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REPRODUCING CHILDBIRTH: NEGOTIATED MATERNAL HEALTH PRACTICES IN RURAL YUCATAN

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REPRODUCING CHILDBIRTH:
NEGOTIATED MATERNAL HEALTH PRACTICES IN RURAL YUCATAN

DISSERTATION

A dissertation submitted in partial fulfillment of the
requirements for the degree of Doctor of Philosophy in the
College of Arts and Sciences at the University of Kentucky

By

Veronica Miranda

Lexington, Kentucky

Director: Dr. Mary Anglin, Associate Professor of Anthropology

Lexington, Kentucky

2017

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ABSTRACT OF DISSERTATION

REPRODUCING CHILDBIRTH: NEGOTIATED MATERNAL HEALTH PRACTICES IN RURAL YUCATAN

This ethnographically informed dissertation focuses on the ways rural Yucatec Maya women, midwives and state health care workers participate in the production of childbirth and maternal health care practices. It further addresses how state health programs influence the relationships and interactions between these groups. Although childbirth practices in Yucatan have always been characterized by contestation, negotiation and change, their intensity and speed have significantly increased over the last decade. Drastic changes in the maternal health of rural indigenous communities in Mexico and throughout the world are directly connected to intensified state interventions that favor biomedicine over traditional health systems. In rural Yucatan, state health programs such as Oportunidades and Seguro Popular support a biomedical approach to birth by distributing medical resources to government clinics/hospitals and encouraging program participation of poor women through conditional cash incentives.

This dissertation seeks to interrogate changing childbirth practices in a rural indigenous community in Quintana Roo, MX to gain a deeper understanding of the complex politics that shape local understandings and approaches to childbirth. It further explores how shifting social relations and political alliances are created within the context of reproductive health. This ethnography highlights how Yucatec Maya women envision a productive, yet negotiated, relationship with the state that allows them control of their prenatal and maternal health while engaging with state health programs. Focusing on the cultural production of childbirth in a rural community in southwestern Quintana Roo, this research seeks to explore the dynamic ways in which indigenous communities are reproduced over time through moments of engagement and contestation with the state. The Maya women in this dissertation exist at the margins of the Mexican government's concerns, policies, and resources. Yet, even at the margins the influence and power of state ideology and policies intimately affect the lives of rural indigenous women. The core argument of this dissertation is that these women, who rely on traditional and historical experience, create strategies for survival and social reproduction despite their marginalized position within the Mexican state.

This research draws from over a decade of fieldwork. Predissertation fieldwork took place during the summer months of 2002, 2003, 2004, 2007, 2008, and 2010. I completed my dissertation fieldwork from January to October of 2013. During that time, I conducted 60 formal and informal interviews and a small survey. Additionally, a large portion of my research took place with a local family that consisted of female healers and health educators, whom I extensively interviewed and conducted hundreds of hours of participant observation. The family was the locus of authoritative knowledge in the community and they provided vital insights into community life and local understandings and approaches to reproductive health. This dissertation follows the Latin American tradition of using testimonios to articulate—and reflexively examine—the layered meanings and intersecting politics that shape changing childbirth practices in rural Yucatan.

KEYWORDS: Reproductive Health, Global Health, Yucatec Maya, Traditional Midwifery, Testimonio, Mexico

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June 25, 2017

Date

REPRODUCING CHILDBIRTH:
NEGOTIATED MATERNAL HEALTH PRACTICES IN RURAL YUCATAN

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This dissertation is dedicated to my parents Veronica Miranda and Brian Gage, and
in memory of my father, Sabino Ibarra Miranda.

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Introduction

Over the last decade, maternal health and childbirth practices of rural Maya women from the southern interior of Yucatan have undergone dramatic changes. These changes, which have taken place throughout Mexico, are a result of the implementation of national health programs such as Oportunidades¹ which are reflective of international maternal health goals and mandates (Gutmann 2007; Molyneux 2006; Smith-Oka 2013a). Oportunidades asserts that maternal health disparities can be overcome by providing biomedical services to marginal populations through the distribution of performance-based cash incentives (Levy 2006; MacArthur Foundation 2008). Oportunidades was founded in 2002 and was largely based on the previous federal program *Progresa*, which was founded in 1997. The state-funded cash incentive program of Oportunidades is made up of two primary components: 1) reducing maternal and infant mortality through preventative care and education; and 2) supporting ongoing education among school age children, especially older girls. This dissertation research is critically imperative because programs such as Oportunidades and Seguro Popular currently serve as models for development worldwide. These maternal health policies cannot succeed unless they take the lived experiences of women into consideration.

Through an empirically grounded analysis of the maternal health related decision-making processes that rural Maya women face daily, this dissertation provides a valuable case study that informs indigenous health policy discussions in Mexico and abroad. In addition, this dissertation adds to the extensive literature on Oportunidades through the documentation of the complex dynamics of indigenous health care by addressing the continuity of local cultural practices as well as their recent alterations, with an emphasis on the knowledge and social position of local empirical midwives and female community leaders. This research also demonstrates how state policies become embedded in everyday decision-making

¹ In September 2014, the Oportunidades program was renamed Prospera. I have chosen to continue using the name Oportunidades in this dissertation because it is what the program was called during my fieldwork and initial write-up.

process, with specific attention to how federal maternal health programs are interpreted and experienced by marginal populations, such as rural Yucatec Maya women. This research has the potential to inform and influence health policy at the local and global levels by demonstrating the complex ways in which state-led health programs are implemented, understood, and experienced by a multiplicity of actors (e.g. local state health workers, midwives, and Maya women).

The ethnographic research in this dissertation focuses on the ways rural Yucatec Maya women, midwives and state health care workers participate in the production of childbirth and maternal health care practices. It further addresses how state health programs influence the relationships and interactions between these groups. Although childbirth practices in Yucatan have always been characterized by contestation, negotiation and change (Elmendorf 1976; Jordan 1993), the intensity and speed have significantly increased over the last decade. Drastic changes in the maternal health of rural indigenous communities in Mexico (Davis-Floyd 2001; Sesia 1996) and throughout the world (Jolly 2002; Kaufert and O'Neil 1993; Van Hollen 2003) are directly connected to intensified state interventions that favor biomedicine over traditional health systems. In rural Yucatan, state health programs such as Oportunidades and Seguro Popular support a biomedical approach to birth by distributing medical resources to government clinics/hospitals and encouraging program participation of poor women through cash incentives. This dissertation seeks to interrogate changing childbirth practices in a rural indigenous community in Quintana Roo, MX to gain a deeper understanding of the complex politics that shape local understandings and approaches to childbirth. It further explores how shifting social relations and political alliances are created within the context of reproductive health. Through an empirically grounded analysis of the maternal health related decision-making processes that rural Maya women face daily, this dissertation provides a valuable case study that informs indigenous health policy discussions in Mexico and abroad.

Focusing on the cultural production of childbirth in a rural community in southwestern Quintana Roo, this research seeks to explore the dynamic ways in which indigenous communities are reproduced over time through moments of

engagement and contestation with the state. For almost a century this was a region where Yucatec Maya fought to exist outside of government regulation. The Mexican government largely neglected the region, viewing it as a desolate, worthless place (Sullivan 1991). This changed in the early 1970s with the onset of the global tourism industry (Clancy 2001). Quintana Roo became a state in 1974. The tenuous relationship between Yucatec Maya and the Mexican state has resulted in continuous marginality for the Maya. Officially, Quintana Roo is economically thriving, but wealth is clustered along the coast leaving the southern interior without many basic resources and necessary infrastructure.

One of the pivotal texts that helped me orient my work was *Nine Maya Women* by Mary Elmendorf. This book, more than any other, helped me think through the work I was doing in this community. Elmendorf was encouraged by Villa Rojas and Redfield to focus specifically on the experiences of women because they recognized that their work on documenting Yucatec Maya culture did not include enough knowledge and depth about the practices, thoughts, and experiences of women. According to Villa Rojas, Elmendorf's "book serves to fill a vacuum in the field of Mayan ethnography, since never before has there been a systemic study of this kind" (Elmendorf 1976:xi). Rather than basing her work on surveys and other generalizing methods, she decided to concentrate her ethnographic work on the women of one extended family. This important aspect of Elmendorf's ethnography became the bases of how I chose to conduct my fieldwork and eventually led to my decision to structure this dissertation around the lives and experiences of one specific family of female healers and health educators/leaders. Like Elmendorf, my dissertation seeks to demonstrate how the experiences of the women of this family speak to the larger discussions about how indigenous women in rural communities throughout the world encounter and participate in their cultural and physical survival in a rapidly changing world.

When I read Elmendorf's ethnography, which was written almost 30 years before I started my own fieldwork, I saw many similarities to life in Sabán and Huay Max. By saying this, I am not arguing that life in these places has remained unchanged. Elmendorf stated that "Mayan women not only accept change, they

initiate or agitate for change—even against their husband’s wishes—if it seems best for them and their children. An example of this is their desire for birth control measures” (Elmendorf 1976:xv). My point, however, is that there was something about Elmendorf’s approach that resonated with my own work—and with the stories and histories that I was hearing about and experiencing while living and working in these rural communities.

Elmendorf’s work helped me understand and talk about how rural Maya women experienced change in a rapidly evolving world. Yet, as her research and mine show, amidst what may seem like inevitable change certain cultural traditions, practices, and knowledges continue to be valued and passed down. Certain aspects of cultural continuity continue to take place during moments of change. My research demonstrates that women in rural Yucatan approach their maternal health in a pragmatic way that considers the newly acquired resources available to them (the benefits of monthly checkups at the community clinic, free hospital births, and access to biomedical medicine and technology that can dramatically increase their safety and that of their unborn child in case of an unexpected complication) while also valuing the knowledge and practices of midwifery that have kept women safe and healthy for generations.

Another influential text that informed my research was Brigitte Jordan’s *Birth in Four Cultures* (1993). Jordan conducted her fieldwork more than a decade after Elmendorf. In her book, Jordan brought reproduction and childbirth into the forefront of Yucatec Maya women’s fight for cultural autonomy and survival. She addressed the asymmetrical power dynamics that existed between indigenous Maya women and biomedical practitioners working for the Mexican state. Her extensive work on authoritative knowledge illustrates how multiple knowledge systems exist in relation to specific spheres of society and how some knowledge systems are valued over others because they are considered the most effective or because they are supported by powerful organizations like the state (Jordan 1993:152). Authoritative knowledge looks at how power relations are organized, maintained, and perpetuated by larger social systems through the production and use of certain forms of knowledge (Davis-Floyd and Sargent 1997). In the case of childbirth, the

Mexican state and its medical practitioners value biomedical knowledge over the knowledge and practices of local traditional midwives. But this is not just about simply *preferring* one system over another. Instead, it is a matter of reshaping the state and its citizenry to fit within a broader historical, political, and economic project. This stems from Mexico's desire to become a "modern" state, in part by replacing the "backward" behaviors of its indigenous citizens with new ideas, ideals, and practices. Yet, as Jordan's work demonstrates, Yucatec Maya women openly challenge this state project, and the unequal power relations that define it, by defending midwifery and holding fast to certain forms of traditional health care. Such acts effectively legitimize traditional forms of knowledge production, while also asserting local autonomy, choice, and desire.

Yucatec Maya midwives and women have alternative understandings and approaches to childbirth that differed from biomedical doctors working in local government clinics. According to Jordan, Yucatec Maya women view childbirth as part of the normal life cycle. They do not consider pregnancy and birth as a medical condition or illness. Birth is not predominantly approached as a threat, problem, or inherently risky event. This view of birth and the birth process marks an important point of departure between these women and the biomedical models that dominate the national health care system in Mexico. But, more importantly, Yucatec Maya women are not denouncing biomedical health care; they openly acknowledge its possible benefits, and often weave aspects of those benefits within a broad patchwork of health practices. While the Mexican state denounces their forms of knowledge, these Yucatec Maya women remain decidedly more open, flexible, and pragmatic when it comes to maternal health. It may be an either-or perspective coming from the state, but this is not the case for the women who are subject to state guidelines, mandates, and discourses.

Finally, the work of June Nash has helped me reflect on how changing childbirth practices and beliefs in rural Yucatan are related to larger neoliberal and capitalist globalization processes that push indigenous and marginalized people to give up their traditional modes of subsistence and survival and move into the formal sector. It is in the formal sector where the state has greater control over the

thoughts, actions, and bodies of people who have existed in its periphery. According to Nash, “the most radical changes are those that have occurred in the settings that were in the past the most marginal to the centers of power” (2001:xi). Nash argues, more specifically, that it is indigenous ways of life that are the most vulnerable to globalization processes. At the turn of the twentieth century, The Mexican government was influenced by the ideologies of intellectuals and politicians who believed that the nation could not progress unless indigenous people rejected their culture and fully integrated into “mainstream mestizo society” (Nash 2001: 66). My dissertation documents how these ideologies continue to take place in the realm of childbirth.

Nash, builds upon the work of Rosa Luxemburg, who explained that global expansion relies upon the incorporation of subsistence-based societies into capitalist forms of reproduction (Nash 2001:6). To achieve this objective, states have participated in a strategy of “systemic destruction and annihilation of all non-capitalist social units which obstruct their development” (Luxemburg 1951:370). Thus, according to Nash, today throughout the world, indigenous people and their cultures are drastically declining.

My work, has also been greatly influenced by Nash’s analysis of gender and globalization. She has shown that women are at the forefront of conflicts over indigenous cultural survival and self-determination because of their commitment to social reproduction (Nash 2001:21). Social reproduction, simply put, is the recreation of society at the household level. It is the unpaid work of women in the home that has ensured the reproduction and survival of indigenous people and peasant society. Continuing with Luxemburg’s attention to expanded reproduction, Marxist feminists have looked at how women’s housework and “mother work” are tied to the mechanism of capital accumulation (Nash 2001:15). Although women’s work in the home is essential to capitalist modes of production and the fulfillment of larger state projects, their labor has largely been ignored and devalued. Nash argues that this is especially the case with development programs. This is seen in rural Yucatan with the implementation of the conditional cash transfer development program, Oportunidades, which does not consider the amount of work women must

do to fully participate in the program. Oportunidades is clear that the target population is the future generations of Mexicans and not the women who birth and take care of them. Women participating in Oportunidades are never rewarded personally for their labor in supporting the objectives of the program. Instead they are morally pressured to participate in the program through state discourses that promote “good mothering” which declare that all good mothers must devote their time and resources into the productive growth of their children (Smith-Oka 2013). In this case, it is the Mexican state that is defining what a good mother is and how children should be cared for.

Building upon social reproduction, in this dissertation, I demonstrate how Yucatec Maya women and the Mexican government have different ideas about what is important and how the reproduction of the family should take place. In this context, women value a home birth and the specialized knowledge that midwives have. These women hold on to specific cultural traditions related to childbirth that they feel are beneficial for them and their family. The Mexican government on the other hand, actively promotes a strategy to move all citizens into the biomedical health care system which the government has discursively labeled “modern” and “safe”. This dissertation explores how ideological tensions between Yucatec Maya women and the Mexican state ultimately take place at the community level. Rural indigenous communities are a key ideological battleground where decisions are made about how and where the next generation of Mexicans will be born.

I would like to conclude with Nash’s work on resistance and the capacity in which indigenous people incorporate change while also holding on to the traditions and practices they value. She states, that “indigenous strategies for survival as a distinct cultural group provide an alternative vision to that of neoliberalism in the global setting” (Nash 2001:20). This dissertation is about how Yucatec Maya women create strategies for basic survival at the margins of the state. It details how these women address their maternal health in a way that grants legitimacy to both state backed biomedical care and traditional midwifery. These practices demonstrate that indigenous approaches to childbirth can exist within state policies. Rural Yucatec Maya women envision a productive, yet negotiated, relationship with the state that

allows them control of their prenatal and maternal health while engaging with state health programs. In the end, this ethnographic work is about indigenous identity, practices, and subsistence against state intrusion.

This dissertation follows the Latin American tradition of using *testimonios* (Behar 1993; Detwiler and Breckenridge 2012; Maier and Dulfano 2004; Nance 2006; Stephen 2013; Rosales 2000) to document the voices and experiences of marginalized individuals. Testimonios are not only an oral telling of a person's experience and understanding of an event (bearing witness) but they are also performative and have the capacity to be used as political tools that document the everyday experiences and strategies of survival of marginalized and subaltern people (Stephen 2011). One of the central themes in testimonio literature is the documentation of human rights violations of a community by "agents of the state" (Gugelberger and Kearney 1991:11). Testimonio strategically speaks "*from within a collective*" with the purpose of inciting social and political change (Mohanty et al 1991:38 italics in original). This means that the specific stories and accounts that are used in testimonio literature come from and represent a larger experience that is shared by the community from which the testimony is being given. Testimonios demonstrate how lived experiences and everyday life are intertwined with larger political, economic, and social processes (Latina Feminist Group 2001).

Mohanty explains how resistance can take place in the practice of remembering, and in the case of this dissertation in the act of telling. As she concludes, "agency is thus figured in the minute, day-to-day practices and struggles of third world women" (Mohanty et al. 1991:38). As Harlow (1987) states, testimonio is a form of resistance literature. Furthermore, Rosaldo (1993) and Gugelberger and Kearney (1991) remind us, the people who have been and continue to be objects of social analysis now challenge the colonial practices of anthropology by insisting on being subjects who speak for themselves rather than objects that are spoken about. By using testimonio I acknowledge that the women with whom I spoke and who participated in this dissertation can clearly articulate how their prenatal and childbirth choices are constrained by the larger social, political, and economic systems in which they live. Although these women understand the

realities of their life and are critical of the Mexican state, their subjectivity and positionality (female, rural, poor, indigenous) does not provide them with enough platforms to publicly voice their opinions and dissent. I am keenly aware that the Yucatec Maya women who participated in this research have the capacity (as they have demonstrated in the past) to demand their voices be heard. I have chosen to incorporate the method of testimonio in this dissertation to provide an additional space where these marginalized women can express their challenges and everyday life experiences as a form of resisting state dominance over their lives and bodies. I am also using testimonio to highlight how women use rumor and personal communications as indigenous modes of resistance and political activism against the encroachment of the Mexican state in their reproductive lives. In the documenting of these women's stories, rumor became a common theme that was threaded throughout our conversations as well as the ones they had amongst each other. Rumor, embedded within storytelling, shifted the power dynamics in favor of rural Maya women over state officials who tried to assert the "right way" to give birth. The testimonios in this dissertation illustrate how rumor became yet another mechanism in which women fought for cultural continuity and countered biomedical hegemony. Women's words are included directly in the text and italicized instead of placed within quotation marks to thread their voices throughout the manuscript. In the end, it is my way of trying to tell a story together.

This research is a product of fifteen years of living and working in a remote community in Quintana Roo. It is a testament to the importance of long-term fieldwork. Every previous encounter and experience informed the current research moment. The most important thing I have learned throughout these years is that an extended amount of time working in the same place on a similar topic has provided me with the invaluable opportunity to gain a more profound understanding of my research and its questions—every time I returned to the community I learned something new, I understood the things I had previously known at a deeper level, and I was also able to check my work and analysis by following up with key participants as well as extending my research network. I serendipitously began working in the communities of Saban and Huay Max as an undergraduate. The

experiences I had during those early years and the relationships I established with various community members continued to bring me back. This next section walks you through my first encounters with rural Maya life and my experiences as young anthropologist.

Anthropological Beginnings

The cold and persistent rains of Humboldt County were at times a bit unbearable for a girl from sunny Southern California. To escape the cold, I would frequently walk through various campus buildings on my way to and from classes. It was my third year at Humboldt State University (HSU). I had just returned after participating in the National Student Exchange program, in which I spent the previous spring semester in the wet, but warm, tropical scenery of the Big Island of Hawaii. After returning from an amazing and enriching experience in Hawaii, I came to the realization that I wanted to continue to explore the world and get to know people living in different places and communities. My time in Hawaii taught me that I did not want to jump around the globe and rush through a place to fulfill the shallow purpose of saying "I had been there." No, I wanted to get to meet people and share in their everyday life experiences by staying in a place for an extended period. As a young college student with very limited means I knew the best shot I had was to enroll in a study abroad program. Luckily, HSU had many. So, as I walked through different departmental buildings, I would frequently look at the patchwork of flyers that littered the walls. One day I found a paper that suggested students come to the Study Abroad Office and look through the numerous programs that were available to students. The next day I went, and looked through a thick binder full of possibilities. One stuck out over them all.

I had found a short description about the Yo'Okop archaeological field school in the Yucatan peninsula. The selling point was that all room and board was paid for if I worked 30-40 hours a week as an archaeology intern. The program had additional benefits beyond being free. I could experience working in my major (anthropology), I could earn a few credits to apply for my degree, and I thought I would have an easier time navigating the environment since I spoke Spanish and

had spent much of my childhood in Mexico. I called the information number, which happened to be a local community college professor's home, and asked if I could join the program. I met the project directors, Justine Shaw and Dave Johnstone, at the information and training meeting held at their home. They talked about their project and had us students play around for a couple hours with the mapping equipment we would be using. There were a total of six of us who had signed up and were ready to embark on this new journey. And that's how in 2002, I started working in Yucatan at the age of 21. It is an experience that has resulted in me working over a decade in the same rural Yucatec Maya communities of Saban and Huay Max.

My undergraduate training at Humboldt State provided me with a good foundation in anthropology, but the strength of the program was in its emphasis on practice and methods. I was encouraged to go into the field as soon as possible and start doing anthropology. I was taught that the foundations of anthropological practice and theory could be applied anywhere. Anthropology was not meant to only be discussed and practiced in the classroom. For a young and admittedly naive adult, this was one of the draws of anthropology. I could go outside and start participating in the world to better understand it. Anthropology provided me with the hands-on approach I was looking for. I wanted to do something immediately that would allow me to apply the skills and knowledge I had gained in my undergraduate education. I felt that I had received adequate training to do anthropology and I was ready to do it. I had taken and passed all my undergraduate courses in anthropology and was months away from receiving my BA in anthropology. However, as I eventually learned, one of the challenges with rushing into the field was that I had not spent enough time learning how to ground the observations I made within a theoretical analysis. I lacked the tools to connect what I was seeing to larger social and political processes. I was young and I was trying to understand the community I was working in with the limited tools and experience I had. I went slow, wrote down everything I thought was important, and focused most of my time getting to know people. I had tons of notes of descriptions but no discussion of the larger meanings behind them, but I made friends and in the process established lasting relationships with many members in the community. And these relationships grew stronger every

year I returned to work after promising the year before that I would come back. Most people were genuinely surprised that I meant what I said and returned year after year.

First Encounters

The Yo'Okop project was named after the archaeological site that pertains to the ejido² lands of Saban. The site is everything I imagined a ruin city would look like. It is completely covered by thick forest vegetation and an abundance of wildlife. It can only be accessed through narrow dirt roads that are maintained periodically by local men who hunt and have their milpa³ in the area. The archaeological site is located 12 km southeast from Saban's main plaza. Due to the remoteness and lack of infrastructure, most of the residents of Saban and Huay Max have not gone and explored the site.

That first summer in 2002, I lived with the Yo'Okop archaeological team at our base camp off one of the small entrance streets to Saban's plaza. Dave and Justine were fortunate to have found a relatively large house that they could rent for the summer since available rental housing was almost non-existent because of a low demand. All dwellings in the community were used and lived in. The base camp consisted of a cinderblock structure that was next to the owner's house and shared a common outdoor area with the owner and his wife. The structure had two large rooms, the first was used as a common work area and cooking/eating place. The other adjacent room was also large but it had a high thatched ceiling and a small basic restroom off to the side. It was in this room where all us students and workers

² As a result of the Mexican Revolution of 1910, Article 27 of the Constitution was written to address land-tenure inequality. Mexico's ejido system granted land for agricultural use to members of a community (primarily men, although women could inherit land) to either farm collectively or individually. The land is communally owned regardless if it is divided into individual plots.

³ A milpa is a plot of forest land that has been cleared for agricultural use. Slash and burn agricultural methods are dominant form of cultivating these lands. The milpa is part of a crop growing system that traditionally has grown maize, beans, squash and other staples together. Maize is the primary subsistence crop grown in these milpas and they are predominantly maintained by men.

hung our hammocks and claimed a 10 by 3-foot space as our own. It was close quarters and we all had to learn to like each other very quickly.

Across the road from our camp house was a little store that was sparsely stocked with basic household and food supplies. The store was built into the front room of a house where a family of 5 lived. The second child was a little girl around the age of 7, named Alejandra who was friendly, full of life, and naturally curious. She was often found playing outside her house with her neighbor, a little boy about the same age named Ricardo. Living across the street from a house full of gringos meant to them that they had access to the best show in town. They had a hard time fighting the temptation to break from cultural norms and stand outside our door and watch everything we were doing. We were now living in a fish bowl, but the kids were young and sweet, and cute, and in the end, we didn't mind having our space invaded by them. We all became friends and by the end of the summer, both Alejandra and Ricardo were unofficially sponsored by the project—meaning we gave them some t-shirts and left-over gear (hats, toiletries, bags) before we headed out of town.

It was because of Alejandra that I met her mother, Elena. Elena was kind, and funny, and had an inviting personality. Her husband, Alonso, was equally as nice and the two would often engage in conversations with us after we came home from a long day working in the field. Outside her store, in the late afternoons, I would sometimes sit and talk with Elena, getting to know a little more about her, her family, and what life was like in the pueblo. As we became friends, I got to meet other members of Elena's extended family. They were a tight knit family that enjoyed each other's company and was supportive and loving. Elena and her family were some of the first friends I made in the community. And when I left at the end of my two-month field season, we said our good-byes with a hug and a smile.

I came back the following summer in 2003, not as an archaeologist, but now as an ethnographer. I had enjoyed the unique experiences and adventures working in Yo'Okop the previous summer. I learned how to survey, map, and excavate. The experience was amazing, but I kept being drawn to wanting to learn more about the people with whom we were working and living. I wanted to talk to people and this

was made clear for the last two weeks of the field season in 2002. I was allowed to help the project's cultural anthropologist, Sandra Bever, conduct an economic impact assessment of the effects the archaeological project had in the community. During those two weeks, I walked around Saban and Huay Max and met many of its residents. I conducted interviews, work histories, and income source lists of 15 people from the community that were employed by the project as either male field workers or female laundry washers.

In 2003, Justine, as the project director, had given me the approval to start my own ethnographic project. I was given complete freedom to decide what I wanted to investigate. I was excited but a little overwhelmed at first with having to pick that one "thing". After much thought and a couple back and forth decisions, I choose to focus on childbirth. My interest in childbirth stemmed from my conversations with Elena and other women in the community the year before. Children were everywhere in the community and there seemed to be a general appreciation and love for them. I think I also chose to look into childbirth because of my own desire to one day have a child of my own. I wanted to learn more about birth because it was something I had very little knowledge of and experience with and I was fascinated by it all.

That second summer, I expanded my network of friends and acquaintances. Through the help of the young intern doctor working at the community clinic, I meet two of the most prominent midwives working in the area. I spent many hours with these women documenting how they worked and the struggles they faced as midwives in a rural community. And our relationships strengthened over the years. Starting my own ethnographic project at the age of 22 was difficult in some ways because I did not have much training in cultural anthropological methods. I had experience with interviews and some survey work, but I struggled with figuring out how to get people to talk to me. In the end, the method I found most useful was spending hours walking around the community—being seen and saying hello to everyone. These were long hot wandering days, but they proved to be the most effective. I would always start the day with some sort of far destination, just so that I had a place I could say I was headed to. Some days I would walk from Saban's main

plaza to the colonial Catholic church in Huay Max. Other days I would walk to various corner stores and buy a random item—a soda, some tomatoes, dish soap. And on other days I would visit the house of people I had talked to on a previous day or had recently made friends with.

In the mist of all my wandering, I would always end up at Elena's house. Maybe it was because she lived across from me, or maybe it had to do with the fact that she was so open and friendly. But I also can't forget how Alejandra and Ricardo would always bring me into their homes. That second summer I started to get to know Elena and her family. I soon started getting invited to family events. I went to Alejandra and Ricardo's elementary school end-of-the-year recital and graduation. I also started going to the home of Elena's parents. Elena's parents owned a big piece of property near the Catholic church off the plaza, which was a short walk from Elena. Most of the properties close to the town center were large and distributed to the earliest residents of the community that came from nearby communities in the state of Yucatan in the early twentieth century. Elena's family owned a valuable piece of land but its value was significantly increased by the housing complex that they had built. The property had a large three-bedroom cinder block house that was divided up into family living spaces for Elena's parents, her youngest brother, and two older brothers and their families. Attached to her parents' house, her older sister, Olivia, built a slightly smaller three-bedroom block house for her and her two daughters. The front room of her house was used as her working space where she spent hours working as a seamstress. Olivia's house also had one of the few land line phones in the community and many people often came to her house and paid to make a call. It was a busy housing compound and there was always someone around doing something⁴.

⁴ Later, in 2011, Olivia built a two-story apartment complex. It was the first of its kind in the pueblo. There was a total of four apartments. Each one had a small kitchen and a private indoor bathroom with a shower and toilet. Olivia rented the apartments to some of the teachers and administrators working at the local schools and for a year she rented a room out to a young girl from a neighboring pueblo who lived during the week in Sabán to attend the Bachiller (high school). And for a short time, a semi-retired physician from Mexico City rented one of the bottom

Elena's family soon took me in and shared meals with me—we celebrated many birthdays and family milestones. To give back I took pictures and would bring back the prints every year I returned⁵. As the years went by my relationship with Elena and her family strengthened. But it was not until the summer of 2008, when I moved into Olivia's back room that I felt a deep connection to the family. I was living in the middle of their family, in the center of everything and everyone—4 different households, not including my own, living symbiotically under one housing compound. My daily life in many ways revolved around theirs. I was conducting my thesis research that summer and I returned to live in the pueblo with my husband. It was the first time anyone had met him. They only knew of him from a photograph I had brought the year before. Everyone was so interested in my new status as a wife. Coming back as a married woman marked my transition into adulthood but that would not be complete until many years later when I returned with my infant son. Marriage and motherhood in the community where the rites of passage that transitioned a woman into adulthood.

My identity as a young university educated Latina—born in the US to immigrant parents from Mexico—has also intertwined with my research in Yucatan. Growing up in the United States and visiting family in Mexico for long trips during most of my childhood, I always felt a sense of belonging to both countries. However, feeling a strong connection to a place does not always mean that its (diverse) people

apartments and attempted to start a private practice in the community. He eventually ended up leaving the community because he did not have enough patients to support his living costs. When we arrived in the summer of 2013, we inhabited the top left apartment which had previously belonged to the young female student.

⁵ My early years in the field I had a 35mm Minolta camera. At that time in the early 2000s I would have to take my film into the city of Valladolid to be developed and printed. This proved to be difficult since Valladolid was a 2-hour drive from Sabán. In the end, it was easier for me to take all my rolls of film home and come back the following year with the prints. And unknowingly, this practice of distributing photos from the previous year proved to be a valuable way for me to get back into the community and re-establish contact each time I returned. By 2008, I had a digital camera and printing photos was much easier and more accessible in Valladolid. After 2008, I distributed all photo prints at the end of my field season to say goodbye and thank you.

will accept you as one of them. Perhaps because of my childhood experiences, which were characterized by years of negotiation of my own identity and attachment to various places, when I came to do research in the Yucatan peninsula I knew that I was an outsider. And everyone in the community also knew it too. Although I had been conducting fieldwork in Saban and Huay Max for more than 12 years and had established lasting relationships with various individuals, many people in the community still referred to me as a *gringa*. This was a term that was especially used by children. In one instance, I remember a couple boys between the ages 5-7 playing outside their house. When they saw me walk by, they stopped playing to sing me an impromptu chant that repeated the word *gringa* about five times. I smiled at the boys and they got slightly embarrassed, smiled, and returned to playing.

I was not thrilled being called a *gringa*. I have never identified as a white woman from the United States. As a woman of color in academia (more specifically, US anthropology, a historically white dominated discipline with colonial roots) I have struggled with feelings of not belonging and have worked hard to carve out a place for myself. Being called a *gringa* by people from Saban and Huay Max was another way in which my identity as a Chicana researcher and scholar of color was challenged. But unlike my experiences in the United States, these instances were different. They were a direct response to my privilege and positionality.

I tried not to show my disappointment or displeasure with being called a *gringa* because I understood why the term was applied to me. It meant, more than anything, that I was from the United States. But it was also a reference to whiteness or a proximity to it. I first came to work in the pueblo with the Yo'Okop archaeological project, which was run by two white archaeologists and all but a couple of the students were white. Since I worked with the project I was considered one of them, and so, was identified as *gringa*. Interestingly, a year later the project employed two Mexican archaeologists, and the lighter skinned archaeologist was also referred by various members of the community as a *gringo*. Being a Mexican national, this was clearly upsetting for him. But there were other legitimate reasons as to why I was called a *gringa*. I spoke English without an accent. I had a US passport that allowed me to enter and leave the United States and Mexico as freely

as I wanted. I was educated at a university and was in the community for the sole purpose to conduct research on the history and contemporary practices of its residents. I looked and acted like other people from the United States. The clothes I wore reflected US fashion trends. I carried with me expensive equipment—a camera, computer, voice recorder. I looked and acted differently than everyone in the pueblo. In the end, I stood out based on my class, privilege, and access to resources. More importantly, being called a gringa was a way in which the Yucatec Maya people whom I was living and working with challenged the power and privilege that I represented—just as they had responded to the physicians working at the government clinic and other representatives of the state. It was important for me to acknowledge that my presence in Saban and Huay Max was part of a long history of outside interference and occupation in rural Maya communities. The small act of being called a gringa powerfully delineated our cultural differences, cemented Maya struggles for autonomy, and defined relationships of mutual respect on their terms.

Working over a decade in the same community provided me with a unique opportunity to learn through experience. I was able to see children grow up, and be a part of people moving through life, even if I was only an observer. But it was not until just recently that I realized my continued presence in the community also meant that its members had in turn also seen me grow and change.

Being There

Living and working in the pueblo meant that my life and that of my family would be entangled with my fieldwork. This was something I knew ahead of time from my earlier field experiences. Yet, I was still surprised by how different it was coming back to Saban and Huay Max with my infant son. Babies are loved in this community. They are passed around and cared for by mothers, fathers, older siblings, and extended family. Babies go everywhere with their mothers—they are at public gatherings, religious events, and community meetings. Having my son with me while I worked in the field provided me with an entry to talk to people about my project but it also humanized me. I was a little less alien, because I too had a child

that was living and growing up in the pueblo. Returning to the field as a mother, I was now seen differently. Even though I gave birth in a hospital in the United States, women in the community started to talk to me like I was part of the conversation because I had also labored and had a child. In 2013, while conducting the bulk of my dissertation research, I came back to Sabán and Huay Max as a married woman and as a mother. I had finally passed the major rites of passage into womanhood that were so revered in the community. I was now socially accepted as an adult and a woman.

Snapshots of an Average Month in the Field

Below are a few examples taken directly from my field notes of a summer month in 2013 that show how my daily life in the field was always tied to my dissertation project. These examples are a glimpse of what life was like for me as an anthropologist, wife, and mother. My reasoning behind sharing these snapshots is to demonstrate how many conversations about women's birth experiences and reproductive health organically came about through daily life. This is how participant observation works. I was living in the community with the women I was working with. I shared space with them and had many meals together. My family and I attended their parties and religious events. And our children played together. In addition to demonstrating how I conducted participant observation, these snapshots introduce the Maya women who live in the research community and they highlight some of the key issues that take place in relation to childbirth and maternal health.

June 24, 2013

Ryan came up stairs after picking up our laundry from Tina and told me that Irene was downstairs visiting. I finished my dinner of Indian lentils and walked downstairs to the front of Olivia's house. There was Irene holding her little baby. Sitting next to her on the curb was Daniela and her baby. Several other little kids were around them playing and messing around. Sonia, Erica, Talia.

Irene talked to me about her birth experience with Violeta. Irene was in a coma for 8 days and it took her 3 days after waking up to remember who her family was and that she was pregnant. She has no memory of the birth or during the time she was in a coma. Her husband and family members; daughter Mia and sister-in-laws had to tell her what happened. She did not get to see her baby until she left the hospital 3 weeks after the birth. After an emergency C-section the baby was kept in the hospital for 3 days and then Irene's husband took the baby home to his brother's house in Chetumal. Mia and Irene's sister-in-law looked after the baby until Irene came home. But it took Irene a long time to recover—she was not able to carry and take care of the baby until Violeta was three months old. She was not able to breastfeed the baby because of the medications that she was taking. She was taking 14 different pills once she left the hospital. The baby never had breast milk.

Irene said that it all started with her experiencing strong pains in her upper abdomen. She said that it was not labor pains. It was her 6th child, she knows what labor pains are. She was planning on having the baby at home with the assistance of Elena. But they decided to go to the hospital because her pains were intense and she knew something was wrong. She was only 36 weeks along. The baby was 4 weeks early. The pains started around 8pm. They [her husband and Elena] had called Daniela to come look at Irene and assess the situation. Daniela had just come home from a C-section. Daniela's baby was born July 23 and Irene's daughter was born July 29. Daniela told them that Irene needed to go to the hospital. So, they took her to Morelos around 11pm. It's the closest hospital. After being admitted and assessed by the doctor he determined that her situation was serious and that she needed to be transferred to Chetumal (a 3-4 hour drive away). She was put in an ambulance with her husband. While passing a small pueblo outside Chetumal, Irene had two seizures. She said that she remembers everything up to that point, and then her memory is completely blank. She said it wasn't

like you see in the movies were the person's spirit is above watching. She said it was like she was dead. Nothing happened; she did not experience life consciously while she was in the coma. She was completely gone.

Irene went on to discuss the reasons why she thought the baby came so early—reasons that were both biomedical and cultural. She also talked about her experience in the hospital and the bureaucratic hurdles they had to go through to get her the care she needed. Irene shared the battles her husband had with the hospital and the state funded insurance (Seguro Popular) to cover all her care while in the hospital. In the end, her husband had to scramble around and borrow money from family to pay for costly blood transfusions that the hospital stated were not covered by the state insurance.

This conversation took place outside in the front patio of Olivia's pink house. In the late afternoons, once the intense mid-day heat has begun to subside, people often congregate outside of their houses. For Olivia's family, this is one of those places.

July 9, 2013

Power was out early this morning, probably around 4-5. No, I think it was more around 5 or 6 before the sun was out. Did not turn back on until 1pm. We were burning up, super-hot, super humid, and Pau was having a hard day—he was ok in the morning but once the heat started coming in he got worse. Super humid—Olivia came up to see us because “Blondie” [Olivia's grandson] heard Pau [my son] cry and pointed up to our room and wanted to see him. We chatted with Olivia for a while. Because the power is out no one could make maza [freshly ground cornmeal], since the molinos [electric grinders] aren't working. Olivia was a little worried about what she was going to give her dad for lunch—no one eats regular store-bought tortillas. Olivia told us how Blondie hasn't been feeling good so they had to get him some ointment for his bottom and they also had to get a bunch of boiled herbs to help bring his fever down. He also had diarrhea and according to

Olivia sometimes that means the intestines are out of place, so Olivia took him to Elena for a sobada [a traditional healing massage] and now he is feeling better. Little Talia is also not feeling good, and has been falling a lot. Olivia told Tina to take her over to Elena for a sobada because her intestines must have also been out. Olivia's oldest daughter, Daniela, did not go to work today because her stomach has been bothering her as well, so she went to Elena's house as well, but there were a lot of people waiting there to get massages. So, Tina and Talia might have to wait a while—this could mean there's something going around.

Power outages were a common occurrence in the community. They reflect the larger problems of instability and unreliability in infrastructure and access to basic resources the community has experienced for more than half a century. Although, the state of Quintana Roo had provided Saban and Huay Max with the infrastructure for power 24 hours a day, it has proven repeatedly to be flawed and undependable. Sometimes the power was out for only a few hours during the day, other times it was out for several days especially if the outage took place on the weekend. The power outages had a direct impact on the daily activities of women who stayed home and spent much of their energy on completing certain domestic responsibilities. Without power, corn could not be ground to make fresh tortillas which were the daily staple in all meals. Many women in the community now had access to basic electric washing machines which significantly cut back the hours they spent washing clothes, but these machines were useless without power. During the hot and humid summer, fans helped provide a little relief from the heat, but again, without electricity, inoperable.

This snapshot also addresses how midwives—in this case, Elena—are viewed by the community as primary health care providers not just maternal health practitioners. People choose to go to midwives to seek care for general health issues or to relieve symptoms of a minor illness, such as an upset stomach, fevers, and diarrhea. Even Daniela, who is a biomedically trained nurse, regularly seeks care from her aunt Elena, an empirically-trained midwife. Daniela, with her medical and

science education, extensive technological training, and years of experience working as a biomedical practitioner in various state settings (hospitals and clinics), values the care midwives provide. Through her own practices of health, Daniela acknowledges that midwives have different types of medical knowledge that is valued by the community. Daniel's valued professional relationship with her aunt Elena is one example of how members of the community grant authoritative knowledge in relation to health and wellbeing to midwives. This example also demonstrates how in a setting where medical pluralism exists, midwives and biomedicine are not always viewed as a binary in opposition of the other, instead they each can provide different specialized form of health care.

July 20, 2013

I talked with Cassandra, Daniela, and Olivia about my birth story. Cassandra had asked what it was like to give birth in the US. I shared with them my experience, and Cassandra and I reflected on aspects of our births that were similar. For example, I said that I had experienced back labor⁶ and that I needed Ryan to constantly push on my lower back to help relieve the pain. Cassandra also had back labor and she said it was because we had boys. According to her, boys produce back labor, whereas with girls the labor pains are felt in the front lower abdomen. We also talked about how painful it was to deliver the placenta because the doctor or nurse has to push hard down on the abdomen to help the body expel it and all the remaining blood.

Cassandra had her mother deliver her first baby, Enrique. He was born at home. With her second, Vicente, she went to the hospital in Morelos to deliver. She didn't want to go. She said that she didn't like the way doctors and nurses treat you in the hospital. Plus, she felt more comfortable in her home and would have preferred to give birth there. She went to the hospital because the clinic doctor at the time was refusing to give women signed birth

⁶ Back labor is intense lower back pain experienced during contractions and sometimes between them.

certificates and was denouncing home births. She didn't want any problems and she wanted to make sure that she got her son's birth certificate as soon as he was born. She said that she felt the labor pains in the middle of the night and left to the hospital at 9am. Vicente was born around noon and she left the hospital that evening and returned to the comforts of her home. She said that she had to labor alone in the operating room. Cassandra and Daniela both said that hospitals here are very strict and they do not let anyone into the OR to accompany the birthing mother. Once you give birth you are transferred to the recovery room. If you have to stay the night, then you will usually be sharing the room with another patient. A curtain between you and the other patients is the only privacy you have. In Morelos, you are able to sleep with the baby whereas in Peto where Laura gave birth the baby was taken to the nursery and brought out only for feedings. During a "normal" vaginal birth you stay in the hospital for a day or two. If you have a C-section your stay in the hospital is three days. Cassandra delivered her third child, daughter Rebeca, at home with the assistance of Elena. She said that now women are back to giving birth at home. Once the clinic doctor left the practice of midwifery continued, only some women go to the hospital to give birth now.

During the many years, I have spent working in the community, I have shared so many stories and experiences of my life. Here, on this particular day, I talked with Daniela, Casandra, and Olivia about what it was like for me to give birth. As I shared my experiences, they opened and shared theirs. We talked about and clearly understood that my experience of birth in the US was remarkably different than theirs. I gave birth in a large hospital in a major city in the US where my husband and mother were allowed to be with me the whole time. This fact was something that I had admittedly taken for granted. It never occurred to me that my husband would not be by my side the whole time I labored and especially during the birth of our first child. I also never questioned the fact that my newborn son would not be by my side the whole time I was in the hospital. Additionally, I had labored and

delivered in a hospital room that was intentionally made to look more like a bedroom than an operating room. So, yes, we were all aware that I had a very different labor and delivery experience. My hospital birth was more like the ones they saw on popular soap operas. Yet, even though our births were so different, we still shared certain similarities. Casandra was the one to bring that up. We talked about what it was like to give birth for the first time and not know what to expect—of being scared and nervous. We talked about dealing with the pain associated with labor and delivery and how we depended on the support from our husbands and family.

During these moments of sharing our birth stories, Casandra talked about the various experiences she had while giving birth to her three children. Her story reflects the ways in which childbirth practices in Saban and Huay Max are directly influenced by the relationships women have with the biomedical practitioners working at the government clinic. Depending on the doctor, women may feel forced or coerced to give birth in a hospital even though they do not want to. This was something I witnessed throughout the years working in the community. Women would often talk to me about their relationship with the current government doctor working at the clinic and explain how s/he treated them and addressed their needs as patients. Some years, women would talk about how the doctor was supportive and accessible and other years they would share their frustration in working with a physician who they felt did not value their perspectives and traditions. Casandra's birth decisions demonstrate the power local doctors have in rural communities. These doctors are not only representatives of the Mexican state but more importantly they are backed by its authoritative power. Furthermore, what is interesting about her story is that it demonstrates how women move back and forth between home births attended by a midwife and hospital births depending on the situation and relationship they have with their state health care providers.

These three snapshots are intended to introduce you to the research community and show how the experiences I had daily while living in Saban were always tied to this research project. The purpose is also to highlight some of the

conditions and ways in which these rural Maya women are addressing their maternal health. This next section goes more into detail about the research setting.

Research Setting

Since the consecutive introduction of the tourist sector and the establishment of statehood in the 1970s, Quintana Roo has grown to be one of the wealthiest states in Mexico—the fourth highest GDP in the country (Talamantes 2008)(see figure 1). However, this wealth has predominantly stayed in the hands of political and economic elites, often from other parts of Mexico or from foreign countries. Geographically, wealth is clustered along the coast, leaving the southern interior without many basic resources and necessary infrastructure. The remote Yucatec Maya communities in Quintana Roo have benefited little from the state's rapid economic boom (Juarez 2002). Communities such as Saban and Huay Max have largely been left out of tourism development projects because they hold few resources that are valued by international tourist—they lack a maintained historical city space such as Merida or Valladolid, their archaeological site of Yo'Okop has not been reconstructed and is largely inaccessible to most people, and most importantly, Saban and Huay Max are at least four driving hours from the coast where the majority of tourism resorts are located. Due to their deemed low tourism value, communities such as Saban and Huay Max have been largely left out of international and federal tourism development projects.



Figure 1. Map of Mexico. The state of Quintana Roo is highlighted in black.

The state of Quintana Roo has a population of 1,319,485 residents (INEGI 2010). Nationally, it holds the 25th place of out 31 states in population size (INEGI 2017). Mexico has a total population of 119,530,753 residents⁷. Quintana Roo is divided into 9 municipios (municipalities). They include Benito Juarez (pop. 659,311), Othon P. Blanco (pop. 243,286), Solidaridad (pop. 158,599), Cozumel (population 79,060), Felipe Carrillo Puerto (population 74,535), Jose Maria Morelos (pop. 37,038), Tulum (pop. 27,526), Larzaro Cardenas (pop. 25,078), and Isla Mujeres (pop. 15,052). The average number of children born alive to women 12 years and older in Quintana Roo is 2.0. It is the second lowest reproductive rate in Mexico—the lowest is 1.9 in the Federal District of Mexico City and the highest is 2.8 in the states of Guerrero and Zacatecas (INEGI 2017). In 2015, the number of infant deaths (children who died under one year of age) in Mexico was a total of 3,862 (ibid). In Quintana Roo, the total number of infants who died in 2015 was 335. The number was at the lower end of the national reported numbers for infant deaths in

⁷ INEGI 2015a (cuentame.inegi.org.mx/poblacion/habitantes.aspx?tema=P)

each state. Maternal mortality in Mexico has decreased by almost half in the last decade (OECD 2015:40). In 2000, Mexico had a national maternal mortality rate of 74 deaths for 100,000 live births. In 2013, the number was 38 deaths for 100,000 live births. Quintana Roo and Queretaro have made the most significant progress in reducing maternal mortality rates by 60 percentage points from 2000-2013 (ibid). The chart below presents the total number of maternal deaths in Mexico from 2002-2011 (Figure 2) (Freyermuth Enciso and Luna Contrerar 2014:51). It also shows how many of those maternal deaths were preventable. Overall, the number of maternal deaths in Mexico has dropped over the last decade. Yet, in as the chart highlights, in 2011, 75.1 percent of all maternal deaths in Mexico were preventable.

Period	Maternal Deaths	Preventable Maternal Deaths	Preventable Maternal Deaths as a Percentage of all Maternal Deaths
2002-2006	6,263	5,257	83.9
2007-2011	5,386	4,046	75.1
Total form 2002-2011	11,649	9,303	79.9

Figure 2. Maternal Deaths compared to Preventable Maternal Deaths in Mexico between the years 2002-2006 and 2007-2011 (Freyermuth Enciso and Luna Contrerar 2014:51).

The research site consists of two adjacent sister *pueblos* (Saban and Huay Max) located in the western border of Quintana Roo (see Figure 3). The pueblos are in the municipality of Jose Maria Morelos (often referred to as Morelos), in southwestern Quintana Roo, Mexico (see Figure 4). In 2014, Jose Maria Morelos was the municipality with the lowest gross revenue in the state of Quintana Roo and it was also the municipality with the lowest gross expenditures (INEGI 2015b). The National Population Council (Consejo Nacional de Poblacion) report (2010) ranks

the municipality of Jose Maria Morelos as the most marginalized in the state of Quintana Roo. It is closely followed by Felipe Carrillo Puerto, its neighboring municipality. Jose Maria Morelos has the largest percentage of people living in towns with less than 5,000 inhabitants in Quintana Roo⁸ (CONAPO 2010). Like the majority of the pueblos in Jose Maria Morelos, Saban and Huay Max are rural and significantly removed from any major highway; inevitably meaning vital economic, political, and health resources are considerably limited.



Figure 3. Location of Saban and Huay Max in relation to other major cities and towns in the Yucatan peninsula.

⁸ The actual number for Jose Maria Morelos is 67.52 percent of the population living in towns with less than 5,000 inhabitants. Felipe Carrillo Puerto comes second with 65.69 percent.

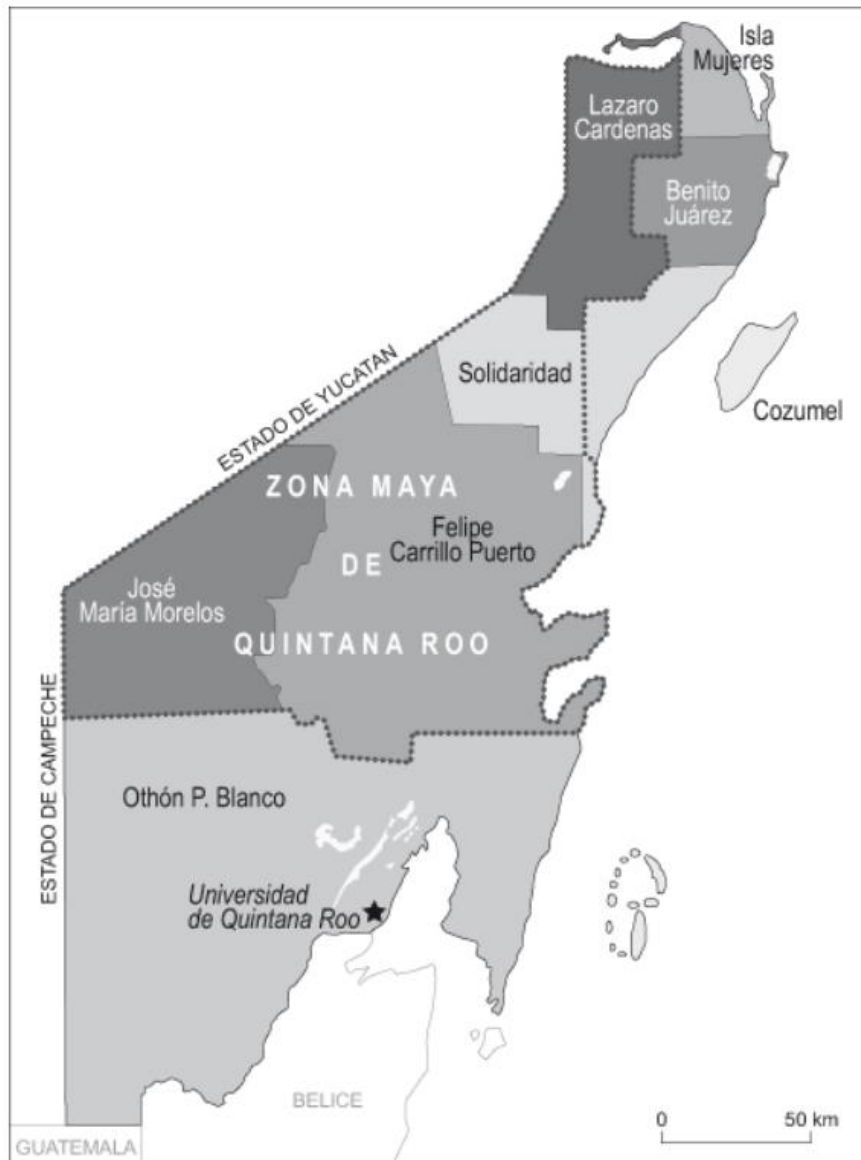


Figure 4. The different municipios located in the state of Quintana Roo. It also highlights the Maya Zone in Quintana Roo. The darkest sections are municipios that have the highest number of indigenous residents (Canul Gongora, et. al 2008).

The municipios of Jose Maria Morelos and Felipe Carrillo Puerto are located in the “Maya Zone” within the state of Quintana Roo (see Figure 4). This classification reflects a high population of indigenous Maya people that are concentrated in a specific region in the state (Canul Gongora, et. al 2008). In 2008, twenty percent of the population of Quintana Roo lives in the Maya Zone (ibid).

The research site sits in the heart of the Caste War region where more than 150 years ago, indigenous Yucatec Maya people revolted against the dominance of the Mexican state and the ruling elite who were primarily the descendants of Europeans⁹. This history is remembered not only through visual markers on the landscape (burnt churches without roofs, destroyed colonial buildings, monuments to indigenous Maya rebels) but also by the political and economic repercussions of the Caste War that left the region underdeveloped and impoverished. Like many other pueblos in the area, both villages were abandoned as a result of the Caste War in 1847 and were not resettled until the mid-twentieth century, when Maya families from nearby villages in Yucatan repopulated the region in search of new farmlands (Forand 2002). Saban and Huay Max are an indigenous community where Spanish and Yucatec Maya are spoken. There are only a few members of community who would be considered non-indigenous Maya. They have married into local Maya families or have come to work as state employees at the clinic, schools, or police station. Saban is the larger of the two pueblos with a population of 2,167 (INEGI 2010). All major state and community resources are in Saban: the government clinic, higher educational institutions (secondary and technical/high school), police station, and la casa *ejidal* (meeting place of the communal land owners and representatives). Historically, Saban has been the seat of power and economic investment in the region. It has one of the largest colonial Catholic churches in the area which demonstrates the historical significance this pueblo has had in the region. The plaza and several of its adjoining streets are lined with the remnants of colonial buildings that were once beautiful and lavish houses and businesses, reminders of an earlier time of wealth and exploitation. The state of Quintana Roo

⁹ Yucatan did not join Mexico until two years after the end of Mexico's War of Independence (1810-1821). Yucatan was part of Mexico between 1823 and 1841. In 1841, Yucatan seceded from Mexico, but its separation was short lived. Due to the rebel advances during the early years of the Caste War 1847-1848, the governor of Yucatan asked for military and economic support from Mexico. The Mexican government quickly sent troops into Yucatan to suppress the rebels. Soon after, in 1848, the governor of the Republic of Yucatan, Miguel Barbachano, declared the reincorporation of Yucatan into Mexico. In the end, Yucatan's secession from Mexico lasted a total of 7 years.

and the municipality of Jose Maria Morelos has designated Saban as the primary distribution center in the area for political and economic state resources. The way this works is that infrastructural resources such as a high school, a police station, and a government clinic are primarily distributed in the pueblo of Saban and smaller surrounding communities come to Saban to access these resources.

The closest pueblo to Saban is the satellite community of Huay Max. There is no clear distinction between the two towns and residents move throughout the pueblos as if they are one¹⁰. An aging asphalt road connects the sister pueblos, beginning at the center of Saban and extending to the smaller plaza of Huay Max, which has a population of 1,399 (INEGI 2010). The two pueblos are historically connected through marriages between families living in each pueblo, shared farmlands, reliance to the same state resources, and a socio-political organization that has traditionally favored the larger pueblo of Saban where the majority of state development and infrastructural projects have been implemented. (Forand 2002). The main sources of economic subsistence in Saban and Huay Max are slash and burn agriculture (*milpa*) and remittances from temporary male migration to tourist zones along the Caribbean coast. Usually, men visit home for the weekend a couple times a month or when the milpa needs to be planted or harvested. Few economic opportunities exist for women. However, some attempt to support household incomes by raising and selling livestock (chickens, turkeys, and pigs), washing clothes, weaving hammocks, embroidering clothing, and selling food.

Following traditional gender roles and distribution of work defined by the community, women spend most of their time in their *solar* (housing complex) or in the homes of other family members (Bever 2002). In public, women typically gather at church¹¹ (either Protestant or Catholic), or at the government clinic, and every

¹⁰ In this dissertation, the combined pueblos of Saban and Huay Max will be referred to as one community based on a historical social, political, and economic relationship between its residents.

¹¹ Although the majority of residents consider themselves either Catholic or Protestant, their religious practice contains many aspects of religious syncretism that combine Christianity with indigenous symbols and rituals. For example, the ritual to ask for rain and a good harvest is conducted by a local male shaman who

now and then some of them will attend workshops in the *casa de la cultura*. Overall, the clinic is the main place where women will gather outside of their home. It is also a primary location where women interact with representatives of the state. Through daily exchanges with health workers, they enact what Joseph and Nugent (1994) referred to as “everyday forms of state formation”.

The government clinic is in Saban, just off the plaza, and directly across from the large colonial Catholic church. It has been in the community for more than thirty years. The clinic is a first-tier health facility that seeks to provide primary care and prevent communicable diseases. Its target population is infants and young children, women of reproductive age, and the elderly. It is the only health care facility in the immediate region. The closest second-tier health facilities are located about an hour away by car in the larger towns of Felipe Carrillo Puerto (103 km from Saban) and Jose Maria Morelos (57 km from Saban). The closest tertiary care facility is in the capital city of Chetumal, three and a half hours away (257 km from Saban). Depending on the state health administration’s budget and availability, the clinic is sometimes appointed a full time resident doctor in addition to the senior physician. The clinic also employs 2-3 full time bilingual (Spanish/Yucatec Maya) nurses. With a population total for both Saban and Huay Max of 3,566 (INEGI 2010), the standard doctor to patient ratio is 1:3,566, however some years when a physician intern comes to the government clinic to complete his/her year of service and assists the full-time senior doctor the ratio drops down to 1:1,783. From 2002-2013, I was only aware of two instances in which the clinic was staffed by both a senior physician and a physician intern at the same time. In that same time frame the nursing staff typically averaged about 3 nurses working full-time in the clinic. The nurse to patient ratio was generally 1:1,189.

Many residents I spoke with, both male and female, expressed their frustration with the shortage of staff at the government clinic. Same day

recites Catholic prayers in Spanish. Additionally, many Catholic churches in the region contain crosses that are adorned with embroidered cloths that resemble the iconic talking cross of the Caste War which was both a symbol and cult of the rebel Maya.

appointments with the doctor or a nurse were difficult to attain, unless you could convince the nurse at the front desk that you were very sick. If a person in the community wanted to see a doctor that day, they would have to arrive at the clinic a couple hours before they opened and wait in line. This meant that sick people or a family member sat outside the clinic as early as 6:30 or 7 am. Once the clinic opened around 8:30, a nurse would take everyone's name down and pass out a numbered chip that designated their place in the queue. According to various people I spoke with, it would frequently happen that the nurse would pass out all the day's appointment chips by 9:30 in the morning. If you were not fortunate to get a chip, then you would have to come back the following day and try again. Or, if you were really ill, then you would have to either take a private taxi or a collective taxi van to either Carrillo Puerto or Morelos and either see a private physician or wait in line at the urgent care office of the county hospital.

The government clinic in Sabán was exceptionally busy because much of its operational hours were spent meeting state mandated health monitoring requirements. Due to the program requirements of Oportunidades and other social health programs, the clinic was required to focus much of its efforts on preventative care and monitoring certain populations (infants, children under five, pregnant women, post-partum women, and the elderly). Vaccination campaigns and women's health screenings were clinic projects that were also state mandated and took a lot of time. The bureaucratic paperwork that accompanied all these state required appointments was immense. At the end of every month, the doctor and nurses were completely consumed with meeting their targeted patient appointments and completing their monthly state paperwork. The small government clinic in Sabán had limited time to meet the general health needs of the whole community because it had to spend a significant amount of time and resources meeting monthly state mandated requirements such as wellness appointments, health education talks, vaccination campaigns, and filling out stacks of bureaucratic paperwork.

In Sabán, there is an ambulance that is owned by the municipio. It is operated by the local police and not the clinic. Police officers are responsible for transporting patients to the hospital (Bever 2002). The use of the ambulance is free; however,

patients are asked to pay for the gasoline because the municipio no longer provides funds to run the ambulance. Providing enough gasoline to reach the hospital is a substantial expense—it is a long drive and the ambulance is a large and heavy vehicle. The majority of the women who are taken to the hospital to give birth are driven in a taxi or given a ride by a friend or family member.

Rural Yucatec Maya women's engagement with government clinics and the biomedical health care system has substantially increased because of participation in the federal poverty alleviation program *Oportunidades*¹², which is managed and distributed through the clinic. Women's relationship with the Mexican state is strengthened through their interactions with physicians working at the community clinic who represent the state and are backed by the power of the federal government. These physicians have been delegated by the federal government to monitor and confirm participants' compliance of *Oportunidades* program requirements. The management of *Oportunidades* has become a major responsibility for community health workers. They must organize their time and work in the community to facilitate all the program's medical requirements such as monthly prenatal checkups and health education talks that all female participants must attend. The paperwork and record keeping that must be filled out at the end of every month is time consuming and draining for the small clinic's doctor and staff. *Oportunidades* plays an important role in women's maternal health in rural Yucatan because it provides conditional cash transfers which are the only secure income that the majority of women have in the community and it provides them with access to biomedical resources such as consultations with government doctors. Women in Saban and Huay Max have repeatedly told me they want and need their *Oportunidades* stipends and they also value the presence of the government clinic in their community. These women want access to biomedical resources that can keep them and their families' health and safe. But, they are also very vocal in stating that

¹² *Oportunidades* will be discussed more in detail in chapter 2 and 5. This chapter provides a brief introduction of the program and focuses on its implementation in Saban and Huay Max.

they want culturally sensitive and respectful doctors who are willing to work with them and their traditions.

My research focuses exclusively on the maternal health component of Oportunidades, which is intended to provide poor pregnant and nursing women access to better health and nutritional resources. Enrollment into the Oportunidades program takes place every two to three years. A program worker comes to the community and registers all soliciting women of reproductive age. Women who can demonstrate that they are in a “stable” relationship through a civil, religious, or common-law marriage are also allowed to apply regardless if they are pregnant or have children. This distinction, that only women who are in a relationship can apply before they have children, reinforces state gender and patriarchy ideals. Through the application aspect of the program, state officials decide what counts as the “right” kind of family—a mother, father, and children.

The Oportunidades official goes to the home of each applicant and conducts a survey to see if she qualifies for the program. The primary questions asked pertain to the family’s income, the makeup of the family, and who resides in the pueblo. Participating women are awarded a cash stipend of 400 pesos (approximately \$36 US) every two months, on the condition that they meet certain demands from the federal government. These requirements include attending monthly educational meetings and prenatal appointments at the government clinic. As stated earlier, because of limited economic opportunities in the pueblos, the Oportunidades cash transfer stipend is the primary stable source of income for many women in the community. Women also participate in the federal health insurance program Seguro Popular, yet their involvement is minimal. They generally only use Seguro Popular when/if they seek care at the regional hospital.

Although the majority of pregnant women in the community use the resources provided by the government clinic, most women also seek additional prenatal care from one of the local midwives. Three midwives currently work in the research site: two in Huay Max and one in Sabán. All three are from the community and speak Spanish and Maya. Midwives typically work out of their home unless they are attending a birth. In that case, the midwife will go wherever the mother is, either

to her home or that of a close family member. In some emergency situations, midwives have accompanied the birthing mother to the hospital.

Giving birth in a state hospital is free, due to women's participation in Oportunidades and enrollment in Seguro Popular. Yet, the majority of women in the community continue to give birth at home with the assistance of a midwife. These choices are not simply the result of ignorance or a rejection of biomedicine. They are deeply personal decisions that are grounded in family, experience, and what might be called the "local knowledge" (Geertz 1983) of health care in these rural pueblos. It is important to understand that local knowledge has an authority that goes beyond immediate social networks. This is where authoritative knowledge and medical pluralism take place in relation to prenatal care and childbirth in Saban and Huay Max. The decisions women make in relation to their prenatal care and childbirth are constructed within a shared social network of values but they must also be understood within a wider context of historical and political marginalization that is intricately grounded in the landscape itself.

Methods

My research in the communities of Saban and Huay Max spans from 2002 to 2013. Predissertation fieldwork took place during the summer months of 2002, 2003, 2004, 2007, 2008, and 2010¹³. I first began working in the communities in 2002 as a member of the Yo'Okop (now re-named Cochuah Regional Archaeological Survey—CRAS) archaeological project. That summer I surveyed, mapped, and excavated the large archeological site of Yo'Okop located in the *ejido* lands of Saban. During that same summer, I assisted the project's cultural anthropologist, Sandra Bever, in conducting an economic impact assessment that focused on the effects the

¹³ I have had Institutional Review Board (IRB) approval for all my research conducted between 2002-2013. When I began my ethnographic research, I had just completed my BA and was therefore not affiliated with any university. I also did not have any external funding other than housing provided to me by the Yo'Okop project. During my MA I worked with San Diego State University's IRB to grandfather in my previous research. I had IRB approval from the University of Kentucky for all my dissertation fieldwork.

Yo'Okop archaeological project had on the communities of Saban and Huay Max. Ultimately, what I gained from that summer was a hands-on introduction to rural Yucatec Maya life. I was also able to meet and establish a rapport with various members of both communities that have lasted throughout the years.

The following summer of 2003, after having just completing my BA from Humboldt State University, I returned to Saban and Huay Max and embarked on my own long-term ethnographic project focusing on rural Yucatec Maya women's childbirth choices and practices. That early research from 2003-2004 focused on women's preference of midwifery over biomedical care for the delivery of their child when physician attended births were provided for free at the local clinic. In the summer of 2003 I focused on identifying existing prenatal and childbirth practices. I conducted a preliminary survey of women's health issues in Saban and Huay Max. My primary mode of ethnographic data collection consisted of participant observation, although I also conducted several informal interviews with two mothers, and I documented (2003) the life histories of two prominent midwives living in Huay Max and the work histories of two local doctors. In the subsequent summer of 2004 I conducted a regional survey in which I interviewed 38 women who had at least one child and lived in the communities of Saban, Huay Max, Ichmul, and X-Querol¹⁴. These communities were all located within a 22-kilometer radius. I also interviewed 2 community doctors each working at the government clinics (Saban and Ichmul). My goal that summer was to expand on the previous research by organizing a much broader sample of participants. Data was collected through semi-structured interviews in addition to many hours of participant observation.

¹⁴ X-Querol is a small remote community of a dozen families that is located on the border between the state of Yucatan and Quintana Roo. It is 18 km from Saban. The town mayor use to drive all the school age children from X-Querol in his old truck to attend middle and high schools located in Saban. Ichmul is located in the state of Yucatan and it is 22 km away from Saban. It is a larger community about half the size of Saban with a population of 1,000 inhabitants. It has its own government clinic, an elementary and middle school, as well as several archeological (colonial and pre-Hispanic) structures. The colonial buildings include three different Catholic churches as well as fortifications built during the Caste War. The façade of the main church contains bullet and cannon wholes that were made during the Caste War.

Ultimately, I concluded my research with more questions than answers. Did women ever use both midwifery and biomedicine while pregnant? Did they identify any limitations to midwifery? Were there any aspects of biomedicine that they valued? Did women ever disagree with health care providers?

I returned to Saban and Huay Max for a short field trip (2 weeks) in the summer of 2007 to follow up on my previous research and conduct pre-thesis research for a MA program in Applied Anthropology that I had started at San Diego State University. While visiting with friends and former participants I was informed of how changes were taking place in relation to childbirth practices. I was told that the new community doctor was pressuring women to have their births attended by physicians in local hospitals¹⁵. According to the biomedical viewpoint of the new doctor, hospital births were both more efficient and safer. A year later, while conducting my MA research, the community doctor told me that she could not support home births because she was under a lot of pressure by her supervisors. This was largely a reaction to a recent death of a young woman in the community who died as the result of complications during a home birth attended by a midwife. Many of the women that I spoke with said that they were not happy with these changes and wanted to continue going to the midwife.

My earlier experiences in the field led me to initiate my thesis research in the summer of 2008. My master's thesis focused on women's decision-making processes during pregnancy and childbirth including the practice of combining biomedical care and midwifery. My methods included: semi-structured, open-ended interviews with eight young women of reproductive age and living in Saban and Huay Max. I visited the women multiple times both before and after the interview, allowing me the opportunity to conduct numerous hours of participant observation with each participant. I would spend my days with these women talking during the afternoon rest hours, attending celebrations such as birthdays, making food and sharing meals, playing with the children, and looking at photographs. In addition to interviewing

¹⁵ Later, when I returned to the field in 2008, I interviewed more women in the community who referred to the doctor's insistence on hospital births over home births as a form of coercion not just pressure.

mothers, I also interviewed various health care professionals (biomedical and state employees and traditional midwives) working in the area as to their experiences, practices, and opinions in relation to childbirth. Just as with the young mothers, I conducted semi-structured, open-ended interviews with three local midwives, a community physician, a second-tier social worker, a second-tier hospital director/physician, and a regional hospital director/ physician. My research noted the increasing significance of the maternal health component of the program Oportunidades for pregnant and nursing women in the community as well as a continued reliance by the majority of women in on midwife-attended childbirth. Again, I ended with more questions. How many women participated in federal health programs? What impact did these programs have on women's approaches to their health? Had women come to prefer one health system over another? Did the recent implementation of state health policies influence generational differences in childbirth practices? I asked this specific question because at the end of my MA fieldwork a couple of participants had mentioned that some families had been considering a hospital birth for their younger pregnant daughters/daughter-in-laws. I was told that these few families had expressed the idea that a hospital birth might be safer and less painful and they wanted the best for their daughters.

Following my thesis research, I returned to the community three different times for brief visits. In 2010, several women informed me that tensions with a clinic physician reached a climax resulting in her removal by the women enrolled in Oportunidades. I now questioned how women viewed their relationship with the state in response to their participation in federal health programs. In July 2011, a key participant reported that the two new resident doctors did not challenge women's preference for midwifery and home births. This led me to ask how the relationships between midwives and clinic staff affected childbirth practices. Another woman from the community mentioned that increasing numbers of younger women and economically secure families were choosing to give birth at the regional hospital. This was the first time I noticed the relationship between socio-economic status and hospital births. In past research, I had known very few women

who had chosen to go to the hospital. I became interested to see the prevalence of this association and its distribution in the community.

My dissertation research was built off years of extended time living and working in the communities of Saban and Huay Max. I completed my dissertation fieldwork from January to October of 2013. I conducted a total of 30 formal interviews, and approximately 30 informal interviews in Saban, Quintana Roo, Mexico during 2013. I also conducted a small survey. But the majority of my research took place with a local family who I extensively interviewed and participated in hundreds of hours of participant observation.

I conducted a small survey of women's experiences with pregnancy and childbirth, speaking with a total of 19 women. I focused on two populations of female residents living in the community of Saban: 1) currently pregnant women between the ages of 16-28; and 2) elderly women who had children who were over the age of 60. I focused specifically on these women because they filled in a large gap from my previous research (conducted between 2002 and 2010). I also interviewed 4 young mothers in their 30s and 5 older mothers between the ages of 40-50.

I formally interviewed 12 pregnant women. All but one of the pregnant women were introduced to me by their midwife, who was also a close collaborator of mine. The majority of the interviews were conducted with their midwife present and/or a family member. I followed up with all the women that had given birth and in one case had a miscarriage. Their midwife would frequently talk to me about their progress while pregnant, how they did during labor and delivery, and how they were recovering.

I formally interviewed 7 elderly women. These women spoke of a historical lack of social and health resources in the community and the larger surrounding region. Many of these elderly women had experienced profound loss early in the establishment of Saban (primarily around the 1960s) when there was no dependable health care available—the majority had either had a miscarriage or lost a child. They talked about how things are different today—there are more resources available (e.g. cars, hospitals, better roads) that have dramatically changed how women in their rural community give birth. They think that it is good that women

and their children now have a safety net that is there in case there is ever a reason for someone to need medical attention.

At the community clinic in Sabán I conducted both 2 formal and 3 informal interviews with the clinic staff. I formally interviewed the current physician who had just arrived and had been working in the clinic for a little over a month. I also informally interviewed his predecessor, the physician who had been working at the government clinic for 3 years. I tried on numerous occasions to formally interview this doctor, but she was not interested and/or stated that she was too busy. As for the clinic nurses, I had several interactions with almost all of them through interviews and moments of participant observation at the clinic. I formally interviewed the newest nurse—a young local woman who had been working at the clinic for two months. We established a close relationship and I was able to interview her numerous times and I participated in her daily life. I had an extended informal interview with a senior clinic nurse and a short informal interview with another nurse. I conducted about 10 hours of participant observation at the clinic where I observed: 1) Oportunidades health lectures; 2) a vaccination campaign for infants and toddlers; 3) daily routines at the clinic. When conducting participant observation, I visited the clinic during the week in the early afternoons.

The primary aim of the dissertation was to produce an ethnography of one specific family to discuss some of the larger issues and practices taking place within the community. This approach is modeled after the work of Mary Elmendorf and her ethnography, *Nine Maya Women*. Elmendorf used the life histories of women from an extended family to help the reader see how personal and local experiences were tied to larger socio-political processes taking place at the national and international level. Her argument connected the experiences Maya women had with globalization and change to larger discussions about indigenous and peasant struggles for cultural survival around the world. Elmendorf also wanted to focus more attention to the lives of women because they were largely left out of the history and ethnography of Maya people at the time she was conducting her research (1960s). Elmendorf's work demonstrates how theory must be grounded and analyzed using examples from the everyday practices and beliefs of individuals and their

communities. I have known the extended family this dissertation is centered upon for over a decade and have lived and worked with them throughout my years of research in Saban and Huay Max. In 2013, I formally interviewed 8 members of this family and conducted repeated informal interviews with each individual (except for Doña Carmen who had died in 2008). I also undertook hundreds of hours of participant observation with this extended family. The primary family members that I spent significant time with include:

- 1) **Don Hector and Doña Carmen:** The patriarch and matriarch of the family. Both moved to Saban from Chikindzonot¹⁶ in the state of Yucatan when they were young and newly married. They were one of the earliest families to re-settle the pueblo. Doña Carmen worked as a midwife for almost 30 years. She had early relationships with biomedical health care workers who taught her basic first aid and how to administer injections. She died in 2008 because of complications of advanced diabetes. Don Hector and Doña Carmen had 4 daughters and 3 sons.
- 2) **Olivia:** Is the 2nd Daughter of Don Hector and Doña Carmen. She worked closely with her mother. She is a single mother and has been able to secure one of the few municipal salaried jobs in the community. She has often helped financially support her extended family. Olivia built a small three-bedroom home adjacent to her parent's house. Her daughter is a nurse and just recently was transferred to the community clinic in Saban. She has 2 daughters who were both born at home and delivered by Doña Carmen. Her daughters have children of their own which they delivered at two of the regional hospitals. Both of her daughters have delivered through cesarean sections.

¹⁶ Chikindzonot is located in the state of Yucatan. There are two roads from Saban to Chikindzonot. The southern route goes through Ichmul and is 46 km in distance. The northern route goes through the larger pueblos of Tihosuco and Tepich. All of these towns are known to be rebel held towns during the Caste War. There is a Caste War museum in Tihosuco and in Tepich there is a monument dedicated to Cecilio Chi (one of the first Maya rebel leaders of the Caste War, who was born in Tepich).

- 3) **Elena:** 3rd Daughter of Don Hector and Doña Carmen. Elena trained to become a midwife under her mother. She has been working as a midwife in the community for the past 10 years. She has attended various midwifery and health lectures in Mexico City and throughout the peninsula. She has 3 children—all were home births attended by her mother.
- 4) **Irene:** Daughter-in-law to Don Hector and Doña Carmen. She is the president of the committee of community leaders for Oportunidades. This is a voluntary and unpaid position which was established by the state Oportunidades program coordinator who manages the implementation and compliance of the program in Sabán and Huay Max. Irene's leadership position, which she was elected for by Oportunidades participants, requires her to support the work of 3 Oportunidades vocales (health education leaders) and insure that they are doing their job by meeting with their designated group of participants and correctly filling out their paperwork. Irene is also responsible for advocating on the behalf of the vocales she oversees. She has held this position for eight years. Irene lived in Don Hector and Doña Carmen's home for 20 years. She has 6 children—4 were born at home and delivered by Doña Carmen and Elena and 2 of her children were born in regional hospitals. Irene's last delivery resulted in an emergency C-section and she was in a coma for a week.
- 5) **Valentina:** Daughter-in-law to Don Hector and Doña Carmen. Valentina is a community leader (*vocal*) for Oportunidades. She works under the supervision of her sister-in-law Irene. Just like Irene, Valentina's position is voluntary and unpaid. She has also been elected for her role as a vocal by Oportunidades participants in her community. Valentina and her family have lived in Don Hector and Doña Carmen home for 15 years. She has 4 children who were all born at home and delivered by both Doña Carmen and Elena.
- 6) **Daniela:** Daughter of Olivia; Granddaughter of Don Hector and Doña Carmen. Daniela has been a nurse for 8 years. She assisted her grandmother towards the end of her grandmother's midwifery career. She has worked at various government clinics and hospitals in region. In October of 2013, Daniela

finally secured employment at the government clinic in Sabán (a position she had wanted for several years). She lives in her mother's home. Daniela is the only biomedically trained health care professional who lives full time in the community. She often assists her aunt Elena by providing a second opinion, establishing if a birthing woman is in high risk by taking a birthing woman's blood pressure, and sometimes referring women to the hospital. Daniela has a young son, who has a heart defect. They travel to Mexico City every 6 months for treatment. She had a planned hospital birth that resulted in a C-section.

- 7) **Casandra:** Youngest daughter of Don Hector and Doña Carmen. As the youngest daughter, Casandra did not learn any specific trade that she could use to earn money. She spends much of her time at her parents and sister Olivia's housing complex. She often helps her sisters and sister-in-laws with their domestic responsibilities (cooking, cleaning, and attending to the children). She does not work outside of the family household. She has 3 children. Two were born at home attended by Elena and one was born in a hospital birth.
- 8) **Raquel:** Oldest daughter of Elena; Granddaughter of Don Hector and Doña Carmen. Raquel is the first person in her family to receive the equivalent of a Bachelor's degree. She is studying to be a school teacher. She is very close to her mother, and talks to her often about midwifery and women's health. Raquel chose not to follow in her mother and grandmother's footsteps because she was both nervous and scared about taking on the enormous responsibilities midwives have. However, she has always valued her mother's midwifery and community health work and hopes to one day support her by helping Elena establish a pharmacy in the community.

This family became a key focus of my fieldwork research. They were the locus of authoritative knowledge in the community and they provided me with vital insights into community life and local understandings and approaches to reproductive health. The unique composition of this family represented a

microcosm of the practices and attitudes surrounding childbirth in Sabán and Huay Max. The family consisted of biomedical practitioners (Daniela) and traditional midwives (Doña Carmen and Elena). It also had women employed outside of the home (Olivia, Elena, and Valentina) and women whose primary labor was maintaining the household (Irene and Casandra). There were university educated women (Raquel and Daniela) and empirically trained professionals (Doña Carmen and Elena). Many of the women in this family had given birth at home assisted by their mother or sister but there were also a few who had chosen to give birth in a hospital. And finally, this family participated in state health programs, such as Oportunidades in multiple capacities such as community leaders (Irene and Valentina) as well as also being recipients of federal social health programs. Each member of the family is deeply connected to the community and their lives all revolve in some way or another around reproductive health. Importantly, however, their views and experiences differ even though they are all part of a close-knit family. Following standard anthropological practice, all names of individuals in this dissertation have been changed and replaced with pseudonyms.

Finally, I would like to clarify that I understand the unique position that this family has within the community. In many ways, it is an elite family. Many family members have access to coveted resources and connections with government officials and state systems that sets them apart from many of their neighbors. For example, Daniela and Elena have access to not only medical and technological health knowledge but they also have working relationships with various state health providers. These two women along with Olivia have secure work that allows them to support their families—Daniela is a registered nurse working in the government clinic, Elena has a successful midwifery business, and Olivia working as a custodian for the elementary school has one of the few full-time government salary positions in Sabán. Valentina and Irene have moved up in their social position and have gained a sense of power in the community because of their work as vocales. They have been granted by state representatives the authority to monitor and reprimand women in the community who are not complying with Oportunidades program requirements. This responsibility is something that they do not take for granted and

they work very hard to try and be fair and just, nevertheless their position grants them a form of power over other members of the community. The matriarch and patriarch were members of one of the founding families that repopulated and resettled Saban. They are revered as respected elders in the community. Don Hector is one of the earliest ejido members and Doña Carmen attended many of the births early on in Saban and Huay Max's resettled history.

Outline of the Dissertation

The primary goal of this dissertation is to understand how the competing interests and decisions of Yucatec Maya women, midwives, and state health care workers organize childbirth practices in a historically marginalized, rural, and indigenous community of Southern Mexico. The specific aims are to: 1) document maternal health resources available to women, focusing specifically on services and resources provided by midwives and clinic staff; 2) examine how federal health programs like Oportunidades and Seguro Popular shape reproductive health practices, emphasizing how interpretations of program goals and mandates affect women, midwives and state health workers differently; and 3) document women's prenatal and childbirth practices, paying critical attention to how they navigate their maternal health through decision-making processes that confront multiple health systems and resources.

Chapter Outline

Chapter 1 examines the theoretical foundations and literature review of the dissertation. Changing maternal health care practices in rural Yucatan are the product of interactions between Yucatec Maya women, midwives, and state health care workers. These relationships are further complicated by the goals, objectives, and regulations of federal health policies and programs. Childbirth in rural Yucatan is politicized as a result of connections to larger economic, social, and political systems. Interactions between Maya people and the Mexican state have historically been characterized by moments of contestation, engagement, and abandonment. These relationships of marginality continue to effect Maya women today and this

can clearly be seen through the decisions they make in relation to their prenatal care and childbirth. Key theoretical discussions take place around the literatures related to testimony literature, the anthropology of the state, political economic approaches in anthropology, anthropological approaches/programs in global health, the anthropology of reproduction, and anthropological studies of Latin America, Mexico, and Yucatec Maya.

Chapter 2 begins with a general history of the region focusing on the engagement and disengagement between rural Maya people and the Mexican government. It discusses the people (and environment) of Yucatan as part of a history of isolation, marginality, and various government-led attempts to control outlying territories. The chapter then transitions towards a history of health in rural communities in the Yucatan peninsula. It discusses the tenuous relationship between community doctors and local women.

Chapter 3 focuses on current birth stories from the responses given by all the young mothers I interviewed. It discusses the diversity of health resources that exist for rural Yucatec Maya women. The chapter highlights how women manage their care through social networks of information and interactions with biomedical and traditional health care providers. This is important because regardless of the Mexican government's emphasis on birth becoming a fully biomedical event, women in Sabán and Huay Max hold on to certain cultural traditions related to childbirth and midwifery. In large part, this has occurred because the Mexican government has not committed the resources necessary to transition all pregnant Mexican women into the biomedical sector. Women in rural underserved communities like Sabán and Huay Max are therefore able to continue to rely on the care provided by local midwives. Traditional midwives in these communities have held on to their prestige as healers and have not yet been forbidden to work by the Mexican government. The social standing of young mothers, especially first-time mothers, is also discussed—who is empowered to speak and how much knowledge and experience these young mothers have of birth before they have their own children. The goal of the chapter is to document how women today are addressing their prenatal health concerns and

document current childbirth practices. These women's voices need to be expressed and listened to.

Chapter 4 focuses on the story of Elena, a Yucatec Maya midwife working in Saban and Huay Max. It provides a brief life history and tells how she became a midwife. Elena's story highlights what it is like to be an indigenous midwife working in rural Yucatan. The chapter discusses the challenges she faces and the various types of support she receives. It also examines the level of involvement she has with biomedical practitioners and federal health training programs. The chapter then moves outward and discusses the politics of reproduction on a national level. The chapter ends with a discussion of how federal programs affect indigenous midwives and their work. It also critically examines how state officials scapegoat midwives or use them as a distraction away from the larger problems of an underfunded and inadequate state health care system.

Chapter 5 introduces the reader to Valentina—a mother, Oportunidades participant, and an elected community leader facilitating on the ground Oportunidades program information and monitoring of participants. Valentina's story is used to analyze how federal health policies and programs play out in local communities and the impact they ultimately have on rural indigenous women's health. The chapter examines Valentina's experiences with Oportunidades to highlight some of the problems and inherent contradictions within the program. It addresses how women openly acknowledge these problems and how they work around them. The chapter also includes a brief life history of Valentina to demonstrate that state program recipients are more than the aid they receive.

Chapter 6 discusses how Daniela, a young woman from Saban, left her pueblo to attain an education and profession and ultimately returned a decade later to work as a nurse at the government clinic. It addresses what it means to be a member of the community and a biomedical health practitioner. The chapter also discusses access to health resources through the example of Daniela's experience seeking healthcare for her sick infant son. Medical pluralism is addressed as well as the implementation of culturally appropriate biomedicine. Daniela represents a possible future for a positive and rewarding implementation of biomedical healthcare in her

community, but her story also highlights the challenges and constraints placed on rural Maya women by the bureaucracies and hierarchies of the state healthcare system.

The dissertation ends with a conclusion chapter which sums up the main points of the dissertation. It restates how rural Yucatec Maya women, midwives, and state health care workers participate in the production of childbirth and maternal health care practices in relation to federal policies and programs. The chapter ends with a discussion of the potential this research has in informing and influencing health policy at both local and global levels by demonstrating the complex ways in which state-led health programs are implemented, understood, and experienced by a multiplicity of actors (e.g. local state health workers, midwives, and Maya women).

Chapter 1

Theoretical Framework of the Dissertation and Literature Review

The theoretical orientation and framework of this research is grounded in political economy, a historically situated approach that highlights the importance of *social process* and social reproduction (Marx 1990; Mintz 1985; Nugent 1993; Roseberry 1994, 1997; Wolf 1982, 1999). Political economy is foundational to my understanding of social processes and culture. It begins with Marx and the importance of looking at the historical processes that produce and shape particular material conditions. Roseberry expands upon the importance of anthropological approaches to history that carefully examine global processes. He advocates for a type of history that can take “account of the major structural transformations of world history, and that traces connections among discernible communities, regions, peoples, and nations” (1994:126). Such a focus deepens historical analysis by complementing it with the specific, localized insights of anthropology. Such approaches are exemplified, especially in late twentieth century US anthropology, by the neo-Marxist work of scholars such as Wolf, Roseberry, and Mintz. Wolf’s approach to history seeks to “search for the causes of the present in the past” through an analytical method that attempted to develop a “global cultural history” (1982:xv). Wolf employs Marx in search of “a new theory of cultural forms” (1982:19-20), arguing for the need to return to the primary concerns of political economy, particularly wealth, class, and power. “It has been said, with reason,” Wolf wrote, “that the social sciences constitute one long dialogue with the ghost of Marx” (1982:20). Wolf was writing at a time when the social sciences had largely abandoned the key concerns of political economy—and Marx—and this was his call to return to critical “unanswered questions” that remained unexplored. In this analysis of changing maternal health care practices in rural Yucatan, political economic theory is woven throughout the literatures of anthropology of the state, medical anthropology, anthropology of reproduction, and in the regional history and anthropology of Yucatan.

I use literature from the anthropology of the state to illuminate how the state is embedded in everyday life. I analyze the mundane ways in which Yucatec Maya women experience and reproduce state objectives through the management of their maternal health and encounters with state health workers. Medical anthropology with an emphasis on global health and the anthropology of reproduction explain how childbirth is politicized as a result of connections to larger economic, social, and political systems. The history and anthropology of Yucatan provides a local context to analyze the ideologies and practices of childbirth among rural Yucatec Maya women. It places current childbirth trends in relation to a larger history spanning five centuries of interactions between Yucatec Maya and various governing entities.

This chapter begins with a discussion of how theoretical approaches to testimonio literature highlight the unequal power relations that exist within ethnography—more specifically knowledge production and representation—to move forward and create a more just and reflexive approach to situating local narratives within larger global processes. Testimonio literature has been foundational to how I have conceptualized this dissertation project both in the field while collecting data and during the analysis and writing phase. A discussion of my understanding and use of testimonio directly affects the theoretical arguments and contributions of this dissertation.

Testimonios/Testimony

My primary goal in writing this dissertation is to focus on women's everyday lives in relation to their reproductive health. I want to paint a detailed portrait of rural Yucatec Maya women's lives that shows the complexity of how women's reproductive health is embedded in quotidian life, yet it is also shaped and constrained by wider socio-political and economic processes. What I mean by this is that women make daily decisions pertaining to their prenatal care (such as what foods to eat, who to ask for advice, and where to seek care for the relief of uncomfortable symptoms related to pregnancy) based on the types of social networks they participate in, the political alliances they have with powerful state and community individuals, and the economic resources they have access to. The

women in this dissertation are more than their reproduction; they are more than just women who are having children. At the same time, their reproductive health is tied to their daily routines and work, and the complicated ways in which being a woman of reproductive age defines who they are within their community, and in relation to the wider Mexican state.

After speaking to different women in Saban and Huay Max, it was clear that they all understood the impacts their reproductive choices had on their lives and that of their family. They poignantly articulated this in interview after interview, conversation after conversation. The choices they made in relation to childbirth were situated within a larger discussion about the political economic environment in which they lived. Women shared how they navigated the different medical resources available to them—which ones were dependable, their limits and advantages, and when they could and should use a specific resource such as a hospital birth. Women also discussed the economics behind their participation in programs like Oportunidades and the value they placed on the added sense of security they attained by attending biomedical checkups at the local clinic. But these women also knew that their participation in Oportunidades was a contractual agreement of co-responsibility with the Mexican state, which in their opinion, was an uneven relationship where the government frequently did not live up to its promises. The women I spoke with in Saban and Huay Max also emphasized how pregnancy and childbirth were deeply connected to cultural ideologies that placed great importance on the home and family, with a particular emphasis on the value of treating women with respect and honoring their bodies as life giving forces.

My years of discussions with women in Saban and Huay Max have revealed the layered, multidimensional realities of their lives and identities. The women I interviewed were mothers, wives, sisters, daughters, community leaders, healers, entrepreneurs, and government program recipients. It has been a challenge to find conceptual frameworks that can help elicit the complexities and positionalities of these women's childbirth experiences. These experiences are individual and personal, yet also highly political and powerful. But, more importantly, they belong to these women: their words, stories, and memories form the foundation of this

work. Because of this, I have chosen to use testimonio to articulate—and reflexively examine—the layered meanings and intersecting politics that shape changing childbirth practices in Sabán and Huay Max. My use of testimonio is a deliberate attempt to recognize that this research is the product of personal relationships, collaboration, and co-produced knowledge. These women have clearly articulated their lives, stories, and perspectives in our conversations, and testimonio provides a way for me to acknowledge their ownership—and authorship—in this process of knowledge production.

Early theoretical discussions about the framework and methods of testimonio focused on the importance of addressing pressing issues of genocide and human rights (Beverly 2004). There is a political component to testimonios—they are more than the act of storytelling or sharing oral histories. In the middle to late half of the twentieth century, testimonio literature was consumed in a “state of emergency”, where marginal and subaltern people’s lives were dependent on the world knowing about their struggles to survive in the mist of systematic state violence, poverty, imprisonment, and human rights violations (Maier 2004). Since then, John Beverley has discussed the adaptability of testimonio literature by stating that “testimonio is a transitional cultural form appropriate to processes of rapid social and historical change but also destined to give way to different forms of representation as these processes move forward” (quoted in Maier 2004:4). The performative aspect of a person telling his/her story as a witness to specific life experiences or moments in time continues to take on an important role in popular movements and discussions of human rights. The act of telling is a political tool of resistance in which the voices of marginal and subaltern people are given the platform to be heard (Gugelberger and Kearney 1991). Lynn Stephen’s work with political protesters in Oaxaca adds that historically the “archiving of knowledge and history” in Latin America took place orally and that tradition of “oral knowledge transmission” continues to be an important aspect for contemporary social movements although literacy campaigns in Mexico and Latin America have succeeded in producing a large literate society in which 90 percent of Latin

Americans can read and write (Stephen 2013:15). Again, the performativity of testimonio is central.

Several scholars have drawn attention to the problems that exist within testimonio literature. Detwiler and Breckenridge critically highlight how historically testimonio studies have privileged the voices of men. Even though the majority of testimonios are produced by women, testimonio studies focus on male-authored narratives and their theoretical dimensions receive the attention of male scholars (2012:2). In response, many feminist scholars (Latina Feminist Group 2001; Maier and Dulfano 2004; Stephen 2013) have actively worked to re-center the focus of testimonio literature to open a space for the narratives of women as witnesses. Nance (2006) discusses how the largest circulation of testimonio literature and academic work is in English—reflecting an emphasis on a Western audience and how the production of testimonio is largely being done by Western intellectuals. Kimberly Nance explains the reason for the dominance of the English language in testimonio production is the result of the “inclusion of testimonio in English-speaking universities, in courses in women’s studies, anthropology, history, world literature, and other programs outside of language departments” (2006:8-9). This is an important point because it addresses the valid critique Spivak (1988) made about Western voices speaking for marginal people. Leigh Binford continues this discussion by highlighting the asymmetrical power relations that exist in the production of testimonios (2012). He critically addresses how traditionally in the production of testimonio literature, narratives move through various people who alter and edit them to tell a certain story or emphasize a certain point (Binford 2012:16). Binford also clearly states that producers of testimonio have a responsibility to situate narratives within larger discussions that address how social, political, and economic systems alter the lives of people (Binford 2012). Testimonios must be contextualized and positioned within larger discussions so that the reader is not the sole determinate of the analysis of the testimonio. He warns that without placing testimonios within a larger theoretical framework and argument, readers might mistake the narratives as “the truth of the other” and unconsciously “domesticate difference or essentialize it” (Binford 2012:16).

My approach and use of testimonio in this dissertation critically reflects on the critiques highlighted above. I am primarily concerned that my voice might overshadow and at times can be seen as speaking for the women who participated in this ethnographic project. I am also clearly aware of my own positionality and privilege—a US born, university educated, lower-middle class Chicana, with roots in both Mexico and the United States—and the differential power dynamics that exist between me and the women I interviewed. I did not go back and work with participants on the production of their testimonios. I made all the editorial decisions without their feedback. Furthermore, I chose to give everyone in this dissertation a pseudonym. I went back and forth with this decision, and ultimately decided not to include the real names of participants, even though I had permission from all but two, because I was bothered by the fact that they could not see how the stories of their lives—how their testimonios—were being used. Everyone I interviewed in Sabán and Huay Max knew I was writing a “book”, but none of them had any reference as to what that would look like and how their narrative would be represented. The norms of the contemporary doctoral process make it difficult for me to include them in the production of my dissertation. Ideally, I would like to return to the community and find a way to co-produce a final document that reflects more of our joint work and more importantly meets the needs of these rural Maya women.

For me, testimonio was something that I came to in the middle of my project—it was not something I had intended to do from the beginning. Originally, I set out to do standard ethnographic methodologies that focused on collecting oral histories and semi-structured interviews to illustrate a specific theoretical argument. But I realized along the way that such an approach was insufficient to capture what I was getting during my interviews with Maya women. I incorporate testimonio into this dissertation for specific reasons. I use testimonio to not only highlight women’s stories, but also critically reflect upon my research and my own place within that process. But this decision is also a response to all the lessons I have learned from these women over the course of nearly fifteen years. With unending patience, these Maya women have taught me not only about their histories, but also

what resistance means for them and why they are so determined to maintain and defend their cultural autonomy. In using testimonio, I had a hard time wrestling with the idea that I as the ethnographer/academic was the one who had the authority to have the final say how these women's personal experiences would be presented and analyzed. For this dissertation, I was looking for something more, something that allowed me to demonstrate the power these women had in telling their stories and how this project that I had embarked upon was co-produced. Testimonio was the closest approach that I thought would address these issues. But I want to again acknowledge that I am using the term while also recognizing the limits and problems of how I am using it.

Following Binford, I have positioned the testimonios in this dissertation within larger theoretical discussion about abandonment and neglect, resistance, and state control over the bodies of reproductive Maya women. I have tried to highlight the stories and narratives that the women from Saban and Huay Max have shared with me while also pulling back and putting them into a larger context. Editorially, I have included large blocks of narrative that come directly from personal interviews I had with participants. I translated them from Spanish to English and lightly edited them for clarity and relation to the larger discussion. Stylistically, I have chosen not to use quotation marks when presenting different women's voices. Instead, I have used italics when presenting a woman's testimonio and have indented large blocks of field notes. My reasoning for this is to present a clear flowing synthesized polyvocal discussion of how contemporary childbirth practices and understandings are produced in rural Yucatan.

I would like to end by reiterating that the stories in this ethnography are not mine. Again, they are not my stories. As a doctoral student, I have been given the task to present Yucatec Maya women's narratives of life, health, and childbirth within a dissertation format that includes a theoretical analysis of how the Mexican state through intense monitoring as well as moments of neglect permeates in to the intimate and personal lives, and more importantly the bodies, of its rural indigenous female citizens. The conventions of the academy still require a dissertation to be written by a single author—the person fulfilling the requirements for a doctoral

degree. The limitations of this format do not account for the politics of reciprocity and the acknowledgement that knowledge is co-produced. My limited use of testimonio in this dissertation is one way of recognizing this. I acknowledge that this is not enough, but my goal is to view this dissertation as a progression—one that does not yet reflect the full dynamics of testimonios—but that provides a means to getting there.

Anthropology of the State

Theoretical contributions from the anthropology of the state challenge us to rethink how we conceptualize state systems. Anthropologists tend to associate the state with social order, rationality, and authority (Das and Poole 2004). This includes an emphasis on state formation in everyday life (Joseph and Nugent 1994) and its meaning in peripheral places and populations (Das and Poole 2004). Feminist scholars have analyzed how women's lives are intimately altered in response to larger state objectives and policies including times of war and social conflict (Aretxaga 1997; Babb 2001; Molyneux 1985; Nash 2001; Stephen 1995), shifting economic systems and neoliberalism (Abu-Lughod 1990; Babb 2001; Collins 2008; Rivkin-Fish 2005), international standing and relations (Anagnost 1995; Krause 2005), and an emphasis on modernity and health (Jordan 1993; Kaufert and O'Neil 1993; Szurek 1997). Theorists also address the important role that ideology plays in state formation and maintenance (Althusser 2006; Gorski 2003; Ferguson 1999, 1994; Scott 1998). Recent theoretical work in anthropology pushes us to rethink the meanings, functions, and power of the state (Das and Poole 2004).

For Marx, state power was maintained by a powerful, repressive state apparatus. Althusser agreed, but added a key theoretical element. In addition to the repressive state apparatus, Althusser outlined what he called the "Ideological State Apparatus" (ISA), which consisted of schools, religion, family, and other social institutions that shaped society through subtle, yet still repressive means (2006). These ISAs function primarily through ideology—the beliefs, ideals, and values that states produce and promote to shape their citizens. My argument is that state backed biomedical health systems are a form of Ideological State Apparatus that

coerce women into adopting state ideologies and values. Importantly, these systems, while they are repressive, work in various ways to contest, reshape, and challenge women's ideas about "proper" health care, approaches to birth, and motherhood. These systems are, as Foucault might put it, not just repressive but also productive (Foucault 1980:119).

Power, for Foucault, is not something that individuals or institutions possess (1980). Instead, it is situational, and highly dependent upon specific social contexts. Foucault argues that power is enacted through individuals and it is not centered in a place or a thing, instead it is circular and extends out like capillaries. The battle between the Mexican state and rural Yucatec Maya women is a battle of power and ideology. This battle plays out throughout small communities such as Saban and Huay Max, enacted through daily, accumulated interactions between women and the state workers who staff clinics and represent programs such as Oportunidades. From the state level, this conflict is a matter of defining the proper rational procedures that can produce a "healthy" population of workers that obey state demands and desires, and generate statistical results that satisfy global guidelines. State discourses seek to convince women that the biomedical system is the best path forward for a healthy, good life. At the community and individual level, however, there is disagreement and dissent about the proper, desirable way to give birth and reproduce the social body. This conflict lies at the heart of my dissertation.

This dissertation argues against framing the state as a monolithic apparatus (Abrams 2006; Foucault 1980). Instead, the state should be viewed as a collection of competing institutions and individuals whose actions enforce and uphold mundane laws and policies (Byrnes 2003; Fox 1992; Jeganathan 2004). This ethnography explores how the Mexican state permeates into the lives of marginal populations, ultimately questioning its parameters. In rural Yucatan, the state is represented through government employees working in federally funded institutions such as community clinics and schools that are positioned to enforce larger federal objectives and policies. Women living in the research community of Saban and Huay Max encounter the state through their interactions with clinic staff and participation in state health programs. These doctors and medical staff view themselves not only

as state workers but as promoters of the larger state project. This dissertation critically addresses questions of citizenship and rights by analyzing how federal programs function as contractual relationships between participants and the state. More specifically, it focuses on how rural Maya women use maternal health programs to make claims on the state. This is where power plays out—in those small debates and battles over money and co-responsibility. It is here where women in Sabán and Huay Max run up against state power and ideology, but also where they push back.

As stated above, it is important to look beyond the idea of a centralized and autonomous state and understand that it is made up of individuals who have particular desires and political goals. For example, the recent history of the government clinic in Sabán demonstrates how health programs are implemented based on the ideas and personality of the leading physician. In some case a physician will follow a literalist understanding of federal policy while another might place it within the local context. Furthermore, state workers also need to be understood as part of hierarchy of power. As Rivkin-Fish (2005) demonstrates in her ethnography of maternal health in Russia, state officials often hold doctors accountable for the actions of their patients. She further shows how these doctors feel disempowered in their low political position yet ironically are unable to identify with the marginalized women they serve. This is true in rural Yucatan where doctors have a difficult time adapting to rural settings and the pressure of intense oversight by urban officials. Regardless of these challenges, many rural community doctors who have worked in Sabán have continued the hierarchy of power relations within health care by imposing their position of authority—backed by the state and federal government—over their patients and the larger community.

According to Weber, bureaucracy is “a dehumanized system of impersonal, rational procedures and rules” (2006:46). States maintain bureaucracies because they are specific, historically formed structures that carry out larger administrative objectives and ideologies. Bureaucracies are tools of control that focus on the whole population rather than individuals. Yet, individuals clearly internalize state policies through their participation in bureaucratic mundane experiences such as applying

for a health insurance, birth certificate, and social welfare programs. As Fox (1992) points out, the state is made up various institutions that are constantly competing against each other to gain power and access to resources. Fox's analysis demonstrates the multiplicity of the state by looking at how different bureaucratic institutions implement state policies through their own interpretations and goals. Byrnes (2003) provides an ethnographically grounded account of how state institutions function in the local level, more specifically how Mexican public policy implementation is enacted and embodied through individuals. She shows how government institutions are made up of people who are left with the responsibility of making decisions on how state programs will be interpreted and implemented in specific settings. According to Byrnes, these state workers "shape and find meaning in part through the work of being the state" (2003:2). More importantly Byrnes discusses how people who embody and enact the state also have personal lives that cannot easily be separated from their work. Everyone takes on multiple roles both in a professional and personal setting which can sometimes overlap. For example, someone can be a state administrator for a maternal health program, while also being a mother, wife, and daughter. The fluidity and inconsistency within bureaucracies and institutions exists because they are made up of people with different positions and situations both professionally and privately.

The state takes on meaning for both individual citizens and federal workers through "the routine and repetitive procedures of bureaucracies" (Sharma and Gupta 2006:11). Molyneux (2006) and Jeganathan (2004) discuss how bureaucracies are encountered through the everyday experiences of marginalized individuals. Molyneux's work shows how state maternal health programs use the bodies and health practices of women to meet larger objectives. Additionally, state health programs are used to manage certain groups of people who are considered at the margins of state control. In the case with Oportunidades, women who participate in the government funded program are told that their relationship with the state is based on conditional terms. The state will provide basic resources for women but they must be willing in return to follow state mandates and guidelines such as attending prenatal appointments and health education meetings at the

government clinic. In the end, for program recipients to receive the full benefits of cash transfer health programs, their cooperation and participation must be officially documented by state workers such as doctors at the local clinic or regional health policy officials.

Documents function to solidify the relationship between individuals and the state and as a mechanism of control. As Das and Poole state, documents embody the “state’s distance and its penetration into the life of the everyday” (2004:15).

Prenatal care in rural Yucatan is largely experienced through the official government paperwork. The Oportunidades program requires specific state forms to be filled out correctly so that women can demonstrate their compliance and therefore receive their cash transfer. Seguro Popular is attained only after women go to the regional hospital and fill out more state forms. Women must be responsible for maintaining and guarding their medical records. They must bring these everywhere they go—to every doctor’s appointment and Oportunidades distribution day. If a woman decides to go to the public hospital to give birth, she must bring all the appropriate paperwork that shows she is insured by the state insurance program, Seguro Popular. If she forgets or cannot locate the paperwork, then she will be liable to pay all, or a portion, of the bill for her hospital stay.

A discussion of checkpoints can illuminate how documents function as a way states attempt to control the movement and bodies of people living in peripheral places. As well as demonstrate how the filling out and checking of documents becomes a routine and performative experience that marks the relationship between the individuals and the state. Jeganathan explains how people moving through checkpoints experience the power of the state through the ritual and routine of presenting identification and interacting with officials. He adds that everyone knows how to work within a checkpoint. The government officials know to demand certain official documents and to ask specific questions. Yet, more importantly, those going through a checkpoint anticipate this and therefore have their documentation ready. My analysis of Oportunidades looks at how the required monthly prenatal appointment with a doctor at a government clinic functions as a ritualized checkpoint. During these appointments, doctors not only check the health

vitals of the pregnant woman, but through their act of documenting the appointment they also certify that the woman has complied with the medical component of Oportunidades. The documents women carry to every prenatal appointment at the government clinic lists each time a woman has seen a doctor and what medical procedures she has undergone. This specific paperwork is essentially a documentation of each encounter a woman has had with a state medical provider during her pregnancy. In addition to documenting every prenatal appointment, doctors also use this time to lecture women about the safety and superiority of biomedical care and question them about their use of midwifery and their decision as to where they want to give birth.

Feminist scholars have been critical of how development projects can function as a way for states to monitor and control the actions of their female citizens. Many of these programs also use discourses of morality to pressure women into conforming and participating in state projects. One of the main mechanisms of control and coercion by the state on the lives of marginalized women takes place within development programs that tie participants' economic need with notions of co-responsibility. For example, in Bangladesh, microcredit programs (such as the Grameen Bank) geared towards poor and rural women have created new forms of debt relationships in which participants feel forced to meet specific requirements and fulfill the objectives of program officials (Karim 2001). Poor women participate in these development programs because they need money and access to additional resources and, once in the program, it is difficult for participants to walk away. Cash incentive programs work in the same way as microfinance programs, in that they shift the responsibility of the state towards its citizens to one in which individuals are responsible for their own wellbeing and success. By placing responsibility on individuals and their obligation to care for themselves and family, state governments can further divest in social services and infrastructure. Furthermore, by focusing poverty alleviation programs on individual women and not the structural reasons for inequality, women become the default for all societal problems.

As seen with development projects geared towards empowering marginalized women, conditional cash transfer and microfinance programs can work to discipline women and bring them into the formal political and economic sector, where they can participate as “good” and responsible citizens (Sharma 2006). These development programs “teach” poor, rural, and/or indigenous women the “right way” to act within civil society with the incentive of more effectively fighting for their rights. However, as Sharma (2006) has discussed with empowerment development projects in India, the push to “educate” subaltern women functions to de-radicalize them by creating docile citizens who do not disrupt civil society and whose labor and bodies the state can use to promote larger state projects. In many ways, these labeled empowerment programs function as yet another mechanism of control which works towards reproducing what the state imagines society to be. Ultimately, development programs that emphasize the empowerment of marginalized women often end up reproducing the various forms of social inequality that they are trying to combat (Karim 2001; Sharma 2006). Therefore, feminist scholars and activists argue that development projects need to reconceptualize the role women play as agentive actors fighting oppression and inequality rather than victims in the need of saving (Rai 2008). Shirin Rai further adds that feminists have pushed development programs to shift their focus from just inserting women into projects, and instead, to place attention on the “underlying biases of socio-economic contexts and political institutions” (2008:3).

Bourdieu’s concept of symbolic violence explains the operation of state power and domination in society (1990b). It emphasized how individuals internalize and naturalize state control. Symbolic violence is fundamentally different from overt forms of oppression. It functions as a gentler, less visible, and disguised form of violence. According to Bourdieu, symbolic violence is “censored, euphemized, that is misrecognizable, recognized violence” (1990b: 126). What Bourdieu is saying in this seemingly contradictory description is that the social and political conditions that uphold symbolic violence are present and recognized in everyday life, yet completely misunderstood. This occurs because individuals have become socialized to not see it as violence; they have naturalized repressive social

conditions by misinterpreting them as the way life is. The power of symbolic violence lies in this misrecognition.

The power behind symbolic violence is attributed to the ways in which socialization occurs and the role of ideology (Jenkins 2008:109). Individuals become socialized to view state domination as natural. Oppressive social, political, and economic conditions remain unchallenged because individuals perceive them as a normal way of life—they have experienced them throughout their everyday existence and have grown accustomed to the conditions in which they live and so their subjugation goes unchallenged. Ideology plays an important part in this process because individuals come to believe in the legitimacy of the social conditions, structures, and realities in which they live, although those very systems are often implicitly repressive. As Bourdieu states, “the most successful ideological effects are the ones that have no need for words, but only *laissez-faire* and complicit silence” (1990b:133). Once again, the power of symbolic violence is attributed to its unquestionable and “misrecognized” acceptance. Symbolic violence can be more powerful than overt forms of domination since individuals are not identifying it as oppression. The misrecognition of the true nature of symbolic violence distorts people’s understandings of reality and the way that power is distributed so that they willingly participate in their own domination. When state control is visible and direct, it can be challenged; whereas benign and disguised forms of domination, go unnoticed and are (unknowingly) allowed to continue.

Bourdieu uses the educational system as an example of how symbolic violence functions. It is an institution that has been established by dominant classes to legitimize their power and control within society (Bourdieu 1990b). Institutional distinctions of authority and legitimacy are established through the distribution of credentials and certificates with the educational system. The educational structure functions to divide and classify different individuals as well as indoctrinate them in the naturalization of unequal distributions of power and domination (Bourdieu 1990a).

Although states can wield an immense amount of power that alters the lives of individual citizens, that power has limits. State objectives and projects are often

met with resistance by local people, and that resistance can take on many forms. James Scott (1985) shows how marginalized people resist authority through small subtle acts that (like Abu-Lughod states) are not always intended to overthrow the larger system. In many cases these acts of resistance are not intended to be visually seen or identified by those in power. Nugent (1998) agree that subaltern individuals like rural peasants and indigenous people have the capacity to resist. Yet these forms of resistance must be understood in relation to particularities of local and regional experiences, national historical contexts, and international relations. As he state, resistance does not exist in a historical vacuum, it “is connected to global structures of power” (1998:14). Nugent also discuss the importance of identifying silences as forms of resistance.

Abu-Lughod is highly critical of anthropologists for romanticizing resistance and focusing their time and attention documenting it rather than discussing how power works through resistance. Power is central to resistance; the act of resisting demonstrates how power works through individuals and how people exist within larger structures of power (Abu-Lughod 1990:42). Abu-Lughod provides two important contributions to understanding resistance and power. First, she demonstrates how resistance is relational and tied to specific forms of power; it is situational and grounded in the historical moment and environment. Second, she states that resistance is not always intended to overthrow the social, political and economic system; instead people strategically resist certain forms of domination while continuing to participate in larger processes. Here is where I began to better understand agency and how what I considered “choice” was always situational. The amount of agency rural Yucatec Maya women had in relation to their reproductive health and childbirth practices was tied to larger social, political, and economic systems. They largely participated in social health programs because they needed the financial support to provide basic resources for themselves and their families. Their participation in the federal health system also transformed them from individuals to a regional collective. It reduced them to statistical numbers that were used to meet national concerns about overall maternal and infant mortality rates.

Rural Yucatec Maya women have demonstrated in a multitude of ways their resistance to state control over how they give birth—and ultimately how these women care for their bodies and address their reproductive health. These women are not passive. Many find creative ways of asserting their autonomy. Resistance often takes place in small individual acts—women drag their feet and attempt to give birth at home first with a midwife and ultimately turn to biomedical care during labor and delivery only after the midwife can no longer effectively help the mother; it is common practice for women who participate in federal health programs such as Oportunidades not to discuss their birth plans with their local physician. Sometimes they appease their doctor by publicly agree with her/him and stating that they will consider a hospital birth even though they know that they will try to give birth at home first. There are some women who feel strong enough to individually state their preference for midwifery care and let the community doctor know that they are also seeing a midwife alongside their prenatal care at the government clinic. In addition to these individual acts of resistance, women from Saban and Huay Max have participated in larger collective protests that loudly proclaim their disapproval of the Mexican state's failure to provide them with physicians who treat them with respect and acknowledge that rural Maya women have valuable insights and knowledge about their health and childbirth. Unfortunately, in the eyes of physicians and state policy makers, these acts of rebellion have further marginalized these women and have served as a justification for statements about their backwardness and ignorance.

Medical Anthropology and the Anthropology of Reproduction

The anthropology of reproduction contributes to social theory by providing a critical analysis of culture, power, and health that places reproduction at the center. An important contribution is the concept of “stratified reproduction” (Colen 1995), which addresses how different power relations contribute to the social inequality of reproduction where certain people are encouraged in their reproductive strategies while others are constrained (Ginsburg and Rapp 1995). Some main themes found in this literature include: 1) challenges and benefits of new reproductive

technologies in Western nations (Becker 2000; Rapp 2000) and the developing world (Inhorn 2006; Khanna 2010); 2) contested knowledges and battles for legitimacy reflected in the hegemony of biomedicine and the medicalization of birth (Davis-Floyd 2003; Jordan 1993; Martin 2001); and 3) structural barriers to maternal health (Mullings and Wali 2000; Lane 2008) and the consequences of international and state health policies on reproduction (Gutmann 2007; Rivkin-Fish 2005) including the politics of population control manifested in pronatalist practices (Davin 1997; Kahn 2000; Kanaaneh 2002; Krause 2005) and the restriction of reproduction (Anagnost 1995; Boddy 1998; Lopez 2008; Roberts 1997).

In relation to the anthropology of reproduction I understand that there are different ways in which women experience reproduction. The anthropology of reproduction demonstrates how reproduction, like many other aspects of life, are politicized and connected to larger cultural and social systems. Ginsburg and Rapp (1995) take their analysis even further by discussing the connections between reproduction to political and economic systems and how power is enacted and enforced through reproductive practices. As Schulz and Mullings point out, “analysis of cultural beliefs and practices must be located in the broader context within which individuals and groups live their lives if we are to understand their relationship to and intersections with broader social, political, and economic contexts” (2006:9). This understanding places health within larger social and structural processes, and demonstrates how health and illness reflect power relations (Farmer 1999). My approach to reproduction is grounded in these critical analyses of power and inequality which place reproduction within larger structures. My analysis of childbirth in rural Yucatan follows the work of medical anthropologists who explore the linkages between childbirth practices, local cultures, and the penetration of the state.

Scholars note how the increased medicalization of childbirth privileges biomedical knowledge, with its evidence-based orientation and reliance on “sophisticated” technology, over traditional forms of maternal health, including midwifery (Barcaly et al 2005; Cheyney 2011; Craven 2005; Davis-Floyd 2001;

Kaufert and O'Neil 1993). Reliance upon traditional health systems and healers has been devalued by state institutions and representatives (Ayora Diaz 2000; McMullin 2010). Yet, even with state delegitimization of traditional approaches to childbirth, scholars have observed that midwives continue to attend the majority of births in rural and indigenous communities throughout the world (Anderson et al 2005; Davis-Floyd et al 2001; Daviss 1997; Geurtus 2001). More specifically, Jordan (1993) and Davis-Floyd and Sargent (1997) have looked at how Yucatec Maya women's reproductive health is framed under the concept of "authoritative knowledge". Their work demonstrated that Maya women can challenge the hegemonic and powerful health discourses of the Mexican state through their support of midwifery care by indigenous women. They further illustrated how Yucatec Maya women create their own discourses of authority and knowledge in which legitimacy regarding maternal health is placed in the hands of local women. Authoritative knowledge allows the space for marginalized groups to present another form of health care that meets specific needs and provides different forms of expertise and skill that are missing within the dominant state backed biomedical system of health. In the end, maternal health needs to be understood as more than a choice between biomedicine and midwifery.

Today, discourses and practice around prenatal care and childbirth in Mexico are dominated by the federal government's emphasis on modernity and biomedicine (Davis-Floyd 2001; Smith-Oka 2015). Thus, biomedical practitioners are supported by the Mexican state in their view that childbirth should take place exclusively in a biomedical setting, preferably a hospital, where the knowledge of science and technology can best address the risks involved with women giving birth. The Mexican state and the biomedical community have largely been successful in establishing this hegemonic control over childbirth through the implementation of national health programs, the positioning of doctors in rural communities, the expansion of a network of clinics and hospitals, and through the distribution of pervasive propaganda via print, radio, and television media. The poverty alleviation development program, Oportunidades, which emphasizes a biomedical approach to health, has further pressured women to seek maternal health care from state clinics

and hospitals. Smith-Oka (2009) argues that population and development policies focusing on women's reproduction produce unintended consequences that ultimately negatively affect women. She states that the conditional aspect of the Oportunidades program requires physicians to monitor and coerce female recipients into following certain requirements. As a result, Smith-Oka states that the Oportunidades program structurally places doctors and medical staff in positions of power over women.

Kaufert and O'Neil discuss how discourses of risk have been used by state governments and medical professionals to pressure women to give birth in hospital settings (1993). Their research with Inuit women and Canadian state clinicians demonstrated how easily physicians presented themselves as the authorities of birth because they were extensively trained in science and had access to superior technology and resources which allowed them to deal with the constant risks associated with childbirth. The physicians who worked at the government clinic in Saban had also talked about childbirth through a discourse of risk. Like the Canadian doctors that Kaufert and O'Neil worked with, these physicians felt that birth was a dangerous event that needed to be heavily monitored and take place at a hospital. One of Saban's doctors went as far as stating that it was a human right for a woman to give birth in hospital because it was the safest place that offered the most dignified experience.

Women living in Saban and Huay Max have chosen to challenge the hegemonic authority of the Mexican state and its biomedical practitioners by granting authoritative knowledge in relation to childbirth to both biomedicine and midwifery. As I mentioned earlier, all most all pregnant women receive prenatal care from both the physician working at the community clinic and a local midwife. Yet, for many women, when it comes to the moment of giving birth, midwifery care is more valuable and dependable over the biomedical care provided by the Mexican government. Like the Inuit women Kaufert and O'Neil (1993) worked with, these Maya women understand that there are risks associated with childbirth but they see them as part of the reality of giving birth in a rural community that has historically been neglected and abandoned by the Mexican government. For them, giving birth

at home attended by a midwife is less risky than depending on the underfunded and understaffed state hospitals that practice invasive and at times abusive approaches to birth. Communities in rural Yucatan, like Saban and Huay Max, have had to learn to become self-sufficient and address their own needs because the Mexican state has proven to be unreliable. Thus, midwives and older women have carried the knowledge of how to care for pregnant and birthing women. These knowledgeable women have always been in the community—to this day midwives continue to be the most reliable health care practitioners in Saban and Huay Max.

Medical anthropologists have documented the existence of medical pluralism, in which different health systems exist in one place and are combined to accomplish specific needs or wants (Frankel and Lewis 1989; McGrath 1999; Obermeyer 2000). This dissertation adds to that literature by addressing through ethnography, how rural indigenous women make everyday decisions pertaining to their maternal health in an environment where multiple health systems exist. Emphasis is placed on the pivotal decisions women make such as where to seek prenatal care, where to give birth, and which health care provider will attend the birth. I also examine the various ways in which local health care providers incorporate various forms of medical knowledge (traditional and biomedical) into their practice. For example, Elena (a Yucatec Maya midwife from Saban and a member of the family I am focusing this dissertation on) has attended various state sponsored workshops that emphasize teaching her biomedical terminology about the body and childbirth related emergencies. Elena has also used the services of her niece, Daniela, who works at the government clinic as a nurse, to help her identify complicated births and to check if a birthing woman is experiencing high blood pressure. Elena, herself, would like to learn how to take a woman's blood pressure so that she can incorporate this life saving knowledge into her practice. This dissertation uniquely contributes to existing literature by critically analyzing the benefits of medical pluralism but also its politics, unpredictability, and limitations.

The women of Saban and Huay Max are pragmatic women. They understand the benefits of biomedicine but also acknowledging its limitations. I discuss childbirth practices in rural Yucatan through the lens of medical pluralism that is

embedded within a political economic framework. These women demand more from the state. They want more and better health resources. But they also want to be respected as rational and contemporary people who choose to hold on to the traditional practices they value. For example, midwifery is often the most reliable and secure form of maternal care that these women have access to. Yet, a national rhetoric and state health policy encourages them to give up “antiquated” practices such as midwifery and participate in a modern biomedical form of health care. The Mexican state has historically neglected this region and the Yucatec Maya, yet it expects rural Maya women to embrace a health care system that is inadequate and underfunded.

Medical anthropology also provides a critical analysis of health inequalities that reflect biases based on ethnicity/race, gender, and socioeconomics (Farmer 2005; Maternowska 2006; Mullings and Schulz 2006). Contemporary health inequalities are a direct consequence of colonial practices of domination and ideologies of ethnicity/race and gender that continue to influence state biases within development, and more specifically the way states address childbirth among indigenous women (Jolly 2002; Van Hollen 2003; O’Neil and Kaufert 1995). Resources are not equally distributed in Mexico, as indicated by the fact that 44 percent of indigenous people are found in the poorest income quintile (Molyneux 2006). The highest rates of morbidity and mortality in Mexico are also found among rural, poor, and indigenous populations (Finkler 1994). This ethnographic research seeks to analyze how Yucatec Maya are constituted as a specific group of people with their own understandings and practices related to health. It also documents how indigenous peoples shape themselves and their cultural identity, in relation to reproduction, the state, and other political and economic forces.

Anthropology and Global Health

At the beginning of the twenty-first century, the term “global health” began to dominate the international aid and development arena. In 2006, the United States replaced what it had previously referred to as “international health” with “global health” (Adams 2010:40). According to Brown et al, “global health, in general,

implies consideration of the health needs of the people of the whole planet above the concerns of particular nations” (2006:62). Adams further adds that global health moves beyond international health by emphasizing “the interconnectedness of all countries (rich or poor, North or South) in a mission to create health on a global scale” (2010:40). Global health is unique from previous approaches to health—such as tropical medicine and international health—in that it bypasses the physical and political boundaries of states and acknowledges the constant mobility of people, resources, goods, information, and microbes. As scholars such as Nichter (2008) and Farmer and Garrett (2006) state, global health has the possibility to alleviate some of the immediate health concerns of globally marginalized populations. In some cases, especially those which focus on human rights and humanitarian issues, global health attempts to provide resources for poor and marginal populations throughout the world, so that they have access to food, basic health care, necessary medicines, and healthy living conditions. Despite some of the potential benefits of global health frameworks, there are key issues, shortcomings, and failures that must be addressed (Adams 2016).

One of the primary problems with global health is that it is dominated by neoliberal ideologies and approaches. Global health solutions tend to address problems through market-based solutions, often relying upon the private sector to fund and implement projects. According to Adams, “global health seeks global solutions with an eye to cost-effectiveness, to scaling up practical, technologically sophisticated interventions that are not only affordable but also profitable and that hold some accountability to the masses” (2016:187). This focus on accountability becomes more visible through some of the common metrics that are used to measure the success of programs. While these metrics are touted as being both reliable and objective, problems can arise when the metrics themselves become the focus, rather than patient health (Oni-Orisan 2016:100). When “accountability” is reduced to a fixation with producing the right numbers, patients often suffer. Another issue, as Adams (2016:189-90) highlights, is that the metrics of many global health interventions can become so skewed that scalability and the potential

for profit become the dominant concerns. All of this reflects a certain set of values that tend to pervade many global development projects around the world.

Benatar et al argue that the dominant values of global health focus on “individualism and respect for human rights, economic liberalism, corporate managerialism, a narrow focus on scientific rather than social solutions to health problems, and an oversimplified, linear approach to health problems” (2010:144). The values that underscore many global health initiatives come with a core set of concerns, approaches, and concepts. Sustainability is one of the key concepts that pervades many global health projects. This concept, which has been borrowed from the world of environmental management, comes with certain assumptions and problems. One of the primary issues with the concept of sustainability is the question of what, exactly, is to be sustained. Global health initiatives that focus on achieving sustainability may end up trapped in the battle between actually creating sustainable, healthy communities and simply sustaining organizations (Yang et al 2010:130). One of the key critiques of health interventions in Haiti, for example, is that they often result in the maintenance and support of NGOs rather than communities.

Global health presents certain challenges to both larger structures and processes at the national level and in local contexts where it intimately affects the everyday lives of individuals. Although global health is theoretically conceived to extend beyond state borders, the political and economic power of state governments continue to play a key role in how policies are envisioned and implemented. Many medical anthropologists and social scientists have demonstrated that global health practices, policies, and goals are not disseminated equally across the globe. In many cases, specific state governments get to define global health needs and where and how resources are distributed, while other states (usually in the global south) are left to deal with foreign decisions and practices (Garrett 2007). Global health does not exist within a level playing field; politics and power must be included in any critical analysis of global health (Farmer 1999; Whiteford and Manderson 2000).

Yet, global health also poses certain burdens to states, health care practitioners, policy makers and patients. More specifically, the autonomy and international positionality of some states have been challenged through global health policies and practices. For example, governments are heavily pressured by the international global health community to reveal certain national health statistics and report disease epidemics especially if they have the possibility of crossing national borders (Nichter 2008). As Fidler points out, global public health and infectious diseases has long been a foreign policy concern (2004). States now have a responsibility not only to their own citizens but also the global community that is made up of a multitude of organizations and governing entities with various social, political, and economic objectives. The distribution of international aid in the form of money and resources challenges the autonomy of politically and economically weak states by forcing them to restructure their government in specific ways that are decided by donor institutions and states. In many cases the public health sector has been gutted and privatized. As Lakoff (2005) argues, this practice of dismantling the state causes further damage to already vulnerable populations by taking away what little resources they have left. Global health practices that focus on providing health through nongovernmental organizations (NGO) have directly affected patients by directing individuals away from the state health infrastructure while simultaneously encouraging talented health workers to leave their state jobs and work for NGOs. NGOs are notorious for competing with the state health sector. They have little to no accountability at the local level. In most cases NGOs pay more than federal public health positions and as a direct consequence many local health care providers choose to leave their state jobs at community clinics or city hospitals (Maternowska 2006). The major problem with this situation is that most poor and disenfranchised people continue to receive health care through a state infrastructure that continues to be underfunded and whose resources and staff is continuously being gutted by international NGOs (Garrett 2007).

What this means is that many of the dominant assumptions and abstractions of global health can, ultimately, end up completely losing sight of the very communities and individuals that are supposedly meant to benefit from these

interventions. This is where critical anthropological perspectives on global health can be not only useful, but powerfully transformative. Nichter discusses the insights of anthropological work on global health by stating that medical anthropologists render “the perceptions and representations, experiences and agendas of different stakeholders visible, thereby facilitating critical thinking, meaningful dialogue, and more fully informed problem solving” (2008:4). Anthropological methods allow for the inclusion of multiple voices, including those of marginal people who are often left out of larger discourses. They further illuminate the politics and economics of global health and ultimately the asymmetrical power dynamics that exist within global health initiatives. Farmer and Garrett (2006) acknowledge that global health can help millions of poor and marginalized populations throughout the world, but only if it incorporates the right kinds of programs. For example, global health approaches that follow vertical programs need to be replaced with horizontal approaches that address the multiple health needs of individuals (Nichter 2008). These needs may include everything from access to basic resources (such as clinics) to problems caused by “blockages” in information flows (Feierman et al 2010). In many cases, individuals do not suffer from only one disease at a time (such as polio, tuberculosis, AIDS), their health is compounded with other issues such as nutritional deficiencies and water-borne illnesses. In the case of Saban and Huay Max, reproductive health is not only dependent on access to reliable and respectful health resources. Women’s reproductive health is simultaneously linked to access to basic necessities like clean water, electricity, and healthy foods.

Another important contribution of anthropologically-informed global health has been to emphasize the critical importance of local health care providers for addressing global health needs. These local practitioners are vital because they are from the communities that they work in and have the knowledge to work efficiently through their communities. This is an important issue for the residents of Saban and Huay Max. They have only experienced a health clinic that is staffed by people who primarily live away from the community. The doctors who come and work in the government clinic in Saban are usually from urban areas from other parts of Mexico. Many of them come for only a year—as a requirement to fulfill their year of service

for them to start their own private practice or work in the public health system. The senior doctors who work at the clinic stay on average 2-3 years (I have seen four different senior physicians work at Saban's clinic in the last decade) and every one of them has lived at least an hour away from the community and commutes to work Monday through Friday from 9am to 3pm. The nurses who are paid a slightly higher salary for working in rural indigenous communities also choose to live outside of the community. These nurses are paid an additional stipend to live in the rural communities they work in, but few if any do. There have only been two exceptions, in the 1990s and early 2000s the clinic in Saban employed a nurse who was not only from the community but also lived there. The last exception, took place at the end of 2013, when the clinic employed another local nurse who also lived in Saban. She had been trying for years to transfer to Saban's clinic and was stalled due to bureaucratic protocols that favored senior level health professionals in job placement. Several community members and a prominent midwife had strongly expressed their desire for the government clinic to hire a health care professional that was from the community—someone who was vested in the place and the people and who understood their social, economic, and political situation. Oportunidades is one of the key government programs that has shaped the relationship between community members and health care practitioners in Saban.

Oportunidades is Mexico's most well-known contribution to global health policies and institutions. It is revered both nationally and internationally as a success and a model poverty alleviation program (Darney et al. 2013; Debowicz and Golan 2013; Figueroa 2014; Ranganathan and Lagarde 2012). Oportunidades is held up as a model program worldwide by powerful international institutions such as the World Bank, Inter-American Development Bank, and World Health Organization (Wilson 2015). It is a conditional cash incentive program that targets women with children and defines them as the responsible caretaker of the family and ultimately the future of Mexico. In Oportunidades, the poor are required to participate in specifically designated practices that are intended to increase their human capital; these include the attainment of continuous education, the regular attendance of

health checkups, and the eating of nutritional foods (Behrman and Skoufias 2006; Levy 2006; Todd and Winters 2011).

One of the key objectives of the program was to draw citizens into the state's health care and educational systems to "provide a skilled labor force for formal sector jobs" (Wilson 2015: 2010). Like other development and global health projects, Oportunidades is a neoliberal program that aims to incorporate marginalized populations into the state project. For the health care component of the program, this is achieved by requiring women to attend prenatal appointments at government clinics. Such requirements effectively require women to participate in the state-supported biomedical health care system.

While Oportunidades is considered a successful model by many health and development experts, there are many flaws, failings, and shortcomings of this program (Wilson 2015; Smith-Oka 2015; Molyneux 2006). According to Wilson (2015:211), the key problematic assumptions of Oportunidades include: 1) insensitivity to gender relations of power within households; 2) assumptions that mothers need to be compelled to care about the health and nutrition of their children; 3) related assumptions that poor people do not behave in a rational manner (and are therefore unable to make their own decisions); 4) lack of acknowledgement of the many demands on women's time that might make fulfilling their "co-responsibilities" difficult; 5) the problematic hypothesis that more schooling translates directly to higher incomes; and 6) a highly questionable belief that the formal labor market can actually absorb newly trained workers.¹⁷

Beyond these issues, Wilson explains, this program, which is geared toward increasing "human capital," rests upon a highly problematic assumption of "meritocratic individualism" in which "the poor, rather than the system in which they are embedded, are responsible for their fate" (2010:213). Such approaches focus so heavily on altering and shaping individual behaviors that they run the risk of completely ignoring—or even dismissing—wider systemic problems that produce and maintain poverty and inequality. In some cases, the problems

¹⁷ Wilson lists these issues as four primary flawed assumptions. I have split a few of them up to highlight some different aspects of these problems.

associated with Oportunidades are unintended yet severely detrimental (Smith-Oka 2009). These unintended consequences can stem from a program design that creates a close association between policies and practitioners that effectively disempowers women (Smith Oka 2009). It is at these points of failure, conflict, and marginalization that anthropology can play a powerful role in critically assessing poverty alleviation programs such as Oportunidades.

As Smith-Oka argues, “providing adequate, humane, and ethical medical care for Mexico’s poor is not merely a matter of founding or funding additional clinics, or even of providing better training for clinicians, but of addressing larger social and cultural dynamics” (2015:9-10). In her critical review of the shortcomings of Oportunidades, Wilson questions the focus on individual responsibility in the program, especially considering the negative impacts on women’s empowerment. Instead, she argues, it may be useful to push for programs that focus on the participation of families and communities to achieve development and health-related goals.

History and Anthropology of Yucatan

As Roseberry so powerfully argues (following Wolf 1999), anthropological analyses must include history (1989). Childbirth in rural Yucatan must be understood within a framework that includes a long history of contentious and at times violent interactions between various governing bureaucracies and Yucatec Maya. These interactions and their subsequent discourses begin from the bloody conquest of the peninsula (Clendinnen 2003; De Landa 1978), through the bitter colonial era and early statehood (Farriss 1984; Hanks 2010; Jones 1989; Restall 1997), the Caste War (Dumond 1997; Reed 2002; Rugeley 1996), Mexican revolution and its aftermath of marginality (Fallaw 2001; Joseph 2003; Smith 2009; Sullivan 1991), and continue to present day struggles for social equity and self-determination (Ayora Diaz 2012; Castañeda 1996). In response to the intense rise of international tourism along Quintana Roo’s coast, many scholars have focused on the political, economic, and social effects of tourism development and the Maya (Hiernaux 1999; Juarez 2002). While tourism research is a pressing issue, in this

dissertation I have chosen to address other critical processes that effect contemporary rural Maya communities in Quintana Roo. My research contributes to existing literature on Yucatec Maya women (Elmendorf 1976; Jordan 1993; Castellanos 2010) by analyzing their relationship with the Mexican state through the management of their maternal health.

Reflecting the subordinate social, political, and economic position of indigenous people in Mexico, many Yucatec Maya consider themselves mestizo or campesinos (agricultural peasants) rather than indigenous (Castañeda 2004). However, this choice in self-identification does not determine how state policy members and workers view the Maya. For them, Maya are indigenous and with that come stereotypes of romanticization, equation to nature, backwardness, and rebelliousness (Eiss 2010; Haenn 2005). Government clinic staff not only classify the Maya women with whom they interact with as rural and poor, but they frame these women's ideologies of health and childbirth as a consequence of their indigenous culture. Additionally, it is crucial to realize that Maya women's identity and the meanings behind their practices are heavily contested. Yucatec Maya women understand themselves as participants of contemporary society who continue to practice aspects of their culture deemed important and worth saving. While seemingly abstract and distant from present day realities, the histories of Yucatec Maya hold immense meaning, just as much as they continue to mark the social and political landscape.

The contemporary relationship between the Mexican state and rural Yucatec Maya women is part of a historical continuum of engagement, contestation, and persistent repositioning. To unpack this dynamic relationship, history is a good place to begin. The Yucatan peninsula—and its inhabitants—have often been characterized by various governing entities (conquistadores from Spain, the Catholic Church, colonial Mexico, and the Mexican state) as harsh and hostile. These kinds of representations dramatically shape the way outsiders, including most biomedical practitioners, interact with and understand their surroundings—including the Yucatec Maya people who are from this supposed “cultural backwater”. The following chapter will briefly discuss the historical engagement

that Yucatec Maya people have had with various governing entities. It will also explore the ways in which state discourses about the isolated jungle environment, including the indigenous people who live there, shape and constrain maternal health care systems in rural Yucatan.

Chapter 2

Lingering Discourses from Yucatan's Past: Political Ecologies of Birth in Rural Yucatan

In rural Yucatan, multiple competing discourses about pregnancy and childbirth powerfully illustrate the clashing political interests, hierarchies, and power relations that pervade the social order. Historically, federal social programs from education to health, are rooted in a centralist form of governance that privileges Mexico City and urban central Mexico (Fallaw 2004). Decisions pertaining to how programs are conceptually organized, developed, and planned for implementation are made at the geographic and political urban center of Mexico and then distributed throughout the country. At a basic level, health discourses in Yucatan can be divided into two distinct groups; those that come from the outside of rural Maya communities (the Mexican state, physicians and medical staff workers, and other non-Maya individuals) and those that come from within (primarily women and midwives in this case). Health is situated within various institutional and local discourses that reflect different ideologies and positions of power that may or may not be contradictory.

Discourses are sets of ideas, behaviors, and actions that have real, material effects. Discourses are not simply abstract ways of thinking about the world; they reflect how people think and talk about the world around us, and how people act based upon the ideas they share and the stories they tell. A discourse analysis approach reveals the “micropolitics and inequalities of power that shape access to information, resources, and opportunities” particularly in relation to health (King 2010:50). Discourses can be understood as a cyclical relationship in which ideologies inform language and in turn how language informs ideologies and practices. Discourses are both a source and a result of knowledge.

In rural Yucatan, state sponsored maternal health discourses are enacted through television and radio announcements, health posters distributed throughout urban and rural communities, and interactions between pregnant women and

medical staff. Yucatec Maya women's discourses about pregnancy and childbirth usually take place through informal conversations with their family members and friends. Women also discuss their maternal health with midwives and older women in the community. Such contemporary discourses and representations flood the Yucatecan social and geographic landscape, and serve to shape and influence daily life and wider political interactions. But these discourses of the present, while important and powerful, are also grounded in a complex historical past.

State and biomedical discourses pertaining to childbirth in rural Yucatan must be understood within a framework that includes a long history of contentious—and at times violent—interactions between various governing state bureaucracies and Yucatec Maya people. These interactions and their subsequent discourses began with the drawn out conquest of the peninsula and continued through the colonial era (through a system that legally divided people based upon their racial makeup and exploited the labor and resources of indigenous people), early statehood (that focused on the unification of a nation which enforced a centralist form of governance and the increase of taxation on peasants) and the revolution (that pushed for a nationalistic identity over a Yucatecan regional identity) all the way to the present day (that include the restructuring of state resources such as land tenure, the education system, and an emphasis on biomedical knowledge overall other forms of health). The official, formal histories of the Yucatan peninsula have largely been told through non-Maya and elite perspectives that do not reflect the lived experiences of rural Maya people, in particular, those of women.

Inga Clendinnen (2003) illustrates how the conquest of the Yucatan peninsula proved to be one of the most difficult and drawn out projects of the Spanish Empire. These difficulties had to do with the hostile geographic environment of the region which the Spanish had a difficulty penetrating and utilizing (more specifically, they had trouble finding fresh water and agricultural soil). The conquest of the Yucatan peninsula was also challenged by the antagonistic opposition of Yucatec Maya people to Spanish domination. These challenges were

reiterated in 1534 by the Spanish conquistador, Francisco de Montejo, when after years of failed conquest of Yucatan, he stated,

In the provinces there is not a single river, although there are lakes, and the hills are of live rock, dry and waterless. The entire land is covered by thick brush and is so stony that there is not a single square foot of soil...The inhabitants are the most forlorn and treacherous in all the lands discovered to this time...In them I have failed to find truth touching anything (Restall 1997:1-2).

The conquest of the Yucatan peninsula was long and bloody. Many people, both Spanish and Maya, died before the Spanish government could take control of the peninsula¹⁸. Spanish rule was achieved due to several combining factors, such as alliances forged with certain Maya chiefdoms that worked with the Spanish to take down their enemies, the devastating consequences new infectious diseases (most notably smallpox) had on the indigenous Maya population (70 to 80 percent of the Maya population died in the early 1500), an economic disruption with the long-distance trading partners Maya chiefdoms had relied upon specifically the fall of the Aztecs in central Mexico and the Maya in Guatemala, and finally the weaponry and military force of the Spanish proved to finally catch up with the challenging environmental conditions and the military was eventually able to exert power and domination over indigenous Maya people (Restall 1997). Following the conquistadores, the Spanish Catholic church began to cement itself throughout the peninsula by building churches and establishing a semi-continuous¹⁹ presence in

¹⁸ The conquest of the Yucatan peninsula was declared in 1547, but in reality, this only included the northwest corner of the peninsula. The Spanish had barely penetrated the rest of the peninsula.

¹⁹ The majority of remote Maya settlements in the Yucatan peninsula did not have a missionary living there permanently. The lack of impact that the missionaries had on Maya people was heavily criticized by Bishop Landa. He was appalled by the pervasive continuation of pre-Catholic religious practices among Maya people living in remote areas. As a result, many Maya were tortured and interrogated. And there was a successful violent campaign that burned mass amounts of Maya codex during the 1560s.

remote areas, not only in the Spanish populated regions located in the north and a few ports on the west and east coasts.

One important point of the Spanish conquest of the Yucatan peninsula is that Maya people continued to speak their languages, maintain a sense of cultural identity, and govern at the local level. Nancy Farriss (1984) states that this was in part possible because the Maya incorporated a practice of accommodation and at times assimilation of Spanish rule over certain aspects of their culture and life. However, Farriss also acknowledges that what played a significant role in the Maya surviving as a people with a deep culture and identity after the conquest and colonialism had more to do with the “favorable environment of the particular colonial regime that was established in Yucatan” than with the “inherent strength or staying power of Maya culture” (9). Colonial Yucatan was at the periphery of Spanish governance due to its low level of Spanish immigration, low export resources, and the existence of a large labor population. Yucatan during the colonial era largely functioned through a system of indirect Spanish rule that fostered an environment of intermixing among caste (Farriss 1997). Although Spanish language and culture were imposed on Yucatecan society politically and economically, assimilation was not one directional. In fact, many mixed race people and descendants of European colonizers incorporated Maya language, food, and culture in their own daily practices. For example, for many people (including Euro-descendant elites) living outside of the capital city of Merida, Maya was their first language (Gabbert 2004).

Women played a vital economic role during the years after the conquest. It was women who produced much of the tributes the Spanish imposed on Maya communities. The most notable was the woven cotton cloth that women had traditionally made (Labrecque 2002). Maya women are revered today for their sewing and embroidery skills that adorn their *huipiles* (traditional dress) and textiles.

During the colonial era in the eighteenth century, the southern interior region was a remote area filled with dense jungle located beyond what many considered to be the periphery of “civilization” (Sullivan 1991; Lapointe 2010).

Throughout the colonial era and early statehood, the seat of government and business in the Yucatan peninsula has predominately been in the northern region. The western area was connected to the north through an extensive system of roads that supported economic and political alliances, but the southeast region was left largely outside of the control of the north. The ruling elite of the Yucatan peninsula, who resided in the north, were predominantly descendants of European colonizers. However, Yucatan's elite, like many other parts of colonial Latin America, were not racially homogenous. In Yucatan, elite political and economic circles were also filled with people of mixed ancestry (European and indigenous) and the descendants of Maya nobles (Hidalgos) that worked with the Spanish government (Gabbert 2004). Since the elite of Yucatan primarily resided in the northern region of the peninsula, they thus perceived the southeastern region as a place filled with fugitives who had escaped civilization and colonial government control.

The southeast became a region that was labeled "static, hidden from external view and economic contact, unsophisticated, rural, supremely traditional, and culturally backward" (Jones 1989:4). In addition, the southern interior became a place characterized as "unhealthy, remote, unproductive, and ungovernable" primarily because of its perceived lack of "economic and human resources" (Jones 1989:12). Due to these negative perceptions, the southeastern region was largely underfunded. At the turn of the twentieth century, the same region was still considered to be closed off and hostile. As Sullivan explains,

outsiders warned each other [saying it] was 'a place of desolation and death', 'inhabited only by birds, wild beasts and the Maya Indians more fearsome than the wild beasts themselves' and all told, 'an excellent place to keep away'. In part, it was the forest itself that repelled would be visitors to central Quintana Roo (1991:6).

Nora Haenn's (2005) work on conservation politics in Campeche highlights how Yucatec Maya are still seen as people who exist closer to "nature", and viewed by many foreigners and state officials as existing outside of civilization.

Mexico's war of independence from Spain (1810-1821) brought in a new era of statehood. Yet, the seat of power and governance did not change and it continued

to be in central Mexico. After statehood, Yucatan continued to exist in the periphery of state governance and control. And for a brief time, from 1841-1848, The Yucatan Republic was independent from Mexico. However, the Caste War, the rise of the Henequen hacienda system, and the discovery of monumental archaeological structures not only brought the Yucatan peninsula to the attention of the ruling elite and powerful politicians of central Mexico, it also placed Yucatan within a global stage.

In 1847, less than a decade after fighting for independence from Mexico, the Yucatan peninsula was engulfed by a class war that began with a revolt by the poor hacienda workers and *campesinos* (farmers) against the wealthy elites (Reed 2002). The rebellion was named the Caste War by Yucatecan elites, Mexican government officials, and foreign states. The Caste War raged on and off for more than fifty years with devastating death tolls for both Maya and non-Maya people²⁰. Villages and crops were often destroyed in attempts to starve out the rebels hiding out in the southeastern interior. And in response, rebels attacked Catholic churches, government buildings, wealthy homeowners, and even Maya communities who the rebels considered allies of the oppressive state. During the war, Catholic churches and buildings owned by wealthy families were targeted as symbols of oppression by the rebels because of the economic tributes they demanded and the agricultural lands they confiscated from Maya people. Thus, the Catholic churches and surrounding colonial buildings were burned by rebel forces throughout the peninsula. To this day, most Catholic colonial churches in the eastern interior lack a roof to protect the worshipers from the harsh afternoon sun. Recently, parishioners from many of these churches have constructed small temporary roofs made from palm leaves or tin to help alleviate themselves from the heat.

What is now referred to as the Caste War was discursively labeled a “race” war by Yucatecan elites to gain political and economic support from Mexican and

²⁰ The Caste War began in 1847 when Yucatan was independent from Mexico. But a year after the start of the war, Yucatan rejoined Mexico and it was the Mexican state that dealt with the remaining 50 years of rebellion and disruption associated with the Caste War.

international communities against their “savage” indigenous enemies (Dumond 1997; Rugeley 1996; Sullivan 1991). The Yucatecan elite promulgated discourses of the war that characterized it as an ethnic/ racial conflict that stemmed from the “traditional hate of the descendants of the Maya against all in whose veins runs just one drop of white blood” (Gabbert 2004:91). It was also framed as a resistance from indigenous people towards progress and civilization (ibid). Yet, as historians have pointed out, the Caste War began when lower class peasants, predominantly Maya, fought against an exploitive tax system and access to agricultural lands (Dumond 1997; Fallaw 2004). The rebels who fought against the Yucatecan elites were motivated by their desire for political and economic reforms rather than a racial conflict. However, to this day, the dominant discourse that is used to describe the Caste War by academics, politicians, and the press is one that centers on racial conflict between indigenous people and whites as well as being viewed as a symbol of Maya resistance and current struggles for indigenous autonomy (Fallaw 2004; Gabbert 2004).

The Caste War continued for more than half a century with Maya rebels establishing autonomous spaces in the southern interior and eastern parts of the peninsula. These rebel-held regions existed outside of government control and influence until the early twentieth century. This was in part, because of a lack of a connecting infrastructure that would have allowed Yucatecan elites and the Mexican military to expand their control outside of the northern and western parts of the peninsula (Gabbert 2004). The rebels financed their fight by raiding non-rebel held towns and hamlets and trading with the British in Belize (Dumond 1997; Reed 2002). Sabán and Huay Max are located within this rebel held region. The capital of the new autonomous state of the rebels was named Chan Santa Cruz after the cult of the talking cross that originated during a time in the Caste War when the rebels were in a vulnerable position and where losing hope. The talking cross became a symbol of resistance that motivated the rebels to continue to fight against the Mexican government. This religious syncretic object appropriated the Catholic cross and altered it by covering it in elaborate painted designs. It was covered with a traditional white huipil (tunic) that was typically worn by women. Today shrines

dedicated to the talking cross exist throughout many of the towns and homes in the southern interior of the peninsula, although they have now become reintegrated back into the Catholic religion and are viewed as cultural religious items. In 1901, the rebel capital town of Chan Santa Cruz was retaken by Mexican troops, and its name was changed to Santa Cruz de Bravo. In the mid- twentieth century, the town's name changed again. This time it was named in the honor of Felipe Carrillo Puerto, the assassinated socialist governor of Yucatan. Felipe Carrillo Puerto is located 103 km southeast from Sabán. Along with various grocery stores and private doctor offices, Felipe Carrillo Puerto has the largest public hospital in the region.

During the late nineteenth century, while the main skirmishes of the Caste War were taking place primarily in the southeastern region of the peninsula, the northwestern region began to shift from colonial cattle and corn haciendas into the commercial development and production of henequen fiber. The northern part of the peninsula had several environmental challenges that affected the successful commercial growth of cattle and corn. These included very shallow soil deposits as well as an overall poor quality of soil. However, it was the heat and dry temperatures that proved to be the most difficult. Luckily, henequen which was endemic to the region flourished in dry conditions. The growth of the henequen hacienda system was supported by various factors including new forms of debt peonage and technological innovations which facilitated the production of rope and twine from the root fibers of the henequen plant and harvesting technology that required twine to bundle agricultural products (Sullivan 1991). The United States southern agricultural industry soon became dependent on Yucatan henequen twine. The rise of the henequen industry and foreign investment in Yucatan, primarily from the U.S., quickly changed the northern region into an economically and socially thriving place. The capital of Yucatan, Merida, was named the "White City"—because it was inhabited primarily by people of European descent and was considered to be a clean city as a result of city sanitation projects—it was filled with large mansions, theaters, international banks, and the conveniences of a modern city (including electricity). By the end of the nineteenth century, Yucatan was the wealthiest state in Mexico and considered "a model for modernization and progress" (Lapointe

2010:32). The Mexican government greatly profited from the tax revenues they received from the booming industry and reminded Yucatan that they belonged to the Mexican federation. Yet, while the henequen industry contributed to the enormous growth of surplus wealth in the region, the majority of the Maya population lived under an oppressive labor system that forcefully removed them from their land and regulated Maya people and peasants to the status of a debt peon who experienced poor living and social conditions (Smith 2009).

The henequen hacienda directly affected both the social and biological reproduction of Maya people and peasants in the north. The industry required a steady labor pool to attend the agricultural fields and produce the henequen fibers into twine and rope for commercial international sale. The energy and bodies of laborers were necessary for the growth of the henequen industry. Peniche Rivero (1994) writes about how hacienda owners devised an elaborate strategy of promoting endogamous marriages of their male workers with females from other haciendas and neighboring Maya communities. Male laborers were encouraged to marry through a financial incentive that was used as a bride wealth payment. This monetary incentive was presented as a gift by the landowner to the peon, who in turn was socially indebted to the landowner. The marriage practices in the henequen haciendas altered the movement of women throughout the region and established new family units that were ever more dependent on the landowner through financial and social debt.

Although the Caste War was officially declared over in 1901, small skirmishes and battles continued for another decade. In 1915, Yucatan's newly federally appointed governor and military commander, Salvador Alvarado, instituted wide social and political reforms that ended peonage, established new labor laws giving workers protections and representation, and provided social services to all citizens such as free education (Wolf 1999). These reforms addressed some of the political and economic concerns that started the Caste War, and they subsequently ended the oppressive living and working conditions on the henequen hacienda. Alvarado's reforms helped finally end the majority of the fighting and social unrest that lasted so long in the southeastern interior. However, it is

important to mention that even until the 1920s and 1930s, there still existed some rebel groups in the southeast and the interior that continued to claim autonomy and were ambivalent to foreigners entering their lands (Sullivan 1991). Even though the Caste War was officially over, fears of a Maya uprising or resistance to the wealthy elite and political leaders of Yucatan continued throughout the twentieth century (Sullivan 1991; Smith 2009) and have extended into the twenty-first century (see Hiernaux 1999).

Ben Fallaw discusses how the development of the federal school system into eastern Yucatan (the territory of Quintana Roo) during the post revolution era in the 1930s has been viewed by some academics as “the mother of all battles between a recalcitrant Maya and an encroaching mestizo/Mexican state” (2004:151). Following this line of thought, according to Fallaw, Alfonso Villa Rojas considered the expansion of the federal school system into the southern interior as an extension of the Caste War where the Mexican state once again sought to rule over Maya people. However, Fallaw cautions against looking at the rollout of federal schools in eastern Yucatan as a simplistic dichotomy of indigenous vs. white, Maya vs. the Mexican state, or cultural tradition vs. change. Instead he demonstrates that some of the failures of the federal school system in rural communities were largely the result of a combination of political battles between competing state institutions, the forced economic and labor contribution that was demanded of community members, the threat of sexual abuse by teachers, and the reluctance early teachers and program supervisors had to include local Maya people into the decision-making process. Successful integration of federal schools in rural peasant and indigenous communities came when local people’s concerns and requests were taken into consideration. For example, many Maya communities fought against co-education which went against traditional gender roles and practices at the time. As a result, early schools separated students by gender and tried to provide female teachers to female students (sometimes this person was the wife or sister of the primary male teacher).

Success of the federal school system in southeastern Yucatan came when teachers approached indigenous peasants as rational actors who would support

federal schools and to a larger extent, programs aimed at rural development, only until they understood and saw their benefits for them, their families, and their community. Schools also gained community support when they could clearly explain the benefits of a federal school education, including the utility of knowing the Spanish language, as well as providing the community with support to increase the material conditions of the town.

For Fallaw, Maya people have continued to exist as a cultural group by coming “to terms with powerful external forces and embrac[ing] change” (2004:152). In this case, resistance is set within a framework focused on negotiation. Although the relationship between rural Maya communities and the Mexican state have at times been contentious, historically, Maya people have accepted Mexicanization when they feel state workers are able to provide them with meaningful political and economic support (Fallaw 2004). The example of the expansion of the federal school system in rural southeastern Yucatan demonstrates that Maya resistance to state programs is not always against the state itself instead it is about how the state through its agents treats and respects Maya people as well as providing them with the resources they need and want.

Mary Kay Vaughan explains that the national focus on women’s literacy and education during the Mexican revolution and afterwards has always been about economics, maintaining an efficient labor force to participate in the capitalist growth of the nation, establishing loyalty to the nation state, and for the larger societal good such as increasing public health (1994:106). Originally, the education of women was not meant to alter women’s subordinate position in the family or society, but through the use of woman teachers in the countryside and the education of rural peasant and indigenous women, some level of change did slowly take place in the family and it opened up some possibilities for women that were previously unattainable. In the Mexican countryside, the enrollment of girls in federal schools did not increase until about the 1960s when the overall quality of life of people was raised due to a greater access to economic resources that improved nutrition and medical resources such as vaccines that reduced infant mortality and provided protection against communicable diseases (Vaughan 1994). During this time, there

was also a political economic shift in Mexico that required the household to diversify its subsistence strategies and educated women provided an additional resource that the family could rely on (ibid).

Today, In Saban and Huay Max, children are socially expected to attend school regardless of their gender. I was told by one mother in Saban that it was a child's job to go to school. From various discussions, I have had throughout the years, parents in the community view the state schooling as a necessity that their children need to increase their chances for successful employment. Additionally, I observed that many families that were participating in Oportunidades in Saban chose to send their daughters to the local high school so that they could continue receiving their education stipend that specifically paid for girls to continue their studies past secondary school.

The post-revolutionary era in Mexico brought a socialist understanding to political participation and rights of citizens. There was an emphasis within the Mexican government on modernity and progress that created programs throughout the nation which were designed to provide all individuals, regardless of their social and economic status, with the tools and support to become productive citizens. In Yucatan, many of these state policies and programs were geared to "civilizing" the Maya and incorporating them into the Mexican national system (Ayora Diaz 2012; Eiss 2010; Smith 2009). This began with the implementation of rural schools throughout the peninsula (Gabbert 2004; Sullivan 1991).

Later, the federal rural clinic system was expanded to follow through with earlier claims by the Mexican state that "all patriotic citizens of modern Mexico" should adopt proper hygiene, visit a medical doctor, and adhere to strict health laws (Smith 2009:162). Socialist leaders in Yucatan, such as General Alvarado and Governor Carrillo Puerto, emphasized the importance proper hygiene had in creating nationalistic "healthy workers less likely dominated by the church or the landowner" and therefore more loyal to the nation (ibid). Women ultimately became the target for health intervention in Yucatan because regulations over their bodies and practices were seen as an effective strategy to ensure the overall health and safety of the nation. Women's general health became a national concern and an issue

that needed to be controlled. Health campaigns in rural Yucatan were led by state supported *ligas feministas* (feminist leagues), who were made up of urban and non-Maya women, and whose ethnicity and class proved to be a major factor that separated the feminists and Maya women (Smith 2009). These feminist leagues believed in increasing the rights of women through education and health and promoted birth control as a resource to elevate social and economic pressures experienced by rural Maya women. The feminist leagues along with Governor Carrillo Puerto followed the cues of national politicians and chose to embrace biomedicine as the modern approach to improving the health of the population. Scientific medical knowledge, technology, and practices were revered above all other forms of health. Alvarado and Carrillo Puerto used the services of legal-medical specialists when creating and implementing state health care services (Smith 2009).

As Anderson (2005) points out, the successes of the rural clinic system and effective health campaigns have provided the Mexican state with the opportunity to convince the majority of its citizens of the value of biomedicine. Today, as Hunt and colleagues explain, “in Mexico, a nationalized health care system has made physician-attended births accessible to almost all women in the country” (2002:100). Mexico has approached women’s reproductive health predominantly through a biomedical approach. This can be seen in statistics that show as of 2006, ninety-four percent of all pregnant women had visited a physician at least once throughout their pregnancy (WHO 2009). Consequently, midwives in Mexico are relegated to a subordinate position underneath their biomedical superiors (Schneider 2006). Like all other forms of state sponsored health care, maternal health care policies and practices are “directed by an ideology that strives for modernization, sophisticated technology, and the medicalization of pregnancy and childbirth.” (Sesia 1996:134). According to a government clinic physician I spoke with in Sabán, rural communities in the southern interior have been designated hotspots by state health policy makers that are focused on lowering maternal and infant mortality rates. In the name of safety, state physicians are instructed by their superiors to persuade women to give birth in hospitals. This is largely a reaction to

the ongoing use of midwifery and the fact that these communities, along with those in Chiapas (El Kotni 2016) and Oaxaca (Sesia 1996), are composed primarily of indigenous people.

The most recent state sponsored health intervention rural Maya women have experienced is that of the implementation of the *Oportunidades* program. As I briefly discussed in the introduction, *Oportunidades* is a national poverty alleviation program that provides conditional cash transfers along with education and access to health care for Mexico's most vulnerable populations: children under five and pregnant and nursing mothers. *Oportunidades* has two primary goals: 1) to reduce maternal and infant mortality through preventative care and education and 2) to support continuous education among school age children. Although my research focused on maternal health and childbirth practices, many of the women I interviewed and informally spoke with had more than one child and their experience with *Oportunidades* encompassed both the women and infants' health component and the child education component. *Oportunidades* is a program that attempts to solve poverty through a complementary multipronged approach that focuses on nutrition, education, and health services (Behrman and Skoufias 2006). As I stated in the previous chapter, the focus of the program is to increase the human capital of future generations; therefore, children are the primary recipients (Dapuez 2016). Women are included in the program because their prenatal care directly effects the next generation of citizens while in utero and nursing mothers provide the primary form of nutrition and care for growing infants. Todd and Winters (2011) claim that the largest impacts on children's health who participated in *Oportunidades* came from those benefiting from their mothers' enrollment in the program while they were pregnant.

Mexico's *Oportunidades* program is one of the first development programs to use conditional cash transfers. Today, it is considered by many as a successful development model that has been replicated around the world—more specifically, throughout Latin America and the Caribbean, Sub-Saharan Africa, India, Bangladesh, Nepal, and the United States (Darney et al. 2013). The cash transfers that *Oportunidades* recipients receive usually cover about 20-30% of rural household

incomes (Fernald et al. 2009). The budget for Oportunidades is the largest of any of Mexico's human development programs with an investment of approximately 66 billion pesos for the 2013 annual budget (about 3.6 billion US dollars)²¹. In 2012, the program covered 5.8 million families (20% of the Mexican population) and more than 86% were rural citizens (Darney et al. 2013:206).

As I mentioned in chapter 1, an important component of the Oportunidades program is the belief that individuals have a responsibility for their own livelihood and economic future. Unlike poverty alleviation programs in past decades, this program breaks away from a practice of providing food subsidies or actual food staples, such as tortillas and milk (Levy 2006). Oportunidades is a "neo-liberal social investment program" that distributes cash transfers with the objective of participants freely contributing to the market economy, therefore providing them with more decision-making freedom and ultimately a greater access to better resources for their success (Luccisano 2006). Oportunidades has both short and long-term objectives. The short-term objective is to immediately reduce poverty through the distribution of cash transfers and access to basic resources such as education and health services. The long-term objective is to reduce poverty in future generations by investing in human capital (de Janvry and Sadoulet 2006). Santiago Levy (the program's co-creator) boldly states, *Oportunidades* "seeks to break the vicious cycle of poverty in all extremely poor households, rural and urban, in Mexico" through its emphasis on investing in human capital (2006:21). The rhetoric behind this program pushes for three primary principles: "participation, empowerment, and co-responsibility" (Molyneux 2006:429).

One of the main tenets of *Oportunidades* is an agreement to accept "co-responsibility" for the health and education of the participant's children, both born and unborn (Molyneux 2006:434). Oportunidades uses the co-responsibility agreement to further invest in the human capital of Mexico's poorest citizens. The requirements for Oportunidades are intended to be "the transformation of the life and the economic conversion of future individuals" (Dapuez 2016:169). Co-

²¹ El Universal 2013 (<http://archivo.eluniversal.com.mx/nacion/202970.html>)

responsibility begins with the state's fulfillment of its part of the agreement by educating and providing health care to all participating mothers, as well as giving them a financial incentive for their cooperation. The other half of the agreement states that women are responsible for adequately feeding and clothing their children, making sure that they continue to attend school, and that they receive suitable nutrition and health care. Pregnant women are told that their responsibility as mothers and care providers for their children begins with the baby in utero, which is why they are required to attend monthly prenatal checkups. Failure to comply with any of the co-responsibility stipulations, results in immediate suspension from the program and therefore no cash transfer—participants are terminated from the program if they continue to not meet program requirements after several months. The rhetoric of co-responsibility within conditional cash transfer programs is also used to reinforce a relationship between the national government and individual citizens (Rawlings and Rubio 2005).

Oportunidades claims that the cash transfers are intended to incentivize parents to invest in their children's health and well-being—therefore implying, that this is not already the case (Fernald et al. 2009). However, my work with program recipients in Sabán and Huay Max tells a different story. The majority of parents I spoke with expressed a strong desire to care for their children and provide them with a better future. They worked tirelessly throughout their lives as parents to provide the best life they could for their children. They did not need Oportunidades to motivate them to do that. What they needed from the program was the money and resources to help them provide more for their children—to give them access to better schooling, medical care, nutritious foods, that ultimately allowed them to live healthier lives. All the women who I spoke with who participated in Oportunidades told me that they used their cash transfer to pay for basic food items and household goods, to buy clothes and school supplies for their children, and to pay for medicines or transportation to doctor appointments at the regional hospital. Dapuez (2016) documented the exact same uses of cash transfers by women in another relatively nearby Maya pueblo (similar in size and make up to Sabán). What this demonstrates

is that participants of Oportunidades are using the cash transfers they receive for their intended purposes—to benefit their children.

Compliance of program requirements from participants is overseen through government clinic physicians and staff and school administrators. The health component of the federal program Oportunidades is managed and distributed through the government funded community clinic. The educational component is managed by the various public schools located in the community. Conditional cash transfer requirements enforce the strengthening of relationships between service providers, such as state doctors, and the poor, specifically women and children (Rawlings and Rubio 2005). For example, pregnant women who participate in Oportunidades must see a clinic physician or nurse once a month throughout their entire pregnancy. For many women from Sabán and Huay Max, this is the first time they set foot in a state health clinic or hospital. Their pregnancy marks the first time that many women will establish personal relationships with the government community clinic and its staff.

The way Oportunidades cash transfers work is that individuals are each given a cash stipend for their completion of certain program requirements. For example, all school age children are awarded a stipend for regularly attending school. To encourage the continued education of girls, female students are given an extra stipend for attending secondary and high school. Infants and non-school age children are also awarded a stipend based on their attendance of doctor well visits and participation in all age appropriate vaccination campaigns. Women also receive a cash stipend for maintaining their health through the participation of health education lectures and by attending regular checkups at the local government clinic. If a woman becomes pregnant while enrolled in the program, she is required to immediately seek prenatal care at the clinic. During pregnancy women receive a stipend of four hundred pesos (about thirty-four US dollars).

Stipends are bundled by family and awarded every two months to the wife and/or mother. In the end, the cash aid a family receives depends on the family size and the number of children living in the home. For example, a family I interviewed which had four children (three in school and one toddler) received a stipend of

three thousand pesos (\$250 US) every two months. This included the mother's stipend. The Oportunidades cash aid is a substantial amount of money for a poor rural family with little to no economic resources available in the community. Families depend on this aid to help pay for basic living costs, such as food and clothing. Yet, the federal stipulation is that this aid is conditional and can be taken away at any moment. According to the Mexican government, Oportunidades aid is dependent on the complete participation and fulfillment of program requirements. It is the participants, who through their actions, determined if they are awarded aid by the federal government.

Historically, state interventions into rural communities have had powerful impacts on Yucatec Maya experiences, and they have not gone unchallenged. Furthermore, many social and economic resources have not been equally distributed throughout Mexico. Consequently, people who have lived in historically remote areas have remained relatively untouched by many state and federal changes (Smith 2009; Molyneux 2006). This is currently the case in the southern interior where most towns lack adequate roads, let alone transportation to health centers and resources. For example, most pregnant women in the research community now have access to biomedical care through Oportunidades and a federal health care system that provides them with free hospital deliveries, but most women do not have a feasible and affordable way to reach the hospital. Furthermore, the regional hospitals are severely underfunded and lack the medical resources and staff to adequately meet the needs of all birthing women in the area. The regional hospital in Jose Maria Morelos is relatively small. It has only one surgical room, one recovery room with three beds, a few consultation rooms, and a waiting room. In 2008, I was told by the hospital social worker that there were usually 2-3 on-call physicians working in the hospital daily. The county of Jose Maria Morelos (in which Sabán and Huay Max are located), has a population of 37,502 (INEGI 2015b). The regional hospital in Morelos is strained by a lack of sufficient resources and staff to adequately service the county's population.

Reflecting the subordinate social, political, and economic position of indigenous people in Mexico, many Yucatec Maya consider themselves mestizo or

campesinos (agricultural peasants) rather than indigenous. However, this choice in self-identification does not determine how state policy members and workers view the Maya. For them, Maya are indigenous and with that come stereotypes that either romanticize Maya people or assume they are more “natural”, backward, and rebellious than modern people (Eiss 2010; Haenn 2005).

Government clinic staff classify the Maya women they interact with as rural and poor, and they also believe that these women’s ideologies of health and childbirth are a direct consequence of their indigenous culture. This frames these women in a timeless, unchanging light, as people who are bound by a static tradition instead of people who have lived, adapted, and changed over time. Maya women’s identities, and the meanings behind their practices, come from shared, often contested histories. These women understand themselves as participants of contemporary society who continue to practice aspects of their culture they feel is vital, meaningful, and worth saving. They certainly do not think of themselves as people who live in some distant, romantic past. But this doesn’t mean they don’t pay heed to history. While seemingly abstract and distant from present day realities, the histories of Yucatec Maya still hold immense meaning, just as much as they continue to mark the social and political landscape. From the burned churches of the Caste War to the persistently bitter relations that exist between the federal government and local communities, history clearly matters. The relevance of history is not just about contestation, but also about *continuity*. Childbirth practices—and the decisions made by pregnant women and their families—are part of a longstanding relationship with place that, from a political ecological perspective, requires a deeper consideration.

Biomedical Discourses of Health: History Repeats Itself

Today, physicians and medical workers recycle and reiterate certain historical discourses to describe the economic and cultural environment of the southern interior. In 2008, I spoke with the regional hospital director in Felipe Carrillo Puerto. He explained to me that it is difficult for him to get physicians to come and work here in the interior of the peninsula. Many young doctors and nurses

simply do not want to live in a rural area away from the coast and the amenities that come with living in a large internationally renowned tourist city. The director, Dr. Daniel Alvarez, emphasized this with a pointed question: “[W]ho wants to work in the hot humid jungle when they can work in Cancún or the Maya Riviera”? In his opinion, there is no way the southern interior can compete with coastal areas or more “beautiful” places like Cancún. Dr. Alvarez admitted that most people come to the Yucatan peninsula because of both Mexican and international media images that focus on the beautiful beaches and tourist zones. Unfortunately, the interior is almost completely left out of these kinds of appealing characterizations, unless a major archaeological site is highlighted such as Chichen Itza or Coba. More importantly, even if communities in the interior are mentioned in tourism and government media, they do not possess the attractive qualities that invite young doctors to make long term investments in establishing their careers in rural communities.

According to Dr. Alvarez, other factors influencing the shortage of physicians in the southern interior are economics and comfort. He explained that the region is plagued with poverty and lacks basic resources. He compared the southern interior of Yucatan with a developing nation by saying “this part of Mexico is the Third World. Yes, there is money in Mexico, but only a very small percentage of people have a lot of money—the majority have very little”. The residents of the southern interior are not the only ones who are affected by the region’s marginality; doctors who work in these communities also face economic challenges. In many cases, the salaries for physicians are significantly lower than their colleagues working in major cities. Additionally, many doctors, who have lived for extended periods of time in cities, have grown accustomed to the services and amenities that come with urban life. Most of the physicians who work in the region are stationed in small remote communities about a two-hour drive to the closest city. Moreover, many of these communities lack basic infrastructural resources like running water and sanitation—let alone tourist commodities like restaurants, hotels, or even grocery stores. Rural life can be incredibly challenging for many physicians—and culture shock is just the beginning.

Between 2000-2013, the government clinic in Saban has had four different full-time physicians. They each averaged about three years running the small, yet busy clinic. None of the physicians lived in the community. They, along with almost all the nurses, lived in the small cities of Carrillo Puerto and Morelos or the larger town of Dziuche; all located on major highways connecting the region to the tourist center of Cancun and the capital city of Chetumal. Biomedical professionals are typically present in Saban and Huay Max only when the government clinic is open. Its hours of operation are Monday through Friday, 9am-2pm. Fortunately for residents, a big positive change came in 2013, when the clinic hired a young nurse and a medical assistant from Saban²². People sometimes turn to them for medical advice and assistance when the clinic is closed. Since a physician is only accessible a few hours a day, five days a week, most people with medical concerns and emergencies are forced to travel to the nearest hospitals in Felipe Carrillo Puerto (103km away) or Jose Maria Morelos (57km away).

Geography, economics, and comfort are not the only deterrents affecting the scarcity of physicians in the region. Equally important is the fact that the peninsula has a large concentration of indigenous people—most living in rural areas in the interior. Yucatec Maya are, after all, the largest indigenous group in Mexico. Physicians and other state health care workers acknowledge that many rural and indigenous residents tend to incorporate more folk and traditional practices and beliefs into their health care regimes. They also recognize that many rural populations are wary, if not outright skeptical, of many of the representatives of biomedicine. Such a setting in which a plurality of approaches to health exist, not only challenges the hegemony of biomedicine, but ultimately, it questions the legitimacy of the physician. It is this possibility of an antagonistic work situation in which the doctor and her/his knowledge and training is challenged that is often viewed as an added obstacle to what many health care workers describe as an already difficult work environment. Racism, discrimination, and a paternalistic attitude are often implicit in such critical and common discourses about these rural

²² This nurse, Daniela, is a member of the main research family that I mentioned in the introduction.

populations. Such tensions highlight how the struggle for health care resources in these marginalized places come down to the power dynamics between state-backed biomedical practitioners and communities of rural, indigenous people.

In the early 2000s, I interviewed the resident physician Dr. Adrian Venegas who was living and working in Saban's community clinic, and asked him about prenatal care and childbirth practices in the region. Dr. Venegas said that most of the women in the surrounding communities came to the clinic for prenatal care but the majority chose to give birth at home with the assistance of a midwife. Although he had high praise for one of the most popular midwives in the community—he introduced her to me as the most experienced and knowledgeable of all the midwives—he later admitted that as a physician he would prefer all the women to give birth in the local clinic or hospital. According to his medical training and cultural views, he believed it was safer and more hygienic for women to give birth in hospital rather than in their homes. According to the doctor, women giving birth at home are in danger of getting an infection, their houses have dirt floors and there are always animals around that can sometimes get into the house. He finished his point by asking me a rhetorical question: "Can you imagine a baby is born and while the midwife is looking the other way a dog comes in and licks the newborn?" Although the doctor never told me he saw anything that came close to this situation, he nevertheless seemed convinced that it was a real possibility. Dr. Venegas' descriptions reiterate earlier discourses that characterize the rural interior of the peninsula as being unhealthy and culturally backward (Smith 2009).

In 2007, I interviewed the full-time senior, and only, physician working in Saban's government clinic. The physician, Dr. Teresa Barrios, was originally from an urban area in central Mexico. She later told me she came to work in Saban to help improve the health of poor indigenous people. Dr. Barrios' repeated similar discourses and narratives as those of her counterparts when she told me that her goal was to change what she referred to as the "traditional" and "outdated" practices of local people and move them into the formal biomedical health care system. In her opinion, biomedicine was the safest and most dignified form of health care.

Upon arriving to her post in 2005, Dr. Barrios made it her goal to move all childbirth deliveries in the community away from the home and supervision of the midwife and into the hospital setting. The reason for this was her belief that home births were a danger to the health of the mother and newborn child. Therefore, the hospital was the only acceptable place to give birth because it was sterile and safe. Dr. Barrios further said that giving birth in a hospital with dignity was a “human right”, and that the designation of a human right should not be equated with a midwife-administered home birth, primarily because it was too dangerous. As she explained, the home is not clean and midwives are not adequately trained biomedical practitioners; they are local women who are empirically trained and have learned their trade from other women. Dr. Barrios, along with many of her colleagues, believed that midwives are not qualified enough to attend births, let alone handle complications that can easily arise during labor and delivery. The Mexican State has created programs to train midwives in biomedical procedures—including how to identify a risky pregnancy or complications associated with pregnancy, labor, and delivery. These programs have usually been carried out by state and regional public health organizations. They provide courses on first aid and the importance of proper hygiene. After completing the course or courses, indigenous empirical midwives²³ can register with the state and receive formal certification that allows them to legally work in their communities. Regardless, of the training that midwives receive, Dr. Barrios believed that midwives could never take the place of a doctor and his/her training. She further argued that midwives in Mexico are different than the ones in the United States. In Mexico, the midwives are empirically trained and often have very little understanding of biomedicine compared to their US equivalents.

Dr. Barrios’ belief in discourses of progress, cleanliness, modernity, and the hegemony of science—in this case biomedicine—heavily influenced her interactions

²³ When I say empirical midwife, I am refereeing to an individual that learned how to practice maternal health care informally without official training and education. This acquiring of knowledge and skills could have come from listening and learning from birth stories told by older generations of female family members, an apprenticeship, divine intervention, dreams, or through trial and error.

with community members and more specifically women of reproductive age. Dr. Barrios admitted that sometimes she might talk to people with a heavy tone, but she was only trying to get them to understand that although their traditions are “beautiful” they are endangering the lives of women and children and therefore need to be changed. As she said, her intention was not to get angry and/or reprimand her patients, but instead to inform them of the value of being incorporated into the biomedical system of healthcare. She stressed the importance of prenatal checkups, vaccinations, the use of prenatal vitamins and good nutrition, and giving birth in a hospital. Dr. Barrios believed that it is her job to inform women of everything that is involved during pregnancy and delivery so that they can better understand why (according to her) all births are considered high risk and should take place in a hospital where physicians are equipped to handle any complication that may arise. One of the strategies that she used to persuade women to give up home births was to equate midwifery with older technology that is no longer necessary. She would ask her patients, “If there is now electricity, which one are you going with, electricity or your candle? Which one is the easiest or the most practical, the most modern?” After the patient would respond by saying that they would choose electricity, she would conclude by stating, “Well it is the same: the midwife or the hospital?”.

Reflecting on her last three and a half years of working in Sabán and Huay Max, Dr. Barrios said she was glad to see that her hard work had paid off. She was proud to say that women were now coming to the clinic on their own for their prenatal checkups. Interestingly, the doctor left out that this was largely the result of women needing to fulfill their Oportunidades program requirements so that they could receive their cash stipend. Women were, in part, going to their prenatal appointments for money. Yet, as women have told me throughout the years, they also went to the clinic to take advantage of the benefits of biomedicine. I was told by every woman that I interviewed, that access to this additional health care provided an added layer of comfort and reassurance. They felt secure knowing that multiple resources existed in the community. In some ways, Dr. Barrios was right—but not

exactly how she imagined it. The women in community did see a value in biomedicine, but they primarily viewed it as a complementary health care system.

In Dr. Barrios view, things had changed: women in Sabán and Huay Max were slowly beginning to understand the dangers associated with childbirth and realizing the superiority of biomedicine. In 2008, according to her, forty percent of all pregnant women in the community were choosing to give birth in a hospital whereas before no normal, low risk pregnant women were freely choosing to go to the hospital. Based upon my own fieldwork, I cannot confirm the doctor's statistics and there is a high possibility that she was right. But what I can verify is that more and more women in the community are going to the hospital for the birth of their child. The motivations behind these changes include fear, the desire to avoid conflict, coercion, and necessity. Some women feared giving birth, in part, because of biomedical narratives that characterize childbirth as a dangerous medical condition. These women are from younger generations, often with higher levels of education, who have had more exposure to these narratives. Other women gave birth in hospitals to avoid conflicts with local physicians; they didn't want to face the repercussions of going against the wishes of state-backed health care workers. Other women participated in the biomedical system because of overt threats from doctors. Dr. Barrios herself eventually decided that the most effective way to get women to give up midwifery and only use biomedical care would be to publicly denounce midwifery and refuse to sign birth certificates for women who delivered their children at home with the assistance of a midwife. This act went against the common practice in rural communities in which the state doctor working in the community clinic would confirm a live birth and sign a birth certificate after seeing the newborn baby and providing its first medical exam. Finally, the majority of women who had hospital births went because of a complicated labor or medical emergency. All the women in this last category planned on giving birth at home and it was only when midwifery care could no longer meet their specific health needs did they seek out biomedical care. In many instances, it was the midwife who suggested the mother be transported to the hospital. Regardless of this fact, Dr. Barrios still believed that midwives should not be working in the community.

The choice between giving birth with a midwife or in a hospital is a continuous struggle for women in Sabán and Huay Max. As I mentioned above, the majority of women who do give birth in hospitals do so out of necessity—when there are complications or medical emergencies. The struggle between the legitimacy and value of midwifery and biomedical practices truly arises in cases where women have more options—at least in theory. This is the territory where social change—and contestation—is taking place. It is characterized by changing ideologies, asymmetrical distributions of power, and battles over access to health care resources. The relationships between women and state workers (hospital staff, doctors, and teachers) play a key role in determining if and/or when a woman will deliver in a hospital. More specifically, women's decisions to give birth in a hospital are tied to the everyday exchanges they have with doctors working at the government clinic in Sabán. The whole situation is highly dependent on who holds the position as the community doctor and his/her relationship with the people. Yet, an increase in hospital births can also be attributed to a slow infiltration of biomedical hegemony in these rural communities. This rising hegemony of biomedical ideas has resulted in an assault on women's choices, especially since the turn of the twenty-first century. The next section will discuss how despite this pressure, women continue to value midwifery and traditional ideals about childbirth.

Maya Women's Reactions to Biomedical Discourses of Health

According to Philip Gorski, "states are not only administrative, policing and military organizations. They are also pedagogical, corrective, and ideological organizations" (2003:165). In Mexico, specific ideological discourses about modernity and progress influence the ways in which the state approaches childbirth. These discourses are embedded within colonial and postcolonial histories where the practices and ideologies of indigenous people have been displaced as a consequence of the fulfillment of state objectives (Wolf 1999). In the twentieth century this was most apparent with the expansion of the rural school system and clinics throughout Mexico. These state campaigns not only extended

basic resources to the majority of the population in an attempt to produce a healthier work force, but equally important, these projects focused on creating a specific kind of citizen that the state deemed to be a productive member of society. Yet, in Yucatan specifically, these powerful discourses and their resulting effects have not gone unchallenged (Sargent and Bascope 1996; Jordan 1993). In relation to childbirth, many Maya women continue to value and use midwifery care and openly defy state doctors. Although outside and/or foreign discourses have dominated geographical and cultural descriptions of the southern interior, they have always been challenged by competing discourses from Yucatec Maya themselves. This is especially true with the way in which Maya view their environment and home. As Nancy Farriss (1984) notes, historically Yucatec Maya have always considered the forests of the southern interior to be a livelihood resource—a point reiterated by Haenn (2005) and Anderson (2005). The forest provides the Maya with the resources to build their homes, the space to plant maize, animals to hunt, honey bees to cultivate, and other wild edible plants that were and still are a basic component of their diet and used for medicinal purposes. These counter practices are assertions of rights, values, and meaning. Such challenges to state discourses begin at home.

The *solar*, or housing compound, is where women spend the majority of their time. Traditionally men go off to work in the *milpa* (agricultural fields) or *monte* (forest), while women work at home in their solar. Women use the resources found in their solar to fulfill their various gendered work responsibilities. Along with preparing and cooking all family meals, cleaning the living spaces and washing the family's clothing, women's gendered work also includes being the "primary health diagnostician" (Kintz 1990). It is women who manage the health of their family and when illnesses, injuries, or any other health issues occur they are the ones who predominantly decide what appropriate treatment is needed. The home proves to be the most important place of health care (Anderson 2005). This is also in response to the fact that in this region biomedical care has historically been nonexistent or inaccessible. The community of Sabán only received feasible access to biomedical care when the government clinic was opened in the 1980s. Since most health needs

are first addressed in the home, many women grow various medicinal plants in their solar to help alleviate their family's illnesses. Herbs and medicinal plants are also found locally in the wild, further cementing the relationship between rural Maya and the forests that surround them (Anderson 2005).

Throughout the years women have walked me through their solar pointing out and talking about the different plants and herbs they use. For example, orange leaves are boiled and then applied to a nursing mother's chest to cure her from *mal viento* (bad wind) and return her milk supply. A concoction of herbs including mint and lemongrass is used to help children recover from *mal de ojo* (evil eye) and help fight off symptoms that include fever, irritability, and lethargy. These herbs are either drunk like a tea or boiled and poured in the child's bath water. Having easy access to these cures is important because *mal viento* and *mal de ojo* can frequently occur, often without warning.

In her ethnographic work on the different uses of medicinal and spiritual plants among Maya community members in Coba, Ellen Kintz documented that most women grew medicinal herbal plants in their solar to help alleviate certain ailments that children commonly faced; such as "fevers, diarrhea, vomiting, rashes, and stomach problems" (1990:15). She also acknowledged that there were also various plants that grew wild in the solar that were also used for medical purposes. Although most houses in Coba had a kitchen and herbal garden, there were certain housing complexes in the community that had extensive cultivated gardens with a large amount of plant diversity. According to Kintz, these gardens belonged to individuals who had a specialized knowledge of the different uses of plants, specifically their use for medicinal purposes. These individuals included a man who cured snake bites, a man who treated female ailments, a few men who had general health knowledge, and a few midwives.

In 2013, I witnessed an infant boy with a heart defect receive treatment for *mal de ojo* three times in one month. His grandmother and aunt concluded that he must have *mal de ojo* because he was getting frequent fevers, had diarrhea, and was fussy. The boy's mother, Daniela, was directed by her mother, to buy an herbal supplement from an elderly woman living in the community who was

knowledgeable about curing mal de ojo. The elderly herbalist, who grew the herbs in her solar, gave Daniela two bundles of herbs; one to boil and bath her son in and the other to boil and make into a tea that he would need to drink. This treatment was given in conjunction with his daily dose of heart medication and periodic use of a fever reducer such as acetaminophen. The boy belonged to a family of healers²⁴; his mother, Daniela, was a nurse and his great aunt (Elena) and deceased great grandmother (Doña Carmen) were both midwives. This family easily blended two different health care systems to best address the cultural and biomedical health needs of the child.

Knowledge and use of herbs and plants for medicinal purposes is primarily passed down from generation to generation. Many women did not recall the exact names of some herbs but they knew their medicinal properties because their mothers and grandmothers had used them and they continued to use the same herbs themselves. Women might not have remembered the exact name of the plant but they could identify it based on its use. These practices are part of the wider political ecology that shapes these women's lives. This generational knowledge is rooted in deeply historical, familial connections to a landscape filled with both challenges and possibilities. Although medicinal plants are cultivated at home and/or locally gathered, there are times when it is necessary to seek outside help. In the case of their health or that of their children, it is primarily women who first decide what kinds of outside assistance is needed—either biomedical from the community clinic or regional hospital, or through a traditional/folk health care system such as consulting with a *hmen* (Maya religious curer and herbalist) or midwife (Anderson 2005; Kintz 1990). It is usually during a serious illness or medical emergency that men, especially those occupying the head of household, will take on more of an authoritative decision-making role.

Local Yucatec Maya discourses about their geographic environment clearly contradict those of state officials and biomedical practitioners. This is further

²⁴ The family of healers I mention is the main ethnographic focus of this dissertation which I briefly introduced in the introduction. The infant boy is lovingly referred to by his nickname, Nicolas. His mother is Daniela, a local community clinic nurse.

illustrated when discussing childbirth. For women living in rural Yucatan, the home is the natural place to give birth. It is the place women feel the most comfortable and have greater agency to move around and labor in a manner that is in sync with their daily practices (Jordan 1993). Laboring at home allows women to be supported by various family members (especially her husband), eat foods that nourish and give her strength throughout labor, receive pain relief from certain home remedies and massages, and labor in a comfortably known position such as sitting/lying in a hammock or sitting on a chair or small bench. More importantly, birthing at home enables women to be active participants in their own labor and delivery.

Homebirths in rural Yucatan significantly differ from hospital births (Jordan 1993). As just mentioned above, one of the primary reasons is that birthing procedures in a medical setting are much more restrictive; examples include the practice of not allowing the birthing mother to eat or drink until after the birth of the child, and the physician or medical staff deciding which positions she must use for labor and deliver (Davis-Floyd 2001). Oftentimes during labor doctors or nurses will have the mother walk around the hospital so that labor can progress and the cervix can fully dilate. Many of the women who had a hospital birth said they were told by the medical staff that they had to walk even if they were tired or did not feel like walking.

Isabel was in her early twenties when she was pregnant with her first child. At the recommendation of the midwife and her family's insistence, she was taken to the hospital in Morelos early on a Saturday morning when her labor at home did not progress. Isabel made a point to say that because she was there on the weekend the hospital staff was significantly reduced. There were only a couple doctors working at the hospital. Soon after arriving, Isabel was taken to an examination room. During our interview, she recounted the details of this experience:

When they attended me, they gave me a chair. And the doctor came in.

And she saw me, and said that there was a lot more time to go. But I felt really bad. I had a lot of pain. And she said "it's not time yet. Now you can go walk over there, stroll in the walkway". But I couldn't walk.

Isabel and her mother left the examination room. They quietly sat side by side on two chairs in the waiting room. And then Isabel began to cry. Seeing her daughter scared and in pain, Isabel's mother walked into the doctor's office and let the staff know that if they did not attend to her daughter now, she would leave and take her to the hospital in Carrillo. Isabel's mother told the staff that her daughter was not well and could not walk. The doctor came out and asked Isabel if she wanted to be admitted early. Isabel said yes, she felt horrible and was in an enormous amount of pain. The doctor complied and sent Isabel alone to labor on a bed in a small room adjacent to the operating room.

If the birthing mother is not walking around during labor, then she would be found lying down in a hospital bed. Once admitted, the hospital assigns every woman a bed and informs her that she must stay there for the remainder of her labor unless otherwise instructed. Women from Sabán and Huay Max are not accustomed to lying on a bed; it is rare to find a household that owns a bed. Almost everyone sleeps in a hammock. Many of the women I interviewed who had a hospital birth complained about having to lie on a bed. To them, beds were hot and extremely uncomfortable. Laboring in a hammock, for the majority of Yucatec Maya women, is far more preferable.

When I toured the public hospital in Morelos in 2008, I was walked through the different rooms by the hospital social worker and told about the general procedures a woman went through during labor and delivery. At the hospital, once a woman is ready to give birth, she will be taken alone into a sterile surgical room where she will be forced to lie down on a medical bed with her legs open and resting in stirrups for the rest of the delivery. After ten years of talking with and interviewing doctors who work in the region (both in rural clinics and state hospitals), it's clear that they all agree that the correct medical position for a woman to deliver a child is lying supine on her back. Many of the doctors cited *safety* as the primary reason for this practice. The room in which the birthing mother will deliver her child is most often cold, foreign, and intimidating with its stainless-steel instruments and sterile medical technology. In many cases, childbirth is the first time that many women enter a hospital, let alone its operating room.

I was told by several women in the community, there have been instances where the medical staff of the hospital or clinic had tied down a woman's arm and/or legs for the delivery. A male physician who previously worked at the community clinic in Saban told me that such procedures were sometimes necessary to help prevent a woman from obstructing the delivery by closing her legs or reaching down with her hands to touch the baby while it was coming out. The physician later clarified that those types of instances rarely happen, but medical professionals need to be cautious and therefore incorporate preventive measures. The practice of tying down a birthing woman's limbs not only demonstrates another example of the lack of power women have over their own bodies in a hospital setting, but it also reflects how medical professionals continue to view their rural indigenous patients as wild and uncontrollable. These women are incapable or unwilling to participate in the "modern/civilized" world by following routine biomedical procedures and that is why they must be forced to do so for their own health and safety. Unfortunately, the medical community chooses to ignore the fact that during a home birth, if a midwife is present, women generally not touch their cervix or physically assist the newborn as s/he is being born.

According to various physicians working in Saban and the directors of both the regional and municipal hospitals, it is not standard procedure for family members to be allowed in the delivery room. Several reasons are given for this decision, but overall an emphasis is placed on safety and health in an environment that must be kept sterile. This also includes removing the possibility of an uncontrollable or overemotional family member impeding the physician's and/or medical staff's ability to care for the birthing mother and newborn child. Many of the women who had a hospital birth said that they often felt alone and scared during their labor and delivery because they had no one to turn to with whom they trusted or felt comfortable. At the hospital, they were forced to depend on the assistance of doctors and nurses who they had no intimate and/or established relationship with. They also commented that both doctors and nurses were often unavailable since they were sometimes too busy assisting other women. It is not until after the birth of the child and after they have been moved into the recovery room that the father,

and in some instances the woman's mother, is allowed to come in and see mother and baby. The rest of the family must wait until visiting hours. Even though it is not an official rule at government run hospitals to deny family members to be present in the delivery room, it has become standard protocol for most hospitals throughout Mexico (Hunt 2002).

At a homebirth, adult family members come and go depending on the birthing mother's needs. Typically, this consists of the woman's husband and his or her parents. On occasion, an older sister or a female cousin may be present during the birth depending on the wishes of the birthing mother. Family members are present at the birth to assist the mother in any way possible with both emotional and physical support (Jordan 1993; Sargent and Bascope 1996). During a homebirth, the mother is never left alone. The presence of the birthing woman's mother and/or mother-in-law provides her with support and valuable advice on how to labor and push. The woman's mother and/or mother-in-law will also console and encourage the mother when she feels weak or fearful.

During a home birth, the husband/father is one of the central figures²⁵. He is present throughout most of the labor and delivery. His purpose is to help his wife stay focused and relaxed. In addition to the emotional support he gives, the woman's husband is the main person who provides her with physical support. When it comes time for the actual birth of the child, the husband helps carry or hold the woman up while she pushes. Both midwives and women emphasize the importance of the husband being present during the birth. More than thirty years ago, Jordan (1993) documented Yucatec Maya women's belief that husbands should be present at every birth so that he can see "how a woman suffers". This exact phrase is continuously repeated today, showing just how strong these convictions are. Women believe that

²⁵ Socially husbands are expected to be present during the birth of their child. However, some husbands are not present due to out-migration in search of work to tourist areas located a minimum of 2 to 4 hours away; and of course sometimes the birth progresses faster than expected and they do not make it back from the fields or work in time to assist their wives. Many women from the older generation shared stories of how they gave birth at home alone while their husbands were out working the milpa. Most of these instances took place long before midwives were easily accessible in the community.

when husbands witness and experience their wives' birthing process they have a better appreciation and understanding of their wives. It is women's hope that in the long run, men will have greater respect for them, ultimately resulting in better treatment and appreciation. Midwives and women in Sabán and Huay Max have expressed their belief that there would be less physical and/or mental spousal abuse if husbands were always present at the birth of their children.

Since 2002, women have emphasized to me the importance of men being present during childbirth and witnessing how much mothers suffer, primarily as a way for them to learn to value women and respect the sacrifices that they make for their families. Yet, it was not until one August evening in 2013, that I finally understood the emotional importance and overall well-being that this has on the everyday lives of women. That evening I was talking with a young mother and Elena, the midwife that was attending to her. The mother, Nayeli, was pregnant with her second child. She was shy and quiet but expressed a strong desire to give birth at home with her husband present. Elena added that this was important for Nayeli because of her current situation. She was living with her husband and two-year-old daughter in her mother-in-law's home. Her husband was an alcoholic. He was verbally abusive and at times things would escalate to physical violence. Nayeli was also mistreated by her mother-in-law, who often defended her son's actions and blamed Nayeli for the confrontations. Nayeli believed that her husband's continued abuse was in part the result of the fact that he was not present for the delivery of their first child. Nayeli had a hospital birth that ended in a cesarean section. Her husband did not see her or the baby until hours after the delivery. Days after they returned home from the hospital, her husband left to work in Cancun. He never saw how much pain and suffering she went through during childbirth and recovering from the cesarean section. This was an emotional conversation mixed with sadness, pain, and anxiety. In the end Nayeli was reassured by the midwife that things would get better and that this time she would be able to have her wish and give birth at home with her husband.

A couple of months later, Elena updated me on Nayeli's situation. Nayeli had taken her daughter and left her husband for a short period after he hit her again; she

was eight months' pregnant at the time. She eventually reconciled with her husband and returned to her mother-in-law's house. When Nayeli's labor began, her husband was home, but her mother-in-law had become nervous thinking that labor would be too difficult and dangerous for Nayeli since a cesarean section was needed for her first delivery. Her mother-in-law suggested that Nayeli be taken to the hospital. Nayeli's husband listened to his mother. Against her own wishes, Nayeli conceded and finally went to the hospital, where her husband waited outside while she had another cesarean section. Although Elena lived close by, she was never consulted, and Nayeli was denied her only advocate. Elena agreed that this was an unjust, distressing situation, but acknowledged that there was nothing that could be done. Even though Nayeli experienced violence in her home and her living situation was not the most supportive environment, it was still important for her to give birth at home with her husband present. For her, a hospital birth reduced her value as a woman, wife, and mother. It also completely cut her off from the support that she would receive at home with a midwife-assisted birth. She was forced to give birth in a hospital, the symbolic emblem of modernity and civilization, and ripped her away from home, a place laden with personal, historical, and cultural meanings and memories. Home was her last place of hope, safety, and comfort. That experience was taken from her, in part, because her own (abusive) family disavowed the importance of home—and place—due to fear that undoubtedly comes from a certain acceptance of discourses that characterize Maya ways of life as backward, regressive, and dangerous.

A multitude of discourses express competing understandings of the relationships between people and place in the southern interior—but those discourses are not equal. Furthermore, discourses pertaining specifically to childbirth are constrained by larger, politically powerful hierarchies that grant legitimacy to biomedical ideologies and practices above all else. Foucault explains that, “medicine, as a general technique of health even more than as a service to the sick or an art of cures, assumes an increasingly important place in the administrative system and the machinery of power” (1984:283). What this means is that a co-dependent relationship exists between biomedicine and states.

Biomedicine and its practitioners need the state to establish institutions which will legitimize biomedical knowledge and in return granting it authority over all other forms of health knowledge. The state relies on biomedicine as a tool to implement its larger state projects and ideologies of modernity and progress.

State officials, medical professionals, and politicians grant authority to knowledge systems that are aligned with those in power. And, because of this process, competing knowledge systems are devalued and dismissed. This process is clearly self-serving in many regards. Brigitte Jordan points out that additionally “those who espouse alternative knowledge systems then tend to be seen as backward, ignorant, and naïve, or worse, simply as troublemakers” (1997:56). Robbie Davis-Floyd (2003) argues that biomedicine is highly technocratic, which ultimately results in an attempt to manipulate and control nature through technology. Like many other developed countries, the Mexican state views biomedicine as a representation of modernity, rationality, and participation in a formal system (Davis-Floyd 2001). This is clearly seen when state health programs, such as Oportunidades and Seguro Popular, strongly encourage women to give up midwifery and traditional forms of health and participate in the state biomedical health system. This preference for biomedicine is not only emphasized through ideological approaches, but economically speaking it is the primary health system in which the Mexican government is investing in.

Even though the Yucatec Maya with whom I worked hold some forms of agency, overall, they do not have the same amount of negotiating power as state-backed biomedical practitioners who continuously devalue the work of midwives and concerns of local women. Yet, even though many local Yucatec Maya women participate in state health programs such as Oportunidades, they also challenge state ideology by continuing to give birth at home with the assistance of a midwife. They have granted “authoritative knowledge” (Jordan 1993) and legitimacy to traditional midwifery, which supports a home birth that more adequately fits both their cultural and health needs. However, the decisions that these rural Yucatec Maya women make in relation to their prenatal care and delivery are complex and layered by various other factors. As Lopez (2008) and Van Hollen (2003) have

highlighted, the decisions women make regarding their reproductive health are always constrained by their political, economic, and social environments. Those decisions are situational and always susceptible to change. Van Hollen explains choice in the context of childbirth in rural India by arguing that “the decision-making process is never a matter of the free will of rational, value-maximizing individuals, but, rather, it is always enacted in political-economic contexts and shaped by socio-cultural factors” (2003:7). Unfortunately, the reluctance of Yucatec Maya women to fully accept a biomedical birth has allowed the state to reaffirm earlier labels of backwardness, ignorance, and rebelliousness.

In over a decade of working in Saban and Huay Max, I have only known of one instance where women in the community openly contested state health practices and ideologies by demanding their right to choose how they manage their maternal health needs. This took place in 2009, when the tenuous relationship between Dr. Barrios and the women in the community climaxed to an outright rebellion. It started when the frustrated physician penalized more than 300 women from Saban who participated in Oportunidades by officially stating that they did not comply with the program requirements for that payment cycle and therefore should not receive their cash stipend. According to Dr. Barrios, the women in the community defied her authority when they refused to clean the clinic grounds. As she saw it, this constituted a failure to fulfill the community service requirement that is sometimes included in Oportunidades. The women from Saban adamantly denied any wrong doing—they argued that they had met all their obligations (attending health lectures and doctor’s appointments) and it was the physician, not them, who failed to follow the contractual rules of the program. The women adamantly declared that the clinic was not their responsibility because the government already paid someone to look after it. This was one of the few salary positions in the community that also included benefits. It was this person’s job, not theirs, to keep the clinic grounds clean. The fact that Dr. Barrios’ actions resulted in the women not receiving their cash stipend was the last straw. The women of Saban organized together and protested their grievances to state health policy officials and demanded the government replace the physician with someone who was more

willing to work with the community while also fairly managing his/her responsibilities within the program of Oportunidades. In the end, Dr. Barrios left, and the community was without a doctor for a few months.

Shortly after the incident, municipal state health officials disapproved of the women's actions by calling them unruly, stubborn, and ignorant. They concluded that since they chose to chase their doctor out of town, the community was undeserving of one. A physician eventually came to work at the clinic, but it was only a resident intern who needed to fulfill his year of service. A couple more physician interns worked at the clinic for the next two years. A full-time doctor did not come and work in the community until late 2011. Dr. Barrios was succeeded by a doctor who had worked in the region for over two decades and was close to retiring. Possibly learning from the community's response to Dr. Barrios, she was more cautious and did not openly contest the practice of midwifery.

The key part of this incident is that the women in the community were not making arguments against biomedicine or even the Mexican state; instead, they demanded more from the government and local physicians. What they sought from the government was more oversight. They wanted more accountability—and respect—from the biomedical doctors and nurses who worked in their communities. This was evident in the women's resistance to Dr. Barrios; a government clinic physician who they felt refused to respect their cultural traditions and approaches to birth. Ultimately, these women were also standing up to doctors and the government to make them understand that their continued use of midwifery is a response to the practical, economic, and political limitations of state health care systems in rural Quintana Roo. In many respects, midwifery is a safety net that many women rely on when the Mexican government is unable or unwilling to hold up its end of the health care bargain.

Yes, state discourse about rural Yucatec Maya women and maternal health are powerful. They are influential and they are pervasive. But are these discourses all-powerful? Do they completely determine these women's lives and decisions? Clearly, they do not. Despite their marginality and conflicted histories, Yucatec Maya

women continue to negotiate, resist and forge their own understandings of the meanings of pregnancy, childbirth, and maternal health.

Conclusion

This chapter has shown, how the ethnographically informed details of rural Yucatec Maya women's lives, thoughts, and experiences reveal the complex human dimensions of their political ecology. A political ecological analysis of health, grounded in an anthropological perspective, demonstrates how health systems are situated within specific social landscapes and environments that are "produced by the dialectical interaction of natural and sociocultural forces" (Baer 1996:453). As Kearns and Moon state, "landscape serves as a metaphor for the complex layering of history, social structure and built environment that converge in particular places" (in King 2010:42). In the case of rural Yucatan, these historically constructed landscapes and environments deeply influence the critical decisions women make in relation to prenatal care and birth practices. These landscape and environments also reflect the marginal position of women in the eyes of the Mexican state, which frames Yucatec Maya women as peripheral actors in the overall scheme of national health care.

In rural Yucatan, a healthy pregnancy and childbirth is shaped not only by geographic factors (distance to hospital and access to transportation) but also by a socio-political environment that is influenced by processes at the national and international level. Harper explains that a political ecology of health perspective illuminates "competing interests and social tensions within social groups and demonstrate[s] the ways in which social relations, the body, and the environment are given meaning" (2004:299). The Mexican state's continuous support of biomedicine and subsequent pressure on women to give birth in a hospital clearly demonstrates that certain technologies, types of knowledge, and places, are valued over others. The hospital is the correct place for birth, while the home is unclean, unpredictable, and dangerous. Historical state and colonial discourses of isolation, unruliness, despair, and backwardness (Farriss 1984; Jones 1989; Sullivan 1991; Eiss 2010) have directly affected the ways in which the Mexican state perceives

rural Yucatec Maya communities. The fact that most physicians working in the area consider a woman's home and the practice of midwifery unhealthy and unclean illustrates the asymmetrical distributions of power and legitimacy that exist. Such attitudes highlight the importance of the geographic and social space in which these health care decisions and conflicts take place.

Many non-Maya have historically viewed the southern interior of the Yucatan as a place outside of "civilization". This tendency is still prevalent today. Many state officials and members of the political class perceive rural Yucatan as a place that exists on the geographic and cultural periphery of the Mexican State (Haenn 2005). The Mexican State reconstructs the southern interior as a social frontier that must inevitably be conquered by the formal biomedical health care system. As Grant Jones so eloquently states, "frontiers have in this sense both cognitive and material referents pertaining to that which is more or less hidden from familiarity, primarily by boundaries of space but also by boundaries of social interaction, time, or cultural knowledge" (1989:6). These frontiers are highly political. As the case of childbirth in rural Yucatan has demonstrated, the Mexican state is continuously attempting to "civilize" Yucatec Maya and subject them to dominant state ideologies about health and progress. By giving birth in a hospital and condemning the old and "backwards" practice of midwifery, Yucatec Maya women become "modern" in the eyes of state officials. They are no longer stuck in the past, but instead an active part of the present. Or so goes the narrative.

However, it is critical to understand how rural Yucatec Maya women perceive and enact the current social, political, and geographic environments in which they live. Most women in the region acknowledge that the various maternal health discourses that they encounter are competing and at times contradictory, yet for these women, midwifery and biomedical systems of health are by no means in opposition (Anderson 2005; Jordan 1993). In fact, most Yucatec Maya women follow a practice of medical pluralism in which they combine aspects from both midwifery and biomedicine that they consider to be the most beneficial to their overall health. The current method of mixing and blending different childbirth ideologies and practices in rural Yucatan supports Jordan's plea for a mutual accommodation of

biomedicine and indigenous health systems to provide women with the highest possible health benefits (1993). By granting legitimacy to both midwifery and biomedicine, rural Yucatec Maya women create productive discourses and practices that bridge indigenous and outside worldviews. These women envision a productive and engaging dialectical relationship between midwifery and biomedicine, on the one hand, and state and local communities, on the other. Now the real question is whether the Mexican state and physicians working in the southern interior of the Yucatan will also recognize the wisdom that thrives in such supposedly “backward” and marginal places.

Chapter 3

Reproducing Futures: Young Yucatec Maya Women's Strategies and Practices for Managing their Reproductive Health

This chapter focuses on the birth stories of four young mothers to discuss how women today are addressing their prenatal health concerns. It documents current childbirth practices and analyzes the ideologies and reasoning behind the choices made by the current generation of rural Yucatec Maya women. The age range of these women is from the mid-teens to late twenties. These four stories illustrate key experiences young women face giving birthing today in rural Yucatan. This chapter addresses what it is like to be pregnant for the first time and the resources that are available to women. Analyzing the contemporary childbirth practices of young women may provide a glimpse of how the next generation of Maya women will approach pregnancy and childbirth.

In rural Yucatan, the process of childbirth is shaped—and complicated by several interconnected factors. First, it is a process that is rich with social meaning. Childbirth is a rite of passage that plays a fundamental role in transitioning young women into adulthood, and further solidifying the social role of women who already have children. It is a highly generational process that defines motherhood and reflects past traditions and changing social practices all at once. Second, childbirth relies on familial support and interwoven social networks of knowledge that help women, young and old, move through the process. The process of childbirth is informed by traditions and histories that guide women through its complexities. It is a process that reflects, creates, and calls upon different social positions throughout the community—mother, father, child, and extended family members. But this process is not without complications and problems.

There are two key issues that I address in this chapter: 1) trust, mistrust, and rumor as they relate to women's fears of violence and abuse in the birth process; and 2) how the bureaucracy of the birth process reifies power inequalities among women and biomedical practitioners, creating a difficult situation in which women

often cannot receive care unless they have the right documents in order. My discussion begins with a young first-time mother, whose story illustrates how different generations navigate the rite of passage that is childbirth. Women pass through childbirth with the support of the women (mothers, in-laws, grandmothers, and midwives) who came before them. But as the following narrative highlights, the birth process is also dynamic and changing, especially as it runs into the norms, rules, procedures, and inequalities of Mexico's biomedical system.

Doña Leticia and Maite: The Social Standing of First Time Mothers

Field notes: Friday, August 16, 2013

Early in the afternoon, Elena and Raquel accompanied me to Doña Leticia's house. Doña Leticia lived off a dirt road on the outskirts of town, about 6 or 7 blocks away from the plaza, on the way to Yo'Okop. There were *milpas* all around. It was a large property with various thatched roof houses and a small cinder block house at the entrance, near the road. Elena wanted to introduce me to Doña Leticia since I had been telling her I wanted to talk to some older women about birth in Saban during their time. However, knowing my research focus was primarily on young mothers, Elena let me know that this visit would be extra useful for me because Doña Leticia's daughter-in-law, Maite, was currently pregnant and I could talk to her too. Elena was Maite's midwife.

Doña Leticia is a calm and knowledgeable woman in her early sixties. She was friendly and kind. Elena, Raquel, and I sat listening to Doña Leticia talk about her experiences giving birth to 12 children and having two miscarriages. Her oldest child is 45 and youngest is 18. Her husband is originally from Saban and she moved here when she got married. She is from a small pueblo in Yucatan, near Valladolid. Her and her husband lived there for a while after she got pregnant with her first baby but came to Saban full time after her fourth child. Doña Leticia has lived in Saban for 44 years.

While Doña Leticia was signing the consent form, Elena was surprised she could write her name because she said that many older people didn't go

to school and never learned how to read and write. Elena told Doña Leticia she was *abusada* (smart) because she could write her name. Doña Leticia attended school until the third grade. Elena said that back then all you needed was to finish primary school and you could be a rural schoolteacher. You were a teacher after 6 or less years of school. This is interesting because her daughter Raquel is currently finishing up her bachelor's degree to become a primary school teacher.

Doña Leticia said in the past (more than four decades ago in the early years of Sabán's reestablishment) Sabán had few resources. There was no road, no doctors, no power, no water. Everyone had to get their water from the well. Back then you didn't have as much help when you were pregnant. Women had to do lots of hard manual work while pregnant, like getting well water, doing laundry, making food, maintaining gardens, sometimes they had to go to the milpa and help their husbands with the crops.

Doña Leticia told the story about how she gave birth to her 7th child. Her husband had gone to the milpa to work early, around 6am. As soon as he left she started feeling labor pains and knew that the baby was coming soon. Doña Leticia gathered all the things she was going to need for the birth, like water, something to cut the cord with, towels. She said that when she felt the urge to push she knelt down and held on to her hammock strings and pushed. She eventually sat down on a low wooden bench and gave the final pushes to deliver her baby. She had placed a cloth on the floor under her to receive the baby. Once the baby was born Doña Leticia wiped him clean and waited for the placenta to be expelled. Once the placenta was out she tied two ends of the cord and cut it. She then laid down with her newborn baby in her hammock and waited for her husband to come home. Her other children were asleep while Doña Leticia gave birth and when they woke, she sent her oldest child to call a neighbor to come help and then fetch her husband from the milpa. All her children were young so they could not help her. When her husband came home he was surprised to find out that Doña Leticia had given

birth alone and they now had their new baby. Before he left she was pregnant, when he returned later that afternoon they had a newborn baby.

After talking with Doña Leticia for quite a while, I asked if I could meet Maite and see if she would be willing to do an interview. Doña Leticia said, yes of course, and then went out the back door to get Maite. A few minutes later, Doña Leticia and Maite walked into the room. She greeted us and sat down in a hammock close to where I was sitting. After explaining who I was and what my project was about, Maite agreed to be interviewed.

Maite is 21 years old and eight months pregnant with her first child. She is married to Doña Leticia's youngest son who works full time in Playa del Carmen. Maite and her husband had been living together in Playa for a few years, but Maite moved back to Saban into her in-laws' home once she found out she was pregnant. Her main reason was that she wanted to have a home birth with a midwife. Doña Leticia had recommended Maite use Elena as a midwife.

Elena and Raquel helped throughout the whole interview. Maite was really shy and quiet. She didn't know how to answer many of the questions I asked. Even basic questions like how did you find out or confirm you were pregnant. Elena and Raquel had to explain the question again to her and offer possible answers—like visiting a doctor, going to the midwife, not feeling well. Even then, Maite did not respond. She was too shy to answer. Doña Leticia also tried to help. She eventually answered the question by saying that Maite found out she was pregnant after visiting the midwife for a sobada. I looked over at Maite and she nodded and said yes. Elena continued to talk with Maite attempting to rephrase my questions in a way that might be easier for her to understand. Elena spoke in both Spanish and Maya. She would often use different examples to explain and re-explain the questions I asked. Since Elena was Maite's midwife she knew some of the answers to the questions but instead of answering them herself, she would tell Maite how she needed to respond. Elena would encourage Maite to include more details to her responses. There were so many silent moments.

After about ten minutes into the interview, with many moments of silence and many other moments of everyone trying to help explain and re-explain the questions, Elena pointed out the problem. She said the issue is that Maite is pregnant for the first time and she doesn't know much about pregnancy and childbirth. Maite smiled and again nodded yes. Elena then explained, "it's because she is a 'first-timer'. She doesn't understand what she is going to say. She doesn't understand more or less what is happening and what will happen". Maite lacked the confidence and experiential knowledge that came with having given birth and that is why she felt uncomfortable to talk. Maite did eventually open up a little more and was able to answer a few more questions. In the end, the interview was very short. It lasted less than twenty minutes.

Motherhood has immense cultural importance for women in rural Maya communities. It is a rite of passage into adulthood and womanhood. With the birth of her first child, a female moves from being socially viewed as a naïve "girl" into an adult woman. Maite's story illustrates this transition. Like the majority of the interviews I had with young first-time mothers, these women tend to defer their care and wellbeing to their family elders and their midwife. Because of their additional years of knowledge and experience, older generations of mothers had established cultural capital and power over younger generations of mothers. It is usually the parents or in-laws that make decision pertaining to what type of prenatal care the first-time mother will receive, what she will be allowed to do while pregnant, and the place of the delivery (at home or the hospital). Almost every interview I had with a first-time mother took place with a parent, in-law, and/or midwife present. These interviews were typically short and like with Maite, they had many moments of awkward silence.

Most young women are unaware of the details of pregnancy and childbirth. It is not something that is thoroughly explained in school or at home. Women begin to learn more about pregnancy and childbirth once they become pregnant. But this form of knowledge acquisition comes step by step with every new experience. Not

much is learned ahead of time. The primary knowledge they acquire pertaining to pregnancy and childbirth comes only after they have experienced it. A women's first pregnancy can be an intimidating time in which many are unaware of what is supposed to happen next. In addition, their social transformation is visually marked on their body. As they go through their pregnancy, their bodies change in ways they have never experienced. Everything is new and their uncertainty comes from a lack of reference.

In the community, it is usually older women who have had several children that are considered to have the highest social standing. They are the ones who are empowered to speak about childbirth and womanhood. Their prestige and authority comes from the knowledge and experience they have gained by giving birth to multiple children. They know what to expect, what will happen. Often, they also know how to identify complications and how to deal with them. Young prospective first-time mothers like Maite are aware of their own lack of knowledge about childbirth and understand their position within their community and family. Therefore, many of them are unable to answer specific questions about their pregnancy and imagine how the birth of their child will be. One of the most difficult questions for women to answer was what an ideal birth would or should entail. I asked several young mothers this question, and they often had no response. They simply could not imagine the other side of something they had never experienced.

The lack of confidence and submissive practices of young first-time mothers is exacerbated once they move into the biomedical setting. The relationship between young first-time mothers and physicians is most often submissive. These newer relationships reflect, at least in some ways, the submissive position that young mothers hold in relation to experienced mothers and midwives. The submissiveness of Maite and other mothers transfers over into the biomedical process, but the results are quite different. While young women enter the traditional birth process as submissive novices, they are expected, as they pass through the rite, to become knowledgeable, adult members of the social order. This is not necessarily the case with the biomedical system, which is defined almost entirely by an expectation of passivity. While in the clinic or hospital young women will silently

follow the directions of medical staff. Interestingly, some women, possibly due to the support of their families, choose to defy their doctor's advice (or demands) once they leave the clinic and are at home. The hospital is a completely new and foreign place. Unlike the traditional birth process, biomedical childbirth is not a process of education or social learning—it's a process of obedience and compliance. It is also a process defined by exams, paperwork, and highly bureaucratic procedures. Most women first enter a hospital when they go and fulfill their local doctor's request to confirm their pregnancy through a blood test. When a woman goes to give birth in the hospital, she is unaware of the procedures and practices involved. She is never given a tour of the hospital before hand or told what to expect. There is no knowledge, and no social growth. Women are simply shuttled through a factory-like process.

In this sense, the biomedical setting can be highly disruptive of the traditional and social rite of passage of childbirth. But this disruption is incomplete and contested. Here one of the key points is that the birth process is very much a social rite that is built upon and contributes to social knowledge. In some cases, as mentioned above, the biomedical system works to challenge and upset traditional social forms and processes of learning. Many young mothers are caught somewhere in the middle between traditional practices and the biomedical setting. This can leave many of these women in a confusing and disjointed state. But this is not the only possible result; 11 out of the 12 pregnant women I interviewed were actively seeking out and employing traditional knowledge to confront, and navigate, the complexities of the present. As the birth process changes with the rapid onset of biomedical norms and practices, so do the ways in which women utilize, value, and engage with existing networks of knowledge. In the next section I discuss one young woman whose story is suggestive of the still powerful role that social networks play in helping women navigate the deep social changes that their communities face.

Araceli: Familial Support and Social Networks of Knowledge

Araceli is four months shy of her eighteenth birthday and legal adulthood. Despite her young years, small frame, and low economic standing, Araceli speaks in

a strong confident voice. She looks directly into your eyes when she talks and is not shy to ask questions. At the age of 16, Araceli became pregnant for the first time. A month after her seventeenth birthday she gave birth at home to a healthy and happy baby boy, named Javier. She is not legally married, but has been with her partner (whom she calls her husband) in a common law marriage since she was 14. Araceli's husband has found work at a rancho in a small neighboring community. He works all day and comes home later in the evening, leaving Araceli essentially on her own to care for their son and manage the household. The couple has limited resources. Their desperate economic situation is visible through the sparseness of their living area and lack of new clothing. Since the couple is unable to afford a home of their own, they currently live with Araceli's father and 13-year-old brother who is physically and developmentally disabled.

I first met Araceli while I was visiting the home of a family I had been interviewing. She had come over to talk to her friend (the newly married daughter of the family). It must have been an odd sight for her to walk into the house and see me. I was a foreign woman wearing nice clothes and carrying a bag full of expensive equipment—a camera, cell phone, and voice recorder. She said hello and then began speaking to the family in Maya. I am not fluent in Yucatec Maya but I understood a few key words and phrases that were spoken and knew they were talking about me—who I was and what I was doing there. This was also made evident by the fact that everyone was looking at me and occasionally pointing in my direction. I smiled and sat there quietly while they talked. Then, I got up and introduced myself to Araceli. I told her about my project and that I was interviewing women living in the community who had at least one child. She nodded and with a bit of a smile she said she was a mother and that I could come over to her house and interview her. I told Araceli I would like to interview her and I would come by the following week. A few days later, on my way to another scheduled interview, I saw Araceli sitting on a bench in front of a small concrete house. She stopped me to say hi. She was surrounded by five young children and her older sister. She asked me, point blank, why I had not come over to interview her. Then before I could answer, Araceli told me that she was not busy at the moment and that I could interview her now. After

years of fieldwork I knew I had to seize moments like this, but unfortunately, I could not—I was already expected at the home of another family. I explained this to Araceli and assured her I would come to her house the following day. She agreed and said she would be there waiting.

Araceli's house was located off a dirt road on the western edge of Sabán. It had a large solar shaded by several green trees. There was a concrete room in the front of the house facing the road and a slightly smaller thatched cooking/sleeping house. I was escorted by Araceli to the thatched house and given a low hanging hammock to sit on. In the room were Araceli's father, younger brother, and infant son. Her father, Salvador, was interested in who I was and wanted to participate in our discussions. Araceli did not mind. And, so with that, I started the interview.

Araceli began her birth story by saying that after feeling ill for several days, she walked to the house of Doña Refugio, one of the midwives in Huay Max. She was exhausted, nauseous, and had been vomiting. She was told by her father the midwife could give her a *sobada* and help her feel better or at least know what was wrong with her. During the *sobada*, Doña Refugio informed Araceli she was pregnant. After explaining the importance of *sobadas* and midwifery care during pregnancy, Doña Refugio then told her that she also had to go to the clinic for care. Araceli received prenatal care from Doña Refugio and the community clinic. She went for at least six *sobadas* with Doña Refugio and attended all her prenatal appointments at the clinic, once a month and any other time they would schedule an appointment.

Araceli and Salvador both explained that she could not miss any of her appointments with the doctors. According to Salvador, "she had to go". Araceli followed by saying, *Yes. Because they need to see how your baby is doing. They see everything. They check that you are complying. All of that. That your baby is healthy. That there is nothing wrong.* Araceli said the service at the clinic was good—if you are sick, they help you. *They give you medicine.* Although Araceli did not personally experience any negative interactions at the clinic she decided to give birth at home with a midwife. The main reason she gave was that she wanted a "normal" delivery, meaning a vaginal birth. She had been warned by her family and acquaintances about the pain and long recovery time of a cesarean section. Araceli did not want a

C-section and knew that if she went to the hospital the chances of having a C-section were high. She explained, *well its better, normal [vaginal] delivery, instead of being cut. Well to be cut, we are unable to work. And who is going to help us? No one.*

Salvador agreed with Araceli's decision to give birth at home with a midwife. He further elaborated on how women should take care of themselves during pregnancy and the importance of seeing a midwife. He discussed the difference between midwifery care and biomedical care from state doctors. As he explained,

Well it's like I told them [his daughters]. I told them to take care of themselves. It's what matters. Work and work, it's normal. But don't do too much. Don't use too much energy. And that's what I tell them. If you feel bad, I tell them to go see the midwife so she can attend you and massage [sobar] you and tell you when the baby will be born or how much time [pregnancy] is left. Everything.

When she goes to see the midwife, the midwife will tell her when she needs to come back again. It's like when a person goes to the clinic. So that is the difference, when someone doesn't feel well, they get massaged and they feel better. The pain comes because the baby is not well [in the correct position]. But in the city, it's not the same. When you feel bad, when you have pains. What is the first thing a person does? They go to the doctor. They give you a shot and the pain goes away. But if the child doesn't fix itself [doesn't properly align], then what is going to happen to you? Later, they will cut you. That is what is bad. That's why I don't like [doctors]. My deceased wife only used midwives. And her mother also helped during the birth.

Salvador was an active part of his children's lives and took the time to talk with them about the various life experiences they encountered. He was particularly sensitive to his daughters—this was in part because their mother was unable to explain the social practices of women, in particularly childbirth. His wife had been sick for many years and eventually suffered from complete blindness because of her unmanaged diabetes. She had been dead for four years when we talked. It was Salvador's responsibility now, to pass on to his daughters how to take care of

themselves during pregnancy, to follow in the traditions of the community, and to help them understand why midwives provided better care than local doctors.

Yet, there was a limit to how much Salvador, as a male, could talk to Araceli about women's experiences during childbirth. Araceli, primarily learned about pregnancy and childbirth from her older sister, who had given birth to two children. She would often go and visit with her sister. They would sit and talk about everything. Araceli would tell her how she was feeling and ask various questions. *Well my sister already had her first child and she would explain to me how everything happens. How to take care of myself. All of that.* Araceli's sister along with her father passed down the cultural practices of how women in the community took care of themselves during pregnancy, the way they labored and delivered, and equally important, the ways in which postpartum care was approached.

Araceli's family not only shared important knowledge about childbirth, they also physically took care of her and the newborn baby during the crucial first eight days after the birth. Understanding the importance of postpartum care, Salvador explained why it was important to stay home and give birth. He said,

You see, it's much better if the birthing mother stays in the house. We fix up her little room with everything. We cover everything up. We have to cover everything well. We put up fabric [blankets over the walls and doors] so that the wind doesn't come in. That's why the children grow quickly. But in a hospital if you don't have money, in two, three days they kick you out. But a woman is still weak. The baby is weak. No one is caring for them properly.

As a seventeen-year-old first-time mother, Araceli was completely dependent on the support and care of her family. When the time came to give birth, her husband and mother-in-law were present to help her. Araceli had a relatively fast labor and delivery, which she attributed to the continuous prenatal care and sobadas she received from her midwife. She gave birth the way she wanted—in the comfort of her home, on her hammock, surrounded by her familial support network. And when the baby finally came, they were there to take care of her and show her how to tend to her newborn son.

Araceli's story illustrates the value of traditional knowledge. She was different from most of the other teen mothers I spoke with. She was not shy. She was more vocal and confident about sharing her experiences. This may be explained, in part, because she had already been through the birth process—and the process of social learning and transformation that comes with it. Her story clearly highlights the continued social meaning of traditional knowledge for women who pass through the childbirth process. Araceli was a more active, engaged participant in the process, I argue, because she had obtained the knowledge and confidence that comes with this rite of passage. This is knowledge that women often do not obtain when they experience birth in biomedical settings. Araceli's story also demonstrates the role that men play in the birth process itself. Her father chose to be present during the interview and he too was deeply involved in the discussion. This interview illustrated how men (husbands and fathers) are an important part of women's maternal health. As I explained in chapter 2, socially, husbands are expected to be present during the birth of their child. The two primary reasons that are given are 1) so they can physically help their wife through labor and delivery and 2) according to many women I spoke with, it is important that a man sees how a woman suffers during childbirth so that he can appreciate her and treat her better. Although men typically defer women's maternal health to other women such as the midwife or older mothers and sisters, they still have an active part in the process. Many men, like Salvador, talk to their wives and daughters and try to find ways to provide them with the best care possible.

Araceli's story demonstrates how care is managed through familial and social networks of shared knowledge and experiences. People talk about what they have experienced, what they have seen, and what they have heard. Traditional practices get passed down through the participation in these networks. Women learn how to manage prenatal care and what to do during delivery by talking with their families and friends. Much of it is based upon first-hand knowledge and experience. Yes, women in rural Yucatan are exposed to books, radio, television, they have interactions with doctors, and many travel often in and out of their communities, but the most important and valued insights they have about addressing their health

come from the intimate relationships they have with their families and friends. While the biomedical system can be highly disruptive and overpowering, many women still hold onto traditional knowledge forms that can guide them through the complexities (and potential dangers) of childbirth. In the next two sections I discuss some of the key risks women confront in the birth process, starting with the rumors and fears that often surround C-sections.

Amalia: Cesarean Sections, Rumors, Threats, and Violence

One fall evening sitting on a bench in front of her house, I talked with Elena about her life, work, and some of the pressing health concerns of the residents from her rural pueblo. As a local midwife and a mother, her knowledge highlights the cultural significance of rumor in local women's encounters with biomedicine and the state. The use of rumors and threats are important places to analyze the different power dynamics between rural Yucatec Maya women and state health workers—each group choosing to counter the narratives and practices of the other through techniques representing their positionality and authority. After about half an hour of conversing, in a lowered voice, Elena shared with me relevant events that transpired earlier that day.

Elena started her story by speaking about a woman at the end of her pregnancy, who I call Amalia. The local clinic doctor had labeled Amalia “high risk” and told her to go to the hospital for the delivery of her child. Amalia had been avoiding the doctor for over a week—hiding in her house every time the physician came by. Amalia had attended all her prenatal checkups at the local clinic and understood the doctor's concerns, yet based upon her positive past experiences with midwifery care and fear of mistreatment from hospital staff, she chose to defy the doctor's recommendation. Amalia believed she could safely have her baby at home with the assistance of a midwife. The clinic doctor, desperate to change Amalia's mind, was motivated by the ethical obligation to provide the woman with the best care possible, but she also needed to absolve herself from the responsibility of caring for the woman's life. According to her superiors the doctor was accountable for the overall health of the entire community. Earlier that day, the

doctor gathered all the local midwives and warned them of Amalia's dangerous condition and tried to persuade them to not attend to her, and to help her convince Amalia to go to the hospital. She ended the meeting by telling the midwives that if the mother died at home it would be the attending midwife's fault. Later that day, the doctor's supervisors came to the community looking for Amalia. After forcing her out of her home they tried to convince her to come with them to the hospital. Amalia held her ground and refused. The doctor and her supervisors agreed to leave Amalia only after she signed a legal document acknowledging her dangerous medical condition and decision to disregard the advice of medical experts. Amalia was coerced to verbally and legally acknowledge that she purposely chose to put her own life and that of her unborn child at risk, in defiance of state backed biomedical expertise and care.

This story illustrates some of the contentious ways in which childbirth is understood and practiced in rural Yucatan. In a community where midwives are the only accessible and dependable health care providers, hospitals and their biomedical staff are often viewed with fear and mistrust. This suspicion of biomedical providers is extended to local community clinic physicians who use scare tactics to change women's behaviors.

As anthropological scholarship has shown, rumors are often mobilized as weapons of the weak, marginal, and subaltern (Turner 1993; Scott 1985; Briggs and Mantini Briggs 2003). Briggs and Mantini-Briggs (2003) address the way in which marginalized indigenous and poor populations in Venezuela used narratives of blame, through rumor, to challenge the neglect of the state to recognize the 1992-93 cholera epidemics among their communities. Venezuela manipulated health statistics to downplay the number of epidemic deaths among poor rural communities. The Venezuelan government was not concerned with the epidemic as long as it was contained within its disposable citizens and the international community was not watching. Briggs and Mantini-Briggs demonstrate how indigenous people used conspiracy rumors and counter narratives to place blame on the state and demand that poor communities receive access to resources (in this case health, sanitation, and clean water). Counter narratives and rumors "can

challenge the pedagogical and performative projects of governmentality, they are of potential significance to communities that do not get labeled as *indigena* or cholera ridden” (Briggs 2004:182). These counter narratives of blame were used by marginal people to represent their frustrations, experiences, and thoughts about the cholera epidemic which were ignored and silenced by the national and international community.

In rural Yucatec Maya communities, women young and old agree that the probability of coming home after a hospital birth with a cesarean section (C-section) is incredibly high. Women refer to the procedure as “being cut”. It implies a violence that is done onto their bodies by state sponsored biomedical practitioners. Women explain that doctors are quick to resort to “cutting” a woman because they are impatient and often unwilling or unskilled to work with a mother through a complicated delivery.

Women often talk about the impatience of doctors and how they are often unwilling or unskilled to work with a mother through a complicated delivery. Doctors are quick to resort to “cutting” a woman. Women understood that doctors had different standards of what constituted a safe and normal labor. Many women said that doctors had a reputation of doing cesarean sections because they were convenient and sped up the delivery. They also thought doctors used cesarean sections a means to take control of the birth. Women viewed most doctors as insensitive and impatient. They felt that there existed few medical reasons for doctors to perform cesarean sections, especially since midwives never did. Doña Refugio, a well-established midwife from Huay Max, further explained the difference between midwives and doctors:

Midwives never operate or cut the mother. They can normally fix a complicated labor by massaging the abdomen and aligning the baby’s head in the right position. When a doctor has a complicated birth he automatically gives you a cesarean section. He does not know how to reposition a baby if it is upside-down. Doctors will also cut the woman down there [perineum]. They do this because they do not want to wait for the body to stretch and

fully open, they do not have patience. Midwives will always wait for the body to stretch [Miranda 2009:47].

In her comparison between midwifery and doctor attended births, Doña Refugio not only reaffirmed the perceived impatience of doctors and the authority they have over women's bodies in the hospital but she also highlighted the limitations of biomedicine.

Many women in the community also talk about the possibility of infertility because of a hospital birth. Women who have had hospital births have questioned why it has been difficult to conceive subsequent children.

Yucatec Maya women use rumors to talk about C-sections and hospital births to criticize the abuse and violence they experience by hospital staff. Through rumors, women challenge the Mexican biomedical community's overuse of C-sections and ultimately their disregard for the lives and experiences of poor indigenous women. Although some stories might be exaggerated, overemphasized, and speculated there is a certain level of truth to what is said and ultimately believed. Castro and Erviti (2003) have documented the widespread violations of women's reproductive rights during childbirth in Mexican public hospitals. They argue these abuses, which are physical and psychological, are a form of institutional violence against women by government hospital staff. For those Maya women who have not experienced a C-section, the encounter is not far away—it is present in their close-knit social and familial circles. Every woman in the community personally knows at least one person who has had a C-section. In fact, the overuse of C-sections is a pressing problem throughout Mexico. A recent World Health Organization report lists Mexico's C-section rate at 37.8% (Gibbons et al. 2010), more than double their worldwide justified cesarean range of 10-15%. For many women, the high rate of C-sections represents the lack of value the state and biomedicine place on the bodies of poor indigenous women. The overuse of C-sections demonstrates how the culture of biomedicine in Mexico has disregarded or underplayed the consequences its practices have on the lives of women—C-sections are an invasive, painful surgery with a lengthy recovery period. Many women poignantly ask, "who will take care of me and my family if they cut me".

Under state pressure to lower maternal and infant mortality statistics, local physicians and regional health workers have resorted to scare tactics to compel women to abandon midwifery for a hospital birth. Threats have become a popular mechanism of persuasion, backed by the power of the Mexican government. Women are threatened with the safety and life of their child. If the hospital doctor considers a woman's labor complicated or failing to progress, she is told that her unborn child will die unless a C-section is performed. Women are also told that all "good" mothers should choose to give birth in the "safest" place, the hospital where they are surrounded by professionals and the advanced technology needed to save their life and that of their unborn child if complications arise.

As Elena's story about Amalia brings into sharp relief, local midwives are also intimidated with threats of severe punishment such as the possibility of imprisonment if they attend "high risk" mothers. Doctors and regional health care professionals claim that midwives support women's decision to defy their authority. Yet, midwives are often left in a bind. They understand the dangerous complications that can arise during "high risk" labors, but they also know that some women will refuse to go to the hospital regardless of what anyone says. Yucatec Maya midwives share some of the same ethics as biomedical practitioners—they too have a responsibility to help people in need. Midwives know that if they refuse to attend women who go against state medical advice and stay home, these women will be left alone to handle a possibly dangerous situation. Morally, midwives cannot let this happen. Their only hope is that the labor will progress without serious complications and if they do arise the mother and/or her family will be open to listening to the midwife's advice to go to the hospital.

Interestingly, if not ironically, threats are also used against local biomedical practitioners. Their work is judge on the overall health statistics of the communities that they are assigned to. If a mother or infant dies during childbirth, the local physician is also blamed. This in no way excuses the tactics they use, but it does speak to the broader power dynamics at play.

Rumors of abuse and the widespread sharing of their painful experiences during hospital births are key motivators that encourage rural Yucatec Maya women

to stay home and give birth with a midwife. However, women also understand the limitations of midwifery and acknowledge the specialization of doctors and biomedical care. Most women have said they want to labor at home but if complications occur they expect their families to quickly transport them to the hospital. They know if they encounter a serious complication during pregnancy and/or childbirth, the hospital is the place to go. The critical insight is that for them biomedicine is primarily seen as a safety net when midwifery care can no longer help the mother. Women also clearly understand the consequences of their decisions and are aware that as soon as they walk into a hospital they are subject to the rules, procedures, and demands of the medical staff. They acknowledge that seeking treatment in a hospital requires them to surrender their bodies to state biomedical workers and, as a result, might lose their ability to question medical staff and speak up for themselves. As Castro and Erviti state, “patterns of health violations that emerge within health institutions are not random acts. On the contrary, they are, at least in part, the result of a state policy that lacks adequate gender perspective and bestows on institutions the ‘right’ to influence women’s reproductive decisions” (2003:106). Women use rumor to challenge and question state power over childbirth, and reassert the importance of traditional practices and knowledge. Such narratives serve as a counterbalance against state discourses, which often seem hegemonic, particularly in small, marginalized communities such as Sabán and Huay Max. Women’s rumors push back against power inequalities that pervade the biomedical system. In the next section, I discuss another way in which power inequality plays out in the birth process: through the bureaucracy of the biomedical system itself.

Patricia: Inefficiency and the State Health Care System

Patricia is twenty-eight years old and is lovingly referred to by her family as Pati. She is a beautiful woman with a calm and sweet demeanor. She clearly expresses her thoughts and experiences and it is generally a pleasure sit and talk with her. She has a four-year-old daughter and is currently five months pregnant. Pati is from a smaller community located a twenty-minute drive from Sabán, but has

lived in Saban since she was fourteen years old. She originally came to Saban to attend bachiller (high school). There are no schools in her community and all the children either bike or walk twenty minutes to elementary and middle school in a neighboring pueblo. Pati was a good student and wanted to continue her education, so her family arranged for her to live with Elena as a boarder. She spent three years in Elena's home and they soon became like family.

Pati is married to Rodrigo. Her husband has a steady paying job in Playa del Carmen where he cooks full time in an Italian restaurant. Pati and her daughter currently live with her in-laws in Saban. Rodrigo returns home to Saban every two weeks to visit his family. Pati informed me that Rodrigo is planning on coming home to be present for the birth. Someone in the family will either call or text him as soon as Pati's labor begins.

During the first years of their marriage, Pati lived with Rodrigo in Playa del Carmen. She had her first child there and only recently moved back to Saban. She has been living in Saban at the house of her in-laws for over two years. Now that she had a young child, Pati wanted to be closer to family and give her daughter the opportunity to grow up with the freedom of pueblo life. Additionally, knowing that she wanted to have more children, Pati was hoping to depend on the support and advice of her family. Living with her in-laws has been a good experience. They all get along well. Pati's mother-in-law and sister-in-law have been very helpful during her pregnancy. They have taken over most of the domestic chores, such as cooking and cleaning. They look after Pati and make sure she is resting and has everything she needs.

Pati is currently enrolled in both Oportunidades and Seguro Popular. When she moved back to Saban a couple years ago she applied for Oportunidades and once successfully entering the program she was switched over from her husband's health insurance to Seguro Popular. Oportunidades has helped her pay for food and clothing for her and her daughter as well as pay for necessary health services. As a pregnant woman with a small child, Pati's Oportunidades requirements are more intensive and time consuming. Every month Pati must go to the clinic at least three times. She takes her daughter for a monthly checkup (a requirement for all children

under 5), she receives her monthly prenatal exam, and she attends a monthly health education talk. Occasionally, Pati must also go to the clinic for vaccine campaigns and specialized doctor appointments. In addition to fulfilling her health responsibilities at the community clinic, Pati must also attend a meeting every two months at the home of her Oportunidades vocal.

Appointments at the clinic are a process that takes several hours. Pati must leave her house early in the morning and wait in line outside the clinic at least an hour before they open. This is the only way she can guarantee that she will be seen. But in reality, it is not a full proof plan. The clinic doctor only sees twenty-five patients a day. So, if a person does not get there in time to be on the list, then they will have to come back earlier the next day and attempt the process again. Pati explained, *it's complicated because there is only one doctor*. Her wish is that there were at least two doctors working in the clinic so more people in the community could get the care they need. She explained that sometimes there are children with fevers who are denied access to the doctor because the patient list has already been filled.

Pati became pregnant for the first time while she was living in Playa. After missing her period, Pati bought a home pregnancy test which confirmed her pregnancy. There were no practicing midwives in Playa, so Pati received all her prenatal care from doctors. She did eventually see a midwife. But it was only a couple of times early on in her pregnancy, when she returned to Sabán to visit family. While living in Playa, Pati was enrolled in Instituto Mexicano del Seguro Social (IMSS) health insurance program which was provided to Rodrigo (and dependents) through his employment. Living in Playa, Pati experienced the difference between city life and that of her rural pueblo. She knew that in Playa she was going to have to give birth in a hospital. However, she assumed it would be a “normal” (vaginal) birth. Sadly, she was wrong.

With her (pointing at daughter), my blood pressure went up. I was scared when it was time to give birth. Because she is my first baby. I was scared and they had to give me a cesarean section because my blood pressure went up. I had preeclampsia. With her I didn't have labor pains. Nothing. I had an appointment with my doctor. I went so

that they could check me but it was close to my due date. The doctor had given me an appointment every week. And I went and he told me that my blood pressure was very high. He took my blood pressure and it was really high and he told me that I had to go to the doctor so that he could do a cesarean section. I went and stayed in the hospital. Yes, they told me they had to give me a cesarean because my blood pressure was too high. I wasn't well and there they gave me a cesarean. I was living with my husband in Playa and he had medical insurance. We had insurance from there and they sent us to Cancun.

From IMSS [hospital in Playa] they sent us to Cancun to have a cesarean because in Playa they didn't do cesareans. They had to transfer me to Cancun. I had an appointment in Cancun for an evaluation. I arrived there for my evaluation in Cancun and the doctor told me that my blood pressure was really high and he told me I had to return to Playa so that they [hospital administration] can give me a paper for a transfer to Cancun so that they could give me the cesarean section. That same day I returned to Playa. Yes, we returned to Playa and went to IMSS and they wrote and gave us the paper. And we returned to Cancun. It was late. And first thing in the morning, the following day, they performed my cesarean section.

They told me that if they didn't perform the cesarean my baby could die. Because a person's body heats up and well, the baby could have complications and die inside my body. When they told me that I was scared... They do not let husbands come in. If they are going to do a cesarean they do not let your husband in with you. Only the doctors. That's why I think you have more fear, because there is no one at your side that you know, for example your husband. After the cesarean, they showed me my daughter and told me everything was okay. Well, then it was worth it that they gave me a cesarean because my baby was well, she was alive.

Pati said she was treated well at the hospitals in Playa and Cancun. However, she wishes the hospital would have allowed her husband to come in with her while going through the cesarean section. During such a stressful and terrifying moment, Pati was left alone—without her husband to help calm her fears. In fact, Pati did not see any family member until the following day when her mother was allowed to visit her. She did not see Rodrigo until two days after she had given birth. The hospital

staff explained to her that men were not allowed in the maternity ward because they had to be respectful and considerate of the other women. Pati informed me that once a woman gives birth in the hospital she is taken to a large room filled with other women to recover from the delivery. She was told that a family member could accompany here but it had to be a woman. Once Pati was allowed to have visitors, her mother came and stayed with her the entire time she was in the hospital—sleeping near her daughter and comforting her. Following standard hospital procedures, the newborn baby was sent to the nursery after the delivery. She stayed there until Pati was discharged from the hospital. As Pati recounts, she saw her daughter right after she was born—when the doctors presented her after surgery. But she did not see her again until two days later. Pati thinks the hospital staff delayed bringing her daughter to her because Pati was still not well. Pati was intensely monitored during her complete stay in the hospital—three days in total. Although Rodrigo was not allowed to visit his wife, he did get to meet his daughter in the nursery room—a day after she was born.

Pati then detailed how she found out she was pregnant with her second child and listed the subsequent events that followed. *Since I missed my period, I went with the midwife so she could massage me. And she told me that most likely I was pregnant. And I bought, to leave no doubt, I bought a pregnancy test. And I did it, and yes, I knew I was pregnant. Then I went to the clinic and they gave me a little paper so that I could get a blood test. And over there [the hospital in Morelos] they did it [the blood test]. And it was the same, positive. I was pregnant. And then I returned [to the clinic] and brought my lab results from the hospital and then I started my prenatal care.*

...Well over here in the little towns, its umm, (smiling) I think it's more of a custom that we have, to know if the baby is well. Maybe that's why we go to the midwife. But at the same time, every month I go to my prenatal appointments at the clinic. I go there too... I went every month for prenatal care. When I go there [to the clinic] they check me, my blood pressure, and they see if the baby is functioning well. They hear its little heartbeat. I heard its heartbeat. It feels beautiful to hear its little heartbeat.

Unfortunately, Pati's second and current pregnancy soon began with the threat of a miscarriage. At two months, suddenly, Pati started bleeding. She instantly was paralyzed with fear. Her mother-in-law told her she needed to lie down and rest. She then called Elena, Pati's midwife, to come over and check on her. Elena assessed the situation and told Pati it was important for her to stay in bed and rest. The next day Pati decided to go to the community clinic for additional care. At the clinic, the doctor examined Pati and gave her a pill to help avoid a miscarriage. She also recommended that she get an ultrasound. The following day, two and a half days after she started bleeding, Pati went to the hospital in Morelos for an ultrasound. The doctor at the hospital told her that her baby was okay but that she should continue resting and taking care not to exert too much energy. Since then, Pati has diligently following the advice of her mother-in-law, midwife, and doctors. Even though the bleeding has stopped and she feels relatively well, Pati and Rodrigo continue to worry about the pregnancy. Pati explained that her fear of a miscarriage is the primary reason she seeks care from doctors when she does not feel well.

A few weeks before we spoke, Pati and her daughter went to Playa del Carmen to visit Rodrigo. While there, she and her husband decided to take advantage of the fact that they were both together and in the city to get an ultrasound for Pati. They knew the community doctor was going to eventually require Pati to have an ultrasound. Having an ultrasound done was also a requirement for her continued participation in Oportunidades. But, the couple was also motivated by their concern for the baby's health and they hoped the ultrasound would help reassure them everything was okay.

Rodrigo took Pati to the Red Cross in Playa to have the ultrasound done. The fee was 250 pesos. Rodrigo's sister, who had several children, recommended that they go to the Red Cross because it was cheaper than other places that charged for an ultrasound. She told them it was better for them to pay for an ultrasound from a private doctor because if they waited to use the services offered by Seguro Popular, Pati would have to make multiple trips to the hospital in Morelos and she would not be able to get an ultrasound until later in her pregnancy at seven or eight months.

Pati further explained the justification and cost effectiveness of paying for an ultrasound from a private doctor. She started off by saying she knew she could get a free ultrasound from the hospital in Morelos through Seguro Popular, *but it takes too long. First, they give you, an umm, an order [referral] so that you can get an appointment at the hospital in Morelos. But sometimes when you get there, the social worker will give you another date. Then you go on that date and sometimes they give you another date. Well the trip from here to there, it costs 45 pesos. A round trip costs 100 pesos. And more if you spend money to buy something to eat while you are there. That's why when I traveled [to Playa] I took advantage to get the ultrasound. It's convenient for me to get it from a private doctor because I only have to go once. Then I already have it done. I have the results. Whereas if I used Seguro Popular it takes a long time, a long time.*

At the ultrasound, the doctor took the time to show Pati and Rodrigo the baby on the monitor. He explained to them what they were looking at and pointed out the different body parts of the baby. The doctor then revealed the sex of the baby—they were going to have a boy. Pati was excited to see her baby and to find out that she was having a boy since she already had a daughter. Unfortunately, the consultation was not all good news. The doctor told the couple that the baby was breeched and if he did not move to a head down position, Pati was going to need a cesarean section. After returning from her trip to Playa, Pati went straight to Elena's home for a sobada. She told Elena about the ultrasound and how it showed her unborn son was in a seated position. Elena gave her a message and gently moved the baby. She then told Pati to come back in a week for another message. When she returned, Elena again gently messaged the baby into the correct position. She told Pati the baby was now in the right place and hopefully he would stay there. But Elena also made sure to tell Pati that it was important for her to come back again later for another massage to guarantee the baby is properly aligned and ready for the birth.

Pati is hoping to have a homebirth this time around. But she acknowledges the complications she experienced early on and places the ultimate fate of her delivery on the advice of her doctors. However, Pati has been assured by Elena, that

a home birth is possible but only if Pati experiences labor pains. If she does not, then Elena confirmed that Pati would need to go to the hospital to give birth. As Pati explained, *it all depends what the doctors say. If I am well. If I am well during my pregnancy. If I can. Because sometimes they say you are narrow, tight, and you won't have [labor] pains. You won't feel any pains. If you don't have pains then you can't give birth normally [vaginally]. And they have to perform a cesarean on you. But if you feel pains, the midwife tells me that I can give birth normally. Yes. I want to give birth normally.*

The midwife tells me that if I can give birth, then I can have the baby here at home. But if not, then she will accompany me. As a midwife, all the pregnant women she cares for and massages, when it's time for their births, if you send for her, she comes to take care of you. She tells you what hour, because they know, what hour your baby will be born, if it's coming. If there are complications during the birth she accompanies you. She takes you to the doctor. She goes with you. She doesn't leave you.

The difference between a normal birth and a cesarean. The cesarean lasts, I think, almost two months for the pain to pass. Whereas with a normal birth, it's only a few days. Three days and that's it, you are able to move around normally. Whereas with a cesarean after months you still continue to feel a little bit of pain. Its more the first and second day, when you get up you feel as if your incision is going to open. That's why my sisters, my sister for example, she says it's better to have your baby in a normal [vaginal] birth. Because you will only feel pain for three days and that's it.

But sometimes I say, sometimes I think, even though I'll feel pain, let them give me a cesarean. Because I know that my baby will be fine. Because if, the labor gets complicated while at home, well I could lose my life as well as that of my baby. That is what I am scared of. More now, because when I went to Morelos [to the hospital] the doctor told me, that in those months [during my due date] it's really difficult [to guarantee me care], because the doctors leave for vacation in December and she tells me that I need to anticipate what doctor will attend me, or where I am going to have my baby. The doctors leave for vacation and well there's a possibility there is only one doctor for an emergency or an accident. That's why my husband tells me that at eight months or a little more than eight months we are going to find out which doctor [will

deliver the baby] or if I can give birth normally. If I can give birth normally, well then. If not then I will have to go to Playa again, even though I am receiving prenatal care here. Well, Playa is a city. Over there, there are no vacations. We are planning in case something goes wrong.

As Pati explained, she and her husband are critically aware of the limitations of the hospital in Morelos. According to Pati, the hospital lacks many resources including specialized doctors. Pati was also informed by her mother that the hospital in Morelos did not currently staff a surgeon who could perform cesarean sections. She explained the reason for this had to do with the local politics of the region. Pati's mother voiced her disagreement and frustration with the new mayor and faulted him for many of the problems faced by people in the community. A lack of confidence in the available health facilities and workers has persuaded Pati, her husband, and mother to agree on going directly to a hospital in the city (Playa del Carmen) if Pati experiences complications during labor and delivery. In preparation, Pati has discussed her plans with her local doctor. The doctor agrees that a birth in a hospital in Playa would be the safest option for Pati. She has started the paperwork issuing Pati a referral to the hospital so that her insurance (Seguro Popular) would pay for her care. Having this ready will save Pati and her family a lot of time and headaches dealing with the complicated process of the state health bureaucracy.

Pati clearly remembers the advice her mother gave her while pregnant for the first time. She told her to take care of herself and not worry when the time came for her to give birth. She told Pati not to be scared—to believe that everything would be okay. Following her mother, Pati shares the same recommendations. She encourages younger women to not be fearful. To control themselves, so that when it's time to give birth, the baby will be born well. Pati suggests that women calm themselves by taking deep breaths and thinking that everything will turn out fine. She emphasizes the importance of positive thinking. However, it is easier to give advice than it is to follow it. Because of her traumatic experience during a hospital birth, Pati has struggled to not worry about the safety of her unborn child. And this has ultimately influenced her dependence and submission to the authority of biomedical care.

Although Patricia has sought out prenatal care from both a local midwife and various biomedical doctors, she has chosen to try and have a home birth because according to her giving birth vaginally is less painful, traumatic, and invasive. However, from her previous experience Patricia also understands the possible dangers that can arise during labor and delivery. She suffered from preeclampsia, a serious condition that could have taken her life and that of her daughter if she had not been treated at a hospital. Pati understands the lifesaving knowledge and technology that exists in a hospital setting and she is grateful that it is there—that she has access to it if she needs it. Therefore, Patricia and her husband have created a backup plan in which if there is any sign of a complication at the end of her pregnancy or during delivery, Patricia will be taken to a hospital to give birth.

Yet, Patricia is also aware of the challenges of living in a rural community and she clearly understands that access to lifesaving medicine is not always available to her and her neighbors. Women in Sabán and Huay Max may consider biomedicine a safety net, but in reality, it is not—at least not in the rural hospitals they are sent to. Hospital staff have openly acknowledged their limitations in resources and the fact that they cannot keep a full staff 24/7 all year long. As Pati's story illustrates, not only are rural hospitals consistently understaffed but they are also negatively affected by cultural traditions that allow doctors to take month long seasonal vacations. In rural Yucatan, it is dangerous to have a child in December because if something goes wrong and you need to rush to a hospital, the chances are there will not be enough staff to help you. You will most likely have to be transferred to a larger hospital in a major city, such as Chetumal, which is a three-hour drive away.

What Pati's story demonstrates is that women and their families think ahead about their births and what they might have to do if a complication arises. They make plans. They do not sit around and wait to see what will happen. They are active in their prenatal care and delivery. They know what is available, their options, as well as the limitations that exist.

Patricia's interview also highlights a new trend in prenatal care in the community. Many women are now going to private doctors for an ultrasound. In

early 2002, it was not common practice for women to have an ultrasound. Within a decade this has become a routine practice in prenatal care. It started slowly with women's fulfillment of their Oportunidades requirements. Women would typically only receive one ultrasound from the state hospital in Morelos, during the 7th or 8th month. At first most women understood the ultrasound as a procedure used to find out the sex of their baby. They did not completely understand what the doctor was looking at. But they remember the doctor telling them the sex of their child in utero. Women were not given a photo of their baby nor were they explained what was going on during the ultrasound.

Women now have a better understanding about the meaning of an ultrasound. They know that the ultrasound helps the doctor see the baby to help identify any problems. It also functions to assure women that their baby is ok. In many cases doctors have also used the ultrasound to tell women to prepare for a cesarean section if they see that the baby is breeched. With this new information, women can be proactive and attempt to avoid a cesarean section by go to the midwife for a sobada so that she can message the baby into the proper position. Women now understand the important health justifications for an ultrasound, however many still consider its importance as a tool to find out the gender of their baby.

After numerous interviews with various women in the community, there are several important differences between an ultrasound experience from a private doctor vs. one at the state-run hospital. With a private doctor, women reported being treated better and given more time. Family members were also allowed to join the woman and experience the ultrasound with her. The technician explains what s/he is doing and shows the mother her baby. The patient is also given a set of photos of her unborn child. And more importantly, the wait time and consultation take no more than a couple hours.

It is a strikingly different experience at the public hospital, where the appointment is quick and women are not given a detailed explanation of what the doctor is doing. Many women had to wait hours outside the hospital before they were eventually seen, regardless if they had an appointment. And some women

reported have to return multiple times to eventually get an appointment to have their ultrasound done at the hospital. Women were also not given a photo of their baby, which the majority expressed a desire for. The photos were important for women because they used the photos of their child in utero to include their husbands and family in the prenatal experience and create a relationship between the family and the unborn child. Although an ultrasound with a private doctor may have cost women more money, many justified the expense by saying that they preferred paying more for the convenience and better care they received. After breaking down the total cost and time they would spend going to the public hospital for an ultrasound, many women said that price was not significantly different. The choices women are currently making regarding where they go for an ultrasound is the beginning of the private biomedical sector moving into the childbirth practices of rural Yucatec Maya women who have traditionally relied on local midwives and state doctors.

One last point that comes out of Patricia's story is a description of the heavily bureaucratic process that rural Maya women must navigate to receive care from the state. Maternal health is heavily documented in rural Yucatan. Women seeking care at the government clinic must carry with them a small medical chart that contains basic information about their pregnancy, such as their monthly weight and blood pressure. They must also keep with them all the results of their lab work, doctor's notes about their prenatal care, and any referrals they have been given. It is very important that women always carry with them their medical paperwork and health insurance cards. Care is often denied or delayed when patients do not carry the appropriate paperwork. Furthermore, women and their families are threatened to pay all the costs of their care if they do not present the forms and identifications the medical staff require.

In Patricia's case, she was told by the doctors in Playa del Carmen that she needed an emergency cesarean section and transferred to Cancun. However, once in Cancun, the admissions officer said that her surgery was going to have to be delayed because she did not have the correct referral form. For her insurance to cover the cost of her care she would have to return to the hospital that transferred her so that

she could get the correct paperwork and bring it back to the hospital in Cancun. It was a process that took a day to complete. At the end, Patricia was exhausted and grateful to finally be resting at the hospital in Cancun where she waited the night and was finally taken in for surgery the following day.

Today, maternal health and childbirth in rural Yucatan is experienced through the audit culture of paperwork and bureaucratic procedure. As mentioned in Chapter 2, doctors and government clinic staff are inundated with the amount of paperwork that is state mandated. The clinic staff in Saban spends the last week of every month trying to get all its paperwork ready to turn into the municipal and state public health officials. In many ways, their jobs and reputations are now contingent upon if they complete the state required paperwork and how well they complete it. The burden and responsibility of maintaining proper documentation is also placed on rural Maya women. To be pregnant and give birth in Saban and rural Yucatan, now means that women must collect, check, and carry the complete documentation of their maternal health journey. In many ways, the paperwork and documents have their own life. They have an immense amount of power and can dictate if a person receives care and assistance. For example, prenatal care is not given at the government clinic or the municipal hospital without the appropriate documents. A woman will not be released from the hospital unless the family can physically present her insurance card or be willing to pay the full amount of her stay while in the hospital. In Saban, a woman who had a home birth cannot solicit a birth certificate from the municipality if she does not have a live birth certificate given out by the community clinic and this certificate is only distributed if the woman can demonstrate through medical documentation that she has complied with all her prenatal appointments. If a woman participates in Oportunidades, she must also show her medical prenatal chart to the program officials to receive her cash stipend. What this all demonstrates, is that life happens through paper. In rural Yucatan, maternal health and everyday life is documented through official documents that travel and live with the birthing mother.

Conclusion

After generations of constant exposure and pressure, state biomedical discourses are finally penetrating everyday understandings and practices related to childbirth. Many more women are now going to the hospital to give birth. The majority of women who went to the hospital first attempted to give birth at home but were eventually transferred to the hospital by their families or midwife after encountering a complication. It is unclear if the definition of what constitutes an emergency is changing, but it is my understanding that the category is being broadened and women are being taken to the hospital much earlier and more frequently than in past generations. Women themselves have expressed more openness to the possibility of having a biomedical hospital birth in case of an emergency. A reason for this is because they might now know that going to a hospital is a real option. The roads are significantly better than they were a decade ago and more people in the community own cars that could drive them to the hospital. In some ways, women know they can count on the hospital staff for expert care—or at least they have the expectation that once at the hospital they will receive the care they need. With the presence of added health resources, women are demanding more of their governments. They expect the Mexican state to provide them with a health care system that meets their immediate health needs and gives them the resources to live a long and healthy life.

When interviewing young mothers, I primarily spoke with women who used the services of a midwife. This was in part because I had easier access to them by getting to know them through my connection with Elena. However, there is a growing number of first time mothers who are young and choosing to go to the hospital rather than first attempting to give birth at home. I spoke with a few women who expressed the desire and choice to seek a hospital birth. They all stated that fear was a major motivator. They were worried that giving birth at home in the community did not allow them access to lifesaving technology and care in case something went wrong with the birth. They understood the geographic limitations of where they lived and knew that a hospital was at least an hour away. In 2008 I interviewed, Alba, a young mother who had tried to give birth at home but was

eventually transferred to the hospital after laboring for more than two days. After telling me how she was mistreated and ignored by hospital staff, Alba said she would consider going back to the hospital to give birth only because in the end, her baby was born healthy and her overall health needs were taken care of. An important point to mention is that Alba had a vaginal delivery at the hospital. This makes a significant difference in her experience. The majority of the women I spoke with who had a cesarean section while giving birth in the hospital stated that they valued the skills midwives had in preventing cesarean sections and for their future deliveries they wanted to try and stay home and have a vaginal birth after a cesarean (VBAC).

An important point to highlight is that the majority of first time mothers living in Sabán and Huay Max were not enrolled in the Oportunidades program. Most first solicited and received Seguro Popular when they went to the hospital in Morelos to obtain a required blood test confirming their pregnancy. Women in the community cannot apply for Oportunidades until the enrollment is opened, once every three years. According to many women, they are only allowed to apply if they are married or have a child. The main problem with Oportunidades not having a continuous open enrollment is that most young mothers are not benefiting from the monthly health education meetings and the financial stipend that is needed to help pay for food and medical costs. Pregnancy and childbirth place an additional cost on a family's budget. Women must pay for transportation to receive needed medical examinations. And many times, women and their families pay out of pocket for medical procedures from private doctors. But the educational component of Oportunidades could really benefit these young women especially since they lack an extensive knowledge of maternal health and childbirth. The primary ways they access information is through their familial and social networks but this can be strengthened if they could have biomedical knowledge about reproductive health which could help build better relationships between mothers and their health care providers. Obviously, that can only happen if they are treated with respect and the educators are not paternalistic and condescending.

First time mothers attend all their prenatal appointments at the clinic without any financial incentive. The majority are not yet enrolled in the Oportunidades program. These first-time mothers go because as one young pregnant woman told me, “its common sense to go to the clinic and see a doctor when pregnant”. Women are aware of the benefits biomedical care and supervision provides for not only their health and but also for their unborn child. Understanding the technical and specialized knowledge biomedical workers provide, women choose to follow many of the medical directives given to them by their doctor. They go even though it costs them money and time to travel outside the community for their appointments with specialized doctors and to get additional tests done. Most pregnant women leave the community to receive an ultrasound, get blood drawn, and visit the gynecologist.

In rural Yucatecan, women’s struggles to assert their own decision-making about childbirth are complex and challenge the notion of what it means to be autonomous. As Abu-Lughod (1990) states, resistance (and in this case autonomy) is not always intended to overthrow a system or is directed by ideologies of emancipation. Instead, individuals work within and attempt to adapt to the various systems of power and knowledge that they live in. Maya women understand the benefits that come with participating in state health programs, these include financial and health incentives that are not readily available in the communities that they live in. These women do not want state health programs like Oportunidades to go away. Instead what they want is to be included in discourses of what is a healthy and safe birth. Maya women view themselves as active participants and citizens of Mexican society. What this also means that they have the right to choose how they want to give birth and how they will participate in state programs. For rural Yucatec Maya women, autonomy does not mean existing outside of the Mexican state.

The female residents of Saban and Huay Max share similar experiences and strategies for self-determination in childbirth practices as other women around the world (Kaufert and O’Neil 1993; Van Hollen 2003). These women are concerned with finding creative and innovative ways to approach their maternal health in response to complex and layered factors. As Lock and Kaufert (1998) explain,

although women make claims against the state through their reproductive and childbirth practices, their actions are also grounded in pragmatism.

Rural Yucatec Maya women understand their health as situated within various power dynamics, yet for many the ability to have a birth that they deem is safe and healthy is of greatest importance. These women have employed multiple strategies that include participating in state health programs to gain access to much needed economic and health resources, incorporating biomedical practices like taking vitamins and nutritional supplements into their prenatal care, following family prenatal advice from their mothers and sisters, and relying on the knowledge and practices of local midwives to deliver their child at home. Rural Yucatec Maya women use whatever resources they have and are familiar with to optimize their health and that of their unborn child. This pragmatic practice of medical pluralism, where state sponsored biomedicine and local traditional midwifery are combined, has proven to be a valuable strategy for these women. By granting legitimacy to both midwifery and state biomedicine, Yucatec Maya women create productive discourses and practices that demonstrate how local indigenous approaches to childbirth can exist within state health policies.

Chapter 4

Elena: Midwifery at the Margins of the State

Every month we take [to the clinic] the papers that they give us. We count how many people we have every month. How many people have given birth. How many we are giving control (prenatal care). Every month we take our paperwork to the clinic. But it's as if they take our paper work and throw it in the trash. That's what the secretary of health does here at the clinic. That's what they do to us. It doesn't matter to them. They don't care. Because we don't receive any benefit from the clinic. Even now they don't give us any materials. Like kotex, alcohol, iodine, merthiolate. Sometimes, if we need something to tie the baby's umbilical cord we have to ask at the clinic. But in the past, we didn't. In the past, it wasn't like that. Every month they would give us [supplies]. We would go and get training. Always. But this time it's nothing. It's been a while. It's been a year since I was taken to Mexico City.

Elena is an empirically trained Yucatec Maya midwife in her early forties from a rural indigenous community located in the southern interior of the Yucatan peninsula. As a daughter of a well-respected midwife, Elena was exposed to midwifery and maternal health early on in her life. But it was not until she was married and had three children of her own that she decided to work with her mother and learn the trade. Like her mother, Elena expanded her knowledge of birth and women's health by attending classes sponsored by the government. She currently holds an identification card which includes her picture and certifies her as a registered midwife. As Elena referred to above, she has also traveled throughout Mexico as part of public health and public relations campaigns sponsored by the Mexican government to promote the work of indigenous midwives. Her work as a registered midwife requires her to work with local doctors and comply with state bureaucratic procedures such as filling out paperwork. But as she mentions, her relationship with clinic doctors is one-sided and inconsistent. Elena's life and work exists at the margins of the Mexican government's concerns, policies, and resources.

Yet, even at the margins the influence and power of state ideology and policies intimately affect the lives of rural indigenous midwives. It is in the margins of the state where indigenous women's maternal health is reproduced through moments of engagement, contestation, and abandonment.

The Current State of Midwifery

In Mexico today, the practice and profession of midwifery remains in a precarious state. The Mexican government has rhetorically proclaimed its commitment to support indigenous midwives throughout the country with biomedical training, the promise of providing them with medical resources, and starting a process of incorporating midwives into the national health care system. However, this apparent support of midwifery is undermined by two primary issues: 1) the state's continued promotion of biomedicine as the ultimate legitimate form of health care; and 2) midwifery is only tolerated because it can be used as a tool to help achieve state goals, not because it might better serve the interests and needs of women throughout the nation.

Mexico's continued emphasis on biomedicine stems from a long, conflicted drive toward and attachment to the ideal of "modernization." Like many other developed countries, the Mexican state views biomedicine as a representation of modernity, rationality, and participation in a formal system (Davis-Floyd 2001). State maternal health policies in Mexico are driven by the goal of granting every woman with prenatal care from a physician and a hospital birth. In the eyes of state officials, the hospital birth is the ultimate, rational, "modern" way of giving birth that all citizens should aspire to achieve (Smith-Oka 2013b). Yet, the Mexican government's aim for a fully biomedical health care system that reaches all its citizens is far from complete.

The Mexican state itself is an incomplete project (see Das and Poole 2004:7). It is a complex mix of histories, territories, citizens, politicians, policies, programs, and institutions. State health care policies about maternal health care—particularly in the case of midwifery—reveal this incompleteness and highlight the margins of state ideals and power. While the state appears to support midwifery on some

levels, this support is both limited and highly deceptive. State promotion of midwifery is largely a matter of finding solutions that can help improve maternal mortality rates in the eyes of international observers. It's about getting the numbers right (Hacking 1990). Midwifery is appealing to state policymakers because it costs less and serves many of the remote populations that exist on the geographic, cultural, and political edges of the nation. Mexican policymakers and politicians aren't rallying around midwifery because they believe it is an important, valuable form of maternal health care. Instead, they are co-opting the knowledge, experiences, and practices of midwives to achieve larger state goals.

Because of these issues, and despite state rhetoric, the practice of midwifery remains on the margins of the Mexican state. State officials continue to laud biomedical approaches over all other forms of healthcare. Today 93 percent of births in Mexico take place in hospital settings, whereas in 1974 the number was 74 percent (Walker et al. 2013). This effectively pushes midwives to the margins of state health care practices and policy goals—whether they work in distant, rural pueblos or within the biomedical system itself. These margins are not just peripheral spaces that persist along the geographic edges of the state itself. Instead, as Das and Poole argue, these margins “run through the political body of the state” (2004:19). The state's margins are places “where state law and order continually have to be reestablished” (Asad rephrasing Das 2004:279). Such displays of state power and authority take place at multiple levels, in various forms—from the state workers who deliver cash incentives to rural pueblos to the intimate hierarchies that persist within state hospital maternity wards.

Becoming a Midwife

Elena was not her mother's first choice as an apprentice. Her mother, Doña Carmen, one of the oldest and most respected midwives in the community, had decided that her successor would be Olivia, her second daughter. According to Doña Carmen, Olivia needed the work more than anyone else—she was a single mother raising two young daughters and living in Doña Carmen's home. But as fate would have it, Olivia kindly rejected her mother's offer, citing her fear and discomfort

seeing women in pain. Although she respected her mother and her work, Olivia knew midwifery was not the right profession for her. Doña Carmen then moved on to her next daughter in line—Elena, who at the time was in her early thirties, married, and raising three young children. When Elena was asked by her mother if she would be interested in becoming a midwife, she said sure she would like to learn.

“Ok”, said Doña Carmen, “if you want to do this then you and your husband have to come over to talk about this, because he has to respect the work and can’t get jealous”. Elena then went home and talked with her husband, Alonso, about her desire to work with her mother and become a midwife. They talked about the commitments and sacrifices involved with the profession. He would have to understand that working as a midwife would require a lot of Elena’s time and occasionally she would have to travel to other people’s home at all hours of the day. When the couple did finally come to the home of Elena’s parents, Doña Carmen looked directly at Alonso and said, “if she is going to do this then you have to be ok with it”. Alonso agreed and consented to Elena becoming a midwife. And there began Elena’s official training as a midwife. Elena would often go in the late afternoons and visit with her mother. They would sit and talk about midwifery and all the things that could happen during pregnancy and delivery—but they primarily talked about Doña Carmen’s experiences. Elena worked as her mother’s apprentice for more than six years, accompanying her mother and assisting her during many deliveries.

In 2007 Doña Carmen suffered a stroke and never fully recovered. She died the following year. When she passed, Elena tried to start her career but many women would not go to her—they said she was a young person who didn’t have enough experience. She had a rough time at the beginning. Yet, regardless of the difficulty, Elena continued to take training courses offered by the government and she opened her door to anyone willing to seek care from her. Eventually, slowly, little by little, people started coming around. At first the only work she had was giving *sobadas* (traditional healing messages) to pregnant and postpartum women, but eventually women in the community started hiring her to attend their births.

More than fifteen years after deciding to become a midwife, Elena is constantly busy attending births and massaging women. Many women in the community say that Elena works just like her mother—and she is now a well-known midwife. Although there are two older and more established midwives living nearby, Elena's practice and reputation continues to grow. When possible, it is Elena who tries to foster close working relationships with local doctors. She acknowledges that doctors treat her differently than the other midwives because she has a strong command of Spanish. She can effectively communicate with state health care practitioners and policy workers. Elena also pointed out that her ability to speak and understand Spanish allows her to defend herself against attacks or false accusations by state health care professionals. Elena's willingness to work with state officials and her ability to communicate in Spanish are primary factors explaining why, on several occasions, she has been chosen over the other midwives in her community to participate in state sponsored national and regional events that promote the work of indigenous midwives.

Living and working in the periphery

Fridays, they [clinic staff] are all gone. Friday, Saturday, Sunday. Monday afternoon they reopen the clinic. What are you going to do? Emergencies? Sometimes you have a patient that needs help on Friday. Normally Friday, Saturday, Sunday, women are giving birth. Where are the doctors? There's no doctor, not even a nurse... So, people come to me for any kind of emergency.

Elena is from Sabán, a rural community in the southern interior of the Yucatan peninsula. Here vital economic, political, and health resources are extremely limited. Although the community has had a government clinic for more than thirty years, the actual staffing and maintenance of the clinic have been highly inconsistent. In many ways, midwives are the only dependable and available health care providers in the community. There is often a large social and practical gap between community members and the clinic staff. Midwives have been there to fill this gap—long before the clinic ever arrived. Their role(s) in the community are

deeply ingrained. As Elena points out, midwives look after the maternal health of the community *and* often function as emergency medical technicians. They have strong connections with community residents, and an empathetic understanding of the shortcomings and limitations of local biomedical practices. This is something that the state and biomedical community have known for decades and that is why historically the federal government has provided some training and materials to rural midwives. Although the Mexican state does not see a place for empirical indigenous rural midwives in its plans of modernization, it has been forced out of necessity to let them exist and continue their work because the state has still not invested enough in the marginal places where rural, poor, and indigenous people live.

Elena is very critical of the health care resources that are available in the community. She is especially critical of the care women receive when giving birth in the nearby state hospitals. She has had many encounters with these local hospitals, and expresses a clear preference for the staff of one, which is in the nearby pueblo of Felipe Carrillo Puerto [which Elena refers to as either “Carrillo Puerto” or simply “Carrillo”].

The doctors there [public hospital in Morelos] are practicantes (practicing doctors). There are some who understand and there are some who don't. Those, that understand, know to wait for the cervix to fully dilate. Because the dilation process takes time. It's not always how you think. Some people take a while... The doctors in Carrillo Puerto are not like the pasantes in Morelos. I usually take my patients to Carrillo. If there are problems, I take the woman. And they [Carrillo hospital doctors] say yes, the baby will be born. They say this even if she [birthing mother] is not fully dilated. They come back later and tell me the baby was born. [The doctors at Carrillo Puerto] know how to wait and deliver a baby.

Even though Elena prefers the hospital at Felipe Carrillo Puerto, she is still critical of the high rate of cesarean sections performed by its staff. This critique of high cesarean rates is not unfounded. The national rate of cesarean sections has drastically increased in Mexico over the last three decades. In 1987, Mexico had a national cesarean rate of 12.4% that quickly climbed to 45.2% by 2012 (Betran et. al

2016). This is an alarming increase that significantly exceeds the World Health Organization's (WHO) recommendation which states that "there is no justification for any region to have cesarean section rates higher than 10-15%" (Gibbons et al. 2010). WHO has stood by this recommendation since first addressing the issue of safe cesarean rates in 1984. According to WHO, extended research has continued to support this recommendation. Mexico's national cesarean section rate, which is 3-4 times higher than the WHO recommendation, reflects a systemic problem with the Mexican health system that goes beyond rural and indigenous communities like Sabán and Huay Max. Cesarean rates are also high in public and private hospitals in urban areas throughout Mexico. The point is that a high cesarean rate is not only a problem specifically encountered by rural communities, but what is interesting is that communities like Sabán and Huay Max who value traditional approaches to childbirth and the work of midwives might actually have more options to prevent a cesarean section than women in urban areas who no longer have access to midwives.

Elena and the majority of women I spoke with in Sabán and Huay Max stated that all the nearby state hospitals had high rates of cesarean sections. Elena and women in the community did not know the actual percentages of cesarean sections that took place in local state hospitals or nationally, instead they used rumor and the empirical evidence of knowing of a family member or neighbor who had received a cesarean section at a state hospital. Rumors of high rates of cesarean sections at state hospitals were a way in which women warned and protected each other from invasive biomedical procedures. Interestingly, as stated in the paragraph above, these rumors of high cesarean sections were not unwarranted and proved to be true. Elena explicitly advises her patients about the challenges they might face seeking care from local hospitals that have high cesarean rates—and often warns them against being overly passive while in hospital care.

I tell women that if they do not want an operation [cesarean section], then they must do their part. I tell women that if they don't want another operation then they must tell the doctor, "no doctor, I want to see my baby be born". They need to talk with the doctor. That is how one of my sister-in-laws talked to her doctor and she didn't

have a cesarean section. They had also told her that she had not fully dilated and therefore needed a cesarean section. But her baby was born well [vaginally]. Doctors work more with cesarean sections because they get paid more. If it's a normal birth [vaginal], then they are not going to get paid much. That's how they do it.

That's why when they ask us [midwives] questions like "why didn't you send your patients to the doctors". And we tell them they don't want to go because they don't want doctors to operate on them. Even if they don't need to be operated on, once they get to the hospital they operate on them. That's why patients don't want to go there to the hospital in Morelos and sometimes at Carrillo.

Elena pushes her patients and other women in the community to be strong—to stand up for their preferences and rights regardless of the fear or insecurity they might feel when confronted by state biomedical practitioners. She encourages them to take an active, assertive role to avoid cesarean sections. She tells them they must stand up to the doctors and speak their minds. She tells women that it is their right to be treated with respect and be given the appropriate care they need. Elena pushes women to *protect themselves* from the possibility of abuse by hospital doctors. Elena's goal is to empower her patients so that they can defend themselves from a state health institution that values biomedical convenience and invasive procedures. Yet, Elena also acts as her patients advocate and defends local women's actions and choices to doctors and health policy makers who criticize local women's resistance to embracing an approach to childbirth that exclusively takes place in a hospital setting. The position Elena takes on this issue must be understood within the wider cultural and historical context. When women talk about biomedical births and C-sections, they often talk in terms of abuse and violence. Through interactions with her patients and local doctors, Elena is directly challenging the authoritative biomedical practices that have created these realities. She has moved beyond her role as a health provider and become a culturally informed political activist defending her patients, her community, and her cultural traditions and knowledge.

Elena has worked with doctors for years. She has developed good working relationships with some doctors, but not with all of them. But this hasn't been a matter of choice; some doctors do not respect the kind of work she does, and this

makes it difficult—if not impossible—to forge good working relationships.

Throughout her life, Elena has understood biomedicine as a positive and important social safety net that helps people in their daily lives. In many ways, she continues to view biomedicine in this way, but she also sees it as a very specialized kind of health care that becomes most necessary when serious problems arise that traditional practices cannot address.

At the same time, Elena also recounts situations in which she was able to correctly diagnose problems that biomedical doctors either could not identify or had misdiagnosed. She has often been able to help women that state doctors were either unable or unwilling to work with. This is why, she says, doctors and professional midwifery students seek her out and want to learn from her. Those who Elena says she has taught include one of the young resident intern doctors who lived and worked in the community during 2011. Elena speaks very highly of this doctor by saying that she was a hard worker and she cared about the community. She was also very knowledgeable but she was young and did not have much experience delivering babies. That is why she would often spend time with Elena and talk with her about maternal health and childbirth. Elena also worked with young female midwifery students who came to her home to interview her and participate in a short internship. These midwifery students came from one of the professional midwifery school in Guerrero—one of two of the state sponsored professional midwifery training programs in Mexico.

Doing this kind of work is not easy. It is hard living and working on the periphery. There are little to no economic resources in her community. And there is also very little social and political support. Elena, like many others who live in this part of Mexico, lives a highly marginalized life. Elena and her family cannot live off the earnings from her work as a midwife. The primary breadwinner is her husband, Alonso, who supports his family by cultivating honey bees and managing his milpa. No one in the household has a sturdy dependable source of income. With two daughters in college and their young son in middle school, money is tight. Elena and her husband are always working and searching for ways to make money. If funds are available, about twice a month Elena and Alonso will buy a large pig, butcher it,

sell pieces of the uncooked meat, and then fry the rest and sell it outside their house. There is usually enough meat left over to feed the family and invite over extended family members. Elena told me she could never sit still. She had to always be doing something, anything, to make money. That is what her mom taught her. Along with her primary work as a midwife, Elena cuts hair, styles women's hair for special occasions, does embroidery, and works at the family store.

For over ten years the family has run a small store built into the front of their house. It is, more or less, like a small convenience store that carries a modest selection of food staples, cold drinks, snacks, household goods, over the counter medicines, and toiletries. The store is stocked depending on the available funds the family has. This is difficult for Elena because she would like to carry more medical and reproductive health items that people in the community need access to. For example, Elena use to sell home pregnancy tests in her store but recently had to stop because she could not afford to invest in the product if it was not going to sell quickly.

In an interview with Elena's oldest daughter Raquel, she mentioned that after completing her degree and once she found secure employment as a teacher, Raquel would like to save her money and help her mother open a small pharmacy. Raquel was in her last year of college studying to be a school teacher. She admired her mother greatly and the work she did in the community to help women, but Raquel was open about not wanting to follow her mother's trade. She explained she would feel uncomfortable and insecure being in charge of helping women during such a vulnerable time such as childbirth. Her younger sister, Alejandra, was more open and involved in Elena's midwifery practice and it was the hope of the family that she would study public health in college. To the initial dismay of her parents, Alejandra chose to suspend her college education to start a family. Recently, Alejandra expressed the desire to return to school once her young daughter reaches school age. Although Raquel did not want to be a midwife, in her own way she wanted to participate in her family's generational work in supporting women in the community and providing them with much needed health resources. Dealing with the marginalized reality of their local community is a multi-generational effort.

Limitations of Biomedicine

Elena tells the story of one of her patients, who had a difficult pregnancy and after consulting with Elena she chose to seek care from a private doctor out of town. The patient had originally come to Elena for a prenatal massage. During the massage Elena noticed that the baby was transverse—in a seated position. Elena would have to carefully massage the baby back into the correct position—head down, resting on the bottom of the uterus. Elena told her patient that it would probably take a few times to correctly position the baby and it might hurt a little since the patient had not come for early prenatal massages. Elena then asked her, *what do you want to do? Do you want me to fix the baby, or are you going to the doctor?* The woman responded by saying that she knew of a good doctor out of town that she trusted. She told Elena that if something was wrong with her baby, the doctor would be able to fix him and align him. Elena respectfully said, *ok, that's fine*. And she escorted the woman out. The woman returned to Elena's home during her second pregnancy. She recounted her experience with doctors and told Elena that she would never return to them for care. She told Elena, "Although you moved my baby, it didn't hurt much. But what the doctors did to me, hurt a lot." Elena shared with me the woman's experience through the woman's point of view.

There is a private female doctor that works with women who have difficult pregnancies. She [the doctor] tries to move the baby using only machines. It's true. The woman [Elena's patient] told me that the doctor checked her dilation and then she started pushing the baby, but with a little rod. She inserted the rod and she watched it on the television. But, it hurt the woman a lot. She said, "My God, no". She told me, "I went with the doctors and I saw how they attended me. There are doctors who are really good people and there are others who are not." And she said, "No, it is better that I deliver with a midwife because they don't mistreat you like how doctors have mistreated us."

Women in the community feel that midwives often provide better care—and are more respectful—than biomedical practitioners. Midwives play a critical role in providing an alternative to biomedical practices—and knowledge. The state promotes its doctors as experts who have superior training, experience, and

knowledge. But, as some local women openly admit, doctors are not always right. Sometimes they get things wrong; there are limits to their knowledge. And this is where midwives step in. Elena tells the story of one of her former patients to illustrate a moment in which she had to intervene when a local doctor had misdiagnosed a patient. The woman came to Elena and said she was experiencing strong abdominal pains. This woman had been seeking care from her local clinic physician but wanted a second opinion from Elena.

She didn't know that she was pregnant. But I told her from the first day she came here to my house that she was seven months pregnant. I told her you know what, you are pregnant. And she said that wasn't true. I told her yes you are pregnant. She said she had not felt her baby move. She had gained weight. You could kind of see her little belly stick out. But it's like I tell you, there are people who are pregnant and don't know. They feel bad so they go to the doctor.

She went and saw the doctor at the clinic in Sacalaca. And they told her that maybe she had a malignant cyst. But I told her it's not a malignant cyst. I also know what those look like because one of my sisters had that problem. That is why I am telling her. I have detected in various people that problem which she mentioned [malignant cyst]. It's not that, I told her. You have a normal pregnancy. I told her if you do not trust me then go to the doctor so that they can give you an ultrasound. So that there is no problem. She said ok that's fine and she left.

When she came back she said yes, I am pregnant. She came back three times for me to massage her... After I told the woman, that first time I met her, that she was pregnant, the baby started to move. She just couldn't feel it and she didn't show. It was only until I massaged her and moved the baby up. But I told her the bad thing is, as you can now feel, is that your baby was crowded to one side, right here. That's why she falsely thought it was an infection. Women can have infections, but that is a separate issue. The infection would be below. [Elena demonstrates where by pointing down her abdomen above the pubic bone and to the side, just before her hip bone]. If it is in this place, then it is a cyst. You can have a cyst here in the uterus or in the ovaries. In those places, you can have a cyst. I have seen this a lot. I have detected this problem in a lot of people.

Useless Aid

They give us these bultos (duffle bags) but they are exaggerated. What am I going to do with a bag this huge? No. They brought me a gigantic thing to supposedly weigh the baby. But its huge. How am I going to carry all of these things when I need to go work? No. And they also brought me this thing for me to put the baby in. But I would have to open its little legs to put it inside. I would be weighing the baby with its legs wide open and spread apart. They sent us things like this. How can doctors think that I am going to put a baby inside something like that?

When I asked Elena if she had received any supplies from the clinic or any other government entity she said no, not really. She then began to tell me that for the most part the clinic and the programs sponsored by the state health department rarely gave midwives like her supplies. Although she and the other midwives would often ask the clinic staff and the health officials they encountered through their midwifery registration and biomedical course trainings for more medical supplies (alcohol, metal clamps, gloves, iodine, aspirators, acetaminophen), their request fell on deaf ears. Elena recalled receiving a pair of scissors three or four years back, but she said that was the only equipment she received. She did eventually mention that the clinic did regularly supply the midwives with sterilized string to tie the umbilical cord and they would occasionally give them some small supplies like gloves or alcohol. Knowing that she cannot count on the Mexican government for help, Elena buys all her supplies. She said it was better that way. So that she could ensure she would always have what she needed.

After talking about her supplies, I asked Elena if she could show me her midwifery tool kit—the bag she takes when she attends births. We sat in her newly built thatched roof kitchen, around a large wooden table. Elena walking inside her house and came out carrying a few bags. She set them all on the table. She started out by showing me a large black duffle bag. It was big. It had to be at least 2 feet in length, a foot in height, and another foot in width. Elena said that she had received this from the government a couple years ago. Inside the bag was a box that contained a large heavy scale that was to be used to weigh the baby. The sling she was given was clearly for a larger child not a newborn. It was also big and as Elena

said earlier it contained leg holes that required the child to be sitting in the sling with its legs spread apart. After showing me the bag Elena laughed about how ridiculous it all was. Holding up the large metal scale she jokingly said that maybe she could use it to exercise. It was the only use she could think of at the moment. The large duffle bag and its contents were neatly stored away at the bottom of a dark closet. Elena explained to me that the materials she received from the state were put away out of reach because they had no use for her. Clearly in Elena's case, bigger was not always better. Although, Elena had indeed received some health materials from the government a couple years before we had our interview, she chose to not consider them as aid. They were useless and had no value in her daily work life. For Elena, federal support and assistance did not count if what she was given did not benefit her or her patients. In this act, she set her own terms as to what would and should be labeled as aid.

After putting the large duffle bag away, Elena showed me the bag she takes with her when attending women. It was a small black bag measuring 12 inches in length, 6 inches in height, and 6 inches in width. It was a kit that was given to her mother by the Mexican government many years ago in Carrillo Puerto after she attended a health training course. When Doña Carmen, Elena's mother, retired she gave the small kit to her daughter. Over the years Elena has added a few things to the kit, but overall the main tools she uses are those given to her by her mother. Elena then takes out a small scale from the bag. It is much smaller than the one Elena had just shown me. It was a 6-inch plastic pull scale with a maximum weight of 20 or 25 pounds. It has a cloth sling where she set the newborn baby down and would gather the ends and clip them to the hook at the bottom of the scale. It was smaller, simpler, and more practical. Elena then showed me all the things she carried in her small bag. She had the small scale, measuring tape used to measure the length of the newborn and the diameter of the head, sterilized string to tie the umbilical cord, a small pack of acetaminophen given to women after birth to help ease the pain, a scrub brush to wash her hands and fingernails, gloves, two different types of nasal and mouth aspirators, and a pink plastic pencil box that contained clean stainless-steel scissors and clamps (some were in plastic bags) and a syringe.

The large duffle bag and its contents was a recent attempt by the Mexican government to provide rural midwives with a tool kit they could use in their practice. The government aid was distributed to midwives without any feedback from them. As a result, the supplies Elena was given were so big and impractical that they were ultimately useless. Elena repeated various times how large and heavy the bag was and that it was too big to carry around. Unlike their midwifery counterparts across the country, such as in Chiapas and Guerrero, most indigenous rural midwives in Yucatan work near a government clinic. What this means is that they focus the majority of their work around prenatal care, childbirth, and the immediate postpartum period. Yucatec Maya midwives provide culturally appropriate childbirth options for women as well as filling a gap in the underfunded and inadequate public health care system. The only time they need to weigh a child is at birth so the midwife can record the weight for the government registry. After birth, children are typically monitored by physicians at the local clinic. This is in a large part because of the Oportunidades mandate that requires women to take their child to regular doctor's visits after birth. Yucatec Maya midwives do diagnose and treat children in the community for various other health issues but do not use the instruments that were provided to Elena, such as the large children's scale. The aid Elena and the other midwives received was not in itself useless, many other rural midwives working throughout Mexico might have greatly benefited from them, but instead the aid given to these Yucatec Maya midwives was inappropriate and ultimately had little use for them.

Interestingly, the Mexican government did get its aid packages right over a decade ago when they provided Doña Carmen and other neighboring midwives with practical and well received midwifery kits. In the case of Doña Carmen, the kit was considered so valuable that it was passed down from one generation to the next. In 2008, during one of our many interviews, Doña Refugio (an older and more established midwife from Huay Max) showed me her medical bag which was identical to the kit Elena shared with me more than five years later. It was something Doña Refugio highly valued and kept in a specific place in her house. With pride, she showed me the contents of her kit and even modeled the bright

white UNICEF apron that was included. It was such a marker of prestige that Doña Refugio decided to preserve it by not using it. For her, the kit represented acceptance by the Mexican government and international organizations through their gesture of supplying rural indigenous midwives like herself with the medical tools they needed to perform their work as health care providers. That famous kit was sponsored by UNICEF, Salud Reproductiva, and the Secretaria de Salud Publico (Secretary of Public Health). The now little old black bag and tool kit that both Elena and Doña Refugio showed me is still immensely valuable and useful today, clearly pointing out that not all aid is useless, especially when the lives and practices of its recipients are carefully considered.

Entanglements with the state

Rural Yucatec Maya women continuously struggle with a lack of communication and/or miscommunication about state health program enrollment processes and requirements. But there is a clear understanding by these women that all state programs are political and their participation in various health programs cements a relationship between rural indigenous women and the state. This relationship is often contentious and rural Yucatec Maya women fight to negotiate aid distribution on their terms. Women from the community frequently talk about their rights as citizens and what is owed to them by the state. Elena was enrolled in Oportunidades while her children were young and attending school. She talked to me about Oportunidades and the politics of aid.

We take advantage of the program Oportunidades because we have children in school. We go to the talks. They [program officials] make us go to the talks. Before they use to make us clean up the clinic. But they don't anymore. It's been five years. We had to protest. All the people united and came to the clinic to protest. We said what purpose do salaried workers at the clinic have. We do more of the work and they are taking advantage of our labor. We had to fight, and fight, and fight. And that is how they left us alone. Of course, we can attend the talks at the clinic every month.

That is how we take advantage of the opportunity that the government gives us. But only if you qualify and have children. Right now, they are doing an

investigation and they are saying, if you have been in the program for seven, eight, nine years, they are going to take away your Oportunidades stipend. They say because you have a little, they are going to take your aid away. But many people say, yes, the government gave me aid. And I might have a little bit of money, but what I have is from my own sweat. What the government gives me is only a piece of what we need to live.

What they give us every two months is only a tiny bit. We as Mexicans, they say, that we have more money here in Mexico, but where is the money? The government takes it all. They misspend it all. And in the meantime, the poor, campesinos, what? Nothing. All the time we are voting. Giving our support and voting. We are voting, we are voting, supporting them [politicians] as they move up. And we get not one benefit... What does the government do for us? It marginalizes us all the time.

...Us who are midwives, they always tell us like that, one day if you take a patient to the clinic they are going to give you a stipend. But it never happened. They always tell us these things but they never happen. We don't know if the secretary of health at the clinic, if they take it, or if we are supposed to sign some papers.

Elena has never received aid from any of the government programs that promise to pay midwives for attending births. She has attended all the required training courses and complied with all the requirements for being a registered midwife, and yet she receives little to no support for her work. As Elena explained, promises for support are always given by the government but it never comes through. Information on how to receive federal aid as a rural midwife is confusing, scarce and often nonexistent. Elena's practice and the health of rural Yucatec Maya women would tremendously benefit from federal programs that pay midwives to attend women and programs that provide them with the training and materials they need. Yes, Elena is already doing her work, caring for women in her community, but she gains very little financial profit. At times working as a rural midwife is unsustainable. Elena struggles to buy all the supplies she needs to provide her patients with the care they deserve. She does the best she can with the little she has. Even with those limitations, Elena along with the two other midwives (Doña Fernanda and Doña Refugio) in the community are the most dependable and available health care providers in the area.

Conclusion

Kaufert and O'Neil (1993) explore how discourses of risk are employed by Canadian health officials and state health workers to legitimize their claims that rural Inuit women need to give birth in an urban hospital setting. The practice of transporting rural Inuit women right before delivery to urban hospitals began in the 1970s with the upgrade of aircraft and landing strips throughout Canada. These peripheral communities were soon viewed as feasibly accessible by emergency and medical staff. By the 1980s it was decided by state administrators that births in rural Inuit communities were no longer acceptable. This was primarily because they lacked knowledgeable staff and advanced technological equipment necessary for a safe delivery. All rural women would now have to give birth in a hospital. The perceived harsh ecology of northern Canada and the inability to control it were a driving force behind state policies that moved childbirth outside of rural Inuit communities and into urban centers.

As Kaufert and O'Neil explain, decisions pertaining to the practice of prenatal transport of northern Inuit women were heavily influenced by the international indicators of community well-being, including infant and perinatal mortality rates. Canadian officials explained that their intervention in childbirth practices in northern Inuit communities by stating that they wanted to lower the gap between mortality rates in the north and southern parts of the country. Kaufert and O'Neil demonstrate how states use the discourse of equality and safety as a technique to legitimize and naturalize their interventions in the reproduction of women living at the margins of the state. They also discuss how metrics are used as an indicator for intervention by demonstrating how statistical health data (such as maternal and infant mortality rates) is presented and manipulated to reach larger state goals.

Although Kaufert and O'Neil discuss the hegemonic power of state discourses of risk associated with giving birth in a rural community, they also explore the ways in which Inuit women challenged these discourses to fight for some level of autonomy. Resistance came in different forms, but most women responded by challenging state discourses of risk through specific language use and ideologies that framed childbirth as a natural event in a woman's life course. For these women,

a certain level of risk was accepted as part of the reality of living in northern Canada. Pregnancy and childbirth were a social part of human life that Inuit women had experienced for generations. For them, childbirth was not a disease that needed biomedical intervention and must take place in a hospital. Northern Inuit women and community elders fought to reclaim the right to give birth in their rural communities by voicing their disagreements with state health officials and in some cases refusing to leave their remote communities and give birth in a state hospital. This political stance was not only important for childbirth, but it also affirmed their autonomy as an indigenous group with legitimate traditions, cultural practices, and ideologies.

In the end, Kaufert and O'Neil argue that state approaches to childbirth among northern Inuit women must be framed through an analysis that views the "medical control over birth" as an equal "expression of the power relationships of an internal colonialism" (1993:50). What this means is that populations, such as rural Inuit women, have been deemed by the state to exist outside of their direct reach and must therefore be included into larger formal systems (health, political, economic) so that they can be easily monitored and controlled. Moving birth outside of the authority of tribal elders and local women reinforces a dependence on the state and dismisses all other health and knowledge systems.

In rural Yucatan, midwives such as Elena, are fighting just as Inuit women in northern Canada, for the state to acknowledge that indigenous communities have developed specific cultural knowledge and practices that have for generations met the needs of birthing women, Elena not only comes from a lineage of midwives and health care providers but she is also deeply rooted in her community—she understands the practices and ideologies of the people she works with and has experienced with them the effects of historical neglect by the Mexican government. Therefore, health care practitioners and community-based activists, like Elena, are vital for the survival of indigenous people and their culture.

Women in Sabán and Huay Max have supported their local midwives by openly speaking out to medical staff at the local government clinic and with health officials about their preference to give birth at home with a midwife. They state that

if they consider themselves healthy and have not experienced any complications during their pregnancy then they should be able to labor and deliver at home. Informally, women have also used rumors about the impatience of doctors at state hospitals and how their unwillingness to allow women to naturally labor has resulted in high rates of cesarean sections. These rumors have, in many ways, created within the community fear of mistreatment and a lack of trust in state hospital practitioners. In return, these rumors have also legitimized the importance and necessity for midwifery to continue in Sabán and Huay Max.

Yet, as Lydia Zacher Dixon (2015) documents, indigenous midwives are not the only types of midwives working in Mexico. She explains how professional midwives (women who have gone through a 3-year state sponsored educational program focused on biomedical training that is complemented with traditional midwifery skills) are being incorporated into some public hospitals and clinics as to lower maternal mortality rates in Mexico and possibly encourage indigenous and poor women to seek care from the state health care system. She explains that this strategy of placing professional midwives came as a compromise to mounting international pressure to lower maternal mortality rates and address international concerns of an overmedicalized approach to birth. Professional midwives, have come to be seen by the Mexican state as tolerable because they have received extensive biomedical training and certification, they are less expensive than other professional biomedical practitioners, and when placed in the state health care system (hospitals and clinics) they work under the supervision of physicians and nurses. As integrated biomedically trained state health practitioners, professional midwives have now become the future of midwifery care in Mexico. But as Dixon documents, this transition to a biomedicalization of midwifery and maternal health care is not without criticism, especially from professional midwives themselves.

According to contemporary state health policies and practices, Elena is not the right kind of midwife. The Mexican state hopes to phase her out one day and maybe replace her with a professional midwife—someone who has gone through the state backed biomedical training and certification and who is deeply embedded in the hierarchy of the health field. Someone who is controllable and when placed in

the state health care system is subordinate to biomedical practitioners, such as doctors and nurses who predominately follow state ideals about the legitimacy and superiority of biomedicine above all other forms of health care. Elena is none of these things. And because of this, she is considered a risk by the Mexican state, but one that cannot yet be eliminated. So, for now, Elena is neglected the majority of the time and only given just enough support until the Mexican state can finally achieve its goal of having a “modern” health care system where childbirth takes place in a biomedical setting attended by a biomedically trained professional.

Elena clearly understands the politics of the maternal health care system that she works in. She argues that her race, gender, economic status, and where she lives, place her at the margins of state health discourses and policies. As an indigenous woman working as a midwife in a remote community, Elena has sparingly received support and aid by the Mexican government. Investment and intervention by the state in the lives of rural Yucatec Maya midwives seems to exist in a push and pull dynamic. There are times when the government has provided midwives with the resources they need to effectively attend the women in their communities, and then there are long periods of time where the state has completely abandoned them. Other examples of push and pull include, officially registering midwives with the government and publicly announcing that these midwives have a right to work in their communities, verses other moments when midwives are condemned by local doctors and publicly told their work is dangerous and antiquated. What Elena’s story shows is that although she may exist at the margins of the Mexican state, her everyday life and work is entangled with the state in a profoundly personal way that is deeply rooted in a contentious history of indigenous cultural survival.

Chapter 5

Valentina: Managing Contradictions in Oportunidades

Fieldnotes: Sunday, August 25, 2014

Another hot day and the streets are quiet and still—everyone is inside or under the shade escaping the intense midday heat. After an endless summer of hot and humid days, August comes along and I start thinking we might get some relief. But I am so wrong, it seems like August is the hottest month of all. Frequent power outages make it all the more unbearable. If only it would rain to help cool things off, just a little, at least for an hour or two. It rained yesterday afternoon, so maybe we'll get lucky.

It was later in the afternoon, around four, during that quiet time, a couple hours after everyone has had their comida (main meal), that I noticed a few women standing outside the rock wall of our housing compound. They stood waiting. Waiting for the official invitation to come in. Slowly more and more women gathered and I soon saw Valentina come out the back door of the house. She was carrying some white plastic chairs. She saw the women and told them they could come and sit. Cristian and Olivia helped bring out some more chairs. Soon the open dirt space between the houses was filled with women and an elderly man. There were about 24 people in total. The women were all dressed nicely. They had all washed and changed after a full day working in the heat completing their daily household chores and cooking. The older women wore their loose white huipils that were beautifully hand embroidered with bright colorful flowers. The younger women wore short sleeve tops with mid-length skirts that hugged their legs. Everyone wore sandals.

There weren't enough chairs for everyone. In compliance with local social practices of deference, the younger women chose to stand or lean against something firm—the rock wall, a large tree, the side of the house. The chairs were left available to be occupied by the elderly and occasionally a

very pregnant woman. There was a constant low chatter as we waited—escaping the afternoon heat under the shade of a twenty-five-foot tree whose branches stretched out like an open umbrella. Valentina stood on the back bumper of her husband’s small, red, fifteen-year-old sedan. After a general greeting she began the meeting in Spanish.

With a notebook in hand, Valentina listed some of the upcoming Oportunidades program events for the month of September—the monthly meeting at the clinic, the distribution of the cash stipend, and the mandatory doctor visits that certain participants would need to attend. She then explained that the program officials have decided to replace all the *vocales* (community leaders for the Oportunidades program). They said there needs to be a new rotation of leaders and they want to give other women in the community a chance to participate. Women will be nominated and voted into the position. Valentina asked if anyone was interested in becoming a vocal. No one spoke up. A few women said that she should keep doing it. Valentina said she couldn’t because the officials wanted new vocales. The women said no. They wanted her to continue.

After discussing Oportunidades procedures and requirements, Valentina moved on to talk about human rights. This is when the meeting became interesting and dynamic. With her hands free, Valentina spoke confidently and with authority about the inherent rights of freedom and choice that every citizen had. She said, “no one can force you to do anything”. A woman standing along the wall in a low voice jokingly asked, then why was the program forcing them to attend classes and go to school. Everyone laughed. Valentina was not upset by the disruption. In a way, it seemed as if she understood why the woman would make that comment. In a direct but friendly manner Tina shared her thoughts, “the way I see it, the program is good for women”. She explained that Oportunidades provided many resources including adult education. She said it is important for people to know how to read and write. Regardless of age, everyone should at least be taught how to write their name. It doesn’t matter if the letters aren’t pretty.

You just need to be able to sign your name so that you could defend yourself. So that they could protect themselves from fraud—someone falsely collecting their financial aid or voting in their name. She told them that if INEA comes she will attend the adult education program. She left school at an early age and she would like to go back and learn more. Many of the women were surprised to hear that Valentina hadn't finished school. They were impressed by the ease in which she spoke Spanish. They all knew that she could read and write. These were clear signs of someone who had at least finished secondary school. She had achieved, in their opinion, the primary reason someone in her generation would need to go to school. And yet, they found it interesting that Valentina wanted to go back to school.

Valentina then moved on to the next topic—poverty. She asked the women “Do you think you live in extreme poverty? Do you think you are extremely poor”? Looking around the crowd, it looked as if the women disagreed with the statement. Some laughed, others shook their heads, and the majority softly said no. After a long pause, Valentina told the participants that she didn't think she was really poor. She said, thankfully her family could get by because of the help she received from Oportunidades. But, she quickly followed by saying the money wasn't enough. It was always used up to pay for basic necessities. There was no extra money left over. They weren't extremely poor but they still struggled.

The meeting was ended with an official roll call. Valentina individually called out each participant's name. After they had responded by saying present, Valentina would write a check next to their name. Once all the names were read, the meeting was officially over. Slowly, the women gathered their things and walked out, returning to their homes to continue with their domestic obligations. Some women stayed behind to help stack the chairs and put them away.

Once everyone left, Valentina asked me what I thought. I told her I was really impressed by her leadership and how she talked to the women. She was patient and she took the time to explain things to them so that they could

better understand. She was open and inviting and she always provided a space for the women to ask questions. I said I was proud of her. I was proud of my friend. She was a good teacher. She replied by saying that she always wanted to be a teacher. If she would have been able to finish school, she would have wanted to be a teacher.

On that hot August day, I sat and watched Valentina give a semi-informal meeting at her home to the 25 Oportunidades recipients that she oversees. As an elected *vocal* (volunteer community representative) it is her responsibility to receive information from government policy officials pertaining to Oportunidades program requirements and policies and disseminate them to her designated group of recipients. It was an interesting day, were I witnessed one of the many ways in which these rural indigenous women encountered and participated in national health and poverty alleviation programs. The meeting highlighted some of the perceived benefits. Yet, more importantly it demonstrated the tensions that exist between program participants and the requirements placed on them by a national welfare policy full of contradictions and rhetoric.

The meeting helped me see how Oportunidades program information is disseminated to its participants and moves through the community. I saw how women came together to listen and discuss their participation in Oportunidades. The meeting provided many opportunities for women to gather together and talk. Women came and left the meeting talking in pairs or groups. The meeting at Valentina's home provided women the space to see other women who participated in Oportunidades and lived close by. Women sat or stood next to their neighbors at the meeting and talked to each other.

The meeting also provided me a glimpse at how local women are used by Oportunidades to disseminate program information and monitor other Oportunidades participants in the community. During the meeting, I heard Valentina announce all the current program requirements and information including the important dates that women needed to know that month (vaccine campaigns at the local clinic and when and where the cash stipend would be distributed). Watching

the meeting take place, it was clear that the Oportunidades program relied heavily on the free labor of women like Valentina. Valentina, was in effect part of the hierarchy of the state health program. Although she existed at the bottom and last level of Oportunidades, Valentina, through her work as a vocal came to represent the program and the Mexican government in a small but impactful way. Not only was she in charge of relaying program information, but she was also given the power of marking women compliant in fulfilling the program requirement to attend the monthly meeting. In return for her free labor as a vocal, Valentina gained social prestige in her community as a leader and knowledgeable person, and more importantly she was granted by the state government a small amount of power over the economic situation of other women in her community.

More importantly, Valentina does more than just provide culturally compatible interpretations of Oportunidades rules and procedures to program participants. Valentina's work as a vocal ultimately shapes the way Oportunidades is both implemented and experienced in rural indigenous communities. As the last official representative passing down program information, Valentina influences how women in her community use and understand Oportunidades. She does not take this responsibility lightly. Valentina sees herself as an advocate for her community and culture. She brings local understandings and realities into her enforcement of program rules and how she passes down program information. Valentina provides a community-based and medically pluralistic comprehension of Oportunidades that counters the power of biomedical practitioners and state health officials. Valentina is a respected community leader who wields considerable influence, even if that is not officially recognized by state officials. Her work is culturally informed political activism that transforms the Oportunidades program so that it is more pragmatically focused and relevant to marginalized indigenous women like those in Sabán and Huay Max.

In this chapter, the Oportunidades program will be discussed through the life and experiences of Valentina, a young mother, community leader, and program participant. Valentina's story illustrates how women's daily lives are affected by their enrollment in government health and poverty alleviation programs. It helps

explain why and how rural Yucatec Maya women use Oportunidades. What is interesting about Valentina is that she is also a vocal. Her experiences as a community program leader shows how the requirements and rhetoric of federal policies are passed down and digested by marginalized indigenous women living in rural communities at the periphery of the national government. I also address how Valentina, in her capacity as a community elected Oportunidades representative, challenges state ideologies and practices that further marginalize rural indigenous women. This is Valentina's testimonio—her participation in state programs embedded within a larger life filled with love and happiness but also pain and sacrifices. Valentina's words are italicized throughout the chapter.

The chapter will begin with a short biographical sketch of Valentina. Her personality and experiences will slowly develop throughout the chapter. Then in her own words, Valentina will explain what it is like to be a vocal and how she came to acquire the position. The next section will discuss some of the problems and challenges with Oportunidades. Valentina's life history will then follow. Her words will be woven through my retelling of her story. The chapter will end with a short discussion.

Valentina: A biographical sketch

Valentina, who is always referred to as Tina, is thirty-five years old. She has a kind and easy-going personality. There is a certain ease to Valentina. Her openness and inviting nature make you feel comfortable talking with her. She is a good listener and thinks about things before she says them. Yet, Valentina is also a strong woman who voices out her opinions and sometimes disapproval. She is a dedicated and loving mother and a supportive wife. Like most women in the community, Valentina works very hard looking after her family. As soon as she wakes up in the morning she is working—washing clothes, cleaning the house, preparing meals, watching over her children. Valentina is married to Olivia's younger brother Cristian. They have four children between the ages of 16 and 2. All four of her children were born at her in-law's home and were attended by her mother-in-law Doña Carmen and her sister-in-law Elena. Valentina has participated in the

Oportunidades program for twelve years. She, along with her sister-in-law Irene, is an Oportunidades vocal. She has filled this role, as a community program liaison and health educator, for six years.

Valentina was born and raised in Sabán but moved with her family to Chetumal when she was young. She met Cristian as a teenager and they married after her seventeenth birthday. The first years of their marriage they lived in Sabán with her in-laws but soon moved to Chetumal so that Cristian could find paid work. They visited Sabán as often as they could and kept a close relationship with Cristian's family, helping them out and giving a little bit of money whenever they could. After her daughter Cecilia turned one, Valentina found work as a nanny in Mérida. Her new job required that she leave behind her own young children. The children were cared for in Sabán by her sister-in-laws and mother-in-law. Valentina would come and visit every two weeks and spend the weekend with her family. Cristian continued to work in Chetumal but would periodically spend long periods of time in Sabán staying with his family and helping out with his father Hector's milpa. After her mother-in-law passed away, Valentina left her job and moved to Sabán. She found it difficult at first to adjust to not having a paid job and living in a rural pueblo without many economic opportunities. Her only income now is the cash stipend she receives from Oportunidades. Since her return, she and her family have lived with Hector and Olivia. For over a decade they have been working on building a home a block away from Cristian's family. The house is almost finished and they are hoping to move in a year.

Becoming an Oportunidades Representative/Community Leader

A male promotor (program official) from Oportunidades came and said we are going to change the current vocales because some of them have had that position for a while. We need to find new volunteers to fill the role of vocal. The man chose 10 new women. He asked if we would be willing to do the job. He said it was for the good of our community. We all said yes.

So, they put us in front of all the people. In front of all the Oportunidades participants, about three hundred and fifty at the time. And the man said, "do you

want Doña Valentina to stay as vocal”? And they said yes. He did that with the rest of the new vocales. And they said yes. And that is how the committee of vocales was formed. There are thirteen vocales in Sabán and five representatives. There are currently four hundred and seventy-six Oportunidades participants in Sabán.

When it’s time to give platicas (talks), he comes and meets with us first. He presents the topic and helps us better understand the new material. Sometimes we have to copy the information. He writes it down on poster boards and he says we have to write down all the information. When we have a platica given by the man, sometimes it’s an hour, sometimes its two. It’s shorter when it’s a day where he tells us what we need to do and we copy it all down.

When it’s time to give the talk, we have to read all the information. But we have to read it beforehand so that we understand it and can explain it. He said if you only read the information and don’t explain it, they’re not going to understand it. It’s like with the children, you have to explain it a little. It takes an hour to an hour and a half to give a talk. But usually an hour. We quickly read to them and explain the material. Then they can return to their homes. It’s not a lot of time. It takes about thirty minutes to review the material before the platica. It’s fast.

When I give a platica, I have to announce it. I used to go house to house, but that took a lot of time because I am in charge of twenty-five beneficiaries. What I do now is I go and I have them make an announcement at the microphone, the megaphone where they announce meat for sale. Well, they make the announcement and the people come. Once word gets out that I am giving a platica, the people come. Sometimes people will come by and say that they missed the platica because they were sick. And I tell them it’s okay. But if people don’t come then we have to mark them falta (absent). But sometimes they get upset when we put them as absent. But I tell them that they need to get use to coming. They have to come. We [vocales] can’t give the information more than once because we have to take time out of our day to give them the platica. The majority of the time, when I have to give a platica, I try to do it once I have finished doing a certain portion of my work. Then I can just give the talk. Then I can continue with my work, doing what I need to do.

And that's how we started participating as vocales. There was a time when the program overseers wanted to change us, but the people didn't want that. They said "no. Let them stay. They work well, they participate well". And we were able to stay and continue to work. But again, they want to change us. They said the committee will change in January. And the people say, "no. These women will continue as vocales". But I say, maybe no, maybe it's better if others get a chance to work, so that they can see this work is voluntary. There is no pay. It comes with no financial support. No extra money. We receive the same stipend as everyone else.

But I have enjoyed being a vocal. I like to participate. Because when we go to the meetings he [Oportunidades official] explains things to us. Because there are people who won't comply with their obligations if they don't understand the information. For example, for us, we are there and they tell us what we need to do and that we need to comply. But there are other people, who if you don't tell them, they won't listen. And then they cause themselves harm.

Yes. It's like the man said, our participation as vocales is voluntary. You are supporting your community. Because if we are not here, who is going to give the information to the women? The Oportunidades officials can't come and give talks every month, every two months. That's why the position of vocal exists. That's their purpose. Through them participants are able to get the information they need.

When I give platicas, I like giving the information. Because people say that when someone is a vocal they need to be friendly, understanding, you cannot regañar (reprimand) the people. Because sometimes, you know there are some people who are elderly and if you treat them badly, they are going to say, "she is bad". But if you learn to get along with the women, then they will always have, how do you say, an aspect where they say "that woman is good. That woman is not bad". But if I reprimand them, all they are going to say is that I am bad.

It's difficult sometimes, when there are topics you don't fully understand. Sometimes you ask, "how are you going to explain it". Yes. For example, over here they teach us about what is the "contraloria social" (public spending watchdog). Sometimes, the people say "what is that? Who forms that"? The man [Oportunidades official] says the public spending overseer is formed by all of us. It's when someone

watches that all the resources that come federally are distributed to the people that need them. It's making sure that it reaches the destinations where it is supposed to go. But if we see that, when they say they are going to deliver support and it does not come. They are instead diverting it to other places. Well then, us as watchdogs, we have an obligation to make a denunciation. To make a complaint that we put into a designated box (at the police department and clinic). There we can write the name of the person and what s/he is saying. For example, when the politicians come, they can't force us to vote for someone that the people don't want. Or for them (the politicians) to say, give me your identification. What they are doing is violating our rights. That's why the man says that we need to learn in case that happens here. But the problem is that people are scared to speak up.

During our platicas we let the women know when the support (cash stipend) will be delivered. The man will let us know a few days to a week before they come to the community and hand out the aid. The man says we can't go and say that we are here to cobrar (collect payment), because "to collect one feels as if s/he is working, and they need to be paid for the work that they are doing. What is being given to you is a support, so that is how you should say it". He explains to us that it is the vocales responsibility to make sure that the participants know that they are receiving support, not payment. And the participants must refer to the Oportunidades cash stipend as a support, not payment. But sometimes many forget and they say, "will you pay us". And the man says "what? Did you work so that I could pay you? What did you come to do"? We came to collect. [Valentina laughs] They forget. But I tell them you can't say it like that. You have to say we came for our support.

Recipients are responsible for taking advantage of the aid they receive from the government. To move ahead and work and help the family. The aid is helpful. It's a little but at least you know that you can depend on a little help every two months. They teach us that the aid is meant to pay for school supplies for the children, for clothing, for food. Kids should be fed well before going to school. They say that many people use the money for other things... They don't use the money to feed and clothe their children. There are children who go to school hungry and without proper shoes. Sometimes they faint at school because they haven't eaten.

But right now, they are taking the aid away from people who no longer qualify. Those who no longer have infants or school aged children. Or those who qualify for multiple programs. They can't be enrolled in two, they must pick one. For example, the elderly have to decide if they want to be a part of Oportunidades or [the program] Setenta y Mas. Everyone enrolled in the programs have obligations. It's just that they have less in the program Setenta y Mas. People are worried that they will take away their aid. But they tell us that we need to become accustomed to the fact that the program isn't for the rest of our lives. It's a support that is given. If my aid is canceled, I can't cry. Because it is a decision from the government.

Challenges and Contradictions with Oportunidades

As I explained in chapter 2, Mexico is framing Oportunidades, a conditional cash transfer program, as an agreement of “co-responsibility”. This co-responsibility is two sided. The Mexican state will help its extremely poor citizens by giving them financial cash stipends as well as providing them with the education and good health they need to succeed. According to the government, by removing these social and economic barriers poor individuals no longer have damaging obstacles set in front of them that would limit their potential (Darney et al. 2013; Levy 2006). It is important to point out that Oportunidades uses the word conditional when describing the program. This means that the resources which are provided to participants are dependent on them complying with certain terms and agreements. Participants are required to follow all requirements or face immediate removal of the program. In the end, the discourse of co-responsibility absolves the state of its obligation to its citizens by placing all social and economic welfare on individuals. Ultimately, what programs like Oportunidades assert is that if an individual is unhealthy and poor it is his/her own fault because the state has provided all the resources need to ensure a good quality of life—education, health care, and financial assistance (Luccisano 2006; Molyneux 2006).

Santiago Levy, the founder of Oportunidades, states that Oportunidades is part of a poverty alleviation strategy that focuses on the importance of “investment today” to gain “higher self-earned income tomorrow” (2006:146). Levy is not only

focusing on state investment on individuals' health and education, but also the necessity for the government to help poor individuals begin to make financial investments in their own futures. When looking at how Oportunidades is played out on the ground, it is clear that for many women the program offers some financial assistance but never enough to move out of poverty. As Molyneux (2006) critically points out, Oportunidades cannot claim to be a poverty alleviation program until it provides women with job training skills and resources such as literacy—things she argues provide women with the possibility of securing long term employment and ultimately self-sufficiency. In the case of Sabán and Huay Max, women not only need job training but more importantly, they need real and dependable employment opportunities in the communities where they live. Furthermore, as I have stated before, Oportunidades does not address some of the infrastructural obstacles that poor rural women face such as safe roads, clean water, availability of affordable healthy foods, and access to a fulltime health care provider in their community. Lomeli (2008) argues that “a more comprehensive approach is required, seeking equity to connect actions on the behalf of the poor with reform of the basic institutions of social security” (492). She states that investment in health and educational services must also be incorporated into development programs that aim to end intergenerational poverty and increase the human capital of future generations. For Oportunidades to truly succeed in its goal of being a successful long-term poverty alleviation program it needs to broaden its scope and emphasize the structural problems and material conditions that impede rural indigenous women and their children's movement out of poverty.

The Oportunidades program is full of contradictions which are clearly acknowledged by its participants. The account of Valentina's meeting at the beginning of the chapter demonstrates how women are open about pointing out the hypocrisies of the program. They clearly see a contradiction between the ideological rhetoric of freedom and choice the program produces and ultimately passes down versus its coerced and forced nature. It was logical for the woman at the meeting to ask why the program was forcing them to attend meetings and go to school when Valentina had just said no one could force them to do anything they did not want to

do. If they truly had freedom of choice then why were they coerced based upon their economic need to fulfill all program requirements even if they felt some of them might not be as beneficial as policy officials and doctors claimed. Although all the women laughed and treated the comment as a lighthearted joke, it represented a way in which women openly discussed and dealt with the inherent paradoxes of the program. Smith-Oka discusses how in her research in Veracruz, indigenous women participating in Oportunidades used laughter to form bonds of community and solidarity— “we have all suffered and so we can all laugh about it together” (2013:157). They also used laughter to cope and diffuse the sometimes oppressive power that the government had over their lives.

Additional contradictions are seen in a rhetoric of human rights and social accountability which also includes government accountability. Participants are encouraged by officials to participate in governance. They must be watchful and properly report all forms of government corruption. If they see a problem, then people have an obligation to let government officials know by writing it down on a piece of paper and putting it in a designated box at the clinic or police department. Women’s participation and criticism of their government ends there. As I discussed in chapter 2, women in the community were reprimanded by Oportunidades program officials for speaking up against their perceived mistreatment and abuse of power by the local doctor (Dr. Barrios). In the end, the officials told the women that they and the community would be punished for their insurrection by not hurrying to find a full-time doctor to replace the one they had just run out of town. In reality, women are not allowed to publicly question the government if it chooses to stop providing aid. They are told by government officials that they cannot make demands on their government because they have already received so much help. They should be grateful for what they have been given and return to their homes.

Oportunidades produces certain discourses that are widely distributed and enforced. Participants must listen to these messages, internalize them, and then use them in their daily life and encounters with officials. The program functions to display the hegemony and power of state ideologies and practices pertaining to clientelism and paternalism. As the Oportunidades representative made clear,

women in the community need to be trained on how to properly request and receive aid. Vocales are told by program officials that it is their responsibility to make sure participants use the correct dialogue when receiving their cash transfer. Program recipients must understand and verbally acknowledge that they are being given aid from their government, not for their labor (because they did not earn their money by working), but because the government has agreed to help them. As Kaiser (2008) points out, the cash transfer is not a “handout” but instead a conditional agreement that results in a transfer of money. The key is the word conditional which emphasizes that participants must meet all their set obligations or else face the repercussion of having their cash transfer suspended. The government considers these women as the true beneficiaries of the program. It is a win-win for them. Not only do these women have access to all the resources they need to keep themselves and their children healthy and educated, but the government also pays them an incentive to become productive citizens. The Oportunidades program official who comes to Sabán uses any chance he can to demonstrate his power and superiority over the female participants. His interactions with them are condescending and demeaning. He makes it a point to make sure women know that the federal government is graciously providing them with aid and they should be grateful—and this gratitude must also be expressed by the unpaid women who work as vocales.

Program recipients are not only taught how to ask for their aid but they are also taught how to use it. Women are constantly reminded by officials that the money they receive is to be used for their family’s nutrition, health, and education. Approved ways of spending the aid is to purchase medicine, food, and clothing—especially for children. Program officials, including local physicians, often mistrust how women use their aid. They feel that sometimes the basic needs of children are neglected so that the family can buy household appliances, like a television or refrigerator. According to my observations in the pueblo and those of other researchers working in Yucatan (Dapuez 2016), this is not the case—women are primarily using the cash transfers on their children. Angelucci and Attanasio (2009) state that Oportunidades recipients faced immediate challenges in response to living in poverty which do not afford them the ability to use the cash stipend for anything

other than food and household goods. The stipend is not enough for them to invest in any additional resource.

An additional challenge Oportunidades places on women in the community is demonstrated through the position of vocal. It begins with a moral argument emphasizing their voluntary participation on behalf of the welfare of their community. Women are then encouraged to devote extra time to educate and more importantly, to monitor their neighbors. They must report to program officials when participants do not attend their mandatory meetings. There exists a delicate balance in which vocales work on providing program information and making sure women understand all the requirements they must comply with. Although they may consider themselves part of their community and have a strong sense of obligation to their people, their position as a vocal means they are now agents of the state and must follow through with at least some of the demands their government places on them. Whether they acknowledge or accept it or not, vocales represent the fringes of the watchful eye of the state. They are crucial for the success of government health programs.

Yet another significant problem with Oportunidades is that it is a top down program, conceived and implemented by elite policy officials. Oportunidades functions at the federal level and reaches rural communities through implementation by outside health policy workers, but it uses local women to act on the behalf of the government. Women from the community are chosen to disseminate program information and monitor participation but their work is heavily scripted. Vocales are essentially given a script that they must recite to their assigned group members. The script at times is condescending and insensitive to the daily challenges that poor rural women face. The script sometimes calls for the vocales to reprimand participants who do not comply with program requirements. The program official encourages Valentina and other vocales to forcefully remind participants that unless they fulfill their obligations they will be dropped from the program and their aid will immediately be cut.

Valentina acknowledges that this is a sensitive matter. She knows that for her to be a good and effective leader she needs to respect the cultural practices and

views of the community. She tries to talk with women and explain things openly and with respect. Valentina tries to work with people even if it goes against the instituted practices of the program. Oportunidades officials who come to the community claim that there is a zero-tolerance policy. The vocales must always mark recipients as *falta* if they do not attend the mandatory meetings. Valentina does not agree with this and she chooses to excuse women from attending the meetings as long as they come and let her know why they could not make it. According to Valentina, most women miss a meeting because they do not feel well or are home caring for a sick family member. Luccisano (2006) also documents women's inability to meet some of Oportunidades requirements such as attending meetings or doctor's appointments due to familial obligations, more specifically when they need to stay home and care for sick children or elderly relatives.

Again, it is important to point out that Oportunidades extends the state to encompass the unpaid labor of rural indigenous women. These women are used as a form of micro-surveillance. In a distant and small way, they are placed in a situation in which they represent the state through their dissemination of state program information and the monitoring of their designated beneficiaries. Assigning vocals to work for state health programs, such as Oportunidades, is part of a long history in Mexico of individual everyday representations of the state (Joseph and Nugent 1994).

Vocales, like Valentina, find small ways to resist the oppressive practices and ideologies of the Mexican government. As I mentioned above, against official program requirements, Valentina tries to work with program participants so they can continue to receive the very much needed cash transfer from Oportunidades. Furthermore, Valentina, challenges the official script she is given and openly questions the responsibility the program has for its participant, especially marginalized indigenous women. Yet, vocales are not the only people who resist government control. Women in the community have battled on numerous occasions with program overseers when deciding where they want to give birth, holding doctors accountable for their end of the co-responsibility agreement, and in Valentina's case, who they want as their vocal. In relation to the position of the

vocal, although officials coming from outside the community can be motivated by issues of fairness and openly distributing leadership opportunities, the majority of the program beneficiaries disagree with their ideas and choices. These women view fairness and justice in continuing to democratically elect the vocales they feel best represent them regardless of the fact that they have held the position for various years. As the women have told Valentina, every time she mentions her tenure will soon end, they want her to continue as their vocal.

Although women continue to participate in Oportunidades, many have expressed strong disagreements with some of the requirements of the program and the state physicians who are in charged with its implementation. As I have discussed in chapter 2, another primary point of contention is where women choose to give birth. As a result of Oportunidades' emphasis on biomedicine, women are required to seek biomedical prenatal care at a local government clinic. This is done with the hope that they will eventually transition from giving birth at home to complying with state recommendations by giving birth in a hospital setting. Many of the physicians working in rural Yucatan also agree that this is an important goal. Yet, most women in the community do not want a hospital birth, unless it is absolutely necessary—this means that a hospital birth is chosen only after a woman has attempted to give birth at home with the attendance of a midwife. For these women, birth at home had deep cultural and social meanings and more importantly it is considered a safe and natural way to give birth.

Women in the community resisted in many ways the demand for a hospital birth by clinic physicians and maternal health programs. Throughout the community, many homes were engaged in conversations about the importance of having a home birth and how the clinic physician had no right to tell them what was right and what was wrong when it came to their health. Many believed that as long as home births were safe they presented a valuable and legitimate alternative to state sponsored biomedical births at hospitals. Women chose to continue to participate in Oportunidades because they needed the cash transfers, and in many cases, they also appreciated the additional prenatal care they received from the clinic. During prenatal visits, women would not voluntarily discuss their delivery

plans, but when asked many would just listen to the doctor and say that they would consider a hospital birth. Yet, when it came down to the birth, the majority of women chose to stay home. Of the 70+ women that I have formally interviewed over the last decade, only four chose to not attempt a home birth and instead went straight to the hospital once labor began.

Lock and Kaufert (1998) explain that in many cases the health practices of women are dependent on pragmatism and what women feel works best for them at that specific time. After more than a decade in the community, Oportunidades is now considered by its participants as a right and obligation of the state to provide for the health of its female citizens. Although the place of delivery is still contested, women have chosen to fully participate in all prenatal requirements and they have completely bought into the program's ideology of co-responsibility. Yet, to the shock of state health workers this notion of co-responsibility is somewhat different than the one they presented. This became evident in 2009 when the women of Sabán chose to gather in protest against the community physician and demand her removal. As I mentioned in chapter 2, according to many women the physician was not upholding her part of the co-responsibility agreement. They stated that although they had meet all program requirements the physician chose to withhold their bimonthly cash transfer because she felt that they undermined her authority in the community. When the state workers came to the community to dispense the cash transfers, the 200 women of Sabán who participated in Oportunidades sequestered those workers and demanded that they be given their money. They further stated that as citizens of the state, they were entitled to fair treatment and a physician who clearly understood the terms of their relationship with the state through the participation in Oportunidades. The women did not want Oportunidades or the community clinic to leave the pueblo; these were acknowledged important and vital resources. What these women demanded was a clear and equally agreed upon relationship with the Mexican state. Inclusion in the national health care system would have to be open to their needs and wants.

What this chapter has also demonstrated is that the unintended consequences of development programs need to be included into evaluations on the

outcomes and impacts of programs. Unintended consequences are important to consider because they highlight the actual ways in which individuals interpret and experience existing programs. In the case of Oportunidades, it is important to critically look at the ways in which women's lives are being overburdened by their added responsibilities. Women must set time aside from their busy days not only to make sure their children attend school and all their health checkups (things they overwhelmingly agree are important) but they must also make time to attend the various mandatory meetings at the home of their vocal and the clinic (which are sometimes time consuming).

The unintended consequences of development programs benefit those in power. Since powerful bureaucrats, professionals, and politicians create and implement social welfare programs in Mexico, it can be argued that unintended consequences are ignored as long as they do not challenge the implementation and operation of state programs. Looking at the experiences of rural Yucatec Maya women enrolled in Oportunidades, it is clear that the program's practice of monitoring, coercion, and surveillance benefit the larger political and economic goals of the state government and not the participants. Social inequality cannot be effectively addressed until development programs begin to expand their acceptance of legitimate discourses and alternative solutions to problems like poverty. Oportunidades has the possibility to be a program that can really help poor individuals transition out of extreme poverty, but only if the voices and concerns of participants are included into the development and implementation of the program.

Valentina's Story

That's my story, mine. There were many things, many difficult things. I left school, I didn't continue studying. Well, like I said, my father did not and still does not know how to care for his children. He always treated us badly. He would come home and always be upset, bothered by us.

One time, I got upset, and I stood up and told my father, if you are going to hit my mother, you are going to have to hit me first. He said "what? Aren't you scared?" I said "no, I am not afraid". I was young, like thirteen or fourteen years old. And I said if

you are going to hit her, then you are going to hit me first. But I am not going to let you hurt her. And, well, he calmed down. To this day, he still drinks a lot. But he does not get upset like he used to. He changed, but it's too late. The damage he did, he already did it.

Valentina's childhood was marked by alcoholism, domestic violence, and poverty. Valentina was deeply affected by her father's relationship with his family. She said she and her siblings didn't know what it was like to have a father who cared for his family. Her father worked and earned money, but the family never saw it. It was his money and he primarily spent it on alcohol. He never bought his children clothes or shoes. The family's survival was left to Valentina's mother. She was the one who had to find a way to feed and clothe her children. Valentina's father's alcoholism caused the family great pain. The children witnessed the physical abuse of their mother, experienced their father's shortness and anger towards them, and endured neglect and a financial struggle to survive on a daily basis.

In 1978, Valentina was born at home in Sabán. She was raised there the first few years of her life and then at the age of five, she and her family moved to Chetumal. The move was difficult, especially for Valentina who didn't know a word of Spanish. With the help of a neighborhood girl, Valentina quickly learned to speak Spanish. Her language skills soon got stronger once she began attending school. But she quickly added, *I never forgot Maya*. She wanted to differentiate herself from other people in the community, primarily younger men. She said, *people leave to go work and they say they forgot how to speak Maya. But it's not true. It is only because they feel ashamed. But not us. We are accustomed to speaking Maya*. Valentina is fluent in both Spanish and Maya. At home, Maya is the dominate language.

As soon as they were old enough, Valentina and her siblings attended school regularly. Valentina liked school and she did well, but she struggled knowing that while she was at school her mother was at home without any help. She knew her mother worked hard. She maintained the house, completing all her domestic responsibilities, but she also worked washing and pressing clothes for people in the neighborhood. This was the early 1980s in Yucatan, electric washing machines were decades away, all laundry was washed by hand and pressed with a fire-heated iron.

It was physically hard work and took a considerable amount of time to complete. One morning, when Valentina's mother was heading out to work, Valentina told her she was going to go with her. Her mother was surprised and asked why. Valentina responded by saying no particular reason, she just wanted to go. They walked together to an older woman's home, and after introducing Valentina to her employer, Valentina's mother went to work washing clothes. That day changed Valentina's life.

When I arrived with the woman she said do you want to earn a little money. I told her yes, what do I have to do. She said, "you are going to sweep all of this, where the leaves are. You are going to sweep it and pick it up. That way you'll have some spending money". And she gave me five pesos. Back then it was a lot of money. And then she said, "right now you have to hurry home because its already twelve and you have to be at school at one".

And I would go [to school]. But because I was studying, my little sister was in school, my older brother was in school, there wasn't enough [money]. My mom had to work. She had to wash [clothes] because that's the only thing she knew how to do. When we needed to buy clothes, she would give us money. And I told her, I am not going to continue studying. And she said, "why? You have to keep studying". But I told her if I am watching you kill yourself working, my father doesn't know anything, if we'll have enough to eat, its better if I dedicate myself to working.

And I went [to the older woman's house]. And I left school. The woman told me "Tina, you have to study, if not then what are you going to do when you get older. You are not going to be able to work any place". Well, [I said] it doesn't matter. I was like twelve at the time. She said "then if you don't want to go to school, you are going to stay here. I am going to teach you how to wash clothes, how to iron, how to clean the house". I told her fine. I will do it. And I would go and she would say this is how you're going to iron. She would lay the shirt down and say, "this is how you iron. Now do it. Let me see if you've learned how". And I would say yes, I have learned.

The woman was a good person. Every time I would arrive she would ask, "Tina, have you had breakfast. Come and have breakfast". When I was a young girl, I don't know what was wrong, but I would faint a lot. All of a sudden, after waking up, I would

have to sit down. The woman would ask, "Tina have you had breakfast?" And I would say no. She would say, "why haven't you eaten breakfast? You need to eat".

And like that. Little by little, my weekly pay kept going up. They would pay me eighty pesos. And like that, the woman told me,

wherever you go to work, you will know how to work. You will always remember me. Because thanks to this old lady, wherever you go, they will never throw you out. I have already taught you. It's like when little birds are taught how to fly. If you decide to leave, I will respect your decision. But if you want to stay with us, it's the same. You are like a daughter to us.

And as I got older, I decided to work someplace else. And sometimes, when I would remember, when I had time, I would go and visit the woman. Even today, she is still living. Her husband died but she has two daughters.

Looking back, Valentina saw the truth in the older woman's statement. She had taught her how to complete all the domestic responsibilities needed to maintain a home. Valentina now had valuable skills that would help her find work and ultimately give her confidence and independence as a woman who could take care of herself. Valentina grew up fast—out of necessity. She learned quickly and was a hard worker. At seventeen she began a new phase in her life—marriage and family.

Valentina and Cristian have been married for almost twenty years. They have a close and happy marriage. They get along well and are very supportive of each other. Cristian is a hardworking, loving, and respectful husband. Unlike many men in the village, he rarely chooses to drink. A trait that is important for Valentina. The two first met in Sabán when Valentina would come and visit family. Cristian had a crush on her and even though they were still young, he told her that one day he would marry her. Valentina smiled and said ok, we'll see. They courted throughout their teenage years and finally married when Valentina was seventeen. They had a traditional wedding at the Catholic church in Sabán. Valentina wore a white dress and they had a big party afterwards to celebrate. The newlyweds chose to stay in Sabán and live with Cristian's parents. Cristian worked with his father and older brother in the milpa and would leave periodically to find paid work in Chetumal.

They left for Chetumal six months after the birth of their first child. Their family had grown and they needed a steady income. They stayed and lived in Chetumal for ten years. They made an effort to come back to Sabán often and visit family. They also made sure that with every pregnancy Valentina would be in Sabán living with her in-laws and under the loving care of Doña Carmen, who was also a well-known local midwife.

Valentina loved and respected her mother-in-law. She learned a lot from her. Doña Carmen taught her how to care for herself especially when pregnant. She explained to her and her other daughter-in-law the basics of childbirth and told them how to prepare themselves for labor and delivery. She taught them about midwifery care and its importance in respecting the wishes of the mother and protecting her from unnecessary invasive biomedical procedures. But, what was of the greatest importance for Valentina was that Doña Carmen returned her love and treated her like a beloved daughter. Doña Carmen wanted her family to always get along and support each other. She told her daughters and daughter-in-laws that she never wanted to see them arguing or fighting. She told them that they must get along well with each other because they were all they had. They were family—and they should turn to each other for help and support. Although Doña Carmen considered her daughters and daughter-in-laws as equals, Valentina admitted that Doña Carmen she had a certain affection for her. In some ways, Valentina was favored and spoiled by Doña Carmen. Sometimes, her sister-in-law Irene, would be sad and a little jealous of the extra attention Valentina received, especially since Valentina did not live with the family. Irene also loved her mother-in-law and wanted to please her and make her happy and proud. Valentina would try to ease Irene's disappointment by saying that everyone shows their love differently and that Doña Carmen loved them all.

When Valentina's third child, Cecilia turned one and was old enough to be weaned, Valentina took a job in Mérida working as a live-in nanny and maid. Her employer, Ana, was a single mother with a young son. Ana was good to Valentina and she loved her. Working in Mérida Valentina earned a thousand pesos a week. All her expenses were paid while she was in Mérida. Ana would also often buy

Valentina gifts and give her money to buy toys or clothing for her children.

Valentina's job provided the family with a good income. She used her money to help pay for building materials for their home, to buy expensive kitchen appliances like a refrigerator and stove, to pay for food and clothing for her children, and to buy small luxuries such as specialty foods.

Although Valentina had a great relationship with her employer and enjoyed many of the conveniences of working and living in a major city, she struggled with the fact that she had to leave behind her family including her very young daughters to find paid work. Knowing this, Ana told Valentina she could bring her daughters to live with her in Merida. She said they would have their own room and they could attend school in the city. She told Valentina that while they lived with her, she and her daughters would not need to worry about food or any other basic expense. It was a generous offer and Valentina was very grateful, but she declined because she knew her children would be happier living in the pueblo. It was their home. It was what they knew. Living in Sabán, they were surrounded by their friends and family. Valentina knew that making the children relocate would be difficult for them. Although she felt it was in the best interest of her children to leave them behind in Sabán, Valentina felt a sense of loss.

Valentina's children were left in the care of Olivia and the rest of the extended family living in the housing compound. That included her aging mother-in-law Doña Carmen and sister-in-law Irene. Doña Carmen loved the girls but her deteriorating health made it difficult for her to watch over them. Irene worked hard in helping the family with cooking and cleaning, but because she had four young children of her own to care for, Olivia took up the role as a mother figure for the two little girls, Erika and Cecilia. Olivia's own daughters had grown to become young independent women, so raising the girls was her second chance at motherhood. Olivia loved the girls and would occasionally spoil them. And the girls loved her too. They would all sleep together in Olivia's hammock. As Olivia described it, they were like little possums. All curled together asleep—her with a baby on each side. It was a sweet analogy and pretty accurate.

Valentina was given leave from her job to come and visit her children and family every two weeks. She would stay for the weekend and then return on Monday morning. She would usually come with food, treats, and/or presents for the family. She would look forward with anticipation to her return home. The visits were usually happy but also a little painful. Due to her extended migration out of the community and ultimately absence in the daily lives of her children, Valentina's youngest daughter Cecilia would sometimes accidentally call her "aunt". This deeply saddened Valentina and hurt her sense of motherhood and the value that she had in the lives of her children. Yet, she returned to work in Merida because at that time, for Valentina, motherhood meant economically providing for her children rather than participating in their daily care.

When discussing motherhood, Valentina thinks back to her own mother. Valentina's mother worked hard all her life to provide for her children. She loved them and cared for them. She tried as best as she could to shield them from the neglect and mistreatment of their father. Valentina and her mother had a very close relationship. In gratitude for her mother's love and devotion to her family, Valentina always tried to find ways to help her. They spent a lot of time together working and taking care of the house. They were a team. However, Valentina's role as a child was also cut short. In many ways, she acted as her mother's protector. She left school to help ease her mother's work load and confronted her father and demanded he end the physical abuse he unleashed on her mother. Eventually, a lifetime of hard physical labor and a constant struggle to provide for her family, took a toll on Valentina's mother. By her mid-forties, Valentina's mother's body was worn down and she was not in the best of health. Valentina's mother died before she turned fifty—much too early, in Valentina's opinion. It was difficult for Valentina to deal with the passing of her mother but she was consoled and comforted by her husband's family and her employer. Valentina eventually accepted her new life without her mother and returned to work in Merida. However, tragedy would soon strike again.

Valentina remembers the last time she spoke with Doña Carmen. She and her husband were both in Sabán visiting. They had come from opposite ends of the

peninsula—she was in Merida and he was in Chetumal. Doña Carmen had been sick for a while and it was evident that her health was rapidly deteriorating. As she was leaving, Valentina said goodbye to her mother-in-law and told her she would be back soon. She said that she was leaving little Cecilia, who was about four years old at the time, to stay with her and keep her company. Valentina noticed Doña Carmen looked sad, but was comforted by the presence of her young grandchild. A few days later, Olivia took Doña Carmen to the hospital emergency room. Doña Carmen had experienced a stroke which subsequently put her into a coma. She stayed in the hospital for two weeks. She was never the same again. When Doña Carmen returned to Sabán, she had experienced severe brain damage. She was in a vegetative state and eventually had both legs amputated. Olivia took charge in being the primary caregiver of her mother during the last days of her life. Doña Carmen eventually died of complications due to uncontrolled diabetes. Her death was a year after the death of Valentina's mother. It was a difficult time. Valentina and Cristian had now both experienced the loss of their mothers. After the death of Doña Carmen, Valentina told Cristian, *there are things that happen in life. It's part of life. But we must continue and survive. It's like they say, life isn't over. If something happens to you, something bad, you will always surpass it. Of course, you never forget them, because you will always remember them, always.* She was talking about the loss of Doña Carmen but also referring to the recent loss of her own mother.

In 2008, Valentina left her job in Merida. She made the decision to come back to Sabán after Doña Carmen's death and the subsequent leaving of Irene and her family. Irene and her husband had also spent many years building a home of their own down the street from her in-laws. Although they lacked a built-in restroom, the basic infrastructure of the house was built and so the family eagerly, but also with some reservation, moved into their new home. Irene was originally reluctant to move because she loved her in-laws and had lived with them for almost twenty years. She was worried about feeling lonely in her new house. Although she could always come and visit, which she often did, moving out meant that Irene's time with her extended family was limited. She now had her own house and her own domestic responsibilities to take care of. Once Irene and her family finally moved out, there

was no one at the family house to help watch the girls in the morning and early afternoon while Olivia was at work. Valentina and Cristian both agreed it would be best for her to come back and live in Sabán. At first, when Valentina told her employer she was planning to leave, she tried to persuade her to stay. She again offered to bring Valentina's daughters to come and live with her. However, Ana soon accepted Valentina's decision, knowing that Valentina had to return home—it was ultimately in Valentina's best interest to be with her family.

Valentina remembers when she said goodbye and left Ana's home. *She told me that she wished me luck. Then she told Cristian "take good care of Tina, of my daughter", that's what she used to call me, her girl. [In front of him] she told me that if for whatever reason I felt I was being mistreated, I only needed to call her and she would come and pick me up and I wouldn't have to ever return to this place. She was crying when she left. And so was I.* Valentina again, reiterated that Ana was a good person and that she was grateful for her kindness, generosity, and love.

Moving back to Sabán was initially difficult for Valentina. It was an abrupt transition from living in the city with a well-paid job to now living in the pueblo with little to no possibility of earning an income. Valentina saw things differently now. Working for and living with Ana, Valentina's world was expanded. She had seen and experienced so many different things—things she admitted in her life would not have been easily accessible. For example, Valentina and the young boy she cared for would frequently visit the movie theaters, watching all the new releases and blockbuster hits. She would often vacation with Ana and her family. They would usually spend the hot summer months at a beach house in Progreso enjoying the ocean breeze and cooling off in the water. And more importantly, Valentina's job provided her with economic security and independence. She found it hard, particularly in the beginning to not have money. She was no longer able to financially help her family. She had to get use to this new situation. She had to get use to not having money and depending on others for basic goods. Cristian has worked odd jobs in Sabán and occasionally in Chetumal, but since the death of his mother and the departure of his older brother Luis and his family, Cristian has chosen to stay in the community helping his father with the milpa and his sister

Olivia with the upkeep of the housing complex. Although Valentina has been receiving a cash stipend from Oportunidades, for several years, Valentina and her family have relied heavily on Olivia to help pay for household expenses. Valentina and Cristian are appreciative of Olivia's generosity and they both work hard to demonstrate it.

Here I am working. Even if it's only making food. I am helping my sister-in-law. And she sees it. I am not just here freeloading. I wake up. I am working. I am helping. Since my mother-in-law died, I came back. I've stayed here. I haven't left to [find] work. Cristian says we're here also to help his father. He says he stays to help them. [Cristian says] "if there is no firewood, I go and cut some. I look after the milpa. I help plant and harvest. All of that. I am working but we are not earning money. But if there is a harvest then there is maize. [I work] only for our food". I say, oh well, you have to get used to it. At first, I use to see it really badly, because I was accustomed to, well, when I wanted to buy something, I had money. I was never without money.

But right now, there is a little, I can't say that we don't have any [money]. If I don't have any, then I ask Olivia if I can borrow some. Then I will pay her back. Sometimes she says "leave it. You are working". But I tell her, sometimes I am embarrassed. I've borrowed money, what if I don't return it? Then the next time they will not give me. Olivia tells me "while you are here, you will not lack anything". I tell her it's true. I am grateful for what you all have done for us. When she [Olivia] goes shopping she buys the baby [Liliana] diapers and milk. That's how she is. Even with Irene. Sometimes when she goes shopping she also buys diapers for [Irene's] baby. If she buys toilet paper, soap, she puts some of it in a bag and takes it to them. That is her way. She will never change who she is. Some people get jealous and say why is she only helping me and Irene. Olivia tells me to ignore them. She says "let people talk. Meanwhile I don't tell you anything, everything is good".

A home birth with a midwife has always been important for Valentina. She had all four of her children in her in-laws' home. As Valentina explained, *...it's better to stay home. If you go to hospital, the first thing they do is a cesarean section. And, if you don't have enough money to pay, then it's a big expense. We are accustomed to give birth at home. Of course, it's still an expense, but it's not the same. I also think it's*

because that's how my mother-in-law taught us. But also, if we see it's a complicated pregnancy, then like the clinic tells us, we go to the hospital. Although she was heavily influenced by Doña guidance, Valentina also listened to the advice she received from government health workers and understood the need in seeking biomedical care if a pregnancy and/or birth encountered serious complications.

Following Oportunidades requirements, Valentina went to the clinic every month for her prenatal checkups. Ultrasounds finally became accessible during her fourth pregnancy, and in accordance with the program procedures, Valentina went to the hospital in Carrillo Puerto for her ultrasound at seven months. Her fourth pregnancy with her daughter Liliana was difficult. She had been seeking care at the clinic and with Elena. The pregnancy was complicated early on because the baby was in a transverse position. For months, Elena tried to turn the baby in utero, but was unsuccessful. The baby's position was confirmed with the images provided by the seventh month ultrasound. The hospital doctor told Valentina that she would need to come back the following month for another ultrasound and if the baby was still transverse she would need to schedule a cesarean section because a home birth would be too dangerous and could cost the lives of both mother and child. Valentina was stressed. She did not want a cesarean section. She told the doctor, *I don't want you to cut me. An incision takes a while to heal. It's not the same. Because when you deliver at home, once the pain has passed, once the baby is born, it's over. You can get up. See your baby. But not with a cesarean section. You have to stay lying down. You have to take more care of yourself.* When Valentina returned to the hospital, the ultrasound showed that the baby had moved and the doctor told her that everything was good. Valentina was so relieved. She was also concerned that her blood pressure would be elevated because of all the anxiety and fear she had been experiencing. She knew from conversations with doctors and from health lectures that high blood pressure in pregnancy could lead to pre-eclampsia. Elena had also spoken of this danger and in her own practice would send patients with high blood pressure to the hospital to give birth.

When it came time for the birth, Valentina stayed home. But Cristian told her he would take her to the hospital if she experienced complications during labor and

delivery. He was worried that the baby would not be able to pass through the birth canal and be born. Valentina labored and delivered her healthy baby girl in Olivia's newly built upstairs apartment. She gave birth the night before Saban's *gremios*, community saint's day festival. The *gremios* were a big annual event and that year, Olivia and Hector were in charge of hosting one of the meals and parties. People from all over the community came the following day and the newly born baby was greeted outside with the chatter and laughter of a large group of party-goers. There was even a band that came and played. Perched up in her room, Valentina rested and enjoyed the first days with her newborn. Three days after the birth, and a couple days after the party, Valentina and baby Liliana came down from the apartment and returned to the main house.

Overall, Valentina's living situation and family dynamics are good—everyone gets along and they try to help as best as they can. But soon, things will change. Cristian is close to finishing up their new home. The walls, ceilings, and roof are up. The doors and windows are in. Everything has been plastered and ready for paint. The only thing left is the electrical and plumbing. If all goes well, they will move into their new house in a few months. Like Irene, Valentina is also nervous about leaving the family home. She has gotten used to living with everyone and her children are also used to being surrounded by their extended family. Moving will be a little lonely, but it was also present the family with a new financial challenge. They will now have to try and find a way to pay for their own household expenses. The Oportunidades cash stipend will help, but it will not be enough to pay for everything. Like most men in the community, Cristian will probably have to leave and find work—most likely he will go to Chetumal.

Olivia also acknowledges life will be different for her too. She has not only grown accustomed to the companionship of her brother and sister-in-law but she has also relied on them for help maintaining the home. She jokingly tells Valentina, “you’re going to go to your house and then us, who knows what we will do. We’ll have to see who will come and work”.

Tina responds by telling her, *well, if I can I will come and help you. Because the lady who I last worked for would always tell me, ‘never bite the hand of the person whose*

feeding you. Because she is giving to you, and if you bite her, it's like if you are betraying her'. And I tell her [Olivia], while I am healthy and not sick, if I can, I will help you. That's why they say, 'do favors, without being partial, you never know tomorrow who will be granting you a favor'.

Like most people, many aspects of Valentina's future are unknown. Regardless, she continues to hope for a certain future. A different future for her children. She wants them to go to school and get good jobs. She wants them to have all the opportunities that she did not have. She wants to support and encourage her children to seek a better life—one that is filled with more possibilities than those presented to her and Cristian. Her dream is slowly becoming a reality. Next year, her oldest child and only son, Manuel, will graduate from a trade school he has been attending in Chetumal. His degree is in tourism and hospitality, which gives him a wide array of job prospects in Yucatan's ever-expanding tourism economy. Although Valentina's oldest daughter, Erika, was reluctant to go to Chetumal for secondary school—a move that would give her more educational opportunities—she is now open to leaving the community in a few years to enroll in a trade school/high school in Chetumal. Her younger daughter Cecilia, has always received high marks in school. She really enjoys it. Valentina recognizes that there is something special about Cecilia—her eagerness to learn, her dedication and perseverance. Although, Liliana is only a toddler, Valentina hopes that she too will do well in school and be self-motivated to work hard and get ahead.

Conclusion

Although Valentina had a difficult childhood, she was fortunate to have met in her adolescence and adulthood strong, independent, and knowledgeable women who loved and cared for her (the elderly woman, her mother-in-law, and her last employer in Merida). Along with her mother, these women acted as mentors and protectors. Valentina often looks back at her experiences with these women and the lessons she learned to guide her through various challenging situations she encounters in her daily life. This is yet, another testament to the importance community and familial relations have in the lives of rural Maya women. Valentina's

story also shows that that she is more than just a program recipient. She has lived a life full of struggles and accomplishments. As her testimonio demonstrates, she has overcome poverty and abuse, endured sacrifices, experienced love and protection from family and close friends, worked hard to provide for her family, and become a mother that her children respect and love. Valentina as an Oportunidades beneficiary is only one aspect of her identity. What she has learned from participating in Oportunidades is an addition to a lifetime of gained knowledge and experience.

Valentina is an example of an Oportunidades participant. She has worked hard her whole life and had to make sacrifices. She lives in a rural community with little to no economic opportunities. As I mentioned in the introduction and chapter 2, there are very few ways in which women can generate revenue in the pueblo. The only reliable and substantial income prospects for women in this community are Oportunidades cash stipends and out migration. Valentina breaks the stereotype that government officials and bureaucrats often say about federal poverty alleviation program recipients. Valentina is not a passive person, sitting around waiting for a handout—she is a practical and hardworking woman who is trying to help her and her family attain a more financially secure future. Although their resources are limited, Valentina and her husband continue to find ways to provide their children with all the opportunities denied to them. Participation in Oportunidades is just one of many of the strategies they turn to. Regardless of all the challenges they face, Valentina and her husband continue to see promise and hope in the future—at least for their children.

Yet, Valentina's interaction with Oportunidades extends beyond her capacity as a program recipient. As a vocal, she is a politically situated person who works through the power dynamics involved in implementing state health programs in rural indigenous communities. As part of her work, Valentina, uses her position and power to fight on the behalf of program recipients and defend her community's cultural ideologies and practices related to childbirth. She uses her community-based knowledge to better adapt the Oportunidades program in her community

with the hope of maximizing its benefits while respecting the challenges rural indigenous women face.

State programs tend to erase the individual. Participants and their experiences are generalized. They become part of a statistic. And value is only placed on their bodies once they are converted into these important numbers (Hacking 1990). This is biopower concretized. Foucault defines biopower as the process in which “the central concern of the state” is on “the fostering of life and the growth and care of population” (1984:17). Biopower is the emphasis on controlling the life and bodies of a population. This is where metrics come in to play and are given importance. Rivkin-Fish explains that, “biopower became the goal of regimes and experts as they assumed the right and responsibility for measuring, monitoring, and intervening to improve both ‘the population’, and individual persons in the name of societal good, including health welfare” (2005:21). What Oportunidades has shown is that its objective is not only to provide much needed resources to vulnerable populations in Mexico, but it is also a mechanism in which the state can monitor and coerce these populations to follow certain practices that lead to larger state goals; such as reducing national maternal mortality rates. By focusing solely on the importance of getting the numbers right, the experiences of women moving through the biomedical health system become inconsequential.

Metrics are what matter to the Mexican government, not the personal stories of its citizens. This is a practice that plays out all throughout the world. The international community, including funding agencies and world health organizations, lead the way on a dependence and fetish of human statistics. Valentina’s story brings the individual back into focus. She breaks all the negative stereotypes of poor indigenous women who participate in state programs. Her life demonstrates that she is more than a state program recipient. She is also a worker and representative of the state in her rural community (and she does her work without any monetary benefit). In fact, the survival and success of Oportunidades is dependent on women like Valentina. It is time to recognize the hardships these women encounter throughout their lives and how they continue to work hard and are determined to provide a better life for their children.

Chapter 6

Daniela: A Portrait of a Rural Nurse

Ever since I was a little girl I knew I wanted to keep going to school. I wanted to keep studying. In fifth grade, a year before I finished primary school, I told my mom that I wanted to go to school in Chetumal. I wanted to go to a real secondary school. If I wanted to keep studying I had to leave Saban, because there is only a telesecundaria here and the bachiller (high school) had not yet been built. So, I went. I lived with my uncle and his family for six years while I attended school. And in 2006, I graduated from high school and received my diploma and license as general nurse.

Daniela and I talked while we sat and ate lunch on a wooden table in a large dark open room used primarily as sleeping quarters and occasionally a kitchen. It was late in the afternoon, of yet another hot and humid day. We were at her mother Olivia and grandfather Hector's house, where Daniela and her young son Nicolas also lived, occupying a small room with a built-in bathroom at the corner of the housing complex. We were eating *relleno negro*, a thick, rich and spicy specialty dish made with corn meal, fowl and pork, water, and ground up spices consisting primarily of black pepper. It is cooked in large metal pots that are buried in the ground overnight. It was leftovers brought to us by Olivia. She and the rest of the family had all gone earlier to Daniela's brother-in-law's family home to eat the meal in honor of the memory of the death of his mother three years ago.

Daniela had just returned home from work. She was still wearing her nurse's uniform; black polyester pants and a white polyester polo shirt with the clinic's name embroidered on the left lapel. Her hair was pinned back in a tight bun and she wore light makeup. I was so amazed how composed and professional she looked despite working eight hours in the sweltering heat and humidity. I struggled daily

with staying clean and dry from the continuous perspiration that often soaked through my loose-fitting cotton clothing.

That day Daniela primarily talked about how she became a nurse. Daniela always wanted to continue with her studies and knew she wanted to get a good education from a school in Chetumal. She knew she wanted to continue going to school past her secondary education. But at fifteen she was not sure what she wanted to study, she did not know what she wanted to be. When Daniela would come on the weekends to visit her family, Olivia would ask her what she was thinking about studying past secondary school. Daniela would shrug and tell her she still didn't know. Eventually Olivia suggested nursing school. Daniela thinks her mom recommended she become a nurse because she knew it was a good career and that there was always work available. There was also a nurse in the family. Her mother's uncle's wife, Tia Gloria, was a retired nurse that worked for many years at the clinic in Saban. Tia Gloria was an axillary nurse which did not require much formal education. Daniela would be going to a vocational school that would provide her with a license as a general nurse, a higher position and pay grade than her great aunt.

Daniela thought for a while about her mother's suggestion and eventually said sure, sign me up. So, Olivia did just that. She enrolled her in nursing school and bought all her books and supplies including her nurse's uniform. Now that her mother had spent all this money, Daniela realized she no longer had a choice, there was no turning back, she had to go to school and finish her degree. At first, she was not sure if she really liked nursing, but she did well in school and received high marks in all her courses. Surprisingly, one of her biggest reservations had to do with the way she looked. Daniela was uncomfortable in the nurse uniform she was required to wear. She had to wear a small white hat over her tightly pulled back hair, white tights, and a white blouse and skirt. The uniform was nothing like she had ever worn before. Pinning her hair back was hard at first since she had always had bangs and often wore her hair in a loose ponytail. Dressed in her new uniform and ready for work, Daniela looked like a different person and she did not like it. In many ways, her choice to seek professional training, forced her to change the way

she experienced her world and altered her sense of identity. Struggling with these issues, Daniela decided to continue and not let it be the reason she quit school. She succeeded moving past her initial discomforts and completed her education and training. Today, Daniela takes pleasure and pride in being a nurse. She enjoys her job and is happy.

Daniela: A Biographical Sketch

Daniela, or Dani as she is lovingly referred to by her family, is in her mid to late twenties. She has a kind, mature, even keeled, soft spoken demeanor. She is of average height in the community, about 5ft, with fair skin and hazel colored eyes that have a slight tint of green. She is Olivia's oldest daughter. In one sentence, Daniela is a young educated professional working mother who attained her status through the support of her family. Who she and continues to rely heavily on to help maintain a healthy and happy home environment for her and her son.

Daniela is in a relationship with a male nurse who like her also works in a surrounding community clinic. They are not always together. Sometimes he lives with her at her mother's house but other times he stays with his family in Chetumal. Daniela and her partner have a son, Nicolas who is referred to by everyone as Nico. He was born in July of 2011. Most often it is Daniela who takes on the full parental role.

After living away from home for almost a decade, in 2010, Daniela finally returned to Sabán to live with her mother. Daniela has always deferred to her mother and aunts when fulfilling women's roles in the household and community, such as cooking, doing housework, and attending Catholic religious prayer groups. This has taken on a whole new level ever since she became a mother. Daniela continuously seeks guidance with knowing how to care for her son's health and overall wellbeing. More specifically she seeks their advice when Nicolas is sick and not feeling well. She follows their home remedies and herbal therapies used to help treat mal de ojo, fevers, irritability, diarrhea, and sleeplessness. A few months after the birth of her son, Daniela had to return to work. She pays her cousin, Raquel about two hundred pesos a week to watch her son while she is working. Raquel

comes over every morning to Daniela's home and watches Nicolas. At home Nicolas is never alone. He is constantly interacting with his extended family that all help watch him and make sure his is happy.

Becoming a nurse

Daniela attended a three-year nursing program at a high school/vocational school in Chetumal; the state capital and a four-hour drive from Saban. In 2005, after finishing her course work and exams, Daniela began her year of service at the government clinic in Saban. She was happy to have returned home. Her goal has always been to live and work in Saban so that she can be close to her family. During that year she worked alongside the full-time doctor, Dr. Barrios. Daniela spoke very highly of Dr. Barrios. She said that she really liked her and they worked well together. Daniela would accompany the doctor on all her house calls. The doctor also enjoyed working with Daniela and she wanted her to continue working at the clinic as part of her medical team. Unfortunately, there were no open positions at the clinic and Daniela had to find work elsewhere. According to Daniela, Dr. Barrios was kind, encouraging, and always supportive of her professional career. In fact, it was the doctor's letter of recommendation that got Daniela her first paid nursing job in Carrillo Puerto. She was incredibly grateful for the doctor's support. Daniela felt that she was very lucky to have found work right after finishing her degree and service. Many recently graduated students must wait a while before they can find secure paid work, especially a job relatively close to home. Daniela was an eighteen-year-old Maya girl from a rural pueblo who had a full time well paid government job. Daniela's relationship with Dr. Barrios was strikingly different from the women I spoke with who were Oportunidades participants. Dr. Barrios might have seen Daniela as an ally in the community. In her decision to pursue training as a nurse, Daniela publicly acknowledged her support of biomedical care. It could be possible that Dr. Barrios felt a sense of affection and obligation in supporting a woman in the community, like Daniela, who chose to embrace biomedicine and the state health system. I never had the opportunity to discuss this with Dr. Barrios, so I will never know for sure what she thought of Daniela and why she chose to help her. What I do

know, is that Daniela had a different experience with the same doctor that more than 300 women in Saban chose to publicly denounce.

Daniela worked in Carrillo for a couple years and in 2008 she was given a promotion with a raise. She was also given a choice to move to another clinic. She submitted a request to work in Saban and it was quickly rejected because there were still no current openings at the clinic. Daniela then requested to move to Dziuche, a large town located about a thirty-minute drive from Saban. At the time we spoke, she had been working in Dziuche for two years. It was a small clinic similar than the one in Saban. It had a full-time doctor and a supporting staff of three nurses and health workers. The clinics in Dziuche and Saban are the two largest clinics in the region. Working in Dziuche enabled Daniela to finally move back home.

With her earnings, she bought a small car that she made monthly payments on. The car gave her the freedom to easily come and go from Saban and her work in Dziuche. She also used it to travel to Chetumal to visit family and drive to Valladolid and Carrillo to run errands such as buying groceries and personal supplies. Owning a car was a major achievement. Daniela's uncle, Cristian, was the only other person living in the family housing complex that had a car. Daniela was a relatively young woman who had bought a new car, the ultimate symbol of prestige.

Daniela is the only biomedical health care worker living in Saban. All other doctors and nurses live in surrounding towns and cities and commute in for work. They are in the community only during clinic business hours; Monday through Friday 8am-3pm. Many people in the community come to Daniela's house or ask her to visit them so that she can administer injections, check blood pressure, and/or provide a biomedical health assessment and recommendation. Since Daniela was born and raised in Saban, there is a higher level of trust and confidence that the community has in her work and professional opinion. Many people feel that they know her and her family. Daniela is the person many people go to for biomedical help when the clinic is closed.

Throughout her medical training and career, Daniela has attended several births in clinics and hospitals. Early on in her career she witnessed a cesarean

section and just recently she had first-hand experience when the procedure was done to her while giving birth to her son in 2011. During her first year working at the clinic in Dziuche, Daniela attended various births under the supervision of the resident doctor. It was an experience that she truly enjoyed. She learned a lot from the doctor, who took the time to explain everything that was going to take place during the birth, what Daniela was going to have to do, and the equipment and supplies that she was going to need to prepare. Daniela admitted that at first, she was scared attending births but she eventually got over her fears and insecurities as time went by and she attended more and more births. She soon got accustomed to the biomedical routine of birth. As she explained to me, the more you do it the easier it gets.

Daniela was 16 years old when she first assisted a midwifery attended home birth. As Daniela recounted with a note of pride, a woman originally from Sabán who now lived in Chetumal was pregnant and wanted Daniela's grandmother, Doña Carmen, to come to her home and deliver her child. Doña Carmen had delivered all the woman's previous children. The woman was insistent that Daniela's grandmother come. She agreed to pay for her passage to and from the community on top of the standard charge for a home birth. Doña Carmen was unsure about attending this woman, especially so far from home. She was now an older woman who was also starting to lose her eyesight. The woman was persistent and Doña Carmen eventually agreed on the one condition that Daniela accompany her and help with the birth. Daniela at the time was living in Chetumal just beginning nursing school, knowing this Doña Carmen told her that she needed to come to the birth and help her. Without hesitation, she obeyed her grandmother. Daniela did most of the work since her grandmother could not see well. Under Doña Carmen's instructions she prepared everything and helped attend the birth.

Daniela's experience with midwifery has continued by assisting her aunt Elena with births and prenatal care. She just recently accompanied her aunt to a birth in the community. Elena had come over to her house and asked Daniela if she would come with her and take a laboring woman's blood pressure. The birthing mother had a long labor that was not progressing. The mother was not experiencing

labor pains and she was still not fully dilated. Elena was concerned that her blood pressure might be high and therefore placing her in a high-risk situation. Daniela went and took the woman's blood pressure and as Elena predicted, the woman had elevated blood pressure levels. Elena and Daniela both agreed that the mother needed to be transported to the hospital as soon as possible. The mother and child returned a few days later, safe and healthy. Unfortunately for the mother, a cesarean section was preformed once she arrived at the hospital.

Life as a mother

Fieldnotes: Tuesday, July 23, 2013

Today is Nico's first birthday. The whole household has been up early preparing for the party later this evening. Dani went to Valladolid a few days ago and bought party decorations, food, a piñata, and lots of candy. Nicolas also had a new birthday outfit.

My contribution was to make a birthday cake. Most people in the pueblo do not have ovens, so having a birthday cake is a big deal, especially a homemade one. While getting groceries a couple weeks ago in Merida, I bought two Betty Crocker chocolate flavored cake mixes and a can of frosting. It was a bit of a gamble to see how it would turn out since we didn't have measuring cups and the oven didn't have a temperature gauge. I had to check it a few times throughout the cooking process but in about 45 minutes it was done. Surprisingly, it turned out well, just a little burned on the bottom but we just cut it off. It was an early treat to eat the little cut off burnt pieces of cake. The kids all wanted to help me make the cake. There were about 5 or 6 kids around the large rectangular table. I told them they had to wash their hands or they couldn't help.

Dani was making a "sanwichon". It's a giant layered sandwich. It's a popular dish that everyone seems to really love. All the kids watched as Dani made the sandwichon eagerly waiting the time when they could eat their slice. You begin by blending a white cheese that comes in a can and is imported from Holland with media crema and a can of roasted red peppers. Next some

of the mix is poured on the bottom of a tray and layered with white sandwich bread with the crust cut off, milk is then drizzled on the bread soaking it, and finally a layer of the cheese mix and a layer of ham are added. And then you start again with a layer of white bread, and so on. You continue with these layers until you are all out of ingredients. Dani covered the top with the remaining cheese mixture and made it look like it was frosted. She cut up strips of ham and spelled out "Feliz Dia". She added a little grated cheese and a few canned peas and strips of roasted red peppers for decoration. We were in the house, in the room with the stove and refrigerator, and it was hot, it was also really hot outside but it was hotter inside because of the oven. We had to fight the flies, especially Dani while making the sanwichon. In many cases the flies won, taking their victory by landing on everything edible. Once the sanwichon was done it was put in the fridge. Dani also made a couple dozen small Jell-O cups for the kids.

All the women in the family came to help with making the tamales. Dani, Irene, Olivia, Elena, Raquel, and Casandra. They were making chicken tamales covered in banana leaves. Even the younger girls came in and helped.

The party was a success. The food was excellent. Plates were full and cups were filled with Coke. I took photos of Nicolas in front of his birthday cake and sanwichon. We sang happy birthday and Nico blew out his candle. His grandma Olivia helped him open all his gifts; mostly clothes but a few gifts included money. The piñata was broken in the big open room in the house. All the kids and even some adults jumped in to collect the candy on the floor. It was a happy day.

There was a heightened sense of importance surrounding Nicolas's first birthday. It was only three months earlier that doctors told Daniela her infant son might not live to see the age of one. Nicolas was always sick as a baby. He had frequent colds that would never go away. Daniela took him numerous times for checkups with pediatricians at different government clinics. She was always told the same thing; that he had a cold and it would eventually go away. No one seemed to be

too concerned. At nine months old, sick with what seemed to be yet another cold, Daniela took Nicolas to see a private general practitioner. This time she mentioned to the doctor she had been noticing for some time that Nicolas's fingertips and mouth were a little blue. The doctor suspected that Nicolas had a heart condition and recommended that Daniela take him to see a cardiologist at Star Medica; one of the most expensive hospitals and consulting offices in Merida. The consultation cost 1,500 pesos. She spent another 1,000 pesos in travel costs.

The cardiologist diagnosed Nicolas with a heart condition caused by a birth defect. Two of his heart valves were deformed; one was too big and the other too small. His little heart had been working so hard to pump oxygen to the body, but his lips and fingertips were still a bluish color. The cardiologist sat down with Daniela and explained to her that her son was very sick and he was going to need immediate specialized care. He asked her if she had any form of health insurance because the treatment that he needed was going to be very expensive. Daniela's job at the clinic provided her and her son with health insurance from Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (ISSSTE); the government funded insurance for state workers. With the doctor's notes and lab results Daniela went to the ISSSTE hospital and doctor's offices in Chetumal.

Within a month after first visiting ISSSTE, Nicolas was given an appointment to see a team of pediatric heart specialists in Mexico City. For reasons unknown to Daniela, Nicolas was moved relatively fast through the ISSSTE system and she was so grateful that he could get the care he needed as soon as possible. In Nicolas's case, it was the initial diagnosis that took so long to get. A lot of people had told her that they were surprised that he had gotten a referral so quickly. Many patients at the hospital in Mexico City had said that they had to wait months and some over a year to get a referral.

ISSSTE health insurance pays for the doctor's fees and for two flights to and from Mexico City. Daniela is responsible for any other travel expenses, including accommodations in Mexico City. Luckily for Daniela, her social network extended far beyond the Yucatan peninsula. A couple of years earlier a doctor originally from Mexico City had rented out one of her mother's newly built apartment rooms and

used it as a consultation office in addition to his living quarters²⁶. He was an older man who had retired from his main practice in an urban city in Mexico and decided to temporarily move to the pueblo of Saban to live a peaceful life. He hoped to finance his living expenses by setting up a small private practice. However, the retired doctor's time in the community did not last long. Few people in the community came to see him for medical care. They all preferred to wait and see the clinic doctor for free or drive to an urban city to receive more specialized care. While the doctor lived in Saban, he became friends with Daniela's mother. When he left, he had given his contact information in Mexico City and told her to give him a call if she or anyone in her family was ever in Mexico City. This doctor was the only person Daniela knew in Mexico City, so she gave him a call and he graciously invited her and Nicolas to come stay at his home. Without this doctor's help Daniela and her infant son would have probably spent their nights sleeping outside the hospital among many other poor traveling patients and their families.

After speaking with the specialist in Mexico City, Daniela learned that ideally Nicolas should have undergone an operation right after he was born to correct the defect. He was now nine months old and surgery was no longer an easy option. It was too risky and there was a high chance that he could die on the operating table. Daniela and her mother both agreed that the risk of surgery was too high and they would prefer Nicolas at home being cared for by his family living the last of his days happy and loved. The specialist prescribed a regimen of heart medications that Nicolas must take daily. He was scheduled to come back every six months for a checkup and to adjust his medication dosage. The doctors all said that at this point medication was the only thing they could do. They just had to wait and see how he does on his medication. Maybe if he responds well and grows stronger, he will be able to undergo surgery when he's a little older.

Being a young first-time mother can be challenging, but having a sick child compounds all fears, stress, anxiety, and/or uncertainty. Daniela lives her life

²⁶ This was the first time I had ever heard of a private doctor setting up a practice in the community. He was a general physician. His time in the community lasted a few months.

constantly worrying about her son's health and how long he will live. She does not know if he will see another birthday or Christmas. Will she ever see him walk on his own? Will she hear him talk to her and say mama? Will she take him to his first day of school? These are all questions Daniela does not know the answer to. Her life is filled with so much uncertainty and unknown that at times it can be overwhelming. Daniela's only strategy is to take things day by day and wait. In the meantime, she and her family have all agreed to give Nicolas the extra care he needs. They try to keep him happy and they work hard to not let him get upset or cry. All of this is done with the knowledge that Nicolas may not live long. It is an enormous sign of hope that Nicolas has made it to his first birthday. A week after Nicolas's birthday party Raquel (Daniela's cousin and Nicolas's nanny) accompanied Daniela and Nicolas to Mexico City for a follow-up appointment. Daniela was given additional optimism when the doctors stated that they were very impressed with how healthy Nicolas was and how well he was responding to his medication. They said that he looked so much healthier than he did when she first brought him three months earlier.

Daniela continues to watch Nicolas and gives him his daily heart medication. Although he is doing better, Nicolas still fights frequent colds and irritability. Daniela has chosen to address his health needs through a strategy of medical pluralism. She will at times give him a dose of acetaminophen while also treating him with herbal remedies. If he is suffering from colic or diarrhea she might ask the local herbalist for a remedy or take him to her aunt Elena for a stomach massage. Olivia and Dani both mentioned that Nicolas has been a victim of *mal de ojo* more than once. They explained that *mal de ojo* is a curse or negative force sent to Nicolas by someone in the community, which was typically attributed to jealousy. Each time, Nicolas was cured from *mal de ojo* by drinking a specifically mixed herbal tea and bathed in another a similar herbal concoction. These remedies were purchased from an elderly female herbalist a few blocks from their house.

Daniela primarily follows her mother's and aunts' traditional health remedies, especially when treating her son's illnesses and discomforts. However, there have been only few times in which Daniela chose her own path and not followed her family's rules and traditions. The most significant moment was when

she decided early on in her pregnancy to seek out a biomedical birth rather than a home birth attended by Elena. More specifically, as Daniela told me, she wanted a cesarean section. She explained that she chose to go to the hospital and have a cesarean section because she feared experiencing the pain of giving birth. She also admitted that she was scared of the uncertainty of giving birth at home. What if something went wrong? Through her training and work as a nurse, the hospital with its doctors and staff had become a normal setting for Daniela. She found comfort and a sense of security giving birth in a hospital setting that was filled with biomedical technological equipment and doctors knowledgeable of the most up to date medical procedures. Daniela knew that if she experienced any complications during birth, the hospital would be the best place to be. She was convinced that she and her unborn child had a higher chance of survival if she chose to give birth in a hospital.

Daniela was told by her doctor to come to the hospital as soon as she started feeling contractions. She did not have a scheduled cesarean section with an advance date. Her doctor wanted labor to begin naturally, even though s/he knew a cesarean section was going to be performed. Daniela had her son, Nicolas at the hospital in Morelos. She was comfortable at this hospital because she knew many of the doctors and staff. She said that she found out that she was having a boy during her first ultrasound which was given at 4 months of pregnancy. The baby's gender was confirmed at the standard 7-month ultrasound. Daniela had a total of 3 ultrasounds throughout her pregnancy. On average women in Sabán only receive one ultrasound at 7 months. She received prenatal care from three different doctors. She went to the ISSSTE clinic in Carrillo Puerto, the hospital in Morelos, and her coworkers at the clinic in Dziuche also looked after her.

After more than a decade studying and working in the biomedical field, Daniela is at ease with its routines and procedures. Although Daniela blends multiple health systems in her personal life and work outside the state clinic, she ultimately believes and trusts that biomedicine is a safer and superior health care system. Sadly, even though Daniela gave birth in a hospital filled with advanced technological equipment and run by university educated staff, her son's life-threatening heart condition was not detected until he was too old to operate on.

Daniela's story demonstrates how medical resources are severely limited in the region. Even as an educated professional state health worker, Daniela was not able to get the specialty care she needed for her son Nicolas. Advanced medical care is only available in three of the major cities in Yucatan (Merida, Cancun, and Chetumal) all about a three-hour drive away. Yet, the real center for medical research and treatment is Mexico City. Although Daniela took Nicolas to various pediatricians for care, he was not diagnosed with a life-threatening heart condition until he was over nine months old. Her story also shows how difficult it is to navigate the health care system. She had to go through a complicated bureaucratic process to finally get the expert care her son needed. But before all of that, Daniela had to spend a substantial amount of money to get a proper diagnosis.

In the end, many factors contributed to the survival of Nicolas. First and foremost, was the tireless dedication and commitment Daniela had in providing her son with the medical care he needed. It was Daniela, feeling that there was something not right with Nicolas, who pushed for a diagnosis. Second, and equally important, was the unique socio-economic resources available to Daniela. She was a trained and educated nurse. She was familiar with biomedical culture and practices. Through her work, she had an extended network of biomedical practitioners that she could ask questions or seek advice. Daniela also came from a lineage of female healers and she had her mother and aunt to consult with. Daniela's full-time job as a rural nurse working in a state-run clinic provided her with a dependable salary and health insurance benefits for her and her son. Her employment and the financial support of her family allowed her to save the money she needed to pay for extensive tests and consultations with a private physician who eventually diagnosed Nicolas. After the diagnosis, Nicolas received medical treatment through Daniela's state workers health insurance. Daniela's position and socio-economic status within her community provided her with many more resources to help her son than are normally available to most people in Saban and Huay Max. Yet, as Daniela and Nicolas's story illustrate, even with additional access to resources, proper medical diagnosis and treatment are severely limited in rural Yucatan.

Returning Home as a Community Nurse

In October 2013, Daniela accomplished her professional goal. She was finally able to secure full time work as a nurse in Saban's community clinic. The position title was only open as a general nurse. Daniela had been hoping to receive the rural nurse position which paid an extra stipend covering her time outside of clinic hours and availability to the community. Daniela would have liked the pay raise, but it was more important for her to live and work in Saban. So, she took the job without hesitation. Daniela is now the only biomedical health care worker living and working in Saban.

Daniela is limited by the position she has in the clinic and within the larger health system. She is the newest nurse and the least paid. She agreed to work in Saban at a lower pay because it allowed her to be home closer to her son and family. According to Elena, all the other nurses at the clinic get an additional stipend that pays them for working in rural communities and requires them to live in the communities they work in, yet there is no government oversight and the nurses continue to get paid this stipend even though they do not stay in the community. Many people including Daniela's family thought that it was unfair that the designated rural nurses working in Saban received this stipend even though they did not comply with the primary requirements of their job. However, the absence of the other health workers has provided Daniela with an elevated status in the community. She is well respected and trusted by many people. And many seek her out for assistance when the clinic staff is gone.

Daniela has a deep history in her community. People know her and her family. Both her grandmother and aunt (Doña Carmen and Elena) have delivered many of the residents of Saban and Huay Max. Her grandfather (Don Hector) is a respected elder and one of the original *ejidatarios*. Her great aunt worked as an axillary nurse in Saban's community clinic. Her mother (Olivia) has one of the few secure jobs in the pueblo working at the elementary school. Her mother is also a well-known seamstress and assists people in giving injections. Two of her aunts (Valentina and Irene) are Oportunidades *vocales* and community leaders. Daniela is from the community in which she works. Her patients are the people she grew up

with and has shared many of their life struggles living in a rural community. Her pueblo sees Daniela as a part of them. She is an insider. Someone they can trust and feel comfortable talking with, especially in the foreign and intimidating biomedical setting.

Daniela represents the possibility of a health care future in which the community obtains a culturally informed biomedical provider. Since she lives in the community, there is always a biomedical practitioner available to fill in the limitations of an understaffed and underfunded health care system. Daniela is deeply invested in her community, whereas the other clinic staff is not. They leave and she stays. She has a connection, understanding, and commitment to her pueblo that extends beyond her working hours at the community clinic. After discussing all the benefits Daniela brings to the small state-run clinic, it seems obvious that the Mexican government should encourage the training and hiring of local residents to take on these jobs. Yet, in Sabán, there is a wide gap between the seemingly obvious and the realities of the current state of health care for many community residents.

Conclusion

Daniela's story illustrates the difficulties of accessing reliable health care in a rural pueblo. But her story is also about social change, despite challenges, contradictions, and inequalities. It's a story about a woman, a family, and a community all at once. When it comes to childbirth and health care, Daniela is participating in and contributing to a long family tradition. At the same time, she is taking her own path. Her story illustrates social change as it is taking place at various levels. Her own decisions, experiences, and actions are part of the changes that are taking place within her family—and her community. But all this change is set within wider limitations and problems in Mexico's state health care system.

Daniela's community faces a critical problem. It is a problem of access. There are few resources, and those that do exist are often highly unreliable. Daniela is one of the "lucky" ones. She is part of a relatively well-off family that has many connections and resources. Still, she faces many difficulties and challenges. Daniela's story is unique because she comes from a family with a long history of local healers,

but she is also part of the biomedical system. She navigates the border between two systems of health care, moving back and forth between them depending on specific situations, needs, and choices. As a result, in her own life and work as a nurse, Daniela has implemented medically pluralistic approaches to health. She sees the value in both forms of knowledge and understands that each offers specific benefits. Her work with her aunt, Elena, shows how biomedicine and traditional midwifery can complement each other and can work together to meet both the cultural and biological needs of Maya women. Interestingly, even though she was exposed to midwifery and home births her whole life, when it came for her to giving birth, she ultimately chose a hospital birth. Her life history illustrates the complexities and realities of such decisions.

Daniela's story is about the shifting traditions of one family, but it's also about a rural community that continues to battle with poverty and extremely limited resources. Daniela represents change for her family and community—a move away from midwifery in some senses, but also the possibility for more secure, stable health care system that is not limited by either/or approaches. Yet, amid these transitions, there continues to be a deep respect for local traditions and meanings. This is an important point she tries to emphasize in her work as a nurse. Her story points to challenges, on the one hand, but also *future possibilities* on the other. Her experiences show that things can, indeed, be different. The community of Sabán and Huay Max has a long history of neglect and marginalization when it comes to access to state resources—and this includes health care. Many of the doctors and biomedical staff simply have little investment in the community; they want to leave as soon as possible. This is how marginalization works. The community is left to fend for itself, to rely on the knowledge and experiences of its members for survival. Here is where midwives play a central role. They are a cultural, historical, and experiential safety net. This is how community members deal with marginalization. And yet the Mexican state is highly critical and unsupportive of midwifery (despite some official rhetoric to the contrary). This leaves the community in a double bind, in which there is, seemingly, no way to win.

Daniela's story is about how one woman is dealing with these contradictions and seeking her own way out of her community's double bind. In the end, she fought hard to be able to live and work in her community. She had to battle against the structures (and habits) of the state health care system to make this happen. From an outside perspective, it makes sense that people should be encouraged to take their experiences and training back to their own communities. They have a deep investment and understanding of their community that is not always shared by their outside colleagues. This is especially true in Sabán, where the majority of its clinic staff live outside the community. They have no connection to the people or the place. They are there purely out of obligation. In the end, this is a situation that leaves an entire community not only without reliable access to health care, but also vulnerable to misunderstandings and disrespect by outside biomedical health care workers. By working as a nurse at the government clinic in Sabán, Daniela has the power to advocate on the behalf of her community—a responsibility she does not take lightly.

Daniela has worked hard to push back against these realities. Her presence in the community as a health care provider with traditional roots and biomedical training cannot be understated. The fact that she lives in the community helps to alleviate some of the persistent issues that have plagued Sabán and Huay Max's health care system for so long. Daniela is, perhaps, symbolic of taking a step in the right direction. But, at the same time, her story should not be overly idealized. Even though Daniela is part of the biomedical health care system, she still faces difficulties getting access to resources and treatment. She does her best, given the circumstances, often making decisions that mix the biomedical and the traditional, the new and the old, in complex ways. In the end, she does what she can to work within the constraints of her own life and profession—as well as those of family, community, and country—to keep not only her son healthy, but to care for health needs of her community.

Conclusion

My first critical encounter with Yucatan took place through my experiences working as an archaeological field assistant in the summer of 2002. When I signed up to join the Yo'Okop/ CRAS project I knew little of the Yucatan, but I was 21 years-old and I was hoping for an adventure. Before that, I visited the peninsula twice during the early 1990s, but those experiences were heavily filtered and constrained by tourism. My family and I spent our entire vacation in the rapidly expanding hotel zone of the recently founded city of Cancun. We only ventured out for a few day trips to popular archaeological and tourist sites—we explored the monumental structures of Chichen Itza and Tulum, and snorkeled at a nature preserve. Everything was meticulously designed and choreographed for us to come take photos and spend money. The only Maya we were presented with were those of the long distant past. There were so many aspects of everyday life in Yucatan that we completely passed by. But as we willingly followed the tourist “must do” check list of Cancun, we also knew something was not quite right about the layout of the city. My mother’s family is originally from Guadalajara, Jalisco (the second largest city in Mexico) and I spent the majority of my school vacations as a child living and traveling through Mexico. Cancun was the first tourist city we visited that had in its design deliberately separated tourist from local residents—in many ways it only felt like we were in Mexico because everyone spoke Spanish and we used pesos²⁷. My mom felt trapped in the hotel zone where the only places to eat were the expensive tourist restaurants. So, after a couple of days we got on a city bus and went to a *mercado* in downtown Cancun. We wanted homemade menudo for breakfast and street tacos for lunch. We didn’t find the menudo but we did find the tacos and the enchiladas. We left the hotel zone one or two other times for food. We were deterred

²⁷ The hotel zone in Cancun typically hires people who come from central Mexico to be the face of the hotel. They came from large cities like Guadalajara or Mexico City. This means that the people tourist primarily encounter in the hotel zone are not Maya. The Yucatec Maya are predominately back stage—working in the service industry such as housekeeping and kitchen staff or building and maintenance (Castellanos 2010).

by the hassle of having to take a 20-minute bus ride just for an affordable and authentic Mexican home cooked meal. In the end, my mom weighed our options and decided to spend the extra money and let us eat hamburgers from the hotel bar for the rest of the trip.

During those first trips to Cancun, I witnessed the building of a tourist zone. At that time, there were still many open lots and several hotels still in the early stages of development. Everything felt so new. But what really stuck out in my mind was how this new city was built primarily for tourists and not for local residents. It was so difficult to get around and explore the city. The layout of the hotel zone, discouraged us from leaving. It was easier to stay at the hotel and go to the beach directly in front of the property. If we did want to leave, the hotel staff veered us towards various tour guide companies. During our time in Cancun, we experienced how this city was deliberately designed to separate tourist and local people and it felt alienating.

That summer of 2002 was one of the most influential moments of my adult life and set the course of my academic career. As a researcher, I was introduced to the complex and dynamic history of the peninsula—this was also the first time I was exposed to what life was like for the majority of its residents. As I soon found out, working as an archaeology field assistant was hard work. The days were long and hot. And I was exhausted at the end of every day. But for me, the most significant experience was living in Saban for the whole summer. Although the pueblo was one of the largest in the area with a population of 3,000 it still lacked many of the conveniences of urban life including running water and a sanitation system. Every week we had to drive two hours to the closest city to get supplies. By the end of the summer I had a new understanding and relationship with the Yucatan, which came primarily from experiencing life in a rural Yucatec Maya pueblo. I began to understand that there were large areas of the peninsula that were almost forgotten by the state. The roads were horrible, basic infrastructure was inadequate, and access to many basic household staples and a diversity of food was limited. These experiences greatly contrasted from the encounters I had in my youth, which were

heavily influenced by the images and narratives promulgated by tourist media, international hotels, and popular discourses.

It has been almost fifteen years since I first started working in Yucatan and every year I continue to delve deeper into the history, politics, and culture of the region. This has only been possible because of the relationships I have cemented with rural Maya women. Over the years, I have established and maintained longstanding relationships with community members built on trust and mutual respect. These women have taught me how to be a better listener and the value of patience. I have been honored to have Yucatec Maya women confide in me and share intimate details of their lives, such as stories of the births of their children, concerns they have in seeking culturally appropriate prenatal care, their need to help support their families, and their desires of a better life for their children. These women have taught me how the everyday life of rural indigenous women is tied to a long history of marginality that at moments has experienced both state antagonism and abandonment. Beyond my research, these women have taught me the importance of family and friendship. I have learned from them how to be creative and resourceful (to use the resources I have access to maximize the health and future of my son)—to work hard, be strong, have perseverance and determination. I am a better mother, wife, and anthropologist because of them and I will be forever grateful.

At the beginning of my anthropological career I had no idea what I was doing. But I was also lucky, because I had two amazing mentors while in the field (Justine Shaw an archaeologist and Sandra Bever a cultural anthropologist) to help me begin formulating the kinds of questions I wanted to ask. I got a lot wrong in those early years, but I did learn that it was vital to get outside and talk to people. For example, in the beginning I thought women in the community did not want to use biomedical care during their pregnancy and childbirth, and I assumed (somewhat romantically) that they were happy with life as it was. I began with the assumption that these women relied primarily on traditional knowledge to guide them through the birth process, and my understandings, at least at first, didn't push much beyond that. As this dissertation shows, over the years I came to understand that women's reproductive choices—where and how they gave birth—were part of much larger

histories, experiences, and politics. But this understanding would not have been possible without the insights and experiences of long-term research—of returning to the same place year after year.

I modeled my dissertation off Mary Elmendorf's *Nine Maya Women* because I felt her approach was a powerful way of documenting women's lives and experiences. Elmendorf used the stories of women in one family to discuss the gendered dynamics of life in rural Yucatan—this included the distribution of labor and the social positioning different women had within their families and their community. Her approach draws the reader in, and connects personal experiences with broader cultural and political contexts. Elmendorf's book may have focused on personal histories and stories, but it was also highly theoretical. She used women's stories to frame larger theoretical discussions that addressed the ways in which indigenous Maya women were grappling with a rapidly changing world.

My work follows Elmendorf's approach, but does not stop there. In this dissertation, I build off Elmendorf's example yet also follow in the footsteps of scholars such as Patricia Zavella (1993, 2001, 2011) and Iris López (2001, 2008). The work of Zavella and López collectively examines how race, gender, and class intersect in the lives of marginalized Latina women. They both use individual stories and experiences to highlight key analytical issues and illustrate critical problems that Latina women face in their daily lives. In *Matters of Choice* (2008), for example, Iris López uses family histories to powerfully illuminate and analyze how colonial legacies, racism, and gender inequality intersect with the reproductive choices and strategies of Puerto Rican women who live in New York City. Both Zavella and López have included themselves in their work to explore the political and economic consequences of being a woman of color. This is a methodological strategy that I have chosen to emulate and expand upon in my own work. As a Chicana feminist scholar, I argue that it is important to look at structural barriers to equality that women face, while also understanding how my own positionality as a researcher from the US affects my work. Iris López argues that the women she works with are not victims. They have choices, even if those choices are constrained. But they are active agents in the fight to confront and shape, day after day, the social and political

realities they continually face. To understand the kinds of choices that women in Sabán and Huay Max make, I not only recognize my own role in the research process, but borrow inspiration from Elmendorf, López, and Zavella.

In writing this dissertation, I use the stories of one key family to provide insight into how the Mexican state interacts with, and shapes, the lives of rural indigenous people. The three women I have highlighted in this dissertation represent different positions of leadership in relation to maternal health. Elena is a prominent midwife who provides maternal health care to many of the women living in Sabán and Huay Max. Elena also attends to the basic health care needs of her community, since accessing a doctor or nurse at the local government clinic is limited and inconsistent. Valentina is a recipient of social services (Oportunidades) and a respected community-elected representative (vocal) who not only oversees the distribution of program information to participants but also adapts the program's meanings and implementation to better fit with the needs of the community. Daniela is a young nurse, who after a decade of working at surrounding regional hospitals and clinics, was finally able to come back to the community where she was born and raised to continue her work. She is a biomedical nurse, but because of her family background, she also sees the value of traditional knowledge. She is the kind of healthcare provider that many members of the community have hoped and asked for since I first started working in the community. These women come from one family, yet their stories and experiences strongly resonate with and articulate the struggles of life on the periphery of the Mexican state.

The experiences of Elena, Valentina, and Daniela also demonstrate the agentive ways in which individuals push back against the power of the Mexican state. All three of these women, each in their own way, have advocated on the behalf of local women's right to decide how and where they want to give birth while integrating Maya cultural approaches, medical pluralism, and community knowledge into their work. Elena has encouraged her patients to demand that doctors listen to them and work with them to prevent unnecessary cesarean sections. She has also openly spoken with physicians about the mistreatment local women have experienced by state practitioners and the general fear that many

women have with seeking care at public hospitals. Additionally, Elena has incorporated biomedical knowledge into her practice and continues to learn as much as she can, even though local doctors have not always been open to working with her. Valentina's work as a vocal has provided her with the opportunity to shield women from the oppressive coercion and monitoring practices of state programs, such as Oportunidades. Valentina transforms the program in ways that make it more pragmatically focused and relevant to the needs of her community. She discusses with women the benefits of Oportunidades while also criticizing its weaknesses and acknowledges the importance of traditional approaches to health. Daniela, is softer spoken, but her refusal to denounce traditional midwifery is an act of defiance against her medical peers and the state health system which upholds biomedical care as the only legitimate form of health. By working with her aunt, Daniela can extend her medical reach by assess the health of women who are fearful or apprehensive about seeking care from doctors and hospital staff. It is in these pivotal moments, when a medical emergency arises, that Daniela as biomedical nurse who has gained the trust of her community, can help save a woman and her child's life. Elena, Valentina, and Daniela embody what it means to practice culturally informed political activism, and as a result, they are securing the physical and cultural survival of their community.

This dissertation fits within a larger discussion in medical and feminist anthropological theory that examines the political economy of reproductive health from the perspective of the women who experience these broad processes. I see this dissertation as a continuation of the work of feminist anthropologists who have actively decided to emphasize the perspectives, concerns, and experiences of women. The anthropology of the Yucatan peninsula has a long history, yet much of the nineteenth and twentieth century works have been written by men. Elmendorf was trained by one of the dominant male anthropologists who worked in this region, and, like Margaret Mead for the Boasians, was encouraged by her mentors to investigate the role of women. But Elmendorf has done much more than this, as have others who have followed in her footsteps, including Brigitte Jordan and Robbie Davis-Floyd.

This work is grounded in and inspired by the broader work of anthropologist who study the state, and particularly key researchers who have worked in Mexico and the Yucatan peninsula. I am concerned with how the Mexican state through the implementation of development programs uses the bodies and reproduction of women to fulfill state objectives. Throughout the dissertation I have demonstrated how state policies are enacted in everyday life through the various decisions women make daily. More importantly, the decisions Yucatec Maya women make regarding their reproductive health must be seen as a direct reaction to the encroachment of the Mexican state in their lives and that of their families. These Yucatec Maya women, conceive a constructive, yet negotiated, relationship with the state that grants them authority over their maternal health while participating in state programs. This ethnography is about the struggles indigenous women face in protecting their identity, practices, and subsistence against state intrusion. This, ultimately, comes down to a battle over how the next generation of Mexican citizens will come into the world.

This work is also deeply informed by a political economic approach. As Ginsburg and Rapp (1991) has argued, reproduction is intricately tied to the political economy of the state. Childbirth is literally about the reproduction of the state itself. Through the participation in state social programs, such as the conditional cash transfer program Oportunidades, women who have historically lived in the margins of the state (Das and Poole 2004) are brought into larger state objectives by being taught how to be good citizens and mothers (Molyneux 2006; Smith-Oka 2009). Not only are women in Sabán and Huay Max told that biomedicine is the superior and “modern” form of health care, they are also told how to use their cash transfer, and instructed on how to ask for their money. The rhetoric of Oportunidades talks about the relationship of rural, poor, and indigenous women to the Mexican government. Through the language of co-responsibility women are told that the Mexican state will fulfill its responsibility to supporting the health and growth of future generations but only if women choose to comply with program requirements that emphasize the morality of being good mothers. In the end, if

children grow up unhealthy and poor, it is the fault of their mother, not the Mexican government.

Much of this comes back to longstanding debates about development. It may be easy to assume that due to the imposing and challenging consequences of participating in state health care programs, women simply would want nothing to do with these programs, but this was clearly not the case. In fact, Yucatec Maya women do participate in state programs, such as Oportunidades, to address significant contemporary needs. This is a more recent form of engagement with the state that has a deep history behind it. These women are not mere pawns of the Mexican state. The core argument of this dissertation is that these women, who rely on traditional and historical experience, create strategies for survival and social reproduction in spite of their marginalized position within the Mexican state.

I argue that rural Yucatec Maya women have demanded more from the government, and from the programs that were supposedly designed for them, to address their critical concerns. They want the state to fix their roads, to fund more hospitals and clinics, and to provide more economic opportunities for their families, especially their children. These women push the government, demanding the support and vital resources they need to get through difficult times. They are certainly not anti-development, just as they are not against the biomedical system. What they truly want is to be heard, and for their voices and concerns to be actively taken into account. They want better doctors, and, more broadly, a more reliable health care system on which they can depend.

And yet, Yucatec Maya women also demand that doctors and state health officials respect their cultural traditions and acknowledge the political and economic challenges they face. More importantly, while women in Sabán and Huay Max value biomedical care, they do not want to relinquish their traditional health care system, based in history and culture, that helped them weather the marginalization, abuse, and abandonment of the colonial period, the twentieth century, and today. In the end, these Yucatec Maya women want a plurality of health care choices that include both biomedicine and midwifery. They want to continue to use state health resources while holding on to the cultural knowledge and practices

they value. These women want the power to decide where and how they give birth. They argue that prenatal care and childbirth are intimate decisions that should only be made by a woman and her family, and not the Mexican government.

One of the primary problems is that the Mexican state often does not listen to these women who desire to be heard. As I have argued in this dissertation, the “state,” as experienced by rural Yucatec Maya women, is not some distant, far off entity that they never encounter. For the majority of their adult lives, the state takes the form of local and regional doctors and other health care providers who wield power over the lives of local women. What I have seen, throughout my research, is that these interactions at the margins of the state are highly dependent on the relationships and politics of individual doctors and health care providers. In Sabán, for years, there has been an ebb and flow when it comes to the relationship between women and local health care providers. During some years, the local resident doctor and staff were more respectful, willing to listen, and open to considering the value of traditional knowledge and midwifery. At other times, however, different doctors have been strongly biased against including traditional systems as legitimate options for local women. But what matters most is that the power relationships here are dramatically uneven. State doctors and health care workers, no matter if they support local knowledge or not, have a powerful and privileged position in the community. They are educated professionals who have a higher social status within wider Mexican society. These doctors and health workers have access to many more resources than the majority of the people living in Sabán and Huay Max—specifically, they have more money. More importantly, since these individuals work for the Mexican government, their position within the community is legitimized and supported by state authority.

Yet, women from Sabán and Huay Max have fought back. They have asserted their voices, they have protested, and they have demanded more from the state. These women are not passive, and not without agency and power—even if their power is constrained (Lopez 2008; Wolf 1999). Women in Sabán and Huay Max have enacted indigenous modes of resistance and cultural persistence that counter biomedical hegemony. More specifically, the choice to give birth at home with the

assistance of a midwife is an act of resistance that counters state discourses and practices that position childbirth exclusively within the realm of biomedical practitioners and hospital settings. Rumors and social networks of informational exchange are one important way in which Yucatec Maya women have responded and pushed back against biomedical ideas and narratives of risk. State doctors and health officials use discussions of risk to delegitimize traditional midwifery and, in return, grant themselves the authority to govern over the bodies of women. However, the rumors and threats that women share amongst each other about the abuse, neglect, obstetric violence, and unnecessary cesarean sections that take place in public hospitals are not unfounded. The practice of sharing information and rumors is a social mechanism through which Yucatec Maya women protect themselves, their families, and their wider community.

Much of this, circles back to questions about agency, power, representation, and voice. This is one of the primary reasons why I have also used *testimonio* as a method—and inspiration—for framing this dissertation. Conflicts over access to health care are about power, but they are also about the production of both knowledge and identity. State health care systems, which are based upon a broad acceptance of biomedical models, promote certain forms of knowledge as legitimate, while delegitimizing others. One of the primary tensions of my research is that so many of the women I worked with rejected such either/or dichotomies, both in their words and actions. I have chosen to highlight their own personal, highly political stories—*testimonios*—to push back against dominant state discourses about health, reproduction, and ultimately citizenship.

None of this is new. This is why looking at history is so important. For rural, Yucatec Maya people, processes of marginalization by the state have been ongoing since the nineteenth century. Contemporary medical discourses about the superiority of biomedicine are an extension of longstanding processes to delegitimize the authority and knowledge of indigenous people. Social programs have been created, in various forms, to quell dissent from Maya people by providing them with basic resources, and in the process bringing in the supposedly unruly, ignorant, backward masses. State health programs, such as *Oportunidades*, are, in

this way, used to “civilize” or “modernize” indigenous, poor and rural women who have not fully been incorporated into the biomedical system.

This dissertation is about maternal health, but it is about much more than that. It is about the survival of a group of people and their culture. Yucatec Maya women’s fight to give birth on their own terms illustrates how indigenous women hold on to the cultural practices and beliefs that they value while participating in an ever-changing world. Childbirth struggles in rural Yucatan are also a struggle for cultural autonomy and survival. These conflicts over maternal health care and access are about power, history, control, and self-determination which have been ongoing for decades, years, and centuries.

My focus on reproduction is a way to talk about the relationship rural Maya people have had with the Mexican government. Nash (2001) has written about indigenous struggles for autonomy, against dominant modes of governance and development that do not value traditional cultures and knowledge. My central concern is that we need to listen to these women. I present their stories and concerns through testimonio, and contextualized by deeper histories, to push back against unequal power relations that continually silence “the people without history” (Wolf 1982). These women have histories, knowledge, voices, and experiences that should be valued, accounted for, and taken into consideration.

My goal is to share the hopes and desires of these women with the people who are actually making the decisions that affect their lives. Policymakers and government officials must begin to reflectively think about the impacts their decisions have on the people who live in rural communities. The state needs to be held accountable, and this accountability begins by listening to the people whose lives are so powerfully shaped by inadequate health infrastructures and resources.

My hope is that the women in Sabán and Huay Max can use this dissertation as a resource to legitimize their perspectives, and to be heard. I want this document to be able, at least in some small ways, to work against those state discourses that marginalize and minimize indigenous women’s stories, perspectives, and lives. I feel obligated, after working with these women for years, to find ways to push myself into these policy circles and to advocate, in any way I can, for the very women

whose arguments have shaped and informed this document. In many senses, it is their ideas, knowledge, and arguments that are presented here, and this, above all else, is what I want readers to know.

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AWARDS AND HONORS

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- 2016 Margaret Lantis Award for Excellence in Original Research, U. of Kentucky
- 2010 O'Dear Award for Graduate Research in Latin America, U. Kentucky
- 2010 Susan Abbot-Jamieson Pre-Dissertation Research Fund Award, U. Kentucky

GRANTS AND FELLOWSHIPS

- 2013 Fulbright-Garcia Robles Scholar, IIE Research Grant
- 2013 Graduate School Travel Grant, U. Kentucky
- 2011 Graduate School Travel Grant, U. Kentucky
- 2010 Foreign Language and Area Studies (FLAS) Fellowship, Duke University
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- 2009 Lyman T. Johnson Fellowship, U. Kentucky (2009/2010-2011)
- 2008 California State U. California Pre-Doctoral Sally Casanova Summer Research Fellowship
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- 2007 Foreign Language and Area Studies (FLAS) Fellowship, San Diego State U. (2007-2008)
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- 2006 Fred H. Bixby Student Scholars Program, San Diego State U. (2006/2007-2007/2008)
- 2005 PATCH Scholarship, Hawaii Department of Human Services (2005-2006)

PUBLICATIONS

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