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Lessons from Chiapas: Caring for Indigenous Women Through a Femifocal Model of Care

Cristina Alonso, Alison Danch, Jenna Murray de López,¹ and Janell Tryon

Abstract

By highlighting the various ways in which indigenous women in the colonial city of San Cristóbal de Las Casas manage maternal health and birth care, in this chapter we intend to provide a counter-narrative to the dominant approach which conflates medicalized maternal health with low mortality ratios; regardless of the quality of interventions and the cultural preferences of diverse populations. Our research and practice experience shows that indigenous and non-indigenous women throughout Mexico continue to seek the services of midwives and out-of-hospital care, regardless of the improvements in access to public services. This observation alone raises important questions about the divide between the type of public services available to indigenous and low-income women, and their needs and desires around the lifecycle process of motherhood. This chapter also discusses Luna Maya, established in 2004 as a **femifocal birth center** and midwifery training program. Luna Maya has provided a safe space to poor and victimized women, and especially indigenous women, to recover their power and strength, becoming a model in Latin America for out-of-hospital birth and integrative care.

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X.1 Introduction

Although Mexico is now considered a high middle income country, there remain significant disparities in health, wealth and social issues across the 32 federal entities. Situated in the south east on the border of Guatemala, Chiapas is one such region that presents challenges to Mexico's image as a global economic power. On the one hand, Chiapas is extraordinarily rich in natural resources and is the most geographically and culturally diverse state in Mexico. On the other, is amongst the top five most marginalized states, with the highest recorded unemployment levels and lowest educational attainment by gender (completing secondary school) of all thirty-two federal states (OECD 2015). Access to health services is particularly poor and is associated with wider political economic and social issues. Chiapas has the second highest maternal mortality ratio (MMR) at 68.1 per every 100, 000 live births, and the highest infant mortality rate (IMR) at 17.9 per every 1000 children under 5yrs in the country as a whole (INEGI 2013).

Approximately twenty-seven percent of the total population of Chiapas self-identify as indigenous Mexicans (INEGI 2010). Indigenous populations are most concentrated in the rural highlands, though internal conflict and economic disparities have led to widespread displacement and transmigration over recent decades. Changes in migration patterns and the impact of national and global recession have resulted in the rural-urban poverty divide being less apparent. The Organization for Economic Co-operation and Development (OECD) reported in 2015 that the urban population is no longer significantly better-off in having access to health services than rural populations. This observation is also reflected in a narrowing in the division between the occurrence of rural and urban maternal mortality and morbidity in both indigenous and mestizo populations.

As with all critical global health debate the aim of this chapter is to look beyond the ‘abstract and bureaucratic considerations of public policy’ (Biehl & Petryna 2013:3) to recognise how lives are actually lived and cared for. By highlighting the various ways in which indigenous women in the colonial city of San Cristóbal de Las Casas manage maternal health and birth care, in this chapter we intend to provide a counter-narrative to the dominant approach which conflates medicalized maternal health with low mortality ratios; regardless of the quality of interventions and the cultural preferences of diverse populations. Whilst the majority of the female urban indigenous population will access public services when they need to give birth, others seek out alternative models of care more closely related to traditional model of care. This occurs on a timeline, as indigenous women may migrate to the city and never find safety and relevance in medical maternal health models, or they may have always lived in a neighborhood where all women birth at home with traditional midwives. In other cases, some women have crossed the cultural boundary to the medicalized model and now desire a return to homebirth due to personal preferences related to family, respect and privacy. In such cases, they may no longer find a traditional midwife and are confronted with having to choose a “postmodern midwife”, crossing a second boundary to being cared for by a mestizo or foreign midwife (Davis Floyd, 2001, 2005).

In the following pages we will describe how the type of maternity and birth care indigenous women will access in the city is dependent upon age, social networks, fluency in Spanish, and their economic and housing situation. Together with other anthropological studies of the southern region, our research and experience shows that indigenous and non-indigenous women throughout Mexico continue to seek the services of midwives and out-of-hospital care, regardless of the improvements in access to public services (Sesia 1996; Murray de López 2015; Flores & Espejel 2015; Smith-Oka 2013). This observation alone raises important questions about the division between the type of public services available to indigenous and

low-income women, and their needs and desires around the lifecycle process of motherhood. This chapter is divided into three sections, discussing reproductive rights, choice and policy, midwifery in San Cristobal and focusing on Luna Maya as a femifocal Birth Center. Drawing from research and the experience of the authors, the chapter draws on narratives and interview transcripts to provide case examples.

Established on August 25, 2004, the Luna Maya Birth Center has provided over a decade of services to women and their families in San Cristóbal de Las Casas in Chiapas, Mexico and, more recently, in Mexico City. In addition to expanding beyond traditional midwifery services, Luna Maya broadened the very meaning of midwifery: “We see birth as the beginning of a whole bunch of processes about becoming aware of your body, of your system, of your relationship to your health” (Alonso 2014). From its inception, Alonso understood that the state of maternal services in Chiapas necessitated a woman-focused, humanized intervention to employ the broadest meaning of women’s health.

Since the medical model of pregnancy and birth took hold in Mexico, women have been offered an increasingly narrow set of maternal health services, which are highly medicalized and often obstetrically violent. Responding to this environment of limited care options, Luna Maya has not only stressed the importance of holistic care, which addresses the psychosocial needs of its clients, but has also provided alternative healing as an alternative to the allopathic framework of popular medical models of maternal care. Moreover, Luna Maya has created a model that understands that the individual is linked to and informed by her environment, which includes her family and community.

X.2 Reproductive Rights, Choice and Opportunities

San Cristóbal de Las Casas is the third largest in Chiapas with a population of 158,102 and with 62,208 inhabitants identifying as being indigenous Mexicans in the most recent census (INEGI 2010). As mentioned in this chapter's introduction, internal conflict and broader economic precarities 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 increase in population (both transient and permanent) in cities close to the highlands, subsequently resulting in heightened pressure on public services. Within the municipal boundaries there are a total of eleven public hospitals and seven (registered) private maternity clinic/hospitals – one of which includes a charitable hospital which also targets low-income families. Of the eleven public institutions two are part of the conditional cash transfer (CCT) programme IMSS-PROSPERA (previously known as IMSS-Oportunidades) and another three are open to the basic assistance programme Seguro Popular. Most significant for the transient indigenous population is the Seguro Popular Hospital de las Culturas, built specifically in 2010 to serve the incoming rural and mainly Tsotsil- and Tseltal-speaking indigenous population (Secretaria de Salud 2013). Upon its launch, the Hospital de Las Culturas was celebrated for being 'the first hospital in the country to include traditional medicine, taking into account the traditions and customs of indigenous peoples' (Periodico La Jornada 2011). In the Traditional Medicine Section of the hospital there are four traditional midwives working as doulas who can attend to pregnant or postpartum women. However, the Hospital de las Culturas does not attend births, and women who attend the Traditional Midwifery Section of the hospital are then referred to the city Maternity Hospital where doulas or traditional midwives are not permitted entry.

Fig. X.1 Indigenous Midwives from Tenejapa participate in midwifery training sessions carried out by Luna Maya

As previously mentioned there are two main assistance programmes running throughout Mexico that provide for those individuals and families without any health insurance and living below globally-defined poverty levels. Seguro Popular (also known as the People's Health Insurance) was created in 2003 and is intended to cover all families that are otherwise uninsured. Seguro Popular is a voluntary family health insurance programme funded by the federal government with resources allocated and delivered at a state level. Seguro Popular is means-tested with a sliding fee-scale for services, and with all fees waived for families in the lowest two income deciles (Homedes & Ugalde 2009). Services provided via Seguro Popular are delivered through existing state and federal institutions, and can also be contracted out to private services. Seguro Popular is currently providing services to approximately 61.7% of the

population of Chiapas, while 21.5% of the state population remain beyond its reach (ENSANUT 2012).

Fig. X.2 An indigenous pregnant woman attends Luna Maya for prenatal care with her small child on her back.

The second main assistance programme is the aforementioned IMSS-PROSPERA. This is a CCT programme that originally targeted impoverished rural areas and, in more recent years, has been extended to impoverished urban areas. Its overall aim is to improve education, health, nutrition, and living conditions for population groups in extreme poverty, as well as to break the ‘intergenerational cycle of poverty. The maternal health

element focusses on the provision of prenatal services to help the proper development of the pregnancy, to protect the mother's health, and to identify high risk pregnancies (SEDESOL 2011). In combination with other national health policies there is also an emphasis on offering contraception choice and family planning advice to all women as part of the regular *platicas* (educational programme) and in prenatal appointments.

Fig. X.3 Health promoters participate in Emergency Obstetric training in Luna Maya to create a network that supports infrastructure and support to women and rural areas.

As a consequence of its high MMR, Chiapas is a principal federal target for the PROSPERA programme. Recent government figures suggest that approximately 32.8% of the urban population and 80.7% of the rural population are in receipt of assistance from PROSPERA (ENSANUT 2012). Whilst the programme has had some relative success with lowering the MMR among the rural population of Chiapas, the MMR between urban (mestiza and indigenous) beneficiaries and non-beneficiaries is reported to be less than ten percent (Freyermuth & Cárdenas 2009). Furthermore, while over one-half of the state population receives aid *Seguro Popular* or *PROSPERA*, the overall maternal mortality rate in public

institutions is improving at just one percent per year (Freyermuth 2010: 2). This questionable impact on urban and rural MMR is steeped in the misconception, despite much evidence to the contrary, that maternal mortality is a quandary to be solved by medicine alone. The reduction of maternal mortality to a distinctly medical – rather than social – problem, ‘means that the only outcome can be life or death’ (Berry 2010:1). The management of pregnancy and birth, in global and local policy, thus becomes framed by a medical rhetoric of saving lives at any cost – mother death for the medical practitioner is synonymous with failure. This in turn leads to an over-emphasis in localised contexts on access to emergency obstetric services and a model of prenatal care that is hypersensitive to diagnosing and managing risk. Pregnant women, as principal benefit recipients and potential agents of social change, become defined within a medical framework as difficult subjects with risky bodies – particularly in terms of their reproductive and sexual behaviour. This is further complicated by social prejudices based upon ethnicity, class and gender. Each category further adds to the health professionals’ calculation of perceived risk.

In everyday practice ‘risk’ is a tricky concept to pin down, as it becomes not one measurable thing but a multi-layered relationship of things dependent upon the actors involved. The competing cultural metaphors of risk at play in the medical environment culminate in an oversimplified idea that women in need of CCTs equate to a potential danger to themselves and wider society. When these ‘risky bodies’ enter into a high pressured, under-resourced public hospital they are, in turn, subjected to a particular type of treatment. One way to understand how poor women embody bio-social ideas about risk is to examine the interactions between them and health professionals in the medical environment. When we bring attention to the marked ethnic and class differences between patients and health professionals, we begin to see the ways in which women are framed by competing notions of risk.

During a period of ethnographic fieldwork carried out in 2011-2012, Murray de López interviewed Ricardo, a recently qualified doctor, about his experience of attending recipients of Seguro Popular and PROSPERA at various maternity hospitals throughout the state. Below he describes the type of contact doctors have with women during what is referred to in the medical lexicon as '*control prenatal*' (prenatal care) or more loosely by many women as '*el control*':

... in hospital the first appointments ... they will give the diagnosis [of pregnancy] or they will give the first appointments. So when they next come to the hospital they are seen in a group for the *platicas*. In my experience the '*control prenatal*' actually happens in the ultimate appointments. They do an ultrasound if the equipment is there, very quickly just to check that everything is okay, to measure how low the baby is, to check the position of the product. And well, when we carry out this evaluation of the product we do a quick evaluation of the patient. Then we will advise [her] when her dates are, the possible due dates ... we tell the woman to be conscious of these dates and understand what the alarm signals are ...

Ricardo's description highlights the emphasis on 'detection of risk' in the approach to *control prenatal*. The phrase itself is an intriguing one as it suggests something, in this case a body or a process, in need of control or management. This terminology is part of a wider medical lexicon that in itself shapes ideas about women's bodies as precarious, at risk of harm, or of harming. The type of interaction that takes place in the prenatal care appointment firmly positions the pregnant woman as passive, yet at the same time responsible, for recognising the warning signs that mean she is 'at risk' of giving birth. Increased access to institutions in urban areas via Seguro Popular and PROSPERA has contributed in practical terms to a national statistic of 94% recorded live births now taking

place in hospital clinics (ENSANUT 2012). In comparison, in Chiapas it is estimated that a more conservative 60.5% of live births take place in a hospital or clinic, despite the large coverage of PROSPERA (Lazcano-Ponce et al 2013). It would be wrong to assume that women who are not included in the 54.9% are simply failing to access hospital care, or indeed that they all require access to a welfare programme. The paucity of data available for women across the social strata who have out-of-hospital births in urban areas of Chiapas makes it difficult to indicate the level of choice involved in doing so. The small amount of research that does exist raises important questions about the actions that women in Chiapas take when presented with the restrictions of the public healthcare system, or when they feel for whatever reason that the pregnancy, birth and postpartum stages of the lifecycle process should be cared for in other ways.

X.3 Midwifery in San Cristobal

There is a popular assumption in Mexico that where possible women, and particularly mestiza women, prefer to give birth in a clinical environment in the presence of an obstetrician. The hiring of a midwife (to attend birth at least) in the dominant social imagination is associated with something that ignorant, uneducated and poor women do – those who have not yet learnt what it means to be a modern citizen of Mexico. Smith-Oka argues across Mexico ‘a tussle exists between tradition and past, represented by the *parteras* (traditional birth attendants), and modernity and the future, represented by clinicians (Smith-Oka 2013:83). In the urban environment this oversimplified dichotomy of traditional and modern is more readily challenged. As the focus of this chapter demonstrates, the reason why Luna Maya continues to thrive arises from the needs of women across the local social spectrum who, for a variety of reasons, seek out-of-hospital maternal health care and the inter-cultural knowledge base and practices of midwifery.

Murray de López (2015) has observed three different types of midwife practising in the urban context of San Cristóbal: The first is the traditional midwife or traditional birth attendant as described in policy initiatives and whom many people associate with the practice of midwifery in Mexico. This image of the traditional midwife is that of an indigenous woman, attending poor women in a rural context, and is reinforced by media representations and development policy alike. Despite this stereotype, there are various traditional midwives practicing in the cities of Chiapas, attending only other indigenous women. The second and most common type of midwife is found in low-income urban barrios, and represents the empirical midwife. The third type of midwife is found in the urban context and is the professional or autonomous midwife, the only practitioner to be working across class and ethnic boundaries, as shall be discussed further below.

The term empirical midwife is sometimes used to denote women who learned midwifery, either through attending women in childbirth or through apprenticeship to another experienced midwife (Mills and Davis-Floyd 2009). Murray de López has extended this definition in her work to distinguish mestiza traditional midwives who employ a combination of traditional and lay-allopathic techniques. This distinction is necessary in areas where homebirth and midwife-supervised aftercare remains popular amongst the low-income mestiza population. Local ethnic divisions between mestiza and indigenous populations mean that an indigenous traditional midwife is unlikely to attend the birth of a low-income mestiza woman. Under Mexican law the title of *partera tradicional* (traditional midwife) is protected as an indigenous custom and traditional practice. This means that the numerous mestiza women practicing as empirical midwives remain without recognition or regulation by the state, and their contribution to maternal health is effectively ‘disappeared’ from debate. The empirical midwife, who is generally hired via mestiza families or close social networks, as well as the women hiring an empirical

midwife are more likely to be combining her services with those available in the public and private health system. The empirical midwife plays a significant and under-researched role in an integrated model of maternal and women's health care beyond pregnancy and birth. For low-income mestiza families, she is particularly significant in the postpartum healing period and the spiritual wellness of the mother-infant unit.

Fig. X.4 Indigenous women and midwives participate in women's circles at Luna Maya to learn about their bodies

Each year there are fewer and fewer empirical midwives regularly practicing and attending births in the barrios of cities like San Cristóbal. There are multiple factors that contribute to the trend of decreasing out-of-hospital births attended by an empirical midwife. These include women's improved access to public healthcare as previously mentioned, the success of CCT programmes and Seguro Popular, and general changes in

the perceptions of risk associated with childbirth. In addition, women are told directly that they will lose access to Seguro Popular/IMSS-PROSPERA and social benefit programs if they give birth outside of government institutions. Although this is not stated anywhere in policy, it has become an “oral” policy, and has been perpetuated long enough for many physicians to believe this is actually the case. The overall aim of IMSS-PROSPERA is to ‘reflect the priority that births should be attended by qualified personnel in an institution as an effective strategy for reducing risks in maternal and infant health’ (IMSS 2015). As a woman is also unlikely to find an IMSS-PROSPERA-affiliated midwife in an urban context, giving birth in an institution is the only likely way that a woman can access the paperwork needed to apply for welfare for her child.

Fig. X.5 A midwife apprentice at Luna Maya exchanges with a traditional midwife

In 2001 Robbie Davis Floyd described the postmodern midwife in Mexico, which she describes as building an emerging identity of a professional midwife (Davis Floyd 2001).

Although it is impossible to say when the postmodern movement of midwifery emerged in Mexico, there are key events that mark its integration into the maternal health conversation at a national level. By 2014, literature describing the midwifery movement in Mexico had described a new term, the “autonomous midwife” (Laako, 2016. According to Laako, the autonomous midwife “emphasizes the political and autonomous aspects of this type of midwife. The concept of autonomy is fundamental in the collective action of these midwives as their profession lacks autonomy in Mexico. However the concept of autonomy also emphasizes the anti-systemic character of these midwives: their critique of the bio-medical system with its pathological perspective of birth and the defence of a rights based approach to birth” (p.171, Laako 2016.

Luna Maya was founded three years after the death of Doña Graciela, a renowned traditional midwife who, according to San Cristobal folklore, attended most births from the 1980’s to the millennium. Luna Maya was founded on a rights-based approach, as witnessed by its vision and mission statements establishing humanized birth and respectful care as human rights. Women who had birthed with Doña Graciela then shifted their care to Luna Maya without even realizing they had become activists of an emerging political movement - they just wanted peaceful births within their own home with a trustworthy midwife.

The establishment of Luna Maya occurred concurrently with a national movement that spoke of peaceful birth, respect for tradition and culture, women’s empowerment, and continuity of care as essential aspects of millennial midwifery. This practice weaves traditional ceremony and technique with modern tools such as Facebook, conferences, WhatsApp conversations and websites.

X.4 Luna Maya Vision and Mission: Empowering Women, Empower Communities at a Femifocal Birth Center

Luna Maya was founded in 2004 to provide humanized health services including respectful maternity care under the vision “to achieve safe motherhood through the empowerment of women” (Alonso cited in Banet Lucus and Tryon 2014). Established as a birth center and midwifery training program, Luna Maya has become a model in Latin America for out-of-hospital birth and integrative care. Highly informed by its international and regional context, Luna Maya’s founding vision outlined the ways in which it would adopt an evidence-based midwifery model of care in an effort to alleviate the burden of maternal morbidity and mortality, deficiency of birth-related and postpartum care services, and obstetric violence on the local level. Luna Maya’s model of care offers a continuum of women’s and maternal health services in a community setting, of which it is an integral part. Luna Maya set in motion a particularly innovative conceptual lens for the midwifery model of care (Table X.1).

Table X.1 The goals and mission of the Luna Maya birth center

<u><i>Vision:</i></u> To achieve safe motherhood through the empowerment of women.
<u><i>Mission:</i></u> Luna Maya works to ensure that all women of Chiapas have access to a safe and humanized birth and birth experience. They believe that the women of Chiapas have the right to make informed decisions about their bodies and access and the right to the necessary means to ensure their health and wellbeing. They believe that safe motherhood is a human right that contributes to the empowerment of women, the improvement of the quality of life, and the strengthening of families.
<u><i>Goal:</i></u> To contribute to the reduction of maternal mortality in Chiapas, Mexico.
<u><i>Objective:</i></u> To improve access to safe motherhood through the empowerment of women utilizing the Professional Midwifery Model of Care and access to the emergency obstetrical care, as needed, in Chiapas Mexico.
<u><i>Expected Results:</i></u> <ol style="list-style-type: none"> 1. An autonomous and sustainable birth center, run by professional midwives 2. Better knowledge and awareness about sexual and reproductive rights, including humanized birth, as it is defined by the World Health Organization 3. A training program for local, Mexican, and international midwives 4. A network of service providers, governmental institutions, and women’s organizations that aims to increase access to humanized birth through collaboration and referral

Fig. X.6 A pregnant woman receives prenatal care from a midwifery student, supervised by a midwife

Matrifocal, a term used to describe matrilineal communities and mother-centered political and cultural structures, necessarily hinges on the figure of the woman. The use of this term has extended beyond these initial fields and forums, becoming one that is used to describe kinds of ideologies relating to and guiding health care service and delivery. While this represents a positive development in terms of the incorporation of a women-specific discourse, there is still the need for further development of the related concepts and phrases used to represent these philosophies. The most notable shortcoming is that the term does not represent all women; namely, it excludes all those who fall outside of the parameters of motherhood, no matter what the reason. Many health care services, globally, are geared specifically towards mothers, thereby excluding women who are not mothers. While the matrifocal movement has

covered important ground by creating a politically palatable way to move the discursive focus towards women from a legacy of male-centricity, there is still the need to broaden the focus to explicitly include all women. Therefore, in order to acknowledge motherhood as one option among many that are presented to women, we suggest the use of the term *femifocal*, thereby encompassing all those who identify as women, regardless of their relationship to having children.

Fig. X.7 Building community: Couples share their birth experience in Childbirth Preparation class

To date in the literature, the term *femifocal* has been used sparsely. When used, however, it has been ascribed to certain types of women-led kinship structures and household patterns that move beyond the strict relationship of a mother to her child (Alber & Thelen 2013). Specifically, *femifocal* describes the transition in kin roles that occurred as men began to adopt more migratory work patterns, thereby leaving the home in the full care of a female. This specific shift to *femifocality* happened through shared experiences and hardships most regularly between sisters. Alber and Thelen (2013) suggest that “social practices and changing household patterns reconfigure kin, gender, and generational patterns” (p. 49). In a similar vein,

through invoking the term femifocal in regards to conceptualizations of health care services and delivery, we are recognizing that there are a multiplicity of experiences for women that must be acknowledged and embraced (Lucas and Tryon 2014).

Fig. X.8 A midwife and new mother share an intimate moment to rejoice in a beautiful, empowering birth

Femifocal can be understood as a mindset, which can then inform policy and behavior. When we discuss femifocal care, we are specifically referring to how this mindset or lens is applied in terms of policy and best-practices development in the fields of medical and health care services and provision methods. Femifocal recognizes that a woman is at the center of her

own social, political and cultural ecology. This includes women and girls who are mothers, have been mothers, those who have never been mothers, those who hope to become mothers, those who intend to never become mothers, and all girls and women who define their own category of relating to their experience as women. Femifocal care is humanized. It views a woman as containing many spheres of experience and existence, rather than solely as a biological machine that needs medical attention.

Fig. X.9 A grandmother listens to her grandbaby's heartbeat at the mother's bedside as the midwife carries out the well baby check.

Similarly, femifocal care understands that humans are nested within larger contexts that can be positive and negative, often comprised of loved ones, family, friends, community, culture, political structures, built environment and natural geography. Femifocal care works with a woman within these multiplicitous contexts. Femifocal care works with a woman across and throughout her life-course, realizing that she is accumulating experiences and history as she grows and develops. The ability to understand the woman in many of her changes throughout her life-course is enabled by the fact that ideally she is seen by the same provider

the whole time, thereby infusing the traditional patient/provider dynamic with more relational and temporally consistent elements. All femifocal care is rooted in a woman's desire to participate (with her informed consent) in the treatment and care, as well as on her elucidation of what her unique health goals are. Femifocal care is women-centered, and individually driven.

Fig. X.10 A new group of Doulas and Birth activists graduate from a one year training program at Luna Maya

X.5 Tenejapa and the Highlands of Chiapas

The Altos of Chiapas is one of eight socioeconomic regions in which the state is divided. With 18 municipalities, 15 have majority indigenous population. A third of the state

indigenous population is concentrated in this region, with almost 75% of its population above 5 years and a monolingual rate (indigenous language) above 32.6% compared to the state average. Most of the population can be considered rural and almost 70% is dispersed among ranches and other places of difficult access and communication, lacking basic services. Although one of the smallest regions of the state, after the Sierra region, it has a higher population density than both the national and state averages.

Almost all indigenous municipalities are classified as having a very high degree of marginalization, leading this region to be the most marginalized in Chiapas. One-half of the total population of 30,640 are below 15 years of age, and 99.5 per cent of the population is Tzeltal. Over 33% of women are illiterate, three times more than their masculine counterparts. In the year 2000, 4,500 women were of reproductive age with an average of 4.6 children, above the national average for indigenous populations (3.9) (INEGI, 2010).

X.5.1 Traditional midwifery in Tenejapa

According to the Ministry of Health there were thirteen midwives in Tenejapa in the year 2000. A baseline survey carried out by Luna Maya in 2003 identified 25 in the 20 communities. However, through a six-year relationship with Tenejapa and with midwives, Luna Maya was able to work with over fifty in 6 years. Midwives attend between 2 to 6 births a month. Although traditional midwives can have a relationship with health institutions, they are generally selected by women, mothers-in-law or husbands in the community. In Tenejapa, Luna Maya found that many midwives preferred not be registered with health authorities, in order to avoid having to travel for long meetings and for fear of arrest or punishment in the case of maternal deaths. Most of the midwives that Luna Maya worked with were above 40 years of age, monolingual (Tzeltal), and illiterate.

X.5.2 Midwifery training

During the period from 2005 to 2010 Luna Maya worked alongside 55 traditional midwives in the indigenous area of Tenejapa. This program aimed to empower traditional midwives as community leaders as well as to educate them on basic life saving skills and safe birth practices. Adult learning techniques were utilized, focused on self-exploration, mind-body therapeutic techniques, and circles of knowledge. When our work began in 2005, maternal mortality had remained stable, with mother deaths occurring 7 or 8 times per year, and representing almost one maternal death every month. The midwives were disorganized, divided among themselves, working alone, and were disregarded. Instead of “teaching” them about risk management in labor, the group has focused on a model which was called “circles of knowledge”. Through this it was anticipated that traditional midwives already have an immense amount of knowledge and wisdom about birth and women’s health. The facilitators, indigenous women themselves, listened to their beliefs and discussed with them additional knowledge from other models, such as biomedical beliefs. In this way, the midwives’ knowledge was expanded and their resources were increased. A principal component to the training was leadership and organization as a group. Luna Maya worked via the belief that traditional midwives are primary community leaders and women’s health advocates.

This program had several accomplishments: the midwives named themselves as a formal association (Metik U, Association of Traditional midwives of Tenejapa) and presented themselves to the local authorities. The Association negotiated direct transport with the taxi company and the local government to ensure that all women with obstetric emergencies were transported to the San Cristobal hospital with the local authorities covering 50% of transport costs. The midwives secured funding to participate in several national conferences and meetings regarding maternal health and midwifery. The midwives also created a network where

Luna Maya served as a recipient site in non-emergency transport sites, enabling traditional midwives to work alongside professional midwives in collaborative care.

X.5.3 Reaching out to the barrios: El Molina, Peña Maria, Hogar Comunitario

Through building relationships with individuals, Luna Maya became known within several outlying neighborhoods of San Cristobal. These neighborhoods are created by migrant indigenous groups who move to San Cristobal fleeing religious or political conflict, or simply in search of better financial opportunities. What is characteristic of these neighborhoods is they often lack a traditional midwife. Two neighborhoods in particular stand out in their relationship with Luna Maya: Ranchería Peña María and El Molino. Both are impoverished and homes are precarious, made of plywood, plastic sheeting and lack indoor plumbing. Most homes have dug-out latrines and connect to a neighborhood electric grid. Women marry young, often before 18 years of age, and have an average of 3 or 4 children. Men work in the service industry or construction and, on some occasions, migrate to the United States.

Luna Maya began working with El Molino when one woman who was at a birth that had lasted two nights, decided to call one of the midwives to ask for assistance. The traditional midwife attending the birth was asleep and could not provide more support or diagnosis. The baby was in an asynclitic position, meaning the head was sideways, and posterior, meaning the baby's back was lying towards the mothers' back. Using the *reboso* (Mexican shawl) to help better position the baby, the midwife helped the mother have a gentle, natural birth and avoid transport to the local hospital. From this moment, women from El Molino would chose to birth with Luna Maya midwives, or call Luna Maya when births were not going well to ask for assistance. Women who birth in El Molino attend late in their pregnancy and are mostly concerned with the babys' position. They do not attend childbirth education classes and inherently believe that birth is a natural event that should occur at home with other women.

They are afraid of the local hospital and believe that all women who birth there are given caesarean sections and are mistreated.

The first birth attended by Luna Maya in Ranchería Peña María was a breech delivery. It was the woman's second pregnancy, and she had been told by the hospital that she would have to be delivered by caesarean section. She began asking for support for a vaginal breech birth and eventually found Luna Maya, who offered to attend the birth. The birth went very well, and since that time the women from Ranchería Peña Maria have selected Luna Maya for maternal, pediatric and family health care. The community has no traditional midwives or healers and is desperately poor – on average, families subsist on one plate of beans a day. Alcoholism is rampant among males and therefore violence against women is at a high rate.

For six years Luna Maya worked with the Hogar Comunitario, Yatzil Antszetik (Community Home). The Hogar Comunitario was founded in 1994 to provide a safe house for single mothers. Although levels of sexual violence are extremely high, when indigenous women and girls become pregnant, if they are not married they are forced to flee their communities. Abortion is not legal or available in Chiapas. Prior to 2016, therapeutic abortion was not legal in cases of rape without a judge's order, which was complex process which women often chose not to carry out. The Hogar Comunitario therefore offered a safe space for pregnant women to live during the final stages of their pregnancy and after. Before Luna Maya was established, all births were referred to the hospital where women were further victimized, including obstetric violence and unnecessary caesarean sections. Luna Maya worked with the Hogar Comunitario from 2005 to 2010 to attend births in the safe house, and to apprentice the nurses who worked in the Hogar to learn midwifery skills. Water birth was included, as well as placental encapsulation. The Hogar nurses eventually developed the necessary skills to provide the care themselves, and Luna Maya remained at a consulting role for the staff.

Luna Maya has provided a safe space to poor and victimized women to recover their power and strength. Through respectful care, informed consent, and careful relationships based on mutual trust and communication, Luna Maya provides a unique space for women whose lives are difficult, violent and very sad, to find the joy in their own power and connect deeply with their newborns. The work Luna Maya has done with each woman from the Hogar and marginal neighborhoods embodies the essence of midwifery. It is one of the aspects that Luna Maya is most proud of - being able to bring the midwives model of care to any economic or social reality and find connection with women.

According to an indigenous woman who has had two children and received well-woman care from Luna Maya:

“Luna Maya midwives have more experience than traditional midwives.

The midwives are very impatient in my community. I felt very safe when my babies were born, I wasn't afraid, I felt very satisfied and felt that I had the birth I wanted. The midwives are kind, they are very loving. Doctors have never been an option for me to have my baby.” (Ana Elizabeth, 2016)

Luna Maya therefore provides a service where women from all socio-economic and cultural backgrounds can access evidenced-based care that involves anti-hemorrhagic medications, diagnostic tests, resuscitation equipment and respect for and honoring of cultural traditions and choice, such as when and how to cut the cord, the importance of massage and fetal positioning, and the choice of who is present at the birth. The following story illustrates an example of how the Luna Maya model of care extends into even the most disenfranchised women.

X.5.4 Sara's birth story

Sara lived alone in one of San Cristobal's poorest barrios, having been sent by her family to the city to work, and she was about to become a single mother. Sara had been sent

to Luna Maya by Guadalupe, another woman who works at the market and had participated in a doula training at Luna Maya. She often referred market women to birth peacefully at Luna Maya and avoid the hospital, where it is common knowledge that young, single, indigenous women are mistreated.

Following the onset of labor, the process was taking its toll on her body, with no family support and little physical will left to begin this new phase of her life, and she was pleading the midwives for help. Just as she thought she could take no more, there was a powerful contraction and the head emerged. The midwife took Sara's hand and placed it under the water and between her legs to let her know there wasn't far to go. She rested for a few moments before the next wave of pain came along. Feeling the baby's head had given her hope that the birth would soon be over, but at the same time filled her with dread at the realization she was about to become a mother.

The next contraction began with more force than the others, bringing her back down to earth as the urge to push took over her body. The baby was born at 8.15PM rising from the warm water of the bath and being placed on her mother's chest without making a sound. The baby lay limp and motionless whilst her mother stared into space, glad that the immense physical pain had subsided. The midwife quickly checked and found a faint heart beat establishing that the tiny baby was alive. With umbilical cord still attached and the placenta yet to be delivered the midwife started resuscitation. Sara looked on without saying a word as the midwife worked to bring life into her child. The midwife told her to speak to the baby by her name, that she would respond to her voice. Sara replied that she couldn't think of a name and didn't know what to say. The apprentice midwife said forcefully "how about Daniella?" and so Daniella she became without any disagreement from Sara. Half an hour later with the placenta delivered and Daniella out of danger both mother and daughter lay in bed together and contemplated what lay ahead. As they slept until the following afternoon, the midwives

decided not to disturb them, only to bring her more food, as they wanted to prolong Sara's return home to an empty house.

X.6 Conclusion

Well-intended improvements in the ability of indigenous women to have access to medicalized care have decreased maternal mortality rates. However, a global trend is beginning to be observed where indigenous women are opting to return to traditional maternity care and midwives, seeking kindness, human contact and a rights-based approach (Molina et al. 2016). This trend appears to indicate that, despite increased technology, some indigenous women still perceive birth as a normal and healthy experience, and as a result, may prioritize familiar relationships and connections over medical safety within a hospital or other medical institution. Within this landscape, birth centers like Luna Maya provide a viable, medically safe and equitable alternative where both evidence-based care and culturally appropriate kindness are woven together in order to bridge gaps between technology and ritual.

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