaron derechos humanos (human rights have arrived)." Human rights are often personified by the people involved in defending those rights, through community trainings, legal counseling, or peace volunteers (Pitarch 2008; Speed 2002). In the face of the absent present state, civil society takes on the role of listening to and protecting citizens. In the case of OMIECH, lynching is a desperate consequence of the many times the state has failed those involved in the dispute: by protecting neoliberal interests and failing to provide land to those in need, by putting political votes before conflict resolution, by failing to settle the event on time, and finally the police negating to respond to the call for help. To paraphrase Burrell, OMIECH's almost lynching story is one of a potential for violence which did
not turn into violence itself (Burrell 2013:124), or at least not fully: there were material and physical damages on both sides, but no deaths. Should it have developed fully, the faith of OMIECH members would not have been different from that of Todosanteros: portrayed as "savages" and "backwards." This is what Micaela and the women sensed when they urged their male colleagues to stop. It is not so much compassion that motivated them, but an understanding that they would be the ones bearing the consequences.

Even though lynching is more than just a moment, there is surely a before and an after lynching. By sparing the invader's life, the men of OMIECH probably saved the organization as well. But this did not change the state's lack of involvement in their problem, nor did it provide immediate or long-term justice. On the next days, the team decided to materialize the idea they had during the first invasion and to visibly occupy the land to prevent further assaults. And this is how the socios become invaders139.

During the month following the invasion, I repositioned my collaboration with OMIECH, rooted in activist-anthropology (see Chapter 1), and tried to find new way to support my colleagues without making promises that a) I would not able to keep (McNabb 1995) and b) might compromise my ethical standards and my security. For my colleagues, the organization was their part of their personal pasts (Icó Bautista 2010; Icó Bautista 2008), their economic present, and their political futures. And even though I supported them, the organization was not my lucha. As an ally, I helped in documenting the case, and assisted with small tasks, such as uploading information and pictures on the Facebook page140. During the first few weeks, the invasion also allowed me to spend time with staff members I would not see that often. As such, it provided an opportunity to renew the anthropological gaze. I met members who traveled from

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139 "And now they became the invasores"—comment of a collaborator of OMIECH during an interview.
140 https://www.facebook.com/areademujeresomiech
their communities for the meetings, and observed *parteras* in another role, as they voiced their concerns about the future of the organization, as *socías, campesinas* and heads of households\textsuperscript{141}.

Doing NGO ethnography and studying colleagues can be unsettling (Markowitz 2001), in particular when it implies disagreeing with them. As early as the first invasion, the directing body pushed the decision to occupy the land for personal use, to prevent further invasions. After two additional invasions and internal negotiations, the decision was applied on January 16. For another month after the invaders left, staff members and *socías* would build during the day, and take turns sleeping and guarding the organization at night. While this experience strengthened the links between the staff and myself on a personal level, it also helped maintaining a distance between us on the political level. Such distance allowed me to perceive and analyze some tensions in the organization, which I turn to in the final section.

*"Ya no es una organización, es un negocio."*\textsuperscript{142} **Measuring a Section's productivity**

Over the Spring of 2014, I conducted long-distance ethnography (see Chapter 2) thanks my colleague who recorded the meetings of the WMS members. During meetings, the conversation would often shift towards the organization itself, the need for funding, and the tensions between Micaela and other Sections. Critically analyzing the trajectory of the organization, one of the organization's advisers attributed the difficulties OMIECH had to survive autonomously to a contradiction between its overarching goal and how it is structured:

"But this initiative, this form of organizing, is not an indigenous form. An NGO is not an indigenous manner of organizing (...). It is a half-adaptation of indigenous medicine with an organizational twist. But this NGO thing is not an indigenous thing"

\textsuperscript{141} For the same reasons, one of the founder *parteras* was never able to come during the invasion. Her fragile health and the numerous women she cares for, in addition to being head of household, kept her from making the travels to San Cristóbal.

\textsuperscript{142} "This is not an organization anymore, it is a business"; comment during a WMS meeting.
The relational model between socios, técnicos (staff) and the Mesa, and of their own relation with external advisers is a heritage from the INI era and differs from the communal decision-making model. In her dissertation about indigenous organizations in Mexico, Calles Romo also attributes OMIECH's lack of financial autonomy to the relationship between the (indigenous) leaders and the (mestizo) advisers. According to her, advisers reproduce paternalistic attitudes classic in State/indigenous relations (2009:125). By doing so, advisers would prevent organizations from autonomously managing their funds. In the case of OMIECH, and as highlighted by the earlier quote, I perceived the relation not so much as paternalistic than a work of translation between state bureaucracy (which is easier to navigate for a mestizo with formal education) and the organizational staff.

Funding agencies often expect that after a certain number of years, the funded organization will become autonomous and self-reliant. However, the many years of unconditional funding, first through INI and then Bread for the World, created the opposite effect on OMIECH, increasing the dependence on external funding. With the Museum, the Herbolaria is the main source of income for the organization. Staff at the Herbolaria make and sell herbal medicine under different forms such as pills, creams, syrups and capsules (Ayora Diaz 1998). There is not always a clear delimitation of the role of the técnicos, who might be at the Museum entrance one day and in the Herbolaria the next. The only roles that are clearly delimited are those of the WMS, whose workers and volunteers are focused exclusively on WMS work. The flow of resources from the Museum and Herbolaria to the staff (salaries) parallels tensions and power relations and contributes to the exclusion of the WMS, which needs to rely on sporadic funding that is used exclusively for projects (workshops, meetings of parteras) and not for workers' salaries. A Section's prestige is based on its usefulness to the organization, measured in
economic rather than political contributions. Because all members of the Mesa participate in the Herbolaria, Micaela is even more isolated in her Section, mirroring gendered and political hierarchies between the Mesa Directiva and herself, a female staff member.

Certainly, OMIECH has been able to survive financially and keeps providing service to the public through the Museum, the Herbolaria, and some workshops. The organization's historical dependency on external funders, especially for workshops, has led to what Ayora-Díaz calls the "commodification of local medicine" (2010:26): in order to survive, OMIECH needs to literally sell traditional medicine, which is contradictory to its goals of protecting it. OMIECH's advisers, members of the WMS and even members of other organizations point out to the lack of political will of the Mesa Directiva and to historical paternalistic relations between the Mexican state and indigenous organizations as the main causes of the lack of self-reliance (Calles Romo 2009:143). The tension is then between economic survival and political survival, which seem to be mutually exclusive. In 2003, the end of the unconditional funding of Bread for the World divided the organization, the Herbolaria relying on government project funding, and the WMS on sporadic help. The urgency to "strengthen self-sufficient projects so as to not rely on external funding" (Icó Bautista 2005) has increased the bureaucratization of OMIECH, and taken over its political mission (the workshops). The current strategy of relying on the Herbolaria and Museum brings immediate financial security, but does not allow organizing regular workshops. This would require investing in an adviser to write grant proposals, which has never been the case in the past. The adviser's salary came from the INI and then CDI from 1987 until 2015, when he retired. The WMS' advisers were first paid by INI, then UNICEF, and then through the Women's Section's projects (until the last one left in 2010).
The increasing polarization of the organization, with the WMS on one side, and all the other Sections on the other, is due both to personal tensions between the staff, and to the opposition between the economic/immediate vision and the political/long-term vision. Few of those defending the economic model are founders of the organization; while Micaela and the (now ex-)adviser, two important characters in OMIECH's history, defend the political vision. The tensions between the different sections and staff members complicate the separation between the personal and the political, and resembles a war. On a sunny May morning, Micaela and I are sitting in the shade by one of the former green houses. She is telling me about a meeting the day before, in a voice filled with sadness and rage. "I cried because I remember the lucha (...) I defend the organization, not my personal interests." Micaela thus positions herself as defending the organization's interest (the political), and not her personal interests (the economic), making a separation between the two, while knowing that both are intertwined. She describes some colleagues are enemies while others are on her side; however, the situation is not so black and white. Most of the técnicos stand somewhere in between, moving from one side to the other depending on the stakes, and on their relation with Micaela. Such is the case with Agripino, who acknowledges the organization's importance in his personal trajectory (Icó Bautista 2010:327). In the struggle between the two visions of the organization, he often acts as a mediator. His personal story and professional journey are intimately tied to the organization's, but his position is more nuanced than Micaela. As a man, he is not in the position of exclusion that his sister is; still, he remains one of the youngest técnicos, which at times reduces his ability to negotiate. Agripino is in charge of the Communication section but is more often found at the Museum entrance, where his video on birth in indigenous communities is screened (Icó Bautista 1999).
The Museum of Mayan Medicine was inaugurated in 1997, through funding by the Mexican government and European organizations (Ayora Diaz 2000:183). The Museum won a national prize in 1998, and is in every tourist guidebook since. Pitarch describes in detail the Museum's different rooms, which have remained unchanged (except for the last temporary exhibit room) since 1997. I will briefly describe the different rooms, but for a detailed description will refer to Pitarch's article (1999). The visitors first enter in the Museum lobby, where they are charged for admission and provided, if needed, with a handbook describing the different rooms. To enter the Museum, the visitors then need to make their way behind panels, and move from the lobby's well-lit space to a room with dim lights. This first room describes the different medical specialties of the Highlands (see Chapter 3), and the visitors then watch the video on birth in a Mayan community (Icó Bautista 1999). In the video, in which Micaela and a partera from OMIECH appear, a Tsotsil woman gives birth in her home with the help of the partera, and a female voice narrates the experience. The film was shot in the late 1990s but, if it weren't for the Coca-Cola bottle, seems timeless. The narration insists on the fact that birth has always taken place that way, and that the partera's knowledge has been transmitted to her from generation to generation across centuries.

At the back of this first room, a small opening leads to a smaller room. This room is the replicate of the church of San Juan Chamula, with the saints, Jesus and the Virgin de Guadalupe represented on the wall. It is in this room that OMIECH's j'ilol receives his patients every morning, mostly urban indigenous people. The next room is a large dark room, with three crosses in the middle, and three mannequins representing indigenous people praying. The realism

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143 The handbooks carry the translation of the explanations posted on the walls of the different rooms. The Spanish handbook summarizes, the explanations, with translations in English, German and French.
144 Even though Micaela’s own birth experience was far from the one portrayed in the video.
145 Not all patients are Maya of course, and occasionally mestizos and foreigners will also seek him.
of the mannequins often startles tourists entering the room. A woman weaving on a backstrap loom is portrayed in one of the corners of the room. The next two rooms are designed to have the visitors walk on a path, and into two different scenes. The first one has them walk into a kitchen, where a Chamula woman is giving birth fully dressed on her knees, supported by her husband; the *tam-alal* is behind her. The path takes the visitors to another scene, the inside of a candle-making workshop. A mannequin of a man making *pílico*, a tobacco blend, is the last figure to greet the visitor. The final room is dedicated to temporary exhibits. In 2013, COMPITCH used it to display the various biopiracy projects in the Selva region of Chiapas, but now images of plants and their medicinal use fill the walls. When exiting the last room, visitors find themselves behind the Museum building, and continue their walk in the medicinal plant garden. An adobe *temazcal* is built in the garden. The Museum handbook informs visitors that there are ceremonies organized, but I have never noticed one during my stay\textsuperscript{146}.

By far the CeDeMM's main attraction, the Museum builds a bridge between OMIECH's activities in the communities and its goal of raising awareness among a larger public. It is geared towards an outside audience, namely non-indigenous tourists who will learn about life in indigenous communities (Icó Bautista 2010:329). Because foreigners were involved in the construction and design of the museum, the end result will necessarily reflect a mixed vision of indigeneity and Mayan life. The rooms, filled with mannequins of indigenous men and women, transmit a sense of hyper-reality, "a simulacrum of community and tradition" (Ayora Diaz 2000:185). The performance of indigeneity has been a constant struggle for state-funded organization (Taylor 2012:184). Under neoliberal multiculturalism, this unique definition of indigeneity gives birth to the *indio permitido* (Chapters 4 and 5), which the Museum has trouble breaking away from. The Museum of Mayan Medicine valorizes the history and knowledge of

\textsuperscript{146} Another illustration of the broken *temazcal*, discussed in Chapter 5.
indigenous people, but at the same time maintains them in a separate spatial and temporal sphere (Pitarch 2007). Instead of challenging the clichés tourists might have about indigenous peoples, the Museum reinforces them (Forbis 2006). The Museum of Mayan Medicine becomes a contact zone (Clifford 1997; Boast 2011) for tourists, who are introduced to indigenous culture without having to leave the city of San Cristóbal — itself an open-air museum (van Den Berghe 1994).

Beyond representation and information, the Museum plays another important role for the organization, as entrance fees are one of OMIECH's two sources of regular income (with the Herbolaria). The Museum also contributes to the organization's income through the selling of publications and boletines, displayed in the lobby. However, for the WMS, these sales are very sporadic, and depend on who is in charge of the Museum that day, and their relationship with Micaela147. Finally, the Museum was conceived to serve the organization's search for outside funding, "so that when tourist come, they can help fund us" (Sebastián Luna to Pitarch 1999:191). So far, the Museum has moderately succeeded in this task: tourists who want to contribute economically usually buy boletines; and those who have been involved on the long run with OMIECH had already heard about the organization before visiting the Museum148. It is to the relationship of OMIECH with outside donors that I turn to in the last section.

Over the years, the organization's main funding sources moved from the state (INI) to private international foundations (Bread for the World). In parallel to this process, individual private funds (through the Museum and European partners) helped maintain daily activities. After fifteen years of funding, Bread for the World "got tired," according to OMIECH's adviser. More precisely, two convergent factors led to the end of the collaboration. First, a change in

147 Some argue that the money made from selling the boletines should go to the organization as a whole, and not just to the WMS.
148 During my stay, and while watching the Museum during the invasion, I have suggested using this contact zone with tourists to ask for funding, or donations towards the AMP. My suggestions did not go through, and I did not insist.
international health politics, which moved from the support of indigenous medicine and TBAs to the training of health promoters and SBAs (Berer and Sundari Ravindran 2000). Second, shifts occurred in development projects, which changed from unconditional support to supporting self-sufficient projects. Still today, every NGO grant proposal must include a long-term self-funded project if it wants to be considered. The Herbolaria and the Museum took on this self-funded role, but do not generate enough income to be allocated to workshops and activities. A staff member points out to the difficulties of fulfilling funding agencies' requirements, "The difficulties [of self-funded projects] is that it depends on the organizational process and of the relationships between the people and the organization. It is a teamwork, a collective effort." The functioning of the organization depends on the trust staff members have among and between one another, and with their international partners.

OMIECH's international partnerships started as early as 1990 (OMIECH n.d.). Most of international collaborations started as personal connections. A German homeopath who met Micaela in the early 2000s helped organize three visits of parteras to Germany. Her German friends also regularly send Micaela remittances, but so far these contacts have not led to a long-term project, to the dismay of certain members of the Section. Still, the small amounts of money help Micaela maintaining the WMS' daily needs, which has created tensions with colleagues, who feel that the funding received through the German contact should be equally distributed among organization members. Because the WMS is isolated within the organization, Micaela's German and French contacts prioritize funding it. This, in turn, feeds misunderstanding by other Sections, which continue to isolate her because they overestimate the help she receives. The information I have been able to gather from previous volunteers and from Micaela, along with my own experience, lead me to conclude that Micaela and her collaborators often show a great

149 Each time, one or two parteras, Micaela and her adviser, were part of the trip.
degree reciprocal of trust (confianza) — a criteria she brings forward when searching for new advisers. Without this confianza, there are no projects. In the past, when the conditions attached to funding were too demanding, OMIECH has resisted them, even if it meant being deprived of support. For example, an international organization ended its collaboration with the WMS, when they realized that OMIECH was not training the parteras in biomedicine. The WMS staff shared how the funding agency switched its support to another NGO that advocates for the professionalization of midwifery.

Since the foundation of OMIECH, the healers have become familiar with the public transcript (Scott 1990) needed to gain recognition by the state and international agencies. "The local healers of this organization achieve legitimacy in the eyes of government and private funding agencies by borrowing the language and practices that legitimate cosmopolitan medicine" (Ayora Diaz 1998:184). This strategy, successful for some years, is now eroding and the organization will need to turn to other sources of funding, including outreach to Museum visitors – a strategy that was debated by members of the WMS, who were worried that funds would not be allotted to workshops for parteras (and instead be spent instantly). This concern brings forward once again the uneasy relationship between the WMS and the other Sections.

Thirty years after its foundation, the political commitment of OMIECH is eroding from the inside, but from the outside the organization still benefits from its involvement against the ICBG-Maya project, and is perceived as a strong defender of indigenous medical knowledge. The staff is still committed to this political project; however it becomes difficult to uphold in the midst of financial insecurity and the lack of external sources of support – which in turns exacerbates the tensions between staff members. These external supports cannot be acquired without a strong collaboration and a common vision between the management (Mesa Directiva)
and the técnicos. Throughout this chapter, I have explored the particular place the Women and Midwives Section represents for the organization. The only feminine space is also the one where one of the last founding members, Micaela, works. By placing the WMS at the center, I was able to analyze the tensions pervading the organization: the marginalization of the political project (workshops) in favor of economic viability; the difficult relationship with the state in the tension between autonomy and the need for basic services such as protection and; the will to preserve indigenous medical knowledge while at the same time needing to commodify it. In relation to this last point, the WMS still holds its ground and refuses to be involved in any project that would threaten the survival of tam-alaletik's knowledge, even though it might mean further marginalization from the emerging national midwifery movement. In the Conclusion, I share some final thoughts about the future of OMIECH, tam-alaletik and indigenous medical knowledge in tomorrow's Mexico.
Conclusion. The Lucha Continues

"The lucha continues, the lucha never ends. Now we are seeing with the women why mothers die, why children die. This is what I am seeing. Because of family problems, problems in society, political problems; because of many things that happen to women and children. Not just like that." (Icó Bautista 2008:481)

From Chile to Chiapas, poor people are caught in programs urging them to modernize their way of life, creating the feeling that "modernity came almost without us noticing it, and this modernity has broken down our own traditions. (...) Modernity also makes us feel guilty for not living well" (Paley 2001: 222). Across the world, women are pressured to change their "traditional" birth habits for "modern" ones, and to give birth in hospitals. In highly stratified societies like the Mexican one, public hospitals are not always welcoming and feed into the "mosaic of violence" poor women face throughout their lives (Speed 2014). The endemic cases of obstetric violence in the country made international headlines when a Mazatec woman delivered her child alone in front of a public clinic in Oaxaca after being denied care (Gomez Licon 2013). Under the New World Order, women's health problems cannot be separated from global forces (Ginsburg and Rapp 1995b), as the globalization of cases of obstetric violence illustrate. In the months following international outrage about the Mazatec woman's experience, the same images were repeated, with women being denied care in Morocco (Sourgo 2014) and Egypt (Abdelatti et al. 2014). Neoliberal policies seeking to create modern individuals making rational decisions over their health fail to take into account the social networks in which health is embedded. Birth is a biosocial event, at the frontier between the intimate and the political (Davis-Floyd 1992; Jordan 1993), and the control of women's reproduction is closely tied to concerns about the reproduction of the nation. On the ground, women carry the moral, physical and social burden of reproduction but rarely make reproductive decisions on their own.
Reproduction has high political stakes which justify intervention, from the socialist state (Andaya 2014) to neoliberal programs (Smith-Oka 2013c). In Chiapas, government programs, raising the specter of maternal mortality, make women doubt and generate fear in parteras' practices, breaking their bond of trust, the confianza necessary for birth. Programs encouraging women to give birth in hospitals contribute to the overcrowding of public health structures. Added to chronic underfunding of the public health system, which relies on unpaid pasantes (interns), these programs end up decreasing the quality of care of poor women – those who can afford it switch to private care, making birth a "business" in the Highlands too (Epstein 2007).

When women and parteras reflect on the changes happening in their lives, comparing their birth experience to that of their mothers or grandmothers, they emphasize their feeling of disrespect of respect – towards their birthing bodies, towards the social role of parteras. In this dissertation, I have argued that respect, ich'el ta muk' in Tsotsil and Tzeltal, is more inclusive than individual discourses about human rights. Ich'el ta muk' symbolizes the "no exclusion, the eradication of poverty, the real acknowledgement of Others, sincere dialogue, the full exercise of all rights, justice and equity for all" (López Intzín 2013:159) and is a path for recovering the sovereignty of Mayan men and women over their practice. It is for this constant fight that Micaela and her colleagues still maintain the organization, despite the many difficulties they face. Organizing from the margins, their struggle lies in keeping their political project alive, even though it is not in line with international funding agencies – which promote the training of professional midwives. The small grants Micaela's partners receive help organizing occasional events, but Micaela is still searching for a volunteer to help her develop long-term projects, so that she can continue her lucha. In the following pages I share other examples of luchas, which are different form OMIECH's but also aim at improving indigenous peoples' health.
Hope for the future: Anthropologists training medical interns

When biomedicine supersedes other forms of medicine, it focuses on specific healing properties (medicinal plants, techniques to attend a breech birth) while disconnecting them from the social interactions in which they are inscribed. The hegemonic power of biomedicine has been theorized by Mexican medical anthropologist Menéndez under the framework of the Hegemonie Medical Model (1981; 2003). During our interview, Ménendez explained, "You cannot resist hegemony, by definition it adapts itself and absorbs any other approaches, altering them in the process. Trying to change the medical system from within is a waste of time." Hegemonic power is by nature phagocytic and adaptive. Biomedical hegemony, like other forms of hegemony, is maintained by

"Both structural power and the internalization of authoritative knowledge. It comes to be seen as part of the natural or cosmological order, and is maintained by all, not just the dominant group, so that it is less likely to be questioned except in situations of crisis or disruptive change or, even if questioned, remains difficult to challenge" (McCourt 2010:4).

One of the difficulties of challenging hegemony is that dominated groups contribute to its maintaining (Gramsci 1971). Even though those affected by hegemony are aware of existing power structures, the difficulty lies in transcending individual experiences of oppression and articulating a collective framework of struggle (Roseberry 1994). Hegemony transforms culture into a measurable unit – a checklist of features that one has or actions that one performs (Smith 2007). Culture then only exists in the form of herbal remedies or a broken temazcal (Chapter 5). In contexts where biomedical power is held by rich, educated and whiter individuals, and traditional medical knowledge by indigenous peoples, the struggle between medicines is embedded in power relations of class, ethnicity and gender (Briggs and Mantini-Briggs 2004; Pigg 1997; Pinto 2008). In the eyes of Mexican biomedical practitioners and state workers,
parteras' situated knowledge (Haraway 1988) makes it less valuable. How, then, to contest biomedical hegemony? To conclude on a hopeful note, I would like to share examples of everyday micro-resistance from people who believe, like Roseberry theorized (1994), that "change from within the structure" is possible.

i. Mexico City: anthropology for pasantes

Alfredo Paulo Maya is the Chair of the Medical Anthropology program at the School of Medicine in Mexico City. His firm critiques of the medical establishment and of biomedical hegemony don't prevent him from trying to change it from within. During a graduate anthropology seminar to which I was invited, Alfredo shared a new program he was developing: teaching anthropology classes within hospitals, to young pasantes. Such courses aim to broaden pasantes' perception of their patients, by asking them questions about their place of residence or the time they spent in transportation before arriving to the hospital, and ultimately seeing patients as people entrenched in social relations rather than clinical cases.

Alfredo Paulo and his colleagues in the Medical Anthropology program believe that another medicine is possible, one that can be respectful to patients. This is why their focus is with future doctors, who are more receptive to their approach than already established physicians (Davis-Floyd 1992). By avoiding the cultural trope of "cultural competency" trainings, the workshops Alfredo Paulo organizes with interns bring to light the various webs of meaning (Geertz 1977) of health, and the different experiences and expectations of patients from various socioeconomic backgrounds. Several young scholars are working on the communication between doctors and their patients, and hope to improve the quality of care and showing that biomedicine and respectful treatment are not incompatible.
ii. Palenque: pasantes in NGOs

In Palenque, future doctors are spending their year of *servicio social* in an unusual way: unlike their colleagues who are staffing the state's rural health clinics, the organization Casa de la Mujer Ixim Antsetik\(^{150}\) provides them the opportunity to provide reproductive health care to women from the city of Palenque, and in indigenous communities. Since 1998, Casa de la Mujer's objective is not limited to providing medical attention, but also to building a collective project, framing health in a feminist perspective (López Silva 2005). The *pasantes'* activities as doctors are combined with a political project: improve the access of poor women to reproductive health care; but also document and condemn cases where women's reproductive rights are violated. In addition to being selected on their grades, the organization also interviews the *pasantes* to screen their reasons for interning and their understanding of the context of Chiapas. As one of the two female doctors shared with me,

"When I was doing my internship [in Mexico City] I almost quit. The only thing I can remember is wanting to sleep all the time; how can you care for people under these conditions? (...) Here, it is different, and I realized there were other ways of offering medical attention. [Here], we focus on the clinical, ask patient how they feel. I don't use gloves to check people; I don't like gloves, because you cannot feel the patient."

At the end of their *servicio social*, young doctors have gained a medical, social and a more human perspective on health, different form their colleagues working in public health clinics. This experience shows how medicine can also be collaborative, and challenge hegemony in everyday actions.

iii. San Cristóbal, cultural training for medical staff

In Mexico, most public hospitals have a Teaching Department (*Enseñanza*) dedicated to the staff's continuous training. In San Cristóbal's Family Hospital, workshops for the staff are organized several times a week. The themes and public vary from "Neonatal CPR" (for

\(^{150}\) *Ixim Antsetik* means Women of Maize in Tzeltal.

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physicians and nurses) to "Interculturality and Health" (open to all personnel). The doctor in charge of the Enseñanza and her staff organize the trainings in a large room on the third floor of the hospital. "Training in Interculturality are offered every month, and each [staff member] has to participate at least once, ideally once a year," she explains, admitting that these were not as popular as other trainings. The challenge is to share with doctors and nurses in only a couple of hours some basic notions about life in indigenous communities, and the isolation and the journey that going to the hospital implies for some families. The doctor in charge of providing Interculturality trainings, Dr. Luciano, is an energetic man in his early sixties, who speaks in a soft tone about the passion for his work. "Nowadays, medicine has been commoditized. But spiritually, we cannot market medicine. (...) Our duty as doctors has to be a social duty." Like his colleagues from the School of Medicine in Mexico, Dr. Luciano is trying to change the biomedical system from within, one person at a time; "There is no more medical humanism," he laments." His deep knowledge and respect for indigenous peoples comes from his personal experience. One of the few kaxlanes fluent in Tsotsil and Tzeltal, he is convinced that the trainings he provides to medical staff across the State can help improve the way indigenous patients are treated in hospitals. In his workshops, he tries to raise awareness on cultural rights, and invites the medical staff to provide space in their clinic their patients' relatives, or to allow them to have certain kind of food brought to them within the hospital (two common complaints by Mayan patients (Berry 2008)).

Are initiatives such as the ones presented only ephemeral, and doomed to be either destroyed or incorporated within the biomedical system? The answer is not clear yet. However, these individual initiatives aspire to positively impact on indigenous patients' daily interactions

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151 Interculturality trainings are funded by the global project Salud Mesoamerica.
with the medical establishment. In a context of violent encounters such as the ones I described in Chapter 6, this is a non-negligible effect. The three initiatives were launched to improve indigenous people's experiences in the hospital, by challenging the overwhelming racist and dismissive discourses about them. None of them specifically target *parteras* however, whose future remains uncertain.

**The uncertain future of parteras**

Reports and newspaper articles emphasizing the need for skilled birth attendants internationally and in Mexico (Walker, DeMaria, et al. 2011), or congratulating Mexican midwives for "entering the mainstream" (Braine 2008) contribute to the idea that the *partera* of the future is urban and educated, as opposed to rural and illiterate. The *partera* of the future would ideally resemble a sort of "postmodern midwife" (Davis-Floyd 2005), technologically and politically savvy, but also caring and culturally competent. Her diploma and formal education would provide her with the first two skills, while the contact with *parteras empíricas* will help her acquire the other.

Based on this model, and with the help of the founder of CASA, the Intercultural University of Chiapas (UNICH) designed a three-year curriculum for prospective midwifery students. During an interview with a nurse working at UNICH, she shared with me the curriculum, which includes classes taught by nurses, *enfermeras obstetras* and *parteras profesionales*. "What about *parteras tradicionales*?" I asked. The answer was ambiguous: in Mexico, to teach at a University, one must have a higher-education degree. So *tam-alaletik* cannot formally teach, but she explained students would be in contact with them during workshops and for their training. It was not clear to me what the *parteras* would get in return. As
I discussed in this dissertation, midwifery is becoming increasingly stratified. *Tamalaletik* are valued for their culture while at the same time their medical knowledge is marginalized.

During a meeting with reproductive health actors in San Cristóbal, the coordinator of the health program presented the future degree. This technical career is not a Bachelor's degree but a two-year diploma, which would then be a problem for those who would like to further pursue their education. The degree promotes a technocratic vision of *partería* (which becomes knowledge of experts) while simultaneously not fully providing the future *parteras profesionales* with the tools to assess their authority in front of biomedical experts (a diploma). Even though UNICH obtained an agreement with the Ministry of Education granting students their *cédula profesional* authorizing them to practice, it is unsure how much leverage students would have in deciding where they would work. They could be then be sent to staff rural clinics, where physicians do not want to go. My question, which the University representative only partially answered, was, "but then what happens to the *parteras tradicionales* in communities where this *partera profesional* is sent?" I was told that they would work together; however, given the very superficial collaboration between *parteras capacitadas* and *parteras profesionales* in the Intercultural Hospital and the Casas Maternas (Chapter 5) it is more likely that young *parteras profesionales* will replace their elders.

Since I left Chiapas in July 2015, change happened in the Intercultural Hospital. Sofia ended her year of *servicio social* and two new CASA graduates replaced her in the fall of 2015 – despite Doña Gabriela and her colleagues' claims that they did not really care for *parteras profesionales* and that they needed an obstetrician. A couple of months later, my colleague Irazú sends me a message, "There was an emergency transfer from the TMA to Tuxtla, and now they want to kick out the *parteras.*" Indeed, after this event, *parteras* were subjected to even more
control, and no more apprentices were allowed in the Traditional Medicine Area. Management tried to close the TMA arguing that they needed the space and that parteras could work in Chamula's Casa Materna (see Chapter 5). The TMA was closed for a few weeks, but the parteras fought back to keep their space, even if it is not clear how long they will be able to hang on to it. Once again, parteras were treated as second-class citizens by the Mexican health system. As I have argued in this dissertation, the state does not care about parteras, and the policies oriented towards them only increase their marginalization. As in other parts of Mexico (Miranda 2015), and as illustrated in the example of Comitan's Casa Materna (Chapter 5), parteras' future seems to be oriented towards them being physicians' auxiliaries — or "little nurses" as OMIECH colleagues call parteras capacitadas — caring for women during prenatal care, and transferring them to the hospital for birth.

It is against this marginalization that OMIECH is fighting. As I have argued in this dissertation, indigenous women and their families seek parteras because they trust them, "because they have more confianza in them, they feel more happy, more content, more comfortable giving birth in their home. [Because] their family is there, everyone. This is what women seek" (Icó Bautista 2008:483). In this context, the push for SBAs and to send women to hospitals violates women's reproductive rights and parteras' cultural rights. "As long as there is one tam-alaletik, then it is worth fighting," OMIECH's adviser frequently repeats. Despite the difficulties the Women and Midwives Section encounter, Micaela continues to fight for parteras' right to practice, with the help of colleagues in Mexico and Europe. I hope this dissertation contributes to their struggle, and that we will have many more occasions to collaborate; the lucha never ends.
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