Becoming (M)other:
Political economy and maternal transition in urban Chiapas

A thesis submitted to The University of Manchester for the degree of PhD in Social Anthropology in the Faculty of Humanities

2016

Jenna Murray de López

School of Social Sciences
Department of Social Anthropology
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of Figures</td>
<td>4</td>
</tr>
<tr>
<td>Abstract</td>
<td>5</td>
</tr>
<tr>
<td>Declaration</td>
<td>6</td>
</tr>
<tr>
<td>Copyright Statement</td>
<td>6</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>7</td>
</tr>
<tr>
<td>Glossary</td>
<td>9</td>
</tr>
<tr>
<td>Maps</td>
<td>10</td>
</tr>
<tr>
<td>Barrio Families</td>
<td>11</td>
</tr>
<tr>
<td>INTRODUCTION PART I – The Research Argument</td>
<td>13</td>
</tr>
<tr>
<td>INTRODUCTION PART II: The Fieldsite</td>
<td>41</td>
</tr>
<tr>
<td>INTRODUCTION PART III: The Fieldwork</td>
<td>61</td>
</tr>
<tr>
<td>CHAPTER 1: Birthing a Nation: Modernization and Maternal Subjects</td>
<td>70</td>
</tr>
<tr>
<td>Mothers and the Mexican State: A Historical Overview</td>
<td>80</td>
</tr>
<tr>
<td>Ideological Glorification and Actual Socio-Economic Discrimination</td>
<td>89</td>
</tr>
<tr>
<td>CHAPTER 2: Power, Resistance and Resignation: Narratives of Clinical</td>
<td>105</td>
</tr>
<tr>
<td>Maternity</td>
<td></td>
</tr>
<tr>
<td>Pregnancy</td>
<td>108</td>
</tr>
<tr>
<td>Birth</td>
<td>120</td>
</tr>
<tr>
<td>Nurturing</td>
<td>137</td>
</tr>
<tr>
<td>Resistance and Resignation as Everyday Practice</td>
<td>142</td>
</tr>
<tr>
<td>CHAPTER 3: Urban Midwifery: Competing Cultural Metaphors of Risk</td>
<td>148</td>
</tr>
<tr>
<td>Midwifery in Mexico and Relations with the State</td>
<td>151</td>
</tr>
<tr>
<td>The Partera Empírica</td>
<td>158</td>
</tr>
<tr>
<td>The Partera Profesional</td>
<td>173</td>
</tr>
</tbody>
</table>
Power, Agency and Political Practice 185
The Social Construction of Natural Childbearing 189

CHAPTER 4: La Cuarentena: Mothering the Mother 192
Carlita 195
Lupita 203
Learning To Be a ‘Good Mother’ 209

CHAPTER 5: A Blessing from God: Transition to Motherhood 227
Madres Solteras 230
Living with the Suegra 242
Undoing Fixed Identities 250
Constructs of (M)other Love and Becoming Through Ideas of Separation 253

CONCLUSION 263

BIBLIOGRAPHY 268

Final Word Count: 78,224 (Main Body)
## List of Figures

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Country Map of Mexico</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>Map of Chiapas</td>
<td>10</td>
</tr>
<tr>
<td>3</td>
<td>Data Collection Phases</td>
<td>42</td>
</tr>
<tr>
<td>4</td>
<td>Detailed map of Chiapas</td>
<td>44</td>
</tr>
<tr>
<td>5</td>
<td>Barrio la Garita</td>
<td>55</td>
</tr>
<tr>
<td>6</td>
<td>Image</td>
<td>56</td>
</tr>
<tr>
<td>7</td>
<td>Mestiza Barrio Families table.</td>
<td>59</td>
</tr>
<tr>
<td>8</td>
<td>Individual Barrio Participants</td>
<td>60</td>
</tr>
<tr>
<td>9</td>
<td>Image</td>
<td>61</td>
</tr>
<tr>
<td>10</td>
<td>Image</td>
<td>88</td>
</tr>
<tr>
<td>11</td>
<td>Image</td>
<td>90</td>
</tr>
<tr>
<td>12</td>
<td>Image</td>
<td>98</td>
</tr>
<tr>
<td>13</td>
<td>Image</td>
<td>164</td>
</tr>
<tr>
<td>14</td>
<td>Image</td>
<td>172</td>
</tr>
<tr>
<td>15</td>
<td>Image</td>
<td>180</td>
</tr>
<tr>
<td>16</td>
<td>Image</td>
<td>212</td>
</tr>
<tr>
<td>17</td>
<td>Image</td>
<td>242</td>
</tr>
<tr>
<td>18</td>
<td>Image</td>
<td>256</td>
</tr>
</tbody>
</table>
Abstract

Based upon fieldwork in San Cristóbal de Las Casas, Chiapas, South East Mexico, this thesis is about how mestiza women in a low-income barrio become mothers. As such, it is an engagement with theories of embodiment, maternal subjectivity, transformation of self and gendered modernities. The chapters are intended to evoke discussion around the roles that mestiza women, the wider Mexican society and the state play in simultaneously embracing and rejecting constructed notions of the good mother. Competing notions of good motherhood come about through local practices and ideals, and also through discourses of risk and global health. The thesis is structured so that the corporeal processes of maternity (pregnancy, birth and nurturing) provide a common and interlinking theme which also demonstrate maternal transition as a life event akin to others. In doing so, this thesis is ultimately about the way in which gendered beings experience change.

I intend this thesis to be both a political and theoretical project which highlights the lives of a community of women in a particular moment in their history. This thesis provides further evidence for the need to formulate new global theories of change that foreground gender in global processes. The women I met during fieldwork, and whose narratives have shaped the direction of this thesis, show that when individuals have recourse to a mixed economy of health care and are not reliant on state intervention, it can result in an outcome that better meets with the woman’s expectations. Women’s combined use of lay and clinical services reveal ways in which they make active attempts to avoid negative pre and postnatal experiences. In doing so, they embody a maternal identity that is deeply rooted in local ways of being-in-the-world. By managing the process of maternity more akin to local ways of thinking about gendered personhood, the women reveal how social change is both assimilated and contested in daily life.
Declaration

I declare that no portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning

Copyright Statement

i. The author of this thesis (including any appendices and/or schedules to this thesis) owns certain copyright or related rights in it (the “Copyright”) and s/he has given The University of Manchester certain rights to use such Copyright, including for administrative purposes.

ii. Copies of this thesis, either in full or in extracts and whether in hard or electronic copy, may be made only in accordance with the Copyright, Designs and Patents Act 1988 (as amended) and regulations issued under it or, where appropriate, in accordance with licensing agreements which the University has from time to time. This page must form part of any such copies made.

iii. The ownership of certain Copyright, patents, designs, trade marks and other intellectual property (the “Intellectual Property”) and any reproductions of copyright works in the thesis, for example graphs and tables (“Reproductions”), which may be described in this thesis, may not be owned by the author and may be owned by third parties. Such Intellectual Property and Reproductions cannot and must not be made available for use without the prior written permission of the owner(s) of the relevant Intellectual Property and/or Reproductions.

iv. Further information on the conditions under which disclosure, publication and commercialisation of this thesis, the Copyright and any Intellectual Property and/or Reproductions described in it may take place is available in the University IP Policy (see http://documents.manchester.ac.uk/DocuInfo.aspx?DocID=487), in any relevant Thesis restriction declarations deposited in the University Library, The University Library’s regulations (see http://www.manchester.ac.uk/library/aboutus/regulations) and in The University’s policy on Presentation of Theses.
Acknowledgements

I would like to begin by thanking the women and families in la Garita, San Cristóbal de Las Casas and Tuxtla Gutiérrez for allowing me into their lives and homes. Since 2003 I have been indebted to the people in Chiapas who have cared for me, nurtured me and taught me so much about life, that without them, I would not be the woman I am today and I would not feel so torn about where to call home.

This thesis and the ideas growing within it only exist because of the individuals and families in la Garita. I would like to thank them for never tiring of my questions and presence in their doorways and kitchens. In the months that my eldest daughter and I spent apart from my husband and son, we rarely felt alone and we always felt safe.

Cristina Alonso has been a critical guide into the complexities and politics of the public health system and midwifery in Mexico. Her work and activism are a constant inspiration and reminder that there will always be much work to do.

I am indebted to my principal supervisor Professor Jeanette Edwards who has encouraged and guided me since the day I arrived at her office nearly six years ago. Her written and verbal feedback throughout the whole process has provided me with focus and the confidence to own my ideas. I also wish to thank my second supervisor Dr. Tony Simpson for commentary and much needed proofing corrections to my early and later drafts. The detailed feedback on two chapters and conversations with Dr. Gillian Evans were invaluable in the writing process. I would like also to mention my former MA supervisor Professor John Gledhill who made the Social Anthropology department at Manchester a place I wanted to return to.

Finally, I want to thank my parents Angela and Paul for their continuous support and encouragement. They brought me up to believe that there is always a way.

I dedicate this thesis to my husband Arturo and our beautiful children Emilia, Issac, Frida and Diego who teach me every day about love and what really matters. Gracias los amo, son mi razón de ser.
In Mexico women are said to carry *la luz de la vida* the light of life. The light is located, not in the woman’s heart, not behind her eyes, but *en los ovaries*, in her ovaries, where all seed stock is laid down before she is even born.

Glossary

Frequent terms and initials

*Casa de Partos* – Birthing House

**Clinically managed maternities** - The corporeal and embodied process of childbearing and early motherhood within the realm of local medical practice and institutions.

*Cuarentena* – Forty-day postpartum quarantine period

**ENSANUT** -  *Encuesta Nacional de Salud y Nutricion* (National Health and Nutrition Survey)

**EZLN** – *Ejercito Zapatista de Liberación Nacional* (Zapatista National Liberation Army, also known as the Zapatistas).

**IMSS** - *Instituto Mexicano del Seguro Social* (Institute for Social Security and Services for State Workers)

**INAFED** - *Instituto para el Federalismo y el Desarrollo Municipal* (Institute for Federal and Municipal Development)

**ISSSTE** - *Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado* (Institute for Social Security and Services for State Workers)

*La mujer abnegada* – the self-sacrificing woman

**Mal de ojo** – Evil eye

**Out-of-hospital birth** – A midwife supported birth that takes place either at home or in a birthing house

**Panza** – pregnant belly

**Partera Empírica** – Empirical/lay Midwife.

**Partera Profesional** – Professional Midwife, licensed, registered and generally qualified outside of Mexico

**Partera Tradicional** – Traditional Midwife. Registered and non-registered midwives of predominantly (Maya) indigenous identity.

**Seguro Popular** - *Seguro Popular* (Popular Health Insurance) is a decentralised agency of the Department of Health in charge of providing healthcare services and programmes to citizens without access to other forms of public or private health insurance.

**Suegra** – mother-in-law

**Susto** – frightened by a spirit or situation

**Tiene Ojo** – To be suffering from the effects of the evil eye (roughly translated as - to have the eye)
Maps

Figure 1. Mexico

Figure 2. Chiapas
Barrio Families

**The Gomez family (house 1)**
Doña Reina, head of family (widow)
Don Marco, Reina’s 3rd son
Doña Carla, wife of Marco
Carlita, Marco Jnr, eldest children of Marco and Carla
Dulce, partner of Marco Jnr.
Alison, Carlita’s newborn
Don Felipe, Reina’s 4th son
Doña Tee, wife of Felipe
Other small children/grandchildren

**The Gomez family (house 2)**
Don Arturo, builder and carpenter, Reina’s 1st son
Doña Perla, runs a small shop from their house, wife of Don Arturo
Rogelio, Carlos and Ricardo, labourers, sons of Arturo and Perla
Magali wife of Carlos
Josefina wife of Ricardo
Other small grandchildren

**The Sanchez family**
Doña Rosa and Don Juan, Doña Frida’s Parents
Doña Frida, runs lucrative doorstep business, aunt to Dulce (Gomez family house 1)
Don Pepe, bricklayer, husband of Doña Frida
Pepe Jnr, Roger, Gustavo and Carlos, labourers, sons of Don Pepe and Doña Frida
Ceci, partner of Pepe
Lila, partner of Roger
Estrella, six-month old daughter of Roger and Lila
Other siblings of Doña Frida and their children
The Mendoza family
Sara, my neighbour, works from home, mother of Ana and Valeria
Ruby, Sara’s cousin and mother of Iván

The Torres family
Lupita, government secretary and my husband’s friend from university
Diego, ex-husband of Lupita
Mateo, young son of Lupita and Diego
Bania, communications assistant, Lupita’s second cousin
Bania’s two daughters

Doña Gertrudis, widow, caretaker and housekeeper for Don Victor
Don Victor, my landlord

The Álvarez family
Doña Maria, owns the barbeque chicken stall
Eric, eldest son of Maria
Mabel, partner to Eric
Carolina, three-year-old daughter of Eric and Mabel
Maria’s two other sons and daughter-in-law
Introduction Part I

The Research Argument

…it is clear that there is no such thing as the family only families.
(Moore 1994:2)

Based upon fieldwork in San Cristóbal de Las Casas, Chiapas, South East Mexico, this thesis is predominantly about how mestiza women in a low-income barrio become mothers. As such it is an engagement with theories of embodiment, maternal subjectivity, transformation of self and gendered modernities. It is intended to evoke discussion around the roles that mestiza women, the wider community and the Mexican state play in simultaneously embracing and rejecting constructed notions of the good mother. Ultimately, this thesis is concerned with the way in which gendered beings experience and react to change, as understood through the transformative processes of maternity and in relation to a broader political economy. In doing so it asks the following questions: How do we formulate new global theories of change that are grounded in the particular, and in which gender is central? As such, can the study of maternal transition, within a broader context of life events, alter our current understandings of how human beings embody processes of change and negotiate forms of power? And, how might the material I gathered from the women in la Garita contribute to this discussion?

In my mid-twenties, frustrated with life and career choices in the UK, I travelled to Mexico on a six-month voluntary work exchange programme. Without putting much thought into the process, I had elected to be sent to Chiapas where I would spend half a year working as a sexual health outreach worker whilst lodging with a family in the state capital of Tuxtlal Gutierrez. Like all well laid plans my family placement
fell through when the family who were to be my hosts realised I was not the spritely seventeen-year-old they were expecting to take in. Instead of the *joven güerita* (young white/western girl) they wanted to place out front in the family business, they were faced with a twenty-six-year old woman with a shaved head and tattoos. After much confusing back and forth negotiation between the exchange programme representative, myself and the family it became clear that things were not going to work out and it was decided that alternative living arrangements would be sought. Though at the time I understood very little about the shape, form and structure of mestiza family lives, I was aware that in some very significant way I did not fit into the family structure. I was definitely not fitting the profile the family required – whether by age, appearance or overall personality. As a twenty-six-year-old unmarried and self-sufficient woman, I was difficult to place into an existing (middle-income) family home reliant on there being specific gendered and aged roles to play. The outcome of this first confrontation with mestiza family life was serendipitous. With nowhere else to go, I moved in with the exchange programme coordinator and her family, *la familia* Perez, and there I remained a constant fixture for what turned into a two-year stay.

In stark contrast to the first family, *la familia* Perez consisted of a close network of female-headed households living within the same neighbourhood of the city. The women at the head of the households were sisters and the central base for everyone was the natal home, a large part-adobe, part-concrete house at the very centre of the city. Two of the sisters, Mori and Albi, had two and three children respectively, and were separated from their children’s fathers. The third sister Carmen had taken on some parental responsibility for two nieces and a nephew who were left orphaned when their mother (sister-in-law) left home and father (the eldest Perez brother) later
died. At the time I lived with them the household matriarch had long since passed away and family matters were negotiated between the three remaining daughters (Mori, Albi and Carmen) and four sons. Day to day governance of the family was very much driven by the three sisters, with substantial financial and property matters being overseen by the three remaining Perez brothers. There was a collectivism to the mothering practices of the children and grandchildren of the family, and all three sisters were known equally as ‘mamá’. Spending two years living amongst these female-headed households gave me an early insight into the gendered workings of mestiza family structures. It was undeniably a one-sided view based upon lone motherhood and female-headed households, but in many ways it provided an emphasis on the maternal subject as principle moral compass from within the home and the high level of economic activity and labour production that women undertake inside and outside of the home.

The close connection between the inter-family households taught me a lot about the pragmatics of communal mothering and how things work when there is no central paternal figure (father, husband or state) to rely upon. The mamas Perez were not the image of lone mothers propagated by much development and policy rhetoric since time immemorial – one of women in need of the state as provider and replacement husband. All three sisters had worked in established professions (nursing and teaching) from leaving school and up until retirement. Their careers gave them the benefit of a state funded pension and they received no other money in terms of welfare. Their children remained in contact with their fathers and received intermittent financial support for things such as school or university fees. The amount of time spent with my Perez siblings and cousins also gave me an invaluable insight into the gendered relations between adult children and mothers and the
intense level of emotional gifting and reciprocity, which formed the basis of family and individual survival. Before I married a few years later, I was known to mamá Albi, somewhat affectionately, as la hija mala, (the bad daughter). For mamá Albi, I had selfishly abandoned my mother in order to go travelling around and placing myself in imminent danger – threatening the very life that had been bestowed upon me via the sacrifice of my mother. The mamas Perez spent a lot of time telling me how much I was loved and welcomed in their homes whilst at the same time begging me to go home so that my own mother could sleep in peace. My experience of la familia Perez was in sharp contrast with my daily work as a sexual health outreach worker where I observed abandoned mothers with HIV living in abject poverty in the city’s shantytowns, teenagers negotiating bodily desires and unplanned pregnancies, and people managing the intricacies of lesbian, bisexual, transgender and gay relationships in a world dominated by heterosexual family norms. Coming into close contact with so many households and social groups informed how I began to view family life and gender relations in ways that challenged historical and state stereotypes of what constituted the archetypal Mexican family.

In 2008, recently married and pregnant with my first child I moved to the neighbouring city of San Cristóbal de Las Casas. Though geographically close to Tuxtla Gutiérrez (around eighty-six kilometres), San Cristóbal is climatically, demographically and visibly distinct from its neighbour. Known as the cultural capital of Chiapas, San Cristóbal is a city with a rich colonial heritage which today has a diverse population of mestiza, indigenous and foreign residents. As such, the traditions, customs and identities of the two cities are remarkably distinct as local residents in both places are quick to point out. My husband and I moved to a small barrio popular (low-income neighbourhood) on the edge of the San Cristóbal city
centre. It was here that I experienced first-hand, prenatal care in the public healthcare system and then later on the varying approaches to midwifery that are practised around the city. For the next eighteen months my neighbours in this barrio became a valuable source of support whilst my husband and I navigated our way through the first few months of parenthood. These early experiences with the public health system and the emerging practice of professional midwifery and homebirth amongst lower and upper middle income mestiza families, coupled with living amongst other mestiza mothers in the barrio, greatly influenced my research path into reproductive health and maternal subjectivities amongst the mestiza population. Influenced additionally with my work in sexual and reproductive health, my research interests initially lay in women’s experiences of pregnancy and birth in clinical environments.

In foregrounding women’s narratives, this thesis focuses primarily on how maternal identity and motherhood is understood in everyday life in a *barrio popular* of San Cristóbal de Las Casas. The thesis explores how and in what ways maternal subjectivity and transformation of self is shaped by the political economy of global health values, which interact with localised ‘moral regimes of reproduction’ (Morgan and Roberts 2012). Drawing on Foucault’s ideas on ‘regimes of truth’ and Fassin’s notion of ‘politics of life’, Morgan and Roberts have proposed the concept of ‘reproductive governance’ as an ‘analytical tool for tracing the shifting political rationalities directed towards reproduction’ in Latin America (Morgan & Roberts 2012:241). Throughout this thesis, I confront the cross-over between reproductive and maternal health policy to show how ‘standards of morality that are used to govern intimate behaviours, ethical judgements, and their public manifestations’ (Morgan and Roberts 2012:242) are targeted specifically at women as maternal subjects. By using the corporeal processes of maternity (pregnancy, birth and
nurturing) as a connecting theme throughout the chapters, my aim is to explore, in the evocative words of Jolly, ‘how these seemingly natural processes of swelling, bearing and suckling, the flows of blood, semen and milk are constituted and fixed not just by the force of cultural conception but by coagulations of power’ (Jolly 1998:2).

At its heart, this thesis is a study of maternal health politics and mestiza women’s experiences of maternal transition; yet in an effort to shift our understanding of maternal transition beyond the limits of reproductive studies, I also wish it to be understood as a gendered analysis of how human beings respond to change. Since the last period of the twentieth century the Latin American region has experienced mass economic, and political restructuring. Reforms have been characterised by a shift from the public to the private sector in the delivery and financing of health and social services. This has occurred at the same time that increased state supported intervention into the wellbeing of nations and equity in health has emerged as a theme in global health and development; leaving Latin American governments to balance these competing priorities. Anthropological work on biopolitics and reproduction in Latin America, produced during this period, has demonstrated the centrality of reproductive and maternal health in wider development and social policy programmes (Castro A. and Singer 2004; Dalsgaard 2004; Carillo and Bliss 2007; Morgan and Roberts 2009; Gutmann 2009; Berry 2010; Smith-Oka 2013; de Zordo 2012). Great effort has been made by anthropologists to connect the roles of international finance and global health institutions in driving health and social policy reforms in Latin America to the recipients of development and policy initiatives (see Armada and Muntaner 2004; Sesia 2007; Gutmann 2007; Berry 2010; Morgan and Roberts 2012). Demonstrating how policy programmes defined by global agendas
are limited by localised political cultures, current literature also highlights the
coeistence of neo-Malthusian and biomedical rationales with population
management and maternal health policy and practices across the region (Sesia 2007;
Berry 2010; de Zordo 2012; Smith-Oka 2013).

With many countries in the region making the transition from dictatorship or one
party rule to democracy, Latin American reproductive anthropology has also gone
some way to evidencing practices of violence directed at women’s bodies by health
professionals that are reflective of high levels of gender based violence in the region
at large (Berry 2010; Boesten 2014; Castro A. 2004; Castro R. 2014; Dalsgaard;
Diniz 2004, McClusky 2001; Murray de López 2015; Smith-Oka 2013, de Zordo;
2013). Despite this, the relationships between intersecting forms of violence¹ and
women’s bodies in healthcare practices, both public and private, remains an
understudied area. I would argue particularly from a perspective that uses emotion as
an analytical category from which to explore women’s experience and notions of
power and agency. The chapters on obstetric violence and out-of-hospital birth I
have included in this thesis aim in some way to contribute to this area of knowledge.

In the case of Mexico, much ethnography on parenthood has focused on maternal
and reproductive health and associated conditional cash transfer programmes
amongst indigenous populations (Sesia 2007; Speed 2007; Smith-Oka 2013); with
the exception of Gutmann’s (1998, 2007, 2009) extensive work with mestiza men
and women in Mexico City and Oaxaca. A central argument appearing across
ethnographies is that national family planning initiatives and maternal health policies
undoubtedly shape the ways in which people at every level of society understand a

¹ Intersecting forms of violence refer to the following categories as developed by Scheper-Hughes and
sense of a gendered self and purpose. Yet, little attention has been paid to those who are not directly targeted by such initiatives, particularly lower-income mestiza women. As such, significant aspects of motherhood in its wider social context (related to economy, gender, sexuality and sexual health) go unconsidered in policy and health debate. As a result, motherhood ‘in highly diverse societies undergoing rapid and unequal processes of social and economic development and change remains largely unexplored’ (Parker cited in Carillo and Bliss 2007:1). All the whilst new policies are implemented at extraordinary rates, in part, due to external pressures to meet the aims of universal initiatives for equity in health. In direct relation to this, while female subjects remain a dominant focus of global health and welfare development policy, critics continue to argue that globalization discourse itself is bereft of gender analysis because there is an unresolvable divide between ‘global’ and the ‘local’ contexts. Yet this unresolvable divide exists precisely because it is portrayed as a linear relationship devoid of gendered influence (Molynuex 2001; Freeman 2001; Htun and Weldon 2010; Ariolla 2010).

With the intention to better connect global health discourses to ‘individual stories and experience’ (Freeman 2001), the ethnographic material in the following chapters explores the corporeal and embodied experiences of mestiza women who live on the fringes of state intervention. In this way, I intend this thesis to be both a political and theoretical project, one which highlights the lives of a community of women (and their families) in a particular moment in history. At times I will draw from the narratives of mothers and health professionals from outside of the barrio, in an attempt to provide a site of comparison within the limits of the city itself. By drawing attention to the experiences of a cross-section of women who utilise services across the city, which are at times accessed by the families in the barrio, I aim to
explore what I would like to term ‘various manifestations of the local’ existing within a seemingly small geographic area. Amongst other things, I will argue that, in spite of the direct and indirect influence of global health discourses, it is the fluidity and adaptability of local beliefs and practices that continue to dominate how mestiza women experience becoming (m)others in the barrio.

Where similarities are drawn with the lives of (m)others in other global regions, either by myself or the reader, I want to see what questions can be raised about why we see similarities rather than be forced to conclude ‘there's nothing new here’. In the same way that anthropology questions difference, there is a need to understand why we often recognize, reflect upon and discount similarity as unimportant. Do similarities arise because I have not dug deep enough or because I have only recognized what is familiar to me in terms of what I want to represent? Are there more political questions that can be asked about gender relations and maternal constructions that also highlight the widespread ideological framing of motherhood as a particular kind of universal gendered performance, which is biologically driven?

I agree with Scheper-Hughes (1993) that ethnographies of motherhood should neither falsely claim sameness nor over-emphasise difference. A particular stumbling block in the study of maternal subjects is the temptation for what Scheper-Hughes describes as ‘essentializing’ and ‘universalizing’ discourses. I have been conscious to bear this critique in mind throughout my writing and my aim in this thesis is to consider the possibility of a theory of maternal subjectivity as locally constituted, all the whilst acknowledging that it is inseparable from the influence of global processes- particularly the processes of global health. As an object and place of study the local should be understood as a site of singularity rather than particularity, in that it is not to be assembled as an example or exception to the general (see Das n.d.).
Echoing Biehl and Petryna’s (2013:5) call to ‘hold social theory accountable for the full range of human conditions’, I understand what is found in the field as serving to critically interrogate theory as opposed to the other way around. In moving between the ‘global’ to the ‘local’, we must find ways in which local and global phenomenon constitute, and are constituted by, each other. This must be done in a way that reveals gender and ethnic/national identity as central to the local-global relationship.

**Global Values, Modernity and Local Bodies**

When I use the term globalization in this thesis, and more specifically in relation to development, I have found that Friedman’s global systems approach, which defines globalization as a subset of global systemic processes, is the most adequate for my purposes. Friedman writes how ‘[g]lobalisation is about processes of attribution of meaning that are of a global nature’ (1995:74), hence as a process globalization is constructed on already existing global fields. He argues that although the production of local identities comes about through the attribution of meaning contained within the practices of globalization, they are not the product of globalization itself, but of active global systems which include globalization processes. The global systemic approach to globalization is useful for imagining the ongoing production of local and global phenomenon where is it impossible to say which one is a product of the other. ‘The global system involves the articulation between expanding/contracting central “sectors” and their emergent/disappearing peripheries…It is…a long term historical process that can only be adequately understood as such.’ (Friedman 1995:76).

In regions of Mexico where poverty has been constructed with not only a female but also an indigenous face, globalization analysis has failed to recognise the role of global health discourses in shaping the maternal lives of middle and lower-income
mestiza women. This is particularly true concerning their experiences with public/private maternal and reproductive health services, and in relation to competing projects of modernity. When I write about maternal and health discourse in this thesis I do so in direct relation to its global context. The ways in which ideas and arguments about maternal health are expressed and understood is shaped by global discourse and universal notions of what constitutes biological processes and wellbeing. There is justifiably a wealth of interest and research on the indigenous populations within the state of Chiapas. Around twenty-seven percent of the total population of Chiapas identify as indigenous Mexicans, and as a group they are over-represented in the state’s multi-dimensional poverty indicator, and in mortality and morbidity profiles (INEGI 2010; OMM 2014; OECD 2015). Economic, social and political discrimination of indigenous populations has been a continuous theme throughout Mexico’s history, and this rightly becomes the focus of much global development and academic attention.

Chiapas remains a militarised state since the EZLN (Ejercito Zapatista de Liberación Nacional or Zapatistas for short) uprising of 1994, and this has direct and indirect consequences for the urban and rural population as a whole. The Centro de Derechos Humanos Fray Bartolomé de Las Casas (Human Rights Centre Fray Bartolomé/FrayBa) describes the consequences of armed conflict in the Highlands of Chiapas as unresolved and ongoing, resulting in continued violations of human rights and displacement of indigenous peoples (FrayBa 2012). In their most recent report on the state of human rights in conflict zones of Chiapas, FrayBa stated that acts of violence against individuals ‘occur as a result of generalised violence derived from the effects of the unresolved armed conflict’ (2012: 84, my translation). The armed conflict has led to a forced displacement of whole indigenous communities
and mass migration of families and individuals from rural to urban areas, of which women, children, and older people have been particularly affected (FrayBa 2012). This has led to a significant rise in population (both transient and permanent) in cities close to the highlands, subsequently resulting in increased pressure on public services. State health institutions absorb the extra bodies and must treat them within the existing infrastructure and without necessarily having access to extra resources. State maternity hospitals are principal recipients of the consequences of this increase in general population.

The level of political analysis and debate resulting from the armed conflict and levels of economic, social and political violence against indigenous populations in Chiapas has been both fruitful and beneficial in bringing global attention to the region. Research has shown the causal relations between high infant and maternal mortality in the region and the ongoing conflict (Freyermuth and Argüello 2011; Brentlinger et al 2005). As such, resource allocation and policy is directed at bettering maternal and infant health via increased access to services and transfer options to institutions in urban locations. Maternal mortality has become just as much a political as a social issue, with mortality statistics becoming a measurement of success for how the government is dealing with the long term impact of conflict (Berry 2010; Boesten 2014). Since 2009 there have been just over 32 health programmes introduced across the country, all with a central aim of reducing maternal mortality alongside better access to (institutional) maternal and perinatal healthcare (Freyermuth 2015). In Chiapas the evidence is only just beginning to emerge about how levels of health, morbidity and mortality are differentiating less and less between urban and rural locations, but this has yet to influence the direction of policy and resource allocation.
Within the oversimplified image of Chiapas as an ‘indigenous state’, the wider ethnic and social complexities, and differences between the rural and urban populations become lost, and much of the state’s population is misrepresented as a result. In Chiapas, there are various manifestations of the ‘local’ due to its diverse and multicultural mestiza and indigenous populations. Within these variations of the local there is also further under-representation in terms of gender, age, sexuality and socio-economic status. The arguments presented in this thesis highlight the need to investigate further the impact of global health and development on at least one variation of the ‘local’ - in this case mestiza women in a low-income barrio of San Cristóbal de Las Casas, through their experiences of, and early transition to motherhood.

The topics of maternity and transformation of the maternal self, as described by the women in this thesis, are well placed to confront questions of social and individual change in relation to global health and state projects of modernity, and production of local modernities in Mexico. When I write of modernity and modernities, I find Hodgson’s work a useful entry point from which to develop my own argument on the relationships between Mexican nation and state, maternal subjects and medicine. In an edited ethnographic collection, Hodgson and the contributing authors set out to ‘explore the intersection of “gender” and “modernity” as they are mediated in the lives and subjectivities of individuals and groups’ (2001:2). Hodgson differentiates between the project of Modernity (capitalised to designate the hegemonic form of modernity premised on patriarchal Western Enlightenment thought) and the production of modernities, ‘other ideas of “being modern” that are not necessarily produced by or even reactive to Modernity’ (Hodgson 2001:2). I have decided to adopt Hodgson’s use of the capitalised Modernity throughout the thesis in order to
signify when I am referring to the project of Modernity premised on Western notions of what it means to be modern – notions that appear in many post-colonial nations via modern state apparatus.

Modernity is clearly defined as a state project constructed in already existing global contexts of what it means to be ‘modern’ (adhering to a Western patriarchal ideology). The emphasis of Modernity as a predefined state project is on economic and social progress through the application of universal principles. This argument follows that by adhering to universal principles of control, order, and rationality, people everywhere will lead ‘better [more modern] lives’ (Hodgson 2001:3). However, focusing solely on the forces and processes of Modernity – as much globalization analysis is guilty of - does not reveal much about the kind of modernities that are produced and which are grounded in localised action. Hodgson describes the ‘production of modernities’ as coming out of an embodied experience of globalization as a localising process. In doing so, her work resonates with the writing of Appadurai (1996, 2000) on grassroots globalization. I find Hodgson’s writing on gendered modernities complimentary to Friedman’s global systems approach to globalization and the production of local/global identities.

Differentiating between Modernity and modernities draws attention to the ‘…systematic interconnections between a variety of cultural, political and economic structures’ (Felski 1995:9). Together Hodgson and Friedman’s arguments provide a way of moving beyond an analysis of globalization that is devoid of the complexities of local gender and power dynamics. Gender is central to the global systemic mechanisms of globalization, including projects of Modernity and the production of local modernities which result from the process. This in turn raises complex
questions about relationships between power, agency and gender in both local and global arenas.

As I will discuss in more detail in Chapter One, competing ideas about modernity and the state in Mexico are prevalent in population control and family planning policies, which are traditionally acted out via medical institutions. In this way, ideas around the changing character of clinical and obstetric medicine and its impact on shaping and being shaped by policy are intrinsic to understanding how the overall modern nation state building project links to everyday practices. State concern with overpopulation amongst the poor in the late twentieth century led to the establishment of the *Consejo Nacional de Población* (CONAPO; National Population Council). CONAPO stated that its main role was to improve maternal and infant health standards (Smith-Oka 2013:100) and also to implement ‘correct family planning’ among the ‘growing number of peasants’ (Laveaga 2007:21). The work of CONAPO denotes a particular historical strategy in Mexico of using social programmes to control behaviours of low-income populations and ‘curtail [their] reproductive and sexual behaviour’ (Morgan and Roberts 2012:241). Ultimately, these programmes are about controlling the behaviours of low-income women (as mothers) who are the principle targets and recipients of social programmes.

The desire to improve maternal and infant health via clinical management results in a dominant techno-scientific model that rejects social models of maternity processes. Women’s contact with clinical health management—whether partial or complete—contributes greatly to their perceptions of maternity and modernity. The techno-scientific model, which is present throughout every stage of the maternity process, ultimately impacts upon how maternal transition is experienced and new subjectivities are produced. For many low-income families in San Cristóbal ‘[a]
tussle exists between tradition and the past’, represented by *parteras* (midwives) and social models of maternity, ‘and modernity and the future, represented by clinicians’ (Smith-Oka 2013:83). The emphasis is placed upon receiving biomedical reproductive healthcare as a ‘necessary step toward achieving development and modernity’ (Smith-Oka 2013:83).

**Maternal Subjectivity and Transformation of Self**

...a woman as mother would be … a strange fold that changes culture in to nature, speaking into biology …

*Julia Kristeva, Stabat Mater* (cited in Stone 2012a:1)

Before I began fieldwork I stood firm by the notion that I would not align my thinking with any one grand theory. My hope was that the material I gathered in the field would inform my wider thinking and lead me to concepts that best spoke to the observations I made and participated in, and more importantly from the narratives I collected and worked with. In preparation for the field I read, considered and wrote about various approaches to the anthropology of the body and bodily practices (Bourdieu 1977; Foucault 1972; Csordas 1994; Ingold 2011; Lock and Farquhar 2007; Turner 1994), maternal being and thinking (Chodorow 1978; Kristeva 1986; Oakley 1979; Ruddick 1989), pregnant embodiment and anthropological notions of subject and self (Ivry 2010; Lester 2005; Martin 1989; Maher 1995; Moore 2007; Rapp 2000; Young 1990;) in conjunction with political economy and medical anthropology (Ginsburg & Rapp 1995; Inhorn 2007; Kleinman 1997, Lindenbaum & Lock 1993). Through the experience of collecting data and subsequent analysis I found my theoretical direction in constant flux as it was directed by the material as opposed to my preconceived notions of what I was looking for. I was constantly
troubled by the notion of analysing ethnographic material through frameworks that are heavily laden with their own historical, cultural, gendered and political bias, and that in the past have been used to misrepresent or judge the actions of (non-Western) ‘others’; particularly maternal and paternal subjects (see Gutmann 1996; Ram & Jolly 1998; Scheper-Hughes 1993). Over time I eventually learnt to see my data as a way to challenge and renew theoretical thinking as opposed to the other way around. This development in my learning has led me to employ what is better thought of as a family of concepts that resonate with the narrative thread in each chapter, and that find a way to explore bodily experience from the women’s descriptions.

Feminist theory reminds anthropology that ‘the process of creating a self through the opposition to an other always entails the violence of repressing or ignoring other forms of difference’ (Abu-Lughod 2006:155). But how can the remaking of self through the processes of maternity, when the notion of other is situated inside the body, or has come out from the former self, help to problematize this idea?

Moreover, how do we approach the remaking of gendered self and the dynamics of change as topics of anthropological inquiry? In her development of a conceptual framework for analysing transforming subjectivities via an ethnography of Mexican postulants, Lester found in dominant social theories either a ‘disembodied self or a de-selfed body’ (2005:44). Neither of which deal suitably with the bodily transformation of self and subjectivity. In her ethnography Jesus in Our Wombs, Lester looks at how ideas about femininity and modernity are challenged through specific processes of transformation. This transformation of self is enabled by the context of the environment. By examining the convent environment as a ‘technology of embodiment’ she explores how postulants work towards an ‘authentic femininity’, one that they feel has been eclipsed by modern society. In Lester’s work types of
femininity are constructed through a process of change itself, not because the change is specific to being a woman. In a different context of maternal transition in 1970s UK, Oakley (1980:179) argues that ‘childbirth shares key characteristics with other less gender-differentiated classes of life event, and that the personal meaning of childbirth to mothers is revealed by describing these similarities’. Oakley’s approach treats the transition to motherhood as a ‘life event akin to others’. In this way maternal transition becomes an argument about ‘the way human beings react to change, carrying tremendous physical, emotional, psychological and social implications for those who engage in it’ (Oakley 1980:179). Both Lester’s and Oakley’s work have influenced my thinking on what maternal transition for mestiza women can indicate about a broader understanding of the dynamics and ways of coping with change. As an approach to maternity, Oakley’s thinking intersects well with current themes in Mexican feminism which locates an ignorance of gender dynamics and a biological determinism to motherhood as the root problem in national approaches to population management. Both Oakley and Mexican feminists argue that the way to move beyond an essentialist (and ethnocentric) feminine paradigm is to approach maternity through questions of gendered personhood in a broader social, economic and political context.

My approach to the theme of maternal transition that has emerged from the ethnographic material incorporates concepts of embodiment and corporeality as dialectic in their relationship. In line with those whose work focuses on a renewed

---

2 My thinking about the complimentary relationship between corporeality and embodiment has been advanced by the recent work of Gilleard & Higgs (2015) on aging, embodiment and the somatic turn. Drawing on Haraway’s distinction between the body as social actant and the body as a site of social agency, we argue for the need to distinguish between aging as corporeality—treating the aging body as a social actant—and aging as embodiment—treating the aging body as co-constructor of its own identity.
sense of self I understand embodiment to mean a material process of social interaction and something that has shared agency (Turner 1994; Csordas 1994; Lester 2005; Probyn 1991; Young 1998). My theoretical project has essentially been driven towards understanding the dynamics of social change in Mexico through the processes by which mestiza women become mothers. I have focused on how mestiza women embody motherhood as a process that adds something more to a person’s sense of self which places them apart from others. Moreover, I have wanted to see how questions of gender can be asked about the topic of maternity, placing it well within a political economic framework that addresses broader questions about dynamics of social and individual change.

Where my political and theoretical projects meet, I am confronting the maternal transition of self, rooted in philosopher Cavell’s (2005) notion of separation from other as opposed to connection with other. In my attempt to further explore this idea of separation as proof of a gendered existence, I have found Stone’s (2012a) inquiry into the possibility of maternal subjectivity, as separate yet part of female subjectivity helpful in the context of motherhood in Mexico. Stone asserts that “[m]aternal subjectivity is a variation on female subjectivity” (2012a:4), and that as such the two should be understood as distinct. In this way, she argues, “we [will not] lose sight of what is peculiar about maternity” (2012a:4). Her quest to define how the maternal past contributes to the emergence of a new subjectivity connects well with how the women in la Garita describe how they learn to become mothers. Together with the writings of Cavell and Stone, I have found Ingold’s attempts to advance anthropological inquiries through a cross-disciplinary approach very useful for thinking through the embodied and corporeal processes of early motherhood.
Ingold’s use of the organism to distinguish biological individuals from cultural subjects, defines the body as undergoing “processes of growth and decay, and that as it does so, particular skills, habits, capacities and strengths, as well as debilities and weaknesses, are enfolded into its very constitution” (1998:26). In this way, embodiment is understood in the sense of being “developmentally incorporated through practice and training in an environment” and the body as organism is an active part of the process (1998:28). A process which is ontogenetic as opposed to culminating in a complete being or fixed embodied identity.

One of the most useful elements of Ingold’s thinking works to dissolve the boundaries between the humanities and natural sciences through a principle of obviation. His intention is to work with an obviation approach as opposed to complementarity, in order to dispense with the biological/social dichotomy that exists to perpetuate differences between the natural and social sciences and also within sub-disciplines of anthropology. He writes that a ‘human being is not a composite entity made up of separable but mutually complementary parts, such as body, mind, culture, but rather a singular locus of creative growth within a continually unfolding field of relationships’ (1998:23). I find in Ingold’s principle of obviation a way of moving beyond the tendency of embodiment theory to deny the implication that with the body there ‘exists some kind of biological residuum that is objectively given’ (1998:27). In other words, a denial of the body as flesh, a living organism that at once constitutes and is constituted by its environment. This is a concept I find essential for thinking with the gendered body reproducing and remaking itself in a way that is inseparable from its surroundings. Ingold’s principle of obviation and Cavell’s reimagining of separation as a signifier of one’s existence, for me, brings into being the remaking of self which is becoming a mother.
Outline of Chapters

This thesis is organised as a site of micro-comparison in that it draws upon ethnography of the barrio La Garita, and at times from the wider city of San Cristóbal de Las Casas. Quite early on in my fieldwork I observed that the families in La Garita were making conscious decisions about when, and when not to use public and private health services in pregnancy, birth and postpartum. I began to think about the social and economic conditions that needed to exist for families to manage a mixed economy of healthcare and what this contributed, if anything, to shaping the experience of maternal transformation. I was reminded of the women I had met in earlier fieldwork and the poor treatment they had received in public and private institutions. Their narratives had revealed how their experiences of pregnancy and birth had impacted upon how they felt, not only about their bodies, but who they were as women and mothers in their local world.

I found that one way to think about and make sense of the maternity practices of women in la Garita, and the choices they made, was to compare them to other mestiza women, and ways-of-being in other parts of the city. This included other lower-income mestiza women who managed pregnancy and gave birth in institutions and/or were reliant on subsidised provision, and also middle-class mestiza women who were rejecting clinical management of birth and hiring the services of professional (and non-family related) midwives. In working towards an ethnography of the particular (the transformation of maternal selves), my comparison with the narratives of other women from different ethnic or socio-economic status, further concretises the material from the barrio as a site of singularity within the particular.
The micro-comparison that arises from the ethnography in Chapters Two and Three reveal local and intersecting ways of thinking about gendered personhood and moreover, how Modernity is both assimilated and contested in daily life. Furthermore, it provides me with the ethnographic material to question how this is recognised in a global health approach to maternal policy and practice that continues to impact on local lives.

Chapter One foregrounds the rest of the thesis and serves the purpose of a limited social and political history of Mexico in which notions of nationhood and motherhood are framed. The idea of maternal subjects giving birth to the nation is directly tied to post-colonial, post-revolutionary Mexico and continues to the present day in the way that women as mothers are used by the State in policy and popular culture. Using social policy, contemporary history and anthropological literature I explore how Mexican state ideology, from the beginning of the twentieth century, has been projected onto and into maternal bodies. Chapter One ends by contextualising motherhood in twenty first century Chiapas in relation to reproductive governance and the mechanisms through which women’s reproductive lives are counted, surveilled, and intervened in.

In Chapters Two and Three I draw upon Comaroff and Comaroff’s (1991) concepts of agentive and non-agentive power, in conjunction with Abu-Lughod’s (1990a) notion of resistance as a diagnostic of power, in order to examine agency, resistance and resignation in clinical and out-of-hospital birth environments. Comaroff and Comaroff describe power as ‘Janus-faced’, sometimes appearing as the relative ‘capacity of human beings to shape actions and perceptions of others by exercising control over the production, circulation and consumption of signs and objects’, which they define as agentive power. The form of power they discuss in most detail,
in relation to the intersecting processes of hegemony and ideology, is non-agentive power, which they describe as hidden in the forms of everyday life. Non-agentive forms of power are not easily questioned as they are ascribed to ‘transcendental, suprahistorical forces (gods or ancestors, nature or physics, biological instinct or probability’ (1991:22). They argue that being understood as ‘natural’ these forces seem beyond human agency, ‘notwithstanding the fact that the interests they serve are mainly human’ (1991:22). The good mother paradigm, in the Mexican context, represents forms of non-agentive power in that in its expression as local values, beliefs and conventions, it is often not experienced as power at all.

My aim in Chapter Two in particular, is to use women’s accounts of hospital maternity care to explore the relationship between resistance, resignation and power as they are located in the body hexis and emotional habitus of the maternal subject. Here I extend the boundaries of narratives to mestiza women of varying socio-economic backgrounds who live within the wider city. My intention is twofold, as explained previously I want to bring attention to how other mestiza women of different socio-economic status experience pregnancy and birth in clinically managed environments. Secondly, I find these comparable narratives useful for thinking about the reasons why many women in la Garita may seek to maintain out-of-hospital birth practices. In Chapter Two I propose a framework that takes into account maternity as a corporeal process that is inseparable from broader social and political contexts. This framework for analysis is applicable to the conditions under which women become mothers; it therefore has a comparative application to both in and out of hospital birth. In this way maternity is not understood as an isolated, female life event but as a bodily process directly interrelated with the social, political and economic world. In Chapter Two (and throughout the thesis) I have taken the
decision to use the term *clinically managed maternity* to cover the corporeal and embodied process of childbearing and early motherhood within the realm of local medical practice and institutions. I wish to avoid the use of *biomedical* as an umbrella term for the medical practises discussed in this chapter. I see it as potentially problematic in reinforcing the biomedical/traditional medicine dichotomy that haunts much work on reproductive health in anthropology. By using the term *clinically managed maternity* the emphasis is placed upon the environment in which practices and relationships occur. Such practices, being intrinsically local will encompass biomedical, lay and ethno-obstetric knowledge transmitted through and embodied by culturally constructed actors.

Women become enmeshed in a hybrid cultural idealisation of femininity and maternity which in turn shapes their experience of bodily transformation throughout their life cycle. Within global health discourses reproductive and maternal health are often treated as interchangeable concepts rather than interconnected. This results in the feminisation of an issue as opposed to one that raises questions about gender. My own research focuses on the lives of women as they transition through the physical, emotional and social stages of becoming a mother in mestiza society. By beginning from a localized subject position, I see the language of reproductive and maternal health as separate and intersecting factors that impact on women’s gendered experience of the world. Chapter Three looks at the local typologies of midwifery and out-of-hospital births in two contexts: la Garita and the casa de partos (private birthing house). In many ways this chapter continues the theme of Chapter Two in exploring the various reasons as to why women choose out-of-hospital birth. The reasons for hiring a midwife and choosing an out-of-hospital birth are dependent upon (though not exclusive to), social class, family tradition, experience of others
close to the woman, global trends and whether or not pregnancy and birth are understood as part of a broader life cycle process of womanhood. The various midwifery models of care that the families use in this chapter raise further questions about agency and local attitudes towards aspects of clinically managed maternity, in a situation where choice is exercised in favour of a woman-centred model of care. The ethnographic material in Chapter Three also, reveals how women's agency should not always be equated with defiance but instead as a subjective act within a specific set of circumstances that is inseparable from particular social values. This notion challenges what Das (2007:7) critiques as the ‘theoretical impulse to treat agency as an attempt to escape the ordinary as opposed to a descent into it’. The ‘ordinary’ for many women in la Garita is to give birth at home with a midwife; as such their agency results in maintaining this, as opposed to it being a specific act of defiance against clinically managed maternity.

Whereas global health and development discourse favours forcing women into reproductive roles as some kind of unavoidable fate of nature, my secondary focus on the maternal transformation of mestiza women comes from a desire to explore how women’s maternity is incorporated into the dynamics of social and individual change in Mexico. It is through the practical and conceptual notions of the dynamics of change that I perceive a link between my political and theoretical project. I wish to use this as a way to explore ideas about agency that involve the manipulation of cultural meanings whilst simultaneously never being free of such meanings (Lester 2005). Not so much writing against culture (in the sense argued by Abu-Lughod 2006), as writing within the parameters of cultural boundaries that are set out by my subjects in the field. Through the transformative experience of pregnancy, birth and early motherhood women come to embody the understanding that their body has
shifted in its social context and meaning. A focus on the transformation of self via the processes of maternity leads to the ‘internalisation of representations of the female body by women which is fundamental to the formation of feminine identity within its collective cultural context’ (McNay 1992:24). I suggest that the process of becoming (m)other involves a remaking of self via notions of boundary, separation and connection. This idea is explored in Chapter Four which looks at the postpartum period and associated postpartum healing and bonding that are encompassed in the forty-day quarantine (known as the *cuarenta días*) traditionally practised in Catholic mestiza homes. The narratives in this chapter reveal how the *cuarentena días* is located and embodied within a wider entanglement of competing cultural metaphors and ways of measuring and interpreting risk - akin to the management of birth discussed in Chapters Two and Three. By exploring the sensory ‘womb like’ environment of the *cuarenta días*, my intention is to show how it is a particularly good subject for analysis of how knowledge is embodied through intersubjective and ‘intersensory states for which we have no common language’ (Sacks 2005:33).

Chapter Four builds upon tropes inherent in medical and lay models of reproduction that see women’s bodies as a potential risk to a foetus or newly born infant. The female reproductive process, particularly pregnancy, has long been of interest to those investigating the problematics of biopolitics and bodies as sites of power relations and conflict. In Mexico (as with many other parts if the world) the clinical management of pregnancy and birth give rise to treating women’s bodies as a potential danger to new human life. Whilst female bodies are charged with protecting and growing new life, through the pathologizing of pregnancy they are also deemed at risk of damaging or ending it. Although ideas about negotiation and agency are prevalent during the gestation and birth stages of maternal transition, this
chapter shows how this does not cease once the infant had been born. Throughout the postpartum and subsequent semi-exclusive breastfeeding period women’s bodies and the fluids contained therewithin continue to be evoked as a source of danger to infants and efforts are often made by doctors to intervene in feeding practices.

The narratives in Chapter Five seek to challenge the notion of fixed maternal identities often evoked to describe mestiza women of low-socioeconomic status. In doing so, I hope to draw attention to specific questions surrounding childrearing as a practice charged with great social significance. By focusing on mothers whose living situations have received little analytical attention, specifically single mothers and mothers in multi-generational in-law households, I question whether ideological glorification of motherhood, which is in part framed by state gender politics, ultimately maintains gendered societal hierarchies and restricts women’s capacity to drive change. How women speak about being mothers, and moreover how they describe their relationships with their children and partners, is bound by a code that is shaped by inherited habits of thought and being in the world. This ethnographic material leads me to think about how ‘natural’ phenomenon such as instinct and mother love are constructed and manipulated by women and state alike.

My challenge in representing the women’s embodied and corporeal experiences of motherhood lies in my own ability to describe their worlds sufficiently and in not depriving their words of life. I have attempted to address this challenge by taking a narrative approach to writing which relies on reproducing transcripts of life history interviews (albeit translated and punctuated by me) and detailed fieldnotes that construct scenes of daily life and conversation. My use of transcripts has been inspired by various feminist ethnographers (including Abu-Lughod 1990a, 1990b; Oakley 1979; Rapp 2000; Scheper-Hughes 1993), and a firm belief that the ‘nature
of women should be described by themselves’ (Oakley 1980:93). By foregrounding
the narratives of the mestiza women in la Garita, the following chapters work
through the interconnected stages of maternal transition including management of
pregnancy, birth, postpartum and the early nurturing stages of motherhood. My aim
is to present an ‘[ethnography] of the particular’ (Abu-Lughod 2006:153), in an
effort to subvert ‘facile expectations of Mexican gender identities’ (Gutmann
1996:3) and begin in some way to address the sparsity of cross-cultural gender
analysis in globalization discourse.

Ethnographic narratives are at heart concerned with movement, from place to place,
in the sense that ‘place’ is not so much a geographical location as an event –
something that comes together via a mass of processes rather than things (Massey
2005). As such, a description of the fieldwork site/s is necessary in order to provide
a moving world within which my interlocutors exist and a place for the reader to
travel to. It is tradition in ethnographic writing to begin with an arrival trope, it has
been a way for the ethnographer to position herself from the outset as an outsider
looking in. Though the arrival trope has been criticised for fetishizing the state of
being somewhere (else), it can serve a purpose of describing the ethnographer’s
initial relationship with the people and place she is trying to communicate to others.
Overall, it provides a place to begin. In the pages that follow, I briefly describe the
fieldwork setting, how my movements in, out and around the barrio began to shape
the data I collected, and how I became positioned in the field and the relationships I
forged as a result.
Introduction Part II

The Fieldsite

Although I stopped living in Mexico in 2009, I returned to San Cristóbal in 2011 and in 2012 to carry out fieldwork in San Cristóbal and collect birth narratives from mestiza women who had given birth in the local public maternity hospital (see figure 3.). For this project I was initially concerned with emerging subjectivities in pregnancy and how a continuing rise in surgical interventions at birth affects how women in urban Chiapas experienced pregnancy and early motherhood. I was very much focused upon the clinical management of birth and exploring women’s agency and decision-making in childbearing. I had been influenced early on by the handful of ethnographic studies and policy analyses that looked at maltreatment of women in public hospitals (Castro R 2003; Castro A, Heimburger & Langer n.d.; Kendall 2009). Though there were arguments and descriptions of maltreatment and violations, existing work lacked recognition of the women’s experience and how it impacted upon their wider subjectivity and relationships. This earlier literature resonated with many of the descriptions given to me by women, and also some of my own observations in the public health system. I was very much focused upon how women interpreted their experiences and how ‘everyday violence’ (as described by Scheper-Hughes 1993) plays out in institutional settings.

I learnt from this preliminary research project that by having such a direct focus on the clinical management of birth, I failed to take into account aspects of childbearing that were important to the women. It left me with many questions about those women who were not wholly reliant upon welfare programmes, but who were sharing the same public services as those who were. By remaining in contact with
my midwife Cristina (who also managed a private birthing house), I was also becoming increasingly aware of women who were choosing, for varying reasons, to avoid the public health system altogether when it came to prenatal, birth and postnatal care. When I returned to San Cristóbal in 2013 to carry out fieldwork for my PhD I eventually settled in another barrio popular - la Garita, for a period of ten months. At the beginning of the fieldwork, I was still primarily concerned with emerging subjectivities in pregnancy, and how a continuing rise in surgical interventions at birth affected how women in Chiapas embodied pregnancy and early motherhood. However, through my daily interaction with women in the la Garita I came to understand that the processes of pregnancy and birth cannot be restricted to a dichotomy of clinical and non-clinical management. Moreover, I came to realise quite quickly that, for the women in the barrio, pregnancy and birth cannot be separated from the wider life cycle processes that becoming a mother is part of. In short, the material I was collecting in the field began to raise more complex questions about gendered personhood and transformation of self in relation to ‘communities that are gradually becoming more tied to multiple and often nonlocal systems’ (Abu-Lughod 1990a:42). The timeline below shows the different phases of data collection which are included in this thesis and also how my ethnographic focus developed over time. Whilst the first phase noted in figure 3 cannot be considered a complete period of ethnographic fieldwork, it nevertheless shaped my research focus and fieldwork questions which led to the subsequent phases of funded ethnographic fieldwork:

3 Phase 2 and 3 was undertaken as part of a Vice Chancellor Early Research Career Scholarship and Christopher Hale Memorial Fund obtained through my employer.
During my first two pregnancies I was living and working in Tuxtla and San Cristóbal. I kept diaries throughout my contact with private and public health professionals and services which later informed research design in subsequent years.

Short-term fieldwork on prenatal care and birth experiences – interviews and participant observation (PO) in birth centres and public institution waiting rooms.

Life story interviews on hospital antenatal care and birth experiences with women from Tuxtla and San Cristóbal, and medical professionals.

Arrive in San Cristóbal de Las Casas to begin residential fieldwork.

Move into la Garita and begin to focus on ethnography of the barrio. Start to map and profile the area and build relations with local community. Attend prenatal classes and parent groups outside of the barrio.

Ethnographic data collection in barrio, follow-up interviews with four of my 2011 participants, archival research on population, policy, legislation and maternal health issues. I give birth to my third child.

Husband and son arrive. Able to gather ethnographic material and data with fathers and men. Begin to record life story interviews with local women. Begin to focus on observing postpartum practices and spending time with new mothers.

Continue to build up family profiles, recorded interviews with women at birthing centre, midwives and health professionals.

Due to my own experience of being pregnant and giving birth whilst living in la Garita, this phase of fieldwork became defined by two distinct periods - the pre and...
postnatal stages of data collection. My eldest daughter was with me for the whole
time I was in the field, and we were joined for two months by my husband, and son
who was three at the time. I was fortunate in that my pregnancy and birth were
trouble free, and I recovered relatively quickly. Recuperation in the field brought on
a profound reflection in regards to my surroundings and I was able to live through
some of the experiences that women had described to me over the years in terms of
postpartum care. The corporeality of my gestating, birthing and postpartum body
drove me to deeper somatic modes of observation, I began to pay a different kind of
attention to the maternal bodies of others. I became much more sensitive to my
surroundings and how myself and others were within it. The pregnant and postnatal
stages in fieldwork shaped the way in which I carried out fieldwork, often influenced
what I focused on and how the different relationships developed with my
neighbours. As a result, the direction of much of the data I gathered and the
boundaries set by the women were down to how they perceived me as a foreigner, a
student, a woman and a mother. In this way, I understand my own position in the
field as something that contributes to making this an ‘ethnography of the particular’
(Abu-Lughod 2006). In every sense of the word I came to embody a maternal
transformation which provided me with a direct comparison to the women, whose
experiences, I was hoping to understand.
Chiapas is in the south east of Mexico bordering with Guatemala. The state has a complex geography with seven distinct regions: Pacific Coast Plains, the Sierra Madre de Chiapas, the Central Depression, the Central Highlands (Los Altos), the Eastern Mountains, The Northern Mountains and the Gulf Coast Plains (INAFED 2010). Despite the marginalisation and overall high poverty levels Chiapas is rich in natural resources with 34.29 percent of the economy deriving from agriculture (predominantly coffee and bananas) and natural resources (minerals, stone, water and gas), making the state a target for national and international development agencies and corporations (INAFED 2010). It is the seventh most populated state in the country and according to the last census currently has around 4,796,580 inhabitants with a population distribution of forty-nine percent urban and fifty-one percent rural (INEGI, 2010).

Chiapas is amongst the country’s most marginalized regions, with the highest recorded unemployment levels and lowest educational attainment (completing
secondary school) of all thirty-two federal states (OECD 2015). It is reported that seventy-eight percent of the state population are economically active in the informal sector (INEGI 2010), and housing and access to public services are below national averages (OECD 2015). Access to health services remains particularly poor and is associated with wider political economic and social issues. In relation to this, Chiapas has the second highest maternal mortality rate (68.1 per every 100,000 live births) and the highest infant mortality (17.9 per every 1000 children under 5yrs). Over sixty percent of the population rely on subsidised primary health care (INEGI 2010). In the reporting of statistics, the various governmental and non-governmental organisations use a combination of employment status, household income and ethnicity to categorise different sections of the population. In this way levels of poverty and income come to categorise social groups as opposed to identification by social class. This also mirrors the language used by people when asked about their social or economic status, people whom I categorise as low to low-middle income will describe themselves as poor or *humilde* (indicating decent, simple folk with little material wealth).

Around twenty-seven percent of the total population of Chiapas identify as indigenous Mexicans (INEGI 2010). Indigenous populations are most concentrated in the highlands, though internal conflict and economic disparities have led to widespread displacement and transmigration over recent decades. Officially indigenous identity in Mexico is defined by spoken language and by this category the dominant groups in Chiapas are Tzeltal, Tzotzil, Tojolabal, Cho’l (Mayan descent) and Zoque (Olmec descent). Changes in migration patterns and the impact of national and global recession have resulted in the rural-urban poverty divide being less apparent. The OECD report that the urban population is no longer
significantly better off in access to health services that rural populations. This raises interesting questions for a critical global health analysis. Previously the emphasis in global health on treating and controlling disease took a ‘Magic Bullet’ approach – the delivery of specific health technologies to address an issue – which failed to take into account social, economic and political factors, often unleashing unintended consequences (Biehl and Petryna 2013). This ‘quick fix’ strategy to disease control transferred to the way in which maternal mortality was approached. With increasing pressure to meet the Safe Motherhood Initiative and later MDG5, development discourse promoted increased access to technocratic prenatal care and emergency treatment as the panacea to maternal mortality and morbidity. In Mexico, the requirements were set for a minimum of five prenatal appointments in the public health system, a goal that was achieved across the country. In Chiapas, this happened alongside the building of and improvements to existing maternal health facilities, however maternal mortality rates remain relatively unaffected and there is little evidence in terms of the standards of care provided (OMM 2015). The narrowing of the divide between rural and urban maternal mortality and morbidity in Chiapas - in a negative direction – is one example of a failure to recognise ‘how health risks are shaped by law, politics, and practices ranging from industrial and agricultural policies to discrimination, violence, and lack of access to justice’ (Biehl and Petryna 2013:3).

Gender inequality as a stand-alone category fares no better than ethnicity or social status via income. Indigenous girls and women are most at risk of mortality and violence in the region for various intersecting reasons (Freyermuth 2010). Chiapas has the highest incidences of forced or underage marriage and adolescent pregnancy (along with its associated health risks). Underage marriage and premature
parenthood are not restricted to indigenous communities; the most recent Mother’s Index study identifies the lower-income mestiza population of girls and young women in Chiapas as equally at risk (Garita Edelen 2016). In urban areas reported incidences of gender based violence, including kidnap, trafficking, rape and murder have increased gradually and significantly over the last decade, of which mestiza and indigenous women are equally represented (at least in reported figures, though actual details are unknown). Despite this bleak picture, I recognise that large scale demographic and census data exist to provide one particular overview of life in the region, and as such cannot represent the experience of everyday life, nor the ways in which such forms of violence enter into the ‘recesses of the ordinary’ (Das 2007). As with all critical anthropology my aim is to look beyond the ‘abstract and bureaucratic considerations of public policy’ (Biehl and Petryna 2013:3) to understand how lives are actually lived and intersecting political, economic and social contexts are embodied.

San Cristóbal de Las Casas: Pueblo Mágico

The colonial city and municipality of San Cristóbal de Las Casas is the third largest in Chiapas with 158,102 inhabitants. The city lies at the valley floor of Los Altos and it is surrounded by hills and dense forests on all sides and only 8.75 percent of ground space in the municipality is urbanized (Ayuntamiento San Cristóbal de Las Casas 2012). San Cristóbal has a relatively young population with 30.6 percent between the ages of fifteen to twenty-nine and is also ethnically diverse with 62,208 inhabitants identifying in the last census as indigenous Mexicans (INEGI 2010). The dominant indigenous groups resident in the city are Tzotziles and Tzeltales who have a long history of migration to the city stretching over five decades (Speed 2008). The principle religion in San Cristóbal is Catholicism and each barrio has a patron saint
and church. Other minority religious groups to be found in the municipality are various evangelical and non-evangelical Christians, Mormons, Jehovah Witnesses and a small community of Sufi and Orthodox Muslims. The city also has a large population of mestiza Mexicans from other parts of the country and a small transient population of North Americans, Europeans and Japanese. The most important economic sectors are commerce, services and tourism, which employ almost sixty-seven percent of the work force mainly centred in and around the city centre (INAFED 2010). The second most important sector is mining including jade, gravel, stone and metals which go to other cities in Chiapas and nearby states. The city itself is made up of one hundred and seventeen barrios and colonias (neighbourhoods) including a historic city centre zone. As a municipality San Cristóbal de Las Casas also encompasses eighty-three rural communities outside of the city proper with a population of 27,890 (Ayuntamiento San Cristóbal de Las Casas 2012).

San Cristóbal’s attachment to its colonial past places the categories of ethnicity, socio-economic status and gender at the forefront of understanding the often contradictory social relations of the city. San Cristóbal is considered to be the cultural capital of the Chiapas mainly due to its large indigenous population, colonial buildings and vibrant artisan trade. Under the government’s programme of promoting tourism and naming towns as of national heritage sites, San Cristóbal was designated as a Pueblo Mágico (Magical Town – an initiative providing a title and funds to promote tourism) in 2003, and then further recognized as “The most magical of the Pueblos Mágicos” by then President Felipe Calderón in 2010. It is an area that trades from its diverse indigenous and colonial heritage, and such a history that cannot be separated from the asymmetrical power relations between ‘colonizer’
and ‘colonized’. Writing about the problem of colour in Mexico’s colonial history Alejandro Lugo writes ‘...these incipient inequalities of conquest both evident and embedded in the colouring of individuals, have never been eradicated from the shifting contours of everyday life; in fact they have left a legacy that only the naive observer can ignore.’ (2008:52). The emphasis on skin colour as a signifier of socio-economic status both in ethnographic and analytical terms is problematic as it has had a tendency to sweep over gender inequalities in and between the social strata, and for the indigenous population leaves any description devoid of the complexities of caste and socio-economic status.

The ethnic category of indigenous becomes synonymous with a social category of poor, regardless of the political status and economic activity of an individual or their family – as though one’s skin colour or language denies the possibility of social status or mobility - which of course in lived contextualised experience is not the case. It is also important to mention that the local mestiza population, those whose families have been in San Cristóbal for traceable generations, identify as **coleto** or **coleta**, referring back to neo-colonial times (Paris Pombo 2000). **Coleto** literally means ‘ponytail’ and refers back to the hairstyle of the original Spanish conquistadors who founded the city (Speed 2008). From around the beginning of the twentieth century the creation of the **coleto** identity original served for men of mixed indigenous and Spanish/mestizo (**ladino**) heritage to transcend ethnic boundaries and enter into the classed based structure of **ladino** society based upon birth right as opposed to skin colour.⁴ Women’s **coleta** identity reportedly differed from the men.

---

⁴ These men were the product of clandestine or adulterous relationships and sexual abuse of indigenous women by ladino men which was common practice in colonial and post-colonial Mexico. Once adult they used their paternal lineage to forge an identity that separated them from their indigenous counterparts and in doing so gained political and economic power and assimilation into the Ladino/mestizo population.
in that they retained the stereotype of the mysterious and passive Indian woman, which became mixed with the devout and caring Catholic mother figure to create the unique image of the *coleta* (Paris Pombo 2000; Speed 2008). When I refer to a mestiza person as *coleta* or *coleto* in this thesis, this is because they will have self-identified as such, as a way of making it clear to me that they were born and raised in San Cristóbal.

Despite the outward impression of a multicultural city, the different ethnic groups rarely mix other than for economic transactions, trade and hiring of labour. Historical tensions remain and the traditionalist attitudes about the unpredictability of indigenous Mexicans have been, in the twenty first century, matched with a mistrust of foreigners amongst the *coleto* population. The *coleto* elite in particular are said to blame the influx of foreigners for a perceived increase in crime and drug use, threatening local traditions and for manipulating the ‘poor ignorant Indians’ into rebellion (Speed, 2008; Gutierrez, 1999). These social tensions were heightened by the events of 1994. The city of San Cristóbal de Las Casas in particular was central to the aforementioned armed uprising as the municipal building and city centre was the sight of a bloody battle between the EZLN soldiers and the federal army. The uprising and consequent conflict was instrumental in bringing the world’s attention to Chiapas and for urging the recognition of Mexico’s indigenous population on the political agenda. In her analysis of the Indian intellectual after the uprising Natividad Gutiérrez (1999:198) argues that whilst capturing the imagination of mainly young, educated middle class mestiza students, the movement has done little to rouse support or empathy amongst poorer mestiza citizens. The lower-income and poor mestiza populations have difficulty relating to or accessing the mainly online
writings of (the predominantly male) Zapatista spokespersons and they remain the reading matter of the educated left or international supporters.

The significance of the Zapatista movement in the everyday lives of the mestiza population in San Cristóbal is questionable. Partly due to the effective propaganda machine of the state and the historical barriers between indigenous and mestiza worlds, the only daily reminder of the uprising in urban life is the consistent yet subtle military presence and the often muttered “things haven’t been the same since the troubles” whenever there is an outburst in the central marketplace, or the frequent sensationalist reports of revenge killings in local newspapers. In the twenty first century San Cristóbal remains a very segregated city and barrios are defined by socio-economic status and ethnicity, with the ‘diverse population’ knowing very little about each other’s day to day lives and personal relationships; Cristina, my midwife and long term foreign resident of San Cristóbal described the city as “very much an unspoken apartheid”.

Although there are significant divides between indigenous and mestiza populations, their complex histories mean that many practices and beliefs have shared roots. This appears to be most evident in descriptions of local biologies, cosmologies, uses of plant based medicine and healing practices. A shared and intersecting history means that in analytical terms these social groupings are not overly-discrete ethnic categories. However, in ethnographic terms mestiza, coleta, or indigenous identity forms the basis of who a person feels they are and to where they belong. They way in which the people of San Cristóbal declare their coleta or outsider identity demonstrates the variability within the mestiza population; that is just as much
misunderstood and under-represented in social science and policy literature as the variations that exist within the indigenous populations.

**The Barrio**

Each morning as we set off on the school run with my daughter Emilia, we opened a large metal door and were presented directly with barrio life. Our little concrete and wood house was situated with four others on a large piece of land surrounded by a high wall. From behind the wall the sounds and smells from the wood fires, kitchens and laundries of my neighbours were a constant reminder that although our house and garden, on one side, looked out onto the surrounding hillsides and quarry in the distance, this was a view far removed from the busy family lives happening beyond the high wall. On the opposite side, beyond the high wall, we were surrounded by dwellings of all shapes and sizes that housed multiple generations of families and that were plotted along the main trade route between the city centre and the highlands. The barrio was first recommended to me by my midwife, Cristina, who lived at the lower end of la Garita. “You’ll be happy there” she told me, “the rents are cheap, the community is strong and the people are nosey. They’re one hundred percent coleta, no foreigners, no bullshit. What’s more, if you go into labour I’ll be just round the corner!” I was around seven months pregnant at the time and had mistakenly chosen to live in the centre of the city in an overpriced house that also served as a barrier between myself and the local community. I was anxious to settle into fieldwork, find a school for my daughter and establish myself in a neighbourhood before my final trimester set in. I took a gamble when Cristina gave me the address. Emilia and I jumped in a taxi and travelled to a part of the city I had rarely visited before.
After a month of troubles and false starts in the city centre, arriving in the barrio felt like a godsend. To be greeted with the comforting smell of burning ocote\textsuperscript{5} and laundry soap, the sound of ranchero music and dogs barking, the heavy chains of the gas truck dragging on the road surface accompanied by the loud tinny jingle that blasted out from the vehicle’s sound system brought back a reassuring feeling that resurfaced in my body from my early married days in a similar barrio on the west side of the city. I was transported back to when I originally became so attentive to the ways of being in the coleta households of San Cristóbal. Though I originally thought that the high wall separated me slightly from my immediate neighbours, I soon learnt that it offered me no privacy at all. My closest neighbours outside the terrain, Dona Frida and Dona Perla had two storey houses that looked directly over the wall and onto mine. Within the walled property where my house was, cousins Sara and Ruby’s house and garden backed on to mine. The back of my house, which marked the far end of the property, was supported by a large concrete and adobe structure housing a family of ten who ran a local laundry business. As much I was aware of my neighbours’ movements throughout the day, family meal times, tastes in telenovelas and music, their arguments and laughter and the visitors that came and went throughout evenings and weekends, they were aware of mine. My tentative need for privacy, which I was so used to having in England, slowly began to dissipate as I immersed myself into daily life in the barrio and my data collection.

Daytimes in the barrio were centred round interactions with the women and children who live there. With just about all adult males out working from the early hours to late afternoon, the barrio often felt like a woman’s domain during daylight hours.

\textsuperscript{5} A type of pine wood used as firelighter.
Before I knew it, the daily activities I had originally understood as aside from my fieldwork – the school run, toing and froing on *combis*\(^{6}\), fetching *garrafones*,\(^{7}\) queuing for tortilla and buying emergency supplies from my neighbours - became the most valuable sources of data and relationship building that would come to shape my research. Through the snippets of conversations I collected during the day, I was able to challenge many preconceived notions I had previously held about pregnancy, birth and early motherhood in San Cristóbal and quickly began to shift my focus on to what wider processes and practices of what mothering meant for the women in la Garita.

![Barrio la Garita](image)

**Figure 5.** Barrio la Garita (purple line denoting boundaries with other barrios)

Barrio la Garita is located to the far east of the city of San Cristóbal de Las Casas and serves as the exit towards the neighbouring municipality of Tenejapa (as shown in figure 5). Barrio la Garita came into existence, like many of the outlying neighbourhoods, as an overspill from one of the city’s original barrios. It is also described locally as an ‘invasion barrio’, because much land was originally squatted

---

\(^{6}\) Local mini-buses  
\(^{7}\) Demijohns of water.
with no access to public services. According to local accounts the area of la Garita was populated towards the end of the nineteenth and twentieth century (CIEPAC 2007; Herrera 2013). Since the 1970s, due to pressure and campaigning from residents, the barrio has gradually developed all necessary public services including non-potable water, household waste collection, drainage, electricity and telegraph poles. The non-potable water system, unlike in the rest of city, is run autonomously and administered by a board of local representatives. The barrio’s drainage system is also maintained by residents along with much of the rest of the barrio’s infrastructure. On the west side of the barrio there is a community plaza with a Catholic church and sports court. The barrio adopted a patron saint – Santa Cruz – which the church is named after and during the 1990’s a public primary school and kindergarten were built.

Figure 6. The main street Calzada la Garita and one of the many callejones leading up to the Plaza Santa Cruz

The majority of houses are built from concrete (breeze) blocks, adobe or wooden planks (as shown above in figure 6), with concrete or earth floors. Many large family groups on the main road have original land plots that have been added to over the years. It is common for there to be three to four generations living under one roof. Where there is space many people keep chickens, hens, cockerels, goats and pigs for
domestic consumption or trade. Houses are either added on to when economic circumstances improve or separate dwellings are built within the family’s plot. Along the main street there are two mechanic and tyre workshops, hairdressers, electrical repairs shop, a hardware store, a fruit and veg shop, two tortilla shops, a beer station, two small general stores and a hairdresser. Women travel to the city centre market to buy wholesale produce to sell from their doorways or door to door. For health services; public security; secondary and high schools; public offices and wage based employment habitants must travel to other parts of the city.

The forest area around la Garita and connecting barrio Cuxtitali are supposedly protected ecological reserves though without sufficient protection from the municipal government groups have taken large sections of forest and built houses or sold land on as their own. Today the upper part of the barrio is predominantly inhabited by indigenous families (of varying low to middle economic status), and the lower half leading down to the neighbouring barrios Guadalupe and Cuxtitali predominantly comprised of lower-income coleta families. Many other inhabitants come from other nearby barrios or municipalities, products of family relations or marriage. There are families from neighbouring municipalities of Chamula, Huixtán, Bochil, Teopisca, Comitán, Chenalhó, Copainalá, amongst others and those originally from the barrio itself. Like many of the mixed neighbourhoods in San Cristóbal indigenous and coleta families live side by side yet apart, communicating generally for economic transactions and trade.

Figures 7 and 8 provide an example of how I categorised and profiled families and individuals in the barrio. The information provided in these tables relates to basic type of household and economic activity in relation to average national income levels. In correlation with census data, the households in my study were reliant upon
informal economic activity to bolster the precarious salaried work. Most adults and young people have completed primary school and a small proportion go on to complete secondary school. Failure to attend secondary school is often explained in policy research as a lack of desire or aspiration to achieve, particularly in girls (see Garita Edelen et al 2016 as an example). When I asked my neighbours why their children did not attend secondary education they explained how distance was a problem, rather than lack of desire. There nearest secondary school was a thirty-minute combi ride away, a financial and time expense that many felt they could not afford. Readiness to learn a trade or begin contributing to household or informal labour was perceived as a more pragmatic option in many cases. In terms of gender, men in this barrio are principally employed in the construction trade or as vehicle mechanics. Some women who work outside of the barrio do so in the capacity as domestic workers in middle-income neighbourhoods and younger women tend to work in shops or hotels in the city centre. Most adult women’s economic labour takes place within the boundaries of the barrio – whether this is informal or formal activity.

The tables below take on the census employment categories of primary, secondary and tertiary. I have added an extra category of informal which in general adheres to the selling of food and small goods either from the home or door to door. The type of household (which demonstrates strength of social network) and income relate directly to the types of public and private health service people will access. This demonstrates amongst other things, the mixed economy of healthcare services that people access are as much to do with an individuals’ social capital as they are income category. Although low-income families often have access or rights to welfare provision, they will often make alternative choices which are dependent on
personal and shared values and proof of citizenship. In Figures 7 and 8 we can begin
to see the idea that income based social status alone is not necessarily a reliable
indicator of the health needs and desires of a population.

Figure 7. Mestiza Barrio Families (as they appear in the thesis)²

<table>
<thead>
<tr>
<th>Family Name</th>
<th>Type of Household</th>
<th>Family Members</th>
<th>Complete Education</th>
<th>Economic Activity (Primary/Secondary/Tertiary)³</th>
<th>Average Income Level⁴</th>
<th>Access to Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gomez² (Plot 1)</td>
<td>Multi-generational</td>
<td>Doña Reina Don Marco</td>
<td>Not known</td>
<td>Primary</td>
<td>Not-Econ Active Self-employed Tertiary/Secondary Informal Econ. Tertiary Tertiary/Secondary Not-Econ</td>
<td>Low-middle: Low</td>
</tr>
<tr>
<td></td>
<td>Doña Carla Caríta Marco Dulce Felipe</td>
<td></td>
<td>Primary</td>
<td>Primary</td>
<td>Primary Primary Primary Primary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gomez² (Plot 2)</td>
<td>Multi-generational</td>
<td>Don Arturo Doña Perla Rogelio Carlos Magali Ricardo Josefina</td>
<td>Primary</td>
<td>None</td>
<td>Secondary Informal Econ. Secondary Secondary Non-Econ Active Secondary</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Primary</td>
<td>Primary</td>
<td>Primary Primary Primary Primary</td>
</tr>
</tbody>
</table>

² The tables represent individuals over 16yrs who appear in this thesis and can be cross-referenced with the family summaries listed at the beginning of the thesis. They are not of course a complete sample from the 3 phases of data collection.
³ The economic activity categories of primary, secondary and tertiary have been used to mirror how national employment statistics are recorded. Within secondary I include manufacturing labour such as carpentry, electrician, builder, labourer and mechanic. Within tertiary I include retail and domestic service. Informal economic activity includes selling food products door to door, from home, hiring out services such as laundry, dress-making, furniture repair, shoe repair. Participants generally do not wish to disclose the formal or informal status of employment unless it is obvious by profession or non-domestic business ownership.
⁴ According to the OECD Mexico’s national average income is $12,806USD per annum. The average wage in Chiapas is around three times less than the highest national average (OECD 2015).
⁵ In the case of the Gomez family there were four separate house plots in the upper barrio belonging to Gomez siblings (Doña Reina’s children). Each plot had between 1-3 separate dwellings, housing adult children and spouses, grandchildren and great grandchildren.
<table>
<thead>
<tr>
<th>Name</th>
<th>Household</th>
<th>Status</th>
<th>Education</th>
<th>Economic Activity</th>
<th>Income Level</th>
<th>Access to Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doña Gertrudis</td>
<td>Multi-generational</td>
<td>Widow</td>
<td>None</td>
<td>Tertiary/Informal</td>
<td>Low</td>
<td>SP, P2</td>
</tr>
<tr>
<td>Don Victor</td>
<td>Single-generational</td>
<td>Separated</td>
<td>Undergrad</td>
<td>Self-Employed - Tertiary</td>
<td>Low-middle</td>
<td>SS, P1</td>
</tr>
<tr>
<td>Angela</td>
<td>Multi-generational</td>
<td>Married</td>
<td>Secondary/Technical</td>
<td>Self-Employed - Tertiary</td>
<td>Low</td>
<td>SP, SS</td>
</tr>
<tr>
<td>Filomena</td>
<td>Multi-generational</td>
<td>Widow</td>
<td>None</td>
<td>Informal</td>
<td>Low</td>
<td>SP, P2</td>
</tr>
</tbody>
</table>
Introduction Part III

The Fieldwork

Figure 09. The barrio during the day is the domain of women and children

When I write of the ‘barrio’, I refer to what Dalsgaard (2004:70), when writing in the context of a low-income neighbourhood in North East Brazil, describes as a ‘loose and primarily experienced unit’ as opposed to a cartographic generalisation. The actions and interactions of individuals and families define how they understand the barrio as a place to belong. On a municipal map (see figure 5.) the area has well defined boundaries and is often defined by administrative or political divisions. The municipal map does not take into account the many callejones and escalones\(^\text{12}\) on the northwest side of the barrio. Nor does it take into account residents’ own interpretations of the barrio’s limits or the numerous unregistered dwellings encroaching onto the surrounding forestlands. The families that were to be my neighbours and informants lived on land plots of various sizes running along the

\(^{12}\) Steep hillside alleyways and backstreets with properties leading off them.
main street. When I asked about ownership of the different land plots it was always explained to me in terms of how many generations of the family had lived there. As I gradually learnt the social and political history of the barrio, it became clear how earlier generations had acquired land and developed official ownership of it over time. When I first informed friends from other parts of the city where I had moved to I was greeted with mixed reactions. Each person I spoke to would produce a different ‘fact’ or substantiated rumour about the barrio. There were countless comments about the strength and pride of the people in la Garita, how they were community minded but not welcoming to outsiders; others said that they were poor, untrustworthy and rebellious. What had first appeared to me as a typical low-income, outer-city neighbourhood dominated by a wide and dusty main road leading to the next town, suddenly came alive with urban myth and intrigue. In the early weeks I spent a lot of time picking through the tales of my friends with older barrio residents and found that, as with most urban myth there is always a point in history that serves as a root cause to stories that persist over generations. Don Juan and Doña Rosa, the elderly parents of my immediate neighbour Doña Frida were an excellent source of clarification and myth busting. At seventy-eight years old Doña Reina, whose family owned a substantial amount of land in the upper part of the barrio, was able to help me draw maps of how the shape and nature of the barrio had changed over thirty or forty years.

Since my primary ethnographic method was participant observation as a resident of la Garita, I participated in daily activities and attended community events such as the patron saint celebrations and residents meetings. In order to gain some socio-economic comparison of other mestiza women’s birth and caregiving experiences, I carried out participant observation at a local casa de partos, attended public courses
and talks on maternal health and parenting. I also met many families through my daughter’s school and holiday activities who were often kind enough for me to take advantage of play dates and conversations as a way of gathering data. In a place where gendered spaces and behaviours are, on the surface, quite clearly defined, my position as a woman, mother and spouse dictated where I was able to spend my time, when and with whom. My position as a neighbour and mother was crucial to forging relationships in the barrio. Carrying out my own mother work whilst I lived in the barrio enabled me to find some, albeit initially superficial, common ground with the women I met in the barrio. On doorsteps, at kitchen tables, in the close confines of public transport (*combis*), and standing chatting on street corners, I gradually became aware of the conversational and special boundaries set by women. I learnt the appropriate ways to ask about and elicit narratives of bodily experience and relationships in ways that, I hope, respected local ways of being and forged relationships of trust.

I came to be most familiar with the world of women and in part my understanding of men was also framed by the actions and speech of women. In distinctly gendered spaces it was often the absence and silence of men that helped me to reflect on their role as partners and in childrearing. Younger men in particular had a constant presence in the speech of their mothers. Doña Perla who had three sons at home would often cry when she spoke about her eldest Rogelio. He was thirty at that time and still single; she was worried he would never find a wife because of his heavy drinking. “They all go out to work with their father, they work hard for us,” she told me one afternoon “but I fear for Rogelio. I can’t sleep because of the noise when he plays his music. Do you not hear it? He locks himself in his room with his music, later I go in and find him on the floor spark out and I worry one day he will choke. If
he had children or a wife like the other two, he would stay sober and be a proper man. When he gets a girlfriend he calms down; then he’ll cheat on her, she finds out, leaves him and he starts drinking all over again.” These types of comments were commonplace and represent in some form how expectations of masculinity are constructed and pressures are placed on young men to produce certain ideals. Men’s abuse of alcohol, inability to work and lack of marriage prospects were a constant worry for some of my neighbours.

Rigid and defined gendered spaces do not of course equate to gender segregation. I did often speak daily to men as husbands, fathers and sons of my female informants and also through my daily interactions with taxi and combi drivers, and water and gas deliverymen. Doña Frida’s husband Don Pepe and their four sons accompanied us most evenings as we sat chatting on the doorstep. Don Marco, husband to Doña Carla, often gave myself and Emilia a lift to school when the combi failed to arrive on time. Don Arturo, the eldest son of Doña Reina and husband to Doña Perla, helped me to map out houses and families in the barrio. His work in the local building trade and as a part-time handyman to my landlord meant that he was often around fixing and rebuilding the houses. Talking to him reminded me that although I was often tempted by the thought that family organisation was a woman’s domain, a male head of the household was still the desired social norm. “It’s not the same [since my father died], there’s no respect anymore,” Don Arturo told me one afternoon when he came to fix my garden steps. As he worked mixing concrete with a small spade, he explained how he had fallen out with his brother (Don Marco) and they had not spoken for two years. Their argument had been about money and the behaviour of Arturo’s eldest son Rogelio, and the heavy drinking that Doña Perla had spoken about. Rogelio had been seen on various occasions drinking and fighting
in the street. Don Marco had demanded that his brother take control of his son and accused him of bringing shame on the family. An argument ensued and each of the brothers refused to back down. Doña Reina intervened and told Don Arturo that she agreed with Marco and that he was at fault for his son’s misdemeanours. Don Arturo was hurt by his mother’s allegiance to her younger son and felt very strongly that this would not have happened if his father had been alive. “You need a man at the head of a family,” he explained, “someone to fear; otherwise it all starts to fall apart.”

The Changing Nature of Space

Aside from the frequent interactions with my neighbours, my regular combi journeys became a principal point of contact with local women in and out of the barrio. Participant observation in the confines of a combi journey (that lasted anything between five to thirty minutes), as an environment that physically moves and shifts as interaction unfolds, presents a microcosm of ethnographic analysis. In her defence of participant observation as a robust anthropological methodology, Evans (2012) presents the case for long-term ethnographic fieldwork to be treated as a learning phenomenon. She argues that as such, ‘would-be ethnographers’ need a theory of learning that is properly instructive, and at the very least demonstrates the fieldwork situation as a unit of analysis. Evans suggests that this approach leaves us better prepared to ask the following types of questions: what is happening here? Who is taking part? What counts as competence? Who are the experts? Who is excluded from the action and why? How is the boundary on participation maintained? Who are the novices? What are the spatio-temporal limits of interaction? What are the bodily skills required to participate and what material/tools? What is the feel and flow of the action? How can I take part? (Evans 2012:99). I found that these same
questions could be applied appropriately, though not exclusively, to my own observations of the *combi* journeys.

It was on bumpy twenty-minute rides in *combis* that I got to know many women from different parts of the barrio and also was able to make connections between networks of families and friends. My regular journeys became a way of mapping women’s movements throughout the day, as well as a means of overhearing conversations and being able to speak to a number of different women all at once. Being squeezed in so closely together with babes in arms and smaller children perched on knees provided the opportunity for many conversations – which mainly centred on family life and on having and bringing up children. The women’s (and my) daily activities mainly involved moving between the market and home, work and home, or church and home. The conversations that took place in the *combis* allowed for bumping into friends and relatives, organising business or social calls and for debating the rights and wrongs of bringing up children and local politics. At times when I was limited in where I could go and what I could do, particularly in the first couple of months after the birth of my baby, the school and market runs in the *combi* became my lifeline for meaningful contact with women from all over the barrio. When I look back over my field notes, the importance of the *combi* journeys is confirmed. There are countless comments in my diary concerning *combis* as a place for learning about the social rules of mothering, space of economic transaction and deal making, an essential cocoon of gossip and exchange of learning, support and information concerning mothering skills.

*Combi* rides are a quick and bumpy reminder that motherhood is a shared practice in San Cristóbal and as such there develops a communal maternal identity with specific public childrearing behaviour. This development of appropriate public childrearing
behaviour is not static and changes in what is and what is not good mothering practice is also noted. One morning whilst travelling in the *combi*, I was surprised to hear a middle age woman comment to her friend, “In my day I was ashamed to breastfeed in public; nowadays they do it anywhere!” My surprise came from the assumptions I had made about breastfeeding in public in San Cristóbal, assumptions that were devoid of class and ethnicity bias. From this passing comment I was reawakened to the idea that breastfeeding was a practice associated with class and mestiza or indigenous maternal identity. I began to take a closer note of who was feeding, when and where, and noticed that there were stark contrasts between the labouring and middle mestiza classes. As much as maternal practices such as breastfeeding are closely connected to notions of being a good mother, there were distinct ways of carrying out this role that depended upon who and where you were.

Being part of this shared mothering space provides opportunity for women to comment on other children, ask about general home and mothering matters and also offer opinions on how or what mothers are doing. The daily observations I made in the *combis* became very useful for comparison when I spoke to women alone, they gave me some idea of acceptable boundaries in social interactions and how they were maintained in public.

The way a woman speaks to, feeds, clothes and carries her baby are under close scrutiny in public and there is a strong sense of pressure to conform (as will become evident in Chapters Four and Five). There is of course no rigid set of rules for all types of places, social status, ethnicity and age will always impact upon what mothering practices are acceptable and where. Outside of the barrio and wider public spaces, I spent much time carrying out participant observation, talking to and interviewing women and families in a local birthing house. Spending time and
getting involved in the activities at the *casa de partos*, as a researcher and an expectant mother gave me an insight into alternative forms of parenting and birth practices that were happening outside the public health system. Similar to many of the families in la Garita, the couples attending the birthing house were seeking to manage pregnancy and birth away from a clinical environment, though in contrast to my neighbours they sought the services of the increasingly recognised *partera profesional* (professional midwife – see Chapter Three). Unlike the strict social divides found in private and public clinics the families accessing the *casa de partos* reflected the diversity of the city’s population more distinctly. From lower to middle income mestiza women, indigenous women far from their communities, and foreigners who were resident or travelling through San Cristóbal, the *casa de partos* was a place where women arrived (though for very different reasons) with a common aim and approach to their reproductive health. Here I attended birth preparation courses, midwifery and doula skills workshops, yoga classes, nutrition and women’s health talks and celebrations.

The *casa de partos* became an essential source for contact with women who had experienced both clinically managed and out-of-hospital birth and from whom I was able to collect birth narratives to compare with the women in the barrio. The preparation for birth courses provided a valuable insight into the pace of social change and the pressure that mestiza couples faced from families in terms of how, when and where they should manage pregnancy and birth. Couples would often share that they were coming to the birthing house in secret because they feared that parents, unfamiliar with contemporary midwifery and home birth practices, would force them to change their birth plans. The therapeutic environment and relative anonymity of the small groups allowed for women, and occasionally their partners,
to talk about their worries, fears and excitement about becoming parents in a way that, they often commented, they could not do at home or amongst close friends where expectations were so predefined.

The identification of these ‘sites of singularity’ (Das n.d) provided not only comparison for the processes through which women in la Garita became (m)others, but also conformation that mothering in Chiapas is a collective activity which plays an essential role in forming a particular type of local female identity. Paying attention to the social mothering practices and norms is one way of seeing how the good mother paradigm (mentioned earlier) manifests in the popular imagination. The habits, practices and beliefs that shape the good mother paradigm work as a diagnostic of conflicting and intersecting structures of power (see Abu-Lughod 1990a). Its significance is such that I shall spend some time in the following chapter discussing the paradigm in relation to social history and nation building in Mexico as a whole. It is necessary to politically contextualise the Mexican good mother as a way of foregrounding the ethnographic material that follows. Ultimately, paying attention to the historical construction of the good mother in Mexico provides a framework for analysing the relationship between forms of power and culture that transcend boundaries between institutions and wider society.
CHAPTER 1

Birthing a Nation: Modernization and Maternal Subjects

Myths live on by disguising themselves in the apparel of modernity
Philip Ball 2015:31

[T]he space for an alternative feminist discourse on maternity can be cleared only after rigorous interrogation of the cultural representations of motherhood
Ziareck 1992:100

I was travelling home from school drop-off and market one stifling morning in July, it was the middle of the rainy season and days were characterized by hot stuffy mornings followed by intense downpours in the afternoon. It was an average weekday, the combi was full of women who had already been to market and, freed of school age children, were well into their daily routines. There were woven bags held between knees and bursting with vegetables and large bunches of coriander, parsley and chard. Sweet bread and tomatoes sweating in plastic bags held within the calloused brown fingers of one hand, whilst the other gripped onto the bench or dipped in an apron pocket to feel the size and shape of coins for the correct fare. As the combi bumped noisily up the dusty main road of the barrio, swerving every few seconds in order to avoid the massive potholes in the concrete road, beep at dogs or miss oncoming lorries that came bombing downhill as though their brakes has been cut, I listened absentmindedly to the conversations of the women. "Where are you going sweetheart"? One senora asked a woman in her early twenties carrying a small child and a large bottle of coke. “It’s my turn to queue for my mum, my sister is with her now but she has to go to work and my mum has to look after the little ones” she replied
"It’s signing on day and she’s been there since eight o’clock waiting for her money. And you, have you been? I’m told there’s a lot in the queue". She was referring to the signing on process for the pension provision of the cash transfer programme IMSS-\textit{Oportunidades} which took place every quarter. The senora shook her head "No I have too much to do at home, the gas ran out this morning and I have to wait for them to deliver more, if not there’ll be no food. I’ve sent my granddaughter to queue for me".

The \textit{combi} screeched to a halt as another driver jumped out in front of it to give an update about a temporary police check point ahead. As a sack of chayote spilled out on the floor its owner tutted and rolled her eyes at the driver muttering "careful young man, we’re not cattle"! Everybody bent over to rescue one of the spikey vegetables and return it to the sack which was now held tight in its owners’ hands. "Do you have a message for your granddaughter"? "Yes tell her I won’t be long, I’m just going to sort things out at home then I’ll be there to sign. Do you know who’s there [from the municipal government]? The last time they sent me all the way into the city because I had one digit missing. If it’s the young one I won’t have problems but if it’s the other, the red head, uuuurrrgh!" The \textit{combi} came to an abrupt halt again and everybody shunted up the bench to allow the new passengers on. It was a woman who looked to be in her early sixties, plump with long pigtails and a blue apron, she was accompanied by two younger women who now stood hanging onto the metal rails above everyone’s head as the \textit{combi} continued on its way. The smell of warm empanadas wafted out from her wicker basket and there was a bucket of \textit{atole} covered over with a cloth held steady in between her feet. "\textit{Buenos días}" she greeted everyone as she shuffled her bottom to create a space on the bench. "\textit{Buenos días}" echoed various voices in the customary reply. "\textit{Buenos días comadre}, what a miracle!" said the first woman to the passenger with the basket “are you off to sign or sell”? “Well a bit of both” she
chuckled, “If I’m going to spend all day waiting in line I may as well make some money whilst I’m there”. “Of course”! replied her friend “We all need to live”.

The combi journey described above highlights the ways on which women collectively navigate state bureaucracy, motherwork and family survival throughout the course of their everyday lives. Their engagement with the functional elements of the state apparatus is often expressed as a molestia (annoyance), a necessary evil that takes precious time away from economic activity and managing the home. Yet at the same time, collectively, the women invent creative ways in which to ‘wait in line’ and develop ways of dealing with the ‘street level bureaucrats’ so that their time devoted to the system does not end in vain.13 Their gendered positioning as principle caregivers and poor female heads of household are what define their day-to-day engagement with the state. The direct targeting of mothers and (grandmothers) as principle recipients of welfare is significant in Mexico and deeply connected to a history of nation-building via the fetishized notion of the good mother figure. As such, it is important to pay attention to how much of a role the state plays in constituting maternal identity and moreover, how the seemingly mundane bureaucratic procedures provide important clues to understanding the micropolitics of state-gender relations – as interactive processes.

In this chapter I will discuss the relationship between nation and maternal identity in Mexico in the broadest sense of the term. My intention is to provide an overview of existing literature that relates directly to my fieldwork in the barrio of la Garita and the surrounding city of San Cristóbal de Las Casas. I will return to these topics

13 It should be noted that Latin American sociologist Javier Auyero has explored at great length the politics of waiting and temporality in the Argentinian state social and administrative services. He argues that whilst waiting in line and navigating the impossible bureaucracies, the poor learn the opposite of citizenship. Auyero considers how the mundane practices of waiting work as a strategy for state control and management of populations.
throughout the thesis in the hope that my ethnographic material will contribute to, trouble and contest pre-existing knowledge concerning societies defined as mother-centric. The mestiza families who appear in this thesis are not wholly reliant on state welfare in managing their family lives; few poor Mexicans ever actually are due to the complexities and structural chaos involved in negotiating the system. As described in the previous chapter, most families in the barrio are low-income and dependent upon a mixture of low-wage and informal economic activity. All families have access to the integrated health insurance programme Seguro Popular (Popular Health Insurance) and some to the conditional cash transfer programme IMSS-Oportunidades, yet in practice they use a mixed economy of healthcare dependent upon needs determined by themselves. This raises important questions about people’s interactions with the state not only via health provision, but also in the ‘mundane bureaucratic procedures’ (Sharma and Gupta 2006) that are involved in everyday family life. Whether this involves obtaining a birth certificate, getting married, or less direct representations or interactions, such practices highlight a need to understand better not only the gendered nature of states, but also how states attempt to regulate gender. The different ways in which the state presents itself in everyday life means that, whether directly or indirectly, it continues to shape ideas about sexuality, gender and caregiving in very specific ways.

When I write of gender-state relationships throughout this thesis, I do so in an attempt to move from an abstract to a concrete notion of state. My aim is to examine what the state means to the low-income mestiza women who encounter it and how or whether they choose to interact with it. In its abstract sense I understand the ‘state’ to be a ‘multi-layered, contradictory, translocal ensemble of institutions, practices, and people’ (Sharma & Gupta 2006:6), which is never far from broader global
political economic concerns. In addition to this ensemble view, the state also serves as ‘a powerful site of cultural and symbolic construction’ (Auyero 2012:6). It is at once a cultural artefact within a specific context and a transnational vehicle for the domination of subordinate populations (Dore 2000; Sharma & Gupta 2006; Brown 2006). In this sense, ‘anthropological analyses of the state, should begin with the counter-intuitive notion that states that are structurally similar may nonetheless be profoundly different from each other in terms of the meanings they have for their populations (Sharma & Gupta 2006:11). Within anthropology notions and contestations of the state in an age of globalization have been much debated (Ferguson and Gupta 2002; Sharma & Gupta 2006; Trouillot 2001). Ideas of nation-state are simultaneously contested and reified by processes of globalisation, as such for anthropology, the state as an object of study requires a constant interrogation and re-imagining in transnational contexts. Despite this wealth of anthropological debate on the state, there remains an absence of a comprehensive account of gender power as a cross-cultural form of dominance and basis for state-centred policy (Freeman 2001; Brown 2006; Dore 2000).

The Latin American ‘state’ has historically been characterised as ruling from the interests of an elite, whilst purporting to rule in the interests of a broader portion of society (Dore 2000). Despite a tendency for dysfunction and often lacking in the most basic resources, Latin American states maintain particular capacities. They grant access to citizenship, provide limited but vital welfare benefits, and exert violence to control unruly behaviour (Auyero 2006:5). They also produce a cultural and national identity that are immersed in particular forms of intersecting power. But what does all this mean for low-income mestiza women in the South East of Mexico? Is there anything particular about how the Mexican state utilises policy to
access women and govern sexual behaviour? And what do everyday attitudes and mothering practices reveal about gender-state relations in the absence of a more comprehensive account of the masculinist powers of the state?

The Mexican feminist movement has wrestled with the maternal subject in its attempt to challenge state and institutional gender constructs whilst trying to shift the focus onto reproductive health politics, socio-economic status and ethnic distinctions and in deconstructing the meaning of motherhood in contemporary Mexico (Bringas et al 2004; Castellanos 1971; García and Oliveira 1997; Guerrero Menses 2004 and González Avila 2005; Lamas 1994; Palomar 2004). Molyneux (2000) argues that in Latin American studies in general there has been a shift away from state-centred analysis to society-centred analysis of power and authority – all the whilst taking into account the problematics of a ‘contained state-society’ dialectic. This type of analysis treats the state as more fragmented and contradictory in how it acts within the context of a constantly evolving neoliberal political economy. In this sense I view the maternal subject as a referent object that goes beyond individual bodies to permeate gender relations in every aspect of Mexican society. From this perspective ‘competing interests vie for power, the outcome [for individuals] is unpredictable' (Molyneux 2000:39) and there is the possibility of some gains for the disadvantaged within societal and state structures.

As a foreground to the rest of the thesis this chapter includes a description of the historical relationship between mothers and the state in Mexico. I deem this necessary in order to take into account the state’s more covert and overt presence in the events that occur in later chapters. Using social policy, contemporary history and anthropological literature, I will briefly explore how Mexican state ideology, from the beginning of the twentieth century, has been projected onto and into maternal
bodies – in direct relation to the building of a national identity. The extensive analyses done by Molyneux (2000), Varley (2000), Dore (2000) and Chant with Craske (2003) on maternalistic social policy approaches in Mexico has revealed just how necessary a re-evaluation of Mexican history is in order to understand fully, the extent to which the shaping and manipulation of maternal ideology has influenced and been influenced by state-society gender relations. It is precisely the unintended consequences of social policy and welfare intervention that demonstrates how states are intrinsically implicated in the ordering of gender relations in the societies over which they preside (Molyneux 2000:39).

Following on from the historical context I will focus more specifically on the lives of low-income and poor mestiza women in Chiapas and their interactions with the state via healthcare. The regions’ economic status and high mortality rates make it a target for national development programmes that frame poor women within a particular global health discourse of ‘needing improvement’. This in turn translates in a national context to a continued fetishization of the archetypal Mexican mother figure – a contradicting economic and politically subordinate persona that mestiza women are meant to aspire to. The simultaneous ideological glorification and economic discrimination of mothers by the state requires unpicking in order to see how this manifests in everyday lives and practices. Ethnographic attention to the concrete ways in which healthcare is negotiated and accessed will provide important insights into how mestiza women confront the many hidden economic and political inequalities they face. The women in the barrio provide a counter-narrative to the ways in which poorer mestiza women are often framed or at times completely ignored by health discourse. As Biehl and Petryna (2013:3) argue, it is only by ‘looking closely at life stories and the ups and downs of individuals and communities
as they grapple with inequalities … and confront novel state-market formations, we begin to apprehend larger systems’ and how they impact on everyday lives.

In that we are all born of mothers (and, for women, the female bodies we inherit define us as potential mothers) maternity has often been proclaimed as a source of sameness and identification between women (Jolly 1998b). Although global cultures vary in how mothers are positioned, childbearing is nowhere deemed insignificant (Kitzinger 2005). The implicit and explicit link between the female body and maternity is at the core of cross-cultural feminist thought that seeks to explain the condition of women. I stated in the introduction to this thesis that I aim to explore the process of maternal transition beyond an essentialist feminine paradigm, and in doing so shift debates about motherhood from the confines of a health context to a wider political economic one. This is in part because when maternal transition is confined to the health context, the female subject retains a certain passivity due to her ‘maternal condition’. She ceases to be a subject and becomes an object of maternal health discourse. The ‘maternal object’ is described and explained in a way that essentializes questions of femininity, as opposed to challenging them. We are led to ideas about women, reproduction and caregiving that are removed from broader societal issues and notions of change. Despite this, there remains a need to contextualise the maternal process within the discourse of global health. I understand that by doing so I risk the accusation of reproducing the very problem I have identified. However, my aim is to understand maternal and health discourse as a strategy through which political economic interests impact upon and manipulate individual bodies as opposed to defining them.

Medical anthropologists have been grappling with ‘that obscure object of global health’ (Fassin 2012) for some time now, but the addition of a ‘critical’ prefix is a
somewhat newer development (Biehl & Petryna 2013). On the one hand, the turn to
critical global health is the renewal of a long-held concern within anthropology: the
need for close attention to the broader knowledge field of ‘public health’ and its
policy and practice. On the other hand, ‘critical global health’ is a construct that
emerges specifically alongside the contemporary biopolitical configurations in which
working towards ‘something called health’ (Pigg 2013:128) are now shaped,
characterised by a ‘multiplicity of actors, all vying for resources and influence in the
political field of global health’ (Biehl & Petryna 2013:6). The focus on maternal
mortality in global health provides a poignant example of this. Success of effective
use of resources in maternal health is measured via maternal mortality rates. Though
numbers can never be exact, global health institutions spend considerable resources
to calculate and measure maternal mortality rates.

The growing significance of maternal health indicators like maternal mortality is
directly linked to new norms of ‘evidence based development’, ‘value for money’
and pressure to ‘demonstrate/produce impact’, and do it in such a way that the results
can be attributed to specific interventions (Sharma 2016). Such a results-driven focus
(enhanced by the pressure to meet globally agreed goals and percentages), fails to
recognise gender politics on the ground and quality of interventions. Conflating
maternal (and by proxy reproductive) health with mortality rates shapes policy and
practice in specific ways. It means that particular populations become targeted (those
deemed most at risk of dying) and the needs of others are ignored, or they become
cought up in the unintended consequences of the quick fix approach. Within this
political field of global health, it is important to ask the following questions: how do
‘some places, people, and health inequalities fall under the purview of global health
while others do not?’ (Pigg 2013:128). How are the main concerns of global health
driven by wider bureaucratic dimensions of governance that seek to normalize the
disciplining of the poor? And, what are the unintended consequences of global health
interventions in culturally constituted translocal systems of power?

In working towards a more critical global health, anthropologists argue that global
health discourse constructs the moral policing of male and female bodies, and turns
sex and sexuality into rational practice via maternal and reproductive health policies
(de Zordo 2013; Pigg and Adams 2005). Understood in this way, reproductive health
promotion and practices become a way of objectifying sex and sexualities with the
specific aim of ‘knowing, manipulating and managing’ female bodies – who are
often the principle targets (Pigg and Adams 2005). Ethnography of reproduction in
relation to the intersection of global health and state must take in to account the
wider social context of caregiving practices and gender roles, particularly in societies
where ‘fertility is sexualised or where pro-creation is central to gendered identities’
(Pigg and Adams 2005:8). This is not to say however, that maternal and reproductive
health should be treated as one in the same, but understood as intersecting.

In writing this thesis I have found it useful to think of global health as a ‘bunch of
problems’ (Kleinman 2010), a set of relations and practices framed through a
discourse of globalization. Through a global systemic lens (such as Friedman’s), I
understand global(ised) health to be a product of global processes which impact on
local (health) identities. In this way the analytical framework of global health
becomes a mechanism for interpreting local conditions from within a global
discourse and vice versa. However, I do remain cautious that whilst a global systems
approach is useful, discussion of the ‘local’ must still be liberated from the confines
of a patriarchal definition of something that is forcibly produced by global processes
and therefore dependent upon masculinised ideas of what global and local mean, and moreover what their relationship to each other mean.

**Mothers and the Mexican State: A Historical Overview**

Maternal identity and the role of mothers in building the Mexican nation has been well documented in historical and cultural studies literature. It is part of a gendered discourse that forms the basis of a large body of knowledge on modernization and nation-building in post-revolution Mexico (Dore 2000; Gutiérrez 1999; Franco 1989; Varley 2000). Twentieth century state formation in Mexico can be characterised by three distinct stages. The first significant stage is post-revolutionary Mexico, a period of great political and economic upheaval leading to the creation of a new constitution in 1917. However, despite spirited feminist campaigns and inclusion of women fighters in the revolution little changed to the gendered order of society. The new 1917 constitution granted married women some new rights within the family such as legalising divorce and equal custody over children, but the general social and political consensus was that women should not feel the need to participate in public affairs and most women remained subject to a 'de facto patriarchal order' (Molyneux 2000:51). The era leading up the 1930s can be defined by attempts at building a new Mexican ethnic identity via the project of *mestizaje* and wanting to separate the country from its colonial past via staunch anti-clericalism. The state was highly influenced by a new European enthusiasm for eugenics and the application of science in social and domestic regulation, which underpinned efforts to modernize the Mexican family through technologies of reproduction, health care and child development (Stern 1999). Women’s devotion to the church and ecclesiastical influence in the home was challenged and declared as counterproductive to the modernization project. Something about this period resulting in contested notions of
the meaning of good motherhood (between state and church) - the reality, as extensively discussed by Mathew Gutmann, is ‘ambiguity, confusion and contradiction’ in the meanings of both fatherhood and motherhood (Gutmann 1998:134).

The second stage of twentieth century state formation, from the 1930’s through to the late 1970’s, was an era defined by corporatism and popularism in Latin American social and political history arguably forged the Mexican nation identity as it is known today. The challenge of governments during this post-revolutionary period was to combine economic development and political stability (Chant in Chant with Craske 2003). This translated in Mexico to single party dominance of the PRI (Partido Revolutionario Institucional Institutional Revolutionary Party) for over seventy years, wryly labelled the ‘perfect dictatorship’ by Peruvian writer Mario Vargas Llosa (Isbester 2011). Varley (2000) argues that the countrywide failure of the mestizaje nation building project led to a focus on modernization placing women (as opposed to the mestizo Mexican) at the centre as key subject and object of change. The nation state became entrenched in the family through the mother figure which supposedly transcended ethnic, class and regional differences. Legal reforms affecting adult women around this period were double-edged dependent upon marital situation. Single women and lone mothers were given greater freedoms via property rights, parental responsibility, economic activity and freedom of movement without chaperone. The move to define a ‘marital’ or ‘conjugal’ home as one inhabited by a married couple and their children was meant to protect women who had no rights when living in the in-laws’ property - there was an overall judicial desire to assign domestic space 'to one, and only one woman' (Varley 2000:244). Though these changes to what constituted a marital home had the intention of freeing young
women from the control of over-bearing (and often abusive) in-laws it idealised the nuclear family home and fostered further state intervention in the domestic sphere. Nor did the married woman cease being the property of her husband under civil law and her domestic role was further cemented via a legal obligation to the responsibility of carrying out or overseeing housework. In the case of lone mothers and widows they became a vehicle to demonstrate the 'compassionate, protective and paternal nature of popularist regimes' (Molyneux 2000:56) where the state's role was to replace that of the hardworking male breadwinner. The consolidation of the iconic Mexican mother and the nation-building project ushered forth the idea of motherhood as civic responsibility (Dore 2000:13).

The final stage of twentieth century state formation, the post-structural adjustment era of the 1990’s, has been defined more widely by Scheper-Hughes and Sargent (1998:7) as a decade of radical transitions to democracy and the pursuit on a global scale of individual human rights. The centralist corporatist bodies and an economic model that depended upon graft and clientelism was made increasingly unviable by economic crises in the late 1970’s and early 1980’s (Chant in Chant with Craske 2003). These crises led to mass structural adjustment and neoliberal reform of most of the Latin American region. A slow process of democratisation began which coincided with the newer incarnation of economic imperialism and debt relationship between Mexico and the rest of North America. This process of democratisation under the constraints of structural adjustment and neoliberal reform was described by the first non-PRI President Vicente Fox as an ‘imperfect democracy’, in his attempt to justify new forms of economic and military oppression that replaced the old PRI regime. During this period the neoliberal economic experiment deemed such a success in Chile (by supporters of free trade) was rolled out throughout Latin
America and manifested economically in Mexico as the North American Trade Agreement (NAFTA). NAFTA created an interdependent economic bond (or debt-credit relationship) between Mexico, the United States and Canada, which also had many social repercussions throughout the states Mexico. Beginning in the 1940s, Mexico had pursued a policy of import substitution industrialisation in which imports are replaced by the local production of goods so as to minimize dependence on foreign markets. This policy resulted in sustained positive economic growth up until the late 1970s. The structural adjustment agreements set out in NAFTA saw an end to the import substitution policy, and locally produced goods became unsustainable. NAFTA also eliminated state subsidies for agricultural products resulting in massive economic loss and economic restructuring to once agriculture dependent states such as Chiapas. As a result, the nature and security of employment markets worsened in favour of flexible accumulation and transmigrant flows between south and north increased tenfold.

Whilst development discourse categorises Mexico as a Newly Industrialised Country (NIC) and an exemplar of social, economic and political development in Latin America, individuals are negotiating within a web of past, present and future ideals where gender tropes persist and shape the everyday lives of individuals and communities. The periodic difficulty in accessing many of the services and benefits available to poorer populations has meant that low-income women do not look to the state for much in the way of support. Amongst the mestiza families in the barrio the general consensus remains that security comes from ‘paid work where it can be found, from marriage, kin and community, and the church’ (Molyneux 2006:428). That fact that this attitude remains amongst low-income families in Chiapas is an indicator that despite the pressure from global institutions for governments to pay
more attention to the social costs of structural adjustment, in reality mistrust in the state to provide continues.

Seguro Popular and IMSS-Oportunidades

This morning I was sent to get some routine blood tests ... When I arrived, the corridor leading to the laboratory hatch had been clearly segregated, chairs on one side and a standing queue on the other. I was feeling tired and sat down in the chair queue. I spent ages wondering what the difference between the queues were as there were other women pregnant and/or with children standing (a mixture of indigenous and mestiza), and some very healthy looking people in the sitting queue (all mestiza). After about an hour, the hatch opened and a lab tech in a white coat shouted that he would begin taking samples from the people on the left (the sitting queue) ... In the end I asked, the person in front why that queue was going first, she pointed at the standing queue and told me, “They are Seguro Popular”

(taken from my pregnancy diary, April 2008).

Health inequalities in Mexico are commonly linked to its fragmented, state-corporatist system of health care provision that has been undergoing decentralisation since the late 1990s (Kierans et al 2013; Homedes & Ugalde 2009). The healthcare system creates a sharp divide between the insured and the uninsured. Workers in the formal economy are provided with contributory health insurance with services provided predominantly by Instituto Mexicano del Seguro Social (IMSS Mexican Institute of Social Security). The IMSS is estimated to cover 55-60% of the national working population (Kierans et al 2013). Health insurance and services for government employees are provided by the Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (ISSSTE - Institute for Social Security and Services for State Workers).
There are currently two main programmes running throughout Mexico targeting individuals and families without any health insurance and living below globally defined poverty levels. *Seguro Popular* (state health insurance) was created in 2003 and is intended to cover all families that have otherwise no access to healthcare. *Seguro Popular* is a voluntary family health insurance programme funded by federal government with resources allocated and delivered at a state level. *Seguro Popular* is means tested with a sliding fee-scale for services, will all fees waived for families in the lowest two income deciles (Homedes & Ugalde 2009). Health services are delivered through existing state and federal institutions and can also be contracted out to private services. This means that government employees with health insurance share the same services and personnel with those in receipt of *Seguro Popular*. As demonstrated in the excerpt from my first pregnancy diary above, this does not equate to parity in the way people are treated within the institutions. *Seguro Popular*, much like *IMSS-Oportunidades*, has received extensive international coverage, including on numerous occasions in the Lancet, ‘where it has been presented as the route to universal health coverage and social protection …’ (Kierans et al emphasis in original). However, earlier positive assessments (notably a collection of articles published in 2006) have been questioned by independent researchers (see Homedes & Ugalde 2009; Laurell 2007). In regards to its de-centralized funding in particular, poorer states with the highest proportion of poor and uninsured (e.g. Chiapas) make a higher supplementary contribution than wealthier states – thereby increasing geographical inequity overall. Healthcare provided under *Seguro Popular* is

---

14 It is worth noting that the 2006 collection of articles were co-authored by Julio Frenk, the minister for health who implemented *Seguro Popular* and de-centralization of health services between 2000-2004 (Homedes & Ugalde 2009).
currently provided to around 61.7% of the population of Chiapas and 21.5% of the state population remain uninsured (ENSANUT 2012).

A further development programme running throughout Mexico is **IMSS-Oportunidades** (Opportunities, previously known as PROGRESA), a conditional cash-transfer programme that started in rural areas in 1997 and was later extended to urban areas. Its aim is to improve education, health, nutrition, and living conditions of population groups in extreme poverty, as well as to break the intergenerational cycle of poverty. **IMSS-Oportunidades** is the second most extensive programme of its kind in Latin America. It is also considered to be the most successfully developed example of the region’s national public health inspired anti-poverty programmes (Molynuex 2006). The programme has been emulated worldwide most significantly in India.

In the area of health, the programme offers an essential health-care package including pregnancy and delivery care for women enrolled in the programme. Health institutions are responsible for providing delivery attendance in their facilities. Attendance at the health promotion talks and medical checkups are a requirement for being registered on the programme and receiving financial benefits. The **IMSS-Oportunidades** programme disseminates a firm belief in empowering women by recognising them as responsible financial heads of the household – any financial benefits are given directly to the women. However, with its strict compliance to medical care and training programmes, and its payments in terms of vouchers, **IMSS-Oportunidades** does not translate into women gaining some sort of independence or financial control over their lives. There is also evidence that, whilst improving overall household incomes and school attendance, the programme has been
associated with poor health outcomes, and with reinforcing maternal responsibilities as women’s primary social role (Barber 2010; Freyermuth 2010; Molyneux 2006).

The city of San Cristóbal, as an important transfer site from rural communities, has benefited from development programmes since 2000 with an *IMSS-Oportunidades* clinic (serving much of the whole municipality rural and urban) and *Seguro Popular Hospital de las Culturas* built in 2010 to target the incoming rural and indigenous population. Increased access to institutions in urban areas via *Seguro Popular* and *IMSS-Oportunidades* has resulted in a national figure of 94% recorded live births now taking place in hospital clinics (ENSANUT 2012). Alongside increased hospital births, the rise in caesarean rates in Mexico has been well documented and recent national figures report an average of 43-68% caesarean section rate in state and federal institutions and an estimate of 70% in private institutions (ENSANUT 2012).

In Chiapas a study of public hospitals in Tuxtla Gutiérrez and San Cristóbal by Nazar et al (2007) found that from 1979 to 2003, the practice of caesarean section had increased almost nine times (870.0%) from 7.8% to 29.7% in the mestiza population and almost four times (394.1%) from 0.0% to 20.3% in the indigenous population. Though Chiapas has amongst the lowest national rates of caesarean section, it is still reported to be between 20% and 34.5% of all births in public hospitals (ENSANUT 2012). Researchers carrying out studies on the growth of birth by caesarean section in developing countries (which include Mexico) recorded no reductions in maternal or neonatal mortality and morbidity when frequency of caesarean section was more than fifteen percent (Althabe and Belizán 2006; Gonzales *et al.* 2013). As mentioned in the introduction to this thesis, maternal mortality in Chiapas remains the second highest in the country at 68.1 per 100,000
live births (compared to a national rate of 38.9) and infant mortality is the highest nationwide.

Studies on the progress of IMSS-Oportunidades in Chiapas between 2004 and 2008 report that just over half of the maternal deaths during that period were beneficiaries of the programme (Freyermuth 2009, 2010); the increase in hospital attendance has led to disproportionate rates of surgical interventions during and after birth (Barber 2010; Freyermuth 2010; Zapata Martelo et al. 2007). There are also disparities between the impact of IMSS-Oportunidades in rural and urban areas. Whilst the programme has had some relative success with maternal mortality among the predominantly indigenous rural population, the maternal mortality rates between urban (mestiza and indigenous) beneficiaries and non-beneficiaries is less than ten percent (Freyermuth and Cárdenas 2009). Also while over sixty percent of the state population are in receipt of Seguro Popular, the overall maternal mortality rate in institutions is improving at just one percent per year (Freyermuth 2010: 2).

Whilst low-income mestiza women remain doubtful of the welfare support available to them, access to healthcare elements of state social policy is of importance. It is when they become pregnant or want to stop having children all together that they begin to engage more seriously with the healthcare options available to them. Despite its vast coverage, the poor implementation and constraints of Seguro Popular mean that women often revert to relying upon family and social networks, and systems of credit in order to address their maternal healthcare needs. However, as I aim to demonstrate throughout this thesis, women often make conscious decisions to avoid public services that place restraints on their biosocial understanding of sex and motherhood, regardless of their low-economic status. The mixed economies of health care utilised by the women in the barrio could be seen as
a failure of the state to provide relevant or good quality services on the one hand. On the other, it could be understood as a form of collective agency and self-determination on the part of the women. In reference to the everyday practice theories of de Certeau (1984), the chapters in this thesis reveal how women employ a ‘myriad of unarticulated practices – tactics’ (McNay 1996:64) in order to escape the ‘hypostatising tendencies’ of particular institutions representative of the state.

**Ideological glorification and actual socio-economic discrimination**

"I don't sleep at night because I'm always worrying about the debt"

Figure 10. Doña Gertrudis (holding my younger daughter Frida), la Garita 2013

As discussed in the first part of this chapter, economy plays a significant role in how social and political attitudes towards family and parenting develop over time. In this second part I will discuss in more detail how the simultaneous ideological glorification and economic discrimination of mothers by the state manifests in everyday lives and practices. A closer examination of the economic activities and relationships between the women in the barrio will also contribute to understanding the quality of social networks available to them, which can enable greater reproductive and maternal agency. In the context of 1970’s industrialised Britain,
Oakley wrote how ‘[t]here is a pervasive ambivalence about motherhood that is expressed in the combination of ideological glorification and actual social discrimination’ (1980:285). In her work on maternal transition Oakley developed the concept of ‘the institution of motherhood’ as a framework for the way that women become mothers in industrialised society (1979:11). Oakley argued that in the institution of motherhood, changes in maternal practices are intrinsically linked to changes in economic activity. This idea provides a way of directly linking macroeconomic development to changes in childbearing and child rearing practices that may otherwise go unconnected or misunderstood. I extend her argument to include economic as well as social discrimination because I would argue that these two aspects are inseparable. Much of what she observed in her ethnographic work in 1970s Britain resonates with the type of economic and social change that has taken place in Mexico over the last three decades. Though limited in cultural comparison, Oakley’s distinction between ideological glorification and actual social (and economic) discrimination can shed light upon the difference in expectations put upon women who become mothers in San Cristóbal today in comparison to the previous generations of women who will be overseeing the latter’s transition to ‘good motherhood’.

Mexico’s restructuring and immersion into a neoliberal economy created the conditions for a flexible and disposable workforce, principally dominated by women and resulting in the feminisation of labour and poverty (Ariolla 2010; Chant 2008; Lugo 2008; Molyneux 2006). Whilst women are more likely to enter the workforce in modern day Mexico they remain underpaid and undervalued (Guerrero 2004). Despite this Chant (2003) reports that the low skilled services and informal economic activity, (which is dominant in the barrio), remain relatively unscathed by
restructuring and that in many ways have strengthened the position of women in households. According to contemporary analyses of mestiza households in Mexico, women’s informal economic activity contributes greatly to households and in fact sustains families in times of macroeconomic instability (Garcia and Oliveira 1997; Gutmann 1998; Chant with Craske 2003). Whilst on the surface this appears to be the case and it remains a stereotype much embraced and manipulated by state rhetoric, the politics and performance of gender roles dictate that male household members must be seen to be ‘bringing home the bread’.

The married women in la Garita, though proud of their economic contributions and ability to keep the family afloat, would never openly suggest their earnings were the principal household income. Gutmann (1996, 1998) has documented the impact of socio-economic change on mestizo masculinity and intimate relations Mexico City. He found that where there is a suggestion that a man cannot maintain his household, there can be negative consequences in terms of an individual’s masculine identity being challenged. As such married women’s economic contribution to the household is only ever seen as secondary to the adult male members of household and to her mother work (Chant with Craske 2003; Gutmann 1998). The situation for lone mothers is yet more complex as their responsibility as sole provider for the household is juxtaposed with their sacrificial actions as good mothers and principal carer to their children. It is in such situations where the ideological glorification of the maternal role becomes at once burden and driver for survival.
The women in la Garita are valued by the time, emotion and energy put into their mother work and economic labour, and overall ability to contribute to the management of a household. This is very much reflected in the historical construction of the good mother, which, as mentioned earlier, began in earnest in the post-revolutionary period (Varley 2000). If a woman needs to find money to feed, clothe or buy medicine for her family she will do so in various ways. Many women in the barrio are divorced, widowed or their husbands don’t have a regular or sufficient income. Strong social and family networks, informal debt and credit relationships and a shrewd ability to seek out and defend earning opportunities are essential to everyday survival in la Garita. “El Mexicano sabe vivir sin dinero” (a Mexican knows how to live without money) my landlord Don Victor told me one day. We were talking about how families were able to survive in the barrio when the wage economy was so insecure and dependent upon the good will of others to pay up on time. I learnt over time that economic survival in urban Chiapas was as much to do with the strength of family and neighbourly relationships and a feminised informal economy as it had to do with resourcefulness, resilience and reliance on credit. For women with a large family network like Doña Reina support from her
nine children and numerous grandchildren and great grandchildren was essential for economic security. Her husband had died later on in life when the older children were married and had established families and businesses of their own. Like other large families in the barrio Doña Reina’s family lived close together with three siblings sharing an extended terrain that also encompassed the family’s original wooden cabin, and two other siblings lived door to door on the opposite side of the road facing the family’s larger terrain. The economic position of each sibling was made clear through the type of house structure they had ranging from wooden cabin, concrete and adobe single storey structures, to Don Marco’s two storey, brightly painted concrete house with a double garage and porch. Despite the range in economic success amongst the siblings, which was clearly expressed by the brothers (and male partners of the sisters) housebuilding activities, the women worked together. Throughout the day activities were divided between the households and there seemed to be a constant stream of laundry, food and children passing between them.

For single mothers and widows with smaller family networks economic survival is very different and this notably impacts on mothering practices and maternal subjectivity (as will be explored in Chapter Five). Doña Gertrudis was a decade or so younger than Doña Reina but she had been a widow for just as long. She worked for Don Victor maintaining the grounds and the cabins. She often came over to babysit whilst I recorded interviews or if it was too wet to take the girls out with me when I had errands to run. Doña Gertrudis is a quiet yet strong and determined woman who had lived her whole life in la Garita. Whenever I saw her in the grounds she was either wielding a machete to cut/tackle? thick weeds, carrying massive piles of logs
for the cabin fireplaces, hanging out mountains of laundry or cleaning and cooking for Don Victor.

One afternoon Doña Gertrudis came over to watch the girls for me whilst I went to record some interviews. Within minutes of arriving at the cabin it began to rain heavily impeding my exit. When the afternoon rains begin there's no point trying to go anywhere, doors are closed, shutters pulled down and everybody waits for it to pass, confident in the knowledge that within the hour the rainfall will be light enough to venture outside. Whilst we waited for the rain to ease off I brewed some coffee and opened the bag of sweet bread I had bought that morning. Doña Gertrudis had finished her work duties for the day and was happy to sit cuddling the baby and sipping coffee. She began to tell me about when her husband died thirteen years ago, leaving her with seven children to look after. “He killed himself with drink” she explained. "I went out with the youngest children to visit my mum, he said to me "I don't want to go, you go with the little ones", so the older ones stayed at home with him and I went. When I came home later on my son was waiting for me, he just said, "Dad's dead" and that was that. I wasn't sad because it was his fault, he killed himself with the drink". She told me how she had always worked and it just meant that in becoming a widow she had to work that bit harder.

Before working for Don Victor she had taken in laundry and cleaned other people’s houses. Her job with Don Victor was the first secure employment she had which had given her a regular income and an extra source of credit in emergencies. Like most domestic labourers without job protection or insurance she was in a constant cycle of debt to her employer as well as others. When her youngest children were small she would take them to work with her but now they are old enough to stay at home and contribute to running the house. "I set them all off working from eight years old, at
first just running errands for my bosses, small cleaning jobs or labouring for builders, they all had to work as soon as they could, it is the only way”. Like most women I have met in the barrio she was calm and quiet in appearance, but in terms of money matters and earning a wage she would never be taken advantage of. She survives by taking out loans which she pays off at the end of the month when she gets paid, she then has to take out more loans to cover the next month and so on goes the cycle of credit and debt. “I don't sleep at night because I'm always worrying about the debt;” she laughs, “I think it's payback for what I put my own mother through”.

As Doña Gertrudis makes evident there are two very distinct and intersecting types of work carried out by women as mothers – mother work (glorified) and economic labour activity (simultaneously glorified and economically unequal). Mother work, as defined by Ruddick (1989:17), is in part to take upon ‘the responsibility of child care, making its work a regular and substantial part of daily life’. In the barrio mother work combines this with the day-to-day management of the household including all domestic chores, maintaining good community relations (for lending, debts and security), caring for domestic animals and older relatives or neighbours and managing the flow of people, goods and finances that pass through the house. Mother work is a collective activity that on the surface appears to be strictly feminine but in practice adapts to the individual dynamics of a household.

Echoing Gutmann’s (1996) findings on parenting and gender roles in Mexico City, though mother work in la Garita was dominated by girls and women, this changed as children got older and also as men’s work patterns faced increasing instability and change. In this sense, mother work does not have to be carried out solely by mothers, it is done by women, girls, men and boys of various ages and is the most common
way of contributing to household labour. Its success relies on the type of multigenerational households that exist in barrios like la Garita and a steady flow of cheap female migrant labour from the surrounding highland communities or poorer barrios. Gutmann (1998) argues that much of what is thought of as traditional mother work in mestiza homes can actually be traced back to Modernity projects of the early twentieth century. Day-to-day socio-economic reality produces different and more flexible and diverse practices, particularly in poorer households. Yet the public performance of gender in la Garita remains more akin to the historical national stereotype, making it very difficult to get women (and men) to talk about their contributions to work traditionally associated with mothers. The lack of decent employment opportunities for young women in the city and the high value attached to mother work and maternity means that, whilst family units remain close, mother work will remain the pride and domain of women for some time yet. Mestiza women may remain discriminated against within the formal economy and framed as ‘poor and dependent’ by state discourse, but the good mother status, as socially recognised and respected, has afforded them much political and economic participation in local informal economies and as such, they are less at the mercy of macro finances than men who went to work outside the barrio.

There are various descriptions and accounts of what constitutes an informal economy and these are often used imprecisely and interchangeably. One of the most generally accepted definitions is ‘income-generating activities unregulated by the state in contexts where similar activities are so regulated’ (Roberts, 1994:6). Whilst this definition is amongst the most useful it still fails to engender the intricacies of economic labour and transaction happening at barrio level in cities like San Cristóbal. Particularly in a gendered economy that often provides the services and
products that are not readily available in the formal sector, or where the formal sector is under-regulated and inconsistent. The type of economic activity and earning carried out by women at the barrio level as a doorstep economy. This is where most business transactions take place whether buying, selling or negotiating. There are countless doorstep economic activities in the barrio, whether it is selling cheese, sweetbread, sweets, tamales or chicken from the doorstep, outside the school gates or knocking door to door with atoles or tortilla; women will sell until they have enough money for what they need that day or week. Women often carry out various economic activities that can change and are dependent upon what is most lucrative at the time.

Based at home for most of the day due to the necessity of mother work also lends many women the opportunity to run formal (though not always regulated) businesses from home. The front room or entrance of the house is often given over to small business such as hairdressing, typing, small shops, sewing and dressmaking. Global and national franchises have also taken advantage of women’s limited movement and work options with a notable growth in catalogue agent work selling anything from health foods, cosmetics, clothes and cleaning products. There has been much critique about the perpetuation of urban mestiza women restricted to doorstep economies and sporadic labour activities and how this is linked directly to exploiting existing gender inequalities, traditional and naturalised caring roles and the social conditions of day-to-day survival (Chant 1996, 2003; Garcia and Oliveira 1997; Guerrero 2004). My ethnography shows the limits to this critique and my observations in the barrio were that the women were afforded a certain amount more economic freedom than their husbands and sons who were at the mercy of employers.
As we saw with Doña Gertrudis, though her employment with Don Victor gave her a regular wage and further recourse to credit, she also remained in a continuing debt relationship with him that restricted her in other ways. Though there is ample evidence to suggest that doorstep economies exploit existing socio-economic status, ethnic and gender inequalities, much of this comes from an assumption that citizens are better off within a regulated economy of employment. Alternatively, whilst employment conditions for women and men in the formal economy continue to worsen, the informal doorstep economy will continue to be the most prominent female economic activity throughout the barrios of San Cristóbal, as it is through much of urban Mexico (Eckstein 2014). Visible economic activity alongside mother work and management of others (daughter-in-laws, daughters, sons and muchachas) in the barrio provides important social and political status to adult women, which also transfers to their position in the community as large. As such, I argue that doorstep economic activity should not be dismissed as secondary to other types of economic and wage-earning activities that are dominated by men.

*Thoroughly Modern Mothers*

One Sunday Emilia and I walked down to Doña Maria’s barbequed chicken stall to buy lunch. This day we had timed it wrong and there was a long queue winding out onto the main road. Not wanting to queue in the afternoon sun Emilia ran around to the doorway from which Doña Maria set up her stall and began to play with three-year old Carolina, Doña Maria’s granddaughter. Weekends were always busiest and Doña Maria had extra help from her three sons and two daughter-in-laws. Doña Maria is in her mid-forties and her sons and daughters-in-law aged between seventeen and twenty-two. By the time I came to be served there were no whole chickens left, just a separate half and quarter and two remaining onions slowly
reducing to mouth-watering softness as they soaked up the heat and smoke of the charcoal. As one daughter-in-law Mabel piled our hot food onto a polystyrene tray and wrapped it in tin foil, Doña Maria and I chatted about the recent birth of her second granddaughter who had been born by caesarean section in the local maternity hospital. “It was an emergency” she explained “they said the baby had pooped and they had to get her out”. “It’s different for girls these days, they don’t manage [the births] as well, they’re too scared, and then they want to carry on afterwards as if everything is the same”. I asked Doña Maria what it was like when she had her sons. “I was at home with the midwife, everyone did it that way then, it was better”. She pointed to her eldest son Eric, “I was two days in labour with him, if I’d have been in hospital they would have had the knives out, as it was I had the partera and my mother-in-law and they helped me. I feel sorry for the girls now, it’s good they have seguro popular but it changes things, they don’t respect our traditions in the hospital and they put fear into the girls about giving birth”.

In Mexico national population growth and fertility rates have generally decreased as a combined result of state efforts and rapid socio-economic development (Bringas et al 2004). The population as a whole has been in a steady decline since The state’s efforts to shape the nation’s attitudes towards good parenthood, family size and use of contraceptives has not been restricted to policy and welfare interventions. Though reproductive health services and campaigns have traditionally been sanctioned and subsidised by the state, federal and state government have used various mediums to influence public attitudes. Popular media – radio and television novelas – billboards and magazines have long been utilised as a strategy for driving forward the image of the modern Mexican family (Soto Laveaga 2007; Hryciuk 2010).
The targeted use of telenovelas, and more recently social media and the cult of celebrity, is a gendered strategy that further implicates women as responsible for shaping national identity. Popular television shows dealing with family, parenting and social issues during my fieldwork in 2013 included *Nueva Vida* (A New Life), *La Rosa de Guadalupe, Lo Que Callamos las Mujeres* (What Women Won’t Say), and *Mujeres: Casos de la Vida Real* (Women: Stories from Real Life) amongst the numerous seasonal telenovelas heavily targeted at female audiences and laden with moral subtexts. Soto Laveaga (2007) found in her analysis of state media strategies, television programmes in particular work to take global concerns, such as population size or reproductive rights, and turn them into ‘Mexican projects’. In this way the universal ‘rights bearing individual’ becomes part of a national identity without the recognition of local cultural constructions (Schepers-Hughes and Sargent 1998:10).

Due to the success of state sanctioned campaigns women in urban Mexico are having fewer children and at a later age than previous generations – with a national average of 3-4 children per family by 1999 from a previous 6-8 children on average during the 1960’s-80s (Bringas et al 2004; Braff 2009; INEGI 2013; Tuiran et al 2009).
Such national attitudes have been apparent during the years I have worked in San Cristóbal. The general consensus amongst women old and young is that “three children is enough work for anyone”. Many of the younger women were happy to stop at two. “If you get one of each then you have a full set”, local hairdresser Angela responded when I brought up the question. In addition to this, most women agreed that a couple should decide when and how many children to have, yet none considered it was a man’s responsibility to organise contraception.

In la Garita, contrary to national trends, the pregnancies that occurred during my fieldwork and women I met in early motherhood were generally between the ages of 16-24 years old. This mirrors data recently published by Garita Edelen et al (2016) in their Save The Children Mexico report on adolescent pregnancy and motherhood. Garita Edelen and colleagues’ research found that Chiapas has the highest incidence of adolescent pregnancy and the lowest reported use of contraception amongst young people who are sexually active. In order to gauge the difference between states that are comparative in economic and population status – 46% of sexually active young women in the state of Guerrero reported to have been pregnant at least once between the ages of 12-19yrs and in Chiapas this figure rose to 73%. These figures converge with the prevalence of reported contraception use which in Guerrero is 57.6% of sexually active women between 15-19yrs and in Chiapas 35.5%, compared with a national average of 59% (Edelen Garita et al 2016:11). This is in part, directly linked to local economic status, education levels and average mortality rates for the region. Throughout Mexico access to state and private reproductive health services and laws surrounding abortion differ greatly and

---

15 I define early motherhood as the first three to five years before nursery education begins.
this contributes to attitudes and behaviours in family planning. The report by Edelen Garita et al suggested that high numbers of adolescent parents, particularly mothers, indicated a lack of economic and educational aspiration amongst young women. When I think of the younger mothers I have met over the years in Chiapas, I find this type of declaration problematic. Though many pregnancies are unplanned, a more complex understanding of what it means to be a mother in mestiza communities challenges the notion of aspirational deficiency. A lack of qualitative evidence in this type of reporting results in many low-income mestiza women from smaller urban neighbourhoods like la Garita being misrepresented, and as such their experiences and attitudes to reproduction are omitted from global and national reproductive health discourse.

Universal feminist discourse on a woman’s bodily integrity and right to a planned parenthood has been used by the Mexican state over recent decades as a platform to shape women’s overall struggles for equality (Gutmann 2009). Although a continuous drive beginning in the late twentieth century has been successful in reducing the ‘population bomb’, it has not addressed existing gender, ethnic and class inequalities in any significant way. Responsibility for family planning and ‘good parenthood’ is continuously placed upon women (Gutmann 2009; Palomar 2004; Soto Laveaga 2007; Smith-Oka 2013). Gutmann’s (1996; 2007; 2009) extensive and detailed ethnographic studies of male contraceptive use and gender relations in central and south Mexico has shown that, if anything, men have been actively excluded from participating in family planning. This exclusion from the bodily practices of ‘good parenthood’ works to reinforce expected gender roles and

---

36 In the state of Chiapas abortion is only legally permitted when the pregnancy is a result of rape, there is significant risk of death to mother, or risk of grave genetic or congenital abnormalities in the foetus (GIRE 2013b:21)
is at odds with the counter rhetoric of universal gender rights and equality also inherent in the social construction of a modern Mexico.

The emphasis on parenting as a female concern is reflected in daily life in the barrio. “Their role in the house is nothing more than a sperm donor” my midwife Cristina commented wryly when I asked her about her observation of men’s contributions to parenting and household politics. The biological reality of pregnancy, birth and lactation together with inequalities in wage earning potential mean that, to a certain extent, women will remain principal carers to small children in the social imagination. It is precisely this shaping of parenthood as a dominantly female occupation that precipitates my preoccupation with women’s experience of the transition to motherhood. The pressures placed upon them to be good mothers, the bodily transition of self and the impact on their relationships with others including their male partners, brothers and fathers. Whilst I do not deny the right of men to be recognised in a caring role and the questions that arise concerning the construction of masculine identity (Gutmann 1996; García and Oliveira 2005), considering these issues would result in a different thesis altogether. In la Garita I lived amongst women carrying out their daily lives in gender specific spaces. As reflected in the literature on reproductive health, development questions of maternities and modernities are gendered in experience and discursive terms (Chant with Craske 2003; Jolly 1998; Mills 2001; Molyneux 2000).

Many of the women I met in la Garita continue to embrace, from young adulthood, the traditional gender roles of wife and mother. However, the women in la Garita do not exist within a timeless vacuum, void of contact with global ways of being and wider socio-economic and cultural change. The young women who become wives and mothers do so within the twenty first century and the values they embody are a
braiding together of old, present and future desire (of what they hope to achieve). My younger interlocutors are very much ‘modern’ women living hybrid lives flitting between competing discourses of modernity. They wore skin tight jeans under homemade embroidered aprons, they spoke of the importance of gender equality and remained faithful to the rule of mothers-in-law, some saw no value in completing a high school diploma, yet they spoke of their aspirations for their own children to achieve economic and educational success beyond the barrio. In this way, and as I shall explore throughout the rest of the thesis, they embody the complexities and contradictions of everyday life in twenty-first century Mexico.

It is at this point I shall move momentarily away from the barrio in order to explore the impact of hospital prenatal care and birth practices on women in the wider city. As mentioned previously, I found one useful way to think about, and contextualise the hybrid lives of the younger women in la Garita was to look at the lives of mestiza women in other parts of city. Chapter Two will provide comparative material and contribute to develop arguments, as I move back to a barrio focus in Chapter Three and beyond, about what is (and is not) particular to the way in which maternal transition is experienced by the women I met in la Garita.
CHAPTER 2

Power, Resistance and Resignation: Narratives of Clinical Maternity

... a first baby turns a woman into a mother, and mothers’ lives are incurably affected by their motherhood; in one way or another the child will be a theme forever

(Oakley 1979:24).

In this chapter I explore how women’s experiences of maternity in the clinical environment reveal ways in which intersecting and conflicting structures of power work together. Power relations within the fields of reproductive and maternal health are shaped by ideas about gender. Abu-Lughod (1990a) asserts that studying cultural forms of resistance can act as a diagnostic of intersecting forms of power characteristic of modern states and capitalist economies. When I write about forms of power, that are hegemonic and therefore difficult to see, I find Comaroff and Comaroff’s (1991) concepts of agentive and non-agentive power useful for thinking with. In their exploration of colonial evangelism and modernity in South Africa, Comaroff and Comaroff argue that power operates on multiple levels appearing in ‘agentive’ and ‘non-agentive forms. The key distinction between agentive and non-agentive forms of power is that the former is clearly identifiable and ‘non-negotiable and therefore beyond direct argument’ (1991:24). They describe its counterpart – non-agentive power – to account for the influence that subtly and silently shape social reality. Non-agentive power ‘proliferates outside the realm of institutional politics, saturating such things as aesthetics and ethics, built form and bodily representation, medical knowledge and mundane usage’ (1991:22). It is the concept
of non-agentive power I am most concerned with in this chapter and in relation to Abu-Lughod’s arguments on resistance as a diagnostic of power. By adopting the concept of non-agentive power I am able to move beyond a focus on the nature of power itself, and instead explore the conditions under which forms of resistance occur and in turn, ask what this can reveal about the complex interplay of power in both its non-agentive and agentive forms. I am interested in how forms of resistance appear in women’s narratives that are not outwardly defined as such. In addition, I want to see if resignation in one context provides the conditions for resistance in future contexts.

I have purposely selected the narratives in this chapter in order to represent aspects of the clinical management of childbearing in public and private economies of care. The socio-demographics of the women in this chapter range from low to middle socio-economic status and they self-identify as either mestiza or indigenous. The series of narratives appear under the subcategories of pregnancy, birth and nurturing in relation to Jolly’s (1998) definition of processes of maternity provided in the introduction to this thesis (see pg.18). Jolly’s approach that understands the processes of maternity as ‘fixed not just by the force of cultural conception but by coagulations of power’ (1998:2) provides a way to think about Abu-Lughod’s forms of power through the maternal subject. This extension of how women embody motherhood as more than a corporeal process of giving birth also lifts the study of maternity from the restraints of a contained biological event to a pattern of gendered power relations that continues throughout the life cycle. The narratives are interjected with discussion and comments on the common themes that arise, but my intention is to place most emphasis on the women’s narratives as they were told to me.
In the final part of the chapter, and in order to further relate this discussion to my overall argument in this thesis, I propose a framework that takes into account maternity as a corporeal process that is inseparable from the broader social and political contexts inherent in the clinical management of maternity. In this way maternity is not understood as an isolated, female life event but as a bodily process directly interrelated with the social, political and economic world. The narratives come from recorded interviews carried out in 2011 and 2013. The women in this chapter (aside from Lupita) live outside la Garita and gave birth in different hospitals across San Cristóbal between the years 2008-2012. In the narratives they relate their experiences of the public and private services that, are known to and occasionally used by, families in la Garita. The subsection on birth in particular, evokes the notion of socio-economic status and gives rise to the question of whether this is, in some way, indicative of the type of experience and treatment a woman will receive.

I wish to remind the reader briefly of my use of the term ‘various manifestations of the local’ which I introduced at the beginning of this thesis (see pg.20). The narratives in this chapter adhere to this approach in that they represent of the types of clinical experience related to me over the years by numerous women of various socio-economic status, across the city. Although these women are linked by clinical experience, it is my hope, that as individuals they challenge the traditional image of the long suffering Catholic mujer abnegada described in the previous chapter – a character devoid of socio-economic status and agency. The way women relate their experiences and how they have come to think about themselves as mothers and women, provide a micro-comparison with women who seek out-of-hospital birth and the services of a partera. As clinical management of birth becomes increasingly the norm, something that many families in la Garita work actively to resist (as we shall
see in the next chapter), it is worth examining how changes in childbearing management, brought about by global health trends, impact upon the women they are not necessarily targeted at.

Gathered in the form of life story interviews, the narratives in this chapter are ‘representations of lives, not lives actually lived’ (Bruner 1984:7). In taking this approach my intention is to foreground the women’s own interpretations of events and experience. In this sense I do not intend the narratives to be about the nature of the events as such, but about the lives of particular persons who are deeply embedded in them (Das 2007). Using a language of reflection and emotion these women reconstruct events from their imaginations and memories in relation to the transition to motherhood. The intimate, life story approach to interviews provided the women with an opportunity to reflect upon how the birth experience impacted on the initial shaping of their new identity as mothers and how they felt towards their child. For some it was the first time they had described their experience, and the feelings they associated with it to another person.

**Pregnancy**

*Bety, 28, mestiza housewife, San Cristóbal de Las Casas*

I met Bety, a twenty-eight-year old mestiza woman in 2013 at the *casa de partos* (local birthing house) in the preparation for birth classes. She had come to the *casa de partos* for her third pregnancy where she hoped to have a VBAC2 (vaginal birth after two caesareans) with the support of the professional midwives. She differed from the other women attending the class in that she was a practicing Sunni Muslim; she also spoke openly about her faith and life amongst the Catholic mestiza community. Bety did not belong to the small community of the Murabitun
movement of Muslims which has grown gradually over the last two decades in San Cristóbal. She told me on numerous occasions how the orthodox (Sunni) and Murabitun did not mix, the latter being critical of the traditional ways of the Sunni. “They are only interested in converting the Maya (indigenous) folk,” she said when I asked her about the differences between the community. “They want business with the mestizos and conversion of the Maya. I prefer to integrate, my family are Catholic here in Chiapas and I think segregation is damaging.” Originally from San Cristóbal, she had studied at the Centro Cultural Islámico de México (CCIM) in Mexico City in her late teens. It was during her days as a student that she met her husband Majd, her Arabic teacher at the time and a first generation migrant from Syria. “He was about thirty-five and I was twenty-one ... and well we married but we didn't really have a plan to have children or anything or any long term life plan, so when I got pregnant it was a bit of a surprise.” After marrying, the couple moved to San Cristóbal so that Bety could be closer to her family.

After meeting on various occasions at the casa de partos, Bety agreed to let me record an in-depth narrative interview with her where she relayed the experience of her first pregnancy and birth, and the period of postnatal depression that followed (which will appear in the sections throughout this chapter). Bety had experienced her first two births in a low-income private hospital run by nuns (known as charitable hospitals). The births had impacted negatively on her early motherhood experiences and how she felt about her body and its reproductive capabilities. On the morning I went to record our interview I was met at the door by Majd, a tall man with a mop of brown curls falling down on to his face, who welcomed me into their home and retired quickly into the background to work at his computer. It was the first time I
had seen Bety without her Al-Amira hijab\textsuperscript{17}. She prepared some tea and cake in her small kitchen whilst she began to tell me about her first pregnancy:

So when I got pregnant with Adnan I wanted to look for a calm place, where I could trust the people. I remembered that there was a hospital that was run by nuns and they had been part of my childhood, as they were Catholic, they looked after me as a child; they taught me Catholicism. And so I went to see them and my father who is a doctor came with us and we spoke to the director and we explained that we wanted a natural birth, that we wanted something intimate and personal and she said fine, no problem … It wasn't private, they call it a charitable organisation but really the charity isn't much because you pay a high price for going there! I remember investigating and all the other hospitals charged so much money. I didn't want to go to a public hospital because I knew that, if I went to a public hospital, they would treat me worse than an old rag. So we didn't have enough money to pay for a private hospital and we went to the place where we thought we knew the people … At the beginning the doctor was very friendly and then suddenly she started to behave strangely. It's only now that I realise from the beginning it was a form of obstetric violence\textsuperscript{18} because I remember I would ask her something or call and

\textsuperscript{17} The Al-Amira hijab is a two-piece veil. It consists of a close fitting cap, usually made from cotton or polyester, and a tube-like scarf and is commonly used by Sunni Muslim women in Syria.

\textsuperscript{18} Bety’s use of the term ‘obstetric violence’ is significant and connected her recent contact with the casa de partos and therapy she had been receiving there. The discussions amongst the women, parteras and therapists at the casa de partos was often politicized, in that it focussed upon raising awareness of reproductive rights and choices. Use of the term is becoming increasingly common amongst specific politicised groups – regardless of social and ethnic category – the common factor linking women who use the term is generally parteras or obstetricians wanting to break from institutionalised practices. It is not however, a commonly used term amongst the majority of women I spoke to from the barrio or wider city, whether their maternal practices involved in or out-of-hospital birth.
explain - "It's because I feel [ill]" and she would say, "No, you need to come now because your baby may be in danger." Imagine how that felt that you're a first time mother who is in her house in the city and who has to travel an hour or so to arrive at the hospital? If she tells you to hurry because your baby may be dead ... and so really I felt that I couldn't enjoy the first pregnancy because of so much stress from the doctor. I was always worried and she was always saying, “let’s do an ultrasound because you don't want the baby to have such and such ...” so I was left with this in my head and I started to look everything up on the internet and learn about all these illnesses which made me even more stressed.

*Rosa, 32, mestiza, legal advisor, San Cristóbal de Las Casas*

I first met Rosa, a federal government employee in 2005 in Tuxtla Gutierrez when I was working as a community health worker. She later relocated to San Cristóbal and became pregnant with her first child in 2009. We met by chance in the market place one weekend and began to visit each other regularly. Her job in the government legal department meant that she received health insurance and received medical attention and gave birth in public health institution for federal employees. I initially interviewed her in 2011 as part of a research project on prenatal care and birth outcomes. At the time of our first interview Rosa was planning to leave the father of her child, and in that first recording, she began to reflect on how her pregnancy and transition to motherhood had made her think differently about her relationship. She had been in a relationship with León (the father) for almost twelve years continuously but they had never been open to her family. León was separated from his first wife but was not willing to declare his relationship with Rosa because he feared upsetting his estranged wife and daughters. Rosa kept León a secret from her parents because they did not
think previously married men were a reliable prospect. The relationship was finally brought out into the open when Rosa fell pregnant, but León still refused to tell his wife and daughters. When I recorded our first interview I asked her to tell me about her experience during pregnancy and birth. We had had many previous conversations on this subject but, as she later told me, this was the first time Rosa had the opportunity to put all the pieces of the jigsaw together and reflect upon events that happened leading up to her birth:

All the time I was pregnant I tried to be calm and look after myself as you should. I was eating a lot of fruit and vegetables so that my baby would be healthy. Around six months I started to get very itchy all over my body, very, very itchy. I started to think that it might be some kind of animal or bacteria, so we fumigated my room; we cleaned it but I continued to itch. I went to see the doctor and he said that I had a liver infection, but when I had my first ultrasound with the gynaecologist he said that my liver had been fine. As time went on, I started to feel worse and so I went to see the gynaecologist, that was now doing my prenatal checks and they did some tests. They checked loads of different stuff to see whether it was anything to do with my liver and in the end they told me that I had intrahepatic cholestasis\(^\text{19}\) and that can seriously threaten the baby’s life. I was very scared because it’s a very delicate organ. I said, “But how can this be? They did an ultrasound [before] and said everything was fine. I don’t understand”. They explained to me that my liver wasn’t happy because

\(^{19}\) Intrahepatic cholestasis of pregnancy is a liver disorder that occurs in pregnant women. Cholestasis is a condition that impairs the release of digestive fluid from liver cells. As a result, bile builds up in the liver, impairing liver function (Source: U.S. library of medicine [http://ghr.nlm.nih.gov/condition/intrahepatic-cholestasis-of-pregnancy](http://ghr.nlm.nih.gov/condition/intrahepatic-cholestasis-of-pregnancy)).
something was trying to move into its space and it didn’t want to be moved. I was so itchy; I felt like I was having electric shocks all the time and on top of this my morning sickness didn’t go away and I was getting very depressed. I knew that I could be doing harm to my baby because I looked this liver illness up on the internet and read that my baby could suffer a lot.

When I was six months pregnant they admitted me to hospital for forty-two days and they did so many tests on me ... I was getting so worried that my baby was in danger and every day the doctors arrived and said, “We’re going to check you for cirrhosis, if you have any fat in your liver, if you have liver cancer we’re going to take the baby out.” It was always something different. But I thought it can’t be anything so bad. I didn’t think a pregnancy would make me so ill. And I didn’t understand why the doctors kept saying that I or my baby could to die, that my pregnancy was high risk …

Thank God that in the end I didn’t have fat in my liver, or hepatitis or anything. They just said that I had an infection in my liver but nothing serious, nothing that was going to kill me. They said I had to get rid of all the toxins that my liver was producing, as there were many. The toxins were poisoning me, it’s a very rare illness, poisoning my blood and I needed to get rid of them … In the hospital they said that when I got to seven months, if I still had problems then they would take the baby out so I wasn’t putting it at any more risks. They said if I went canary yellow, if my nails went a yellow colour that I should go straight away to the hospital. They also said that if my wee turned the colour of coca-cola that I should go straight away because it meant that the baby had died. Every day I woke
up thinking, “My God has the baby moved?” Sometimes it moved and other days it didn’t until around midday and I would touch my belly and try to make it move. I lived in constant fear until I felt the baby move then I would be okay … I lived in torment, desperate to get to eight or nine months. I just wanted my baby to be born. The doctors had said to me that I couldn’t have any more babies after this one, that hopefully they could save this one. They said it would be difficult for me to get pregnant again so every night I was praying that my baby would be born safely … At seven months I went to a new doctor and he said that it was better to wait to go full term. I felt split because I wanted them to do a caesarean because I thought my baby was suffering. I thought it’s better they get him out if he’s suffering, but also I was thinking that it was too soon and he needed more time to grow. During the whole pregnancy I was never at peace. … Every month they took my blood and did tests and continued to tell me that my pregnancy was high risk. And I would say, “Yes, I know” and then different doctors would say things like, “Do you know that you could die?” And I would think, “Yes, but if die, I die. Only god can decide.”

_Lupita, 28 (at time of pregnancy), mestiza, Government office worker, la Garita_

Lupita and her parents were the only family in la Garita whom I knew before my stay there in 2013. I first interviewed her towards the end of her pregnancy in 2011 and then subsequently in 2013. When we recorded our first interview in 2011 she had been married for two years to her childhood boyfriend Diego and they were looking forward to the arrival of their first child. As a consequence of her work and family commitments, Lupita received prenatal care in San Cristóbal and Tuxtla. Lupita chose a combination of public and private services depending on her needs and location.
Similar to Bety she had clear expectations and desires for a ‘normal’ (vaginal) birth from the beginning of her pregnancy and sought out the support that she thought would best help her achieve this outcome:

In Tuxtla I was going to the Regional Hospital because of my insurance. I like it better here in San Cristóbal because I can see parteras [local midwives] or curanderas, they are more human. I also have a doctor in San Cris who is fantastic. The other doctor who saw me in Tuxtla as part of my insurance, she was very against me going to see parteras. I didn’t like her because she told me I had to take medicine, whether I like it or not. They were iron tablets and they made me feel awful. When I found my doctor here in San Cristóbal, she said, “If they make you ill, stop taking them, eat lots of green vegetables instead” ... The one in Tuxtla she was very narrow minded, my appointments never lasted more than five minutes, she would be like, “Anything wrong?” No, nothing, “How are you?” Ok, “Did you bring your test results?” Just like that, “See you in two months then” … The doctor in Tuxtla also said I couldn’t travel and this was a problem because my family are here in San Cris and my work is in Tuxtla. I didn’t want to stay in Tuxtla, but she told me I was at risk if I travelled. The doctor here said it was fine, as long as I felt healthy and took care of the changes in altitude, and so now at eight months I’m still travelling to and from without any problems ...

I’m very scared, not of the birth, but that there could be complications, I’m doing everything to help prepare for a normal birth … [my friends] say that it hurts a lot, but I don’t see it as anything I can’t handle, we women are made to cope with this type of pain. It’s strange because in work they say,
“How are you going to have the baby?”, “No! Normally? How brave!” ...

Lots of women in Tuxtla ask why I’m not having a caesarean they say, “Oh but it doesn’t hurt, they just give you an injection and there you go easy, it’s just an operation.” But I’m much more scared of a caesarean than of a normal birth ... When I started to see the doctor in Tuxtla she always talked about how hard it was to have a baby and when I said I wanted a normal birth she would say “Do you think it’s so easy? Do you think that what will happen will be so easy? Giving birth is hard you won’t be able to do it normally …”

The rhetoric of risk is apparent in these prenatal narratives guiding both medical practice and women’s embodied experience of pregnancy. Present in these and many other pregnancy narratives I heard is the use of technology as a way of measuring risk that outweighs any belief the women may have about their health or that of their growing foetus. Rosa and Bety in particular were preoccupied with a fear of death throughout their first pregnancies. Whilst Rosa’s fears were rooted in underlying health problems and physical symptoms, Bety’s fears were evoked by the risk-based approach to medicine her obstetrician employed when answering her questions. In both cases the use of technology appeared to emphasize rather than obviate negative risk – whilst in Rosa’s case also giving rise to other potential risks. The pregnancy experience for both women was negatively affected by the fear of death and possible damage caused to their babies. Both of their narratives show the gradual path from happiness to anxiety caused by their interactions with medical professionals, searching the internet and navigating their physical changes and individual responses to pregnancy. The impact of this, in part iatrogenic anxiety, left the women feeling in
conflict with professional advice and in doubt concerning their own bodily knowledge.

Rosa and Lupita’s narratives demonstrate how professionals within the public health system often provide conflicting information that further adds to confusion and stress. The mixed messages also provided a way for the women to negotiate their own bodily experience and knowledge as legitimate. Lupita was unhappy with her original doctor in Tuxtla and sought out alternative obstetric care closer to home. Where women have employment related health insurance, but are not beholden to it they can avoid potential maltreatment. All three women spoke of their dissatisfaction and their preconceived ideas about the public health system. Not beholden to employment based health insurance, Bety chose to forego the public system altogether. It is important to consider how and why women come to form these opinions and how this impacts on the choices they make about the services they use.

Most new mothers followed the advice of family and friends when it came to thinking about where and how they wanted to give birth. They paid most attention to the stories of women they knew and coverage of incidents in the media. As many women did not have much choice of where they would give birth, usually based upon economic factors and practicality, preconceived notions about the various public and private clinics in the city added to their apprehension about giving birth. The likelihood of a birth ending in a caesarean section is a common topic of conversation amongst women and many tried to develop strategies to avoid this. In the public system Lupita was faced with pressure to have a caesarean section and with being reprimanded for how she was managing her pregnancy. The attitude of her doctor in San Cristóbal fitted more closely to her own ideas about childbirth and using parteras. This allowed her to make the decision to reject the doctor in Tuxtla
and plan for the ‘normal’ birth she wanted, with the medical approval she needed. By finding a practitioner who respected ideas and beliefs about local biologies and the partera’s role as something that could go alongside the medical model of pregnancy rather than against it, Lupita described her pregnancy as ‘happy and calm’ and one in which she felt ‘in control’ of her birth plans.

Professional and social attitudes to risk and birth outcomes are also revealed in the narratives. Clinically managed maternity in San Cristóbal is legitimately preoccupied with high maternal and infant mortality. As mentioned previously, Chiapas has the second highest maternal mortality rate and in the most recent Mother’s Index study for Mexico the region is ranked the most challenging place to become a mother in the country (Garita Edelen et al 2016). Pressure to react to such highly publicised data, meet the aims of initiatives like the Programa de Acción Específico by 2018, matched with the actual reality of high maternal mortality means that the level of emergency obstetric cases dealt with in public hospitals will shape societal and clinical attitudes towards the perceived dangers of childbirth overall. As Berry (2010) argues, this reduction of maternal mortality to a distinctly medical – rather than social – problem, ‘means that the only outcome can be life or death’ (2010:1). The management of pregnancy and birth becomes framed by a clinical rhetoric of saving lives at any cost, death for a medical practitioner is synonymous with failure. This is in direct opposition to the way in which women speak of pregnancy and birth as the creation of new life (for both mother and child). The language of maternal transition used by the women focuses on becoming other, regardless of the type of outcome resulting from the birth.

The treatment that women receive in healthcare services contributes to shaping their experience and more often than not provides the vocabulary with which they begin
to talk about the pregnancy, birth and postpartum stages. A woman will describe her pregnancy in the terminology used by the medical professionals she comes into contact with - securely anchoring her reproductive experience in a particular social and historical moment (Lock 1993:375). This can be observed in all the women’s narratives where there is a distinct shift to preoccupation with life or death as the women engage more frequently with control prenatal. The use and language of technology (which emerges as a way of ‘seeing’ what the eye cannot) further legitimizes the belief that death can be cheated by avoiding the risk (translated as certainty) of human error. The technocratic model of birth is evident wherever women recount their experiences of prenatal and birth care in the clinical environment. The links between technology and relationships of power are revealed where women describe the conflict between their own bodily knowledge and that which is produced via the tools of the medical practitioner. Technology becomes a locus of knowledge which foregrounds the foetus as though it were already separate from the maternal subject. The mother ‘is rendered transparent, invisible; she vanishes from view (Wendland 2007:226).

The complex and multiple implications of the technocratic model of birth in low resource settings are significant in terms of the decision making that occurs around the pregnant or labouring woman. Public hospitals in San Cristóbal, for instance, often lack the technology – ultrasound, electronic foetal heart monitors, Pitocin and analgesic supplies, emergency obstetric and neonatal equipment - required to manage pregnancy and birth as defined by the technocratic model. Where equipment is available it is often found to be out of service or lacking in quantity to meet the needs of the hospital population (GIRE 2014). With the technocratic approach comes a reliance on measurability and timing, even more so when clinical actors are aware
that the much depended on technology may not be available when needed. Events must be foreseen and preparation for early intervention must be made. As the pregnant subject moves from the stages of gestation to labour the pressure to save the nearly-born from the hostile environment of the uterus becomes ever more apparent in the actions of those around her.

**Birth**

The narratives in this section relate to the event of birth: what was happening to the woman from her point of view and also memories of what was happening *around* her in the clinical environment. The births culminated in outcomes of either emergency caesarean or vaginal birth.

*Emergency caesarean section outcomes in public, private and charitable clinics*

*Bety* (continued).

I was in labour in the house for around two days but really the contractions weren't very strong; it wasn't anything I couldn't cope with. When I got to the hospital we arrived in the night time and honestly I thought the doctor was going to stay with me, I really thought she was going to stay with me during the whole labour. But it wasn't like that. They admitted me and the doctor was there for about an hour and then she said her shift was over and she was going home ... and so the doctor left us and was away the whole night and I don't know if psychologically I was thinking that I couldn't give birth that night because the doctor wasn't there and also the room was very cold, the whole place was very cold and they treated you very coldly ... It's very annoying that [the nurses] just came in and did internal examinations and then left and then came back and did another internal ... And you can't
just be even in comfortable clothes or you want to get up. It's your instinct to want to stand up but you can't because they've put a drip in you. And you've had a hospital birth as well haven't you? Can't you remember how they put all these things in you and you can't move and with each contraction you feel like you want to move? You want to stand up but you can't. And so this is how we passed the night time, and my husband was really tired and they put a little camp bed up for him and he stayed there and slept ... and it was horrible and really after some point the contractions started to get out of control. They come so fast. You don't really know how much [pitocin] they're putting into me because the doctor would enter and say, "Right, give her another injection [of pitocin]," and then they'd leave and after about 40 minutes they'd come back and inject me again …

In the morning the doctor came back around 9am ... and then she said, "Oh this is taking a long time. I think we're going to consider a caesarean." I felt very bad because I really didn't want a caesarean and my husband, I think for his lack of knowledge on this subject he was saying to me, "Well if the doctor is saying this is what you need there must be a reason"... It was horrible because it's your body and it’s like they're laughing at your body, laughing at your intimacy. It's like this thing that you've dreamed about being beautiful and lovely very quickly turns into suffering ... The doctor without even asking my opinion just said, "We have to break the waters now," and put this thing inside me. It was long and metal that looked like a needle. And so water started to come out but it was green. In the moment that she saw the green liquid she said that I must have a caesarean straight away. She said, "Now it's an emergency caesarean. We can't wait
any more time because the baby will start to eat the poo and if it does it ...”
and so can you imagine how that must feel, a woman in the middle of
labour and the doctor tells you that your baby could die, so you say, “Okay
do what you want…”

They did the caesarean and I felt a horrible sensation, very horrible because
she said, "In the moment we take your baby out you're going to feel pain
in some of your organs, in the parts that aren't affected by the
anaesthetic"... And you know what, it was the worst pain because my
husband saw me ... I screamed but with desperation. It was a pain that felt
like they were touching my internal organs. I don't know if the anaesthetic
was done wrong or what ... And when they took him out, I screamed
because it felt horrible and then after they did that they gave me a
tranquilizer and I remember that I did hear my baby but in between hearing
and not hearing him … I was there for three days without seeing him,
because of where I was, you couldn't just see your baby when you wanted.

It is evident from Bety’s birth narrative how her expectations for a natural (vaginal)
birth began to unravel once she entered the clinical environment. Her narrative,
together with the others in this section, highlights how quickly women can lose a sense
of control over the situation. What is happening around her signals that her body has
shifted from something that harbours life to something that endangers it. A common
theme in birth stories of long labours resulting in emergency caesarean sections was
that women felt they were being prepped for surgery from the moment they entered
the hospital. They often spoke of being denied food and liquids, and having their
mobility restricted during labour due to either IVs or simply hospital policy. This
occurred with women across the social spectrum and so highlights something specific
about the clinical model of birth across public, private and charitable institutions in San Cristóbal.

_Felisa 19 (at time of birth) Tzeltal, student and domestic worker, public hospital San Cristóbal de Las Casas_

Felisa gave birth in the regional maternity hospital where she was accompanied by her elder brother. She had separated from the baby’s father at the time she found out she was pregnant, but had managed to continue her studies at high school and work throughout. She lived with her brothers and sisters and did not register the pregnancy or attend any prenatal checks. Because of this Felisa was not registered on any assistance programme and her economic status was assessed upon arrival at the hospital. Her birth narrative demonstrates how authoritative medical knowledge and reproductive habitus compromise agency and bodily integrity:

> When I first got my pains I thought the baby would be born, I didn’t know better; it was my first. I went to the clinic and they told me I had a lot longer to go, that I wasn’t open yet and I should go and walk around. My waters broke and I couldn’t stand the pain, I knew they wouldn’t take me at the clinic so I went to the Regional. I was with my brother. They said that my waters had broken and so the baby had to be born. They said the baby’s neck was in the wrong position so it couldn’t be born normally. They said I needed a caesarean. I told them I didn’t want a caesarean and they said if I didn’t have one my baby would die, that I might die. I said I didn’t want one, I wouldn’t sign the paper. I thought if I die there will be no-one to look after my baby so it would be better if we both died. I wouldn’t sign the paper, so they told my brother and he signed it instead
and they took me and did the caesarean. They cut me vertically\textsuperscript{20}. They said it healed better that way ... It didn’t hurt when the baby was born, but afterwards \textit{oohh} it was painful. The nurses were really nice to me, they knew I was alone so they helped me with the baby, showed me how to bathe and change his nappy. They were really nice ... They didn’t charge me a lot because they knew I was alone. They charged sixty-eight pesos, they ask you many questions when you first go in to find out what money and support you have. It wasn’t the cost of the caesarean that was hard, it was the medications I needed afterwards. They cost about six hundred pesos. I had my stitches out after a week and went back to work and school ten days later. My sister looked after the baby when I went to classes …

\textit{Elbi 32, mestiza, solicitor, private clinic, San Cristóbal de Las Casas}

I met Elbi when our daughters formed a close friendship at a summer holiday club. She offered to tell me about her birth one afternoon whilst we were waiting for our children to come out of their activity session. I was struck by where the similarities and differences lay in how she spoke of her experience in a higher-income private clinic to those who had undergone emergency caesarean section in public clinics:

I had been seeing a gynaecologist in Tuxtla I woke up with pains one day and we drove there. He said I wasn’t in labour and that I should go home, I knew he was wrong; I felt like I was in labour, but then again it was my

\textsuperscript{20}The vertical cut to the abdomen known as the classical or midline incision was common practice in this particular hospital which dealt mainly with emergency caesareans. There is no global agreement over which is the preferred technique in terms of horizontal midline or vertical traverse abdominal incision (see WHO 2009; Deka et al 2009). Medical justification for the horizontal midline incision is for speed of access to the uterus. Although this is undoubtedly an advantage in emergency situations, the disadvantage to the woman is in the scarring left behind, damaged muscle tissue, longer healing time in addition to the risks of caesarean section overall (Gonzalez et al 2013; Gibbons et al 2010).
first baby and I wasn’t sure so I did as he said. On the way back to San Cristóbal we got stuck in a traffic jam and I started to have very strong contractions. We couldn’t turn back to Tuxtla because of the traffic, so we got to San Cristóbal and drove to a private clinic my brother knew. After we arrived they did an ultrasound and said that the cord was around the baby’s neck and that they would have to do an emergency caesarean. I was very nervous as I didn’t know any of the doctors or nurses there. I was really upset because I had dreamed of a natural birth. I said I couldn’t decide and would have to call my husband. I wasn’t willing to make a decision without him. It was then they started to put pressure on me and say I would have to decide because the baby’s life was in danger. All throughout these conversations they were prepping me for surgery. They said if I didn’t agree and the baby died then it would be my fault and not theirs. I spoke to my husband on the phone. By this time the contractions were really strong and I couldn’t think straight. He said I should do what the doctors said and not take any risks. He said I should sign the papers. In the end, I agreed as long as they didn’t knock me out completely. I wanted to be awake to see and feed the baby. They asked my brother if he wanted to come in with me, but he was too scared, so I went in to theatre alone. I remember the staff chatting over me about their lives; I felt invisible. They did the caesarean and the baby was fine ... The nurses wanted to know why I hadn’t brought a bottle and formula to feed her with. I said I wanted to breastfeed and they looked at me as if I was mad! ... When I think about it I feel like a failure. For a while I didn’t feel like a real mother. I wanted a normal birth so much but it turned into an emergency and I lost control …
Rosa’s birth narrative illustrates the constant negotiation a woman enters into with those around her during the second and third stages of labour. Women are unaccompanied in the public labour wards and as a consequence are often left vulnerable to coercion:

At eight months I went to the doctor and they said, “How far along are you, eight months?” And I said, “Yes why? Are you going to take the baby out now?” This doctor said that he needed to check first. It’s because the gastroenterologist always said that if the tests came back clear we should wait another month, and the gynaecologist said, “I’m going to examine you to see when the baby will be born.” I didn’t think it was necessary, but I agreed and he did the [internal] examination. It was very uncomfortable, they are not as delicate as they should be … I lay back on the bed and he put his hand in my vagina to see if the baby was going to be born. He said, “Señora, you are dilated one centimetre.” I said, “That’s crazy! How can that be if I’m only eight months?” But I felt something painful that he did when his hand was inside me, I was very uncomfortable afterwards and bleeding. I thought that the doctor was bringing on labour because my baby wasn’t due to be born yet. All day I was happy because I wasn’t going to make the baby suffer any more. I was finished with the sadness of thinking I was making my baby suffer … I don’t think it was normal to start labour this way, but around midday I started to get strong pains. It’s quite a coincidence that after going to see the doctor I started to get pains. They
lasted all day, small at first but I couldn’t sleep, it went on forever. The baby didn’t come. I felt like it was going to be born, but it didn’t come. I just felt pains and nothing else. My mum said when I started to feel the pains go really strong I should tell her … At around four the next morning I woke my mum up and said I thought the baby was coming. I was in so much pain and wanted to go to hospital … We had arrived at 4am and at 8am they gave me a bed and the hours passed - nine, ten, eleven. They said they wouldn’t let it go past 2pm. I was in so much pain. I said at one point to the doctor, “I don’t understand, why won’t my baby come out?” He said, “It’s because you’re not trying hard enough.” So I started to push a lot and it still didn’t come out, and I started to think it was strange that it wouldn’t be born. Other women came and went so why not me? So I asked the doctor again, “What’s wrong, why can’t I do it?” He asked, “Did you drink anything?” And I said, yes, I had drunk some juice earlier. He told me that was a massive error, that I should never have drunk anything. He said that my bladder would be full and would be stopping the baby from coming out … He said I should go to the toilet and empty my bladder. I said I wanted to but couldn’t move. Then two student doctors came along and they told me not to worry that they were going to examine me and see that the baby was born. But that was horrible because they put a hand inside me to make the baby come out, but it didn’t, it still didn’t come ...

Another two hours passed and still nothing, so I asked the doctors again what was wrong. They said not to worry, that I should just keep trying. But I was trying as hard as I could and it wouldn’t budge … In the end they said to me, “Señora your baby is stuck. If anything else goes wrong then
we will have to do a caesarean. If you don’t try harder the baby won’t be born.” So I thought, “Okay, I’ll carry on,” and finally, I thought that it was going to be born. A doctor came by and said, “Well are you ready to have this baby?” He put his hand inside me and said that the baby was stuck behind a membrane. After that the labour pains were a lot worse because he broke the membrane and because he kept his hand inside during contractions, or putting things in me, I had no idea what he was doing. And then he said, “Right, I think one more big push and your baby will be born. He has a lot of hair, if you were on this side you would notice that you’re nearly there.” And then with one last try they took me into theatre and the baby was born, and I was the happiest women alive! … [The doctor] said straight after the birth, after the placenta came out, “We’re going to put an IUD in,” and I said no, that I didn’t want one. He said that I would die if I got pregnant again and that I should learn from what happened to me. In these moments I don't think you’re capable of making a decision … He just said, “Señora you will die if you have another child.” At this moment I wasn’t quite sure what he was telling me. He said they were going to put the IUD in and I said no, so then he said, “You are irresponsible, wanting to bring another child into this world, put another child in danger. You are a bad mother because you want to bring another baby into the world to suffer.” I wasn’t sure what he was going on about so in the end I just agreed …

Present throughout these narratives is the marginalisation of the mother in favour of the baby about to be born. The themes of fear, death and culpability continue particularly for the women who faced emergency caesarean sections. Though none
of the women questioned the legitimacy of their emergency, they all faced intense pressure to comply with the decision. The meanings that can be associated with a language of emergency and risk are significant and have been much discussed in relation to biopolitics, societal control and political economy, (Douglas & Wildavsky 1982; Fordyce & Mareasa 2012; Farmer 2004; Lupton 1999). I would not want to suggest that the decisions made by the obstetricians involved in these birth narratives were unnecessary. I am not in a position to say so and it is not my intention to deny that complications can occur in childbirth. My argument is not about the reality of emergencies, but about how they are perceived and politicised in an institutional setting. My interest lies in what creates the conditions of emergency, from whose perspective and how language and relationships of power shape the unfolding of events. The construction of what constitutes a medical emergency, in a labour and birth situation, makes for an interesting point of analysis from which we can make direct links to a broader reproductive and emotional habitus. Power reveals itself here as part of the everyday conditions of emergency in the clinical environment. Ascribed biological or probabilistic meanings, this form of power is not easily questioned within an institutional environment. Being ‘natural’ and ‘ineffable,’ this form of power reveals itself to be beyond human agency, ‘notwithstanding the fact that the interests it serves may be all too human’ (Comaroff and Comaroff 1990:22).

In these narratives the conditions of emergency come about via the language and rhetoric of risk. Douglas contends that the modern risk concept, as it manifests in politics and therefore governmentality; ‘now means danger; [and] high risk a lot of danger’ (1990:3). This is in contrast to its more original connotation in the natural sciences as probabilistic reasoning brought about by rationality. Presenting the argument for risk as a forensic resource in global culture, Douglas examines how
political debate (such as the socio-economic causes of maternal mortality) travels across national boundaries couched in terms of risk. In public institutions that are guided by global discourses, where science (medicine) meets political economy, competing meanings of risk intersect with practices. In this sense the modern concept of risk in a global context has become an uncontainable notion, albeit one that exists in direct relation to negative certainty. The presence of risk and conditions of emergency in these narratives are a confusion of accountability, ‘a contest to muster support for one kind of action over another’ (Douglas 1990:3). The actual reality of danger to life in these narratives exposes how the meanings associated with risk connect danger and fear of danger with moral action as part of how the world works. The fact that real danger is linked with some kind of disapproved behaviour, in this case not listening to or resisting the orders of medical professionals, codes ‘the danger in terms of a threat to valued institutions’ (Douglas 1990:8).

The rise in caesarean rates in Mexico has been well documented and recent national figures report an average of 43-68% caesarean section rate in state and federal institutions and an estimate of 70% in private institutions (ENSANUT 2012). In Chiapas a study of public hospitals in Tuxtla Gutiérrez and San Cristóbal by Nazar et al (2007) found that from 1979 to 2003, the practice of caesarean section had increased almost nine times (870.0%) from 7.8% to 29.7% in the mestiza population and almost four times (394.1%) from 0.0% to 20.3% in the indigenous population. Though Chiapas has amongst the lowest rates of caesarean section, it is still reported to be between 20% and 34.5% of all births in public hospitals (ENSANUT 2012). Though lower than the national average this statistic is still significant. The most recent (2015) figures for the largest public maternity hospital in San Cristóbal (where Felisa gave birth) is a 51.48% caesarean rate (Secretaria de Salud Aug 2015 personal
The disproportionate caesarean section rates have been associated with varying factors, including increased access to medical attention at birth, financial gain (for private clinics), medical perceptions of necessity and public health system resource issues (Castro R & Erviti 2003; Castro A 1999; Castro A & Singer, 2004; Barber 2010; Smith-Oka 2013). As previously mentioned, it has been well documented in global health literature that increased access to medical attention and hospitals does not translate to better quality of attention (Berry 2010; Berer 2013; Say et al 2014; van Teijlingen et al 2014; Garita Edelen et al 2016). In the case of Mexico and Chiapas, the continuing rise in caesarean section births, lack of meaningful improvement in maternal mortality in hospital settings and increased reporting of reproductive rights violations at birth (see GIRE 2015) all add evidence to this claim. Despite increasing global recognition of maltreatment in low-resource settings, global and national maternal health policy for 2013-2018 continues to promote increased medical attention at birth and access to emergency obstetric services as a panacea to maternal mortality.

In the reporting of national statistics, a difference is made between programmed (elected) and emergency caesarean sections. This poses interesting questions for the circumstances under which the surgery is carried out in public health institutions. In the discourse of global health, state and federal institutions are encouraged to support vaginal birth wherever possible. In terms of technological and financial resource it is cheaper and arguably better for the health and wellbeing of the mother and baby. This means that in practice programmed caesarean sections are reserved for either those with full insurance coverage, women whose pregnancies are deemed high risk
for medical reasons or if previous births were by caesarean section. All other caesarean sections are carried out under the definition of emergency. Therefore, in the largest public maternity hospital in San Cristóbal where programmed caesarean sections are rarely carried out (the women would be referred to an alternative state institution), it is worth asking the following questions: why do emergency caesarean sections make up over half of the birth outcomes? How can women’s birth narratives provide a different perspective on how permission for surgery is negotiated? And what can this tell us about forms of gender power, resistance, resignation and coercion in clinical environments?

Aside from perceived medical emergencies the expectation of compliance is evident in the narratives in relation to family planning. Reproductive rights discourse in Mexico promotes the universal right for women to control when and how many children they have, regardless of their social situation. This discourse legitimises and emphasizes the responsibility on women to control their reproductive lives through the use of contraception. Conversely, the Mexican government’s continued refusal to legalize abortion, across states, is another form of controlling women’s reproductive options and reproducing the notion of individual responsibility (Gutmann 1986; Lamas 2001). All methods of contraception for women are provided free of charge in the Mexican public health system. Most commonly women are offered intra-uterine devices (IUDs) and tubal ligation, though since the early twenty-first century the contraceptive pill or injection is becoming more available and popular amongst younger women in urban populations. Over the years I have never witnessed a public health programme discussing vasectomies as a contraceptive option for couples. The

---

21 Vaginal birth after a caesarean section in most cases is not proven to be a problematic process by a midwifery or obstetric model of care. It is a policy decision based on resources as opposed to evidence-based practice that public hospitals refuse to support it as a practice.
emphasis in public health (which is also reflected in the local population) is always on how the woman can protect herself from unwanted or future pregnancies via female contraceptive devices. In his work on sexual health and gender politics in Oaxaca, Gutmann (2009) describes how the introduction of the Oferta Sistemática (roughly translated as ‘the standard plan) around the end of the twentieth century, sought to increase the adoption and employment of birth control by women. With the Oferta Sistemática every time a woman of child-bearing age came into contact for any reason with a doctor, a nurse, or other health care worker, whether in a clinic or in her home, she was offered contraception. Gutmann argues that through this direct targeting of women in the health system a female contraceptive culture emerged and was reinforced institutionally, including through the public health system, so that women were systematically confronted about birth control by health personnel in ways that few men ever experienced (Gutmann 2009).

In the public health institutions in Chiapas the practice is to offer women the IUD or tubal ligation in prenatal appointments. However, this often does not happen for systemic reasons or if the woman has not accessed clinical prenatal appointments before presenting in labour. “We just don’t have time to discuss things properly with the patient” my friend and colleague Dr Ricardo told me, when I asked him about clinical birth management from the physician’s point of view. “I did so much time in control prenatal when I was qualifying and you just have to rush them through, and the other professionals, the social workers, nutritionists, psychologists, we don’t communicate. They never come out of their offices, apart from when it is too late. Like for instance ... it's always done when the woman is still giving birth when she is feeling the most pain or just after and they say, "Do you want an IUD?" "Do you want to have children?" "Here sign this", and the nurse will do it. The nurse has a
specific job to do, to check and make sure all is okay for the doctor and so we will say, "Pass me the paper so she can sign it." Or if it is in a [caesarean] section and the women is barely awake, she is between sleeping and awake, we pass the paper and say, "Sign this." But if the woman says, "I won't sign" and she has six children and she is twenty-four to twenty-six years old we, the doctors and nurses, won't argue but we go and talk to the social worker, we say, "Tell the husband or the mother to sign this paper." Ricardo’s comments give an insight into the priorities of health and medical practitioners and how systemic weaknesses also contribute to creating the conditions of emergency, framed within a language of risk – in this case the need to regulate a woman’s uterus and sexual practices. Douglas (1990:7) writes that ‘[t]he modern risk concept, parsed now as danger, is invoked to protect individuals against encroachments of others’ (Douglas 1990:7). What arises in pregnancy, labour and birth management, in this instance, is a reversal of Douglas’ argument where it is the community, an imagined future foetus, the institution and the woman herself who must be protected against the encroachment of the sexual, maternal subject. This idea that a woman who is not averse to risk (of future pregnancies) poses a danger or a threat is evident in Rosa’s narrative. When she attempts to resist the pressure to have an IUD inserted or tubal ligation straight after birth, her behaviour is interpreted as irresponsible and the threat of death and suffering is invoked once again in order to coerce or silence her.

Aside from Bety, the women in this chapter never describe what happened to them directly as obstetric violence or a violation of rights, yet their stories highlight an enforced position of isolation and submission common to the clinical birth environment. In Felisa’s case, her wishes were overridden completely when doctors went to her brother for permission for surgery. In all cases the threat of death to the
unborn child was asserted in order to obtain compliance. Overt attempts at resistance by the women were met with the assertion of medical authority via the use of threats or by turning to the relative or person accompanying them. The outcome of women’s resistance in these situations results in being silenced by the actions of the medical professional. It demonstrates that the form of power at play here requires complicity from others in order to have legitimacy.

The poor treatment of women during birth, and violations of reproductive health rights is certainly not a recent phenomenon, nor one restricted to the Mexican public health system. Maltreatment of women has been documented and discussed in a global and cross-cultural context ever since feminist researchers began to question the consequences of the medicalisation of childbirth (Davis-Floyd & Sargent 1997; Kitzinger 2005; Martin 1989; Oakley 1980) and also in direct relation to global health politics (Bohren et al 2015; Ginsburg & Rapp 1995). In the Latin American context, the use of the term violencia obstétrica (obstetric violence), by activists, practitioners and politicians alike, is significant and requires some definition. The term is not exclusive to the practice of obstetricians; it relates to the malpractice of any health professional and also to systemic forces that create an environment that fosters oppression and abuse. For this reason, the term obstetric violence is problematic for use in cross-cultural comparison and in global discourse ‘violations of reproductive rights’ appears to be the preferred term in academic literature. Despite this, in Latin American literature (Benítez Guerra 2012; Cisneros 2011; Poljak 2009; Villanueva-Egan 2010), reproductive health activism (CEDAW 2012; GIRE 2013a), and in Mexican state legislation (the 2009 Law on Access to a Life
Free of Violence for Women in the State of Chiapas, *violencia obstetrica* is a widely used and accepted term describing acts and situations that relate to descriptions given by women in my own research. Within the aforementioned literature there are two specific dimensions to obstetric violence that appear both in activist discourse and legislation: the physical and psychological. The physical dimension applies ‘when a woman is subject to invasive practices and given medication when there is no medical justification based on her state of health ... or when the duration and possibilities of a natural birth are not respected’ (Villanueva-Egan 2010: 148, my translation). This dimension manifests in disproportionate caesarean section rates (indicating medically unnecessary intervention), episiotomy as routine practice and insertion of contraceptive devices or sterilisation without informed consent. The second dimension is the psychological model of obstetric violence, which includes ‘inhumane treatment, verbal abuse, discrimination, humiliation when the woman requests an assessment, or requires attention, or when carrying out routine obstetric practice’ (Medina 2009: 3, my translation).

Elbi’s narrative illustrates that acts of coercion can take place in private clinics which are generally accessed by middle-income women. This suggests that the rhetoric of risk and conditions of emergency are inherent in clinical practice across the board - as opposed to being specifically linked to low socio-economic status or ethnicity. While there are commonalities between clinical practices in private and public institutions, a specific distinction is embodied by the scar left behind after an

---

Ley de Acceso a una Vida Libre de Violencia para las Mujeres en el Estado de Chiapas, 23 March 2009, Gobierno Estatal de Chiapas. The law is available at: http://www.cndh.org.mx/sites/all/fuentes/documentos/programas/mujer/5_LegislacionNacionalInternacional/Legislacion/Estatal/Chiapas/B/Ley%20de%20Acceso%20a%20una%20Vida%20Libre%20de%20Violencia%20para%20las%20Mujeres.pdf
emergency caesarean section.\textsuperscript{23} The women I encountered who had undergone emergency caesarean at the regional maternity hospital, and therefore who were low income or welfare recipients, were clearly marked with a vertical scar stretching from the umbilicus to the pubic region. The scars on women who underwent emergency caesareans in local private clinics were cut horizontally with a transverse incision, described to me by Bety as the ‘bikini cut’. The symbolism of women who carry a midline or transverse scar has profound analytical consequences in terms of class-based interventions in clinically managed maternity.

**Nurturing**

In the excerpts below Bety and Rosa describe how the birth helped to shape their experiences of the postpartum and early motherhood period:

_Bety (continued)_

During my recovery I also got a really bad cough, my father said it could be the anaesthetic in my body that I was reacting to ... so I had mastitis, the fever of 40 degrees, the cough and without being able to feed my baby because they’d given me antibiotics ... It was a terrible time. Even my husband was so tired of seeing me so ill, but he was very patient with me. He didn't lose patience at all. He was always a lot calmer because it was so difficult for me. Honestly, after having my first son I said I never want to do this again ... It was horrible ... and like I said the doctor never said that she would visit, come and see how I was after the birth ... It was a

\textsuperscript{23}The relationship between caesarean scars, class status and ethnicity has also been noted by Roberts (2012). In her fieldwork it is middle-class women in Ecuador who use the traverse incision scar indicative of private hospitals to remain distinct from the ‘governed masses’ who need to access social services.
difficult time, as much for my husband as it was for me. Because I saw him looking really stressed as well but I couldn't help. By this time I had started to fall into depression. From the moment I got back home I found it really difficult. It wasn't what I had imagined but I thought maybe after a few days I'll be able to start doing things around the house, but I couldn't. I felt like my body had let me down. I was angry with myself and irritable with the baby … It was very difficult because during this time I started to hear voices. He would cry and I would hear voices saying, "Don't go to him", "Kill him; he's bad" and so inside I was very worried because I knew it wasn't right. I thought to myself: How can I do anything to harm my son? He was born from my body, I felt him grow inside me - he's made from love; he can't be bad… I would go to the kitchen and have suicidal thoughts, you see you have no idea how it is to walk around your house and everything you see you think about how you could use it to kill yourself … And so I started to go over to my mother's house for a few days, then back home for a few days and this worked for a while because when I was with my mum I talked a lot. We spoke about everything and, because I was talking, I didn't have the time to think the bad thoughts. In the end I could breastfeed and look after the baby, but it also got to a point when, because of the depression my milk started to dry up. Around 6 months I started to lose my milk and it got to the point where I couldn't even produce a drop … After the caesarean it took a long time to heal. But they say that the depression has something to do with it, that your body doesn't heal well after the surgery because you feel down. My husband always helped me with curing the wound; he helped me wash and clean it.
He said a few times that he noticed puss coming from the wound. That’s why I had antibiotics afterwards. But speaking of the wound, the most interesting thing for me is that the wound doesn't stay in your body, the wound is in your heart. Because it’s an experience that, although consciously you are saying that you've got over it, but after a long time you realise that you still haven't got over it, when suddenly you get thoughts or reminders that really you haven't got over what happened. It's then you realise that everything that happened is still there. You have it trapped inside and you don't want to let it go. And it carries on hurting you but you don't want to let it go. When you learn that you can let it go, that nothing will happen, it will go and you will feel better that's really when the scars begin to heal and begin to disappear …

*Rosa* (continued)

I wouldn’t like to repeat the experience; I wouldn’t like so many people to see my body again. It was lovely to have a child, but not the process of having all these people touch you. That was horrible and it wasn’t even just one doctor it must have been about seven different people putting their hands inside me … They were all male doctors apart from one and apart from that they were really mean. I heard them say to other women who were screaming out, saying like “Oh I’m going to die.” They would say, “Oh yes, and I bet you didn’t scream like that when you made the baby.” That’s why I didn’t cry or anything. I suppressed all my feelings because I didn’t want them to shout the same things at me. They were saying to all the women that cried, “Why are you crying? This is no reason to cry. When you did it you weren’t crying were you?” I waited till I got home, when I
was alone in my house I thought about the whole situation and I cried …

Being a mother is a beautiful thing and it was worth it, though only once!

Two or three times more maybe but I am too scared because of what happened. The situation with my partner isn’t ideal either. Today I saw him before I came here and he was making comments about more children … I don’t like having this thing [IUD] inside my body; it has brought about drastic hormonal changes that I don’t like. But to be honest I don’t want another baby, so for now I won’t have it removed … I don’t want another baby not because my heart doesn’t desire it. I would love to have another child but I’m not in the right situation. We were talking about it only today. My partner said to me, “Why don’t you take that thing out?” But I think he’s doing it just because he wants to keep me always for him. He thinks he’ll secure me with one more child. You see in Mexico a man won’t accept a woman with two children, not even with one.

The culture of blame and individual responsibility inherent in the clinical environment shapes early motherhood in various ways. In many of the birth narratives I collected, the women spoke of coming to terms with a feeling of failure, humiliation and loss of expectations. Women are often left with conflicting emotions and analyse their behaviour during pregnancy and birth, searching for answers of how and where it went wrong. A common theme in the birth narratives presented in the previous section is that, although women felt shamed and humiliated by professionals, more than this, they felt let down by their own bodies. The women who underwent unplanned caesarean sections spoke of a sense of failure, which took time to reconcile, and impacted on them as maternal subjects.
Withdrawal from clinical management in the postpartum period resulted in women dealing with many unanswered questions, which they ultimately began to turn inward on themselves. Bety had a very difficult time coming to terms with the birth of her first child, and the unwanted caesarean section outcome. Her psychological and physical health were greatly impacted upon by her pregnancy and birth experience. Though it is impossible to say whether the events leading up to and during the birth were the cause, from Bety’s point of view her postpartum suffering was inseparable from what had happened in the hospital. Although her postpartum account is more extreme than most, Bety’s narrative illustrates how the trauma of birth can profoundly influence early motherhood and maternal subjectivity. In her case an undesired outcome leads to a belief that she is unworthy as a mother, to the point where she wants to do harm to either herself or the baby. Bety describes the conflict between not achieving what ‘nature intended’ (a vaginal birth), which then develops into ‘unnatural’ feelings towards her child, and the difficulty coming to terms with what she is supposed to be feeling as a mother. She relates the non-compliance of her body to the perception of being a bad mother, which ultimately affects her personal relationships and ability to heal after a traumatic event.

In her birth narrative Rosa touched upon an aspect of childbearing that is often omitted from maternal discourse: the thoughts and feelings around surrendering the body to the hands of strangers. She provides an example of how women sacrifice bodily integrity for the welfare of the life within their uterus. In the moment of giving birth, the obstetric gaze gives priority to the unborn child and its safe delivery to the outside world. Clinical practice dictates that the woman must be compliant in order for the medical practitioners to achieve this goal. Women are expected to open themselves up literally, to be examined by multiple pairs of hands, adjusted and cut
without presenting any opposition. As I will demonstrate in Chapter Three, this differs greatly from out-of-hospital birth, where common midwifery practice is to avoid any internal contact whatsoever with the labouring woman.

Rosa’s birth narrative demonstrated how health professionals will often interpret a woman’s silence as cooperation and compliance. From Rosa’s perspective her silence was a form of resistance, which in turn also served to protect her from receiving a scolding from the doctors and nurses and allowing her to maintain some control over the situation. When she breaks her silence to refuse the offer of an IUD, she is judged for putting herself at risk of getting pregnant again. The Mexican state has promoted the concept of the modern woman in relation to her choices of low risk behaviour (Smith-Oka 2012b). Women who go against medical advice are seen to be increasing their risk of complications and in doing so they are considered bad mothers and a danger to the wellbeing of society. Adhering to medical advice therefore defines women as good mothers because they are demonstrating risk-averse behaviour. Childbearing and childbirth happen in a medical, social and economic context that has the capacity to shape a woman’s transition to motherhood beyond the events of the clinical environment. Rosa’s strategic use of silence extends to her relationship with her son’s father. She tolerates the discomfort of an unwanted IUD in order to protect herself from becoming trapped in a relationship that may have no future. The compromises to bodily integrity she made during pregnancy and in labour are continued in her roles as good mother and responsible modern woman.

**Resistance and Resignation as Everyday Practice**

Yet the silent power of the sign, the unspoken authority of habit, may be as effective as the most violent coercion in shaping, directing, even dominating social thought and action

(Comaroff and Comaroff 1991:22)
My aim in this chapter has been to use women’s accounts of clinically managed maternity to explore the relationship between resistance, resignation and power as they are located in maternal bodies and institutional practices. In an effort to move beyond a notion of resistance as a product of power, I set out to explore not the status of resistance itself, but what forms of resistance indicate about the forms of power they are up against. Abu-Lughod’s assertion that studying cultural forms of resistance ‘will allow us to get to the ways in which intersecting and often conflicting structures of power work together…in communities that are gradually becoming more tied to multiple and nonlocal systems’ (1990a:42) ties in well with my attempt to present events from the memories and perspectives of the women who embody pregnancy and birth in a Mexican clinical context. The way that acts of resistance and resignation are described by the women reveal the forms of non-agentic power at play in the clinical environment. When the conditions of emergency are created, in part, through the rhetoric of risk, it demonstrates how the non-agentic form may not be experienced as power at all. This kind of power is ‘internalized as part of a cultural repertoire that may be experienced negatively as constraints, neutrally as conventions, or positively as values’ (Lock 1993:384). In the case of childbirth, the guises of constraints, conventions and values are all equally attached to dominant socio-political thought surrounding the preservation of life.

In these concluding paragraphs I aim to further develop Abu-Lughod’s notion of resistance as a diagnostic of (non-agentive) power in relation to matters arising from the narratives in this chapter. I propose that Abu-Lughod’s ideas about diagnostics of power can be extended to think about forms of resignation, alongside resistance, as a diagnostic of intersecting and contradictory forms of power in clinically managed
maternity. In order to do this, I suggest a framework for analysis, informed by themes arising in the narratives, that takes maternity into account as a corporeal process that is inseparable from broader social and political influence. In this way maternity is not understood as an isolated, female life event but as a bodily process directly interrelated with the social, political and economic environment. This framework understands everyday forms of resistance and resignation as tactical micro-practices (in De Certeau’s sense of the word). De Certeau’s notion of tactic is something he describes as an ‘art of the weak’ (1984:37). Contrasting this to the use of ‘strategies’ by the powerful, De Certeau defines a tactic as a ‘calculated action determined by the absence of a proper locus’ which is played out in ‘the space of the other’ (1984:37). The idea that resignation, where overt resistance is not possible, is a tactical micro-practice allows for human action to have multiple potentials, avoiding also a problematic binary in which untroubled notions of resistance and submission are reproduced.

Through this framework I have observed two main points about forms of resistance and resignation in relation to space, human action, power and Modernity. These observations encompass both successful and failed attempts at resistance, how acts of resignation contribute to producing future practices of resistance. The first observation is that women are afforded greater opportunities for self-conscious resistance in the pregnancy and nurturing periods of maternity. During pregnancy women try their best to identify the support that will allow them to have the birth they desire and they often withdraw from professionals that threaten their desires and beliefs. These women are not anti-interventionist, their priority ultimately is the safety and wellbeing of their child. Within this notion of wellbeing are collective and individual beliefs about what they deem to be necessary and unnecessary interventions. In order to carry out this form of resistance, the women must not be
dependent on public services and they must have alternative options available to them such as parteras or private obstetricians. This also raises questions about socio-economic status and social networks. In the postpartum period, women will often not return to the place of birth, especially if it holds particularly traumatic memories for them. This is what I identify as a future practice of resistance that arises from an act of resignation in the management of birth. They avoid further compromises (acts of resignation) to their own bodily integrity and that of their new baby by staying at home during the postpartum period and failing to turn up for postnatal check-ups.

Where women suffered infections postpartum or complications in healing, they reported seeking out alternative care and, where needed, borrowing money to pay for a private doctor rather than return to the hospital where they gave birth. Where they have little choice but to return to the clinical environment, they will arrive with female family members as support.

The second observation is in relation to unsuccessful attempts at resistance in the clinical environment, particularly in the second and third stages of labour. Failed attempts at overt resistance to surgical intervention, intrusive assessment or inhumane treatment remain important factors for understanding forms of power at play within the confines of a clinical environment. They show that regardless of women’s expectations of, or preparations for birth, or their own feelings on how labour is progressing, once an emergency situation is evoked, resistance (to clinical decision making) is impossible. But rather than reading this as a sign of the futility of resistance, it raises important questions about the dynamics of power that hide behind the concept of an ‘emergency situation’. Declaring a life or death emergency allows doctors to manipulate and coerce women to comply with orders. The use and threats of caesarean section resulting from the evocation of emergency is a strategy
by the powerful to control the outcome of the birth situation in their favour. The rhetorical question “do you want your baby to die?” is employed as a coercive strategy that further bolsters the reasoning for carrying out a caesarean section. Thus making caesarean section, over other forms of surgical intervention, a necessary subject of analysis and possible indicator of other less tangible forms of violence in obstetric settings. Women become implicated within a ‘circular logic where the cultural arbitrary is imposed upon the body in a naturalised form whose cognitive effects (doxa) result in the further naturalisation of arbitrary social differences’ (McNay 1999:100). In other words, the perception of childbearing as high risk and the need to intervene with non-complicit bodies becomes the naturalised rule rather than the exception. The continuous evocation of death and risk of dying present in the women’s narratives illustrates this and also the assumption that lives must be saved at all costs.

In conclusion, the pathological emphasis placed upon childbearing as high risk, and therefore inherently dangerous, portrays the women as needing to be saved from themselves, as though they and their bodies are the root cause of perceived complications or risks. The evocation of risk as danger, as argued by Douglas, appears particularly evident in the clinical environment. There are clear links with governmentality. Asserting medical authority if a woman is seen to flout best practice does not leave space for considering why she may be doing so – instead it results in miscommunication, lack of informed consent or perceptions of non-compliance (Smith-Oka 2012a). Women’s bodies become a site of struggle and where resistance occurs professionals misinterpret women’s actions often accusing them of being uncooperative or bad mothers. In the next two chapters I will discuss how meanings of risk change outside of the clinical management of maternity.
Through exploring birth and postpartum practices in out-of-hospital and midwifery models of care, different ideas about agency and what constitutes risk in relation to good mothering become apparent.
CHAPTER 3

Urban Midwifery and Competing Cultural Metaphors of Risk

“Mis 9 hijos, mis hijos hijos y ahora sus hijos todo nacieron en casa con la partera, así es”

“My nine children, their children and now their children all born at home with a midwife, that’s the way it is” (Doña Reina, fieldnotes April 2013)

In la Garita, and a handful of other barrios across San Cristóbal many women continue to give birth at home with a partera (midwife), and surrounded by close female kin. Over recent years, there has also been an increase in middle-income mestiza women hiring a partera profesional (professional/qualified midwife) in order to have an out-of-hospital birth in a casa de partos (private birthing house) or at home. Whilst I cannot claim that this is the dominant birth model in the city, there are enough women hiring the services of a partera to make it of ethnographic interest. The various midwifery models of care that families use raise some important questions about economy, agency, and different attitudes towards the clinical management of childbearing. As such, there is a need to further investigate the hiring of parteras and out-of-hospital births as part of more complex belief systems that link to broader lifecycle processes.
This chapter will examine typologies of midwifery and out-of-hospital birth in two contexts: lower-income families of la Garita and middle-income families form the wider city. I am interested in how a comparative study of urban midwifery practices can inform ideas about agency and the ways in which spaces of contestation appear through competing metaphors of risk. In their decision making about maternal management and healthcare women are able to take advantage of the symbolic and cultural tools available to construct their moral character as good mothers (Rouse 2004). They must navigate between medical and social rules about risk during the interconnected stages of pregnancy, birth and postpartum. As observed in the previous chapter, medical professionals can gain control over women’s bodies by ‘creating risk’ (MacKenzie and Van Teijlingen 2010) and by turning bodily metaphors of risk into objective facts (Rouse 2004). Women must balance these risk transactions in public and private health with the competing and equally as indeterminate notions of risk in the bio-social management of maternity. By shedding light on the different types of parteras available to women in San Cristóbal, this chapter will demonstrate how the social status and trust afforded to parteras, by women and their families, places them in a privileged position as facilitators of change. Yet at the same time, their greatest challenge lies in the refusal of the state and medical institutions to see them as equal partners in the provision of quality reproductive and maternal healthcare.

The chapter is divided into three parts beginning with a brief historical contextualisation of midwifery in Mexico. Paying attention to the historical progressions and regressions of midwifery will reveal its chequered and complex relationship with the Mexican state and medical profession. In the second part I will explore two different approaches to midwifery – the partera empírica (empirical
midwife) and partera profesional - paying particular attention to why women hire their services and how their practices compare and contrast. The chapter will conclude by considering power, agency and politics in relation to out-of-hospital maternity management and asking briefly what the comparative analysis of midwifery and risk can reveal about local understandings of childbearing as a natural process.

Similar to my approach in the previous chapter, I have chosen to highlight these two types of partera as a way to provide a micro-comparison of local lives. In doing so, the material in this chapter draws attention to the different types of maternal healthcare available to mestiza women of varying socio-economic status. Though these women may perceive the role of a partera differently, and may hire their services for different reasons, they do share the common aim of wanting to avoid a clinically managed birth. Global health and development discourse, as it is translated on the ground in Mexico, offers an oversimplified view of parteras as practitioners of traditional medicine, attending to an ignorant minority and whose most important role is that of gatekeeper to at risk populations. The attitude towards parteras as ‘dangerous, dirty and anti-modern’ has deep roots in Mexico’s own complicated relationship with gender, ethnicity, class and the desire to present as a sophisticated modern nation. The historical emphasis on improving maternal mortality via access to primary healthcare during pregnancy and birth has served to exclude parteras from any meaningful debate in equitable maternal health provision (Freyermuth and Argüello 2015). This behaviour is reflective of policy discourse on a global level where the solid evidence has been provided about the essential role of midwifery in high-quality maternal and newborn care (see Lancet 2014; Sandall et al 2015), only to be quickly silenced by dominant obstetric voices who view birth and midwifery as
inherently high risk practices (Dahlen 2016). The lack of attention paid to the various models of midwifery and birth that exist within complex nations such as Mexico (outside of anthropology), allows this type of critique to fester and prevents any serious change to how maternity is managed in ways that puts the experience of the mother at the centre.

By drawing attention to the types of midwifery practiced in an urban environment, this chapter aims to offer a counter narrative to the health policy discourse on parteras as Traditional Birth Attendants (TBAs). In doing so it will raise questions about women’s reproductive agency in relation to their decision making on maternal health management. By examining the relationship between women and parteras I want to focus not on what the decision is, but on how or why the decision is made in its bio-social context. Taking into account the role of emotion and desire when listening and observing the actions of women is essential to making links between the body as inseparable from the social world it is part of (Lyon and Barbalet 1994; Csordas 1994; Lock 1993). Unnithan-Kumar argues that public health policy and provision does not recognise women’s emotional attachments and desires that result in certain kinds of healthcare choices (2001:28). The deeper emotional engagement and closeness that often occurs via the midwifery models of care, provide one way of addressing emotion in policy discourse (the other being greater attention to traumatic experience as described in Chapter Two).

**Midwifery in Mexico and Relations with the State**

As discussed in Chapter One, in the 1970’s there was a significant shift in global health and development towards the primary health care (PHC) model. This was very much connected with the realisation and critique that ‘top-down’ approaches in development were ineffective and costly. The PHC model acknowledged the social
significance of traditional healers and midwives in local communities, and understood them as a way of connecting with traditionally hard to reach communities. Endorsed by the World Health Organisation, the PHC models incorporated ‘a comprehensive strategy for achieving a more equitable provision of health care’ (Pigg 1997:236), a message which is still very much apparent in the WHO’s sustainability agenda launched in mid-2013. The PHC policy approach between the 1970’s and 1990’s was to identify key traditional practitioners and TBAs and provide them with training programmes as a way of getting the biomedical healthcare attention to those who needed it most. The intention was to train ‘indigenous practitioners’ as health auxiliaries and health promoters in an attempt to solve staffing and resource inadequacies in rural locations. It was not however, to recognise their skills and knowledge of health and illness as comparable to that of biomedicine (Sesia 1996; Pigg 1997). Tied in with this strategy of defining and training TBAs in particular, was the desire to target development funds to combat high maternal and perinatal mortality in poorer countries.

The misdirection of funding and initiatives to improve maternal mortality and the consequential side-lining of TBAs and other types of non-clinical health workers has been the focus of much cross-cultural critique within anthropology (Jordan 1993; Sesia 1996, 2007; Pigg 1997; Berry 2010). Despite this, international development organisations and governance continue to promote the ‘recruitment, development, training and retention of the healthcare workforce’ (un.org 2016), without recognising the overwhelming evidence that definition, recognition, promotion and

24 In the Mexican context the terms ‘indigenous’ and ‘traditional’ practitioners and practices become synonymous with ‘medical views and modalities of care that peasant and indigenous communities, among other sectors, have dynamically and historically developed to explain and cope with illness’ (Sesia 1996:136). This distinction is proved problematic when one pays attention to the lives of lower-income mestiza communities in urban locations incorporated into development programmes.
protection of midwifery (understood as professional not traditional practice) continues to be a ‘vital solution to the challenges of providing high-quality maternal and newborn care … in all countries’ (Lancet 2014). By continuing with what Pigg (1997) describes as the ‘linguistic diplomacy’ of terms such as ‘healthcare workforce’ and ‘traditional or skilled birth attendant’, the governors of global health transfer power to national governments to define who they want their healthcare practitioners to be. Though this is done with the intention of cross-cultural consideration and flexibility, it maintains existing and inequitable structures of power and preferences for ‘measurable’ techno-scientific knowledge to dominate national policy making and practice.

Although the Plan Nacional del Desarrollo 2013-2018 (National Development Plan 2013-2018), its linked initiative Programa de Acción Específico para la Atención (PAE) a la Salud Materna y Perinatal (SMP) 2013-2018 (Specific Action Programme for Maternal and Newborn Health 2013-2018), and the NOM-007-SSA2-2016 Para la atención de la mujer durante el embarazo, parto y puerperio (National Minimum Standards for Attention during pregnancy, birth and postpartum period 2016) all make some reference to the inclusion of community parteras, the attitudes towards their actual position in the public healthcare system is impeded by a history of disrespect and mistrust. In a country like Mexico, where health policy makers have historically ‘ignored or blatantly condemned all traditional medical practices’ (Sesia 1996:122), of which midwifery has always been categorised, it’s meaningful inclusion into public health practice will demand a deep cultural shift. The historical account in the following paragraphs is provided as a way of foregrounding evidence of the ongoing contentious relationship between midwifery, public health care
providers and the state which became apparent during my fieldwork in San Cristóbal.

The socio-cultural context of birth across Mexico and the high social status of the partera in pre and post-Colombian times has been well documented. Luna, Sanchez and Velasco (2015) describe how the efforts by the Spanish to regulate midwifery and parteras in the fifteenth century, was more to do with the institutionalisation of public health that the medicalisation of birth as such. Yet it was through attempts to bring midwifery practices into institutions, that would lead to the gradual displacement of partera’s biosocial knowledge about pregnancy and birth, and to their permanent relegation to a ‘secondary role as subordinates to men and biomedical science’ (Luna, Sanchez & Velsaco 2015:51). In a historical account of the birth and death of midwifery in Mexico, Carrillo argues that in the nineteenth century the qualified partera role was introduced temporarily in an effort to eradicate traditional indigenous parteras. The role of the partera profesional was introduced as a way of coaxing mestiza women into the clinical environment to give birth. Childbearing had yet to be separated from its bio-social context in the public imagination and trust lay in the hands of the partera in all matters relating to birth. Like the obstetric nurse and partera técnica in contemporary Mexico, the entry requirements of a complete secondary education excluded indigenous and peasant mestiza women from entering into the profession, and the partera profesional became a role occupied by the mestiza middle class. Carrillo documents how the parteras profesionales were often manipulated politically at a time when technoscientific advances were redefining the nature of ‘normal’ and ‘abnormal’ pregnancy:
On 24\textsuperscript{th} March, 1892, the Ministry for Medical Governance published a policy for qualifying midwives, in which one can observe the university medics deterring them from attending normal birth and perinatal cases alone, besides also using them to convince patients and families of the importance of seeing the doctor in complicated cases (Carrillo 1999:178 my translation).

Carrillo goes on to describe how, by the twentieth century, \textit{parteras profesionales} employed in state hospitals had been redefined as ‘obstetric nurses’ and demoted in terms of having any official value or skilled role beyond that of supporting obstetricians. However, this strategic attempt to bring women into the hospitals and away from traditional \textit{parteras} was unsuccessful, particularly in rural regions such as Chiapas. This was in part due to women’s beliefs and preferences to give birth at home where postpartum traditions and care could be carried out immediately, and also the failure to implement access to hospitals across the southern region.

Notwithstanding, the general shift towards dominant medical models of childbearing with its separation of pregnancy and birth from its cultural context as part of a wider life-cycle process of transition, in addition to the repeated global development trends to improve maternal and infant mortality through greater access to institutions, gradually fostered the notion that, for many urban mestiza women at least, \textit{parteras} where an inferior option to modern obstetrics.

This attitude is reinforced by the fact that since the change of title to ‘obstetric nurse’ midwifery, in any guise, ceased to be recognised as a profession or professional health practice in Mexico. Instead, midwifery is categorised as a \textit{tradición and costumbre} (traditional practice) and therefore associated with indigenous rights and customs only. In global health terms traditional birth attendants, trained or untrained, became excluded from the World Health Organisation definition of skilled birth
attendant in 1996 (Berry 2010). Non-indigenous parteras, of any type, exist in a no
mans’ land where they are neither legally recognised as traditional practitioners nor
regulated as a profession.

The legal position on attending births outside of medical institutions is complex and
contradictory. In theory, a woman has the right to birth where she chooses; if she
wishes to give birth at home, she has the option of hiring the private services of a
partera (of any type), though legally a birth cannot be planned outside a medical
institution. Where homebirths are recorded, it is done so as if it was an emergency
and there was no time to reach a hospital. Women that give birth at home using a
local partera will take the baby to a public clinic a few days later where it will be
registered by a licensed medical professional as a spontaneous birth at home. A casa
de partos, a private birthing centre often set up by the emerging partera profesional
does not exist as a legal concept in Chiapas. Therefore de facto casas de partos
cannot be registered as places to birth or where births are planned to happen. When
births take place in the casa de partos, they are registered as home births. The
birthing houses are presented as private women and family health clinics that can
offer prenatal and other women’s health services. In order to do this, they must be
run by a licensed medical practitioner. There remain federal and state legislative
contradictions, meaning that whilst midwifery is not recognised as a health or
medical profession, licenses cannot be issued to parteras profesionales, and casa de
partos are never fully legitimised as a place where women can choose to give birth.

During my fieldwork, I observed three different types of partera practising in an
urban context: the partera tradicional is the woman described under policy
initiatives and whom many people associate with the practice of midwifery. This
image of the *partera tradicional* as an indigenous woman, attending poor women in a rural context, is reinforced by media representations and maternal health and development policy alike.\textsuperscript{25} The second and most common type of *partera* to be found in low-income urban barrios is the *partera empírica*. The term *partera empírica* is sometimes used to denote those who learned midwifery, either through attending women in childbirth or through apprenticeship to another experienced partera (Mills and David-Floyd 2009). The *partera empírica*, who is generally hired via mestiza families or close social networks, is the kind of *partera* I encountered in la Garita. In terms of technique and medicines mestiza *parteras empíricas* use a mixture of traditional and allopathic methods. I found that women hiring a *partera empírica* are more likely to be combining her services with those available in the public and private health system.

The third type of *partera* is the more contemporary and self-identified *partera profesional* who would attend births at home or in a *casa de partos*. This type of *partera* is also sometimes referred to as a *partera autonoma* (Laako 2016). Davis-Floyd (2001) has previously documented the development of the *partera profesional* and of one specific midwifery training school that began to produce qualified *parteras técnicas*, though midwifery still remains outside any legislated definition of a medical profession.\textsuperscript{26} The women who hire a *partera profesional* tend to come from affluent parts of the city and are often battling against wider family attitudes that favour clinical management of maternity. These women expect to pay a higher price for services (which in practice legitimates its status as a different or

\textsuperscript{25} The *Plan Nacional del Desarrollo 2013-2018* and the *Programa de Acción Específico para la Atención a la Salud Materna y Perinatal 2013-2018* only make reference to *parteras tradicionales* in their rural context and as gatekeepers for health professionals.

\textsuperscript{26} The technical qualification remains subordinate to an obstetric nurse or obstetrician and is not recognised as a ‘professional qualification’.
modern/Western type of midwifery), attend prenatal and postnatal check-ups, and they also place greater emphasis and awareness on up to date research and technology for managing ‘natural’ or ‘humanized’ birth. The partera profesional will also attend women who have previously had caesarean sections and want a vaginal birth (this is known as VBAC – vaginal birth after caesarean).

Though as this chapter will evidence, there are many similarities between the ideologies of partera empírica and the partera professional - and the mestiza women who hire their services - they are also differ in many ways. In the following section I shall explore these differences in more detail beginning with the practices of Filomena, the partera empírica serving families in la Garita and surrounding barrios.

The Partera Empírica

I first met Filomena on Doña Reina’s doorstep after she came to visit her granddaughter Carlita towards the end of her pregnancy. Filomena is a typical coleta woman, short and plump, her serious face framed by shoulder length black hair, usually tied into a ponytail at the nape of her neck. She spoke in a low voice that at times resembled a whisper. Our conversations were often fleeting as she was always on her way to see women, prepare herbs or source medicines. She was never comfortable with any request for a lengthy interview or recording about her life as a partera, but was always happy to chat when I bumped into her on various doorsteps. During my first few months in la Garita, I was in the final trimester of my third pregnancy and upon each meeting she would look down at my panza (belly), declare the sex of my foetus and estimate how many weeks or days I had left. Filomena was a regular visitor to Doña Reina’s family, she had attended the births of all her grandchildren and great grandchildren born at home. At 49 years old she was relatively young for a barrio partera having devoted twenty-eight years of her life to
helping pregnant women bring new life into the world. Originally from the upper part of la Garita, she has lived in the neighbouring barrio of Peje de Oro since marriage but continues to serve many families in la Garita as well as her own barrio. Born in 1964, she described how she was brought ‘earthside’ by a partera who was also her own grandmother. She told me “in these times there were no doctors or unless my mother didn’t know any or have any access to one, life was more difficult”.

Filomena was a well-established partera in this part of the city and knew many of the families very well. She was distantly or closely related to most of them through blood or marriage ties. Most mature women in the barrio make some claim to experientially based knowledge on maternity, and even the experience of assisting a daughter, a daughter-in-law, a granddaughter, a niece, or a neighbour in giving birth (Sesia 1996). What sets the partera empírica apart from the women who make these claims is the authority she holds within the community, the number of women outside of the family she has attended, and how she charges for her services. Though most local parteras (registered or not) have a fixed price of anything between 500 and 1500 pesos for a birth, Filomena was guarded about how much she charged telling me that it depended upon the family and how well she knew them or their financial situation. Although Filomena told me she did not differentiate between boy or girl babies, she (and other women) would tell me of parteras who charged more depending on the sex of the baby. There are various reasons given as to why this is so including that - “The boy it is supposed will be the one to go out and work when he is older, he will bring more money to the household because the girl will just stay at home and not earn. But today it is a bit different because actually most women do work, but some still charge more for a boy” or, as one woman explained to me “To
see or attend a birth if it’s a boy, it always complicates because the umbilical cord
gets wrapped around his penis and so that’s why they charge more”. Though many
younger women, like one of my neighbours Rosita, were unsure of why the practice
existed or continued: “There’s another partera up at the top” she told me one day.
“She charges $1000mxn if it’s a girl and $1500mxn if it’s a boy, I have no idea why
or what the difference is, a baby is a baby!”
Like most parteras empíricas, Filomena’s midwifery knowledge has been obtained
through generations of women in her family. She explained:
I am a midwife thanks to my mother and my aunt. When I was twenty my mother
started to take me to different births, she showed me how to position and how to
catch the baby and that’s why now I attend births.
Filomena has extensive knowledge of local plants and herbs not only for use in
pregnancy, labour and postpartum recuperation, but also for many minor ailments
and illnesses. She is not registered with the health authority and so has never
accessed any of the training programmes that are sporadically offered to parteras
attending births in and around the city. Her opinion on government interventions
such as training programmes is that “They are a waste of my precious time”. She
knows how to recognise potential complications that would need medical help and
she is suspicious of “Being told what to do by doctors”.
The relationship between parteras and medical professionals is often fraught, this is
emphasized by the fact that they generally only come into contact when there have
been complications or in an emergency. Many women (during prenatal periods) will
not tell their doctors when they are seeing a partera or plan to give birth at home, as
this often leads to problems including threats to withdraw treatment in an
emergency. In San Cristóbal attitudes varied greatly amongst medical professionals
depending upon their personal experiences, age and how familiar they are with the city and its population. Whilst some doctors are accepting of a woman seeing a *partera* for prenatal, non-biomedical interventions for example a *sobada* (massage), they may feel very differently about a *partera* attending a birth. Many younger doctors first come in to contact with *parteras* when they are completing their training in more rural locations.

Attitudes of senior colleagues often impact on shaping younger doctors’ ideas about *parteras* and out-of-hospital birth. This is evident in Ricardo’s description of his days as a student doctor in public maternity hospitals:

> In my experience I only ever saw *parteras* that brought patients in, I saw that, *parteras* who believed or considered that something wasn't right [in a labour or birth], they themselves brought the women in ... But many times the doctors, we didn't listen to the *parteras*. The doctors would often just say thank you, or in many cases tell the labouring woman off saying that if anything happened it was her fault, or the *partera*'s fault ... We never let the *partera* in to accompany the woman, nor did we let them explain what had happened. When I think back now we never asked whether they had given Pitocin or asked how the baby was positioned, or what the complication may be. No, we just left them outside and let the mother or the husband in. Many times I heard [the doctors say] that if anything happened it wasn't our fault. There was an attitude that no-one wanted to treat that patient because there could be a complication that was the *partera*'s fault or the patients’ own fault ... I never saw an interaction between the senior consultant, or the obstetrician with the *parteras* ... I also heard the consultants, from the obstetrics department, say that they were against the new policies
brought in to train parteras ... They saw the partera as someone who was there to trip us up, or who came to judge our work as medics.

(recorded interview September 2011)

Why do women hire a partera empírica?

Each year there are fewer and fewer parteras like Filomena regularly practicing and attending births in barrios like la Garita. There are various trends that contribute to a decrease in out-of-hospital births attended by a partera empírica. These include women’s improved access to public healthcare, state commitment to MDGs, SDGs and the Plan Nacional del Desarrollo 2013-2018, the requirements of conditional cash transfer programme IMSS-Oportunidades, and social changes in the perceptions of risk associated with childbirth (as discussed in Chapter Two). Although the reasons for the decrease in out-of-hospital birth are numerous, the explanations given by women in la Garita for wanting to continue to give birth at home are connected to the well documented maltreatment of women discussed in the previous chapter. This demonstrates a level of political awareness and motivations not often attributed to this particular social group.

The overall consensus of women who continue to give birth at home, and who encourage their own daughters and daughter-in-laws to do the same, is that hospitals are dangerous places to give birth, the present great social and personal risk. In its bio-social context birth is not something that should be experienced alone (or without the presence of close female kin). As shall become evident in Chapter Four, when I discuss the postpartum practices in the barrio, the vulnerability of a mother and newborn in the perinatal and postpartum periods to external threats and illness beliefs effected by thermal dynamics, make public hospitals and strangers (medical professionals) dangerous things to be around. When I spoke to women who hire the
services of a *partera* over (free to access) clinical services they always remarked on the likelihood of ending up with a caesarean section, or being subject to some form of poor treatment as the reason for not wanting to give birth in hospital. There is a clear understanding amongst the women of what goes on in hospitals. Their opinions are formed through the lived experiences of either the women themselves or people they know. Women prioritise a relationship of trust when describing their preferred birth environment. They make their own minds up about the kind of birth care they wish to receive and seek out the support they require. Women in la Garita are aware of clinical birth practices and of the high levels of caesarean sections carried out in public and private hospitals. By hiring a *partera* they are consciously taking action to avoid it. Both women and *parteras* of any type, consider out-of-hospital birth as the only viable alternative to a caesarean section.

I noticed early on in my conversations with women in the barrio that they did not prioritise the pain of childbirth in their birth narratives. This is in a stark contrast to the women describing or preparing for births in a hospital where fear of pain appeared to take precedence over any other aspect. For women who give birth at home, there is an emphasis placed on the body as naturally capable of carrying and giving birth to a child. The idea that birthing at home with family and a *partera* as “proper” is used synonymously with “nature’s way” or “how things should be”. For the women who hire *parteras empíricas*, childbirth itself is not understood as high risk, but as a natural, normal event. Although within this perspective, beliefs about birth as a natural event are not equated with a negation of interventions - whether they be herbal, spiritual or tactile. Local sensory models do not recognise the pain of labour and childbirth as a negative, but rather as a necessary part of the process.
Having the support of close female relatives and the partera was often explained as a way of coping with the pain or “uncomfortableness” of the stages of labour. Even when I was able to ask new mothers about pain in relatively short periods after they had given birth I was told “Well yes I suppose it hurt but I don’t really remember it now.” It is impossible to generalise as to whether the pain of labour is experienced differently in the home as opposed to hospital, particularly as pain-as-suffering was omitted from most homebirth descriptions. But, it is the way in which it is omitted in one type of birth narrative, and dominant in another, that leads me to suggest that although pain is experienced by all, in some way it is perceived differently depending on the environmental context. The recognition of having experienced pain and a distinct bodily transition becomes more apparent in the postpartum quarantine period (as I will discuss in Chapter Four).

Over the years I have had many conversations with women in San Cristóbal and Tuxtla Gutiérrez about their feelings and experiences of giving birth in hospitals. I noticed early on that descriptions of maltreatment and poor experience in hospitals were commonplace, such as those described in the previous chapter. Though women often spoke with regret over their repeatedly negative hospital experiences they rarely talked about seeking alternative care or challenging their treatment. The women often spoke about maltreatment as though it were par for the course in having a baby in hospital. However, I now realise this does not translate to poor treatment and abusive practices being condoned by pregnant women, nor could they face the accusation of colluding in their own oppression. As I found with the women in la Garita, there are subtler and collective ways of avoiding potential abuse,

---

27 My evocation of the term resignation, as discussed in Chapter Two, grew from this idea of this kind of resigned acceptance that maltreatment was common in public hospitals, to a point where it was often expected.
particularly when it came to reproductive health matters. It was not until I went to stay in la Garita and found such prevalence of homebirth in the barrio, and then in surrounding barrios of similar socio-economic status, that my own understanding of women’s maternity knowledge and active resistance to clinically managed birth transformed my way of thinking about the subject. Until this point, I had mistakenly understood women as passive in managing their reproductive and maternal healthcare. Now instead, I found that they were very much active participants in defining their own birth outcomes, with the partera empírica playing a vital role in making this possible.

There are three key stages of the reproductive lifecycle where women in the barrio seek out the services of parteras like Filomena – during pregnancy, actual birth, and during the postnatal period (lasting traditionally up to forty days). Women also seek the parteras’ services for fertility problems and abortions (though this is never openly discussed). The prenatal period is the time that younger women in particular use a combination of partera and medical obstetric services. The increased reach of Seguro Popular and the IMSS-Oportunidades programme has brought the importance of prenatal care to the attention of childbearing women. The commodification and easy access to technologies such as ultrasound has also undoubtedly increased prenatal attention and intervention for current generations.

There is no doubt that the technocratic model of birth translates into a profitable business for the private health economy, though whether it has any overall increased benefit for women is debatable. A woman can find a walk-in gyno-obstetric practice, laboratory, and ultrasound clinic on almost any street in the city centre. Although they are private services, women with sparse economic resources will pay for numerous ultrasounds and lab tests (bloods, urine, amniocentesis etc.) throughout
their pregnancies, often on the advice or insistence of doctors in public hospitals. They will then take images and results back to their consultant to interpret.

Figure 13. The photographs above are examples of the numerous walk-in clinics available to women in and around the city. Women will pay on average $300-500 (Mexican Pesos) for a 2D ultrasound and $600-1000 for a 3 or 4D image of their foetus. Some public hospitals will provide ultrasound at prenatal appointments but women are generally sent to get them privately as most public hospitals remain under-resourced.

The public and private prenatal services available to women are plugging a gap seen as unimportant by previous generations accustomed to hiring the local partera. Prior to the influence of global maternal mortality strategies, women did not give control prenatal, in its medical sense the same importance as the care provided at birth. In the barrio there are strict rules pertaining to what a pregnant woman may or may not do, but this is not the same as the checks carried out as part of the clinical management of maternity (weight, blood pressure, urine checks, ultrasound). Once a pregnancy is confirmed (by home test kit or lab test) many women will not call upon a partera until they reach the second trimester (around 5-6 months). This first contact is usually for the purpose of a sobada, to check on the progress of the pregnancy, and have the partera estimate the actual gestation. Many third or fourth time mothers will not call upon a partera until they are in labour. In this local midwifery model of care, the woman and her female relatives, not the partera are the
active subjects. Women decide when and where they want support (Sesia 1996). This approach taken by the women and the *partera empírica* is akin to what Davis-Floyd defines as the *holistic model of birth* (cited in Davis-Floyd et al 2009) where pregnancy and birth are understood as inherently healthy and normal, mind and body are integrated, and mother and baby are an inseparable unit. How women behave and when they choose to seek support during pregnancy reveals much about their bi-social understanding of risk. The vulnerability of the mother-baby unit (which begins in pregnancy and carries through to the postpartum period) to external forces (an interconnection of physical and spiritual threats to health) raises questions about what kind of risk women are seeking to avoid. Again the role of emotion in connection to maternal desire and spiritual belief is essential to understanding these cultural models of risk which value inter-dependence and community.

There are more notable changes in the pregnancy practices of younger, first time mothers. Increased universal primary health coverage is providing wider access to prenatal services, which in turn is changing attitudes towards this aspect of childbearing. Bio-social ideas about protection from external forces remain at the forefront of young women’s care throughout pregnancy. Rather than replace or reject old notions of risk for new, women incorporate biomedical and global health messages into local systems. The young mestiza women in la Garita use their close family networks and access to credit to navigate between lay and medical knowledge systems – meeting both biomedical and bio-social needs of pregnancy. As found in other communities who are ‘tied to multiple and non-local systems’ (Abu-Lughod 1990a:42), women use a variety of private practitioners (of which I include *parteras* and spiritual healers) as a way to avoid the undesired aspects of the public health system (see also Unnithan-Kumar 2001; Smith-Oka 2012b; Denham 2012 for
comparative discussion on this expression of agency). The way that women talk about pregnancy management suggest that any active resistance to clinical management of pregnancy is arguably a ‘secondary, unintended outcome’ (Unnithan-Kumar 2001). Instead, their use of a mixed economy of care is a way of incorporating bio-social knowledge and beliefs about bodies and maternity, family and social values and competing notions of risk.

Lupita is an example of a new generation of women who straddle the divide between traditional and allopathic practices. As a result of her work commitments in the capital and travel back and forth to San Cristóbal she received prenatal care from various sources – at a public hospital as part of her employee health insurance and private as the insurance only covered her for the city within which she works. Her decisions on where to seek support depended upon her perceived medical need, obligations to fulfil health insurance requirements, personal feelings towards services, family networks and cultural and religious beliefs. She saw a variety of doctors in public clinics, a private obstetrician in San Cristóbal and a partera empírica for the ‘things the doctors can’t see’. She often sought out the services of her local partera on the advice of her mother and aunts. Lupita was always open with doctors about seeking the services of the partera and found their attitudes differed according to whether the proposed treatment was seen as threatening to medical practice (such as labour intervention, positioning the foetus and any form of diagnosis). Like most women I spoke to on this matter, Lupita valued the expert knowledge of the partera and her ability to ease physical discomfort with a relatively hands-off approach. She also deemed the partera necessary for dealing with the symptoms of mal de ojo (evil eye), susto (fright), and emotional unease:
I had been very uncomfortable with my back and one Saturday my mum sent me to see the *partera*. I was about six months pregnant. At first she didn’t even touch me, she took me out into the garden and asked me to walk around and she just stood watching at me. Then she asked me to go and get her some water for the bathroom and to carry the bucket with my right hand. I did so and when I had finished I carried the full bucket to her outhouse. Then we went inside her house and she gave me a *sobada* (massage on the abdomen and lower back), though only for a minute and a herbal tea. I’m not really sure what she did but my backache never came back! ... The next time was when I had a false alarm. I thought I had gone into labour about eight days before I was due, my hips hurt a lot and my mum called the *partera*. They put me in a bath and they poured very hot water over my hips and back, and they gave me a tea made from *mishto*... They told me if you’re ready to give birth this will quicken everything up and if not it will help to calm the pains and that’s what happened. The pains calmed down.

It is important to note that the *partera empírica* never comes into physical contact with the genital area or with internal organs, no vaginal examination takes place before, during or after birth. The *partera’s* focus leading up to the birth is on the position of the baby, which she will often adjust using a *sobada to acomodar* (position) the baby. As I did not witness this first hand it is not possible to say whether the *parteras* in la Garita were providing a massage or also turning (external cephalic version in biomedical terminology) on suspected breech or side positions. All knowledge is gained through external touch and observation of the woman, what

---

28 *Mishto* is a local herb with oxytocic properties of which there is no known analogue.
she is saying and sensitivity to her environment as well as extensive empirical experience. This partera’s approach and sensitivity to the mother-baby unit is akin to the holistic model of medicine/birth mentioned earlier. Kitzinger explains how ‘[t]ouch given or withheld by those present during labour and delivery may be a central theme to the social analysis of the culture of birth’ (1997:209). As Rosa and Bety’s narratives in the previous chapter demonstrated, unwanted touch and vaginal examinations during the first stages of labour, by strangers, impacted significantly on how the women felt about their bodies and their births. Something that is not recognised in the technocratic model of birth is the link between emotion and touch. Touch ignites sensations and triggers emotions and this is something that is acknowledged within cross-cultural models of midwifery practice. The sensory apparatus of touch (and non-touch), combined with intuition are key tools within midwifery models of care. Paying attention to the bodily form of others also includes attending to one’s own body in relation to others and the environment. Csordas writes that there can be a visceral component to attending to aspects of other’s bodily forms (1993:139) – which is no more evident than when a partera is attending to a labouring woman.

When I write of intuition in this context, I make reference to a physical manifestation of the parteras’ sensitivity to the environment and the pregnant body they are attending to. Intuition as part of the sensorium is neither arbitrary nor biologically determined (though this may be the explanation given locally), but is understood to be culturally constituted. This use of ‘intuition’ in practice results in an action or non-action on the part of the partera – whether this be to suggest the labouring woman move position, change something about the environment or sit back and observe further. Though observation (for example sight) plays a significant role in
deciding when to give or withdraw touch for example, parteras (both empírica and profesional) will often speak of using their intuition when it comes to decision-making. The limited verbal communication (from the mother to those around her) often associated with second and third stages of labour requires the partera to attend with her own body in order to support the labouring woman – both instinctively and physically she must feel the best action to take in that given situation.

Parteras and birth at home in la Garita demonstrate that, within these families, birth is women’s work, and every woman is expected to know what her part is. Giving birth at home is described by many women in the barrio as simply the ‘right way to do things’. Their bio-social knowledge of birth is inseparable from the wider life cycle process of which becoming a mother is part of. It is also a process that adheres to strict gender rules concerning who can witness the moment of birth. Although on rare occasions a man may be present (father, partner or brother), ‘he is marginal to [a] community who use skills passed on by women’ (Kitzinger 1997:211). This differs from indigenous Mayan traditions where the husband is usually present (Carey 2013), and also from contemporary Western birth trends and ideas where the father is encouraged to become an active part of the birth experience.

Aside from the social value of giving birth at home, there is a significant moral economy at play concerning the hiring of parteras. Cost is often one of the first things mentioned when discussing their merits of the local partera. The focus on how much families are prepared to pay a partera for her services indicates her ‘worth’ as a practitioner in relation to medical professionals. This appeared to be quite separate from the trust that families would place in her social standing and empirical experience – something that isn’t necessarily measurable in terms of a commodity. Price is linked to the popularity of a partera as indicated by Rosita
when she first advertised the services of her mother to me – *‘cobra poco y atiende mucho’* (she charges little and attends many births). One afternoon in the early days of my fieldwork I had gone over to visit Doña Reina, her younger son Felipe had just arrived home from work. I was seven months pregnant at the time and he began to ask me about where I was going to give birth:

F: It’s proper to have your babies at home. My three were born here with Doña Filomena. She’s good a lot cheaper than the other *parteras* and has loads of experience.

J: How much does she charge?

F: Well it differs, she didn’t really charge us for attending the birth but I paid for the herbs and bits and pieces. I’ve probably spent about 1000 pesos on each child. She doesn’t charge much, wages are very low around here

J: Does she just turn up to the birth or do you see her before?

F: She came three times, once or twice to position the baby and then for the birth. She comes afterwards to cure the bellybutton and stuff. I can put you in touch with her if you want. How much does your *partera* charge?

J: I think it’s about 8000 pesos now

Felipe raised his eyebrows and smiled

F: That’s a lot, I can find you a cheaper one if you want.

The concern with how much it is proper to pay a local midwife is juxtaposed with the expense that families will pay for the services of private obstetricians, ultrasound clinics and paediatricians. The families in la Garita are of varying low to lower-middle income and most are entitled to primary health care under *Seguro Popular* or
*IMSS-Oportunidades*, though as mentioned many use a mixed economy of health services depending upon perceived need. As discussed, prenatal care in the clinical sense had not traditionally been a priority for women in the barrio and many are happy to attend appointments at the public maternity hospital in order to be registered there for emergency treatment. They attend *control prenatal* and pay for private scans and tests, whilst also hiring the services of a *partera* because they describe the various services as meeting different needs. Despite the opinion that one should not pay over the odds for the services of a *partera empírica*, the women and their families are very clear about what value she holds in the moral economy of reproductive and maternal health care. This is distinctly different to the women who access the *partera profesional*, where the cost of services is often used by them to defend the level and quality of service provided.

**The Partera Profesional**

![Image](image_url)

*Figure 14. The partera profesional uses an approach that incorporates traditional and clinical methods of managing pregnancy and birth.*
*Luna Maya Centro de Partos*\(^{29}\) was founded by the Spanish-American professional midwife and public health consultant Cristina Alonso in 2005. After originally being involved in a state programme to lower maternal mortality rates in Chiapas (*Maternidad Sin Riesgos*), Cristina decided to set up a non-governmental organisation and *casa de partos* in response to what she felt was a crucial absence of out-of-hospital birth and midwifery training in the commission’s work on improving maternal mortality. Below she explains how previous approaches to improving mortality failed to recognise the importance of *parteras* and midwifery practice in communities:

> [At the time] they were publishing all that stuff about emergency obstetrical care and the basic understanding at that time with maternal mortality was that out-of-hospital birth is attended by people who don't have the competencies to identify obstetrical emergencies. So, if you can set up systems for identification, transport and rapid attendance in hospitals then maternal mortality rates will descend. What was missing in that structural programme was an understanding that midwives actually have better outcomes.

She also saw that there was a need to address the birth choices and reproductive healthcare of women who chose out-of-hospital birth for a number of different reasons, regardless of their socio-economic status or ethnic identity. Since its beginnings, Luna Maya has served women from all sections of society. Within twenty-four hours Cristina and her apprentice can attend poor women with no social

\(^{29}\) Although known locally as the *casa de partos*, Luna Maya has the official title of *Centro de Partos* (Birth Centre) because of the complex legal implications mentioned earlier regarding registration and places where birth can be planned to happen.
support, foreign residents and affluent mestiza couples who are seeking to avoid a caesarean birth or poor clinical practices. Although the parteras at Luna Maya and the additional services they and their associates provide (prenatal group, yoga, parenting skills and alternative medicinal therapies), are predominantly marketed at an educated, higher income population, the parteras profesionales maintain a responsibility to the population at large and adapt their services and charges appropriately and when necessary.

The ethical commitment to universal reproductive health and parteras as a collective with a mixture of approaches has been present in the work of Luna Maya since its early conception. Originally the organisation was set up with two projects running concurrently, the casa de partos based in San Cristóbal and an educational, maternal mortality focused project in nearby town of Tenejapa working with indigenous parteras tradicionales, community health promoters and medics. The work in Tenejapa had an approach that took into account the existing knowledge of the parteras tradicionales and built on this by asking the parteras to identify what they wanted to learn. This approach differed greatly from previous initiatives that were led from a biomedical perspective and often driven towards limiting the practices of the parteras tradicionales to being a trusted referral mechanism to public hospitals. Coming from an out-of-hospital midwifery perspective, and respecting local midwifery and experiential knowledge of the parteras tradicionales, was essential to the success of the project as Cristina explained in one of our recorded conversations:

What we did was we went up there and we started scouting them out, and we had a really good outcome because we were homebirth midwives ourselves. And we would say you know, “I'm a midwife, I'm not here to ask you what you do” … I said we want to build a circle of
midwives so that we can all together improve our competencies. And
they wanted to talk about breech. They wanted to talk about stuff that
all midwives want to talk about, stuff that the medical community
would say things like well, “You just don't do breech” … So with the
midwives we did a five-year training thing where we actually taught
them competences. The first year we had to do the emergency stuff
because we had to keep the funders happy…and it was actually really
interesting because at the first circle of midwives, they said to us that
maternal mortality has to do with violence. Women that die in labour
are women that are isolated from the community: that aren't attended
by midwives, that are attended by their husbands, and they are women
that … if they didn't die of childbirth they would die of violence. They
would die of malnutrition or they'd die of whatever because they are
women that are in horrific violent situations … So it felt like totally
pointless to even do this training because they knew they weren't the
problem and for the last twenty years they've been drilled with
emergency stuff, so what we did was that every year we focused on a
theme …

After a period of three years, just after the global financial crisis of 2007, the work in
Tenejapa came to an end and the Luna Maya became increasingly established in the
local area as an alternative maternal health provider and small scale training centre
for parteras. Although the number of births being attended by Cristina and her
apprentice parteras has gradually increased year upon year, the position of the
partera profesional and out-of-hospital birth provision remain in limbo in terms of
legal and professional recognition. As I mentioned earlier, a casa de partos or
The term \textit{partera profesional} does not currently exist as a legal concept in Chiapas and therefore Luna Maya cannot officially be declared as a place to birth or where births are planned to happen. The \textit{Norma Oficial Mexicana NOM-007-SSA2-1993} (Secretaria de Salud, personal communication) sets out the rules that a planned birth must happen in a hospital delivery room with a delivery bed or table and emergency obstetric and paediatric equipment, as well as in the presence of a registered skilled birth attendant (of which \textit{parteras} of any type are not considered because they are categorised as a traditional practice not a profession). This does not stop local women referring to the organisation’s building as \textit{the casa de partos} though it cannot be named as such on documentation or publicity. Calling the organisation ‘\textit{Luna Maya Centro de Partos}’ allows it to remain within the legal lacuna. When births take place in Luna Maya they are registered as home births.

Luna Maya is registered officially as a \textit{consultorio médico} (medical clinic) that can offer paediatric, family and other women’s health services. In order to obtain this status, they must have a licensed medical practitioner in charge. In the case of the Luna Maya this is Dr. Yolanda paediatrician and family doctor who has worked in partnership with Cristina for many years. In practice the work of the \textit{partera profesional} is recognised by the Ministry of Health and by medical professionals though there remain federal and state legislative contradictions that mean their role is never fully legitimised by the state (and therefore omitted from health policy). There are pockets of professional midwifery initiatives around the country. The newly formed \textit{Asociacion Mexicana de Parteria} (Mexican Midwifery Association or AMP in its Spanish acronym), of which Cristina is a founding member and current President, was beginning to take shape during my fieldwork. The AMP has received
direct funding from the MacArthur Foundation\textsuperscript{30} since 2010, and is a registered non-profit organisation working towards a nationally recognised definition of a \textit{partera profesional}, legal registration and monitoring of practice, certification and education of both traditional and professional parteras (Cristina, personal communication 2014).

Most \textit{parteras profesionales} work independently and have trained in some part alongside midwives from the US, and also often with registered \textit{parteras tradicionales} in Mexico or Central America. Unconnected development projects such as one specific training and education centre and a handful of private schools have been set up in other parts of Mexico, funded by health professionals from the US or Europe.\textsuperscript{31} This has led to fragmented efforts to improve women’s maternity choices whilst never tackling the root problem of state attitudes towards \textit{parteras} as non-experts in reproductive health care.

Luna Maya is the only out-of-hospital project run by a \textit{partera profesional} in Mexico that currently records prenatal, birth and postnatal data through the Midwives Alliance of North America (MANA) database. Cristina is privileged in the sense that she can back up her arguments for \textit{partera} assisted birth with numerical data, but disadvantaged in the fact that no other out-of-hospital skilled birth attendants record information of this detail. Therefore, there is little comparative quantitative evidence

\textsuperscript{30} The MacArthur Foundation is the 10th-largest private philanthropic foundation in the United States. The Foundation provides fellowships and supports non-profit organizations in the US and globally.

\textsuperscript{31} The most documented is the CASA Hospital and Professional Midwifery School in San Miguel de Allende, Guanajuato which has received much scholarly attention from anthropologist Robbie Davis-Floyd (2001b; 2005; 2009). This midwifery school inspired a brief step forward in that it obtained approval from Mexican Secretariat of Public Education (SEP) for the qualification/title of \textit{Partera Técnica} which incorporated students graduating from the school in health policy and legislation. Though the SEP would not recognise the \textit{partera técnica} as a profession in itself, but instead a ‘technical qualification’ and the title only applied to students from CASA, it was never implemented as a national qualification at the time of writing.
available to strengthen her case and work with the AMP. The lack of legal and professional recognition, and therefore regulation, of the *partera profesional* in Mexico has meant that no one has been under obligation to record their practice or birth outcomes.

Though recorded data for the Luna Maya, in Chiapas, only dates back to 2007, it provides a valuable snapshot of private, out-of-hospital reproductive healthcare rarely available elsewhere. Overall the recorded birth outcomes between years 2007-2014 conclude that out of 290 live births attended at the *casa de partos*, and in the home, there were only thirty-five hospital transfers (yearly average of 5.4), resulting in twenty-eight caesarean sections (a yearly average of 4.6) and zero maternal deaths overall (manastats.org 2014). Although in comparison to public and private hospitals (of which no detailed statistics are publicly available), Luna Maya attend only a small percentage of the population, their quantitative data demonstrates the success of their work so far. Their data is significant in a state that remains amongst the top three for maternal mortality rates and overall has the highest birth rates (SINAIS 2009; INEGI 2010), and in a country that nationally has a higher than fifty percent rate of caesarean birth (rising to an estimated seventy percent in the private sector).

Lack of progression as a recognised profession has resulted in years of frustration for *parteras* like Cristina who continue to attend births and make vast improvements in women’s reproductive lives. Whilst not obtaining recognition as a profession they are unable to legitimise both their presence and contribution to improving maternal and infant mortality:

> The problem is that there's no legal hole for us you know. There's no place to place us, as a place that does out-of-hospital birth ... When there has to be a medical intervention we transport to a medical centre. But it
has to do with the same thing that with no professional midwifery, then
where do you put birth centres? ... And we have done [work] at a federal
level with a group of midwives. We've done a couple of processes
where we worked on a competencies document for educating midwives
at a federal level. But I never see that any of these *initiativas* make it
past the offices where we work on them. I've had people saying, "Yeah
we need to regulate birth centres". "Yeah I totally agree we need to
regulate midwives etcetera", but nobody wants to do it.

**Why do women hire a partera profesional?**

The women who pay for and access a mixture of services aside from prenatal care
and birth attention are predominantly educated mestiza women from middle-income
families who independently access various sources of information in regards to
childbirth. At an average age of twenty-seven (according to the MANASTATS
archive) the clientele of Luna Maya are looking for an alternative to hospital birth
with an obstetrician. They are very aware of the high rates of caesarean sections in
public and private hospitals (as with the barrio women) and are generally open to
alternative ways to thinking about birth. They make a clear distinction between the
indigenous *parteras tradicionales* or the *parteras empíricas*, and the *parteras
profesionales* who have been trained outside Mexico and who are seen as
cosmopolitan or ‘thoroughly modern’ (as described by Davis-Floyd 2001b).
Influenced by national and international celebrity endorsement, and sporadic online
media attention the status of the *partera profesional* is gaining recognition amongst
the professional and upper classes (Velasco 2013). These social groups are clearly
separating the *partera profesional* from the image of the *partera tradicional* or
empírica who is still deemed in the national popular imagination as old fashioned, dangerous and backwards. The demand for out-of-hospital birth amongst middle-income mestiza families has increased significantly over the last five years with a second casa de partos (independent of Luna Maya) opening up in San Cristóbal, and an increase in the number of births being attended by Cristina and her apprentices in the nearby capital of Tuxtla Gutiérrez. The image of the partera profesional as cosmopolitan and ‘first world’ serves couples who face a great deal of resistance or pressure from close family who believe that a clinically managed birth in a hospital is the only safe option.

The approach of the partera profesional mostly resembles the humanistic model of birth, defined by Davis-Floyd as a counterbalance to ‘technomedicine with a softer approach’ (2001:15). In this respect the partera profesional does not reject the use of technology but aims to ‘humanize technomedicine – make it relational, partnership oriented, individually responsive, and compassionate’ (Davis-Floyd et al 2009:442). Like the women who seek their services, the partera profesional incorporates competing cultural metaphors of risk connected to birth, in order to promote change in the perceptions and practices of others. In their discussion of cross-cultural birth models, Davis-Floyd et al argue that the meaning within the humanistic model is particularly significant in the Latin American context. In Mexico and in the wider Latin American Region the term parto humanizado (humanized birth) is commonly found in policy rhetoric as much as in the various birth activist movements. When I spoke to women at Luna Maya about why they sought out alternatives to clinical management they would often reply “porque merezco un parto humanizado” (directly translated as – “because I deserve a humanized birth”). By saying this they meant, in a similar way to how Lupita spoke of wanting the “human touch” as her
reason for going to a partera empírica, that they wanted to be feel cared for. The strategic use of the term parto humanizado to focus efforts on reform in public health is very relevant in a culture where the clinical management of birth is overtly dehumanized.

Figure 15. Akane the apprentice partera explains the workings of the placenta during the preparation for birth class

The women who attend the prenatal preparación por parto (preparation for birth) class often discussed how to communicate with family members in order to reassure them about the safety of out-of-hospital birth attended by a professional partera. Partners were encouraged to attend the classes, though they rarely came for the duration of the course. Expectant fathers appeared to be more comfortable attending private sessions or intensive day courses that were offered to couples. Men were also often working or looking after older children whilst the classes took place in the evenings. The classes comprised a ten-week course covering a diverse range of topics such as nutrition and health, fears and intentions, stages of labour, postpartum care, peer women’s circle and sharing experiences with other couples. The peer education approach and inclusive environment of the class provided a space for
women and their partners to deal with societal attitudes towards out-of-hospital birth and the conflicting advice they often received from medical professionals.

Already immersed in the private health economy or with employment health insurance, many women at the class continued to see obstetricians throughout their pregnancies. They initially saw the two approaches as complementary, hoping to manage the transition to parenthood and a birth with the partera, whilst receiving a clinical model of prenatal care from an obstetrician. At the initial stages of pregnancy, the couples using this mixed economy of care were often undecided as to whether to plan for a hospital or out-of-hospital birth. When I spoke to couples, they said they felt encouraged to talk openly in the classes and had confidence in the midwifery model of care, processes of natural birth and learnt from listening to the experiences of multigravidas. At the same time, they received much contrary information from obstetricians and family members. Gradually, as pregnancies developed into the second and third trimester couples wanting an out-of-hospital birth supported by the partera often felt pressured by conflicting opinions of professionals.

The root of the conflict between the midwifery and obstetric approaches to maternity often lay in perceptions of risk and how this should be managed. Couples at Luna Maya reported being put under pressure from obstetricians about the perceived disproportionate risks of out-of-hospital birth. Reasons given to couples by obstetricians for justifying out-of-hospital birth as high-risk (and therefore very dangerous) included: the size of foetus compared to perceived size of cervix; risk of haemorrhage; first-time mothers not being prepared to endure labour; high or low blood pressure; needing to be induced if reaching full term; gestational diabetes; twin births; breech or occiput posterior positioning; vaginal births after previous
caesarean (VBAC) and overall the supposed inferiority of *parteras* to deal with any
kind of emergency. By framing out-of-hospital birth and *parteras* as high-risk, the
language that obstetricians used with couples was strongly focused upon
proportioning blame for the certainty of a negative outcome. Risk in this clinical
custom context therefore, is about proportioning blame and creating certainty from
uncertainties. When this pressure mounted, couples still hoping for out-of-hospital
birth stopped attending appointments with the obstetrician and decided to place their
faith in the *partera profesional* in preparation for the birth.

A significant and growing aspect of the services provided by the professional partera
is support for women who want a vaginal birth after a previous caesarean (VBAC).
Public hospitals will not generally support women with VBACs and generally
recommend that if women want more children then second or third caesareans must
be performed. VBACs are not medically more dangerous than previous vaginal
births, unless the original surgery was significantly badly performed and internal
scarring has not healed correctly. Complications can also be caused by low vertical
external incisions still practised in some public hospitals which is overall more
complicated to heal. Systematic reviews carried out in a global context, have shown
that risk of internal scar rupture in VBAC is low in comparison to the other physical
and emotional risks to mother with a repeat caesarean section (see Dodd et al 2013;
Tahseen & Griffiths 2010 for recent international studies). The literature argues that
level of risk is deemed the same for VBAC after two previous caesareans (VBAC2)
and only increasingly slightly for VBAC after three caesarean (though studies for the
latter are limited).

Cristina explained to me that preparation is needed for a successful VBAC in
physical terms because the muscle tissue at the front of uterus may be weaker due to
surgery, which can result in a longer labour, and also in psychological terms that the woman may have to overcome fear of failure. Both these physical and psychological factors will be dependent on the woman’s previous treatment and quality of prenatal care. Heightened public awareness of the dangers associated with repeat and unnecessary caesarean sections has led to more women seeking out the partera profesional for VBAC support. In Luna Maya VBACs are successful because of the individual support and education the women receive from the parteras, combined with a determination not to suffer further surgery or psychological trauma. Cristina’s recordings in the MANASTATs archive since 2007 demonstrate a ninety-eight to one hundred percent success rate for VBAC and VBAC2 and 3, which in turn is having a significant impact on the postpartum and continuing health (physical and psychological) of her clients. An essential element for a successful VBAC is adequate support and trust in the care provider. Women at the prenatal class spoke about the distress of being promised support with a normal birth or VBAC at private hospitals only for it to end in caesarean section. Women spoke of blaming themselves for not being able to achieve a normal birth and that this was often also insinuated by medical professionals who treated them.

Power, Agency and Political Practice

Throughout this chapter it has become evident how competing cultural metaphors of risk and care within global health and development discourse, local policy and actual midwifery practices open up spaces for contestation. By making use of the competing professional and social discourses women are able to negotiate what it means to be a good mother. By analysing the more discrete actions and decision making of women (and parteras), within the systems that constrain them, an alternative approach to analysing agency and social change can be identified.
Professional midwifery is constituted by the ‘praxis, the discourse, and the political engagement’ of parteras ‘who are educated, articulate, organized, political, and highly conscious of both their cultural uniqueness and their global importance’ (Davis-Floyd & Davis 1997:320). The parteras profesionales in Chiapas are marketing their services across the different social strata in Chiapas and they work hard to challenge the negative stereotypes constructed by decades of obstetrical dominance in global health policy. In San Cristóbal the casa de partos are providing a space for women and their families to explore alternative approaches to childbearing and other aspects of reproductive health. Their use of the universal midwifery model of care that incorporates prenatal, birth and postnatal stages as connected lifecycle events, provides the opportunity for women to decrease the need for mixed economies of care. As such, women are avoiding the problems and stress caused by conflicting views of the midwifery model of care and biomedical obstetric approaches, and receiving a better continuity of care overall. Once a woman and her family have had a positive experience with a partera profesional they are more likely to return for subsequent pregnancies and also recommend the service to close friends and relatives. This has been the case with Luna Maya whose business has grown significantly by word of mouth in much the same way empirica or traditional parteras have practiced in the area for centuries.

The parteras are reliant on good outcomes because unlike hospitals, just one maternal or infant death will be highlighted publicly as a sign of failure and damage their reputation as trusted practitioners. As Cristina explained to me pragmatically one day: ‘we get paid a lot less money to spend a lot more hours with people who innately don't trust us, in a society that thinks that we're crazy and that what we do is dangerous and threatening to the mother and the baby’. Maternal or infant death in
hospital on the other hand can be explained away within a clinical discourse that very rarely places blame at the foot of the medical professional but rather at the ill-functioning body of the pregnant woman and high risks associated with childbirth. The increasing use of the two casa de partos currently providing services in San Cristóbal, and growing national membership of the AMP, is evidence that women who previously would only have had clinical management options for pregnancy and birth are actively looking for alternatives. This in turn provides a further platform for question and analysis as to why women are looking for alternatives that call for a return to midwifery traditions within a professionally recognised framework. In short it recognises women’s agency within reproductive health care and the body politic in its broadest sense.

Political practice in terms of the partera empírica manifests in the opportunities she provides for working class and poor women to avoid the conditions of welfare programmes and public health that go against their needs and desires – namely that of out-of-hospital birth. For the women and their families in la Garita the partera empírica is also key to the broader life cycle beliefs connecting the pregnancy, birth and the postpartum period that are devalued by the local clinical system. Women in the barrio are not consciously resisting medical dominance of their reproductive health - rather they are acknowledging a time and a place for a mixture of healthcare that suits their individual needs. This incorporates a complex moral economy based upon the professional and social status of the person providing the service required. These factors are reflected in the growing importance of prenatal care within the public and private healthcare system and women’s use of it. The increase in popularity of attending control prenatal is a combination of the long-term impact of
global health and development rhetoric, and a tactical manipulation of the system in order to secure emergency treatment if needed and registration of new births.

It would be over simplistic to argue that women are coerced into prenatal care by a combination of state power and medicalised health discourse as this would also deny them as having any agency in the process. However, the exercise of agency for these women should not be construed as a matter of wholly voluntary choices. As Jolly (1998) identifies in the histories of maternities and modernities in Asia and the Pacific, choices are saturated, not just by the power of gender difference, but also by class and ethnicity. Unnithan-Kumar (2001) also found, in the context of northern India, the importance of certain kin above others influence women’s desires and actions with regard to health and other reproductive matters. This observation is equally apparent for the women in San Cristóbal. Global health ideologies are represented in popular media and brought straight into people’s homes via telenovelas, radio talk shows, mass public information campaigns and increasingly by online social media. Everyday access to reproductive technologies such as ultrasound images, portable ultrasonic listening devices (dopplers) and high street laboratories, all bring focus to the prenatal period and preparation for motherhood.

Growing acceptance of prenatal care establishes where these women see clinical and technocratic models fitting in with local ethno-obstetric models of childbearing. Their choices to use a mixed economy of care also shows that women separate the processes of pregnancy and birth, pregnancy becoming interchangeable between natural process and physical change needing monitoring, and actual birth understood as a low risk event that should take place in the family environment. The risk that women take in accessing clinical management of prenatal care is the exposure to authoritative medical knowledge that may attempt to interfere with their desire to
birth at home. The marginality that keeps the practice of the \textit{partera empíricas} alive in the barrios also keeps them isolated from the transnational politics of midwifery and valuable inclusion in maternal health strategies. Ultimately they are reliant on the families they serve to stay in practice and remain a central part in maternal lives of barrio women. Their relative invisibility provides a space for women to resist clinical management and regulation of their bodies, but it also renders the \textit{partera empírica}'s role vulnerable to disappearance.

**The Social Construction of Natural Childbearing**

I would like to conclude by touching upon how the material in this chapter can inform our understanding of the social construction of natural childbearing. Women in la Garita who hire \textit{parteras} for all or part if their maternal healthcare speak of the desire for a 'normal' birth; by which they mean to give birth vaginally. Women who give birth in hospital with obstetricians also generally have the intention and desire to do the same. Just about every conversation involving a newborn on public transport or in the street begins with the question: “¿\textit{fue normal o cesarea}?” (Was it normal or caesarean birth?). The difference is made between how the baby came out of its mother rather than whether or not the method was natural per se. There is no agreed global definition of what ‘natural childbearing’ entails, as it is no less a culturally constructed notion than the idea of ‘non-natural childbearing’. If natural childbearing involves working with the body, then how one conceives of the body will determine its scope (Cosans 2004). The most useful biosocial definition in the literature on this topic is provided by Cosans who suggests the use of ‘naturalistic practices’ rather than the problematic term ‘natural’ (2004). By this she means placing emphasis on working \textit{with} the biological body as opposed to against it. Cosan’s definition is useful for thinking about natural childbearing in the context of
San Cristóbal because for most women, use of epidural or other form of pain relief, episiotomy or forceps delivery do not take away from whether or not a woman had a natural birth. This raises the important ethnographic questions surrounding what women and parteras understand natural childbearing to mean.

The use of terminology such as normal and natural in relation to birth all contribute to the cultural construction of childbearing as a biologically determined and natural event. Emphasis is made on the power of women’s bodies and their unique ability to manage the natural process of reproduction as a way to counteract the pathological and highly technocratic models of birth that dominate the public health system. Where nature is understood as unpredictable, dangerous and in need of controlling in the clinical management of maternity; in the midwifery models of care it is seen as something that should be embraced, a positive power that women should become reacquainted with. However, the idiom of nature sets limits which, from either perspective, result in reproducing the notion of women as natural caregivers whose bodies are made for childbearing and childrearing. Although it is meant in a way to empower women, the approach taken in contemporary midwifery practice draws upon ‘traditional’ ideologies and the fetishization of motherhood that is characteristic of the gender stereotypes historically utilised by the Mexican state. In reference to how social and economic change manifests in ‘folk diagnosis’ of psychological conditions in children, Gutmann argues how ‘biologically-worded rationales explained with reference to the “ancient ways” justifies the acceptance of natural realities of gendered modernities’ (2001:158). In a similar way, the increasing demand for the services of the partera profesional and out-of-hospital birth is more to do with the social and gendered consequences of Modernity than it is about a yearning to return to nature’s way. When women in la Garita hire the services of
Filomena, or when the educated, professionals seek out Cristina and the classes at Luna Maya, they do so in part due to a perceived risk of maltreatment or trauma in a hospital – something that they are conscious about through personal or shared experience.

The type of practices that constitute professional and empirical midwifery reveal that women require support and guidance of some kind in order to give birth safely and without trauma to themselves or their baby. Women’s willingness to seek prenatal care, attend preparation for birth classes, be surrounded by female kin and seek guidance from others means that they want to learn the how of becoming a good or competent mother. In this way, what they describe to be a natural and instinctive process is also understood as something that needs to be learnt. Giving birth at home, with the support and expertise of a partera, is one way that women in la Garita and the clients of Luna Maya have some control over how they are supported through the transition to motherhood.

Analysis of natural childbearing as an ethnographic category reveals its place as a process – or step along the way – as part of a wider life cycle. The comparative approaches to midwifery discussed in this chapter can be seen as reconceiving rather than retrieving, the natural facts of birth (Macdonald 2006:240). The understanding of a continuum of, ‘naturalised’ yet supported care highlights how partera practices interlink with the postpartum period as the ‘next essential step’ towards motherhood. The role of the partera can be more clearly recognised as providing an essential link in the continuum of care which is equally as important to local women as it is to universal models of midwifery (as will become evident in the Chapter 4). Both the partera empírica and the partera profesional embody the life cycle approach to
transition, and like the women they attend, the *parteras* in San Cristóbal negotiate the competing discourses of risk between culture and institution.
CHAPTER 4

La Cuarentena: Mothering the Mother

‘Jamás veas un bebe tan chiquitito en las calles por acá’
‘You never see a baby that tiny out on the street around here’
(Carolina after seeing me out walking with my newborn Fieldnotes June 2013)

The first time I had encountered the postpartum cuarentena (translated literally as ‘quarantine’) or more locally called la cuarenta días (the forty days) in San Cristóbal was in 2008 shortly after my first child had been born. Although I was very used to seeing babies, toddlers and children in every kind of public space in San Cristóbal, it wasn’t until this point I noticed that I could not recall having ever seen any babies outside of the house who were less than around two months old. A neighbour’s daughter Sandra had recently come to stay in her natal home after giving birth in a local clinic. Whilst I had been alone at home dealing with the first emotional and practical throes of being a first time mother, Sandra was convalescing surrounded by the comfort of hot food, warm blankets and female relatives. I can still clearly remember the first time I was invited over to visit, the impact of going into a warm, darkened room at the back of the house has stayed with me ever since. The windows were covered over with bed sheets. The only light was a lamp giving off a warm glow from the corner of the room where under a mountain of fleecy blankets, on a large wooden bed lay Sandra feeding a barely visible baby shape wrapped up under yet more fleece blankets. Sandra and her baby would not leave that cocooned environment for around a month. At the time I thought it reminiscent of a womb, a serene warm space that protected the senses from the harshness of daylight and realities of the world outside. I remember the smell of warm atole (maize
drink) and sweet bread wafting in from the kitchen mixed together with the scent of baby talc and *jabon zote* (laundry soap bar), the muffled sound of the telenovela in the adjacent sitting room, and all throughout the visit fighting back an overwhelming desire to crawl under those blankets with my own baby and have the women take care of me for a few days.

Being new to motherhood, I had no knowledge of the type of forty-day postpartum quarantine that many mestiza Catholic families abide by in San Cristóbal, nor what the physical and emotional implications were for both mother and baby, but my visit to Sandra did raise specific questions that still help me think about this practice today: What is happening here? Who are the experts in this space? Is the new mother still a novice during this period, whilst all but feeding is taken care of by older female relatives? And how does this forty-day period begin to shape the type of mother she will become? What type of bodily transformations are taking place? Where was her husband? Where were the men? How is the marital relationship affected by the temporary return to the maternal home? How does the need for a forty-day bed rest conflict with work duties, other children and how does this work for lone mothers?

The *cuarenta días* is certainly not unique to San Cristóbal, it is practiced throughout the country and versions of it are prevalent in both indigenous and predominantly Catholic mestiza families of low to middle socio-economic status. Variations of forty-day quarantine practices appear historically across cultures from medieval England (Kitzinger 1997) to modern day China, Jordan, Lebanon, Egypt, and Palestine (Kim-Godwin 2003). It is a tradition in Maya communities that women convalesce for twenty days or less and it has been suggested that extension of the rest period to forty days probably derives from Spanish colonial influence (Jordan
1993; Katz 1996). The literature on the Mexican postpartum quarantine (anthropological and non-anthropological) is sparse and mainly restricted to reports on immigrant practices in the US (Martinez-Schallmoser et al 2005; Niska 1999; Waugh 2011) or indigenous postpartum practices in the Highlands of Chiapas or Mixtec Highlands of Oaxaca (Katz 1996; Groark 1997; Jordan 1993; Resau 2002). Nevertheless, to date, specific attention has not been awarded to postpartum practices in mestiza homes in urban Mexico, its meaning in the broader construction of maternal identity and practices, and furthermore how this may have been impacted upon by Modernity and social economic change over recent decades. As such there remains a disparity of analysis in motherhood studies in Mexico (and elsewhere) that identifies conception, pregnancy, birth and nurturing practices as an interconnected process within a broader socio-political and economic context.

By paying particular attention to the way the cuarenta dias occurs in la Garita, this chapter centres on the postpartum narratives of my friend Lupita and my neighbour’s daughter Carlita. Both primerizas (first time mothers) in very different situations, their confinements were typical of new mothers in the barrio and demonstrate at times the struggle for recognition as a ‘mother’ together with the need to be mothered as they transition into this new life phase. Though there is a significant age difference between them (around fourteen years) both Lupita and Carlita are members of a generation that straddles the divide between barrio and family tradition, and contemporary motherhood influenced by social media, television, films, the ‘borderless, fast-pace dissemination of commodities and styles’ (Freeman 2001:1010), and rapid advancement in reproductive health technologies. Their narratives reveal how the cuarentena dias is located and embodied within a wider
entanglement of competing cultural metaphors and ways of measuring risk - akin to the management of birth discussed in Chapters Two and Three. For the purpose of this chapter I define postpartum culture in the sense of a ‘moral community in which members share a similar perspective about what constitutes moral outcome’ (Rouse 2004:517) and who share a common cosmology and language. I limit this moral community to the mestiza families in la Garita, where particular discourses and dispositions are shared amongst neighbouring families and framed by predominantly local ideas about what constitutes a good mother. For the purpose of my discussion in this chapter I limit the postpartum period to Romano et al’s (2010) first two phases: the acute period, the first six to twelve hours after birth and the subacute period lasting two to six weeks. Using Romano et al’s phases promotes analysis of the cuarenta días within a comparative obstetric framework which recognises the bodily transition and healing that takes place within a specific timeframe. The acute and subacute phases are equivalent to the local concept of the cuarenta días. It is during the cuarenta días confinement that new mothers have the opportunity to heal, establish feeding and milk supply, and also when they are most likely to remain in contact with medical professionals in regards to either maternal or infant health.

Carlita

I knew that Carlita was coming very close to her due date when I bumped into her walking with her mother (Doña Carla) one early evening in July. The afternoon rains had begun to ease off and the cool breeze coming down from the mountains made it perfect conditions for walking. I recognised the wide gait of a woman reaching the end of her pregnancy, the slow, heavy and methodical steps up and down the uneven concrete pavement as she held onto Doña Carla’s arm. Her large panza had now dropped to her hips and was protruding out between her sweat pants and knitted
poncho, one hand placed under the bump as though gravity itself wasn’t enough to hold it up. Everything about her movement said heaviness. I stopped to say hello:

Doña Carla: We’re on our way to the temple steps.

J: Is it time to give baby a nudge?

Doña Carla: (smiling) Something like that!

There are many different ways to help bring labour on with full-term women and it is common to try everything in order to avoid a visit to the clinic, particularly when women plan to birth at home. Although this intention is not declared openly, the activity surrounding the pregnant women as she nears her due dates such as walking, extra visits from the partera for massages, baths and herbal teas suggest an attempt to help things along without medical intervention. Walking up and down steep steps is the least intrusive method and one that does not require calling the partera out unnecessarily, thus avoiding a small charge. It was a common sight to see accompanied, heavily pregnant women quietly huffing and puffing their way up and down the steep temple steps in the early evenings. When reaching the top it is also common to attend mass or say a prayer for a safe passage into the outer world for both mother and baby.

It is generally the senior female in the household who decides what action to take (mother, grandmother or mother-in-law) in these circumstances. In households like those of my neighbours in la Garita where partera assisted home births are expected, it is more likely that these practices will occur and a visit to a maternity clinic will be the last resort. It is also in these circumstances where there is evidence of the absence of men in the decision making. The way that male family members are consulted (or not) is similar to the strategy used with health professionals, a method of
hoodwinking in order to maintain the peace and a façade of compliance with medical opinion. In the week or so leading up to Carlita’s due dates I noticed a conflict between the plans for birth depending upon who I spoke to. The women of the household and immediate neighbours were calm about the progress of the pregnancy, making the necessary preparations for when the partera would be needed. As the family partera Filomena, in this instance was also Carlita’s suegra (mother-in-law) she benefitted from extra visits almost daily towards the end of her pregnancy and there was no suggestion that the outcome would be anything other than a home birth. When I spoke to the Don Marco (Carlita’s father) he told me there was a caesarean section programmed for the following week upon the advice of the obstetrician they had been seeing for check-ups and ultra-sounds. Whenever I bumped into Don Marco in the street or when he gave me a lift on the school run he appeared unaware of the women’s intentions to make sure the clinic’s deadline was never met.

I visited Carlita around one week after her baby had been born. The baby girl Alison had been born at home attended by Filomena, Doña Carla, Doña Reina. There had been no complications and the labour had been relatively quick for a primagravida, around twelve hours in total. Carlita’s boyfriend Raul visited briefly each day though was not permitted to stay for a long period – “mejor que se duerman en paz” (it’s better they’re left to sleep in peace) was Doña Reina’s response when I asked why his visits were so brief. Carlita and baby Alison had left the house just once since the birth in order to go to the maternity hospital to register the birth and obtain vaccinations. As Filomena is not a registered birth attendant they must register the birth as a spontaneous home birth and obtain a signature from a doctor at the maternity clinic to legitimate the birth of the Alison. Without this signature the family cannot obtain the birth certificate or social security number and Alison will
not exist in the system. The exchange involves having the newborn physical exam and first round of vaccinations before they are allowed to leave the clinic with the paperwork.

At sixteen years old Carlita was still very much a girl in the eyes of her family and particular care was being taken to ease her into the role of mother. Carlita had originally planned to move back in with her suegra after her cuarenta días which is common practice with young couples. She had been living there since she found out she was pregnant, but moved back home when she was nearer to her due dates.

“She’s always on her own because of her suegra’s midwifery duties,” Doña Carla told me “She needs to be here where we can look after her.” During her final weeks Raul visited on a daily basis but he was not permitted to stay overnight. On the morning that I visited Carlita she was being attended to by her maternal grandmother, mother and sister-in-law Dulce. A room had been set aside for her cuarenta días that was normally the marital bedroom of Carlita’s brother Marco Jr, Dulce and their two-year old son. The room had been cleared apart from a double bed and child’s single bed on opposite sides of the square room, a large, dark wooden wardrobe with a television positioned on top stood opposite the double bed and neat piles of baby clothes in white, pink and yellow placed on a small dressing table. Next to the clothes were packets of baby wipes, sweet smelling creams and nappies. A curtain made from bed sheets hung across the width of the room as a barrier between the door, ensuring that any cold air or light from outside would be kept out of the room and away from mother and baby. There were no other windows in the room and the only light was provided by a bare light bulb hanging from the ceiling and the warm, orangey glare from the daytime show Hoy! which beamed out from the television on the top of the wardrobe. Underneath a pile of woollen blankets
lay Carlita feeding baby Alison under a further mound of soft, fleecy covers. I could just about see the top of Carlita’s head as she smiled and nodded to say hello. A large rebozo (woollen shawl also used for wrapping and carrying babies) was wrapped around mother and baby whilst Carlita breastfed, ensuring that the blanketed bodies became fused together as though despite their recent separation mother and child remained attached. She stayed quiet whilst her mother directed the conversation. Carlita’s maternal grandmother was perched on the single bed opposite and I was also offered a seat at her side. Dulce was sent out of the room and reappeared five minutes after with a sweet, milky coffee and rounds of dry toast for me to dip into it. I balanced them precariously on a small stool as I took my newborn out of her rebozo and began to feed her:

Doña Carla: You see (to her mother) they don’t care for them the way we do. (Turning to me) doesn’t she get cold, doesn’t she get hit by the aire frio [cold air]? I see you take her outside all the time.

Jenna: No she has warm blood

Doña Carla: How old is she now?

Jenna: Nearly two months, more than forty days

Doña Carla: She’s out of danger then but still, you should protect her from the aire frio. You should cover her more.

Dulce: Do you cover her when you go out? If they give her the ojo32 too much her eyes will turn brown, it can take the blue away and she’ll have brown eyes like us. It happened to my cousin’s baby. He was born with clear eyes but they took him outside too soon and they gave him so much ojo

32 Evil eye
cooing at him that they turned brown! You must be careful even now she’s past forty days. You wouldn’t want to lose those eyes.

Doña Carla: Look at her boobs, not like our little ones you could feed all the babies around here with those! Do you have lots of milk? Look mamá they feed their babies as well.

Her mother turned to me, nodded and smiled.

Jenna: Yes I’m lucky I’ve always had a lot. [To Carlita] Has your milk dropped yet?

Carlita: Yes, I think so, she’s feeding quite a lot so I suppose so.

Doña Carla: Yes, it’s coming. The partera gives her fennel tea and she also drinks oat milk that helps it to drop. What do you use for your milk?

Jenna: Dark beer

Doña Carla: (eyes wide) Doesn’t that damage the baby?

Jenna: Well I don’t drink it every day, just one or two to help get things going. It’s what women do where I come from.

After a short while Doña Carla and her mother left the room to attend to other duties and the tone of the conversation changed. Carlita and Dulce were very intrigued about the idea of drinking beer to help the milk supply – “though we just couldn’t” Dulce said “we should only drink oat milk”. Before I left I asked Carlita about the birth and how she was feeling in her body:

Carlita: It was okay, it hurt but I can’t remember too much

Jenna: Do you have any stitches?
Carlita: No, I just feel sore but also I have my faja, are you still wearing yours?

Carlita lifted up her jumper to show me a shop bought girdle, looking at her tightly bound torso made me suddenly very aware of my own soft, fleshy midriff still recovering from its third gestational stretch, I felt open and loose. I started to regret all the neighbours’ offers to fajarme (bind) after the birth and wondered if it was too late.

Jenna: I didn’t use one, is it comfortable?

Carlita: It’s okay I’ll wear it for a month. How are you so slim? Where did your panza go? What about your womb it can fall?

Jenna: I don’t know I feel alright, maybe I’ll try one next time

Carlita’s cuarenta días was interrupted by the sudden illness and hospitalisation of baby Alison. The baby’s illness went undiagnosed for almost a week and there was a second, shorter admission to hospital, after which came various non-specific explanations from emergency doctors and paediatricians. I went to visit them two weeks after the emergency and found Carlita and Alison back in their womb-like sanctum, wrapped together underneath blankets with the curtain still partitioning the room to stop any aire frio from entering. Doña Carla explained that Alison had caught a stomach infection that had then moved to her brain. She had started with a fever and then was coughing up blood when they decided to take her to a private clinic. The first doctors to assess her had blamed the infection on the baby not having received all her vaccines at birth. When I asked her which one they meant she replied that the doctor has said “There should have been one in the leg and you missed it”.

202
The doctor was placing blame on the female family members for not having provided the correct medical attention after the birth. This explanation was later contradicted on a follow up visit to the clinic after Alison and Carlita had returned home. A second paediatrician had suggested that the infection had been passed through Carlita’s milk as she had a history of colitis. In this case blame was proportioned further to the baby’s mother with the suggestion that her milk was contaminated. In each case medication was prescribed without any official diagnosis as to the problem. The paediatrician suggested to the Don Marco (Carlita’s father) that they put Alison on formula and stop breastfeeding. Doña Carla sought advice from Filomena and then made a decision to continue with the medications for the stomach infection diagnosed by the clinic. Though Filomena did not question the prescribed medication, she advised that Carlita should continue breastfeeding with the addition of fennel tea given to both baby and mother to help settle the stomach.

Carlita and Alison completed their cuarenta días without further complications and Carlita continued to breastfeed without having to substitute with formula. This is not the first instance I have been told about mother’s milk or the mother’s body itself making a baby ill. Such explanations generally come from the women themselves based upon family knowledge or interpretations of medical advice. Local postpartum advice often included how a woman should wash her breasts before feeding her baby as dirt on the mother’s body could cause stomach infections. On occasions when babies were taken ill with stomach upsets older women in particular would comment

---

33 The reference to *colitis* is understood as an ethno-diagnosis given by medics to many women I spoke to though not necessarily referring to the strict medical definition of inflamed colon or diarrhoea. Over the last five years or so it seems to have replaced a disproportionate diagnosis of *gastritis*. I also noticed during fieldwork in 2013 changes in television and radio adverts that were once dominated with over the counter cures for *gastritis* had now moved on to cures for *colitis* though they listed the same symptoms and dietary causes for both illnesses. In either case there is no medical evidence to suggest that breast milk can become “contaminated” by the mother’s stomach complaint.
on how the mother mustn’t have sterilised her breasts properly. The practice of washing breasts resembles very closely the public health advice given to women around bottle feeding and home hygiene. This message is validated often by doctors and nurses in the prenatal platicas at public clinics and reinforces the moral notion of the mother’s body as a source of contamination for the baby. Women also often spoke of personality traits in mothers and emotional outbursts that could cause a mother’s milk to go bad (mala leche) making the baby ill or interrupting milk flow and feeding. The sources of such understanding were various: from personal experience, public health messages, often dramatized in telenovelas, local ethno-methodologies and religious beliefs about purity and women’s bodies.

Lupita

Like many young couples in the barrio Lupita and Diego’s families knew each other very well and were closely linked through social roles and community. They both came from fairly middle-income Catholic families, though they were relatively well schooled compared to other families in the barrio. The three eldest children in Lupita’s family had all studied at the university in nearby capital Tuxtla Gutierrez, this is quite rare in the barrio and so it resulted in the family obtaining a respected status higher than most. Lupita’s parents ran a busy general store on the high street and were very knowledgeable about most goings on in the barrio. Although resident in the barrio at weekends Lupita worked in Tuxtla and spent the week there, travelling home on Fridays. Lupita had always worked in Tuxtla since studying at university there. The couple had a large loan they were paying off for their house and the secure job she had as a State government administrator in the capital was vital in order to keep up with the payments. Wages differ as much as by fifty percent between Tuxtla and San Cristóbal, and job security is rare in either city.
Her workload had not lightened during the pregnancy and she often worked from seven in the morning to ten at night Monday to Friday, and sometimes weekends prohibiting her from getting home. Most free weekends were spent fixing up the new marital home, a small breeze block house on a plot close by to parents and in-laws in the lower part of la Garita. Diego worked during the week in a paint shop and had a second job at weekends. The couple had been accustomed to making the most of any time they had together, though Lupita admitted this did place a strain on the relationship. They also began to argue a lot because Diego spent his wages going out drinking with friends whilst Lupita put all her spare cash back into the house. During their arguments he often told her “You are away what am I supposed to do stay at home alone crying and waiting for you?” The couple had married against their parents’ wishes and Lupita’s mother also expressed concern over the pregnancy arguing that the couple were not ready for the responsibility of a child. Lupita, the second of four children had fought with her mother for independence and often stated that she was over protective and controlling. When I first recorded an interview with her when she was eight months pregnant, she spoke at length about her joy of becoming a mother:

I’ve cried a lot because I’ve been alone [in Tuxtla), so it’s very difficult, for example the first time I felt the baby move it was beautiful, but I was alone ... Now I worry about eating well. If I get stretch marks or not that’s okay; it’s nothing serious, they go away and if not so what ... Maybe it’s a crazy idea I have but I feel like the baby is looking after me from the inside, or I don’t know, as if he came to cure me of everything, all the anguish I had. Because of the colitis, I was nervous. I was hysterical all the time. Now I’m calm. Because I am pregnant and I have him inside
I’m very calm and I’ve always said that this baby came to make me better from the inside out ... [the pregnancy] has been wonderful, very beautiful ... I told you how this baby came to help me prepare for many things. For example, sometimes I wake up in the night, but it’s okay I still get up for work and I do everything I need to. I just go to bed earlier these days, I think I’m going to be run off my feet, but anyway I’ll get on with it alone ... the love for your child, everything you have to do, for him to be okay and you also, I have to make sure I’m okay so that I can be there for him.

Lupita wanted to birth in her maternal home to be close, to family. She originally planned to give birth at her aunt’s house using a local partera known to her mother and godmother, and to be supported by her senior female relatives. Although her mother and godmother knew the partera, Lupita didn’t meet her beforehand and received no prenatal attention from this partera in particular. The day that Lupita went into labour her godmother was out celebrating her barrio’s patron Saint day and was not in a state to track down the partera to attend the birth. Her private gyno-obstetrician, who she had seen for prenatal check-ups and who was sympathetic to vaginal birth, would have attended her in the local public clinic but she had recently moved cities. Having arranged a new obstetrician just three days earlier she took the decision to go to a private clinic so that her mother could accompany her during the birth. “I couldn’t bear going to the regional” she later explained “I felt really vulnerable and I needed to have someone with me. I knew if I turned up to the regional I would have been alone because they don’t let anyone in with you.” The eventual outcome at the private clinic was emergency caesarean section after six hours of labour at a cost of thirty thousand pesos plus extra treatment for the baby. Three days after the birth Lupita was taken to her aunt’s house in order to begin her
cuarenta días. Faced with a large medical bill to pay Diego took on some overtime at work. He visited Lupita most evenings before either returning home alone or staying at his mother’s house. Due to her employment, Lupita was entitled to twelve weeks’ maternity leave which enabled her to complete her cuarenta días in San Cristóbal.

Lupita allowed me to record her postpartum narrative in 2013, almost two years after the birth of her son Mateo. Her life had changed significantly since our first recorded interview. Around one year after Mateo was born, Lupita and Diego separated. Problems, in part caused by balancing her job in Tuxtla and married life in San Cristóbal and Diego’s reluctance to curb his drinking and partying had led to him to eventually return home to his mother. Lupita continued to manage her job and single motherhood in Tuxtla during the week, returning at weekends to the couple’s house in la Garita. She hired a muchacha to help with childcare, domestic work and ultimately companionship and was going through an on and off battle with solicitors to obtain regular child maintenance from Diego. During the recording she reflected on how the postpartum period could have affected her marriage:

So as I said [after the clinic] I went to my aunt’s house. It was uncomfortable very uncomfortable. If I have any more children I'm going to go back alone to my own house! I would wash the [section] wound. When I bathed I would wash it and my aunt helped me to dry because I didn't have bandages or anything but they did bind me. First they buy a venda (wide strip of cotton), very tight, a normal one, one of these about 30cms wide and then they put a body sock and then the faja (girdle). It was cotton the one I had because there are others that are made from polyester but they make you itch. So I had one made from cotton. And
well, I could only drink *atoles*, eat chicken and nothing else, *atoles* and chicken. Because of the *faja*, it was so tight I could hardly breath and I couldn't eat, my food would get stuck in my throat ... I said to my mum "Please take it off!"... I didn't have any milk at first. For the first eight days, [the nurse] said I couldn’t feed because of the medication after the caesarean section. They had given me antibiotics. My milk hadn't dropped so [my aunt and my mother] gave me an herb bath. There were a lot of herbs *juncia, medallon, eucalypto, arnica, la azucena de chamula* and I don't remember what else. It was very funny because I remember that Mateo was lying down nearby and they started to pour the hot water over my back, they put you in a bath with the herbs and they pour the water over you. It's very hot, it burns it's so hot, but it was funny because suddenly drip, drip it started then drip, drip, drip quickly. So they said "Bring the baby" and they took Mateo's clothes off and put him in the bath with me and he started to feed and from then on it was fine ... Also because they didn't let me do anything with the baby, for example when I wanted to bath the baby alone I had to lock the door, because they would arrive and be like "Leave it, leave it I will see to the baby"... I couldn't change him, bathe him. For example, there were times in the early morning or the middle of the night when he cried and suddenly my aunt was in the room "What happened, what's wrong with him" "I don't know, he's crying I think he's hungry" "No, give him to me" and whoosh, she'd disappear with him! There was my aunt, my mum, my *suegra* and anyone else who wanted to come, there were many women ... [Diego] stayed with me sometimes but sometimes he went out or he would say he was very
tired and he'd go and sleep at the house. I was twenty days in my aunt’s house, I couldn't cook or do anything I was very uncomfortable because Diego would arrive after work and wanted to eat but sometimes my aunt hadn't made the food and I couldn't move a lot. It's not that I couldn't move it’s that they wouldn't let me. They would say, "No hija," but I felt fine because I would walk up and down stairs without problem but my aunt would be like "No, no leave it to me, I'll do it" and so Diego would say "You know what, I'm going to eat with my mum" and he would leave me with the baby.

After these twenty days I went to my mum's house and it was the same. My mum would make Diego's food but it was complicated because she made what she could and when he wanted it, whilst I was with the baby. Like I said they didn't let me see to the baby much and it got to a point where I'd had enough because they wouldn't let me do anything, I couldn't see to him. If I went to clean his belly button they would say "no, you're doing it wrong"... After the cuarenta dias was up I went straight home to my house. By that time Diego had said to me "okay that's enough we need to go home". We went home and it was much better, I felt a lot better because I could see to the baby and do things in my own house. I felt much better, free. I felt more sure of myself because all the time they would tell me what to do and how to do it and in my house it was just me and the baby.

**Learning To Be a ‘Good Mother’**

Upon becoming a mother, one returns to, remembers, and relives one’s early intense experiences of being with one’s mother … This is because the mother’s
relation to a new baby is immediately corporeal, sensuous, tactile, and non-verbal … The sensory experiences unique to this relation … arouse in the mother varying levels of memory of her preverbal bodily past

(Stone 2012b:135)

In this second half of the chapter I will discuss how Carlita and Lupita’s narratives illustrate the cuarenta días as ultimately concerned with learning good mothering, embodying transformation and negotiating relationships. Both Carlita and Lupita’s narratives shed light on the significance of home postpartum care in reproducing and producing maternal practices that are socially constituted and individually experienced. These narratives also reveal how techno-scientific models of risk that first appear during pregnancy and birth continue throughout the postpartum period to shape women’s lives as modern citizens and ‘good mothers’. Paying attention to the way in which new mothers feed, comfort and cradle their babies in the postpartum environment reveals shared dispositions and bodily learning that helps to explore how women develop maternal practices based upon a notion of instinct.

Conceptually, I have understood the cuarenta días environment to be an intersubjective milieu of developing embodied knowledge (Csordas 1993) and a meshwork of human interaction consisting of ‘entangled lines of life, growth and movement’ (Ingold 2011:63). In this way analysis of the cuarenta días focuses on forms of power and agency that interrelate in an environment with specific and temporal boundaries in relation to bodily practices. Within these temporal boundaries growth in the form of transformation of self takes place, ‘in part moulded through the superimposition of ready-made structures’ (Ingold 1998:26). To continue with Ingold’s argument, aside from ready-made structures, ‘[r]eal humans, however, grow in an environment furnished by the presence and activities of others’. The type of bodily and social transformation of self that takes place during the
postpartum period is wholly reliant upon who is providing the care and where it is taking place. In this sense embodiment is one and the same as the development of the body-as-organism in its environment - socially constituted and individually experienced.

My intention throughout this chapter has been to demonstrate that the *cuarenta días* is a particularly good subject for exploring how maternal knowledge is learnt and internalised through intersubjective and ‘intersensory states for which we have no common language’ (Sacks 2005:33). Carlita and Lupita’s postpartum experiences provide a way to consider ideas about embodiment as having multiple potentials, as opposed to a binary split between fleshy, environmentally incorporated processes (see Ingold 1998) and more abstract notions of inscription and being-in-the-world (see Csordas 1990, 1993). The physical and conceptual boundaries created through the practice of the *cuarenta días* provide a temporal environment in which competing cultural metaphors of the body intersect with interpretations of risk and constructions of maternal identity. New mothers find themselves in an in-between space where interpretation of risk is dependent upon the importance of being a good mother in the eyes of the state and clinical practitioners or adhering to intercultural norms of mothering. In the narratives struggles over the meanings of maternal bodies and practices are present which bring about questions concerning the role of embodiment in orchestrating objective social outcomes (Rouse 2004).

*Embodying Transformations*

Throughout the *cuarenta días* transformations take place that begin to shape women’s understandings of their bodies during recovery. Two particular transformations arise in both Carlita and Lupita’s stories. The first is the importance of binding the abdomen (*fajarse*) and its significance in terms of embodying local
biologies and gendered expectations. The second transformation is when the maternal body, no longer occupied by an infant in utero, becomes a site of conflict and a threat to the health of the newborn.

The vulnerability of mother and child to illness and death caused by aire frio, mal de ojo (evil eye) or other type of contamination are taken very seriously. Thermal dynamics are deeply rooted in mestiza and indigenous illness belief systems, and can be found both transnationally and locally (Waugh 2011; Palazuelos & Capps 2013). The hot-cold dichotomy inherent in local thinking represents a complex system of understanding and interacting with the world that has been influenced by history, and is reinforced through important social relations (Palazuelos & Capps 2013:25).

Definitions depend upon who you are speaking to but in general it is a belief system based on the principle that health is maintained when the body is both internally balanced and externally harmonized with the natural world and society (Palazuelos & Capps 2013:25). Aire frio in particular provides the largest threat to postpartum mother and newborn and all preventative practices are focussed upon creating and maintaining bodily and environmental warmth. At birth babies are understood as cold and are deemed not to be able to retain enough heat to survive on their own. “Its lungs are simply not ready to defend against the air” was how Doña Reina explained it to me. As the baby develops during the initial cuarenta días it will become stronger and have a better ability to retain heat. For women the postpartum body is left cold, open and susceptible to physical and spiritual illness. The concept and embodiment of thermal dynamics plays an intrinsic role in how the senses shape and inform action in local postpartum practices. The theme of vulnerability and openness intersects with notions of increased susceptibility to negative vibrations (caused by mal de ojo or the strong emotions emitted by others) which in turn can cause illness.
or mental distress to mother or infant. Awareness of intercultural ideologies of hot and cold brings a cosmological interpretation to the women’s actions and demonstrates how local biologies (in Lock’s definition of an ongoing dialectic between biology and culture in which both are contingent, 1993:xxi), contrast and converge with universal obstetric knowledge about postpartum healing phases. The context of thermal dynamics in local belief systems demonstrates the ways in which transformation is understood as inseparable from ones’ physical environment. A closer awareness of thermal dynamics and sensory apparatus also reveals how local biologies contrast and converge with medical ideas about postpartum healing. I have identified three main elements of mestizo postpartum practices in the mestiza homes in San Cristóbal: 1) the importance of hot and cold, 2) the necessity of confinement during a specific period of time after giving birth, and 3) vulnerability of mother and baby in this period. These three elements converge with the beliefs around thermal dynamics which are also deeply rooted in local Mayan cosmology. The close proximity and shared spaces of indigenous and mestiza Mexicans (many of whom in Chiapas share mixed heritage over generations) means that it comes as no surprise that cosmological and environmental understandings appear cross-culturally. The Maya Tzotzil (dominant indigenous identity in San Cristóbal) believe that everything in the universe is thought to contain a different quantity of heat or dynamic power (Classen 2005:149). Steam baths or sweat lodges (temazcal) along with the use of various medicinal herbs are used to restore heat to the woman’s body after birth, promote lactation and for the restoration and maintenance of the reproductive organs following birth (Groark 1997). The warmth of the steam bath, for the Tzotzil, is considered essential to the physical and spiritual well-being of both mother and child. In the period immediately following birth the indigenous partera
will enter the *temazcal* with the mother to help facilitate postpartum recovery and the baby will be brought to the mother in order to benefit from the heat (Groark 1997; Katz 1996).

Though it is rare for mestiza houses in la Garita to have a *temazcal* built in the patio, herbal steam baths are carried out in postpartum bedrooms using tin baths and hot water boiled on the kitchen stove. For mestiza women in particular marking the transition from *dando luz a la vida* (to give birth translated literally as - giving light to life) to actual motherhood involves binding the abdomen tightly in order to close the body. After bathing, the mother’s abdomen will be tightly bound with a wide strip of cotton (*venda*) and then with a shop bought girdle called the *faja* (as seen below in figure 16.). She will continue to wear the *faja* for the duration of the *cuarenta días*, only taking it off to wash.

![Figure 16. The cotton *venda* and the shop bought *faja*](image)

As discussed the postpartum body is understood locally as being open and vulnerable to external forces such as *aire frio* and infection. It refers physiologically to the openness of the uterus after birth whether from vaginal birth and/or the open wound of both uterus and abdomen after a caesarean section. The notion of the body being open lasted for the *cuarenta días* period, usually also around the time that vaginal bleeding stopped, though binding often continued for up to six months, post
birth. According to the women I have spoken to in Chiapas, the abdomen has a variety of purposes including closing up the uterus, healing incision wounds and returning a body to its pre-pregnant state. In many ways this practice signifies a return to the mundane and domestic life of a woman and is an embodiment of expected gender roles. Binding allowed women to return to duties around the home within or soon after the forty-day period. With everything held tightly in place they could pick up other children, shopping or heavy loads of washing without causing a hernia. Asking women about why it was necessary to bind straight after birth revealed much about local biologies and understandings about the internal workings of women’s reproductive organs. Experienced mothers and grandmothers explained to me that binding was essential due to the ‘looseness of the womb’ and the ‘floating organs’ that were at risk of falling out if they were not bound into place. Women also saw binding as essential to healing caesarean section wounds, even when in reality, as Lupita experienced, it caused a lot of pain and discomfort. In addition to the risk of the womb falling, younger mothers (generally those under 30) spoke of binding as essential to flattening the stomach and pressing it back into shape. This purpose is reflected in figure 16. where the advert declares “¡Tu cuerpo…de Nuevo!” (roughly translated as Your Body … Renewed!). Many young women were very concerned with physical appearance soon after birth. Pressure from the constant media coverage of national and international celebrities who appeared to get pregnant, give birth and reappear in an instant as their former selves contributed to younger women’s attitudes to postpartum binding for cosmetic rather than physiological reasons. Similar to the assumptions made about the pregnant body, the postpartum body is a source of conflict in terms of how it can at once protect and endanger the newborn. This conflict is prevalent in both medical and social discourse where ideas about risk
are not mutually exclusive but continuously intersecting. Emotion, temperature, diet, illness (stomach upset, colds, pains) are all factors in the mother that can put the baby at risk during its first forty days of life outside the womb. Ethnotheories and beliefs about the continuing physical connection between mother and baby served to validate how women were feeling (Ivry 2010). Such local knowledge and beliefs are also used by medical professionals and family members to intervene in and regulate postpartum bodies. The opportunity for external intervention in between mother and baby is very much present in the success and failure narratives of breastfeeding. The passing of milk from one body to another provides medical professionals with tangible evidence of the intimate connection between mother and baby that has the potential to be harmful.

There are stark differences between how difficulties with breastfeeding are dealt with at home and by medical professionals. For the women who observe it the cuarenta días provides a vital period for new mothers to establish a milk supply and much care is taken straight after birth to ensure success in breastfeeding newborns. The beliefs and concerns about the risks and consequences of mothers’ milk ‘gone bad’ were manifest in both lay and local biomedical knowledge practices, though the approaches to managing this and retaining the corporeal and emotional connection between mother and infant were in stark contrast. It is through the contradictory and indeterminate nature of medical discourse that competing cultural metaphors of the maternal body and mothers’ milk exist and are negotiated. Rouse (2004) writes, in the context of competing bodily metaphors in the case of a dying child in the US, how universal discourses are often contradictory and indeterminate in practice. She contends that these contradictions open up a space for social contestation and in her
fieldwork, semiotic transition through the manipulation of social work and medical practice values. Rouse describes how marginalised individuals can employ a ‘currency of ethics’ in order to change the perceptions and practices of those who hold power in a situation. In the case of Carlita, though the doctors and the partera do not communicate it is Doña Carla, mindful of the social significance of breastfeeding, who negotiates and interprets Alison’s diagnosis in a way that incorporates the recognition and need to treat illness with the long-term necessity to breastfeed.

Local practices and maternal thinking consider mothers’ milk and breastfeeding to serve a purpose that goes beyond nutrition. The mestiza women and men in the barrio are in agreement that infants should be breastfed for as long as is deemed necessary. In the postpartum period the health and nutrition focus of care is important in that the quality of milk is checked regularly by elder female relatives and parteras. Attempts are often made to maintain or improve the quality of milk by the mother drinking oat milk or atole (local maize based drink). Different herbs such as fennel, spearmint, pine and eucalyptus, either consumed as infusions or inhaled through steam baths, are used to increase the flow of milk. The use of herbs and foods to help milk supply continues throughout the breastfeeding lifecycle but is most intense during the initial postpartum period. The forty-day confinement, though often interrupted for various reasons, provides the opportunity for mother and baby to remain relatively protected from external (outside family) influences. It serves to retain or recoup the bond that began in utero. The confinement and intense support is evidenced to have a positive effect of breastfeeding retention and mental and physical wellbeing of the mother. All the while the efforts made to ensure a peaceful and protected environment for mother and infant, and the use of herbs does suggest
that mothers’ milk is not always deemed of a sufficient quality and strength alone for a healthy baby. In this sense it is impossible to decipher whether this is a gradual effect of medical discourse in regards to maternal bodies, particular in terms of strength and quality, though it is unlikely to be so simple.

The comments from women about quantity and quality of milk – that it is not enough to fill the baby or it is too watery – do mirror the types of things told to women, by medical professionals, who are encouraged to supplement with formula milk. It is a case of bolstering pre-existing beliefs as opposed to creating new ones. The environmental protection afforded to a new mother and her infant demonstrates the importance of emotional connection and mutual reliance in the process of recuperation. In this way breastfeeding and the flow of milk are part of a comprehensive system of beliefs that is deeply entrenched in sensory awareness.

Thermal dynamics – notions of hot and cold – vulnerability and risk play an intrinsic role in how the senses shape and inform action in local postpartum practices. Overall in the context of this chapter the postpartum practices show that though susceptible to contamination, mothers’ milk can be made pure again. The emphasis in the home postpartum practices is on the bodily and sensual connection between mother and infant via breast, mouth and milk being paramount for the wellbeing of both.

Clinical and state attitudes to breastmilk and maternal bodies appear contradictory and disjointed at best. The strength of the Mexican state’s efforts to project Modernity through maternal bodies meets with techno-scientific models of risk so that responsibility and blame lay squarely at the feet of mothers. Medicalised reproductive care is part of the state apparatus for achieving Modernity and as part of this medical authority is perceived as legitimate, privileged and consequential (Smith-Oka 2012b). In doing so other ways of knowing are often dismissed and/or
delegitimized (Jordan 1993; Sesia 1996). The narratives in this chapter show how local ways of knowing are not simply dismissed, but manipulated to legitimize physicians’ interventions in postpartum and feeding practices. This is however challenged by women’s authoritative knowledge which lies within more comprehensive and holistic maternal belief systems. The decision to interrupt semi-exclusive feeding or cease and replace with formula depends upon the wider social network of the mother. It is strongly connected to the strength of family networks and whether aspects of women’s reproductive health and caregiving are deemed to be outside the realms of medicine.

The mother as novice

In la Garita the cuarenta días postpartum quarantine comes into being through close family ties, spiritual beliefs, traditions and reconnection to the natal home (in most cases). It is also a place where external medical influence, lay midwifery, Modernity and economy interweave in similar way to the out-of-hospital births discussed in Chapter Three. The cuarenta días is practised no matter whether a birth takes place at home or in a clinic and regardless of birth outcome. It is often interrupted for working women and lone mothers who lack family networks for support and therefore its practice is closely linked to political and labour economies. The cuarenta días provides an important focus for the study of local maternities because it is a point of postpartum convergence for all types of birth outcomes. Analytically it is a way of bringing together women who share the same moral culture but who within this take various paths into giving birth. It is a space where internal and external life entangles to create a particular sensory learning experience for the new mother. It is quite clear in the cuarenta días environment who are the experts in postpartum health and mothering. Senior female relatives and the partera pull rank
in their duties to the new mother and baby whilst a particular kind of passive behaviour is expected from the mother. Under closer inspection the performance of passivity in the new mother makes her complicit in the construction of a maternal identity that works to strengthen the social value of dependency on others.

Although the two narratives chosen here are from first time mothers, similar postpartum routines and compliance are required of women having second, third or fourth babies where established support networks are available. This means that mestiza women of low to middle socio-economic status and who live in multi-generational households, are well placed to reproduce this form of postpartum care routine. Great emphasis is placed by senior family members such as Doña Carla or Doña Reina on the importance of the *cuarenta días* as an essential period of protection. These women understand the *cuarenta días* as an opportunity for experienced mothers, knowing what hardships lie ahead, to provide a further gestation period for mother-baby unit and as time for the new mother to gather strength.

Aside from the health implications, there is the supposition that the new mother is still very much a novice and not ready to take on sole responsibility for her child. In this sense the *cuarenta días* is a temporal breathing space between pregnancy and actual motherhood. It provides an opportunity for a woman to learn the basics of childcare behind closed doors and with an abundance of advice. For women with strong family networks they will rarely be left alone with their child as it develops up to school age. Often in the joint care of grandmothers, aunts, siblings, cousins or hired domestic help for many hours during the day mothering comes under a definition of communal practice in barrios like la Garita. As demonstrated in Lupita’s narrative this can create tension between social and individual values on
care giving. In many ways the *cuarenta días* introduces the new mother to the reality that birth itself does not denote passage into experienced motherhood. She will remain very much a novice in maternal matters until she produces further children or even becomes a grandmother herself. The belief that mothering is not a solitary practice became very apparent to me during my residence in la Garita due to the daily concern expressed by my friends and neighbours in regards to the absence of my husband. I often explained that he was away working and looking after my son, to which further concern was expressed until I added that my own mother was taking care of them. My neighbours always conveyed a sense of relief when my mother-in-law and other female relatives or friends came to visit. Doña Reina in particular was always commenting, “Your daughters are company but a mother shouldn’t be on her own”.

The belief in mothering the mother, as the title of this chapter suggests is an essential ideal of postpartum care. There are interlinking elements of care, protectiveness and control that reproduce ways of mothering through generations. Taking the mother and baby back into the maternal home environment for birth and postpartum care reinforces that a woman is still very much a daughter who has not been abandoned by her own family. Or in the case of my neighbours Lila, Magali and Josefina (as we shall see in the following chapter), who all moved in to their mother-in-laws’ households when pregnant and stayed on postpartum, it demonstrated that they were accepted as daughters by their new families.\(^{34}\) In such a tight knit community like la Garita I did not witness any lone mothers, living alone and unable to complete the *cuarenta días*. There were of course lone mothers in the sense of absent fathers but

\(^{34}\) In the cases of Lila, Magali and Josefina both households were dominated by men due to their mothers-in-law (Doña Perla and Doña Frida) only having sons. In these male dominated households it is very common for the daughters-in-law to be welcomed (and protected) as daughters, as they are an essential help to the female head of household.
in the barrio they lived amongst family. In the wider city there were many women usually rural migrants who, alone in the city received no postnatal care other than the post birth hours in hospital and who were often back at work within days of giving birth. These women generally viewed as outsiders were pitied by the local women and midwives and very much abused by hospital staff as irresponsible mothers (as seen in Chapter Two). The *cuarenta días*, understood as a distinct set of learning practices, reveals how dependency on others remains an important social value for mestiza families. In this way new mothers embody a collective resistance to a state Modernity project that promotes independence from family and community as a core socio-economic value.

Many women I spoke to about the *cuarenta días* defended the necessity of it and were grateful of the time to recover and bond with their child. For others, like Lupita it was a stifling and frustrating experience that led to them locking themselves away in order to be alone with their babies. Recognising the role of emotion is essential to understanding the meshwork of interactions and relationships at play during the *cuarenta días*. Learning and embodying the language of mother love is implicit to the creation of the maternal subject in the early days of motherhood (and beyond). Lupita and Carlita understand the social necessity of becoming a good mother and that this is, in part, displayed through a language of emotion. A gender stereotype prevalent in Mexican society promotes motherhood and the desire to mother as a natural part of the lifecycle. Much emphasis is placed upon the belief in a maternal instinct and love that guide women towards being good mothers. There is a collective consensus that a woman feels her way through motherhood using the child as her guide. I attempted on numerous occasions in groups of mothers to pose the question (in various forms), “How do you know how to mother?” In group
conversations I always received a unanimous answer in regards to instinct. Focus on postpartum care however, reveals that the direction and training in the basics of feeding, bathing, clothing and comforting that takes place in the cuarenta días demonstrates transference of core social values via bodily practices which are expressed as natural (instinct) when they are clearly culturally constituted. Here new mothers have an embodied sensibility to social norms and in doing so exhibit awareness and social control in their modes of attention to others (Rouse 2004). Aside from the benefits in creating the mother-baby bond and getting to grips with the basic care giving skills, the cuarenta días is positively associated with reducing stress in the new mother. A crisis postparto, as in the clinical diagnosis of postpartum depression, is not a phenomena recognised by most women in the barrio. The existence of postpartum stress or ‘baby blues’ is mentioned occasionally and is understood to happen as a result of not adhering to the rest period or not receiving enough social support. This indicates that those who practice the cuarenta días rest period see it as making an important contribution to the overall wellbeing of the new mother and her transition into motherhood. This attitude mirrors existing studies that associate the cuarenta días with lessening chances of postnatal depression and establishing milk supply and confidence in breastfeeding (Waugh 2011; Martinez-Schallmoser et al 2005; Niska 1999). Lack of recognition of postnatal depression or other postnatal mental health problems does not equate to their non-existence (as Bety’s narrative demonstrated in Chapter Two). Collective silence on a subject can just as much indicate that it is a social taboo as opposed to it simply not existing. Children and pregnancy (or the foetus that results from the pregnancy) are described by all as a blessing - meaning there are few culturally appropriate spaces for women to express unhappiness or inability to cope. The coming together of close female
relatives to take care of the new mother and support her in making a connection to her baby can be read as a way of acknowledging her vulnerability to stress without having to openly speak of it.

*Negotiating Relationships*

The *cuarenta días* is very much a women’s space where relationships between mothers or close female kin and daughters are central. The presence of close and extended female family members forms a further protective barrier around the mother and baby. The exclusion of fathers from this period is often further underpinned by the temporary return to the maternal home. In indigenous and mestiza postpartum care a woman is meant to abstain from sexual intercourse for the duration of the *cuarenta días* as her cold body is susceptible to illness. Indigenous thermal dynamics understand penetrative sex and mixture of bodily fluids, characterised as heat, as a potential risk to the woman’s health resulting in dryness and diarrhoea (Katz 1996:103). Sperm also carries a risk to the quality of milk. Though I did not hear this type of reasoning whilst I lived in the barrio the adherence to some form of quarantine period for most new mothers, which involves a physical separation from partners, suggests that the sexual activity in this period is something to be avoided. It also implies that a woman is not always able to negotiate abstaining from sex due to established gender power differentials. The absence of male relatives and partners from the mestiza postpartum environment and presence of senior female relatives ensures that a new mother remains protected from sexual advances. Though sex was not openly discussed with most of the postpartum women I spoke to, the way in which the new mothers were cocooned during the *cuarenta días* suggested
measures were in place to protect them from intimate contact with anyone apart from the baby.

Though I witnessed few complaints from men during this time I was only privileged to very brief discussions with new fathers, and so unable to gain any real insight into their opinion on the matter. It was possible however, from conversations with women to see that many new young fathers turned to their own mothers during the postpartum period in search of some mothering for themselves. A shift in interpersonal boundaries and personal space during the cuarenta días had to be further negotiated when the couple returned to the marital home or bedroom (if living within parental family home). These new boundaries often continued with the mother tending to co-sleep with the baby during the first six months to a year or more. It is impossible to say whether the rules for abstinence and isolation alone during the cuarenta días have any significant impact on couples’ relationships in the long term. The introduction of children full stop brings changes to any relationship and defined roles are just as likely to help in such situations as they may hinder.

Much emphasis is placed on how the maternal body contributes to the survival of a baby in the first few weeks of life. Within this context paternal bodies, after the donation of sperm are effectively defunct – and during the postpartum period a man’s sexual energy can put the baby at risk (Waugh 2011), hence the need for protective boundaries in the quarantine. Such bodily practices act to reaffirm set caring roles from the outset. Matthew Gutmann (1996) describes parenting in a mestizo barrio in Mexico City as an ideological concern intimately connected to a practical one:

A system of constraints is perceived by many such that infant care is routinely equated to maternal care ... For example, in a baby’s first year, breastfeeding is more common ... This requires the mother’s rather
constant presence and establishes a fairly rigid division of labor from early on ... The body – in this case the man’s inability to lactate – influences but does not in any sense dictate culture, yet the body is routinely used to justify and explain cultural forms (1996:75-76).

For young men caught between generations of paternal role defining and the contemporary image often portrayed in the media of the hands-on father as opposed to the distant macho stereotype, what they were actually supposed to do as fathers was a matter of some confusion. Whether their exclusion from the cuarenta días practices provides the opportunity to avoid caring responsibilities from the outset or whether it creates tension in the couple’s relationship is a matter for further exploration. According to Lupita, “It certainly didn’t help a problem that already existed”.

In this chapter I have used a combination of ethnographic narrative with theoretical approaches to the senses, environment and bodily practice to discuss the significance of the cuarenta días to the lives of mestiza women in an urban barrio of San Cristóbal de Las Casas. Thinking about the senses, emotions and transformation in direct relation to environment and practices has wider implications for the understanding of embodiment in the context of maternity and learned bodily practice. The commitment to carrying out the cuarenta días and its associated practices in la Garita demonstrates that it continues to form a significant part of shaping the early experience of motherhood. The local importance of adhering to the cuarenta días, whether in part or full, highlights a shared social value as well as an individual corporeal process of postpartum recuperation. Although not exempt from outside influence the cuarenta días is an important part of the reproductive life cycle
yet to come under the control of the state or be seriously modified via medical
intervention. It is reliant on strong family networks, need to protect mother and baby,
and respect for knowledge of thermal dynamics. Within this external womb-like
environment state notions of Modernity are contested and local maternities are
reproduced. For young women it is a space where they are mothered and experience
a gradual transition of self that is implicit in the maintenance of local maternal
ideologies – and within which a form of collective agency occurs. This does not
however, translate to an individual freedom in the remaking of self. Instead, it results
in a transition to (m)otherhood that adheres to the norms and beliefs of what makes a
good mother within the constraints of local ways of being.
CHAPTER 5

A Blessing from God: Transition to Motherhood

In short, to love a child is like being permitted to rise amongst the clouds of incense, until one reaches the pinnacle of self-sacrifice

Rosario Castellanos 1971 [1992]:290 (my translation) Mexican poet and feminist

Being a mother is the most beautiful thing in this life because it is a blessing from God

Angela 36, la Garita

In this chapter I am concerned with the wider social and political economic issues that shape the transition to motherhood for women in la Garita, and in the process I will make two related arguments. Firstly, I will demonstrate the strength and limitation of women’s individual agency when developing their maternal practices and identity in regards to the pressure to conform to an established gender role within the social, political and economic constraints that surround them. Taking lead from Nancy Scheper-Hughes’ (1993) call for a pragmatics of motherhood and Arjun Appadurai’s (1996, 2000) writing on cultural hybridity and agency I will use
women’s narratives to think about how new mothers ‘create their own culture, but they do not create it just as they please or under circumstances chosen by themselves’ (Scheper-Hughes 1993:342). Secondly I will argue that women’s agency and capacity for social and individual change is challenged in hierarchal societies where motherhood is valued as the most desirable attribute, and where a direct link is made between the capacity to bear and the capacity to rear. This ideological glorification of motherhood results in a state and societal rhetoric that ultimately maintains social hierarchies and restricts women’s capacity to drive change. On the other hand, however, as I have demonstrated in previous chapters, the contradictions brought about by everyday practices as part of competing discourses can also open up ways for women to contest accepted norms and drive social change on more subtle levels.

Woven into the fabric of the two arguments I propose in this chapter, is a political economy of emotions and the trope of mother love that is universally applied to all women regardless of social status, age or ethnicity. How women speak about being mothers and moreover how they describe their relationships with their children and partners is bound by a code that is shaped by inherited habits of thought and social imagination. The tropes of mother love are intricately connected with a form of divine status that mestiza mothers have traditionally been given in Mexican society; which places responsibility firmly in the hands of maternal subjects as moral regulators of children and partners alike. Where I have discussed notions of mother love, emotion and instinct in previous chapters, it has appeared as a contained ideal wrapped up in the processes of pregnancy and the early postpartum period. In this chapter the pragmatics and practicalities of mothering beyond babyhood show a
more complex intersection and friction between maternal and female subjectivities that develop throughout the lifecycle.

Amongst my neighbours in la Garita there are two specific and common dwelling situations that arise in terms of the lives of new mothers and which are directly related to the average age that women become mothers. Firstly, women who had moved into their partner’s parental home (living with the suegra – mother-in-law) and secondly madres solteras (single mothers) who had remained in the family home or less frequently those who lived alone whilst remaining close by to family. These two categories are very different in a practical sense and they are worth looking at separately with a focus upon how transition is experienced, and how maternal subjectivity can be reconceived and individually constructed as both separate and simultaneously part of a continuously developing female subjectivity. Whereas Stone (2012a) asserts that we must not lose sight of what is peculiar about maternity, I would extend this argument to say that in the identification of maternal subjectivity as distinct from female subjectivity, we must not lose sight of what is peculiar about the circumstances within which maternity occurs. In this sense my discussion in this chapter will situate the process of becoming firmly in relation to the environment and as a result of the forms of ‘separatio’ which occur within it.

Though they also differ by family and educational background the women in this chapter are linked by the fact they all had unplanned pregnancies when they were under twenty-five. Unplanned pregnancies were common amongst most of the younger mothers I met in la Garita and this reflects much about how relationships are conducted and the void between reproductive rights rhetoric, social values and everyday realities. Becoming pregnant in this way was a defining factor in their transition to early motherhood. For all the women emotional work had to be done in order to
accept that their pregnancy was part of ‘God’s plan’ and that it was something they wanted. As will become evident they use the language and feeling rules of mother love as rooted in the divine to explain this transition to acceptance.

**Madres Solteras**

Unless they are closely linked through family connections, young couples tend to develop relationships away from the prying eyes of parents and older relatives. They manage this with the collusion of younger siblings and cousins who they are charged with looking after. An unplanned pregnancy is often what brings fledging relationships out into the open and a young couple under the spotlight. Of course not all women become *madres soleteras* at the reveal of the pregnancy test, many relationships are supported through the process and survive (as will be seen further on), and many other women find themselves abandoned, divorced or widowed much later in their maternal lives resulting in a very different kind of experience. As my focus in this chapter is on the transition to early motherhood I have decided to let the narratives of Sara and Bania guide the discussion on single mothers. They faced pregnancy and motherhood without their partners, one through abandonment and the other by choice. Their narratives reveal much about women struggling with expected and established gender roles, intersecting projects of modernity and daily economic survival. Grappling with the production of modernities and maternities in this way this type of single motherhood ‘questions the need for the stable married couple and the good mother ideology that champions the fulltime mother’ (Bringas et al 2004:68 my translation) in Mexico. These two women, albeit with very different tales to tell were also significant in the fact they left the family home soon after their first children had been born. In la Garita, as with most mestiza barrios in San Cristobal it would be difficult for both financial and cultural reasons for a single mother (of any
age) to leave the family home, yet occasionally women like Bania feel like they have no choice, or in the case of Sara the decision is made for them. Bania and Sarah provide a challenge to local ideas of mothering as communal practice, and in doing so they also gain a liberty of movement as women that can come at a cost.

Sara and Bania were not friends; I often thought they should have been as they had a lot in common. They were both single mothers, in their late twenties who were working hard to bring up their daughters in ways that challenged local convention. They knew of each other, as everyone in the barrio did, but they lived at different ends of the barrio, their families were not connected like most through blood or marriage and so their worlds were apart. Sara was my immediate neighbour and the person I could hide nothing from. Our small yards were connected and her two storey house loomed over mine where she was privy to most of my everyday routines of mothering, laundry, mealtimes, occasional visitors and evening television viewing. She shared her house with her cousin Ruby, also a single mother to ten-year-old Iván, but was mostly there alone with her youngest daughter Valeria as Ruby often worked away. Besides the obvious visual insight into my daily home life Sara and I maintained an ‘over the garden fence’ friendship which generally consisted of barrio and town gossip and the ups and downs of parenting. I liked Sara on a personal level; she struck me straight away as being unusually candid about her family life and feelings about being a mother. Like other single mothers I met living outside of their family home she was very proud of the challenges she had faced and the way she was able to maintain her small family unit in the face of all odds. The metaphorical garden fence between her yard boundary and mine gradually served as a daily confessional from which she recounted her life and the difficult choices she had to make from the time of her first pregnancy. One morning as we stood watching
over the girls playing Sara told me about her eldest daughter Ana who lived with her mother at the lower end of the barrio. I was a little confused at first as she had never mentioned her before, I had assumed that Valeria was her only child. I asked her why she and Ana lived apart and she told me how she first got pregnant in her late teens and at that time had remained living at home with her mother, older brother and aunt:

I got pregnant at nineteen and like always when you say you are pregnant they [the men] disappear and I was left alone … It was a beautiful pregnancy, I lived with my mum and she had student lodgers at the time, they all looked after me a lot. After I gave birth things became more complicated because then I was a single mother and my family are very strict. When Ana was about two years old I met Valeria’s father and the problems started. I wasn't allowed to go out or have a life of my own because I had a child, but I mean I was twenty-something, about twenty-two years old which is still young. After a while I met someone else and I wanted to move in with him, they [her mother and aunt] took my daughter off me, my mum hit me and threw me out and because my mum had cancer at the time I didn't wanted to fight with her. I went to live with Valeria’s father and his mother …

In this narrative Sara highlighted the social transition to mother that took her from one identity to another. Though she had given birth she remained unseparated from her baby in the sense that she must be seen to live only for the child. Leaving home in order to pursue a new relationship meant losing the right to parent her first child in any meaningful and emotional sense. In this situation as a young woman Sara was powerless against her own mother, who in this one act temporarily stripped her of
her mothering status. Sara explained to me that her mother, a devout Catholic and embodiment of the abandoned *mujer abnegada* (self-sacrificing woman), held the belief that “I shouldn’t go out or speak to anybody, I shouldn’t have a life”. Sara’s father had left the home when she was a young child and like most women of her generation her mum had devoted her life to bringing up her children. It had not been an easy childhood and Sara was often left alone in the house whilst her mother ran errands or worked. “She left me with this person, with that person. My dad was busy with his women and my mum with my brother. I remember or lots of people have told me that [when I was little] my food would be left by the door, one leg would be tied to the bed and the television switched on”. She told me that her mother refused to acknowledge that this had been the case and instead spoke of the sacrifices she had made for her children, as any good mother should. Her mother’s beliefs of what constituted a good mother led her to the drastic action she took by removing Ana from Sara. Sara described that time in her life as “unbearable and suffocating” yet she often spoke about it pragmatic terms. “Since she was born she was with me, she came to work with me, she bathed with me, I would breastfeed her and she would sleep with me, that’s why it was so sad”. In order to resist a traditional submissive mother role and defend her right to “have a life” as a young woman, Sara was made to temporarily relinquish parental responsibility and redefine her role as a mother to Ana. Other Grandmas and aunts I knew who had taken or been given ( unofficial) custody of children explained it within the rhetoric of self-sacrifice. Children were seen as ‘better off’ with grandmothers or aunts and young mothers were being ‘given the chance’ to pursue a career or marriage by being released from the obligation of mother work.35

---

35 Though they were not released from the obligations of loving and providing for their children.
This early transition from a protected pregnancy period to a difficult and unstable early motherhood shaped how Sara understood herself as both a woman and a mother in modern day Mexico. Although Sara had eventually split up with Valeria’s father after he had an affair, and she had worked hard to rebuild the relationship with her own mother, she had never regained full custody of Ana. She had settled with moving back to the barrio in order to be close to Ana and attempted to parent her in the more practical aspects of her life she was able to control, but this was not without complication:

I am the one who supports her [financially], her uniforms, school, between her father and I, but for example if I want to take her out I get “No, the girl is not coming”! It is my mum’s sister, my aunt they call her Niña Vieja [old maid]\(^{36}\) like she’s never married or had any children and she doesn’t want to let go of my daughter. So she really is the problem, but with my mum I don’t get angry because well, where will it end? I try to remain calm…

Part of accepting her role as “absent mother” to Ana was to do with love and a protective need to “do what’s best for her” no matter how she may be viewed by other women as abandoning her child for a man. In resistance to her mother’s maternal ideology Sara wanted to parent her daughter’s differently in the hope that when she was older Ana would understand her actions and come to live with her. “They [mother and aunt] blackmail her emotionally and she feels bad, but I won’t play that game, she needs to know I’m not that way”. She felt that by taking a different approach to single motherhood she could show her daughters that her love

\(^{36}\) Nina Vieja also refers to a woman as a child or having never grown up to be a woman.
allowed them to live more freely and that having children did not mean your life as a woman came to an end. The desire to parent differently from previous generations was a common theme arising in conversations I had with new mothers. This was not exclusive to women who felt estranged from their families and highlights the tensions within meanings of modernity and gender discourse. For many women a contention in the early transition to motherhood was a conflict between wanting to “do things differently” and being aware that in trying to do so they often unintentionally mirrored their own mothers.

The category of *madre soltera* comes into question as problematic when women’s lives are placed under greater scrutiny beyond that of social and political rhetoric. Women in la Garita rarely mother completely alone and despite the efforts of their own mothers and aunts they often continue to maintain on-off relationships with the fathers of their children and also find new partners. The label *madre soltera* takes on a false permanency that assumes a woman will always remain the sole principle carer of her child no matter how her personal relationships develop. It performs the act of stripping women of their sexuality and reinforces the ideal that the maternal role is defined by a level of self-sacrifice in a similar way that the title of widow does to other women. It fails to adequately represent the women I met and grates against the description they give of their own lives and relationships. My friend Lupita’s cousin Bania is a poignant example of this oversimplification of women’s maternal lives. I saw Bania often when I went to visit Lupita on my supposed downtime from fieldwork (which was never the case!). She was providing valuable emotional and practical support to Lupita during her separation and subsequent divorce from Diego. Educated in the capital alongside her cousin, Bania was outspoken and analytical about her position in society and role as a mother. One
morning I was dropping my daughter off with Lupita whilst I went to record some interviews. Bania had stayed over the night before because Diego had taken to dropping by the house on his way home from the cantina. “If she’s on her own she’ll just let him in” she said nodding towards Lupita, “she never learns”. Lupita grimaced and shook her head “it’s not like that, I just don’t want to end up alone, it’s alright for you, you chose to go it alone”. I asked her what she meant by choosing. She told me how she had left her partner soon after her first baby had been born and had lived alone as a madre soltera for four years until recently reuniting with him:

I think I fell into some kind of depression. I split from my partner and went to live alone with my daughter. I wanted to show myself that I could do it alone, I think really I was just following what my own mother had done, I was stubborn.

Comparable to Sara’s childhood, Bania often spoke of a lack of expression of love in her childhood as something she hoped to remedy with her own children:

…my mum tells me that when we were young she held us, kissed us, she showed us love, but I hardly remember, I just remember my mum shouting … because my dad was absent, they fought a lot so my mum left with us, and then later she fell into alcoholism. Can you imagine? I said I would never be like that.

When she talked about becoming a mother Bania often reflected upon how the breakdown of her relationship with her own mother and subsequently living her teenage years with her father had shaped her identity as a young woman and her ideas about mothering practices:
We live in a patriarchal system where men rule and I was brought up to be more like a man than a woman … when I started my periods it was my male friends who taught me what was happening, no woman ever explained it to me, that’s why I felt closer to men than women. I knew that a man would look after me better than a woman. But then I became a mother and thank God because now I understand that as a woman, as a mother I can look after my children.

Bania interested me as a woman and as a mother who challenged convention in a social world where staying in an unhappy marriage was preferable to not being in a marriage at all. It was an everyday story to hear of a man leaving his wife for another woman, but Bania was the only woman I knew during my time in the barrio who had voluntarily left her partner in order to live alone with her daughter. This was made all the more significant by her partner coming from a ‘good family’ and being described (by other women) as a man who knew *ser buen hombre* (to be a good man) in that he worked, did not drink and was not violent or abusive. Lupita once described her as *una loca* for giving it all up. Bania created a categorical distinction between object (child) and experience (motherhood) when she spoke about the negative impact of her unplanned pregnancy. She often wanted to stress that the ‘trauma’ she lived through during her initial unwillingness to accept motherhood was separate to how she felt towards her daughter. Using the vocabulary of mother love, she was able to describe how being unexpectedly thrown into motherhood had challenged everything she knew about herself and her world. She also spoke about how for her, it is her daughter as opposed to society or self who confirms her legitimacy as a good mother:
I don’t consider my daughter to be a mistake, because everything happens for a reason, I don’t know if it was a message from God, from life or destiny but it happened for a reason. So my experience with Kia caused drastic change in my life because at the time I was enjoying being free. I was twenty one, young, independent and then suddenly I was a mother … it was the emotional change, the change to say whether or not I could or couldn’t do things, thinking about what people would say about me, whether I should get married or not. All of this and also the physical changes that I just didn’t feel ready for … It took a long time to accept the first baby, even after she was born I still didn’t feel like a mother I felt estranged, I would stay looking at her for hours when she slept and think *is this mine, did I make that, now what do I do?* I would keep touching her to see if she was breathing. I think it was a combination of many things no? Obviously my age, immaturity, well actually I think we are all immature with our first … When I see her laugh or when she calls me *mamá*, when she hugs me and says I’m the best mum in the world, not because I tell her to say it but because there’s an honesty, a sincerity in her words. Or sometimes there’s no words and just hugs. This is when I know I’m doing okay that I’m becoming a mother.

Bania’s self-imposed isolation from her partner, in-laws and family resulted in her feeling more in control of her maternal practices and she measured her successes (and failures) by her daughter’s actions. When mother love was reciprocated it often validated the women’s sense of ‘motherness’ and made them feel that they were making the separation they desired from their own experiences of childhood.

Similarly Sara was keen to construct relationships with her daughters that were very
different from her relationship with her own mother. She once told me “I like to be a child with her we watch cartoons, tell jokes and laugh. I am her mother but we can also be friends”. Here is an example of how the constructed notion of unconditional maternal love is anything but; Sara shows she has a strategy in place. For her the giving of love is an exchange for the recognition that she is a good mother and capable of effecting change. By defining for herself (albeit from within a popular maternal discourse) what mother love is and should be used for she is enforcing a particular ideal on her daughter. She is shaping how she will come to understand maternal love in the future.

Conflict and disciplining their children also served to validate who they were as women and as mothers. Mothers in mestiza homes have been previously documented as the principal disciplinarians and instigators of physical punishments against children (see Gutmann 1996). Though not in every home this was more often than not the case in the families I knew more intimately in la Garita. When the madre solteras in the barrio spoke of disciplining their children it was with little difference to how co-habiting mothers acted. The difference with the madre solteras who lived alone was that they were left to regulate their own actions away from the eyes of other family members. I found that younger mothers were more reflective in how they dealt with the consequences of lashing out. This resonated with media representations of modern families37 and a fashion for experts in the attachment theory, pop-psychology approach to parenting that often appeared on daytime television. Both Bania and Sara spoke about how they unconsciously repeated the actions of their own mothers particularly when they referred to the stress of

37 This was particularly prevelant in telenovelas and regular daytime moral laden mini-series such as Lo que callamos las mujeres and La Rosa de Guadalupe and Mujeres: Casos de la vida real
parenting. But they also sought to remedy this by self-regulating and developing coping strategies to avoid hitting out. Lutz (1990) refers to this as rhetoric of emotional control common to hierarchal societies. She argues that to speak about controlling emotions is to engender the view of emotions as dangerous, irrational and in need of regulating. This then transfers onto gendered bodies who acquire the same attributes and forms of regulation. Sara was aware that being alone with Valeria could often lead to a conflict of emotions that spilled out into her maternal practices:

… Sometimes I notice that I’m sad and then she is sad, it’s like your mood affects theirs, how you feel is how they feel. So I try to stay calm so that she is calm … I do hit Valeria, I don’t hit her all the time, because neither is it the case I’m walking about with a stick, but yes sometimes she does some things … I put her in her room and slam the door, I will be on one side crying and she will be on the other side crying as well. After she had calms down I say, “Ya te pasó?” and she will come out and say “it’s because I’m angry because my dad hasn’t come”... We’ve started to talk a lot like that, if she feels angry about her dad then she tells me and we talk ...

When Bania spoke about arguing or losing her temper with her daughter she described a split in identity between her own self as a woman and her social role as a mother that helped her to justify her actions:

Practically you forget who you are as a woman and you just dedicate yourself to being a mum. But just the fact of being a mother, that doesn’t mean you lose who you are completely but in terms of feelings, it hurts when you have to scold them, or hit them on the behind, but you have to
do it as a mum, you have to guide them. I am a mother and okay sometimes
I say or do something and I say to myself “hey calm down, think about
what you're doing because you're not acting with your heart”, if I’m
chasing after her with my shoe or something I think, “Ay calm down!”
Although I know that there must be a reason why the child is acting up and
that it’s better to talk than start hitting them but sometimes, perhaps I have
some inner demons or something horrible and I start being like that …

It is self-explanatory that madre solteras who live alone will spend more time in
isolation with their children. In many respects this made the initial transition to
motherhood a very intense period for these women and they used an equally emotive
language in which to describe the mother-child relationships that develop as a result.
I had a fleeting conversation with Bania one rainy afternoon as we sheltered in a
doorway waiting for our combis. I dutifully jotted our conversation down soon after
as I always did. It was only months later that I looked at the notes again and saw that
in a few comments she had managed to encapsulate the emotion work that takes place
in the ongoing transition to motherhood:

What I’ve lived through has been worth it, becoming a mother to Kia.
When I arrived home late from work and she would say “Come on mum
let’s play a little” and I would be like okay just for a while. But in those
five or six minutes I would be rolling around the floor laughing, it’s that
simple. It’s so nice just for those ten minutes or so not to be worried about
the next day or anything else. You have to live for the moment. Every night
I try to give her many kisses and hugs and tell her how much I love her. If
we argue about five minutes after I say let’s talk about it, I don’t want to
feel bad because it hasn’t been sorted. I feel empty [after we argue] like
I’ve lost the connection with my daughter and I have to sort it out.

Living with the Suegra

Figure 17. Doña Frida, her two live-in daughters-in-law Lila and Ceci, baby Estrella and my daughters

In the barrio, tradition dictates that in the case of unplanned pregnancy or a relationship that has been outed a young woman moves in with her partners’ family. Over the months I spent in the barrio I began to unpick the family networks between my neighbouring households and work out who was who in terms of blood and non-blood relation. I eventually came to understand that every household on my block housed two to three generations of son plus daughter-in-law family units. I became more curious about why this was and what it said about the continuation of established gender roles and mestiza family life in modern Chiapas. There is a gender bias associated with this subject in that attention is generally placed upon la suegra as opposed to los suegros (the in-laws). This relates historically to legal definitions of marital homes, as discussed in Chapter One, where the home and domestic labour were enshrined in family law as pertaining to ‘one, and only one

38 Meaning it has been made apparent that the young couple are in a sexual relationship.
woman’ per household (Varley 2000:244). The underlying message insinuates that it is women who dominate the running of the home and who maintain family structure. In the day to day lives of married couples there is of course negotiation and decisions made in partnership but as established gender dynamics dictate matters of day to day running of the house are generally made in reference to the Doña. The presence of daughter-in-laws in households was not new to me, it has long been a popular representation of mestizo Mexican families in both real life and fiction (see Franco 1989). Outside of these representations I had never really thought about it from the point of view of the young couple and the young woman who becomes a mother under these circumstances. The negative gendered stereotype propagated in classic literature and popular media is of the daughter-in-law as a concubine in la casa de la suegra (mother-in-law’s house) where she constantly fights for her husband’s affections and secretly desires to separate him from his mother. My midwife Cristina often commented on the problems women had when preparing for motherhood “They don’t say it as such but many of my clients insinuate in consultas that they wish their mother-in-laws would stop ‘sleeping with their sons’, they say their husbands won’t do anything in their defence”. Despite often hearing attitudes like this and mindful of oedipal insinuations I wondered if the mother-son (and daughter) relationships I had previously allowed myself to see were really as they appeared. Was there more to the over-bearing behaviour of women towards their sons and their partners?

As with most gendered stereotypes - madre soltera, widow, la mujer abnegada, el macho - there were expected behaviours attached that serve to perpetuate and embody myths. But such a reductionist view of a fixed identity bears little relation to of everyday lives and relationships in la Garita (and other mestiza communities).
classic representation of the suegra (as with the mujer abnegada) is harmful to Mexican female identity and glosses over the complexities, similarities and differences of women and their intimate family relationships. Mother-son relationships depend far more on specific family history and individual personalities than on any overriding cultural imperatives (Gutmann 1989:106). In my earlier naivety I had been seduced by the myth of the suegra and failed to see the wider significance for gender politics and power relations. When I got to know the families in my block on a more intimate level I began to see how the situation worked for the family on many different levels most importantly economic, interpersonal relationships and shaping maternal practices. If the relationship was a good one the move into the partner’s family home can be a positive one and provide a transitional experience with support. If the relationship is poor or abusive then there were problems as Cristina had noted in her consultas. A good arrangement will provide a young woman with security, protection in her relationship and training in motherhood that may differ from her own or act to confirm what she already knows.

The young women who lived with their in-laws on my block appeared content and were loved by their new families. It is possible that their arrangements were successful because where there were children they were dedicated to mother work, (whether they were mothers or not) and contributed greatly to domestic labour within homes. “I don’t know what I would do with them” Doña Perla said when I called by her shop one morning, “I was on my own with all men until they moved in, now with the extra help I can run the business and the house is seen to”. For my neighbours Doña Perla and Dona Frida their daughter-in-laws provided welcome female company and a gender balance to previously male dominated households. It was not difficult to see the benefits for the suegra in having extra pairs of hands around the
house but I wanted to know more about how the young women experienced living outside of their own families as they became mothers for the first time.

As we saw in the last chapter married women tended to return to the maternal home for the duration of the postpartum quarantine and that this period was as much to do with the protection and bonding of female kin as it was to do with risk of illness and learning for new mothers. The scrutiny over new mother’s abilities was particularly intense during this period with everything from maternal practices to bodily transformation overseen by more experienced women. Many of the younger women on my block had arrived to live with their boyfriends due to the outcome of unplanned pregnancies, and unlike the married women they did not return to their family home for postpartum recuperation. Their forty-day convalescence had been overseen instead by their suegra and sisters-in-law, with their own mothers visiting regularly. Ultimately these women had arrived at a decision to stay with their in-laws during this period, they were certainly not sequestered against their will, and so questions arise as to how their transition to motherhood was shaped by the experience. Were they able to exert more agency in how the baby was cared for? Did they achieve a more adult status in the household or did they remain still very much in girl status within the household gender hierarchy? And in relation to paternal practices were the fathers better included in the initial transition to parenthood?

One September afternoon after around seven months living in the barrio I was finally able to speak to Lila. She is the daughter-in-law of Doña Frida and mother to the much doted upon baby Estrella. Doña Frida and her family lived in a large house made up of several extensions built up over the years. The land plot originally belonged to Frida’s father Don Juan and different sections have been given to his
children as the family has grown. Don Juan and Doña Rosa still lived in the main part of the house with Frida’s brother Hernán, his wife and their two children. Doña Frida, her husband Don Rogelio, four sons, two daughter-in-laws and granddaughter live in the right hand annex of the original concrete and adobe house. With so many young residents it was the most alegre household on the block with the sounds of música ranchera or thumping cumbia, family debate and laughter floating out through windows and spilling out into the air from early morning to late evening. Doña Frida ran many enterprises from the side entrance to her house and she was the ‘go to’ woman whenever you ran out of cheese, eggs, or sweetbread. In the late afternoons and evenings she set up stall at the front of her house selling corn on the cob dripping with mayonnaise, chilli and grated cheese, chayote boiled to within an inch of its life and much to my daughter’s delight popcorn and chilli sweets. It was on these afternoons that the smell of the corn and chayote would lure me out of my cabin and I would sit chatting to Doña Frida and her family until the evening temperature dropped and she scolded me for having the baby outside so late. It was also on these occasions that I was able chat to the men and get some idea of the part they played in family life.

Lila was common law wife to Doña Frida’s second eldest son Roger, they had been seeing each other for about a year when Lila fell pregnant. At the time she was nineteen and working in a hotel in city centre at the time. Early on in her pregnancy she moved from her parent’s house to live with Roger and his family. I very rarely saw Lila alone outside of the house and only occasionally saw her in the sole capacity as mother to Estrella. Being aware of family hierarchies I approached Doña Frida in order to ask permission to speak alone with her daughter-in-law. She agreed without hesitation “I’ll send her over when she’s finished feeding the baby” she
responded. About an hour later when Lila knocked on my door I felt very conscious that she had arrived under duress but she was quick to reassure me that she was happy to talk. I wanted to find out what it was like to become a mother in such a lively household far away from her own family home. In order to find some clarification and deeper perspective on relationship dynamics I starting by asking her why so many women left their families and moved in with their in-laws: “Here they say that when a man wants to be responsible he should take the woman home to live in his house. That's why I came to live here”. Hearing this opened up a new way of thinking about young couples and what moving in with the in-laws symbolised to the nearby community. It highlighted that in many cases it was a necessary move to make if the reputation of the young man and woman (and therefore their families) were to remain intact. I asked her to tell me more about when she found out she was pregnant and what she felt about it:

When I found out I was pregnant it was difficult because I saw when my sisters got married very young that it was a lot of work, that they were really still young and I felt the same when I got pregnant. I thought ‘what am I going to do’? I didn't know how I was going to face up to it alone but then I told my partner and he said that he would support me. My mum was really angry with me when I told her but my suegra welcomed me in she treats me very well. I felt horrible because I didn't feel very secure in myself as it wasn't planned, but everything happens for a reason though at first I was very scared. When I first went to get the pregnancy test the doctor asked me if I wanted to [have an abortion] she said that she would charge me so much and well I did think about it. I did think that maybe it was for the best if I didn't go through with the pregnancy but then I thought
that I couldn't, that I would have the baby. My husband helped me see that it was a blessing from god and it had happened for a reason. So I started to enjoy the experience like any other pregnant woman, I started to dream about being a mother. I was ready to meet her I was very excited … [The doctors] told me if I didn’t look after myself I would miscarry so I focused a lot on that and looked forward to meeting her …

Like all mestiza families in the barrio Lila’s family and her in-laws are practising Catholics and although she did not find being offered an abortion a problem in terms of recognising it as a right to choose, the dominant shared belief that children are a blessing from God influenced her final decision to stay pregnant. I asked her how her pregnancy had been and how she had been supported during this period and when she went into labour:

I had prenatal care in the local free clinic from around four months until nine months and my suegra took me to see the partera every month to make sure everything was okay. My suegra said I should give birth with the partera but I was too scared to do it at home, I was scared so I wanted to give birth in the local clinic but they kept sending me home, they said I wasn't ready yet. My suegra gave me the option to go to a private clinic where they could check mis dolores [contractions] give me something and have the baby there. We spoke to my suegro and he said they would take me if that's what I wanted and so I went to the private clinic …

Though it is clear from Lila’s narrative that the prenatal care decisions were overseen by Doña Frida she was acting out of care rather than control. Lila’s fears and feelings were taken into account and she was supported to give birth where she
felt safe. The act of providing her with access to a private clinic is significant as it involves a much higher cost than the local partera or the public clinic. That her in-laws were willing to do this without question demonstrates a level of affection and responsibility they felt towards her. After giving birth Lila returned to Doña Frida’s house where she completed her forty-day quarantine and was given the same care and attention that mothers and grandmothers give to their own daughters in the postpartum period. The postpartum period was as challenging for Lila as for any new mother with struggles and doubts over her abilities and niggles concerning the changes to her body:

After the birth I suffered a lot, I had a lot of tears and I had stitches but they came apart. The stitches hurt a lot and I suffered. But everything else was fine, here [at home] I was able to recuperate with support. I didn't have a lot of milk in the first days. I felt that my baby wasn't getting enough, she cried a lot and so I knew I didn't have a lot. There was milk but it was very watery. I used formula and they said that I should take noche buena [hibiscus], I took some and my milk came but I felt very dizzy. It was a woman who lives here nearby who told me. So I took it and got very dizzy, coconut water helped as well and also oat milk. But I never had lots of milk it's like water still, it's not white like milk. My suegra said that it has to be really white to be any good … When I came home after the birth they bathed me in herbs to close up the body and bound me. My suegra used a faja made from cotton. I wore it for about two months, for the whole forty days at least but I still have a tummy and lots of stretch marks. To be honest I’m not happy with my body, I feel chubby, I look down at my stomach and I don’t like it. After the birth I felt awful, I felt really fat and I didn’t
like it. My husband says that I’m fine, that I’m not fat. He says I look better now. My suegra says that it is not a game having children and that your body changes. Even my periods aren’t the same, I haven’t had a proper period since I gave birth six months ago but my suegra she says that it’s normal.

**Undoing Fixed Identities**

With my use of the narratives in this chapter I have sought to undo the notion of a fixed maternal identity. In doing so I hope to draw attention to specific questions surrounding childrearing as a practice charged with great social significance that is yet paradoxically experienced subjectively. Historically in Mexico the idea that good motherhood and good womanhood are synonymous has dominated cultural representation and social thought (Sanders 2009). In the following pages I will consider the ways in which these ideas prevail and also how it is challenged through the production of local modernities. By relating my ethnographic material to combined theories of maternal transition and emotion, I will return to the arguments I raised in the introduction concerning the pragmatics of motherhood and women’s agency and capacity for social and individual change. In order to provide an analytical framework from which to develop my argument of the aforementioned I will use the following three observations made from Oakley’s work on the institution of motherhood and transition to motherhood in industrialised societies (1979;1980):

1) the idealisation of motherhood and its ramifications constitute the greatest problem for women in industrialised societies

2) The institution of motherhood demands that women mother by instinct and their mothering be a selfless act relating to the creation of others. In industrial society the
notion of instinct has been naturalised and promotes a widespread belief that it qualifies women for childbearing and childrearing alike.

3) There is a pervasive ambivalence that motherhood is expressed in the combination of ideological glorification and actual socio-economic discrimination. Encompassed within this there is a falsehood in gender equality perpetuated by the state (via rights discourse and legislation) that acts as a smokescreen for the everyday lives of women.

Though Oakley’s work is based upon a sociological ethnography and analysis of transition to motherhood in 1970’s UK, I find that much of her arguments resonate with my own observations in la Garita, and with Mexican feminist discourse on maternity, womanhood and modernity (Bringas 2004; Castellanos 1992; Guerrero Menses 2004; Gonzalez Avila 2005; Lamas 2001; Palomar 2004). Though I draw from cross cultural feminist perspectives throughout this thesis the application of local feminist thought (which in itself is hybrid) can advance a wider understanding of transition to motherhood in Mexico and offer a critique of maternalist social policy from within a cultural context. Jolly (1998) writes how Asian and Pacific feminists have embraced the maternal subject position, in part to distance themselves from what are perceived as anti-family tendencies in Western feminism. Castellanos echoes this standpoint arguing ‘if we propose to create an authentic feminism that is above all effective, we have to move away from the position of others …’ (1992:288 my translation). Mexican feminism has wrestled with the maternal subject in its efforts to challenge the state, institutional and medical constructs, whilst trying to move the focus onto reproductive health politics, gender, class and ethnic distinctions, and in deconstructing the meaning of motherhood in contemporary Mexico. Mexican feminist thought uses the maternal subject as a referent object that
goes beyond individual bodies to permeate gender relations in every aspect of Mexican society – therefore giving questions of maternal identity and practices a broader scope beyond the mother-woman dichotomy. Some Mexican feminists have presented the argument that the question of maternal policy is better approached as a gender issue in order to make policy more effective and highlight more efficiently continuing inequalities (Gonzalez Avila 2005; Palomar 2004). Highlighting the transition to motherhood for single mothers and new mothers living in matriloc, multigenerational homes contributes to Mexican feminist debate in a way that juxtaposes distinctly female bodies with a politics of parenting that is inherently gendered.

The way that mothering is understood as communal practice in la Garita (without demoting the actual mother to a secondary role), demonstrates a challenge to patriarchal social and political frameworks which value autonomy. Communal parenting within close family networks suggests that autonomy and independence are negative characteristics in the local imagination and not conducive to good mothering practices. In a mother-centric society where the ‘mother-infant fusion’ is encouraged for a longer duration into early motherhood, the developmental preference for separateness and independence is challenged as a desired position. If we think of this in terms of the wider neoliberal political economy which has promoted individuality and personal responsibility through adherence to state values, we can see how local maternal practices – as gendered behaviour - that value dependency and bodily intimacy go against state ideals and projects of Modernity which are shaped by neoliberalism.
Constructs of (M)other Love and Becoming Through Ideas of Separation

Love is love. It is without a category, without description, without title and without labels. It is just love. Love is free from judgement, it doesn’t question, or restrict, it doesn’t damage or hurt, love is pure and unconditional. It is because of this love that we are able to live; it is why we exist. When we start to put labels on it or attempt to justify it, it is then we become prejudiced and limited and then we don’t love. We respond and act out what we are shown is love, we act according to custom, according to taboos and general cultural rules … You see true pure love in your children, even though you may scold them they come back to you, they just love you they don’t ask why you scolded them. If we restrict this right to love we become limited as people.

Bania, during a group Facebook conversation on how the women define a mother’s love (August, 2013)

In her eloquent words above Bania highlights the tension and contradictions integral to the political economy of mother love where discourse of nature and awareness of social construction intersect. This perception of love as a disembodied and divine force that is at once internally produced and externally manipulated provides a symbolic vehicle by which the ‘problem and maintenance of social order can be voiced’ (Lutz 1990:72). The construct of maternal love in Mexico requires a psychophysical essence that is tied to an emic notion of instinct assumed to be unmanageable and problematic on the one hand and something to be manipulated as a force for good on the other. When these mothers act out of love their embodied actions employ emotional discourses as communicative performance (see Lutz and Abu-Lughod 1990) based upon their judgements of the world around them. In this
way they utilise mother love not as a vehicle of expression but as a way of negotiating power relations embroiled within maternal ideologies and subjective experience. The vocabulary of mother love indicates that these women are striving to adhere to the good mother paradigm much perpetuated by Mexican modernity discourses that promote a particular view of women’s roles. Single mothers and unmarried young mothers come within the cultural definition of bad mothers (Smith-Oka 2012) and as such their strategic use of mother love reclaims their right to be regarded as moral women and valued citizens.

I understand the transition to motherhood to be at once inseparable and separated from the biological process of childbearing. In the sense that the biological activities of conceiving, gestating, giving birth and lactating are culturally organised and given meaning in a context of dynamic social interactions and relationships (Arendell 2000). The way the women in this chapter speak of their transition to motherhood adheres to this notion of this inseparability when they talk about maternal emotion, bodies and relationships in the context of their personal and social interactions and their physical environment. How the women speak of their maternal identity and practice is very much placed in a context of family relationships, social networks and the embodied experience of being in the world. They make connections between the biological activity of childbearing and childbirth and learning to care for and love their children, however they separate these events through their feelings. They also relate their identity and practice to their life histories and adherence to maternal feeling and performance rules. The overlapping and inseparability of biological from social avoids imposing a false nature/nurture position whilst at the same time acknowledging that there are elements of psychobiological experience that are impenetrable and limited by description.
My route to understanding what external forces shape women’s transition to motherhood lies in the concept and vocabulary of mother love and how it is interpreted, utilized and embodied in relation to the wider political economy. Feminist literature on political economy of emotions has proved useful for thinking through how mothers in the barrio (and wider society) speak of mother love in the context of global and local modernities. It demonstrates a widespread ideological framing of motherhood as a particular form of self-sacrifice which is prevalent in many societies; one which does not take into account intersecting structural factors which create the conditions for the ideology to exist in the first place and penetrate across cultural contexts. Following Lutz and Abu-Lughod’s assertion that ‘emotion talk must be interpreted as in and about social life rather than as veridically referential to some internalistic state’ (1990:11), I understand mother love to be emotion as discourse which incorporates speech as an expression of sensation and an indicator of social feeling rules.39 In this way emotion is embodied and shaped through social interaction and is historically constituted in the learning of maternal practices. Lutz and Abu-Lughod (1990) suggest extending Bourdieu’s definition of body hexis to emotions in order to grasp how they are reproduced in individuals in the form of embodied experience.

Learnt maternal feeling rules and emotions are expressed through bodily posture, gestures and facial expressions that are a result of being reared under similar physical and social conditions. A woman embodies and reproduces the social position and role of her mother and her grandmother before her in the way she carries, feeds and sleeps with her baby. For example, in the working class barrios of

---

39 Here I refer to Hochschild’s definition that society’s feeling rules are ‘rules about what feeling is or isn’t appropriate to a given social setting’ (1990:122).
San Cristobal infants are carried on the front, side or back of women using a rebozo (see figure 18 below). This enables the women to carry out their work, feed whilst walking, standing or travelling and ensures the safety and warmth of the infant. Using the rebozo and breastfeeding in various moving and sitting positions whilst carrying out other tasks inevitably shapes the posture of the woman to reproducing that of a good mother (in a particular social and political context).

![Figure 18. Embodying maternal posture through shared practices](image)

The significance of carrying and holding infants is often expressed in general conversation with mothers. When I asked my hairdresser Angela about how she felt about her relationship with her son she replied “I carried him on my back all the time and he behaved himself. Now he doesn't because he is growing and he wants to play with his cousin, so he goes off playing and forgets about me. Imagine, he's six years old and he's already off having his own life, in his own world”. Here she is evoking the emotional language of loss and the emotional physicality of carrying her son to refer to the mother work she carried out in order to show she could keep him safe and monitored. Angela’s words demonstrate how emotions are ‘tied to tropes of interiority and granted ultimate facticity by being located in the natural body’ (Lutz and Abu-Lughod 1990:1). Ideas about emotion and embodiment that are located in the natural body are inherently gendered and as such vulnerable to misinterpretation.
and ethnocentrism. The women’s narratives in this chapter provide the vocabulary that represents the maternal feeling rules characteristic of local values and they also demonstrate the limits of language in the expression of the bodily sensation incorporated in becoming a mother. My use of the concept and vocabulary of mother love arises from an attempt to show how the meanings and symbolism attached to emotion are used by mothers to navigate their way between subjective experience and social expectation. In her study of negative maternal emotion, Donath (2015) observed how women negotiate with systems of power in ways that indicate the intensity of social and cultural mechanisms that institutionalise good motherhood and womanhood. She uses Hochschild’s concept of emotional regulation to show how mother love relates not only to local maternal ideals but also to the cultural thinking of children as innocents. The giving of love to a child is entrenched in the meshwork of the relations between social conditions and forms of power. Bourdieu describes this form of interaction in terms of an ‘intentional transfer to the Other’ which happens via the ‘harmony of habitus’ (1977:82). Understood in this way the emotion discourses concerning biological maternal instinct and mother love become thoroughly socially and politically situated with systems of power that govern maternal feelings.

The emotion work that women undertake is significant in shaping who they are as mothers and the experiences of those around them. In her writing on love as political action, Ahmed (2004) contends that acting in the name of love enforces a particular ideal on others by requiring that they live up to that ideal. For the daughters of Bania and Sara, this meant they were required to recognise their mothers’ actions and reciprocate accordingly with praise, appreciation and love. In relation to this, Oakley writes how the apparent self-sacrificing love a mother feels for her child has
different gendered outcomes. She argues that, from this, daughters have unrealistic expectations of maternity (from which they then suffer from as a result) and that son’s attributions of maternal love to women ultimately sustains the idealisation of motherhood that is central to hierarchal capitalist societies (Oakley 1979). Yet, as Bania and Sara strove to distance themselves to the way they had been mothered, it can be argued that they attempted to shape their expectations to meet the reality of their situation. According to Oakley what happens to women as they become mothers reflects what has already happened to them as they become women. In other words, they find themselves being fitted into an existing role that is shaped by an element of biological universality and which evades any type of cultural hybridity. This leads to unrealistic expectations and prevailing disjunctures ‘between the ideologies of mothering and motherhood, and the experiences of real women’ (Arendell 2000:1196).

The women in this chapter are evidently dealing with preconceived notions of what a good mother is and how the other women around them impact on how they mother. Yet, they are also conscious of how and who they want to be – incorporating rather than perpetuating ideology in their ongoing transition to motherhood to produce new, historically, culturally and socially determined, ways of “being modern” (Hryciuk 2010). They are contesting the imposition of a fixed identity by using their life experiences and a hybrid of local and global influences to think about who they are as women and as new maternal subjects. Abu-Lughod (1990a) writes that in the case of Bedouin women, although individuals may desire and embrace aspects of modernity (such as cosmetics or alternative styles of dress) because they signify resistance to historically dominant gender ideals, these individuals make themselves subject to new forms of power that accompany and inform modernist projects.
Amongst my informants in la Garita, the new forms of power that emerge as a result of rejecting both aspects of tradition and Modernity are less obvious and perhaps, as such, provide greater scope for collective agency to bring about a different kind of social change in the long term.

The narratives demonstrate how maternal subjectivity can be understood as developing out of the mother’s separation from the other, whether it be the child at birth or by other means. This way of re-centring the mother provides scope to reimagine the concept of maternal subjectivity in its own right – in a way that is not reliant on the presence of a child. The way that the mother role, in the mestiza Mexican context, reunites the maternal subject directly with the female bodily form gives rise to a new kind of subject who generates meaning and acquires agency from her place in maternal body relations (as argued by Stone 2012a:3). These ideas about separation which arise from the narratives of lone motherhood warrant further exploration from the position of the maternal subject and her experience in its own right. Here, Cavell’s standpoint that “…the ‘proof’ of the others’ existence is a problem not of establishing connection with the other, but of achieving, or suffering, separation from the other…” (2005:146), provides the key to maintaining the maternal subject as central. Separation in Cavell’s terms provides proof of existence from the experience of the mother in her own right, without denying that this individuation is in “respect to the one upon whom [her] nature is staked” (Cavell 2005:146). The ‘unbearable certainty of separation’ for Cavell marks the ‘moment of being known’, or alternatively a remaking of self and a recognition of transformation. These perspectives resonate profoundly with the way in which women spoke to me of their experiences and how they had lived through significant changes in their lifecycle. This moment of being known through separation points
towards the notion that the child does not have to be physically present for a type of maternal subjectivity to emerge. This provides a way to think about mothers who are separated from their children either for long periods or permanently. As Sara clearly demonstrates, women do not cease to feel like a mother in the absence of a child – they become a mother of their own making albeit in circumstances not chosen for themselves.

The women in la Garita share the idea that on the one hand, maternal instinct and love are a divine notion granted by the appearance of a child – a blessing from God – but on the other good (competent) motherhood, is not something that comes pre-programmed or naturally. In the way they express themselves verbally, they are clear that motherhood requires hard work and is something that requires guidance from others. On a macro-level however, it is arguably still the case that representations of motherhood are ‘expressed in the combination of ideological glorification and actual socio-economic discrimination’ (Oakley 1980:285). There remains to be a falsehood in notions of gender equality perpetuated by the state (via rights discourse and legislation) that acts as a smokescreen for the inequalities in the everyday lives of women on domestic and localised grounds. Yet, these inequalities remain in a system that purports to eradicate them through a project of modernization that places the (good) mother role as central to its success. The women in la Garita appear to comply with this when they speak of their roles as mothers as central to their existence in relation to others, but not central to their selves as women. For them

---

40 The false notion of equality inherent within neoliberal economies which is closely linked to the emergence of human rights discourse since the 1990’s (see Harvey 2005 for an in depth critique). An emphasis on gender and ethnicity drives political rhetoric on equality where it then becomes enshrined in legislation and policy and therefore becomes naturalised as a phenomena that exists to be defended, all the time failing to deal with the cultural and systemic causes of inequalities and merely shifting their trajectory.
being a woman and mother are not synonymous, yet neither does one identity exist without the other. In this way they reflect the arguments made by Mexican feminists that, in their position as mother, they gain a certain social and political standing that other women are denied and they do not accept that liberation comes from having to reject motherhood completely. Their maternal identity is central to them at the time that it most serves a purpose but this does not define who they are in every aspect of their lives.

Though the themes of agency, established gender roles, Modernity and change are prevalent throughout all their narratives, they manifest in different ways and in priority. Transition to motherhood takes place in a complicated web of global and local processes and individual expectations where women come to embody the understanding that they have shifted from one context to another. These narratives show that the process of becoming a mother happens differently for women depending upon their own social worlds. Knowing they have made the transformation to (M)other is intrinsically linked to the recognition of their maternal practices by others, which in turn informs their thinking and perceptions of their world and their role within it.

For Bania, the actions and presence of her daughter confirm her maternal identity and for her act as a measure to how well she is doing. Sara however did not stop being a mother to Ana when she left home to live with a new partner. Her role as a mother did not cease to exist, it merely changed course. Lila’s maternal identity is reinforced by the presence of her baby and family unit around her. Her transition to motherhood is validated by her suegra who oversees her practice but who is at the same time careful not to deprive Lila of her own maternal status. All of these women are immersed in what Hodgson (2001) terms the ‘production of modernities’:
processes that expect women to adjust to the needs of the modern state and which are mediated and transformed in local socio-cultural contexts by the activities and opinions of individuals differing in positionality (Hryciuk 2010:498). They are negotiating with systems of power that govern maternal feelings and that indicate the social and cultural mechanisms of institutionalised motherhood within the confines of local social relations.
CONCLUSION

I began this thesis with a problematic: How do we formulate new global theories of change that are grounded in the particular, and in which gender is central? As such, can the study of maternal transition, within a broader context of life events, alter our current understandings of how human beings embody processes of change and negotiate forms of power? And, how might the material I gathered from the women in la Garita contribute to this discussion?

In order to address these questions, I have structured this thesis in an attempt to map out the different stages of maternal transition for a particular group of women who live in a small barrio on the fringes of San Cristóbal de Las Casas. Not only are these women geographically on the fringes, but also systemically in their mixed use of public and private services, and decisions not to access welfare. When I presented my research argument in the thesis introduction, I introduced Freeman’s assertion that globalization discourse is bereft of gender analysis because it is hard to connect the ‘global’ with women’s stories and experiences. I have tried to confront Freeman’s assertion by attempting to demonstrate the subtle ways in which indirect consequences of social policy impact on women of low socio-economic status, who are both interdependent and in tension with the state because of their maternal status.

I am in agreement with feminist critiques of globalization discourse that, amongst other things, perspectives of global ideology tend to overlook local variations in the causal processes of inequalities, and as such, fail to deal with root causes and effect change (Abu-Lughod 1990b; Chant and Craske 2003; Das 2008; Freeman 2001; Mohanty 2013; Nash 2007). At the same time, I have been wary that in my urge to
locate these mestiza lives in the macro, I “run the risk of romanticizing as well as overplaying their significance” (Freeman 2001:1032).

Through an ethnography of the social relations in which women in la Garita become mothers, I have linked themes of community, relationships and gendered personhood to broader discourses of global health, political economy and modernity. I have situated the transition of self within these relations and used ethnographic narrative to describe how women negotiate the spaces between tradition (as locally constituted and understood) and Modernity (as constituted by global relations and state), ultimately to produce new hybrid and gendered modernities within a local context and as part of ongoing local processes. The way in which the ethnographic material has led me to think about the problems of masculinization within macro theories of globalization has drawn my attention to the complexities of how we theorise maternal subjectivity in ways that are applicable cross-culturally. This in turn has led me to think about the limitations of embodiment theory in terms of maternal subjects and the undeniable physicality of human reproduction. Similar to the feminist critique of macro globalization theory, approaches to embodiment often suffer from a denial of the corporeality of sexed bodies that provide the context for embodiment to occur.

In trying to imagine a new gender centric theory of social change which is grounded in the particular, we need to pay attention to not only how ‘global processes enact themselves on local ground but how local processes and small scale actors might be seen as the very fabric of globalization’ (Freeman 2001:1009). In the case of Mexico, the universal and interchangeable notions of sex and gender in global health discourse often results in a continuing emphasis on women as natural carers. This issue is further complicated by a blurring of the lines between maternal health
(concerned with female bodies) and reproductive health (concerned with gendered bodies). Though they may intersect under the umbrella of gender policy, treating maternal and reproductive health as one and the same perpetuates social inequalities in a way that mostly impacts on maternal subjects. The maternalisation of reproductive health (and rights) actively excludes men and women who do not wish to be mothers, regardless of ethnicity, socio-economic status or sexuality, from being incorporated into policies directed at family planning, and reproductive behaviours. It reinforces dominant attitudes about the nature of gender relations and fails to challenge wider societal inequalities in Mexican society. The non-recognition of local gender dynamics in reproductive and maternal health policies also fail to represent the everyday diversity in the distribution of household labour and family structure and dynamics (Gutmann 1996, Palomar 2007). Essentially, maternal and reproductive health policies, framed in global health discourse, are aimed at promoting universal ideologies of gender equality. As such, on a macro level, they seek to make fundamental social change and therefore challenge historical patterns of state-society interaction concerning relations between the state and the market (Htun and Weldon 2010:207). In order for social change to be equitable, the politics of locality must be taken into account when policy is being developed.

In Mexico maternal and reproductive health policies are framed by a rhetoric of rights which are interdiscursive with concerns over maternal and infant mortality. For the state, the right of mother and infant to survive birth takes precedence over local beliefs and knowledge about maternity as a process within the wider female life cycle. The maternal management and practices in la Garita, the dependence on communal mothering and the growing numbers of other mestiza women seeking the services of professional midwives, demonstrate the varying nature of maternal and
reproductive health issues in local worlds. The choices that new mothers make in managing the different stages of maternity are clearly influenced by political and social ideas of what it means to be a good mother. Taking this into account I can locate their actions in broader questions of what it means to be a modern citizen in Mexico. The framing of maternity in global health language is born out of a pathologizing of childbearing and concerns with biopolitics (population control, political economy of mortality and morbidity). This is in contrast to the local understandings of childbearing and childrearing as life cycle events indissoluble from biosocial relations. Where the local and global become enmeshed, a situation arises in which ‘…instituted interventions intersect with political cultures, medical institutions, domestic norms and individual strategies’ (Das n.d.:5) in order to generate maternal experience. Although these interconnecting factors retain their own agendas in shaping the maternal subject, it is the unintended consequences of their intersection that demonstrates how external forces become implicated in the ordering of gender relations in any given society.

Ultimately, this thesis highlights how becoming a mother for the first time is a life change that carries ‘tremendous physical, emotional and social implications for those who engage in it’ (Oakley 1980:179) and with it. The women I met during fieldwork, whose narratives have shaped the direction of this thesis, show that when individuals have recourse to a mixed economy of health care and are not reliant on state intervention, it can result in an outcome that better meets with the women’s expectations. Women’s combined use of lay and clinical services reveal ways in which they make active attempts to avoid negative pre and postnatal experiences. In doing so they embody a maternal identity that is deeply rooted in the various local ways of being-in-the-world. By managing the process of maternity more akin to
local ways of thinking about gendered personhood, the women reveal how change is
contested and incorporated within the everyday practices of family and social life.


Freyermuth, G (2010). Desiguales en la vida, desiguales para morir. *La mortalidad materna en Chiapas: un análisis desde la inequidad: Informe sobre Desarrollo*


Database of Systematic Reviews, (8). Retrieved from: http://dx.doi.org/10.1002/14651858.CD004667.pub3


