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Traditional Midwives a Link Between Cultural Rights and Women's Rights

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Abstract

Women's rights are often perceived as existing in direct opposition to cultural rights. If we provide and protect Indigenous Peoples' or minority groups' collective cultural rights, it is commonly assumed that this will come at the expense of women's rights. However, such limited definitions of culture and rights fail to understand that culture can be a means through which to localize rights. This paper argues that traditional Mayan midwives in the Yucatan Peninsula—Campeche, Yucatan, and Quintana Roo—can provide reproductive services and women's rights visibility by protecting and maintaining their culture in their communities. Through unstructured interviews and participant observation, this author interviewed midwives, mothers, and activists in the region to provide a larger picture of the reproductive health situation in rural communities. Mayan women, who experience high levels of obstetric violence and structural oppression, are in dire need of culturally competent programs that support and validate their reproductive needs and experiences. The findings presented in this thesis suggest that midwives are crucial actors in localizing women's and cultural rights in their communities and greater support by medical personnel can help increase reproductive safety.

Keywords: Cultural Rights, Midwives, Women's Rights , Obstetric Violence, Mexico

Para mi papá quien lucha día tras día por la dignidad del migrante. Quien me enseñó que los testimonios y las historias de todas las personas son validas y a veces lo mejor que podemos hacer es escuchar. Y para Doña Neyi, abuela, mamá, activista, y guerrera de Xanlah. Quien su fortaleza me inspira y me hace una mejor persona.

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Introduction

The Sustainable Development Goals, developed by member states of the United Nations, include the ambitious goal of reaching gender equality and an improvement in health worldwide while leaving no one behind. This global commitment to reach even the most marginalized communities should serve as a catalyst for discussions on how services, policies, and institutions disproportionately affect Indigenous peoples. Indigenous women in Mexico are often at the intersections of gender discrimination, ethnic discrimination, and low socio-economic class.¹ Discrimination in health clinics, language barriers, lack of access to health clinics, and economic difficulties often serve as obstacles for Indigenous women to receive the same health care as non-Indigenous Mexican women.² At the same time, traditional midwives are socially excluded and legally criminalized because they do not align with Western biomedical thinking.³ By further criminalizing, restricting, and belittling Indigenous women's access to traditional midwives, the state makes it harder for women to receive adequate reproductive health care. This paper aims to reject the often-perceived notion that cultural rights and women's rights are in constant conflict.⁴ Instead, the following research argues that culture can be an avenue for social change, women's empowerment, and for the delivery of human rights. By encouraging, supporting, and promoting midwifery through a dynamic link between the health care industry and midwives, the Mexican government can provide accessible health care to marginalized communities and help improve the overall status of women in society.

Mexico, which has ratified Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) and signed the Declaration on the Rights of Indigenous Peoples (DRIP), needs to be held accountable when it comes to providing access to reproductive health

¹ Pelcastre-Villafuerte, Blanca, Myriam Ruiz, Sergio Meneses, Claudia Amaya, Margarita Márquez, Arianna Taboada, and Katherine Careaga, "Community-based health care for indigenous women in Mexico: a qualitative evaluation." *International Journal For Equity In Health*, 13.1. (2014):3.

² Leyva-Flores, R., Servan-Mori, E., Infante-Xibille, C., Pelcastre-Villafuerte, B., & Gonzalez, T., "Primary Health Care Utilization by the Mexican Indigenous Population: The Role of the Seguro Popular in Socially Inequitable Contexts," *Plos ONE*, 9.8. (2014):1-6.

³ Pelcastre-Villafuerte, B., Ruiz, M., Meneses, S., Amaya, C., Márquez, M., Taboada, A., & Careaga, K. "Community-based health care for indigenous women in Mexico: a qualitative evaluation". 2-18.

⁴ Cowan, Jane K., Marie-Benedicte Dembour, and Richard A. Wilson. "Introduction," in *Culture and Rights: Anthropological Perspectives* ed. Jane K. Cowan, Marie-Benedicte Dembour, and Richard A. Wilson. (Cambridge: Cambridge University Press. 2001).

services while respecting Indigenous peoples' cultural heritages. Although some reproductive policies the Mexican state has implemented have had positive effects, Mexico needs to further adapt their current policies to empower Indigenous knowledge and provide cultural training for all health care providers, including midwives. In addition, reproductive and sexual rights abuses endured by Indigenous women in Mexico can be defined as torture or as cruel, inhumane and degrading treatment which violate the UN Convention Against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment (CAT). As a ratifying state to the Convention Against Torture, Mexico needs to be held accountable to the reproductive abuses Indigenous women experience.

There is a gap in academic research focusing on the destruction of Indigenous cultural heritage through the criminalization of midwifery. My research will fill this academic gap by making the connections between health care policies that criminalize midwifery and a lack of health care access in the Mexican Yucatán Peninsula. Research does exist that demonstrates the positive effects on health care access in rural areas that result when governments support midwifery and other traditional birth attendants, and other research explores the devastating effects of cultural heritage destruction on Indigenous peoples.⁵⁶ However, this paper in particular will provide the testimonies of midwives, mothers, and activists who can attest to the consequences that legal policies and social restrictions have on Indigenous women's cultural heritage and reproductive rights.

This paper will first address the current academic literature available, starting with a historical background on Mexico's reproductive policies and Mayan women's access to health services. The *Literature Review* will also address the tensions between cultural and women's rights, followed by the theoretical framework shaping this research. The following chapter, *Methodolo-*

⁵ Godlonton, Susan and Edward N Okeke, "Does a ban on informal health providers save lives? Evidence from Malawi", *Journal of Development Economics*, 118.(2016): 112-32

⁶ Parks, Shoshaunna, Patricia A. McAnany, and Satoru Murata, "The Conservation of Maya Cultural Heritage: Searching for Solutions in a Troubled Region" *Journal of Field Archaeology* 31.4. (2006).

Skutnabb-Kangas, Tove. *Linguistic Genocide in Education-or Worldwide Diversity and Human Rights?* (New Jersey/London, Lawrence Erlbaum Associates,2000), 209-215.

S. Rama Rao, "The Relationship between Intellectual Property and the Protection of Traditional Knowledge and Cultural Expressions", *Traditional Knowledge and Indigenous Peoples*, ed. Uliya Popova-Gosart,(Geneva, WIPO Publication, 2009) 40-54.

Stamatopoulou, Elsa, "Taking Cultural Rights Seriously: The Vision of the UN Declaration on the Rights of Indigenous Peoples", in *The UN Declaration on the Rights of Indigenous Peoples*, (2011): 387-412.

gies, will discuss the research methodologies used to collect the testimonies and oral histories from midwives, mothers and activists. Chapter IV, *Reproductive needs and obstacles*, addresses the issues of accessibility, acceptability, availability and quality of reproductive services in the Yucatán Peninsula. This chapter aims to address the obvious limitations of state health institutions in remote communities. The following chapter, *Cultural importance*, explores the cultural role midwifery has in different Mayan and mestizo communities. This chapter argues that the lack of cultural flexibility in hospital regulations constrains women's diverse and specific cultural traditions and needs. Chapter VI, *Obstacles in birth, obstacles in culture: Human rights violations*, addresses the human rights violations Mayan and mestizo women experience in the peninsula, referred to as obstetric violence. In addition, this chapter focuses on the legal and social criminalization and restrictions on midwifery and the effects these have on decreasing women's right to choose where to give birth. The following chapter, *Midwifery as an avenue for social change*, discusses the role midwives and reproductive health activists have as advocates for human rights. It is through birthing spaces that discussions on gender, race, class, and rights arise. The final chapter provides recommendations and final thoughts on the strengths midwives and traditional birth attendants have in these communities, and the possible links that could be created between them and state-run health care institutions.

The following questions framed this research: How has the criminalization of midwifery in Indigenous communities in Quintana Roo, Yucatán, and Campeche been detrimental for Indigenous women's reproductive rights? How have governmental policies been detrimental for Indigenous cultural heritage? How accessible are health care provisions for Indigenous Mayan women in the Yucatán Peninsula? How can midwifery serve to bridge the connection between women's rights and cultural rights?

Literature Review

The literature review will be divided into three parts: a historical background of Mexico's Indigenous reproductive policies and Mayan women's access to reproduction; a discussion on cultural rights in relation to women's rights; and, finally, the framework for this research.

Mexico's Indigenous reproductive policies and Mayan women's access to reproduction

Indigenous people's reproductive access in Mexico has strongly been linked to midwifery and demographic policies enacted by the Mexican government. Huber et al., Davis-Floyd et al., and Carey provide a historical context that highlights Mexico's shift to medicalizing birth and homogenizing the country's medical system.⁷ Before the 1970s, the Mexican government strongly condemned Indigenous medical knowledge as being non-scientific, following the world's trend of invalidating what could not be explained "scientifically."⁸ However, by the mid-1970s, the Mexican government started to partially acknowledge and accept midwifery if Indigenous midwives adopted biomedical techniques such as birthing acceleration drugs that supported the health pharmaceutical industry and promoted the state's demographic interests.⁹ Instead of providing greater access to health clinics around the country, the state encouraged the training and licensing of midwives to provide the same medical services as doctors but at a cheaper cost for the state. Between 1974 and the beginning of the 1980s, 15,000 midwives underwent state-sponsored medical training which, according to Davis-Floyd and his colleagues, were "powerful instruments for imposing, extending, and further legitimizing biomedical obstetrics."¹⁰

Today, midwives constantly report the pressures to medicalize birth and remove rituals or customs that have no lucrative gains or scientific reasoning to them. Once midwifery training became mandatory, there was a dramatic increase in the use of oxytocin and vitamin B injections

⁷ Carey, David., *Engendering Mayan history: Kaqchikel women as agents and conduits of the past, 1875-1970*. (New York: Routledge, 2006).

Floyd, Robbie, and Carolyn Fishel Sargent, *Childbirth and authoritative knowledge cross cultural perspectives*. (Berkeley: University of California Press, 1997)

Huber, Brad R., and Alan R. Sandstrom. *Mesoamerican healers*. (Austin: University of Texas Press, 2001)

⁸ Huber, Brad R., and Alan R. Sandstrom. *Mesoamerican healers*. (Austin: University of Texas Press, 2001).

⁹ Ibid.

¹⁰ Ibid., 399.

that accelerate birth and increase the need for cesarean deliveries.¹¹ The process of medicalizing natural processes for monetary gain is a global trend stemming from the colonial era. Although the medicalization of birth has served to save millions of lives, our societies' shift towards only pharmaceutical-centered medicine has had the effect of alienating and excluding marginalized people from gaining the same health care as the rest of the world.¹² Certain rural and Indigenous midwives do not receive training or licensing at all due to the lack of state resources, yet are criminalized or cited when practicing their profession.¹³ For Mayan women in Mexico, the medicalization of birth and the licensing of midwifery have had different consequences. On one hand, Mayan women have often stated that they avoid hospitals and health clinics due to past mistreatment, language barriers, shame from being exposed to male doctors as opposed to female healers or midwives, and fear of surgery.¹⁴ As a result, medicalization has further alienated women seeking health access through midwives due to a fear of ending up in a hospital.¹⁵ On the other hand, contemporary Mayan women have also been found to combine both treatment from midwives and doctors. Similarly, midwives have developed relationships with particular doctors and hospitals in order to best support their patients.¹⁶ This is a testament to how Indigenous peoples are able to maintain their cultures without having to freeze them.

In 2003, the Mexican government introduced *Seguro Popular* as an economically accessible health care institution to serve Mexico's lower class.¹⁷ Although *Seguro Popular* did remove economic barriers to health care, other barriers such as lack of confidence in the medical

¹¹ Ibid.

¹² Adams, Vicanne, "Against Global Health?" in *Against Health*, ed. J. Metzl and A. Kirkland. (New York, NYU Press, 2010), 40-58.
Farmer, Paul, Jim Yong Kim Arthur Kleinman and Matthew Basilio, "Introduction: A Biosocial Approach to Global Health" in *Reimagining Global Health: An Introduction*, ed. Farmer, Paul, Arthur Kleinman, Jim Yong Kim, and Matthew Basilio. (Berkeley/Los Angeles, University of California Press, 2013).

¹³ Huber, Brad R., and Alan R. Sandstrom. *Mesoamerican healers*. (Austin: University of Texas Press, 2001).

¹⁴ Floyd, Robbie, and Carolyn Fishel Sargent. *Childbirth and authoritative knowledge cross cultural perspectives*. (Berkeley: University of California Press, 1997).

¹⁵ Ibid.

¹⁶ Huber, Brad R et al. *Sandstrom. Mesoamerican Healers*.

¹⁷ Leyva-Flores, R., Servan-Mori, E., Infante-Xibille, C., Pelcastre-Villafuerte, B., & Gonzalez, T., "Primary Health Care Utilization by the Mexican Indigenous Population: The Role of the Seguro Popular in Socially Inequitable Contexts", *Plos ONE*, 9.8. (2014):1-6.

system, poor treatment, unavailability of care and remoteness of medical centers remained intact.¹⁸ The most popular program within *Seguro Popular* among Indigenous peoples is *Oportunidades*, a cash transfer program that alleviates women's poverty in Mexico by focusing on health, education, and nutrition.¹⁹ Through *Oportunidades*, women receive economic support only if they meet the criteria set out by the state. Recipients of *Oportunidades* are required to have their children enrolled in schools, attend workshops, attend medical appointments (for both mothers and children), and are even subjected to revisions regarding the "cleanliness" of their houses. If women or their children fail to meet these set standards, their grants get cut in half or they could be removed from the program completely.²⁰ Since late 2014, *Oportunidades* has been renamed *Prospera* and underwent minor changes. The changes added new benefits such as children receiving a university scholarship instead of a final payment when they turn 18, as well as the possibility for women to receive a business grant investment. Although these changes have reportedly received popular feedback, *Prospera* continuously fails to regard women's empowerment and their bodily right to choose where and how to give birth.

Vania Smith-Oka's research, conducted in Veracruz, argues that through state programs in Mexico like *Oportunidades*, Indigenous women are forced to accept fertility controls because of the government's fear of increasing poverty by allowing the poor to over-reproduce.²¹ *Oportunidades* as a demographic control program promotes doctors to strongly push Indigenous women to have two or less children, which inevitably undermines reproductive autonomy and disempowers women.²² Through her research, Smith-Oka found that Indigenous women were susceptible to agreeing to such control because of the shaming and scolding they experienced by the health professionals they encountered. In addition, because of the monetary incentive to continue with the program, they were unlikely to opt out even if they did not agree. *Oportunidades* disem-

¹⁸Ibid.

¹⁹ Ibid.

²⁰ Paris-Pombo, María Dolores, "Health Promotion and Gender Power in the Oaxaca Mixteca." *Agricultura, Sociedad y Desarrollo Enero-Junio* (2008): 53-69.

²¹Smith-Oka, Vania, "Unintended consequences: Exploring the tensions between development programs and indigenous women in Mexico in the context of reproductive health" *Social Science & Medicine*, 68.11, (2009): 2069-2077.

²²Ibid.

powers women by alienating health promotion; health promotion moves from being an issue about women's bodies and what they need to an outlet to promote the interests of institutions.²³ Although this program provides economic support to women, it impedes their empowerment by accumulating responsibilities, such as keeping their houses clean to the standard of the state, thereby holding even the minutiae of their lives accountable to the state and its institutions.²⁴

Through contemporary programs like *Prospera*, and state-sponsored midwifery trainings, midwives are scrutinized to fit a biomedical standard or criminalized for being non-scientific. During several of the testimonies collected for this research, Mayan women expressed that if they chose to give birth with the assistance of a midwife they were either belittled by health professionals for their choice or economically punished by programs such as *Prosepera*.²⁵ Carey and Smith-Oka conclude that state-sponsored reproductive policies that are meant to provide better health access to Indigenous women in Mexico have often "unintentionally" disempowered them.²⁶ Homogenizing reproductive health in Mexico has not brought greater health care access to Indigenous people and in some cases has in turn restricted and belittled Indigenous medicine and customs.²⁷

Cultural and women's human rights

The literature analyzed in this section regards cultural rights and their often perceived opposition to women's human rights. A strong proponent of cultural rights is Will Kymlicka, who believes culture is necessary for a meaningful life.²⁸ The author argues that if marginalized

²³ Paris-Pombo, María Dolores, "Health Promotion and Gender Power in the Oaxaca Mixteca," 53-69.

²⁴ Ibid.

²⁵ Sabrina Speich, Tulum, August 26, 2016.
Elodia Catzim, Tulum, August 27, 2016.
Mirna Aracely Tuz Acosta, Xanlah, September 2, 2016.
Rafaela Can Ake, Chumbec, September 8, 2016.

²⁶ Smith-Oka, "Unintended consequences: Exploring the tensions between development programs and indigenous women in Mexico in the context of reproductive health." 2069-2077.
Carey, David. *Engendering Mayan history: Kaqchikel women as agents and conduits of the past, 1875-1970*.

²⁷ Smith-Oka, "Unintended consequences: Exploring the tensions between development programs and indigenous women in Mexico in the context of reproductive health." 2069-2077.
Carey, David. *Engendering Mayan history: Kaqchikel women as agents and conduits of the past, 1875-1970*.

²⁸ Kymlicka, Will. *Liberalism, Community, and Culture*. (Oxford: The Clarendon Press, 1989).

groups are not able to protect their culture, they will eventually be assimilated into hegemonic society.²⁹ Counter to Kymlicka's proposal of having specific group rights is Susan Moller Okin who argues that cultural rights and group rights are anti-feminist and therefore liberal democracies should shy away from exclusively protecting cultural rights.³⁰ Okin believes feminism and multiculturalism are not easily reconciled as tensions exist where groups internally oppress women.

It is important to note when talking about cultural rights that Indigenous peoples' rights are not the same as minority rights but can and may share similar characteristics. Indigenous peoples, like those of minority identity, have to be self-identified and can include markers such as holding a non-dominant position in society, possessing distinct social, economic, and political systems, languages, cultures, and beliefs, and a determination to maintain a distinct identity. However, minorities "do not necessarily have the long ancestral, traditional and spiritual attachment and connections to their lands and territories that are usually associated with self-identification as indigenous peoples."³¹ This distinction is important to note in the context of Indigenous women's reproductive rights due to the high importance placed in women's and communities' ancestral roots. Several Indigenous women discussed the passing of birthing knowledge from one generation to the next as crucial to their identity.³²

In *Multicultural Citizenship: A Liberal Theory of Minority Rights*, Kymlicka outlines how since the start of western civilization, governments have strived to achieve homogeneous polity through various different policies. Cultural minorities were either physically extinguished, subject to coercive assimilation, or segregated completely and denied economic, political, and cultural rights. Prior to World War II, states had made bilateral treaty agreements indicating they would protect cultural minorities, however these treaties were often destabilizing whereas power-

²⁹Ibid.

³⁰ Moller Okin, Susan. "Is Multiculturalism Bad for Women?" *Boston Review* (1999).

³¹ Office of the High Commissioner of Human Rights, "Minority Rights: International Standards and Guidance for Implementation". *United Nations New York and Geneva*, 2010. 4. http://www.ohchr.org/Documents/Publications/MinorityRights_en.pdf

³² Rafaela Can Ake, Chumbeq, September 8, 2016.
Marta Lucia Camal Mix, Chankom, September 1, 2016.
Maria Ofelia Mix Can, Chankom, September 1, 2016.
Sabrina Speich, Tulum, August 29, 2016.

ful states justified invasion over weaker states on the grounds of violating treaty rights. After World War II, liberals shifted their emphasis from protecting minority rights directly through treaties to indirectly protecting vulnerable groups through universal human rights that guarantee basic civil and political rights to all individuals. As Kymlicka argues, Liberals assumed that once basic human rights were protected, the United Nations could delete references of ethnic or national minorities in the Universal Declaration of Human Rights.³³ For post-war liberals the separation between ethnic minorities and the state was similar to religion and the state. They believed that cultural minorities could maintain their ethnic identity and heritage privately but the state had no responsibility to “attach legal identities or disabilities to cultural membership”.³⁴ The state’s sole responsibility was to protect against prejudice and discrimination without establishing any additional rights to groups. However, Kymlicka argues that traditional human rights standards do not cover the controversial questions around minority rights such as how to navigate local autonomy, physical boundaries, language rights, and naturalization policies. Traditional human rights lack the specificity needed to deal with a multicultural society.³⁵

Since the early 1990s, minority cultural rights have again taken prominence in the United Nations system and have been addressed predominantly in the 1976 International Covenant on Civil and Political Rights and the 1992 Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities.³⁶ In 2007, the General Assembly adopted the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), which helped solidify the difference between Indigenous rights and minority rights. However, Kymlicka argues that even though these declarations are seen as successes, they tend to be vague and impractical due to the fear that group rights can be abused for racial segregation and domination. He believes that if we use a liberal theory of minority rights within international relations, minority rights could coexist with traditional human rights to enhance the multicultural world we live in. Minor-

³³Kymlicka, Will. *Multicultural Citizenship: A Liberal Theory of Minority Rights*. (New York/Oxford: Clarendon Press. 1995):4.

³⁴ Ibid.4.

³⁵ Ibid.

³⁶ Office of the High Commissioner of Human Rights, “Minority Rights: International Standards and Guidance for Implementation”. *United Nations New York and Geneva*, 2010. http://www.ohchr.org/Documents/Publications/MinorityRights_en.pdf

ity rights could therefore be limited and restricted by traditional human rights such as “individual liberty, democracy and social justice.”³⁷

Kymlicka argues that it is important to distinguish between two meanings of “collective rights.” Collective rights either refer to the internal group limits, in order to solidify and maintain cultural purity, or they can refer to a group’s right to limit economic or political power by the larger hegemonic society over the group. The latter definition of collective rights can be used to ensure that their resources and institutions are protected and are not forcibly assimilated or erased. Collective rights as external protections do not conflict with individual liberty. A liberal theory of minority rights will therefore accept some external specific protections while being critical of internal restrictions.³⁸ Kymlicka argues that if cultural rights aren’t protected separately from individual rights, then minority cultures are threatened to assimilate into hegemonic cultures, restricting their ability to live meaningful lives.³⁹

A strong critic of Kymlicka’s proposal is Susan Moller Okin, who argues that group rights are antifeminist because they provide entitlements to groups usually controlled by men. Because male members are generally those articulating the group’s culture, beliefs, and interests, women’s rights are inherently limited.⁴⁰ Okin argues that liberal defenses, such as Kymlicka’s, which focus on individuals needing culture to develop community, neglect that culture is often formed and transmitted without individual agency. Religious and cultural groups tend to be particularly restrictive in regards to “personal law” therefore the “defense of ‘cultural practices’ is likely to have much greater impact on the lives of women and girls than those of men and boys.”⁴¹ Okin argues that when most religious cultures began, their intentions were to control and restrict women. Although most cultures have softened and become more progressive, fundamentalist versions remain.⁴²

³⁷Kymlicka, Will. *Multicultural Citizenship: A Liberal Theory of Minority Rights*. 6.

³⁸ Ibid.

³⁹ Kymlicka, Will. *Liberalism, Community, and Culture*.

⁴⁰ Moller Okin, Susan. “Is Multiculturalism Bad for Women?”.

⁴¹ Ibid. 4.

⁴² Ibid.

Okin argues that the liberal approach to cultural rights not only provides additional legal and social power for the oppression of women but also makes it harder for women to leave oppressive identity groups.⁴³ Okin states that all cultures are patriarchal, yet she seems to be more critical about cultures from the Global South because of legal protections in the Global North.⁴⁴ Okin does acknowledge Kymlicka's skepticism on internal collective rights in order to maintain internal liberalism. However, Okin believes few cultures could claim group rights under his liberal justification because oppressive beliefs and practices are often imposed in the private sphere and not necessarily overtly. Kymlicka opposes granting oppressive cultures group rights if they practice sex discrimination, however most cultural oppression is done privately and there is not one culture in the world that can accurately claim that it has no gender discrimination.⁴⁵

For Okin, to truly attain a legitimate liberal model of multiculturalism, group leadership should become diverse and composed of women's voices as well as men's voices.⁴⁶ When working with group rights, special attention should be given to within-group inequalities. Although Kymlicka and Okin disagree on the overall importance of cultural rights, both agree that tension exists among women's rights and group rights. Other authors such as Sally Engle Merry and Cowan et al. argue that cultural rights and women's rights are more complicated than simply being oppressive or not oppressive.⁴⁷ Group rights are needed to validate minority groups' world understandings and they can often empower women's rights.⁴⁸

Merry argues that posing the question of culture's rights versus women's rights is counterproductive to a meaningful discussion of human rights.⁴⁹ Cultural relativism is juxtaposed against universalism wherein culture is essentialized as traditional and stagnant. However, cul-

⁴³ Moller Okin, Susan. "Mistresses of Their Own Destiny: Group Rights, Gender, and Realistic Rights of Exit." *Ethics* 112.2 (2002): 205-230.

⁴⁴ Moller Okin, Susan. "Is Multiculturalism Bad for Women?"

⁴⁵ Ibid.

⁴⁶ Moller Okin, Susan. "Mistresses of Their Own Destiny: Group Rights, Gender, and Realistic Rights of Exit." 205-30.

⁴⁷ Merry, Sally Engle. *Human Rights and Gender Violence : Translating International Law into Local Justice*. (Chicago: University of Chicago Press, 2006).

⁴⁸ Stamatopoulou, Elsa "Taking Cultural Rights Seriously: The Vision of the UN Declaration on the Rights of Indigenous Peoples", 387-412.

⁴⁹ Merry, Sally Engle. *Human Rights and Gender Violence : Translating International Law into Local Justice*.

ture is hybrid and can become a means of rearranging power dynamics and enhancing social action.⁵⁰ Cowan et al. state that instead of positing culture relativism versus universalism, we should see these tensions as “part of the continuous process of negotiating ever-changing and interrelated global and local norms.”⁵¹ Culture can therefore be used as a means to localize universal human rights. Taking advantage of culture as a strategy and space for social change provides a more flexible and hybrid way to approach human rights.⁵²

Similarly, essentializing culture as stagnant and as part of a national essence runs the risk of culture being used as an excuse to not intervene when human rights are being violated.⁵³ The fluidity of culture, and therefore the ability to change and critique, has the effect of protecting marginalized members of groups.

Midwifery is an important part of Mayan culture in the Yucatán Peninsula. Traditional birthing methods involve giving birth while on a hammock, burning the placenta, and other familial rituals.⁵⁴ Certain cultural factors such as having the husband, the mother, and the mother-in-law in the room during the birth are important to establish community.⁵⁵ When health clinics refuse to have culturally sensitive regulations, it alienates women from seeking medical help.⁵⁶ State health care policies create a hierarchical and authoritarian model of social relationships within the health care system where midwives are on the bottom rung.⁵⁷ When attended to in hospitals and clinics by Western-trained physicians and nurses, Mayan women claim mistreatment, scolding, language barriers, and a belittling of their cultural traditions.⁵⁸ However, as Jor-

⁵⁰Cowan, Jane K., Marie-Benedicte Dembour, and Richard A. Wilson. “Introduction.” 1-20.

⁵¹ Ibid, 6.

⁵² Merry, Sally Engle. *Human Rights and Gender Violence : Translating International Law into Local Justice*.

⁵³ Merry, Sally Engle. *Human Rights and Gender Violence : Translating International Law into Local Justice*.

⁵⁴ Jordan, Brigitte. *Birth in four cultures*. (Montréal: Eden Press, 1983).

⁵⁵ Ibid.

⁵⁶Ibid.

⁵⁷ Huber, Brad R., et al. *Mesoamerican healers*.

⁵⁸ Ibid.

dan's ethnographic research found, the culture behind birthing changes as time progresses. Culture is not stagnant; rather, it evolves as communities evolve.⁵⁹

Carey's research argues that through midwifery, women contest gender roles and assimilation by keeping their traditions alive.⁶⁰ Mayan midwives gain their titles because they are chosen by fate through dreams, sicknesses, and/or being born on specific days. Since they are chosen by a higher power, they are often seen as having spiritual powers themselves.⁶¹ Midwives are not passive contributors to their community, as they gain a certain respected status for contributing in such a vital way. These women are revered, often becoming godmothers in the children's baptism, and they are respected throughout town.⁶² Several midwives take such positions only once they are widowed out of economic necessity, and also because this profession can take a toll on their marriage. These women contest prescribed gender roles by being independent and powerful within their community.⁶³

My research aims to understand the fluidity of culture to provide another example where cultural rights can be beneficial for women's rights. In the reproductive rights context, midwifery provides more people qualified to assist with women's health needs. In addition, midwifery is a cultural practice that provides a space to challenge gender roles and norms. Like Merry argues, culture is flexible and therefore able to support the feminist agenda, especially if women are at the forefront of cultural rights demands.⁶⁴

Framework

This research will be explained through two theoretical frameworks. The first framework is that Indigenous peoples are subject to structural violence through health policies. Structural violence is defined by Quesada et al. and Paul Farmer as "indirect violence built into repressive

⁵⁹ Jordan, Brigitte. *Birth in four cultures*. 3rd ed. Montréal: Eden Press, 1983. Print.

⁶⁰ Carey, David. *Engendering Mayan history: Kaqchikel women as agents and conduits of the past. 1875-1970*.

⁶¹ Ibid.

⁶² Ibid.

⁶³ Ibid.

⁶⁴ Merry, Sally Engle. *Human Rights and Gender Violence : Translating International Law into Local Justice*.

social orders creating enormous differences between potential and actual human self realization.”⁶⁵ Structural violence is different than institutional violence because it does not have to be traced to a specific institution. Human vulnerability to structural violence depends on their location in hierarchical societies and in relation to its diverse powers.⁶⁶

Leyva-Flores et al. states that Mexican Indigenous peoples constitute 7 percent of the Mexican population in 2010 and 44.2 percent of them are residing in Indigenous municipalities that suffer from extreme levels of poverty. In 2010, research showed that the infant mortality rate was 63 percent higher among Indigenous communities as compared to non-Indigenous ones.⁶⁷ According to Pelcastre-Villafuerte et al., “Indigenous women constitute a subgroup of the Mexican indigenous population with the highest lag in health status. As three kinds of discrimination converge—ethnic, gender and class—... [these correlate] to this triple subordination”.⁶⁸

The second theoretical framework this paper will employ is Indigenous Latin American Feminism offered by Bastian.⁶⁹ Indigenous feminism in Latin America differs from liberal feminism because their demands are both collective and individual. Mayan women feminist organizations are at the forefront of identity politics, political exclusion, antiracist policies, and cultural discrimination. Indigenous feminists often critique liberal feminism for responding to the needs of white, mestiza, urban upper- and middle-class women while simultaneously imposing concepts and methodologies removed from Indigenous women’s realities. My research and thesis is based on an Indigenous Feminist framework, one that privileges cultural rights equally to women’s rights.

Finally, for my personal framework when doing research and writing my thesis, I must keep in mind the continuous issues of speaking for others and essentialism. Using the theories provided by Alcoff, power dynamics persist in telling the narratives, hearing the narratives and

⁶⁵ Quesda, James, Kain Hart, Laurie, and Bourgois, Philippe. “Structural Vulnerability and health: Latino Migrant Laborers in the United States.” *Medical Anthropology* 11.4. (2011):339.

⁶⁶Farmer, Paul. “On suffering and structural violence: A view from below”. In *Daedalus*, 125.1. (1996): 261-283.

⁶⁷ Leyva-Flores, R., Servan-Mori, E., Infante-Xibille, C., Pelcastre-Villafuerte, B., & Gonzalez, T., “Primary Health Care Utilization by the Mexican Indigenous Population: The Role of the Seguro Popular in Socially Inequitable Contexts”, 1-6.

⁶⁸ Pelcastre-Villafuerte, Blanca, Myriam Ruiz, Sergio Meneses, Claudia Amaya, Margarita Márquez, Arianna Taboada, and Katherine Careaga, “Community-based health care for indigenous women in Mexico: a qualitative evaluation.”³

⁶⁹ Bastian Duarte, Ángela Ixkic. “From the Margins of Latin American Feminism: Indigenous and Lesbian Feminisms”. *Journal of Women in Culture and Society*, 38.1. (2012):153–178.

then sharing them.⁷⁰ Socio-economic class, gender, and ethnic differences between the participants and myself provide dynamic structures that need to be addressed early on in the research. The results of this research do not essentialize all Indigenous women or all Mayan women. These are specific experiences and the contexts of specific individuals and instances.

⁷⁰ Alcoff, Linda. "The Problem of Speaking for Others." *Cultural Critique*, 20 (1991): 5-32.

Methodology



This research relies heavily on a qualitative methods approach. In 2014, I spent five weeks in Saban, Tulum, Xanlah, Chumbec, and Campeche conducting research on obstetric violence. It was through these interviews and experiences that I understood who formed the backbone of reproductive and women’s empowerment in these communities: midwives. I returned in the summer of 2016 and spent four weeks predominately in five communities—Saban, Campeche, Tulum, Xanlah, and Chumbec—conducting ethnographic research on midwifery, reproductive rights, and women’s rights.

In all of the communities except for Tulum and Campeche, I stayed with a midwife and/ or activist fighting for maternal safety. It was through them that I was able to enter peoples’ homes and facilitate informal interviews that allowed me to discuss controversial and taboo subjects such as sex, gender, and reproductive rights. Most of the interviews were conducted while *torteando*, making tortillas, in the kitchen, or conducting other household chores. Some commu-

nities such as Tulum, in the state of Quintana Roo, have a population of almost 15,000 people, while others such as Chumbec, in the state of Yucatán, have a population of only 237 people.⁷¹⁷² Due to the smaller nature of communities such as Saban, Xanlah, and Chumbec, I went to communities nearby for day trips to interview midwives, mothers, and activists in the area. In the end, I conducted interviews in Jose Maria Morelos, Saban, X-Querol, Tulum, Xanlah, Chankom, Ticimul, Chikindzonot, Pochichen, Chumbec, Kantunil, Sudzal and Campeche.

It was important for me to develop relationships with the communities and the women leaders to reduce reactivity or people changing their behavior because they are being studied or saying what they think I want to hear.⁷³ According to Russell, through presence in a community, trust is built, and this trust lowers reactivity. In turn, there is an increase in the validity of the data collected.⁷⁴ My presence in the homes of the participants allowed me to ask sensitive questions and develop trust.

All of the women interviewed for this research identify as Mayan or mestizas and were either mothers, midwives, and/or activists fighting for maternal safety. Typically, mestizo refers to the mixing of the Mayans and the Spaniards. However, the participants used “mestizo” interchangeably with “Mayan,” and therefore this paper will use it synonymously acknowledging that there is no “pure” race. All of the women spoke fluent Mayan and varying levels of Spanish. Their ages ranged from 25 to 88 years. Only two of the participants had attended college. All but one of the midwives had taken some sort of course regarding birth. For the purposes of this research the terms “traditional/Indigenous midwives” and “midwives” in general refer to “Mayan midwives” unless otherwise mentioned. All of the participants were asked if they would like to have a pseudonym or be identified in the research by their name. All of them said they wanted their name and community to be explicit. These are the names of the people interviewed for this

⁷¹ “Tulum-Quintana Roo,” *Nuestro Mexico*. <http://www.nuestro-mexico.com/Quintana-Roo/Solidaridad/Tulum/>. (Accessed December 5, 2016).

⁷² “Chumbec,” *Mexico Pueblos America*, <http://mexico.pueblosamerica.com/i/chumbec-2/>. (December 5, 2016).

⁷³ Russell Bernard, H. *Research Methods in Anthropology: Qualitative and Quantitative Approaches*. (Lanham: Altamira Press, 2006.)

⁷⁴ *Ibid.*

thesis and their communities:

Yucatan

- Mirna Aracely Tuz Acosta- Xanlah
- Rafaela Can Ake- Chumbec
- Felipa Moo Cahum- Chikindzonot
- Germina Patlo- Chikindzonot
- Maria Del Carmen May-y-Batù- Ticimul
- Maria Ofelia Mix Can- Chankom
- Marta Lucia Camal Mix- Chankom
- Juana Mix- Chankom
- Neyi Amparo Cime Arseo- Xanlah
- Rufina Kantun Batun-Pocbichen
- Maria Carmen Sanchez- Kantunil
- Maria Ines Navarro Yah- Kantunil
- Irene Coco Cahuich- Sudzal
- Elijia Concepcion Chan Ortega- Sudzal
- Perfecta Socorro Yah Navarro -Xanaba
- Dulce Maria Villegas Ojeada- Kantunil
- Maria Eulalia Parra Pech - Chumbec
- Cynthia Rebecca Canche Parra- Chumbec
- Gilda Raquel Cache Parra- Chumbec

Quintana Roo

- Maria Elide Chan Chan- Saban
- Manuela Dzul Batún- Jose Maria Morelos
- Maria Imelda Cohuo- Xquerol
- Sabrina Speich- Carillo Puerto/ Tulum
- Elodia Catzim- Tulum

Campeche

- Argentina Casanova- Campeche
- Isabel Margarita Pech Ku- Campeche

It was important to conduct unstructured interviews because, as an outsider, I did not want to mold the answers and testimonies. According to Russell Bernard, unstructured interviews follow a pre-planned list of questions however they are “characterized by a minimum of control over the people’s responses. The idea is to get people to open up and let them express themselves in their own terms, and at their own pace.”⁷⁵ I chose unstructured interviews because of the sensitivity of the issues at hand. Interviews were conducted in Spanish, voice recorded, and then transcribed and translated by me.

In addition to unstructured interviews, I chose to take a participant observation approach on one occasion. I conducted participant observation during a meeting of twelve midwives while they were completing a grant application for a Mexican NGO. Participant observation allowed me to collect qualitative data on things I heard and saw in a natural setting without interfering.⁷⁶ Because participant observation can be a harmful and insensitive methodology that has historically “othered” Indigenous communities, I only used participant observation on one occasion.⁷⁷ Participant observation “involves getting close to people and making them feel comfortable enough with your presence so that you can observe and record information about their lives.”⁷⁸ Consent is therefore blurred since people might be saying or behaving a certain way, forgetting your role as an investigator. To make sure participants consented to this particular method, I only used this methodology during a midwife meeting in Kantunil about submitting an NGO grant application. I told the participants I would be sitting in the back listening to their conversations

⁷⁵Russell Bernard, H. *Research Methods in Anthropology; Qualitative and Quantitative Approaches*. 211.

⁷⁶ Ibid.

⁷⁷ Ibid.

⁷⁸ Ibid. 342

without interfering. They were informed that I would be writing things down, and they would not be associated with any one idea or thought since names would not be identified with what was being said. The 12 participants verbally agreed and started the two-hour conversation and grant proposal process as I took notes. As a *complete observer* in participant observation, I recorded discussions, ideas, and behaviors without any involvement in the meeting.⁷⁹ I was invited to the meeting because of my relationship with the leader of the group, Doña Rafa, with whom I was staying in that community.

Several limitations of my research should be considered. First, as a foreigner, a couple of women declined to speak to me regarding their personal lives. Due to the constant colonial power dynamics between foreigners and Indigenous peoples, it was important for me to respect those who declined to speak to me. To relieve this issue, I used the snowball sampling method in order to get interviews.⁸⁰ Before I arrived to each community, I had organized only one interview and asked the woman I planned to interview to recommend other women to talk and share their stories with me. Through this method, women who came to me already knew another person in the community that had trusted me with their story. Using word of mouth to get my research explained to women I did not yet know was important in establishing trust in the community.

Another limitation was my inability to speak Mayan. Unfortunately, I had to decline a couple of interviews due to the language barrier. In addition, several anatomical words or expressions would be said in Mayan during the interviews, which are lost in the transcriptions. It is important to note that many expressions are lost when translated to the colonial tongue and academic spaces privilege certain languages over others.

Finally, my outsider position—being of a different ethnicity and socio-economic class—was also a limitation. People were aware I came from the U.S. and had idealized notions of Mexican-Americans. My Spanish accent, stemming from years of living in Mexico City, is one often presumed as privilege. My positionality as someone from the U.S. from a certain socioeconomic class could have been a factor limiting what was told to me and how these stories were shared.

⁷⁹Russell Bernard, H. *Research Methods in Anthropology: Qualitative and Quantitative Approaches*.

⁸⁰ *Ibid.*

It is important to note that the research collected during the fieldwork are the perspectives, narratives, oral histories, and testimonies of the women I was able to talk to. Their perceptions are guided by their experiences and should not be taken as objective truths. Needless to say, this does not negate their validity. According to Alessandro Portelli, “there are no 'false' oral sources.... oral history consists in the fact that 'untrue' statements are still psychologically 'true', and that these previous 'errors' sometimes reveal more than [a] factually accurate account.”⁸¹ Indigenous peoples, people of color, and other marginalized communities’ perspectives are often not perceived as having scientific or legal validity because they come from oral histories or personal experiences.⁸² Even if testimonies included in this research may include “untrue” facts, their existence proves sentiments of racism, oppression, and gender inequality as lived experiences. Oral histories as a method of research are usually belittled and assumed to not fit the Western paradigm of research.⁸³ This has segregated people’s voices from academia. This research validates these midwives’ stories as worthy of academic spaces while realizing the biases that exist in all of our perspectives and lived realities.

⁸¹ Portelli, Alessandro “The Peculiarities of Oral History” *Oxford Journal* 12.1 (1981): 100.

⁸² Ibid.

⁸³ Ibid.

Reproductive Needs and Obstacles

Over the past two decades, the Yucatán Peninsula, encompassing the states of Campeche, Yucatán, and Quintana Roo, has been subject to rapid growth due to the tourism business.⁸⁴ Tourism has led to several social changes from migration to big tourist cities like Cancun and Tulum, to the rapid increase of sexually transmitted diseases.⁸⁵ Traditionally agricultural communities have been displaced as men have migrated to wage-earning jobs popular in tourist areas. Simultaneously, the exploitation of the Mayan identity as a tourist attraction has shifted identity politics.⁸⁶ Regarding medical access, tourism has brought greater access to privatized hospitals and clinics to some regions, but in more segregated areas where tourism is still non-existent, there seems to have been little to no progress in terms of access to medical care. Every woman I spoke with listed economic difficulties as an obstacle to their reproductive care, followed by lack of transportation. This chapter will discuss the inaccessibility and unavailability of medical care in all of the communities this author visited in the Yucatán Peninsula. Economic impediments, lack of accessible transportation, and lack of culturally sensitive health resources are just some of the obstacles Mayan women experience when fulfilling their reproductive needs.

In a conversation with Ime, a 24 year old maternal health activist from X-Querol, I asked why she did the work she did.⁸⁷ She shared with me the story of her sister-in-law whose blood pressure rose dramatically in the middle of the night when she was eight months pregnant. Coming from a community of less than 200 people meant there was no access to cars, ambulances or other modes of transportation. Because the only local midwife had passed away, there was no one left to assist in her delivery. She had to ride her bike to Sacalaca, a distance of 6.4 km, where she found someone who could drive her to the town of Jose Maria Morelos. After the hour and a half car ride to the municipality, the doctors there found the complications she was experiencing

⁸⁴ Pi-Sunyer, Oriol. and R. Brooke Thomas, "Tourism and the Transformation of Daily Life Along the Riviera Maya of Quintana Roo, Mexico." *The Journal of Latin American and Caribbean Anthropology*, 20 (2015):87–109.

⁸⁵ Cantú, Lionel. "De ambiente: Queer tourism and the shifting boundaries of Mexican male sexualities." *GLQ: A Journal of Lesbian and Gay Studies*, 8.1. (2002):139-166.

⁸⁶ Pi-Sunyer, Oriol. and R. Brooke Thomas, "Tourism and the Transformation of Daily Life Along the Riviera Maya of Quintana Roo, Mexico."

⁸⁷ Maria Imelda Cohuo, X-Querol, August 22, 2016.

were too grave for the clinic and she had to find transportation to go to Carillo Puerto. Ime's niece was born in Carillo Puerto but eight days later, after being transferred one last time to Chetumal, Ime's sister-in-law died of complications in the hospital.⁸⁸

Stories like this were common in my interviews. Women constantly said that transportation was one of the biggest impediments to reproductive health care access. In Saban, according to Doña Elide, the one ambulance that is available costs around 900 pesos for one trip, making it virtually impossible to be used.⁸⁹ Several of the older generation of midwives claimed they became midwives because their day of labor came and they had to learn how to give birth simply from experiencing it on their own.⁹⁰ Today, most of that generation has stopped practicing either because of policy controls set by the government or the recent criminalization of midwives. Doña Rufina from Pochbuchin says she stopped assisting births when the doctors came to her community and told her if she continued doing her "magic" and something went wrong, they would fully prosecute her.⁹¹ Even though she knows doctors have no jurisdiction to prosecute her, the belittlement of her knowledge and the threat to her safety made her stop practicing her profession. However, she says she could never stop helping someone in need and so women come to her when their contractions begin so that she can massage the baby in a position that will last the length of the car ride from Pochbuchin to the nearest clinic in Chikindzonot.

According to Doña Rafa, if a pregnant woman in Chumbec wants or needs to give birth in a hospital, the doctors provide the pregnant woman with a sheet indicating which hospital and which "waiting home" she should stay in for the days leading up to her labor in Izamal.⁹² The insurance company pays for the stay in the "waiting home," but the women are left without the company of their families or loved ones. Doña Rafa mentioned how only few women had the luxury of leaving their families long enough to stay in "waiting homes" weeks in advance and,

⁸⁸ Maria Imelda Cohuo, X-Querol, August 22, 2016.

⁸⁹ Maria Elide Chan Chan, Saban, August 23, 2016.

⁹⁰ Rufina Kantun Batun, Pochbichen, September 3, 2016.,
Juana Mix, Chankom, September 1, 2016

⁹¹ Rufina Kantun Batun, Pochbichen, September 3, 2016.

⁹² Rafaela Can Ake, Chumbec, September 8, 2016.

even if they were able to do so, they claimed it was a lonely hospitalized stay leading up to the birth.⁹³ While validating the experiences and feelings women feel when separated from their community, this is a step certain clinics take in order to solve the lack of transportation as an obstacle. By keeping pregnant women close to the hospital they ensure greater accessibility to their services.

In addition to the limited access to transportation, respondents argued there was also a lack of availability within the medical resources provided by the state. In towns like Jose Maria Morelos, Saban, Chankom, Xanlah, and Chikindzonot, which were large enough to have a clinic, the hours the government-sponsored clinic was open was limited to 11am to 3pm Monday through Friday.⁹⁴ The clinics are not there to assist women who went into labor at night or on the weekend, or have any other unscheduled emergencies.⁹⁵ The doctors who come to work at these clinics are *pasantes* (people that pass by), spending one or two months in the community to do their social service after having gone to medical school elsewhere. Rarely did a doctor speak Mayan, nor did they stay for more than their allotted time.⁹⁶ As Margarita said, “they learn and practice on our bodies.” Margarita shared that after they had given her the epidermal shot and she was not fully conscious, several students touched her vagina without her consent. She said these students did not know what they were doing to her and ended up hurting her.⁹⁷

⁹³ Ibid.

⁹⁴ Maria Elide Chan Chan, Saban, August 23, 2016.
Maria Ofelia Mix Can, Chankom, September 1, 2016
Germina Patlo- Chikindzonot, September 3, 2016
Rafaela Can Ake, Chumbec, September 8, 2016.
Mirna Aracely Tuz Acosta, Xanlah, September 2, 2016
Maria Imelda Cohuo, X-Querol, August 22, 2016.

⁹⁵ Maria Elide Chan Chan, Saban, August 23, 2016

⁹⁶ Isabel Margarita Pech Ku, Campeche, August 25, 2016

⁹⁷ Isabel Margarita Pech Ku, Campeche, August 25, 2016

Several women mentioned how common it was to give birth in hospital bathrooms, parking lots, or hallways.⁹⁸ Mayan women who arrive at hospitals or clinics are often told to go back home because there are no beds or resources for them. Women are also sent home if they do not have health insurance. Margarita stated that:

“The violence is so institutionalized that health insurances have names normalizing it. For example, a *camazo* is the insurance name for someone who gave birth in a hallway or hospital yard where the conditions aren’t sanitary for the birth of a child... Doctors often don’t want to provide service to Indigenous women because they lack insurance so they end up having children in inadequate spaces. The government forces doctors to attend women regardless of their insurance but several women do not know their rights.”⁹⁹ It is common across other states in Mexico for Indigenous women to give birth in hallways, bathrooms, parking lots, and other non hygienic places because they have been refused treatment due to lack of resources such as beds, racism, and payment options.¹⁰⁰

All women interviewed for this research mentioned economic limitations as the main obstacle in receiving medical care from hospitals or clinics. A vaginal birth in a hospital or clinic in the peninsula costs between 17,000 and 64,000 pesos, and if it is a cesarean section it is between 25,000 to 85,000 pesos depending on the location.¹⁰¹ To help provide some context for these numbers, as of 2015, Quintana Roo and Yucatán’s average daily salary was around 200 pe-

⁹⁸ Argentina Casanova- Campeche August 26, 2016,
Isabel Margarita Pech Ku, Campeche, August 25, 2016
Elodia Catzim, Tulum, August 30, 2016.
Sabrina Speich, Tulum, August 29, 2016.
Rafaela Can Ake, Chumbech, September 8, 2016.

⁹⁹ Isabel Margarita Pech Ku, Campeche, August 25, 2016 “Ya esta tan institucionalizado que en el seguro hasta nombres para normalizar la violencia. Por ejemplo dicen que la mujer dio el “camazo” que es cuando una mujer de a luz en el pasillo o en el patio del hospital que son condiciones no aptos para el nacimiento de un bebe. Aunque el hospital sea el mas igienico hay lugares para tener los bebes y las mujeres tienen que ser atendidas y no dejarlas tener a los bebes en el patio. A veces los doctores no quieren atender a mujeres indigenas porque no tienen seguro entonces terminan teniendo hijos en lugares no adecuados. El gobierno fuerza a los doctores a atender a las mujeres tengan o no seguro pero muchas mujeres no saben ese derecho.”

¹⁰⁰ “Le niegan atención y da a luz afuera de hospital en Oaxaca,” Noticieros Estados, Televisa. January 27, 2014, <http://noticieros.televisa.com/mexico-estados/1401/nace-otro-bebe-afuera-hospital-oaxaca/>. (accessed December 7, 2016).

“Mujer indígena de la luz en la calle, frente a hospital de Ayutla,” Excelsior. November 10, 2013 <http://www.excelsior.com.mx/nacional/2013/10/11/923053>. (accessed December 7, 2016)

Lago, Gabriel, “Cigüena adelantada: bebés nacen fuera del hospital,” Azteca Noticias, Azteca. October 4, 2013. <http://www.aztecanoticias.com.mx/notas/estados/170047/cig%C3%BCena-adelantada-bebes-nacen-fuera-del-hospital>. (accessed December 7, 2016).

Matias, Pedro, “Irma, la indígena mazateca que parió en el patio de un hospital,” Proceso. October 4, 2013. <http://www.proceso.com.mx/354510/irma-la-indigena-mazateca-que-pario-en-el-patio-de-un-hospital>. (accessed December 7, 2016).

Thomas, Lupita, “Mujer indígena da a luz en baño de hospital,” El Universal, January 16, 2015. <http://archivo.eluniversal.com.mx/estados/2015/impreso/mujer-indigena-da-a-luz-en-banio-de-hospital-97503.html>. (accessed December 7, 2016).

¹⁰¹ “¿Sabes cuánto cuesta tener un bebé en Cancún?” Novedades Quintana Roo, November 15, 2014, <http://sipse.com/novedades/exhortan-a-planear-antes-de-concebir-un-hijo-123016.html>. (accessed December 7, 2016).

sos while Campeche's was 400 pesos (due in part to Campeche's oil industry).¹⁰² This does not take into account that salaries differ greatly based on high tourism in certain areas. Government insurance companies such as IMSS or ISSSTE can fully or partially cover the costs under certain conditions but the price disparity to midwives is still significant. Doña Felipa from Chikindzonot charges 400 pesos or whatever the family can provide.¹⁰³ Similarly, Doña Elide charges 400 pesos including the physically tiring work of coaching through the labor, massaging the woman every three days for a month post-birth, and on the eighth day tying the mother up so her body returns back to "normal."¹⁰⁴

Doña Rafa from Chumbec charges between 1,000 to 2,000 pesos for her labor. She said half of her clients are Mayan women from around her community and the other half are upper/middle class women from the capital of Yucatán, the city of Mérida. For the women residing in Mérida she charges more, while for the women in Chumbec and other Mayan communities she sometimes does not charge anything at all or receives other gifts such as livestock for her service.¹⁰⁵ Midwife Sabrina from Tulum is in a similar situation: whereas before 2005 she said she assisted mostly Mayan births and no foreigners, today it is the opposite.¹⁰⁶ Most of her clients are usually international foreigners coming to Tulum to give birth with the help of a traditional Mayan midwife. Because of the rapid change in client demographics, she charges 15,000 pesos and will only work with the assistance of a gynecologist. Sabrina says that after 2005, midwives began to be incarcerated for birthing accidents and blamed for the state's maternal and neonatal mortality rate. As a result, to maintain her profession, she only assists births with the help of her business partner, a gynecologist.¹⁰⁷ Sabrina is one of the many midwives who advocated for a greater link between doctors and midwives working together to provide better ser-

¹⁰² Instituto Nacional de Estadística y Geografía. *Encuesta Nacional de Ocupación y Empleo (ENOE) 2015*. <http://www.beta.inegi.org.mx/app/biblioteca/ficha.html?upc=702825070366> (accessed December 7, 2016)

¹⁰³ Felipa Moo Cahum Chikindzonot, September 3, 2016

¹⁰⁴ Maria Elide Chan Chan, Sabán, August 23, 2016.

¹⁰⁵ Rafaela Can Ake, Chumbec, September 8, 2016.

¹⁰⁶ Sabrina Speich, Tulum, August 29, 2016.

¹⁰⁷ Ibid.

vices. The cost between 17,000 pesos and 400 pesos differs greatly. In the end, however, most of the midwives interviewed said they never turned down a patient due to economic difficulties. Doña Rafa says it is not uncommon for families to owe her money for the birth when the child is already in high school.¹⁰⁸ Such economic leeway is not possible at hospitals or with insurance companies.

It is important to note that around 90 percent of the women interviewed reported being *Prospera*, previously *Oportunidades*, beneficiaries. This is not surprising considering it is the most popular program among Indigenous peoples in Mexico.¹⁰⁹ As *Prospera* beneficiaries, women received a monthly stipend for each child if the family follows certain conditions like attending a state clinic regularly while pregnant. Although this program was created to provide economic support, empowerment, and health services to women and children, it has had the unintended consequence of disempowering women by alienating health promotion from a women's choice to a state-sponsored agenda.¹¹⁰ As the medical business booms, the state and private medical companies have an incentive to medicalize otherwise natural procedures by defining what is healthy and what is unhealthy and in need of institutional intervention.¹¹¹ For example, institutions construct norms of who is sane or insane and therefore needing either a mental facility or prison, which increases lucrative gains for the elites running these institutions.¹¹² Using such a theory, one could argue that by pushing and forcing beneficiaries of *Prospera* to have hospital births, the state and its elites make capital gains in medicalizing the birth process. According to Sabrina, Elodia, Imelda and Doña Rafa, *Prospera* is one of the main avenues through which midwifery has been criminalized and is becoming increasingly extinct.

¹⁰⁸ Rafaela Can Ake, Chumbec, September 8, 2016.

¹⁰⁹ Pelcastre-Villafuerte et al., "Community-based health care for indigenous women in Mexico: a qualitative evaluation."

¹¹⁰ París-Pombo, María Dolores, "Health Promotion and Gender Power in the Oaxaca Mixteca." *Agricultura, Sociedad y Desarrollo Enero-Junio*, (2008):53-69.

Smith-Oka, Vania, "Unintended consequences: Exploring the tensions between development programs and indigenous women in Mexico in the context of reproductive health"

¹¹¹Hanna, Bridget and Arthur Kleiman, "Unpacking Global Health: Theory and Critique" in *Reimagining Global Health: An Introduction*, ed. Paul Farmer, Arthur Kleinman and Jim Kim. Berkeley/Los Angeles: University of California Press, 2013.

¹¹² Ibid.

Prospera's website states

“The Program *Prospera* is the principal strategy by which the government deals with poverty in the country; attending 6.8 million beneficiary families who receive support in education, health, and food.... The main beneficiary of *Prospera*, usually the mother in the family or who is in charge of the home, has to comply with certain health and education responsibilities in order to receive the economic support... The responsibilities for health include: registering the whole family in the state corresponding health center, making sure that every family member attends medical appointments and that they assist community workshops on how to improve self health”¹¹³

Prospera's website says nothing regarding midwives' roles in providing birth, nor anything about supporting their profession.

During Sabrina's interview, she said that “in the communities, *Oportunidades* [now *Prospera*] erased midwifery because they gave them [women] monthly money only if they received the baby in the hospital. They would take the money away if they went with a midwife. It is incredible to what extent women will let themselves be manipulated for a couple of pesos. It is very sad.”¹¹⁴ Elodia, another midwife in Tulum, said: “*Seguro popular* {state insurance} made birthing free but *Prospera* forced and limited women.”¹¹⁵ Those who implement these programs, according to Sabrina and Elodia, treat Indigenous women badly by assuming they are dirty, non hygienic, and savages. Mayan women must absorb such violence in order to reap these limited economic benefits.¹¹⁶

Imelda, Elide, Mirna and Doña Rafa were a little less apprehensive when it came to *Prospera*. As Imelda put it, “*Prospera* is a good program because it helps mothers and children economically but it has its disadvantages. An advantage is that they can use the money for the

¹¹³ “Prospera: Programa de Inclusion Social” Gobierno Mexico, <https://www.gob.mx/prospera> (accessed December 7, 2016). “El Programa PROSPERA es la principal estrategia del Gobierno de la República para contrarrestar la pobreza del país; atendiendo actualmente a 6.8 millones de familias beneficiarias, que reciben apoyos de educación, salud y alimentación... La titular beneficiaria, que generalmente es la madre de familia o quien se hace cargo del hogar, deberá cumplir junto con la familia responsabilidades en salud y educación para poder recibir los apoyos monetarios... Las responsabilidades en salud con las que se deberán cumplir son: registrar a toda la familia a la unidad de salud que le corresponde, que cada miembro de familia acuda a las citas médicas y cumplan con la asistencia a los talleres comunitarios para el autocuidado de la salud.”

¹¹⁴ Sabrina Speich, Tulum, August 29, 2016.

“Que en los pueblos el programa de Oportunidades que arraso con la partería. Porque les dan dinero y le dicen tu beca mensual solo lo recibes si tienes el bebe en el hospital. Te quitamos el dinero si te vas con una partera. Es increíble el grado que las mujeres se dejan manipular por unos pesos. Es muy triste”

¹¹⁵ Elodia Catzim, Tulum, August 30, 2016.

“Luego el seguro popular tambien. El seguro popular les abrio el camino para que puedan parir gratis pero Oportunidades las oblige y las limite.”

¹¹⁶ Sabrina Speich, Tulum, August 29, 2016.

needs of their children, it's an economic support needed now when it is hard to receive an income. The disadvantage is that the government forces women to go to a hospital or else they get punished economically.”¹¹⁷ The good intentions of *Prospera* increase the popularity of the program. The program is a double-edged sword, as it can provide economic autonomy but restrict bodily autonomy. A more comprehensive approach that supports women's choices in their birthing method is therefore needed to fully support women's reproductive and economic needs.

According to a press statement published in May 2016 by IMSS (Instituto Mexicano Seguro Social), the collaboration between the Mexican social security and *Prospera* entitled IMSS-PROSPERA has trained more than seven thousand midwives to attend birth in rural and Indigenous communities in Chiapas, Veracruz, Puebla, Oaxaca and Hidalgo.¹¹⁸ The statement says that the teamwork between doctors and midwives helped reduce maternal mortality by training midwives in themes like infant health, a clean birth, gender perspectives, and maternal mortality.¹¹⁹ When asked about it, the midwives I interviewed stated they had never heard of *Prospera* providing training nor support to midwives.¹²⁰ Doña Rafa said IMSS used to support them but ended the program in 2008.¹²¹ This program, if widely implemented throughout Mexico, could prove to be a good sign and a step towards a more dynamic relationship between midwives and institutional health professionals.

Access to and achievement of the reproductive needs of people in Yucatán, Campeche, and Quintana Roo are complex in the differentiation of communities. In big tourist areas such as Tulum and Mérida, reproductive health has become privatized and prices for birth-related ser-

¹¹⁷ Maria Imelda Cohuo, X-Querol, August 22, 2016.

“la verdad prospera es un buen programa porque ayuda a las madres de familia a los niños en cuestiones económicas pero tiene sus desventajas. ventaja porque pueden comprar lo que necesitan los niños. es un apoyo ya que ahora esta difícil conseguir dinero. desventaja es que como es parte del gobierno obligan que vayan al hospital y tienen que ir al hospital todo el proceso o les ponen falta.”

¹¹⁸“El IMSS cuenta con más de siete mil parteras para la atención de mujeres en comunidades rurales e indígenas” IMSS Prensa, IMSS. May 5, 2016. <http://www.imss.gob.mx/prensa/archivo/201605/072> (accessed December 7, 2016).

¹¹⁹ Ibid.

¹²⁰ Maria Elide Chan Chan, Sabán, August 23, 2016.
Maria Imelda Cohuo, X-Querol, August 22, 2016.
Sabrina Speich, Tulum, August 29, 2016
Elodia Catzim, Tulum, August 30, 2016.

¹²¹ Rafaela Can Ake, Chumbec, September 8, 2016.

vices have soared. In smaller communities, reproductive necessities have either been ignored or restricted. Women living in communities such as Xanlah, X-Querol, Saban, and others face obstacles such as a lack of transportation, inaccessibility to state provided medical services, and economic limitations. In order to provide adequate health services, the state and its medical institutions need to provide available, acceptable, and accessible services in remote Indigenous communities. In addition, these institutions need to bridge greater bonds with midwives who are on the ground and can better support their communities.

Cultural Importance

*“El parto, es un evento cultural.
[Birthing, is a cultural event.]”*¹²²

When discussing women’s rights and cultural rights, culture is often addressed both in the CEDAW committee and the ICESCR as being negative to women’s human rights.¹²³ Women are often perceived as culture keepers in their private life while the state’s legal efforts are employed to regulate traditionally oppressive norms.¹²⁴ However, the positive effects of culture on women’s human rights and “its potential for changing women’s lives towards gender equality”¹²⁵ are often neglected. Discussions tend to forget that women not only live within culture but are also active participants in culture. Keeping in mind that culture can and is often dominated by men, women are still actors of creating, challenging, and maintaining culture.¹²⁶ In particular, spaces that are predominately run by women are shaped and adapted by women. Giving birth at home, with the assistance of a midwife, and/or with the support of women such as one’s mother and mother-in-law, holds a space of cultural importance for women created by women. Midwives in the Yucatán Peninsula are therefore crucial actors in the creation and maintenance of culture. The following chapter will discuss how and why midwifery is of cultural importance for the Mayan and mestizo community in the Yucatán Peninsula.

The professional pathway to becoming a midwife differed among women, communities, and experiences. Several midwives like Doña Elide, Doña Ofelia, and Doña Germina learned the trade as it was passed on from their foremothers.¹²⁷ Other midwives such as Doña Felipa and

¹²² Sabrina Speich, Tulum, August 29, 2016.

¹²³ Stamatopoulou, Elsa. *The Universal Declaration of Human Rights : Cultural Rights in International Law : Article 27 of the Universal Declaration of Human Rights and beyond.* (Boston: Brill | Nijhoff, 2007.)

¹²⁴ Ibid.

¹²⁵ Ibid. 131

¹²⁶ Merry, Sally Engle. *Human Rights and Gender Violence : Translating International Law into Local Justice.*(2006).

¹²⁷ Maria Elide Chan Chan, Sabán, August 23, 2016.
Maria Ofelia Mix Can, Chankom, September 1, 2016.
Germina Patlo- Chikindzonot, September 3, 2016

Doña Rafa learned midwifery through dreams. Doña Felipa, an 85-year-old midwife from Chikindzonot, remembers working in the field forty years ago when suddenly a marble hit her back.¹²⁸ She kept the marble, thinking it was a prank from the children running around in the field, but following the incident she started having high fevers and night terrors. She went to the town healer who told her the marble was a gift given to her by the Virgin Mary and that her symptoms would not subside until she began using her newly given gift. A couple of months later, she saw in her dreams how to assist births and she knew what her calling was.¹²⁹

Similarly, Doña Rafa recalls getting sick when she was 23-years-old and finding no explanation for her high fevers and migraines.¹³⁰ Months later, she dreamt that a man called her to assist his wife in the birth of their child. Doña Rafa said in the dream that she did not know how to help, but that she would call her husband to accompany the man to the nearest midwife. When she ran home she saw in the corner an old man sitting. Instinctively, Doña Rafa started crying and kneeled down beside the man, who placed his hand on her head. He told her, “Don’t fear. I’ll help you, but go because they are waiting for you.” In the dream, Doña Rafa then stood up and went to assist the birth, but when she looked back the man had disappeared. Following that initial dream, Doña Rafa began dreaming of instructions on how to assist births. Her skills, she claims, were given to her through dreams by the hands of God. Eventually, when doctors came to her community in search of a “health auxiliary” they had a town meeting and people elected her to get official medical training. At first she denied, saying she barely spoke Spanish, did not know how to read, and had five toddlers at home. Eventually, with the support of her husband who taught her to read and write in Spanish, she found the strength to go to the capital and be trained. Her one-year training was cut short when the doctor told her that she already knew everything by the eighth month. She was the only midwife of the group who was given the certificate early. The

¹²⁸ Felipa Moo Cahum Chikindzonot, September 3, 2016

¹²⁹ Felipa Moo Cahum Chikindzonot, September 3, 2016.

¹³⁰ Rafaela Can Ake, Chumbec, September 8, 2016

doctor assumed she had learned from her grandmothers, but little did they know that Doña Rafa had learned everything she knew from her dreams.¹³¹

Although dreams and religious miracles are common midwifery stories, many midwives learned their profession because it was passed on through the generations. Marta, a 31-year-old mother of three living in Chankom, is slowly learning how to *sobar* (massage) pregnant women in order to place the fetus correctly.¹³² Marta is learning from her mother, Doña Ofelia, a 60-year-old prominent midwife in Chankom, who in turn learned from her mother, Doña Juana. As of now, her family has passed on the gift of midwifery through four generations, making it an important aspect of their identity as a family.¹³³ Doña Juana originally learned midwifery out of necessity, due to the lack of medical services in her community. She thought it was important to teach at least one of her daughters to prepare them in case of an emergency.¹³⁴ On the other hand, Doña Ofelia claims she is teaching her daughter because she fears the profession is dying out.¹³⁵ Doña Ofelia worries that if midwives become extinct and the state health services continue to be unreliable, women will be left to suffer the consequences. In addition, Doña Ofelia is grateful for the trade because it has provided an income for her and her family in the hardest of times. By training her daughter Marta, she is also providing her with a sustainable income.¹³⁶

Through these narratives, I found that stories concerning how and who becomes a midwife stem from deep cultural traditions, religious associations, and identity politics. In their communities, midwives are respected as second mothers, godmothers, miracle workers, or religiously gifted healers. Their roles in their communities are created and contested by women, privileging them to protect both their reproductive rights and cultural rights. Women's testi-

¹³¹ Rafaela Can Ake, Chumbec, September 8, 2016

¹³² Marta Lucia Camal Mix, Chankom, September 1, 2016

¹³³ Maria Ofelia Mix Can, Chankom, September 1, 2016.

¹³⁴ Juana Mix, Chankom, September 1, 2016

¹³⁵ Maria Ofelia Mix Can, Chankom, September 1, 2016.

¹³⁶ Ibid.

monies proved midwives hold cultural importance and when their knowledge is belittled, their culture is equally belittled.

It is important to note that culture is not homogenous as these communities differed in size, location, politics, and more. Yet this author discovered several similarities between the roles held by midwives in many different areas, as they appeared through narratives and conversations. For example in Xanlah, midwifery was for the most part extinct as the elder midwives were physically unable to assist in the strenuous work of labor.¹³⁷ In Xanlah and Jose Maria Morelos, younger generations would often tell me I was following an already extinct culture common in their mother's generations, however all of them and their friends had some contact with a midwife before giving birth.¹³⁸ Although midwives in their communities were not assisting during the births anymore, they were active participants in the pregnancies. Mirna said her mom always thought her daughters would give birth like she did, at home and with a midwife. As Mirna said,

“Not so much has the culture changed, but the laws changed as they did not permit midwives to register live or still births, and this prohibited the continuation of tradition. Yet all of my sisters and I think it is still important that a midwife massages you. They help you. For example, a doctor can see your ultrasound and make sure the baby is ok but they cannot adjust the baby in the right position so during birth you are not as tired. The midwife positions the baby so your legs are liberated. Even though I had to attend a monthly consult [because of *Prospera*] I also went with the midwife. She was the first one to tell me the gender of my child.”¹³⁹

This recent phenomenon of combining the work of midwives and doctors to best serve the needs of women both culturally and medically seemed the most successful. As younger generations tend to have greater familiarity with doctors and health clinics, as opposed to their parents' generation, they have managed to build and reconstruct a culture that best serves their

¹³⁷ Mirna Aracely Tuz Acosta, Xanlah, September 2, 2016

¹³⁸ Mirna Aracely Tuz Acosta, Xanlah, September 2, 2016
Maria Imelda Cohuo, X-Querol, August 22, 2016.
Neyi Amparo Cime Arseo, Xanlah, September 2, 2016

¹³⁹ Mirna Aracely Tuz Acosta, Xanlah, September 2, 2016

“No tanto la cultura fue cambiando, sino que las leyes que ya no permiten a las parteras tener registro de vivo o muerto- eso sientes que impidió que siga esa tradición de partera! Pero todas nosotras, mis hermanitas y yo pensamos que es importante que una partera te talle – te ayuda, por ejemplo- un médico, vas a tu ultrasonido, te revisan, ven como esta el bebe, todo pero ellos no te pueden ayudar, porque si uno se cansa en el parto, porque uno se cansa! La partera te ayuda a acomodar el bebe, a que te liberen las piernas. Yo estaba en los dos lados, con control mensual y con la partera y la primera que me dijo que iba a ser mujer fue la partera.”

needs. They continue to respect and value the knowledge that midwives have while adapting to the state's demographic and reproductive programs and changing technologies.

The testimonies I collected reflected a deeper meaning and significance of midwives within communities. Midwives were not only there to assist births, but have the potential to provide other services like birthing massages, providing health advice, creating traditional medicine, reading cards, and making medical referrals.¹⁴⁰ All of the midwives interviewed considered the birthing massages to be the most important part of their work.¹⁴¹ They recommended mothers get massaged at least once a month during their pregnancies to accommodate the fetus and make their pregnancy less painful. In addition, several midwives grew plants in their backyard, which they used to make traditional medicine.¹⁴² Doña Manuela, an 82-year-old healer with midwifery experience, argued that her patients preferred her natural medicine because it was cheaper and more efficient than Western medicine. She would sell her medicine based on donations and whatever people could provide. Her father passed on his knowledge to her, and she claimed doctors often came to see her as, thereby validating her knowledge of plants and local remedies.¹⁴³

According to women's testimonies, another important aspect of a midwife's job is to refer people to doctors or emergency care. Doña Elide, Doña Manuela, and Doña Rufina all had stories to tell about men and women coming in due to pain and them discovering cysts or infections.¹⁴⁴ Midwives are able to detect early signs of fetus distress, diabetes and hepatitis and,

¹⁴⁰Manuela Azul Batún, Jose Maria Morelos, August 22, 2016
Maria Imelda Cohuo, X-Querol, August 22, 2016.

¹⁴¹ Maria Elide Chan Chan, Saban, August 23, 2016.
Manuela Azul Batún, Jose Maria Morelos, August 22, 2016
Rufina Kantun Batun, Poebichen, September 3, 2016.
Felipa Moo Cahum Chikindzonot, September 3, 2016
Germina Patlo- Chikindzonot, September 3, 2016
Mirna Aracely Tuz Acosta, Xanlah, September 2, 2016
Maria Ofelia Mix Can, Chankom, September 1, 2016.
Rafaela Can Ake, Chumbec, September 8, 2016.

¹⁴² Rufina Kantun Batun, Poebichen, September 3, 2016.
Manuela Azul Batún, Jose Maria Morelos, August 22, 2016

¹⁴³ Manuela Azul Batún, Jose Maria Morelos, August 22, 2016

¹⁴⁴ Maria Elide Chan Chan, Saban, August 23, 2016.,
Rufina Kantun Batun, Poebichen, September 3, 2016.
Manuela Azul Batún, Jose Maria Morelos, August 22, 2016

due to the cultural importance of their position in these communities, their medical referrals are taken seriously.¹⁴⁵ Imelda, a young aspiring midwife, mentioned that several people in her community refuse to go to hospitals because the space is associated with death.¹⁴⁶ Without the pressure and referral from a midwife, people would wait until it is too late to seek medical help. Community trust is therefore one of the biggest strengths midwives have, which can help bridge a link between doctors and health clinics.

In addition, community midwives are able to communicate fluently in Mayan and therefore understand the symptoms of the people they are treating.¹⁴⁷ Margarita recalls stories of people from her community that have had to wait for hours in hospitals until a translator can come and help them.¹⁴⁸ For that reason, midwife Doña Ofelia will accompany any of her patients to the doctor and serve as a translator if needed.¹⁴⁹ A midwife can therefore serve the role of advocating for Mayan speakers in health-related situations. Their position can help navigate as a link between state health care professionals and the community.

Health care workers often state that by identifying culturally important traditions and teaching staff “cultural competency,” health care workers will have a greater understanding of marginalized communities and can best serve these communities. However, recent research has proven that teaching “cultural competency” to medical students in the U.S. has promoted the “othering” of communities.¹⁵⁰ Instead of seeing cultural barriers that arise within structural forces, medical students are predominantly taught to label common assumptions as cultural barriers to health care.¹⁵¹ Metzl and Hansen “contend that medical education needs to more systematically train health-care professionals to think about how such variables as race, class, gender,

¹⁴⁵ Maria Imelda Cohuo, X-Querol, August 22, 2016.

¹⁴⁶ Maria Imelda Cohuo, X-Querol, August 22, 2016.

¹⁴⁷ Maria Imelda Cohuo, X-Querol, August 22, 2016.

¹⁴⁸ Isabel Margarita Pech Ku, Campeche, August 25, 2016

¹⁴⁹ Maria Ofelia Mix Can, Chankom, September 1, 2016.

¹⁵⁰ Metzl, Jonathan M. and Helena Hansen, “Structural competency: Theorizing a new medical engagement with stigma and inequality” *Social Science & Medicine*, 103, (2014):126-133.

¹⁵¹ Ibid.

and ethnicity are shaped both by the interactions of two persons in a room, and by the larger structural contexts in which their interactions take place. And, that as such, clinicians require skills that help them treat persons that come to clinics as patients, and at the same time recognize how social and economic determinants, biases, inequities, and blind spots shape health and illness long before doctors or patients enter examination rooms.”¹⁵² As this research has contested, attention to cultural competency is not enough when structures such as state-run institutions are not taken into account.

During her testimony, Doña Rafa argued that traditional midwives could provide cultural rituals doctors often belittle due to a lack of understanding of or knowledge about such traditions.¹⁵³ However, training or educating health care professionals on specific rituals poses the danger of defining a ritual without acknowledging its placement within structural institutions that historically marginalize Indigenous peoples. Using Metzl and Hansen’s theory, pushing for the identification of cultural Mayan rituals without a broader understanding of who, how and why medical institutions are the ones to define them, can potentially essentialize Mayan communities and further “other” them. Additionally, rituals, ceremonies, or traditions among communities are not homogenized. Whose “culture” would be validated and spoken for as “the Mayan identity” is worrisome. In addition, as midwife Sabrina said in her testimony, essentializing an act as a “Mayan ritual” serves to promote the image of ancient Mayans as opposed to contemporary people whose culture continues to adapt.¹⁵⁴

Rituals, ceremonies, and/or traditions fail to be homogenous among communities. For example, on the eighth day after a birth, Doña Elide ties a big cloth tightly over the patient’s body. From head to toe she wraps women in order to close and tighten their bodies after the birth.¹⁵⁵ A different cultural tradition important to Doña Ofelia and her clients is to bury the pla-

¹⁵² Ibid. 127.

¹⁵³ Rafaela Can Ake, Chumbec, September 8, 2016.

¹⁵⁴ Sabrina Speich, Tulum, August 29, 2016.

¹⁵⁵ Maria Elide Chan Chan, Saban, August 23, 2016.

centa so the baby has a connection with the land.¹⁵⁶ Doña Rafa, on the other hand, encourages her patients to eat their placenta in a milkshake for health purposes.¹⁵⁷ Midwife Elodia recommends her patients put the placenta on their faces to rejuvenate their skin.¹⁵⁸ These cultural traditions are specific to communities, to individual people, and even to specific instances. Doctors are expected to be culturally competent and respect these traditions, however when these traditions fail to be homogenous, it is harder to fight for them collectively. Sabrina and Elodia are concerned that if these cultural rituals are institutionalized, Mayan people will be further essentialized and “othered”. The lack of flexibility in hospital regulations constrains women’s diverse and specific cultural traditions and needs. Midwives can help advocate for those spaces and protect what is important for each individual woman’s cultural needs.

¹⁵⁶ Maria Ofelia Mix Can, Chankom, September 1, 2016.

¹⁵⁷ Rafaela Can Ake, Chumbec, September 8, 2016.

¹⁵⁸ Elodia Catzim, Tulum, August 30, 2016.

Obstacles in birth, obstacles in culture: Human rights violations

The previous chapters have demonstrated the reproductive needs and obstacles of people in the Yucatán Peninsula followed by an understanding of the cultural importance of midwifery. This chapter will analyze how the common narratives of the women interviewed for this research constitute human rights violations. Obstetric violence and the criminalization of midwifery—both legally and socially—have led to greater institutional and gendered violence in marginalized communities, which have come to normalize such violence.

The Grupo de Información en Reproducción Elegida (Information Group on Reproduction), hereinafter referred to as the GIRE, has developed two revolutionary reports, in 2013 and 2015, on the status of reproductive rights in Mexico using a human rights perspective. Their research and reports exemplify the high levels of obstetric violence women in Mexico experience when giving birth assisted by health professionals.¹⁵⁹ Obstetric violence has been defined as physical or physiological harm done to women, inherently damaging their autonomy and ability to decide freely about their bodies during birth and postpartum.¹⁶⁰ In 2007, Venezuela was the first country to legally criminalize and define obstetric violence.¹⁶¹ Under Venezuelan law, the following acts by health personnel are considered obstetric violence: 1) untimely and ineffective attention to obstetric emergencies; 2) forcing women to give birth in a supine position if not necessary; 3) impeding early attachment of child/mother without medical cause; 4) altering natural process of low risk delivery with acceleration techniques unless women are informed and can accurately consent; 5) using cesarean section when natural birth is possible unless women consented; and 6) forced sterilization or family planning techniques.¹⁶² According to GIRE's 2015 report, obstetric violence is the product of institutional violence and gendered violence as the

¹⁵⁹ “Violencia Obstetrica; Un Enfoque en Derechos Humanos” *Grupo de Información en Reproducción Elegida and Fundación Angelica Fuentes*. 2015. <https://gire.org.mx/wp-content/uploads/2016/07/informeviolenciaobstetrica2015.pdf>. (accessed December 7, 2016).

¹⁶⁰ Ibid.

¹⁶¹ Belli, Laura F., “Violencia obstetrica: otra forma de violacion de los derechos humanos.” *Revista Redbioetica/UNESCO*, 4.1. (2013): 25-34.

¹⁶² Belli, Laura F., “Violencia obstetrica: otra forma de violacion de los derechos humanos.” 25-34.

structures created by the state often normalize unequal violence against women.¹⁶³ Due to the socioeconomic, educational, and cultural marginalization of Indigenous peoples, they are often the most vulnerable group to such violence.¹⁶⁴

Most of the women's testimonies included stories of obstetric violence that either they or someone they knew experienced. This is not to say that doctors or health professionals are not saving lives in these communities, but rather that obstetric violence is a lived reality for many women. The invisibility of obstetric violence in policy and in the media is due to the normalization of such violence.¹⁶⁵ Women who live in poverty and receive free medical services often think such violence is the cost they have to pay for the service.

A more comprehensive definition of obstetric violence requires the contributions of the people who live such realities. As such, I will rely on the testimonies gathered during my interviews to exemplify the realities of women giving birth in the Yucatán Peninsula. A common representation of obstetric violence was the yelling and humiliating comments women endured when giving birth. According to Mirna, when she was giving birth the nurses yelled, "If you didn't yell when you were doing it, why do you yell now?"¹⁶⁶ Similarly, when Marta was giving birth at the age of 15, the nurses told her, "If you liked doing it [sex], you need to endure it [the pain] now" when she was screaming in pain.¹⁶⁷ Such aggressive and belittling statements hurt women's self-esteem and shame them for their sexual past and the birthing pain they are experiencing.

Another common representation of obstetric violence is forced sterilization or family planning methods without the patient's consent. Midwife Doña Elide shared that she has a 21-year-old patient who is survivor of obstetric violence, whom she is treating to increase her fertili-

¹⁶³ Ibid

¹⁶⁴ Ibid

¹⁶⁵ Belli, Laura F., "Violencia obstetrica: otra forma de violacion de los derechos humanos."

¹⁶⁶ Mirna Aracely Tuz Acosta, Xanlah, September 2, 2016
"Si no gritabas cuando lo hacias, porque gritas ahora?"

¹⁶⁷ Marta Lucia Camal Mix, Chankom, September 1, 2016
"Si te gusto hacerlo, tiene que aguantartelo tambien"

ty.¹⁶⁸ According to Doña Elide, when her patient gave birth at the age of 14, neither her nor her parents spoke Spanish so the doctors failed to inform her that they were inserting an intrauterine device (IUD) to temporarily prevent her from getting pregnant so young. Seven years later she went to the doctor because of pain in her uterus to find that the IUD that was placed inside her body without her consent or knowledge was infected and severely damaged her chances of getting pregnant again.¹⁶⁹ Similarly, midwives Sabrina and Elodia said they had friends and patients who, after giving birth and still under the effects of epidural, were sterilized without their consent or their husbands consented for them.¹⁷⁰

Doña Rafa and Doña Ofelia were concerned that most of the patients that came to them after having already given birth in a hospital had received an episiotomy during the delivery without their consent.¹⁷¹ Although Doña Rafa acknowledged that an episiotomy can save both the baby and the mother's lives if dilatation is not fast enough, Doña Rafa was concerned that most of her patients were cut to accelerate the process of birth soon after arriving at the hospital.¹⁷² For Marta, the cutting of her vagina significantly affected her self-esteem.¹⁷³

According to Margarita, an activist from Campeche who works in an NGO that provides legal aid to women who have suffered from obstetric violence, unnecessary cesarean section births or non-aesthetic cesarean sections (without medical reasoning) constitute the highest number of obstetric violence cases she encounters.¹⁷⁴ Non- aesthetic cesarean scars can damage a woman's self-esteem, particularly when they have not been informed beforehand.¹⁷⁵ According

¹⁶⁸ Maria Elide Chan Chan, Saban, August 23, 2016

¹⁶⁹ Ibid.

¹⁷⁰ Sabrina Speich, Tulum, August 29, 2016.
Elodia Catzim, Tulum, August 30, 2016.

¹⁷¹ Rafaela Can Ake, Chumbec, September 8, 2016.
Maria Ofelia Mix Can, Chankom, September 1, 2016.

¹⁷² Rafaela Can Ake, Chumbec, September 8, 2016

¹⁷³ Marta Lucia Camal Mix, Chankom, September 1, 2016

¹⁷⁴ Isabel Margarita Pech Ku, Campeche, August 25, 2016

¹⁷⁵ Isabel Margarita Pech Ku, Campeche, August 25, 2016.

to the World Health Organization (WHO), there is a growing concern with the rising global trends of cesarean sections.¹⁷⁶ Unnecessary cesarean sections have higher risks of maternal morbidity, neonatal death, and neonatal need for emergency care. Simultaneously, the WHO is concerned that particularly in low-income countries among the poorer communities, cesarean sections are not always accessible when needed.¹⁷⁷ The testimonies from the interviews I conducted proved that in the Yucatán Peninsula, Indigenous women were often victims of either not having access to health services when needed—such as emergency cesarean sections—or are being pushed into unnecessary cesarean sections without consent.¹⁷⁸ Sabrina believes the high rates of cesarean rates in Tulum are the product of the low wages and limited time frames provided to doctors in public hospitals. She said doctors have incentive to conduct cesareans, as they are more time efficient and lucrative.¹⁷⁹

These contradictory testimonies showcase the complex medical realities of people living in poverty and in remote communities. According to the National Institute for Statistics and Geography (INEGI), as of 2009 38.1% of total births in Mexico occurred through cesarean sections.¹⁸⁰ The WHO recommends countries maintain a cesarean rate of 15%, however it acknowledges the complex realities of setting a global recommended rate.¹⁸¹ Overall, Mexico has had a 50.3% increase in cesarean rates in the last 12 years. 60.4% of that increase was document-

¹⁷⁶ Cavallaro FL, Cresswell JA, França GVA, et al. “Trends in caesarean delivery by country and wealth quintile: cross-sectional surveys in southern Asia and sub-Saharan Africa.” *Bulletin of the WHO* 91.12. (2013). <http://www.who.int/bulletin/volumes/91/12/13-117598/en/>

¹⁷⁷ Ibid.

¹⁷⁸ Maria Imelda Cohuo, X-Querol, August 22, 2016.
sabel Margarita Pech Ku, Campeche, August 25, 2016.

¹⁷⁹ Sabrina Speich, Tulum, August 29, 2016.

¹⁸⁰ Instituto Nacional de Estadística y Geografía. *Estadísticas a propósito del Día de la Madre. Datos Nacionales*, México, May 10, 2012. (December 7, 2016).

¹⁸¹ Cavallaro FL, Cresswell JA, França GVA, et al. “Trends in caesarean delivery by country and wealth quintile: cross-sectional surveys in southern Asia and sub-Saharan Africa.”

ed in private hospitals while a 33.7% increase was documented in public hospitals nationally.¹⁸² According to the GIRE's report, in 2010, Yucatán had the highest cesarean rate nationally.¹⁸³

The form of obstetric violence most publicized by the media in Mexico is that of Indigenous women being denied access to hospitals when giving birth due to discrimination or a lack of resources in public hospitals. The most popularized case was of Irma Lopez, an Indigenous woman in Oaxaca who gave birth in the hospital's yard because she was denied access and told to wait.¹⁸⁴ Several women reflected similar experiences in their testimonies. For example, Mirna shared that her sister-in-law was denied access to a hospital, due to a lack of available beds, after falling from her hammock at 8 months pregnant. Thanks to Mirna's extensive knowledge of her rights and her persistent calls to the hospital, her sister-in-law was treated 15 hours after they arrived to the hospital.¹⁸⁵ Mirna's sister-in-law was taken in and the family did not hear anything from the nurses until the next day. They had no way of knowing what was going on behind closed doors as the doctors refused to give them answers. Unfortunately, the fetus died with the impact of the fall and the fetus's death could not have been prevented. But as Mirna explained, "the inhumane treatment could have been prevented. They take advantage of you because they think you are unaware of your rights. And sadly, most [women] don't know their rights."¹⁸⁶

According to the 2010 Population Census (Censo de Poblacion y Vivienda), seven out of every ten Mexican women over the age of 15 have given birth.¹⁸⁷ Obstetric violence is hard to

¹⁸² Instituto Nacional de Salud Pública, *Elevada recurrencia a las cesáreas: revertir la tendencia y mejorar la calidad en el parto*, en Encuesta Nacional de Salud y Nutrición, 2012.

¹⁸³ See Annex

¹⁸⁴ "Violencia Obstetrica; Un Enfoque en Derechos Humanos" *Grupo de Información en Reproducción Elegida and Fundación Angelica Fuentes*. 2015. <https://gire.org.mx/wp-content/uploads/2016/07/informeviolenciaobstetrica2015.pdf>. (accessed December 7, 2016).

¹⁸⁵ Mirna Aracely Tuz Acosta, Xanlah, September 2, 2016

¹⁸⁶ Mirna Aracely Tuz Acosta, Xanlah, September 2, 2016
"el trato inhumano pudo ser prevenido. Se aprovechan de ti porque creen que no sabes tus derechos. Y tristemente la mayoría no saben sus derechos"

¹⁸⁷ Instituto Nacional de Estadística y Geografía, *Censos y Conteos de Población y Vivienda*, 2010.

measure yet a common experience among women in Mexico.¹⁸⁸ A common alternative for Mexico's reproductive service limitations is to promote midwifery. The saturation of public hospitals leave few accessible resources for women giving birth. As a result, several countries have begun to put their resources into training and certifying midwives to best support the reproductive needs of their countries.¹⁸⁹ In 2014, the United Nations Population Fund (UNFPA), in collaboration with the WHO and the International Confederation of Midwives, published a report called "The State of The World's Midwifery: A Universal Pathway to A Woman's Right to Health."¹⁹⁰ The report showcased and validated the work midwives do to support reproductive services around the world. United Nations documents have forcefully come out to validate traditional knowledge as one of the many solutions countries and communities can use to improve health.¹⁹¹

According to UNFPA's report on midwives, only 78 professional midwives attend births out of the 104,379 professionals dedicated to reproductive and maternal health. These numbers suggest that midwives attend a little less than .01% of the births in Mexico.¹⁹² This does not include traditional midwives, such as the midwives interviewed for this research, whom according to UNFPA make up 15,000 traditional midwives. In the report, UNFPA recommends that Mexico promote and train midwives across the nation. In particular, the report calls for Mexico to acknowledge and support traditional midwives as "valuable actors" in reproductive health.¹⁹³

¹⁸⁸"Capítulo 4: Violencia Obstétrica" in *Omisión e Indiferencia: Derechos Reproductivos en México*, Grupo de Información en Reproducción Elegida. 2013. <http://informe.gire.org.mx/caps/cap4.pdf>. (December 7, 2015).

¹⁸⁹ "Violencia Obstétrica; Un Enfoque en Derechos Humanos" *Grupo de Información en Reproducción Elegida and Fundación Angelica Fuentes*. 2015.

¹⁹⁰"The State of the World's Midwifery 2014: A Universal Pathway A Women's Right to Health" *United Nations Populations Fund, International Confederation of Midwives, World Health Organization*. 2014. http://www.unfpa.org/sites/default/files/pub-pdf/EN_SoWMy2014_complete.pdf (accessed December 7, 2016).

¹⁹¹ Permanent Forum on Indigenous Issues, fourteenth session. "Study on the treatment of traditional knowledge in the framework of the United Nations Declaration on the Rights of Indigenous Peoples and the post-2015 development agenda" *Economic and Social Council*. February 2, 2015.

¹⁹² "El Estado de las parteras en el mundo 2014: Oportunidades y retos para Mexico" *Organización Panamericana de la Salud, Organización Mundial de la Salud, Comité Promotor por una Maternidad Segura en Mexico, United Nations Populations Fund*, 2014. http://www.unfpa.org.mx/publicaciones/Las_parteras_del_mundo.pdf. (accessed December 7, 2016)

¹⁹³ Ibid.

As the lack of further information in the UNFPA report alludes to, there is limited information and support for traditional midwives. The testimonies of the midwives in the Yucatán Peninsula further prove the difficult position midwives are put in. Their experiences showcase the legal and social criminalization of midwifery.

For the purposes of this research, the term “criminalization” goes beyond legal restraints by police and the state. The criminalization of midwifery is seen as a process that stems from restriction of the profession to belittlement of the practice by authorities. Under that definition, through these testimonies and close examination of policies, midwifery is criminalized nationally by restricting the profession, locally by denying midwives proper documentation and certification, and socially by the belittlement of the practice by health authorities.

In Mexico, laws and regulations determining the requirements for midwives are state-specific. The country has failed to release a comprehensive legal document that establishes requirements for midwives nationally, making it hard to document who is legally recognized as a midwife.¹⁹⁴ However, the Ley General de Salud (the General Health Law), hereinafter referred to as the LGS, outlines the Mexican government’s duty to respect the human right to health.¹⁹⁵ According to article 64.IV, health authorities have the responsibility to train health workers to provide the highest attainable standard of health. The LGS only mentions traditional midwifery when stating that it is the obligation of the state to train midwives without any acknowledgement to the legal recognition of midwives as either private or public actors in the national health care system.¹⁹⁶ Although the Mexican Constitution recognizes the right of people to choose freely their profession, state entities can place restrictions and requirements on a profession.¹⁹⁷ In order to have juridical security both for midwives and women who choose to give birth with the assistance of a midwife, the state needs to release normative guidelines that define and establish the

¹⁹⁴ “Violencia Obstétrica; Un Enfoque en Derechos Humanos” *Grupo de Información en Reproducción Elegida and Fundación Angelica Fuentes*. 2015.

¹⁹⁵ “Ley General de Salud” in *Leyes y Reglamentos Federales de la Secretaría de Gobernación*. May 14, 1986 updated March 24, 2014. http://www.diputados.gob.mx/LeyesBiblio/regley/Reg_LGS_MPSAM.pdf. (accessed December 7, 2016).

¹⁹⁶ Ibid.

¹⁹⁷ “Violencia Obstétrica; Un Enfoque en Derechos Humanos” *Grupo de Información en Reproducción Elegida and Fundación Angelica Fuentes*. 2015.

role of midwives. The lack of a comprehensive system leaves the criminalization of midwives at the hands of the local judicial system.

According to Sabrina, a midwife working in Tulum and Carillo Puerto, the profession of midwifery is threatened by the state's "witch hunt" against them.¹⁹⁸ Midwives Elodia, Sabrina, and Doña Rafa stated that midwives are often blamed for the state's maternal and natal death rate when most births happen in hospitals and health clinics.¹⁹⁹ Sabrina says:

"The Health Ministry is waiting for midwives to commit a mistake. Last year in Cancun they incarcerated two midwives. One of them was a 70-something-year-old woman! The Ministry encourages this hunt for midwives, making the job very stressful. When a woman dies in the hospital due to preeclampsia they get all the midwives together and teach us what preeclampsia is, claiming they are strengthening the health system by training us. But privately to me the health director told me: 'At home no one dies during birth, where they die is at hospitals in Cancun.' However, they blame us for the mortality rates in Quintana Roo."²⁰⁰

The lack of comprehensive state laws or regulations outlining the roles and requirements of midwives leave local governments with the power to take action how they see fit. As a result, Doña Rafa's granddaughter and aspiring midwife Cynthia said, "midwives are in constant fear of being incarcerated or facing legal restrictions if something goes wrong."²⁰¹ Cynthia, a member of Doña Rafa's midwifery training program, says that in a hospital, women sign documents protecting doctors against lawsuits in the case of accidental deaths during labor. However, midwives are left to defend themselves when unpredicted complications arise.²⁰²

The most common form of restriction midwives discussed in the testimonies was the restrictions of *Nacido Vivos*, the Live Births document which those attending the births fill out so

¹⁹⁸ Sabrina Speich, Tulum, August 29, 2016.

¹⁹⁹ Sabrina Speich, Tulum, August 29, 2016.
Elodia Catzim, Tulum, August 30, 2016.
Rafaela Can Ake, Chumbeec, September 8, 2016.

²⁰⁰ Sabrina Speich, Tulum, August 29, 2016.

"La secretaria solo espera que te hagas un error y ya en Cancun encarcelaron a dos parteras el año pasado. Una señora de 70 y tanto años. Pero la secretaria lo fomenta, esa casería de parteras, es un trabajo muy estresante. Cuando una mujer muere en el hospital de preeclampsia reúnen a todas las parteras para enseñar que es preeclampsia cuando la mujer murió en el hospital. Entonces siempre nos usan para mostrar que ellos si están mejorando la salud en Quintana Roo porque educan a las parteras. A mi el director de salud me dijo en privado, 'en casa nadie muere en partos, donde mueren esta en Cancun en los hospitales.' Pero sin embargo nos culpan a nosotras por la mortalidad de infantes en Quintana Roo"

²⁰¹ Cynthia Rebecca Canche Parra, Chumbeec, September 7, 2016

²⁰² Ibid.

that the parent can legally register the baby as a stillbirth or a live birth.²⁰³ Without this document, registering the baby is harder. The restrictions of *Nacido Vivos* given out by health professionals to midwives happened at different rates in the Peninsula. For Doña Felipa, in Chikindzonot, it was as recent as two years ago when the clinic stopped giving her the document.²⁰⁴ Now she writes down the weight, size, and time of birth of the child on a napkin and accompanies the mother to the clinic so they can fill out the legal documents.²⁰⁵

On the other hand, Doña Rafa from Chumbec, Yucatán, remembers clearly the restriction of *Nacido Vivos* in 2008.²⁰⁶ Doña Rafa was trained in 1981 by the Ministry of Health (Secretaria de Salubridad y Asistencia) but was employed soon after by the Mexican Social Security IMSS to assist births as a midwife in her community and communities nearby. In 2008, IMSS retired all the midwives in their system, around 70 midwives, and prohibited them from continuing to assist births by denying them the *Nacido Vivo* document. Facing dismissal, Doña Ake quickly went to the Ministry of Health and told them that they initially trained her and that she had several patients who currently needed her. Miraculously, according to Doña Ake, the Ministry continued to give her the documents she needed and has continuously done so for the past eight years. When telling me her story, Doña Ake would sob and express the constant fear she has that the Ministry will stop providing her the documents she needs. She witnessed how from one day to the next, IMSS stripped her of her income, title, passion, and identity. Doña Rafa says that when asked, IMSS claimed they stopped providing the document due to a lack of resources. However, Doña Rafa believes it is the result of a larger national movement to hospitalize births for lucrative purposes.²⁰⁷

²⁰³ Maria Ofelia Mix Can, Chankom, September 1, 2016.
Sabrina Speich, Tulum, August 29, 2016.
Rafaela Can Ake, Chumbec, September 8, 2016.
Felipa Moo Cahum, Chikindzonot, September 3, 2016
Mirna Aracely Tuz Acosta, Xanlah, September 2, 2016
Maria Imelda Cohuo, X-Querol, August 22, 2016.

²⁰⁴ Felipa Moo Cahum Chikindzonot, September 3, 2016

²⁰⁵ Ibid.

²⁰⁶ Rafaela Can Ake, Chumbec, September 8, 2016.

²⁰⁷ Ibid.

According to Mirna's testimony, when women give birth through a midwife and then attend the clinic the next day to collect the *Nacido Vivo*, doctors often shame women for having chosen to give birth at home.²⁰⁸ Retrieving the document can therefore be an instance where women are shamed and belittled for choosing to give birth at home. In addition, Sabrina mentioned her frustration that statistically the births she attends are attributed to a doctor because the *Nacido Vivo* is signed by a doctor not her.²⁰⁹ According to her testimony, restricting and denying midwives from signing the *Nacido Vivo* makes it harder to have correct data on how many births are assisted by midwives.²¹⁰

The lack of courses and certificates for midwives further criminalizes their profession by putting their patients at risk, as well as by limiting their freedom due to the risk of being accused of malpractice. Doña Rufina, Doña Germina, and Doña Ofelia all said the last time they had any training was three to five years ago.²¹¹ Their training was sponsored by the local clinic or through a private organization. According to Doña Elide, fifteen years ago there was a multitude of free courses that paid the midwives the workday for attending.²¹² Today, Doña Elide says courses require midwives to pay for transportation and stay, as well as lose the workday, limiting the amount of midwives willing and able to attend. In addition, courses today almost never have a Mayan translator, which thereby excludes Mayan-only speaking midwives from attending and participating.²¹³ Doña Elide shared that she often has to lie to her husband in order to attend training because of the loss of family income. However, she takes such a risk because she says it is important to stay informed and committed to new knowledge. She also appreciates the ability to speak with other midwives about their techniques and experiences and learn from each

²⁰⁸ Mirna Aracely Tuz Acosta, Xanlah, September 2, 2016

²⁰⁹ Sabrina Speich, Tulum, August 29, 2016.

²¹⁰ Ibid.

²¹¹ Germina Patlo- Chikindzonot, September 3, 2016
Maria Ofelia Mix Can, Chankom, September 1, 2016.
Rufina Kantun Batun, Poebichen, September 3, 2016

²¹² Maria Elide Chan Chan, Saban, August 23, 2016

²¹³ Ibid.

other.²¹⁴ Doña Elide is now taking a course at the Intercultural Mayan University of Quintana Roo, an hour away from her community, for free in exchange for helping train doulas. Imelda and other students, professors, and alumni at the university are trying to hire her as a professor but because Doña Elide never finished elementary school, they are being blocked by bureaucratic gridlock.²¹⁵

On the other hand, midwife Sabrina had negative experiences from trainings and therefore refuses to attend courses unless other traditional midwives teach them.²¹⁶ In her testimony, Sabrina said it was good that there were fewer courses now than there were 15 years ago because the courses only served for doctors and government officials to shame midwives and their traditional knowledge.²¹⁷ Sabrina said:

“In the course, they don’t teach, they just yell. They tell you that you don’t know anything as a midwife. They tell you that you can’t treat patients under 18 or over 35 nor first time mothers. Courses were just part of a program to hospitalize women and they have managed it since. In 2001, 45% of women gave birth at home and now 93% of women give birth at the hospital. The last course I was invited to was in ’93. Two or three years ago they [Health Ministry] held a course but it was only a publicity stunt because once the press left, they (teachers) stopped coming. According to the social worker responsible for training midwives, the mortality rate in Cancun has lowered due to her courses but the last course was fifteen years ago. I think it is the other way around: the mortality rate has lowered because they have stopped giving courses and traditional knowledge is still active in remote areas.”²¹⁸

According to Sabrina, the courses often did more harm than good in dismissing Indigenous knowledge and shaming midwives for their labor. Sabrina also stated in her testimony that in the past, during these courses, the Health Secretary would provide midwives with experimental contraceptive drugs to try on their patients. Sabrina said that the packages would say in small ink

²¹⁴ Ibid.

²¹⁵ Maria Imelda Cohuo, X-Querol, August 22, 2016

²¹⁶ Sabrina Speich, Tulum, August 29, 2016.

²¹⁷ Ibid.

²¹⁸ Sabrina Speich, Tulum, August 29, 2016.

“En el curso no te enseñan solo te dicen y te regañan. Te dicen que no sabes nada como partera. Te dicen que no debes de atender a menores de 18 o mayores de 35, ni primerizas. Fue todo un programa para hospitalizar a las mujeres y lo lograron porque cuando nosotros trabajamos en el 2001 45% de las mujeres parían en casa y ahorita 93% paren en hospital. El ultimo curso que nos invitaron fue en el ’93. Hace dos o tres años nos convocaron en un curso. El primero día llega de Cancun, llega la prensa, para mostrar que están haciendo su labor con las parteras pero solo llegaron dos veces y se fueron y nunca hicieron nada. Según la trabajadora social capacitando a las parteras la mortalidad en Cancun esta bajando por sus cursos que dan cuando el ultimo curso que dio fue hace quince años. Yo creo que es al revés la mortalidad esta baja porque no han dado cursos. Porque los conocimientos siguen siendo antiguos en muchas áreas.”

“experimental treatment” but sometimes neither the midwives nor the patients could read nor understand it.

Seeing the restricted and sometimes discriminatory nature of these courses, Doña Rafa decided to take matters into her own hands and build a community group in Chumbec that trains midwives and teaches Indigenous herbal knowledge.²¹⁹ The group consists of twelve women from Kantunil, Sudzal, Xanaba, and Chumbec. Seven of the women have been previously trained as midwives but find it important to keep coming together to learn new techniques, especially when the state has stopped providing these spaces for professional growth. The other five members of the group are learning the trade but lack experience.²²⁰ There are three main goals for this group. First, they want to get all the midwives trained and practicing. Second, they want to become some type of union that can serve to protect midwives from lawsuits and incarceration. Finally, they want to change the common relationship between doctors and midwives to a more dynamic and supporting link between them.²²¹ Raquel, one of the twelve women in this group, said:

“Doctors and midwives can work better together. There are things doctors can’t do that midwives can and the other way around. For example the doctor can’t massage and accommodate the baby while the midwife cannot conduct a cesarean section”²²²

The group Doña Rafa has spear headed is an alternative to the state-sponsored courses that the state has failed to provide in the last couple of years. Because these courses are taught and facilitated by midwives, they understand the needs of the community and validate Indigenous knowledge.

Finally, social criminalization of midwifery was experienced both by clients and midwives alike. Mirna and Margarita said it was common to hear doctors and nurses speak badly about midwives during their pregnancy check-ups. Margarita’s doctor told her “If you choose to

²¹⁹ Rafaela Can Ake, Chumbec, September 8, 2016.

²²⁰ Rafaela Can Ake, Chumbec, September 8, 2016.

²²¹ Ibid.

²²² Gilda Raquel Cache Parra, Chumbec, September 7, 2016

“Los doctores y parteras pueden trabajar mejor juntos. Hay cosas que hacen los doctores que las parteras no pueden hacer y al revés. Por ejemplo el doctor no puede sobar y acomodar al bebe mientras la partera no puede hacer una cesaría”

give birth through a midwife, do so at your own risk.” Meanwhile, Mirna was told “Why do you even go to midwives for massages? They do not know what they are doing.”²²³ Similarly, Sabrina says that once during a birth complication she took her patient to the doctor, who yelled at the patient for being “stupid enough to go to a midwife.”²²⁴ Such social criminalization has led to younger generations rejecting home births and wanting to schedule cesarean sections because they have internalized ideas that it is more safe and modern.²²⁵

²²³ Isabel Margarita Pech Ku, Campeche, August 25, 2016
Mirna Aracely Tuz Acosta, Xanlah, September 2, 2016

²²⁴ Sabrina Speich, Tulum, August 29, 2016

²²⁵ Cynthia Rebecca Canche Parra, Chumbec, September 7, 2016

Midwifery as an avenue for social change

The testimonies discussed in the latter chapters discuss the difficulty in accessibility, acceptability, and availability of reproductive services available for Mayan women in the Yucatán Peninsula. While reproductive services are scarce and lacking, social and legal criminalization of midwives has further restricted women's health rights. Instead of providing the highest standard of health nationally, the state and health care systems are pushing back against Indigenous knowledge. In order to provide better health services, the state and the health care system need to develop a broader link with traditional birth attendants who can provide assistance when the state cannot.

According to Cowan et al., contemporary debates regarding rights and cultures have been conjoined in three different ways: rights versus culture, rights to culture, and rights as culture.²²⁶ In the latter, rights as culture, Cowan et al. argue that culture, “rather than being solely an object of analysis, can be employed as a means of analyzing and better understanding the particular ways that rights processes operate as situated social action.”²²⁷ Finally, the fourth aspect scholars can apply to this debate is that of culture as a means to rights.²²⁸ Culture can be the mechanism by which to localize rights. Using that theory, midwives can therefore be cultural actors who localize rights. Through the testimonies collected for this research, women and midwives alike are exposed to private conversations with their birth assistants that brought to light topics such as feminism, gender equality, racial discrimination, and so on. It was in these private spaces that women felt they could freely discuss their rights.

Mirna, a 28 year old women's health researcher in Xanlah, said in her testimony that talking about women's reproductive bodies often leads to larger conversations on topics such as machismo and feminism.²²⁹ Mirna works for Yucatán's Health Ministry, visiting communities

²²⁶ Cowan, Jane K., Marie-Benedicte Dembour, and Richard A. Wilson, ed. *Culture and Rights; Anthropological Perspectives*.

²²⁷ Ibid. 4.

²²⁸ Ibid.

²²⁹ Mirna Aracely Tuz Acosta, Xanlah, September 2, 2016.

once a month collecting information such as how many people are pregnant, what is the breast feeding rate, what is the common age for pregnancy, what is the preferred family planning method, what is the local knowledge on STIs and HIV/AIDS, and so on. Mirna makes a one-month commission of 300 to 800 pesos (\$16-\$44 USD) for her research. To collect her data, Mirna invites groups of women to discuss what they know about family planning, breastfeeding, STIs and more. Mirna targets three groups; women of reproductive age, women leaders, and high school students. At first, Mirna says she encountered resistance in all groups but once she was familiarized with the communities, people started to open up. Even now, after five years of collecting data, she says that some groups still resist meeting with her. If a meeting has a low turnout rate, she goes door to door asking participants why they did not attend. She said 90% of the time she is told by the women they did not attend because their husbands did not let them or their husbands get mad if food is not made when they return from the field. She now makes it a point to talk in her meetings about gender equality and women's right to live not under the control of their husbands. In her meetings she says most women are surprised when she tells them they have the right to choose how many children to have and when to have them. Domestic violence is another common topic, as women attending the group meetings say certain people do not attend because their husbands beat them if they come back demanding their rights.²³⁰

Apart from private family violence discussed in these meetings, Mirna also brings up the violence that Indigenous peoples experience publicly such as institutionalized discrimination. Women constantly talk about racial discrimination experienced in hospitals while high school students discuss discrimination in schools and public spaces. After five years of doing this line of work, Mirna has little faith that the information collected is going anywhere useful. She says that the bureaucratic office she submits her reports to is always changing personnel and lacking funds, making it hard for them to implement change with the data she collects. However, she continues working, with little to no pay sometimes, because of her personal commitment to opening these spaces for discussion. She believes that even if Yucatán's Health Ministry does nothing with the demographic information she collects, by validating women's and youth's experiences she gives people some closure. In addition, Mirna hopes these conversations can bring

²³⁰ Ibid.

waves of change. Her most recent accomplishment was working with government authorities in Xanlah and lobbying for an ambulance. After two years of working with women to demand an ambulance, the authorities agreed to pay civilians who take someone with a medical emergency to the nearest clinic. Although Xanlah did not get an ambulance and the community still depends on people with vehicles to receive health care, the monetary incentive provided by the provisional authority is an accomplishment for a group formed through Mirna's work. Early on, Mirna thought her work would be a quantitative analysis of simple questions such as how many people are pregnant in a particular location. Now, her work has expanded to discussions about private and public violence experienced by Mayan and mestiza women in her area and practical tools for enacting social change.²³¹

Doña Rafa's midwifery group is a great example of where reproductive rights extend to larger conversations of gender and sexual orientation. I had the honor of attending one of the group's meetings in Chumbec where they were filling out a grant application for Semillas, a Mexican NGO that provides funding for women's groups and people making social change in Mexico.²³² One of the questions was, "What does your group understand about feminism?" The collective response submitted in the application was:

"Feminism has helped women's roles to be recognized and validated. Feminism helps women be free and work. It helps create gender equality and give women voice and voting rights. It is important to rebel ourselves against machismo to complete our purpose and make social change. Sometimes men do not support change and that is why it is important women fight for their rights and not be silenced. Feminism is also supporting and respecting without discrimination based on gender and sexual orientation"²³³

The process of twelve women drafting a collective response to such a broad question was incredible. Not all women immediately understood what the application meant by feminism but this group tackled different definitions, opinions and perspectives. The group consists of twelve women ages 23 to 60. They are mostly widowed, some married, and one single mother. Their

²³¹ Mirna Aracely Tuz Acosta, Xanlah, September 2, 2016

²³² Fondo Semillas. www.semillas.org.mx (accessed December 7, 2016).

²³³ Collective statement by the Parteras de Yucatan Convocatoria de Semillas, Chumbec, September 7, 2016- "El feminismo ha ayudado que el rol de la mujer sea reconocido y validado. El feminismo ayuda a que las mujeres sean libres para trabajar. Ayuda a crear equidad de género y darle a la mujer voz y voto. Es importante rebelarse al machismo para que cumplamos nuestros propósitos y hagamos cambio social. A veces los hombres no apoyan por eso es importante que las mujeres luchen por sus derechos y no se queden calladas. El feminismo también es apoyar y respetar sin discriminación por género y orientación sexual."

perspectives of gender equality differed greatly. A conversation that stood out was whether or not to include sexual orientation in their definition. Some midwives believed it was not necessary in their line of work since “lesbians could not give birth.”²³⁴ Other members of the group felt it was important to mention it in order to come across as an inclusive and progressive group. Someone mentioned a transgender woman in their community and how she would never need a midwife. Automatically someone responded that she could still come to them asking about family planning methods. The conversation ended with a discussion on whether this transgender individual’s sexual orientation was or was not connected to her gender identity. Through my observations, I saw people step out of their comfort zones and speak openly regarding things they had never discussed. It showcased one of the many spaces where midwives used their position to break community barriers.

The largest misconception of rights and culture, which contributes to the tensions between them, is that they represent static definitions. The idea that culture will always encourage violence against women fails to acknowledge the flexibility of culture. According to Merry, seeing “violence against women as a common opposition between culture and rights fails to acknowledge the contested and variable cultural support this variety of behavior receives in different social groups.”²³⁵ By assuming that violence against women is the result of one homogenized notion of culture, we fail to acknowledge that culture is a changing process and that the debates regarding what constitutes a cultural act differ among different peoples within one group.²³⁶ Similarly to culture, the definition of “rights” has also changed significantly over the years. For example, violence against women used to not be a human rights violation fifty years ago.²³⁷ Authors such as Comaroff and Comaroff have expanded the definition of culture to being a space “in which human beings construct and represent themselves and others” rather than a habitual

²³⁴ Collective statement by the Parteras de Yucatan Convocatoria de Semillas, Chumbec, September 7, 2016

²³⁵ Merry, Sally Engle. “Changing Rights, Changing Culture” in *Culture and Rights; Anthropological Perspectives*. (Cambridge: Cambridge University Press, 2001).

²³⁶ Ibid. 38.

²³⁷ Ibid.

practice, as it contains contestable images, messages, and actions.²³⁸ Culture is therefore not situated in one place, but rather a contestation of ideas, messages, and signs. Furthermore, culture can be a place where values are introduced, appropriated, deployed, reintroduced and redefined for social transformation.²³⁹

The testimonies collected for this research supported an idea of culture that continues to change and adapt. All of the midwives said in their testimonies that they continue to learn from each other and trainings on how to provide better quality of care. Sabrina, for example, started working in a team with a gynecologist in order to protect herself from legal repercussions.²⁴⁰ She refuses to assist a birth without a gynecologist in the room not because she is not qualified but rather because of the changing needs and demands of her clients. Similarly, Doña Elide says that pregnancies have changed since her mother was a midwife, forcing her to change with time as well.²⁴¹ According to Doña Elide, her mother did not use IVs on her patients nor did she learn how to take women's blood pressure. Doña Elide blames neoliberal policies that have made grocery food cheaper while climate change has destroyed the land and made it more expensive to live organically. As a result, women eat less healthy foods, have greater exposure to hormones and pesticides, which in turn make labor harder and more dangerous.²⁴² Doña Elide now measures women's blood pressure and provides IVs when needed.

Doña Rafa, a midwife from Chumbec, has changed how she assists births due to the change in the demographics of her clients.²⁴³ Since she started assisting births of people of high socio-economic class in Mérida, she learned from a client the health benefits of consuming one's placenta. She now recommends her patients both from her community and from Mérida to keep the placenta and eat a part of it immediately after birth in a milkshake. She asks her clients to

²³⁸ Comaroff, John and Jane Comaroff, *Ethnography and the Historical Imagination*. (Boulder: Westview, 1992).27.

²³⁹ Merry, Sally Engle. "Changing Rights, Changing Culture"

²⁴⁰ Sabrina Speich, Tulum, August 29, 2016.

²⁴¹ Maria Elide Chan Chan, Sabán, August 23, 2016.

²⁴² Ibid.

²⁴³ Rafaela Can Ake, Chumbec, September 8, 2016.

bring fresh fruit, such as strawberries, so that after the birth she can quickly make a milkshake to help with the recovery process. She grinds the rest of the placenta into powder and puts it into capsules, lotions, soaps and medicinal drops. Together with other plants, these medicines help with cancer, burns, anemia, acne, and more. She sells her remedies to people in the city and in her community.

According to Doña Rafa, in addition to learning about the health benefits of placenta from her Mérida patients, she also had the opportunity to assist on a cesarean section. One of her clients she was massaging was having twins and therefore was a high risk for a home birth. However, the patient wanted Doña Rafa to be present during the cesarean section. Similarly, one of Doña Rafa's clients was interested in a water birth and paid for Doña Rafa's training. Doña Rafa hopes to one day purchase a water birth pool to provide the option for her clients.²⁴⁴

Davis-Floyd's research examines the global phenomenon of what he calls "postmodern midwifery," a term encompassing traditional birthing, professional midwifery, and modern biomedicine.²⁴⁵ Davis-Floyd defines postmodern midwives as "relativistic, articulate, organized, political and highly conscious of both their cultural uniqueness and their global importance" and understands that the discrepant systems of birth often conflict but can be complementary.²⁴⁶ Through his research, conducted in Mexico and elsewhere, he found that through exchanges of knowledge and technologies among hegemonic biomedicine, professional midwives, traditional midwives, networking, and so on, it muddles anthropologists' attempts to find "*authentic* cultural practices and valued systems."²⁴⁷ These findings underscore the inadequacy of the modernist rhetoric that there is linear progress from midwifery to biomedical birthing strategies. Traditional contemporary midwives intersect different cultural domains based on their patient's birthing demand and for the benefit of women-centered humane birthing methods. "Dancing fluidly at the interface of biomedicine, holistic alternatives, and traditional birthways, these midwives are

²⁴⁴ Rafaela Can Ake, Chumbec, September 8, 2016.

²⁴⁵ Davis-Floyd, Robbie, "Daughter of time: the postmodern Midwife" *Estudio Teorico*. (2006).

²⁴⁶ Ibid. 707.

²⁴⁷ Ibid. 708.

strategically negotiating the boundaries between knowledge systems and creatively producing a hybrid and increasingly well-articulated knowledge system of their own.”²⁴⁸

The testimonies collected for this research showcased the multiple changes midwives have made to their techniques, proving that Indigenous culture is not frozen in ancient teachings or methods. Birthing culture and midwives’ knowledge continue to change and adapt to the needs of the client. Culture can therefore continue to adapt to help localize rights and promote human dignity.

According to Merry, Indigenous women are constantly articulating their goals for equality within a human rights framework in panels and local events.²⁴⁹ Through her experience, she has seen how Indigenous women often want to utilize a rights framework without individualizing these rights. Indigenous women are using more fluid definitions, both theoretically and empirically, of culture and rights and shifting them to their needs.²⁵⁰ The testimonies collected for this research highlight the ever-changing nature of culture and rights. The midwives and maternal activists in the Yucatán Peninsula are actors that use their positionality to raise awareness of rights. Midwives provide spaces for social change as well as reproductive services. It is therefore crucial to build a greater and more supportive links between the formal health care sector, the state, and midwives.

²⁴⁸ Ibid. 709.

²⁴⁹ Merry, Sally Engle. “Changing Rights, Changing Culture”

²⁵⁰ Merry, Sally Engle. “Changing Rights, Changing Culture”

Conclusions

As the preceding research argues, cultural rights and women's rights can find a common ground since women are creators, protectors, and advocates of culture and their rights. For reproductive rights, midwives provide access to services and traditional knowledge as well as can provide a link between institutional health professionals and communities. As state institutions continue to provide services lacking accessibility, availability, acceptability, and quality, midwives fill that gap with traditional knowledge. Ideally, both midwives and health institutions can work together to provide higher quality of care nationwide using their particular strengths. As trusted members of communities, midwives refer patients to doctors, can provide care at all hours, and provide culturally competent care that validates community needs.

The contemporary argument that culture inherently clashes with human rights prevents a productive discussion on rights among Indigenous women, who often hold strong feelings about a community's collective right to self-determination. This is not to say that some community values do not have violent restrictions on women's rights. In her testimony, Argentina addressed a case of community violence in Calakmul, Campeche.²⁵¹ Argentina is the founder and president of an NGO called El Observatorio that provides legal and psychological services to victims of gendered violence. Two years ago, she worked on a case where a girl from Calakmul, a remote Indigenous community, publicly reported that her teacher had sexually assaulted her. Community members, afraid of the repercussions of having outsider legal and social involvement, shunned her for bringing attention to their community. For speaking out, Argentina's 12-year-old client was pushed out of her community, thereby stripping her of her Indigenous identity.²⁵² Argentina acknowledges that this is a clear example of gendered violence promoted by this particular community but felt the need to reiterate that gendered violence occurs everywhere. Gendered violence does exist and can sometimes be promoted by a specific group or culture but as argued previously, culture continues to change and adapt and group actions are not representative of everyone within the community.

²⁵¹ Argentina Casanova, Campeche, August 26, 2016

²⁵² Argentina Casanova, Campeche, August 26, 2016

According to Stamatopoulou, the state has an obligation to protect women's rights, but this is not at the expense of the community's cultural human rights.²⁵³ She argues that cultural rights are not just group rights but also individual rights, making women individual holders of cultural rights. For Stamatopoulou it would be a contradiction to recognize cultural human rights of a group when this violates the human rights of women. The issue is therefore not "cultural human rights of the group v. the human rights of women," but "the culture of the group v. the human rights of women."²⁵⁴ Using her theory to examine Argentina's case, Calakmul's denial of her client's Indigenous identity is a violation of her individual cultural right as well as ignoring the sexual violence she endured, making it a violation to her human rights. In addition, using Merry's argument that culture is not homogeneous to a whole community would mean that the client, as part of a community, has a say in her own culture and therefore by speaking out she is demanding for a change of a specific cultural component in her community.²⁵⁵ Argentina acknowledges the frustratingly slow process of speaking with community members about the devastating effects of shunning her client from her community. However, she states that this is not a homogenous decision, as other mothers of sexual assault survivors from the school are also slowly speaking out.²⁵⁶

Argentina's testimony serves to illustrate that this is not a black and white situation. Culture and rights, as ever changing processes, should continue to be challenged and improved. Doctors and midwives alike should be trained regularly to provide structurally competent services that reject obstetric violence. Similarly, as medicine adapts, doctors and midwives should continue to improve techniques to provide the highest quality of health. As the United Nations and other international forums continue to validate traditional knowledge, doctors and health care institutions locally should begin validating traditional knowledge as equal to Western med-

²⁵³Stamatopoulou, Elsa. *The Universal Declaration of Human Rights : Cultural Rights in International Law : Article 27 of the Universal Declaration of Human Rights and beyond*.

²⁵⁴ Ibid. 234.

²⁵⁵ Merry, Sally Engle. "Changing Rights, Changing Culture"

²⁵⁶ Argentina Casanova, Campeche, August 26, 2016

ical knowledge.²⁵⁷ It is with the inclusion of the two sides of health knowledge that quality of health will improve.

As the academic world attempts to become more validating of Indigenous knowledge, programs are being created that combine different world thoughts. Johns Hopkins University's Center for American Indian Health developed Family Spirit, a home-visiting program that follows a Native family from pregnancy until the baby is three-years-old while successfully interweaving Indigenous practices alongside Western medicine for optimal health. According to the website, "Family Spirit addresses intergenerational behavioral health problems, applies local cultural assets, and overcomes deficits in the professional health care workforce in low-resource communities. It is the only evidence-based home-visiting program ever designed for, by, and with American Indian families. It is used in over 70 tribal communities across 15 states."²⁵⁸ Women who opt into this program get linked with a trained member of their Indigenous community who helps them gain access to services and informs them of their health needs during the pregnancy and following the birth. In addition, this program works with partners, grandparents, and/or other family members involved in raising the child.²⁵⁹ The program covers different birthing methods since so many of these mothers live in remote areas and Family Spirit workers might be midwives or medicine men, varying by community. If the tribe has ceremonial practices that happen when a new child is born, Family Spirit adapts to include these practices.²⁶⁰ This program shows the potential of working collaboratively with culture to provide reproductive services, a program which could be replicated in Mexico.

The testimonies collected for this research expressed obstetric violence as a common experience among Mayan women in the Yucatán Peninsula. The Mexican state has a responsibility to address this form of violence and to protect Indigenous women from torture. The Center For Reproductive Rights published a report arguing that abuses of women's sexual and reproductive

²⁵⁷ Permanent Forum on Indigenous Issues, fourteenth session. "Study on the treatment of traditional knowledge in the framework of the United Nations Declaration on the Rights of Indigenous Peoples and the post-2015 development agenda."

²⁵⁸ Family Spirit Home Visiting Program. <http://caih.jhu.edu/programs/family-spirit> (accessed December 7, 2016).

²⁵⁹ Ibid.

²⁶⁰ Family Spirit Home Visiting Program. <http://caih.jhu.edu/programs/family-spirit> (accessed December 7, 2016).

rights often rise to the level of torture or cruel, inhumane, and degrading treatment therefore violating the UN Convention against Torture (CAT). According to the report, “Women seeking medical care may experience abuse and mistreatment at the hands of health care personnel, who hold clear positions of authority and often exercise significant control over women in these contexts.”²⁶¹ The CAT Committee and the Inter-American Court of Human Rights have both said that states who have ratified the Convention, such as Mexico, have a specific obligation to protect marginalized and often discriminated individuals from torture and cruel, inhumane, and degrading treatment.²⁶² For Indigenous women, who are often at the intersections of multiple forms of discrimination, Mexico has a particular responsibility to protect them from torture. The report highlights several reproductive rights abuses that can constitute torture such as abuse of women in health care settings, coercive sterilization, denial of medical care, denial abortion and post-abortion care, shackling during birth, and more.²⁶³ Most of the women interviewed for this project had first-hand experience of health care professionals abusing their power, being coerced into having fewer children, being forcibly sterilized, or being denied medical care due to discrimination.

Mexico, having ratified and signed the Convention on the Elimination of Discrimination Against Women and the Declaration on the Rights of Indigenous Peoples, has an obligation to provide the highest standard of health to all women while supporting Indigenous peoples’ right to self-determination. This paper argues that training, supporting, and encouraging a greater link between midwives and health professionals is therefore crucial to respect both CEDAW and UNDRIP. Building programs like Family Spirit or encouraging *Prospera* and IMSS to work collectively for the reproductive rights of Indigenous peoples is urgent as Indigenous women are often at the intersections of discrimination based on gender, socioeconomic class, and ethnicity.

This paper began by examining the current literature on Mexico’s reproductive policies and the tensions between cultural and women’s rights. Through the testimonies of Mayan women

²⁶¹“Reproductive rights violations as torture and cruel, inhuman or degrading treatment or punishment: a critical human rights analysis.”*Center for Reproductive Rights*. New York (2010):18.

²⁶² Ibid.

²⁶³ Ibid.

in the Yucatán Peninsula, collected through participant observation and semi-structured interviews, this paper argues that midwives can provide reproductive rights and women's rights in their communities. The reproductive needs and obstacles faced by Mayan and mestiza women in their interactions with state-sponsored reproductive services, highlight the limitations of these state institutions. In addition, the testimonies collected supported the idea that midwifery is of high cultural importance in communities while arguing that the lack of flexibility in health care regulations constrain women's diverse and specific cultural traditions and needs. These testimonies highlighted the high levels of obstetric violence women experience while giving birth as well as the criminalization of traditional knowledge and reproductive services. This criminalization, instead of improving health services, further restricted and harmed women's bodies. Midwifery and cultural birthing spaces provide the space to localize women's rights. Midwives can be the cultural means through which to localize human rights. Greater support to midwives and a wider understanding of the role traditional midwives have in their communities can help improve health services and gender equality.

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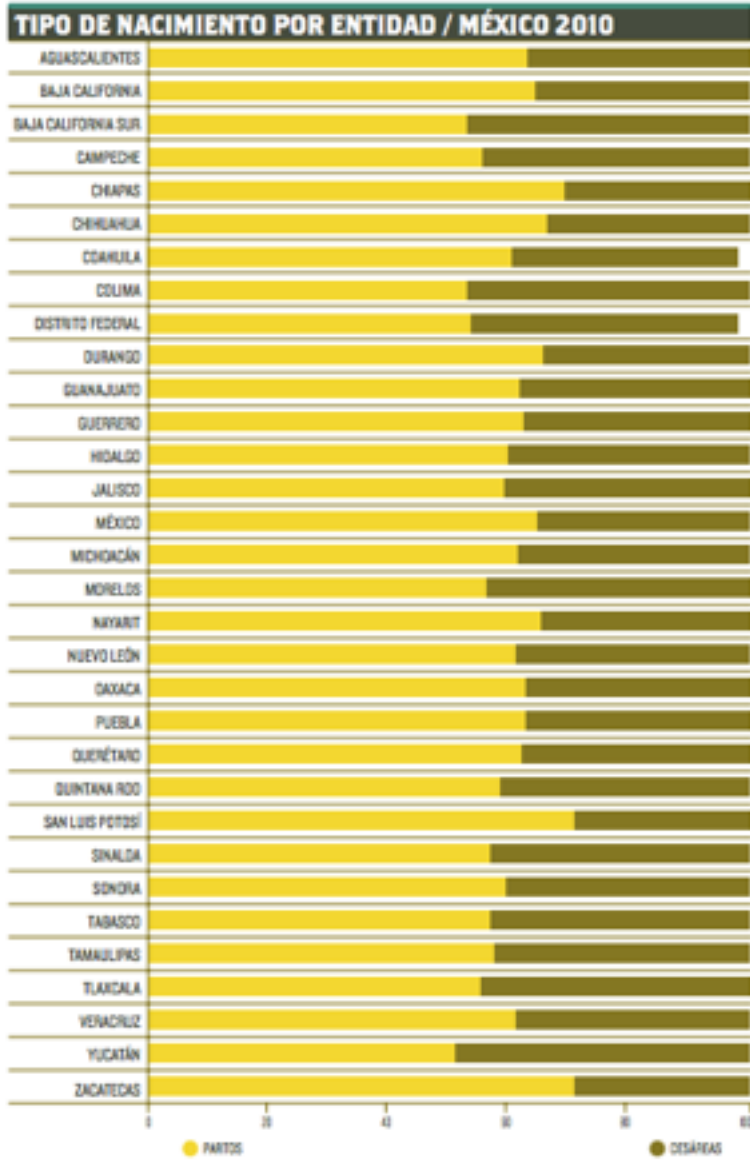
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Annex
Image 1



Fuente: Elaboración propia de GIRE a partir de la información del SINAIS.