

UNIVERSITY OF CALIFORNIA, SANTA CRUZ

RESISTANCE OF MAYAN WOMEN AGAINST OBSTETRIC VIOLENCE

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ABSTRACT: Mayan women in Mexico are often victims of obstetric violence in the Yucatan Peninsula. Obstetric violence is defined as violence women experience by health officials or midwives during birth. This research will look at five different communities within the states of Yucatan, Campeche, and Quintana Roo in Mexico and compare and contrast activism efforts against obstetric violence among Mayan women. Throughout the Yucatan peninsula, Mayan women are organizing to create unions for midwives, workshops on reproductive rights and health care, and demonstrations that advocate for the end of obstetric violence in their communities. This research characterizes the variability in the experiences women face when giving birth, the expressions of activism women utilized to counter obstetric violence, and the obstacles they encountered while organizing. Through semi-structured interviews and participant observation, this research found that women's organizing changed based on structural barriers, access to capital, and the relationship activists have with healthcare institutions. This research can serve to understand the obstacles Mayan women face and provide strategies for organizations, governments, and institutions to further support and empower women's organizing strategies. This research contributes to a relative lack of research about the health care oppression Mayan women face and their mobilization in response. Such research is important for informing practical solutions to end obstetric violence in these communities.

Keywords: obstetric violence, Mayan women, maternal health, organizing, activism, Mexico,

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Preface

The heat was unbearable in mid-July in southern Mexico. Embracing my first solo travel adventure, I was exploring ancient Mayan ruins, a treat to myself before embarking into Mayan communities to start my fieldwork on the current health care obstacles Mayan women experience. During my visit to Uxmal, a famous Mayan political center, I decided to visit a *cenote* on my way back, an underground water cave where ancient Mayans held their rituals. While exploring the *cenote* I accidentally slipped on some muddy rocks, fell backwards, and instinctively put out my hand to cushion the fall. The moment I hit the ground, I knew my wrist was broken. I immediately fainted because of the pain. Thankfully two Italian tourists came to my rescue. One of the Italian tourists was a doctor so before I was even conscious she had already emptied her bag and with two socks, her shirt, and a pen had created a sling to keep my wrist from moving. Two hours after I had broken my wrist, I managed to arrive at a hospital in Xtepen, the closest town to the *cenote*, only to find that attention to emergencies closed at 3pm on that Wednesday. Consequently, I had to travel for another hour in order get to the hospital in Uman, where I sat for five hours in a public hospital's crowded waiting room- that smelled like bleach, had chipped paint, and not enough plastic chairs- cradling my wrist in the hopes that the throbbing agony might subside. Most of the people in the waiting room were expectant mothers and family members. When I was finally called to the doctor's office, I crossed a crowded hallway where, to my surprise and dismay, a woman lay on a bed, legs spread and about to deliver her baby, without any privacy as people walked past in the corridor. At that moment I witnessed firsthand an example of the fundamental problems of the Mexican healthcare system when it comes to partum care, stemming from inaccessibility and insensitivity to the lack of resources.

Finally, after waiting another forty minutes, the doctor examined my wrist and confirmed what was already painfully evident—the wrist was broken. He matter-of-factly informed me that the Uman hospital had no resources to treat me, and I had to travel to the capital. When I arrived to Merida it was 10pm and I had broken my wrist nine hours prior. I was taken to a small hospital and the doctor agreed to place a cast on me, but only if I could prove beforehand that I had sufficient funds to pay for the procedure, and of course they did not take debit cards. At 10pm, completely alone and still cradling the wrist, I walked in the dark to an ATM to withdraw what I

think was an exorbitant amount of money for such a basic procedure. Around 2am I woke up to a hospital bed, recovering from anesthesia and thankful for a cast. Now all I had to do was to make it back to my hostel after a day of mostly useless waiting, long bus rides, and smarting exasperation.

By the time I left Merida to visit the first study community, I had little to no mobility in my left arm and was grappling with strong feelings of giving up and returning home. I took some comfort, however, in knowing that I had perhaps hit rock bottom from the outset and could not fathom my experience becoming even more challenging. I stared at the plane ticket back to CA, transfixed at the return date a full two months from the accident, and decided to proceed with my research. Part of me just wanted to get away from the blazing heat of the hostel, but mostly I reminded myself of the commitments I had made, both to myself on this journey of personal discovery and challenge, and more importantly to the women with whom I had communicated for the past six months in preparation of my arrival. The topic of my research had become more poignant and personal; forty-eight hours after my arrival in Merida I had already experienced the inadequacies of the healthcare system, experienced the lack of accessibility of medical care, and seen how it degrades women's bodies. I felt it was my responsibility to share these stories of structural violence, but not fall into the common narrative of portraying indigenous women as victims. The story I want to tell is one filled with resistance, independence, and persistence of Mayan women activists committed to ending obstetric violence. Compared to the institutional violence and social oppression that Mayan women confront every day, how could I allow a broken wrist to prevent me from learning about their courageous fight for social justice in their communities?

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Chapter 1: Introduction

Motherhood is considered one of the most prized experiences women go through. Although not all women are mothers or should value motherhood as an obligatory experience, it is a popular and highly enjoyed stage in the lives of several women. Unfortunately, the experience of birthing a child, which is not the only path towards motherhood, is sometimes a painful and violent experience. In the Yucatan Peninsula there are two stereotypical types of birthing, the traditional Mayan one, and one characterized by a modernist and biomedical approach.

According to Jordan (1983), a traditional Mayan birth, in Yucatan, begins the moment a woman finds out she is pregnant and seeks the care of the community midwife. During the pregnancy the midwife accompanies the mother's experience with monthly, sometimes weekly, massages. By the time the birth has occurred women have developed a strong relationship with the midwife (Jordan, 1983). In comparison to hospitalized births, I noticed through my research that most Mayan women who gave birth in a hospital do so in public clinics where they meet the doctor the day they are scheduled to give birth. In a traditional Yucatan Mayan birth, Jordan (1983) says there is high cultural importance in having your family around during lengthy pregnancies. Doña Ake¹, a midwife in Chumbec, Yucatan states she demands the father and grandmother of the baby to be present during the births because they support the woman in labor and are there for the baby. During a traditional Mayan birth Rogoff (2011) and Jordan (1983) state that women usually give births on a hammock, a plastic chair or stool. According to Jordan, Yucatan women give birth at a semi-sitting position which is different than a modernist practice where a woman's body is in the lithotomy position. The lithotomy position "is known for its negative effects on the mother's blood pressure, cardiac return, and pulmonary ventilation." (Jordan, 1983: 61). Once the baby is born Jordan (1983) states that the placenta is buried under the house in order to protect the baby from evil spirits. Doña Ake states that method is antiquated and although she will do it if it is requested she prefers to keep the placenta for medical purposes or feed it to the mother. Rogoff's (2011) found in her research with Mayan births in San Pedro that the care of the placenta has changed across generations. It is not uncommon for certain practices to die out while others are reborn.

¹ Doña Ake is a participant in this study, pseudonyms were created to maintain the women's anonymity

Contemporary Mayan women who give births in hospitals through modernist biomedical approaches report being denied medical help until it was too late as well as being forced into quick cesarean births. Women in hospitals also experienced discrimination and the belittling of their culture and language. At the same time, a couple of contemporary Mayan woman described their experiences with midwives painful and violent. The testimonies I heard of Mayan women who gave birth in the Yucatan Peninsula were filled with pain, humiliation, and rejection by health care officials. Because of these experiences, mostly perpetuated by modernist biomedical approaches to assisting births, women across the Yucatan Peninsula are organizing to the end of this violence.

The research I conducted in the Yucatan Peninsula during the summer of 2014 reflects the necessity of starting a conversation about Mayan activism and obstetric violence. Obstetric violence is violence women experience when giving birth by those assisting the delivery (Ibone Otza, 2013). Scholarly research defines obstetric violence as the dehumanization, by health care providers, of a woman's body when giving birth (Belli, 2013). Here, I specifically focus on better understanding the Mayan experience on this issue.

Contemporary Mayan people live in Guatemala, Belize, El Salvador, Honduras, and southern Mexico. In Mexico alone, 800,291 people were registered as Yucateco Mayan speakers by INEGI in 2001 (Pfeiler, 2006). It is important to note that the term Mayan encompasses different countries, languages, and cultures, meaning that the experiences documented in this research are only reflecting those of a small group of Mayan people, Yucateco Maya.

This research explores the structural violence perpetuated on Mayan women in their reproductive care, as well as their resistance against this violence. This research will not only bring to light narratives of women who have seen or experienced obstetric violence, but it also seeks to fill a relative gap in scholarly attention about these issues. Drawing from experiences of women in five different Mayan communities, this thesis examines obstetric violence towards mothers and midwives, as well as explains why midwives sometimes perpetuate this same violence. This research also highlights the various expressions of activism of nine Mayan women and explores these methods through three lenses: structural barriers, capital, and institutions. These women, self-proclaimed change agents, are just a small sample of the women who assert

their reproductive and human rights; it is important to note that just maintaining dignity and strength in daily life is a form of activism practiced by Mayan women.

According to Kaplan (1997), it is common for women activists to have *femme consciousness*-- the identity mothers and women use to take action for their families and future-- when advocating for social change. Although only one of these women identified herself as activist, their acts for change and resistance showed their commitment to creating change in the spaces in which they live. Kaplan (1997: 4) argues that grassroots women are different from 'visionary leaders' because instead of standing as head of their community, "a grassroots leader seems to enhance the ability of the group to reach a higher moral plane, she doesn't stand out herself so much as she helps the community come together." Mayan women activists in this research refused to denote themselves as leaders or activists because of their strong connections and feelings of solidarity with their community. However, for the purpose of this research I use the term activist interchangeably with grassroots leader and advocate for change. Their struggles and resistance are reminders of oppression and the power of activism.

This thesis focuses on the structural violence health care officials and the Mexican state perpetuate in Mayan communities. The research questions that led me to Mexico include the following: what obstacles do Mayan women face regarding maternal health? How do Mayan women in these communities organize for maternal health? What are the various expressions of activism among Mayan women and what are their reasons for choosing the type of activism in which they engage? As I discuss, Indigenous women not only face discrimination based on their socio-economic background, but they also experience gendered and ethnic discrimination when seeking healthcare (Belli, 2013).

The data I collected highlighted three main issues that activists took into consideration when organizing. These three factors are structural barriers, capital, and the relationships these activists had with institutions. This paper will use these three themes in order to theorize why these Mayan activists chose the method of activism in which they are pursuing. Certain structural barriers such as transportation and location affect methodologies chosen for activism because they encompass economic restraints. The second theme is capital, or the advantage one has to produce profits or reproduce them (Bourdieu 1986). Economic, social, and cultural capi-

tals serve to create advantages within social groups and disadvantage those without access to the benefits of capital. Using Bourdieu's work on capital, this paper will explain how capital influences the methods of activism Mayan women chose when organizing. The third theme that influences women's choice in their activism method is the type of relationship they have with institutions. According to Kate Murray (2012), since the 1970's activists have moved away from eliminating an unjust system to working within the system to find possible solutions. Murray states that now activist participation is shaped in predictable ways to mirror institutions and structures. These three themes-structural barriers, capital, and institutions-explain the methods women in these communities chose to conduct their activism.

This thesis is organized by seven chapters. The first chapter, the introduction, focuses on introducing obstetric violence, activism, and what this thesis attempts to accomplish. The second chapter, includes a review of the literature available on the role of the Mexican state in birthing experiences in indigenous communities, obstetric violence, indigenous women organizing. The literature review will also highlight the obvious gap in the academia which my research attempts to close. The third chapter will discuss the methods I used for conducting this fieldwork, introduce the participants, as well as reflect on the limitations I can encountered. The fourth chapter, "Definitions and Experiences of Obstetric Violence" will focus on documenting the testimonies of woman who have seen, heard, and/or experienced obstetric violence. Obstetric violence is an umbrella term which covers several manifestations of violent acts when giving birth. Because of the broad nature of the term, the definitions and experiences of obstetric violence differ from woman to woman. This chapter will be divided by mothers who are victims of it, followed by midwives who experience it, ending with midwives who perpetuate obstetric violence. Chapter five, "Mayan Women's Activism against Obstetric Violence" will highlight the activism methods of nine woman when fighting against obstetric violence. This chapter will showcase the incredible efforts of their resistance. Chapter six will discuss how structural barriers, access to capital, and relationships with institutions are important factors that affect the methods of activism Mayan women engage in. Chapter seven will conclude my findings as well as provide solutions for NGO's, states, and the academia to better support Mayan women organizing against obstetric violence. Obstetric violence is a reality for most women in the Yucatan Peninsula and their resis-

tance proves their unwillingness to be victimized. This research is important because it brings awareness to the violent conditions Mayan women face as well as their constant resistance when organizing for change.

Chapter 2: Literature Review

The topic of resistance against obstetric violence in Mayan communities is not a popular research topic, in part because of the specificity. Because of the limited nature of the literature available, this literature review is divided in three different parts that highlight the most important areas of this topic; the state, obstetric violence, and indigenous activism. The chapter begins by providing a historical analysis of the relationships between birthing in Indigenous communities in Mexico and the state. Because of the limitations in the academia on Indigenous women organizing for obstetric violence the literature review then focuses on the closest alternative, obstetric violence and institutional oppression followed by Indigenous people mobilizing for reproductive rights. The intention of my research is to close the academic gap by introducing obstetric violence as well as bringing awareness of Mayan activism.

Relationships between the state and birthing among Indigenous people in Mexico

Important historical information regarding contemporary Indigenous people's healthcare access in Mexico can be highlighted through the research of Floyd (et al., 1997), Huber (et al., 2001), and Carey (2006). According to Floyd (et al., 1997) there was an important shift in Mexican policy in the 1970's concerning birthing in indigenous communities. Before the 1970's, the Mexican government rejected and condemned traditional medical practices such as midwifery. By mid 1970s the state changed its position on midwifery to partial acknowledgement and acceptance if it could be justified within biomedical thinking. The state wanted to spread "modernization" rapidly by forcing biomedicine such as birthing accelerating drugs. *Biomedicine* in Mexico became the hegemonic standard for health and in order to spread it in marginalized communities that lacked access to health clinics, the state encouraged the training and licensing of midwives (Floyd et al., 1997). Between 1974 and the beginnings of the 1980's 15,000 midwives underwent training which according to Floyd and his colleagues, these courses were "powerful instruments for imposing, extending, and further legitimizing biomedical obstetrics" (1997, p.399).

According to Huber and Sandstrom (2001), currently midwives get licensed because it provides state protection if the mother or child die during birth. If midwives are not registered they can be cited. Increasingly, women giving birth prefer trained midwives because of their rela-

tionship with certain hospitals if something were to go wrong during the birth. Another big change since the training of midwifery became mandatory, was the dramatic increase of oxytocin and vitamin B injections that accelerate the birthing process as well as an increase in cesarian births (Huber and Sandstrom, 2001). In Merida, Yucatan hospitals have increased cesarean births 30-50 percent since 1994. Huber and Sandstrom (2001) state that midwives are still bombarded with pressures to “modernize” their birthing tactics by adopting Westernized obstetrics. Mayan women have responded differently to these policy changes. Huber (et al., 2001) and Floyd (1997) said they found that some Mayan women are still afraid of hospitals and health clinics because of past mistreatment, language barriers, shame from being exposed to male doctors as oppose to female healers or midwives, and fear of surgery. Other Mayan women have attempted to combine midwifery and westernized medicine (Huber et al., 2001). However, Carey (2006) and Huber (et al., 2001) agree that the most affected and pressured to adapt to these policy changes are midwives. Carey (2006) argues that Mayan midwives often become leaders in their communities. Mayan midwives contest traditional gender roles by being independent and powerful which make them natural actors for social change.

As I discuss further in subsequent chapters, midwives comprise most of the activists fighting against obstetric violence. Carey (2006) argues that Mayan midwives often become leaders in their communities. Mayan midwives contest traditional gender roles by being independent and powerful which make them natural actors for social change. Carey (2006) and Huber (et al., 2001) argue that it is the historical and cultural context that empowers and places these women in spaces for advocacy. The activists interviewed in this research are mothers, midwives, and women. The historical and cultural context of Mayan people as a whole and individually are important when analyzing their activist efforts.

Obstetric violence and institutional oppression

All but one of the women who were interviewed in this research specifically mentioned obstetric violence as the act they were resisting. Although the term obstetric violence was brought up constantly during the interviews, it was a term I had previously not known. To my knowledge the term obstetric violence has not been popularized in English-spoken academia

making literature concerning this topic very limited.

Although obstetric violence is not commonly referred to in English academia it is more common in Spanish academic circles. *Violencia obstetrica*, refers to violent acts provided by healthcare providers during their female patients' delivery process (Ibone Otza 2013, Belli 2013). The term was legally coined for the first time in Venezuela in March 2007; officials defined obstetric violence as "...the appropriation of the body and reproductive processes of women by health personnel...bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality" (Ibone Otza F. 2013: 48). Obstetric violence takes a variety of forms of (in)action, such as when health personnel respond untimely and ineffectively to emergencies, force women to give birth in a supine positions if not medically necessary, impede early attachment of child with mother, alter natural process of low risk delivery with acceleration techniques unless women are informed and can accurately consent, and finally conducting cesarean births when natural birth is possible unless women previously consented (Ibone Otza F. 2013).

According to Ibone Otza F. (2013), a Spanish scholar, the lack of research in general is due to the "negative" view the term places on birthing healthcare officials. However, Ibone Otza F. argues that obstetric violence is more common than what the media, literature, and health care officials portray it to be; in the U.S., about 18% of women reported having being subjected to authoritarian decision-making, abuse, and a lack of control when giving birth. Women who have experienced obstetric violence feel a lack of respect, humanity, and care when they giving birth (Ibone Otza F. 2013). This dehumanizing experience is perpetuated by social institutions and structures such as health care providers or midwives when assisting births (Belli, 2013).

Women victims of obstetric violence are put in harms way by social institutions and structures that prevent them from receiving the care they need when giving birth. The women I interviewed argued that institutions such as doctors, health care officials, and midwives were acting violently towards them making their violence structural. Structural violence is defined as "indirect violence built into repressive social orders creating enormous differences between potential and actual human self realization" (Quesada et al. 2011: 34). Structural violence is different from institutional violence because it cannot be traced to specific institutions. Structural violence includes cultural factors such as gender and racism. Human vulnerability to structural vio-

lence depends on their location in hierarchical societies and their diverse powers. According to Quesada et al. (2011), Latinos experience structural violence because they are vulnerable due to their economic location and ethnic discrimination. Historically, economically exploited and politically subordinated people often internalize and normalize everyday violence imposed by society and institutions (Bourdieu 2000). By understanding structural violence and how it is represented in the health care system scholars can further identify how poverty and cultural subordination are side effects of violence rather than the product of individual choices. By acknowledging structural violence as a society we can stop blaming the victim for their marginalization.

According to Quesada and his colleagues (2011) structural violence is strongly connected to poverty and marginalization. An example of those marginalized by such violence is indigenous people in Mexico. Leyva-Flores et al. (2014) state that Mexican indigenous people constitute 7 percent of the Mexican population in 2010 and 44.2 percent of them are residing in indigenous municipalities that suffer from extreme levels of poverty. In 2010, research showed that infant mortality rate was 63 percent higher among Indigenous communities than non-Indigenous ones. Pelcastre-Villafuerte et al. (2014) find that in 2008 the national maternal mortality rate was 53 per 100,000 live births while in Guerrero, a state with a large indigenous population, had a maternal mortality of 104 per 100,000 live births. According to Pelcastre-Villafuerte et al. (2014: 3) “Indigenous women constitute a subgroup of the Mexican indigenous population with the highest lag in health status. As three kinds of discrimination converge- ethnic, gender and class –...[correlate] to this triple subordination”. These statistics demonstrate the continual marginalization indigenous communities face through their interactions with the health care system.

There is a fair amount of research done about the marginalization of indigenous communities concerning the healthcare system. However, very few academic articles discuss how institutions can be reformed to better serve the needs of indigenous women in the healthcare system. Leyva- Flores et al. (2014) examine the introduction of the governmental program *Seguro Popular* as an economically accessible healthcare institution to serve Mexico’s lower class and how it affects Indigenous people. The Mexican government introduced *Seguro Popular* in 2003 as a public policy strategy to act as a social buffer by enhancing health care regardless of ethnicity. Leyva- Flores et al. concluded that *Seguro Popular* did remove economic barriers to health care

access, but did not increase general accessibility for Indigenous people to obtain health care services because of other barriers that were not taken into account. *Oportunidades*, a *Seguro Popular* program, focuses on women and children gaining healthcare support, had the highest indigenous population than any of the other programs coming out of *Seguro Popular*. *Oportunidades* is a cash transfer program that alleviates women's poverty in Mexico by focusing on health, education, and nutrition. In order to receive this help they need to see government doctors, who represent the interests of the state (Smith-Oka, 2009).

Even though *Seguro Popular* had some successes like *Oportunidades*, according to Leyva-Flores et al. (2014), other services still did not remove some important barriers. Indigenous people that did not use primary health care services said it was because of a lack of confidence, poor treatment, unavailability and remoteness (Leyva-Flores et al., (2014). Huber et al. (2001) research identifies why Indigenous people lack confidence in the system, finding that Indigenous Mesoamerican women are afraid of hospitals because it is a place associated with dying. When they do go to hospitals and health clinics they fear mistreatment, scolding, lack of communication, language barriers, shame from exposure to male doctors, and fear of sterilization and surgery (Huber et al. 2001). Leyva-Flores et al. (2014) state that another reason why indigenous people did not seek government health care services is due to its unavailability and remoteness. Harrold et al. (2014) argue that geography affects *potentially preventable hospitalization* in indigenous communities. Their research is regarding Australian indigenous populations and how geography and Indigenous status explain differences in rates of *potentially preventable hospitalization* admission between indigenous and non-indigenous people. Their conclusion states that the deeper segregated and the further away these communities are from Westernized culture the higher admissions of *potentially preventable hospitalization*. This means that the location of the communities has a strong correlation with health care access. Although programs exist that attempt to increase access to healthcare for Indigenous people, these programs are not only limited but they are ill equipped to take into account their lack of accessibility and cultural differences. The research of Leyva-Flores et al., (2014) and Huber et al. (2001) show that much work is needed to provide accessible health care programs for Indigenous people in Mexico.

Pelcastre-Villafuerte et al. (2014) provide an analysis of a program called "Casas de La

Mujer Indígena” which was created to bridge the cultural distance between institutionalized forms of health care and Indigenous medical traditions and understandings. This project specifically focused on alleviating language differences to encourage effective doctor-patient communication as well as foster trust in Western medicine among communities. This project was created to increase the quality of services offered to indigenous women in Oaxaca, Chiapas, Guerrero, and Puebla. According to Pelcastre-Villafuerte et al. (2014), the program was successful in making health care institutions adapt to local and culturally appropriate treatments. Pelcastre-Villafuerte et al. (2014) argue that the success is mostly due to the inclusion of local leadership and local women into the creation and reproduction of the program. The program facilitated Indigenous women’s access to referrals to other institutions for emergency obstetric care. However, Pelcastre-Villafuerte et al. (2014) argues that in order for programs like this one, that facilitate access to effective and culturally appropriate health care systems within social inequality, can only work if they take into account geographic, economic and cultural barriers to care. Pelcastre-Villafuerte et al.(2014), Huber et al. (2001), Harrold (2014), and Leyva-Flores et al. (2014) argue that there are several barriers that prevent Indigenous people from gaining health care access and programs need to address more than just economic barriers. However, only Pelcastre-Villafuerte and his colleagues offer an example of programs that can benefit indigenous people. There needs to be greater emphasis in academia that will analyze and promote programs that can benefit Indigenous people’s right to health care access.

Vania Smith-Oka’s (2009) research, conducted in Veracruz, argues that through state programs in Mexico like *Oportunidades*, indigenous women are forced to accept fertility controls because of the government’s fear of increasing poverty by allowing the poor to over-reproduce. Smith-Oka (2009) argues that doctors “forcing” indigenous women to have only two children undermines their autonomy and disempowers them. According to Smith-Oka, who cites Molyneux (2006) and Skoufias (2005), these population policies led to no positive relationship between women’s wellbeing and family planning. She states that because indigenous people need programs like *Oportunidades* they have little agency to fight against their disempowerment. Medical officials use state programs to promote the state’s concern of family planning, which in turn disempowers their target population. Pombo (2008) agrees, saying that programs like *Opor-*

tunidades disempower women by alienating health promotion from it being an issue of women's bodies to an outlet to promote the interests of institutions. Although this program provides economic support to women, it impedes their empowerment by accumulating responsibilities, such as keeping their houses clean to the standard of the state, which holds them accountable to the state and its institutions (Pombo 2008).

As highlighted in this section of the literature review there is sufficient research regarding structural violence through healthcare institutions and policy by the state towards indigenous people in Mexico. However, there is a limited amount of academic research regarding obstetric violence in English spoken literature. Obstetric violence in Indigenous communities is also lacking in both English and Spanish academia. My research attempts to close those gaps by providing the testimonies of Indigenous women victims of obstetric violence resisting this form of structural violence.

Indigenous people mobilizing towards reproductive rights

An important aspect of this research is to discuss the incredible forms of resistance Mayan women engage in against obstetric violence. This research will bring the stories of resistance of Indigenous women towards obstetric violence into academic spaces. In general, research on Indigenous people mobilizing for reproductive rights is limited. There are few academic analyses that cover Indigenous uprising in Mexico and most of them revolve around activism for the right of autonomy, territory, economic exploitation, and cultural alienation (e.g., Gutierrez Chong 2010; Icaza and Vasquez 2013). There is also more academic analysis on activism of Westernized movements regarding reproductive rights (Thomsen, 2013, Fried Gerber, 2013). But to the best of my knowledge, there is no research that bridges both these literatures, pertaining to activist efforts by indigenous women in Mexico towards reproductive rights.

Escobar and Alvarez (1992) state that female organizing is usually over engendered forms of power, in which protests are usually concerning the stereotypical work of women such as being mothers, domestic workers, seamstress, and more. Kaplan (1997) would argue it is the *femme consciousness* what empowers mothers and women to fight for gendered justice. Escobar and Alvarez (1992) say that Latin American social movements center around identity, often em-

phasizing the processes in which actors create collective identities as a means to share democratic spaces. They define social movements as “complex theoretical systems with collective and heterogenous practices” (1992: 6-7). The industrialization of Latin America brought about an increase in women organizing when their needs were not being met, such as maternal health. Since then women organizing has helped construct women’s identity and relations of power.

Morgan et al. (2012: 241-242) argue that since the Cold War there has been a shift in reproductive governance that has moved away from explaining reproductive rights as social struggles but now in terms of rights. “In Latin America, neo-liberal economic processes and related struggles over who shall be worthy of rights, in regards to reproduction, invoke old and new categories and actors like, who appear to arise on their own as independent entities” (2012: 244). By making reproductive rights be universal rights, organizing has allowed for issues concerning indigenous rights and indignity to emerge in Latin American. Historical events in Peru exemplify this shift. In the 1990s, President Fujimori of Peru was responsible for allowing the clandestine and coerced sterilization of hundreds of thousands of Indigenous women. After huge international outcry, President Toledo in 2001 made an effort to distance himself from the past administration and worked with institutions to recognize the claims of indigenous groups and their collective identities. Although Toledo’s administration allowed for the introduction of indigeneity among the reproductive rights struggle his administration significantly cut back access to reproductive health services in general. Morgan et al. (2012) argue that in Latin America, specially in Bolivia and Peru, indigenous rights trump reproductive rights because women’s rights are framed as a movement to eliminate ethnic discrimination and humanize healthcare rather than bodily autonomy. This is a big difference between U.S. based movement for reproductive rights concerning “choices” (Morgan et al., 2012). There has been significant retrenchment in access to maternity and prenatal services in Latin American countries. The retraction of the state has led to rapid expansion of privatized medical care, high cesarian birth rates, and a burgeoning infertility industry. Authors have argued that the ability of a woman to choose whether to have a cesarian in several Latin American countries depends on their ability to purchase privatized reproductive medicine (Morgan et al. 2012). Morgan and his colleagues’ (2012) main point is that reproductive governance in Latin America has allowed the introduction of new actors with social

distinctions, identities, citizenship status which in turn has broken down ethnic boundaries in the political sphere.

Smith (2005) explains why activist Native peoples in the United States reject the term feminist and often refuse to focus their activism on gendered issues. Smith, through a series of interviews with Native activists, shows that although several Native women activist support “feminist” issues such as abortion, Native struggles over sovereignty, land, and survival take precedence over other issues. Smith’s research argues that by separating gendered struggles from Native struggles, Native activists reaffirm colonial and European thoughts of patriarchy and gendered violence in order to silence women. Although Smith (2005) urges Native women to see “feminist” struggles as struggles over Indigenous identity, she also argues that labeling gendered activism as “feminism” or indigenous rights is a form of forced assimilation into westernized academics. Although Smith’s research was not intended to generalize the idea that indigenous people do not organize for reproductive rights and gendered struggles, her research illustrates the lack of academic research done on Indigenous women mobilizing for reproductive rights.

This chapter was divided into three parts, understanding the relationship between the state and birthing in Indigenous communities in Mexico, obstetric violence and structural violence in Indigenous communities, followed by literature on Indigenous mobilizing for reproductive rights. Floyd (et al., 1997), Huber (et al., 2001), and Carey (2006) provide a historical analysis of the constant policy changes in Mexico regarding Indigenous midwives. Currently, midwives are being subject to training by the state in order to transform their traditional practices to biomedicine (Huber et al., 2011, and Carey, 2006). The women I interviewed believed that these forced practices of “modernized” biomedicine subjected them to obstetric violence when giving birth. Obstetric violence is violence experienced by women when giving birth promoted by healthcare officials (Ibone Otza, 2013; Belli, 2013). This type of violence constitutes structural violence because it is harm promoted by social structures and institutions (Quesada et al., 2011). Authors such as Leyva-Flores et al. (2014), Pelcastre-Villafuerte et al. (2014), Vania Smith-Oka (2009), and Pombo (2008) discuss different state sponsored health access programs that have affected Indigenous women poorly. Programs such as *Oportunidades* (Pombo, 2008; Vania Smith-Oka, 2009) create structural violence because they disempower and harm women instead of support-

ing them. The women I interviewed did not take obstetric violence passively but they resisted and mobilized against it. According to Escobar and Alvarez (1992) and Kaplan (1997) it is common for women to take up resistance in gendered issues such as reproductive rights. Historically, in Latin America the introduction of reproductive rights activism has opened the doors to other struggles such as indigeneity (Morgan et al., 2012).

There is little research on indigenous organizing concerning reproductive rights. My research attempts to close that gap and bring awareness to the countless stories of resistance from indigenous Mayan women concerning obstetric violence. This research brings the testimonies of obstetric violence, which is a relatively new term in English academia. The academia is also lacking research on indigenous women mobilizing for reproductive rights. This research will attempt to close that gap in the academia by providing the methods of activism of nine incredible women.

Chapter 3: Methods

This research was done with the support of Semillas, a Mexican NGO, based in Mexico City. Semillas is an organization that supports women’s groups and indigenous leaders to improve the status of women. It has worked in the past with indigenous leaders working to prevent maternal mortality, domestic employees fighting for legal protection, indigenous women fighting for land, *maquila* workers fighting for equal wages, and LGBTQ activists fighting against discrimination. Semillas is a women’s fund that provides economic support as well as builds skills, knowledge, tools, and networks for the participants. I contacted Semillas about partnering with them for my research. Semillas provided me with the contact information of seven women in five different communities in the Yucatan Peninsula fighting for maternal safety. With the help of Semillas I was able to identify a location for my research and establish contacts and hospitality before embarking on my research.



Figure 1: Map of study area, giving general location of study communities.

I spent a week in five different Mayan communities to interview women about their experiences with maternal health and their activism to end obstetric violence. The communities were X-Querol, Tulum, Campeche, Xanlah and Chumbec (Figure 1). I was able to stay either with the

women I was interviewing or their family friends in exchange for a small monetary stipend. Their hospitality gave me the opportunity to facilitate informal interviews during informal settings. It allowed me to speak about controversial and taboo subjects such as sex, gender, and reproductive rights while working in the kitchen with them or doing other household chores.

I conducted participant observation during the week I spent in each community. This allowed me to attempt to fully immerse in their daily life and collect qualitative data through everyday conversations. After a day of bonding with the community doing daily chores such as washing dishes, accompanying the woman to the milpa, or taking care of the young children I would return to my hammock and document in my journal important conversations or actions people took concerning maternal safety. This allowed for the collection of informal data and released the pressure of formal interviews and conversations.

I also conducted five unstructured interviews and three focus groups. According to Russell Bernard (2006) unstructured interviews follow a pre-planned list of questions however they are “characterized by a minimum of control over the people’s responses. The idea is to get people to open up and let them express themselves in their own terms, and at their own pace.” (Russell, 2006: 211) I chose unstructured interviews because of the sensitivity of the issue. I did however have a list of questions I kept next to me to make sure I was following a structured plan (see Appendix 1 for interview questionnaire and focus group script). The five interviews were specifically with five out of the nine women leaders this research paper focuses on because of their detailed organizing campaigns and goals. The interviews allowed for a better understanding of their activism methods. All interviews were conducted in private as to allow conversations to go on tangents and not be restricted to the pre-planned questions. I voice recorded all interviews as well as took extensive notes. The five women interviewed privately were America, Margarita, Doña Ake, Irna, and Ime, introduced below².

The three focus groups were created because some women leaders wanted to introduce me to other activists but stay in the room and contribute to the conversation. Focus groups occurred because some women did not want to be interviewed alone and required some-

² Pseudonyms were created to maintain the women’s anonymity

one else to participate with them. As Russell (2006), focus groups can be used for the collection of data about content and process rather than personal attributes. The focus groups lasted forty-five minutes to an hour and were conducted in the women's kitchen. All of these focus groups had two participants. Four of the women interviewed through these three focus groups are activists highlighted in this research. The four women are Yuritzí, Itzel, Elide and Neyi, introduced below.³

All the women interviewed for this research identified themselves as Mayan. All of the women spoke fluent Mayan and varying levels of Spanish. Some of the focus groups were facilitated by me and a translator to facilitate understanding and to make women feel more comfortable.

For the last three communities, another undergraduate student from the University of California, Santa Cruz, Mireya Gomez, joined me through my research. All of the interviews after that were done with her assistance. We would take turns asking questions, each take our own notes, and after a day of interviewing we would review them and discuss. Mireya's research is on options women have to give birth in the Yucatan Peninsula and Oaxaca. Her experience with interviewing women in Oaxaca was crucial for the development of better focus groups and individual interviews.

Study Participants

Five of the women interviewed for the research are Semillas partners, which means they receive a small stipend each month to continue their activism work. Two of the women highlighted in this research are assigned mentors by Semillas, who oversee the work of three of the five Semillas partners. The recipients of the Semillas fund have to report to their mentors each month in regards to their work. Semillas recipients are also invited to several workshops and classes that can better equip them to fight for social justice. The mentors, workshop planners and facilitators are all Semillas personal who neither receive funds nor have affiliations with government parties.

³Pseudonyms were created to maintain the women's anonymity

Although five of the women I interviewed and conducted participative observation with were scholarship recipients from Semillas, all the people I interviewed had some connection to Semillas recipients. The two other women activists who are highlighted in this research either work alongside Semillas recipients or are related to them. Semillas' funding impacts efforts for social change for more than just the people they oversee. Aside from providing contact information for my research, Semillas invited me to participate in their annual symposium from September 1st through 5th. This event invited 46 women activists they fund from all around Mexico. I had the honor of meeting women who worked on topics such as pro-choice activism, Afro-Latina inclusion, workers rights, and more.

This research will focus on the narratives of nine different Mayan women, five of which are Semillas recipients. All of these women identify themselves as Mayan but come from different cultures, locations, and ages. Each participant brings to the conversation a different experience and situation to contextualize violence against women. I will briefly introduce each woman; Ime Cohuo, Yuritzi Speich, Itzel Cazim, Doña Ake, Irna Tuz, America Cassanova, Margarita Pech, Elide and Doña Neyi. Their names have been changed to maintain anonymity.

Ime Cohuo is a twenty-three year old activist that currently lives in the Jose Maria Morelos County in Quintana, Roo. She is originally from a Mayan community called X-Querol within the county. X-Querol has approximately 85 residents and only provides public education until second grade. Most of the community members only speak Mayan and live off of the *milpa*. Ime Cohuo studied in the Universidad Intercultural Maya de Quintana Roo where she majored in Community Health. She works in a student "albergue" which is similar to a boarding house for students from around the county who move to Morelos, Quintana Roo to receive further education. Ime, who is a Semillas fund recipient, is currently working on a documentary on obstetric violence that she wishes to show midwives, women, and doctors in order to bring attention to the issue and educate the community on their rights.

Ime introduced me to Elide, a midwife in a town near her. Elide is an older midwife in the town of Saban. Elide says Saban is commonly known around Quintana Roo as a rebellious, activist-filled community that rarely interacts with nor accepts state officials. Elide's activism includes speaking up against community violations by being a vocal advocate, getting the com-

munity united, as well as writing letters to state officials.

Yuritzi Speich is a forty year old certified midwife living in Carillo Puerto, Quintana Roo. She is a Swedish immigrant who moved to Quintana Roo to learn traditional Mayan birthing practices. Yuritzi Speich is a public figure and recognized leader in the peninsula because of her strong roots with the community and experience assisting births. She is the founder of the Asociación Civil Parteras Tradicionales Unidas, which is a union-like association of midwives in Quintana Roo. She is one of the mentors Semillas hires to oversee projects in the peninsula of Yucatan. Yuritzi continues to practice midwifery throughout the Quintana Roo coast and serves both Mayan women and tourists who arrive to Cancun or Tulum to deliver their babies using traditional Mayan techniques. Yuritzi is a strong advocate for the eradication of obstetric violence.

Itzel Cazim is also a forty year old retired midwife living in Tulum. She works in a tourist hotel as a masseuse after giving up her position of midwifery because of social and economic pressures. Tulum is located in the Mayan Riviera, a high-tourist area in Mexico. Itzel, who is Semillas partner and receives funding from them, works on bringing awareness to obstetric violence through marches and workshops.

Doña Ake is sixty year old Mayan woman living in the community of Chumbec, Yucatan. She has been practicing midwifery for the past forty years both in the areas surrounding Chumbec as well as the capital of Yucatan, Merida. Doña Ake, who is a Semillas fund recipient, was trained by the state but earned the degree much sooner than her colleagues because she already knew how to assist births. Doña Ake proudly states she has never lost a parent or child during delivery. She is a respected member of the midwifery community and has been invited to give birthing classes in several states of Mexico and abroad. Doña Ake serves both Mayan women in her community as well as the “upper class” of Merida. Apart from midwifery and spending time with her great grandchildren, she is currently working to form a midwife union that will protect the rights and interests of midwives.

Irna Tuz is originally from Valladolid, Yucatan but currently lives with her husband and toddler in the community of Xanlah, Yucatan. Xanlah is a remote community close to the ancient Mayan ruins of Chichen-Itza. Irna, who receives funding from Semillas, works day to day providing workshops and classes on reproductive rights, gendered rights, sexually transmitted

diseases, sexuality and sexual orientation, and more. Irna received a degree from the University of Valladolid on business administration and works on a daily basis with people from her community and those surrounding by increasing visibility to social issues.

Irna's mother in law, Doña Neyi is also a woman profiled as an activist for this research. Doña Neyi is a respected leader in her community, a mother, grandmother, and community elder who fights day to day to improve the living conditions of the residents of Xanlah. Although Doña Neyi only received a second grade education she was seen and treated as the most knowledgeable elder in her community.

Margarita Pech is a thirty year old mother of a toddler in Campeche, Campeche. She is originally from Tenabo, Campeche a Mayan community a few miles north of the capital. Margarita studied Psychology from the University of Campeche and currently works in an organization against gendered violence. Margarita, who is a Semillas partner, specifically works on eradicating obstetric violence by teaching women in different Mayan communities how to recognize it and the options they have for filing charges.

America Casanova is the founder of the Observatoria de Violencia Social y de Genero en Campeche and NGO that fights to eradicate gendered violence. Margarita works for America's NGO in Campeche. America received a degree in journalism from the Campeche Institute and a masters in Culture and Literature of Latin America from Modelo University in Merida, Yucatan. America has dedicated her life for the creation of her NGO that educates women on gendered violence and their rights as well as the economic and legal support to seek legal council. She is also Margarita's mentor who reports back to Semillas with Margarita's activist progress. America is both a poet and activist who has been part of several conferences in Mexico and abroad.

The nine women discussed in this research come from different backgrounds, levels of education, communities, and more. They have different passions and methods for fighting against obstetric violence and other gendered violence.

Limitations

Several limitations of my research should be considered. First, I was an outsider in their communities and most of these communities are extremely remote, which limits the amount of

foreigners locals are accustomed to. Because of my status as an outsider, in some communities about one in every ten people declined to talk to me and those who agreed could have said what they thought I wanted to hear. I attempted to relieve this issue by making the interviews as casual as possible as to not intimidate their participation. However, most communities were extremely welcoming and willingly provided me the opportunity to conduct my research.

Another limitation and fear I had while doing this research is that historically researchers have found that indigenous people often feel ashamed of their customs when speaking to researchers. Public discourses tend to put down indigenous medicine and makes it seem unmodern therefore women might lie about their acceptance of traditional medicine (Carey, 2006). Surprisingly, the women I interviewed were strong advocates for traditional medicine and therefore spoke openly about their discomfort with “westernized” medicine.

Not speaking Mayan was also a limitation. Although I attempted to learn a few words in Mayan during my research I did not come close to be able to sustain a conversation in Mayan. All interviews were done in Spanish; a couple of interviews had to be conducted in Mayan and therefore a Mayan translator assisted me. Nevertheless information is easily lost through translation.

Finally, my position as an outsider with a different ethnicity and socio-economic class could have also been a limitation. There was always someone in a community who would mention their family member who lived in Texas and California who lived a better life than they did. My Spanish is also a limitation because although I speak fluently I have an accent from Mexico City which is often presumed as privileged. My positionally as someone from the U.S. from a certain class could have been a factor that limited their willingness to share with me.

Chapter 4: Definitions and Experiences of Obstetric Violence

Like most cases of structural violence, obstetric violence is hard to define and pin point because it is subtle, pervasive, naturalized, normalized, and institutionalized. Women who have suffered from obstetric violence have gone as far as calling it “birth rape” because they feel their bodies have been violated and coerced (Ibone, 2013). The term, which is usually directed towards doctors and nurses, has an aggressive undertone that prevents it from academic utilization. Similarly, the naturalization of such violence and other structural violence discredits research on these violent cases (Quesada et al., 2011). Obstetric violence is a common experience for women all around the world, but a highly ignored form of violence against women (Ibone 2013; Belli 2013). In this chapter, after brief discussion of various legal definitions of obstetric violence, I turn to my conversations with Mayan women and their definitions and lived experiences, which provide a rich cultural context to understand this phenomenon. This chapter will be divided by mothers’ who experience obstetric violence, midwives who are victims of it, and midwives who perpetuate it.

Obstetric violence has its roots as early as the nineteenth century when “modernized” hegemonic health methods began to be legitimized (Belli 2013). Soon modern biomedicine became institutionalized and all other birthing methods were discredited and belittled (Belli, 2013). In 2007, Venezuela was the first country to legally criminalize and define obstetric violence. Article 51 of the *Ley Orgánica Sobre el Derecho de las Mujeres a una Vida Libre de Violencia* (Organic Law on Women’s Rights for a Life Free of Violence) states that obstetric violence is “...the appropriation of the body and reproductive processes of women by health personnel...bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality” (Ibone 2013: 48). Under Venezuela’s law the following acts by health personnel are considered obstetric violence: 1) untimely and ineffective attention to obstetric emergencies, 2) forcing women to give birth in a supine position if not necessary, 3) impeding early attachment of child/mom without medical cause, 4) altering natural process of low risk delivery with acceleration techniques unless women are informed and can accurately consent, and 5) using cesarean section when natural birth is possible unless women consented (Belli 2013).

Belli (2013) argues that obstetric violence is a violation of our human rights. She argues that our human rights obligate states to provide conditions for citizens to live happy and healthy lives with access to health care services. The human right to live should not be separated from the human right to health which is connected to the human right for dignity from the 1993 Vienna Convention on Human Rights (Belli, 2013). Obstetric violence removes the dignity in motherhood, which violates the basic human right to life.

The prevalence of obstetric violence is hard to quantify given the nature of the experience and the marginalization of many victims. According to Ibone (2013) a little less than 20 percent of women suffer post-traumatic disorders after giving birth in hospitals in the U.S. This means that several women have traumatic deliveries but very few recognize it as violence. Belli (2013) states that the invisibility of obstetric violence in policy and the media is due to the normalization women give to gendered violence. Women who suffer from poverty and receive free health care often believe such violence is the cost they have to pay to receive such services. Indigenous women are more vulnerable to obstetric violence given their socioeconomic, educational, ethnic, and cultural marginalization (Belli, 2013).

Mayan Women's definitions of obstetric violence

Although academics may agree on the same definition of obstetric violence, a more complete and comprehensive understanding requires the contribution of those who know the problem first hand and work to eliminate it. I found a range of definitions for obstetric violence articulated by my research participants, who deemed obstetric violence as the main obstacle of maternal safety in the majority of the interviews.

According to Yuritzi, obstetric violence is when health officials humiliate, yell at, deny access to information, tie down, immobilize, and act without consent of the women giving birth. Itzel, a timid 40 year old retired midwife, who was sitting next to her, added that the lack of privacy or ignoring the women's wishes for privacy are an example of obstetric violence. Yuritzi says she knows of women who were sterilized with the consent of their husbands after they had explicitly said they did not want to be sterilized. She argues that decisions made by women when they are under the effects of painkillers or an epidural should not be taken as meaningful

consent. Itzel believes that obstetric violence happens to almost everyone in Quintana Roo but almost no one reports it.

Doña Ake argued that another form of obstetric violence is the dehumanization and belittling of their culture, including midwifery culture. A midwife in Chumbec, Yucatan, she stated that health care institutions do not take into consideration important cultural traditions such as having family members present during births. Doña Ake believes that a woman about to give birth should be in the company of their mother, mother in law, and husband. Without them, the woman is bound to feel rejected by her community. She stated that her ancestors had been assisting births for centuries and believed strongly in the need for immediate connection between mothers and newborns. Doña Ake argues that children nowadays are distant and rebel against their elders because their introduction to this world consisted of procedures conducted by health-care officials rather than the embrace of a mother. Doña Ake also argues that another form of obstetric violence is the way her work is degraded. Because midwifery is belittled in public hospitals women are made fun of or criminalized for choosing home births. She states that whenever she has had to send a patient to the hospital because of complications during the birth they are received with hostility. By criticizing the choice of women to have a home birth, hospital officials and state officials belittle that woman's culture.

Yuritzi and Itzel also report the belittling of midwifery from institutions as a form of obstetric violence because they prevent women the autonomy to decide how to give birth. Yuritzi states that state sponsored organizations like *Oportunidades* prevent women the sovereignty in their bodies in deciding how to give birth. According to Smith-Oka (2005) and Pombo (2008), *Oportunidades* is a cash transfer program that allocates funding for mothers only if they follow certain hygiene guidelines and attend certain workshops. Pombo's (2008) study showed that programs like *Oportunidades* disempower women because they alienate health promotion from a woman's body for institutional purposes. Women are forced to attend state-created workshops that criminalize non-state sponsored birthing methods. Yuritzi, Itzel and Doña Ake argue that the state and programs such as *Oportunidades* discredit midwifery and force women to choose hospital births; this breach in sovereignty is a form of obstetric violence.

Ime defined obstetric violence through a different perspective. She argues that a form of

obstetric violence is the inaccessibility of state provided healthcare. Ime says that when a medical emergency occurs in her community of X-Querol, Quintana Roo, those in need are forced to bicycle for two hours until they reach the next community. Ime, who studied in the local university, Community Health, was inspired to continue through higher education when her sister in law suffered from birth complications and was forced to ride her bike from her community to the next after her water had already broken. Ime's sister in law traveled by bike to one community, by bus to the closest city, and from there to a larger city. By the time her sister in law arrived to Chetumal she delivered a stillborn. Ime says that the lack of accessible ambulances and health care clinics are forms of obstetric violence. Ime also states that health care officials are not the only perpetrators of obstetric violence, but midwives as well. She, believes that the current shifts to "train" midwives in biomedicine have instilled in them violent techniques they reproduce on women. She argues it is equally possible for women to be hurt by hospital and midwifery care.

Margarita, a mother of a four year old boy, says obstetric violence is all violence women experience from conception until giving birth. She says it can be seen the moment an under-aged pregnant girl goes to a consultation and the doctor criticizes her for her age and demonizes her choices. She also states that the omission of information is a form of obstetric violence and is commonly seen when young women ask their doctors for future birth control methods. Margarita states that obstetric violence occurs when women are yelled at, insulted, or made fun of when giving birth. She says that the most common form of such violence is unnecessary cesarean births or cesareans in which large incisions are made across a mothers stomach when only a small incision was necessary. Margarita, who received her psychology degree from the local university, states that such cesareans leave a physical mark on a woman's body that can have a negative influence on self-esteem and be a constant reminder of a violent birthing experience. She argues that in Campeche doctors are pressured by time constraints to deliver as many births as they can, which results in hurried and pressured cesareans. Doctors can also have economic incentives to conduct surgeries rather than natural births. Another form of obstetric violence is using a pregnant mother to set an example in public hospitals. Margarita argues that in free clinics doctors need to teach medical students how to deliver babies. Because women who attend these free clinics feel they cannot receive better care, they do not complain when students prac-

tice their skills on them. Women report having been touched violently and feeling their privacy overstepped when used as an example. Margarita remembers her mom telling her that the moment women give birth they lose all modesty. She says she did not understand what that meant until and experiencing the constant touching, opening of legs, and lack of privacy when she gave birth. Margarita also believes that when she gave birth to her son she suffered from obstetric violence because they forced her into a cesarean birth without telling her why. She says “te violan tu cuerpo y tu decisión” (they violate your body and your decision making).

Out of the seven activists interviewed for this research, only one did not discuss or identify her activist struggle in relation to obstetric violence. Irna fights for gender, reproductive and human rights and social change. Although she does not explicitly use the term obstetric violence, her activism is included in this research because it showcases the gendered struggles of women in her community. Irna states she began her activism when she started to notice the large number of young parents and increase in sexually transmitted diseases. She realized that in her remote community information was lacking and activists like her had to step up and educate others. Through her activism, she found that because of a lack of information, women and youth are vulnerable to such injustice. Her activism efforts, although not on obstetric violence, is connected to the same thread of violence and oppression that victims of obstetric violence experience.

Several women attempt to explain why obstetric violence occurs. Yutziri and Itzel state that doctors engage in obstetric violence because it is part of the routine, as it is been institutionalized. Itzel says doctors come from Mexico City with certain perceptions about what is “safe” and necessary when giving birth and it is hard to convince them otherwise. Often doctors are forced to follow a certain protocol and may lose their job if they do not respond to emergencies in a certain way. Yutziri says that in many cases doctors working in public and free clinics are not paid enough to live comfortably therefore have to take extra shifts from different hospitals. Their time then becomes scarce and to make birth deliveries faster and get more free time they conduct more cesarean births. Margarita says that the question of why obstetric violence happens is too hard to explain because it has been normalized and internalized. Margarita argues obstetric violence is too institutionalized to pin point a cause. She says that obstetric violence is so

institutionalized that even language has been created to naturalize the process. Insurance companies use the term “camazo” to refer to women who gave birth in hallways, bathrooms, or parking lots because hospitals did not have enough room for them or doctors refused to treat them. According to Margarita, by naturalizing unhygienic births with a term, insurance companies have institutionalized the violence.

America Cassanova, a founder of an NGO in Campeche that fights against gendered violence argues that the naturalization of obstetric violence is the hardest thing to overcome. She says, “Definitely this is very naturalized, above all the restriction and control over our bodies. Thus it is very difficult to observe when obstetric violence or reproductive health violations are occurring” (“Definitivamente esta tan naturalizada la violencia, sobre todo la restriccion y control sobre nuestros cuerpos entonces hay mucha dificultad para observar cuando esta pasando violencia obstetrica o violacion de derechos reproductivos”). America states that her biggest obstacle when helping women seek legal council against obstetric violence is first recognizing they have been victimized. She states that as women, our bodies have been continuously restricted and controlled, therefore it is hard to realize when we are victims of obstetric violence or our reproductive rights are being violated. The constant dehumanization of female bodies lead to the naturalization of violence which is internalized and almost impossible to break through. This next section speaks to the experiences of women, first as mothers and then as midwives.

Mothers’ experiences of obstetric violence

During my stay in Xanlah, Yucatan, Irna suggested we visit towns near by and talk to women about birthing practices to get a larger perspective on the issues women face in the region. Xanlah is a small community in the county of Chankom with a population of about 406 so it was not surprising that my host felt she needed to show me a variety of towns in her county and her neighboring county⁴. The counties of Chankom and Chikindzonot are right in between the tourist rich ruins of Chichen- Itza and the tourist city of Valladolid. The county of Chankom has a population of 4,430, who 85 percent of its adult habitants speak an indigenous language

⁴ <http://mexico.pueblosamerica.com/i/xanla/>, accessed February 15.

and only about 0.32 percent of households have access to a computer.⁵ Irna asked her father-in-law to lend her his car and together we visited Muchucuxcah, Chickindzonot, and Chan-Chichimilá. Although from her community to the farthest one away is less than 30 km away, the state relation with midwives differs completely. Irna's community of Xanlah had two living midwives, both of whom were close to turning 90. Her generation did not give birth using midwives. She stated that in her community, midwifery was a dying tradition and that all the women she knew took the trip to the big city to deliver their children. Her mother in law, Señora Neyi, stated she give birth to five of her six children with the help of a midwife but by her sixth child her doctors and programs warned her that she was too old (age 43) to be having a child outside of a clinic. Her last daughter, who was born four years after the fifth child, was delivered in the hospital in Valladolid because according to Neyi, *Oportunidades* told her it was the best option. Señora Neyi did not regret having her last child in a hospital because she felt she was older and weaker and that she would not be able to stand the violence enacted by conservative midwives. Señora Neyi is one of the few mothers who claimed midwives could be violent and participate in obstetric violence. All of Señora Neyi's grandchildren were born in hospitals; she says no one in her community gives births with midwife assistance anymore because of the age of the midwives and because of the pressure from *Oportunidades* and doctors. According to Gretimaria, one of the midwives in Xanlah, she has not been invited to take a midwife course for the past 10 to 16 years. She believes that the government has stopped providing courses because there is no money to fund them.

Neyi has an interesting perspective on birthing because she's experienced giving birth with a midwife and in a hospital. The closest hospital is in Valladolid, but the most affordable is in Izamal. In Valladolid, the service is be free for qualified patients, but they and their families have to find room and board until the hospital can accommodate them. Izamal hospitals on the other hand have free room and board but are further away, about four hours away in a car. Neyi said that in hospitals women are often hurried out like cattle. Most women told me they are forced to have cesarean births and women report having to wait for hours to be treated. Neyi's oldest daughter had a complicated pregnancy in a hospital. They arrived to the hospital on a

⁵ <http://mexico.pueblosamerica.com/i/chankom/>, accessed February 15.

Thursday, but she was sent back because she was not dilated yet. They returned Friday when she had a fever and was denied once more. When she arrived on Saturday the baby was almost dead and they forced her to sign a paper taking all the blame for not arriving on time and therefore having a forced cesarean. The mother was sick for weeks after the birth of her child and the hospital never took responsibility.

Irna has a similar story when she gave birth. She arrived to the hospital at 3am but there was no doctor or anesthesiologist near by, as well as no ambulance to take her to the next community. The nurse told her “if you know how to pray start, because if your daughter doesn’t die you will” (“si sabe rezar empiece, porque si no se muere su hija se muere usted”). Thankfully, her daughter was born healthy, but she remembers the experience as shameful because the nurses and doctors treated her with condescension and those who attended to the birth had not yet graduated. Both Neyi and Irna describe a sense of hostility from the doctors who delivered their babies; their hospital birthing experience was marred by treatment from doctors that was aggressive, violent, and inconsiderate. They both stated that their experience was common for most of the women in their communities. Obstetric violence for them was a normal birthing situation.

In Morelos, Quintana Roo, Ime discussed the diverse experience of the women in her natal community compared to the experience of women in her current residence. Ime was born in X-Querol, a community has about 85 people who live in 18 different structures (viviendas). The majority, about 85 percent, of the adults living in X-Querol speak Mayan and the closest community and health clinic is a two hours bike ride to Saban.⁶ As previously stated, Ime became involved in combatting obstetric violence after her sister-in-law had a stillborn. Her sister in law had to ride her bike for two hours with her water bag already broken to a clinic only to find it was closed and they had no working ambulance. Ime says the lack of medical care in X-Querol is very alarming not only for maternal safety, but her community suffers greatly from diabetes. She says that the only vehicles that arrive to her community are Coca-Cola trucks and beer trucks. The high consumption of sugar in her communities has resulted in high rates of diabetes. She says every family in X-Querol has at least one person whose limb has been amputated because of diabetes. The lack of health care accessibility in her community is her main motivator

⁶ <http://mexico.pueblosamerica.com/i/x-querol/>, accessed February 2015.

to become an activist against obstetric violence.

Ime currently lives in José María Morelos, Quintana Roo, which is commonly referred to as Morelos. Morelos is located in the José María Morelos County and has a population of around 10,000 people.⁷ Ime says that there are two main hospitals, one for the wealthy and one for the poor. Other clinics have been built in response to the increase in population, but Ime says they are supposed to be open Monday through Friday from 10am to 2pm but they rarely are. During the week I stayed in Morelos, the Municipal Clinic never opened. Ime says that political candidates open new clinics in order to get elected but once election time is over they close them down. According to her it is just another example of empty promises by politicians who make healthcare accessible only to gain votes only to close them once they have been elected, she is not sure why this happens. With more complicated medical emergencies people from Morelos travel to bigger tourist cities such as Chetumal and Carillo Puerto.

In the state of Campeche the women I interviewed, America and Margarita, are activists living in the capital, San Francisco de Campeche. Margarita who works at a center against gendered violence and specifically works on issues of maternal safety. She says birthing in the state has rapidly moved away from midwifery and to hospitalization. But although the state has promoted hospital birthing, the state has failed to adapt to the shift in demand for services. Clinics are scarce and women have to travel to obtain health services. There are few ambulances and the ones they have are antiquated. According to Margarita, because of the scarcity, clinics are usually overflowing with patients and pregnant mothers are commonly asked to wait several days before being admitted. It is common for women to give birth in parking lots, bathrooms, or hallways because the doctors cannot see them or refuse to see them.

America, who is the founder of the center against gendered violence where Margarita works, says the clinics especially turn away Mayan women because of discrimination. Because they are Mayan, hospitals do not want to treat them because they probably lack insurance. Margarita says Mayan women are disrespected because of their language, clothing, and birthing rituals. Women are often asked to leave waiting rooms if they are barefoot with the pretense of hygiene, however Margarita says it is a common excuse for hospitals to deny access to the poor.

⁷ <http://mexico.pueblosamerica.com/i/jose-maria-morelos-14/>, accessed February 2015.

Margarita says hospital employees know who will be able to pay for their services and who will not and discriminate them based on that. For many Mayan women having family present during the birth is an important cultural tradition but clinics refuse to let families be part of the process. Margarita says women who want their family members to be present are often made fun of for being weak and dependent, when for many women having family present is of cultural importance. The experience of obstetric violence is doubly painful when the woman is not only a mother but also a midwife, a topic to which I now turn.

Midwives who experience obstetric violence

Midwives experience obstetric violence in a variety of forms. Like other women, midwives expressed being victims of obstetric violence while giving birth, but due to their line of work, midwives are also marginalized when their work is belittled or mocked by hospital officials, when midwifery is criminalized, or when the state refuses to provide courses and aid. For many midwives, the act of denying them proper certification, courses, and material is an example of obstetric violence because it denies women the right to choose where and how to give birth. Most midwives interviewed had received some contact with state training or state funds in the past. The three state institutions that train midwives in Mexico are the Ministry of Health (Secretaria de Salubridad y Asistencia SSA), Mexican Social Security Institute (Instituto Mexicano de Seguro Social IMSS) and the National Indian Institute (Instituto Nacional Indigenista INI) (Huber and Sandstorm, 2001). However, very few stated they adhered to government training and influence. The only case of midwives I met who currently received government trainings were in Yucatan in communities close to Xanlah, Yucatan. With the help of Irna, I managed to interview five midwives around her county of Chankom, Yucatan and see how the relationship between institutions and midwifery culture varies. All of the midwives Irna put me in contact with had experienced a different type of obstetric violence. Communities just a couple of kilometers away from each other had radically different pressures and aid from the state.

Muchucuxcah is 12.7 km away from Xanlah, where Irna is from. There I met a midwife couple where the husband, José (82 years old) and wife, Gregoria (77 years old) have been the town midwives for the past 40 years. Unlike the midwives in Xanlah, José and Gregoria said

they received their last training three years ago but seem to not remember who trained them. The couple is currently retired, but their daughter continues the tradition in the town nearby. José and Gregoria, who speak little Spanish and insisted of having this interview in Mayan, stated they took three to four courses a month in the past fifteen years with the collaboration of doctors and state officials but for the past three years they have not been re-invited and have not received equipment given by the state. They believe they have stopped receiving training because the demand for midwifery has lowered dramatically in the Yucatan. The refusal to continue to provide training by the state is a form of obstetric violence because they are denying women the choice of how to give birth.

In Chikindzonot, another midwife has a completely different experience. Chikindzonot is around 17 km away from Muchucuxcah, which is about an one hour drive away on poorly maintained roads. Maria, who has been a midwife for the past 35 years, and continues to deliver births, said she received her most recent training on June 16, 2014 in Chemax, Yucatan, just two months before our interview. Maria, whose services include witchery (*brujería*) and delivering births, said her latest training was provided by the Ministry of Health (*Secretaria de Salubridad y Asistencia*). The recent training took place in a clinic and was conducted in Spanish but had a Mayan translator. According to Maria around fifty other midwives were invited. She often takes her daughter to these trainings because Maria cannot read or write. Maria, who is constantly invited to trainings, receives instruments and equipment from the doctors she meets such as gloves, syringes, and more. Maria said that the only major shift she experienced of midwifery is that she is forced by her contacts/colleagues in *Oportunidades* to help deliver births only if the mother had been to a clinic as well. In order to keep receiving the documents needed to declare birth (*nacido vivo*), Maria has to make sure her patients have attended state provided healthcare clinics. She says she approves of this shift because it protects her from judicial punishment and allows her to maintain positive ties with healthcare officials. Only seventeen kilometers away, Jose and Gregoria had completely different relations with doctors and experienced obstetric violence differently than Maria. The violence Maria experienced from the state was the criminalization of midwifery if she did not meet the specific regulations of the state.

In Chan-Chichimilá, which is 11km away from Muchucuxcah, or 45 minutes driving, I

met Doña Felipa, a midwife who was soon to turn 84 years old. She had helped deliver a baby the day before our interview. Doña Felipa, who tells everyone who would listen how the Virgin sent her a sign to be a midwife, has been assisting births for the past forty years. When I asked her if she had seen a decline in customers wanting home births, she laughed loudly and said she had assisted the birth of the county president and his five children. She said home births in her town are every day less popular because for the past 20 years she has been forced by doctors to send her patients to the hospital right after assisting their deliveries in order to receive proper documentation to register the child. Doña Felipa states that first-time mothers would rather just get it all done in one place instead of going to the midwife first and then the doctors. The patients she does assist during births get sent to the doctor right after the birth with a piece of paper where she writes the baby's time of birth, weight, height, and other notes. She also makes a copy of the information for her records, and showed me about 200 little notes, some written in the back of receipts, napkins, and notebook paper. Doña Felipa says she feels shame (*vergüenza*) when she is around doctors, and therefore has always done her best to avoid training. She questions the teachings of doctors as she believes her gift was given by a divine power that transmitted birthing teachings through dreams. However, even though she protests classes, she has been forced to take courses in Chemax, Valladolid, and Chayokdzonot in order to continue with her profession. She said three months before our interview, in May, Doña Felipa received medical instruments by the Ministry of Health. The last course she took was a month before our interview in July 2014 in Chayokdzonot. She believes that the last course she took before the one in July was three years before. Doña Felipa attends courses only when she feels pressured to go by her patients, however she says if she can avoid them she does. She said she trusts her virtue more than anything else. Obstetric violence here is reflected by the shame Doña Felipa feels around hospital doctors, which deters her from being trained.

Doña Ake is from Chumbec, Yucatan in the county of Suzdal, a town of about 250 people where around half of the adults speak Mayan⁸. Doña Ake is currently around 60 years old and began the process to become a midwife when she dreamed, at the age of 24, that an old man told her it was her destiny. Few months after she had understood her dream, in November 27, 1981,

⁸ <http://mexico.pueblosamerica.com/i/chumbec-2/>, accessed February 2015.

the Ministry of Health (Salubridad) set up a town meeting and made the town vote for one woman to get trained as a midwife and a healer (curadora). The town voted for her, but because of shame of barely speaking Spanish and not knowing how to read or write she quickly turned it down. However, her husband Don Julio pushed her to take the job because he says he knew her potential. She said little by little she started to lose her shame and learned how to speak Spanish. The training was scheduled to be a year and a half long and required her to leave her family and move to the city Monday through Friday. During the weekends she had to take a two-hour horse ride back to her town to see her children. Fortunately, the doctor in charge of trainings saw that Doña Ake was more knowledgeable than the project expected her to be and gave her a license after just eight months of training. When asked by the doctors how she knew so much, she lied and said it was because of her grandmothers but confesses that in reality she was taught how to assist births through vivid dreams.

Doña Ake was trained by the Health Ministry but for most of her life worked as a midwife licensed by the Mexican Social Security Institute (Instituto Mexicano de Seguro Social, IMSS), which provides the proper documents to register babies as well as training and equipment. However, in 2008 the IMSS retired all the midwives in their system and prohibited them to continue assisting births. Doña Ake says that 70 midwives were let go and denied the right to practice because they were not given the proper documents to register a birth. Facing dismissal, Doña Ake quickly went to Salubridad and told them that they initially trained her and that she had several current patients who needed her. By a miracle, according to Doña Ake, Salubridad gave her the documents she needed and has continuously done so for the past seven years. When telling me her story, Doña Ake would sob and express the constant fear she has that Salubridad will stop providing her the documents she needs. She witnessed how from one day to the next, IMSS stripped her of her income, title, passions, and identity. She says she would not be surprised if Salubridad did the same thing. These feelings of fear and intimidation by the state are representations of obstetric violence. Doña Ake knows that if Salubridad refuses to provide the documents she needs, it will be impossible for women in her community to receive home births and will undermine her livelihood and drastically reduce her family's income.

Doña Ake's goal is to protect midwives from biomedical practices that promote obstetric

violence and to make midwives more accessible to women to prevent such violence. She and her family economically depends on midwifery. Although she is one of the few midwives in her region able to assist births, her clients are less and less indigenous women like herself. Doña Ake travels twice a week to the capital of Yucatan, Merida—a three hour bus ride each way—to massage and/or deliver births of “rich” women or non-Mexican women. There, professional Mexican women such as nurses, teachers, and lawyers want experienced Mayan midwives. Foreign-born women also travel to Merida to receive an “authentic” Mayan birthing experience. Doña Ake partners with a doctor from one of the many private hospitals in Merida and together they deliver births. She says this doctor is the only one that respects her and treats her as an equal. To women in Merida of economic means, she charges \$8,000 pesos (around \$600 dollars) compared to the \$2,000 pesos (around \$140 dollars) she charges indigenous women. With help from Semillas, Doña Ake’s continues to go to courses offered all around the country. She has also adapted her practice to fit the requests of foreign and upper class women. For example, ancient Mayan tradition calls for the burning or burying of the placenta (Jordan 1983). However, after several classes and requests she now provides the service of cooking the placenta for the mother to eat after giving birth. If the client does not want to eat it, she keeps it and then makes pills and soaps to cure a variety of things. Doña Ake and few other midwives noticed a trend of wealthier women popularizing home births while indigenous women were being denied these birth experiences. Wealthy women are given more autonomy of their birthing choices, while the state simultaneously criminalizes lower class women’s birthing choices. *Oportunidades* and other state programs have the power to restrict and direct how indigenous women should live because of their economic vulnerability (Smith-Oka 2009). While higher-class women have the ability to consent and decide the birthing option they want, lower class and indigenous women have to conform to what is available.

In Jose Maria Morelos, Quintana Roo, Irna introduced me to one of the seven registered midwives, Doña Guadalupe. Doña Guadalupe is an older widowed woman who economically supports herself through making hammocks and assisting in births. Doña Guadalupe said that ten years ago she would receive ten to fifteen births a month, but now she is lucky if she gets one. She believes that the lack of demand for home births is due to the “weakness of younger

mothers.” She states that a couple of years back, women wanted to give natural births and valued the pain inherent to the experience. Now, younger mothers are concerned with having no pain and shorter recovery time. She says now she mostly just massages pregnant women during their pregnancy. Even though she is concerned about the demise of midwifery, she is somewhat relieved when women chose to go with doctors because that puts her less at risk of being blamed for natal mortality. She says doctors often brainwash women into believing that stillbirths can only happen with midwives in order to scare them. She says that even though she only massages women, she still gets blamed for hospital’s mistakes. Now if a baby dies in the hospital, the women believes it was because she got massages from the midwife. Doña Guadalupe says that the last course she took was three years ago. She says she would like to attend other training courses, especially because they provide free equipment; however they are not accessible anymore. She says the Health Ministry has stopped providing them because of lack of funding. She recalls and speaks of these courses fondly. The obstetric violence she has suffered is constant belittling of her work and being blamed for births going wrong.

About a two-hour car drive away from Morelos, Quintana Roo, is the town of Saban, which has around 2,000 habitants of which 82 percent of the adult population speak Mayan. Saban has the reputation of being a community where doctors, politicians, and police stay away. Not only is it considered one of the most dangerous gang related communities in Quintana Roo, but it is also a highly independent community. According to Elide, a popular midwife in the town, doctors last two to three months stationed in Saban and then leave because the community does not respect them as much as they do local healers and midwives. Elide, who started assisting her mother in delivering babies when she was 7, has delivered most of the people in her town. Elide, who is fondly called *madrina* (godmother) by the townspeople, delivers ten to fifteen births a month and charges \$600 pesos, or about \$40 dollars. She says she received her certification by *Salubridad* and the Ministry of Health, but recently they suddenly stopped offering courses. She blames the sudden end of courses to the political change in the Federal Government from a PRI party domination to a PAN party⁹ domination. However, she says that is not

⁹ PRI, or Partido Revolucionario Institucional, is the Mexican political party that governed the country for 71 years in what is usually referred to as the “perfect dictatorship”. In 2000 President Vicente Fox from the PAN party, Partido Acción Nacional, won the election changing the longstanding party in power (Klesner and Lawson 2001).

really an issue for her because the courses seemed to be a waste of her time. She said she does not even miss the free equipment they would give her because she rarely used it. She likes to practice midwifery like her mother and her grandmother—Elide is a third generation midwife.

The first time I visited Elide, she said she had no relationship with the doctors because they were not really active in the community. However, the second time I stumbled into her home there was a couple of mothers, the elected mayor of Sabán (a man who spoke little Spanish), and Elide sitting in front of a laptop typing up a letter to the Ministry of Health Commissioner in Carillo Puerto demanding the reinstatement of a doctor. I will discuss this experience in the following chapter. However, this encounter indicates how rocky and unpredictable relationships with doctors can be for midwives. From one day to the next Elide had gone from not having any experience with doctors to actively fighting to reinstate a doctor.

In Tulum, the heart of the tourist rich Mayan Riviera of Quintana Roo, I met two midwives Yuritzi and Itzel who described experiencing completely different birthing options than that of Morelos. Tulum is an hour away from Cancún and a popular destination for those interested in seeing Mayan ruins while enjoying Caribbean beaches. Yuritzi, who is a Swedish immigrant who speaks Mayan and Spanish fluently, is one of the most active figures in the Yucatan Peninsula concerning midwifery. Everywhere I went someone would recommend I speak to her. Yuritzi, who was a midwife in her natal country of Sweden moved to Quintana Roo to learn Mayan birthing methods and never went back. Itzel, born Quintana Roo, currently does not assist births but massages pregnant women and actively protests against obstetric violence. Itzel and Yuritzi met 20 years ago when they expressed interest in learning how to assist births from the local midwife. Itzel and Yuritzi shadowed the local midwife for a couple of years, took several birthing courses from the Mexican Social Security Institute (Instituto Mexicano de Seguro Social IMSS) and were eventually certified together. Yuritzi says that the last course offered in Tulum was fifteen years ago and that was the last state sponsored course they both attended.

Yuritzi said she was glad they stopped providing these courses because they did not teach midwives anything useful; instead they would be publicly humiliated and belittled. According to Itzel, instead of teaching midwives how to make sure the uterus was healthy or perform an episiotomy, they would yell and shame them for their beliefs. The doctors also tell them they are

not qualified to treat women under the age 18, over 35, or first time mothers. Yuritizi says the treatment to midwives during the courses is a product of the state's successful effort to hospitalize birthing. She says that in 2001, 45 percent of women had home births but now 93 percent of women have births in hospitals. Yuritizi says that the state claims that these courses have lowered infant mortality rates. However, she believes that the infant mortality rate has lowered because the courses are not accessible and promoted and therefore midwives are not taught these tactics.

Itzel does not practice midwifery anymore because of the current backlash midwives face in the region. Yuritizi says that the state has called upon a witchhunt against midwives. The state is waiting for midwives to make a mistake and incarcerate them. Midwives are often publicly humiliated and belittled while being blamed for infant mortality. The constant dehumanization they face for their profession is a type of obstetric violence because it prohibits the opportunity of women to choose where and how to give birth. According to Yuritizi, two midwives in Cancun were incarcerated for malpractice, one of them being a seventy year old women. Itzel says midwifery is an incredibly stressful job with no economic benefits; therefore most midwives have retired, like her, and now only massage. To protect herself against the state, Yuritizi has been working alongside a gynecologist for a year. A year ago when a mother was having birthing complications, she would send her to the hospital where doctors would yell at the woman that it was her fault because she had gone with a midwife. Doctors would belittle the midwives' work and the mothers would become anxious. Midwives then faced repercussions both from the state and the mothers. Yuritizi would rather not work with the gynecologist but she says it is the only protection she has.

Yuritizi, who still practices midwifery in Carillo Puerto, Tulum and Cancun, says that since 2005 most of her clients are foreigners. She speaks English and Spanish more commonly when attending births because her patients are usually American or European. Like Doña Ake, Yuritizi has had to adapt to what her patients want from the experience so she now offers water "Mayan" births as well as the ability to prepare the placenta for consumption.

Midwives living in Quintana Roo experience different treatments and relationships from the state even though they are governed by the same institutions. Ime and Elide experience a

very “hands off” approach by the state in regards to healthcare. The state does not criminalize Elide or Doña Guadalupe the same way they do Yuritizi and Itzel when all of them are Mayan midwives from Quintana Roo. Interactions with the state, criminalization of Mayan birthing tactics, and the home birth clientele can vary greatly within the same state. Within the state of Yucatan the political situation of birthing is different. Greater analysis should be made that attempts to understand why women and midwives have vastly different experiences and availability to birthing options. Some of these differences can be explained based on the location of the community. That hypothesis will be deeper analyzed in the next chapter. Other reasons for the differences in birthing experiences could be due to population size, transportation ability, proximity to ancient ruins, and more. Similar to Yucatan, Campeche and Quintana Roo also have extreme variability in the experiences Mayan women face when giving birth and their relationships with the state. Midwives in this state also experienced obstetric violence differently. Some midwives experienced it by the removal of state training programs, by the state’s restriction, and others by the criminalization of midwifery.

The research I conducted the summer of 2014 proved the inconsistency of implementing the Mexican government’s healthcare policy among different communities and states. Research shows that since the mid 1970s the Mexican state began to play an active role in Westernizing birthing norms and by late 1980s the state began criminalizing those who used midwifery for giving birth (Carrey 2006; Floyd et al. 1997). The state realized that most indigenous communities were not accessible to health care clinics, and therefore to spread Western biomedicine, they had to train midwives who were easily accessible to remote communities. Floyd and his colleagues argue that midwifery training was a “powerful instrument[s] for imposing, extending, and further legitimizing biomedical obstetrics” (399,1997) Contemporary Mayan midwives have been forced to adapt to Westernized medicine and obtain a license to maintain clients. According to Huber and Sandstrom, midwives often get licensed because it is a state protection if the mother or child die during birth. If midwives are not registered they can be cited, incarcerated, or denied documents (2001). Increasingly, women giving birth prefer trained midwives because of their relationship with certain hospitals if something goes wrong during the birth.

My findings coincide with the research of Floyd et al. (1977), Carrey (2006), and Huber

and Sandstrom (2001). Most of the midwives I interviewed had received some form of training and received certain certifications. However their research conducted in the early 2000s, seems outdated, fails to foresee or explain why some midwives reject receiving training as well as this crucial shift away from training midwives and into total rejection of home births in some communities. This research also fails to acknowledge the negative impact these trainings can have over women's bodies. My research found that some mothers felt midwives had been forced to adopt violent Westernized medicine which can hurt the mothers. A midwife even mentioned that through these trainings midwives were taught how to conduct obstetric violence.

Midwives who perpetuated obstetric violence

Irna and Neyi from Yucatan argued that midwives can be equally as aggressive as doctors when delivering babies. Irna says that midwives in their region are older conservative women that feel that pain is natural during birth therefore women should endure their pain. Neyi says that it is very common for midwives to pull and tug at women's vaginas. She also says that midwives almost never conduct an episiotomy when there is a tear in the perineum, the skin between vagina and anus, which is not only painful but also dangerous because it could cause a hemorrhage. Neyi says it is not until after a hemorrhage occurs that midwives send their patients to clinics but by then it might be too late. Jordan states that "it is our [those who assisted her with the research] impression that compared to western practices where the pushing is delayed until the cervix is completely dilated. Maya women are encouraged to push too early. Consequently, in a long labor a woman may endure more pain and exhaustion than necessary." (1983:27). Jordan's work shows how obstetric violence has been around since the 80s and can also be perpetuated by midwives.

Yuritzi from Tulum, Quintana Roo provided insight on why midwives can adopt obstetric violent techniques. She says that through the training midwives were often belittled, discriminated, made fun of, and blamed for natal mortality rates. With these constant methods of oppression, midwives internalize and normalize their discrimination. Midwives legitimize "modernized" hegemonic health tactics because their methods are discriminated and belittled (Belli 2013). Structural violence is reproduced because it is internalized by those who suffer it (Que-

sada et al. 2011). According to Yuritz, midwives who are commonly victims of obstetric violence are often the ones who perpetuate obstetric violence as well.

America, founder of an NGO from Campeche, said that they rarely work with midwives but the greater the distance from the capital, the more popular midwifery becomes when dealing with women's health. I asked her if she had ever received a case where a midwife promoted obstetric violence on a woman's birthing experience. She responded that most communities in Campeche were unwilling to talk about their oppression when it involved others in the community being the oppressors because it brought negative attention to the community. She called it "community violence" where a community would rather put down the victim to prevent them from speaking out against the community as a whole. America says that midwives, healers, religious clergy, teachers, and other important community members are protected by the community and often not held accountable for human rights violations in order to prevent a scandal or foreign intervention.

Midwives in these regions are forced to take up violent obstetric tactics when delivering births because their methods are discredited. This means gendered violence when giving birth can happen to women through both hospitalized births and with a midwife. America's perspective of community violence also proved the historical hostility westernized culture has had on indigenous birthing methods (Huber et al., 2001). Some community members are afraid of letting in western law enforcers and health officials because they can continue to make fun and oppress them. Communities would rather hide the violence among them than subject themselves to violence from the state.

This chapter discussed the experiences women face when giving birth in their communities as well as the experiences of midwives who assist in deliveries. Nine Mayan women in five different communities and three different states report obstetric violence or some form of institutionalized violence towards women. Their narratives highlighted the variability of experiences among states and communities. In some communities the state took an active role in promoting midwifery through courses or acknowledging that is the only option. In other communities midwifery criminalized and restricted. I shared accounts about mothers who are victims of obstetric violence, midwives who experience obstetric violence, and midwives who promote obstet-

ric violence. Mothers experience obstetric violence by hospitals and the states when they lack the option to have home births and when they are treated violently in the hospitals. The communities in this research from Yucatan, Quintana Roo, and Campeche, discussed a lack of accessible health care clinics and availability to health resources. This research shows that midwives experience obstetric violence through the refusal of training, the criminalization and belittling of midwifery, as well as the restrictions midwives have to continue their jobs. Midwives also promote obstetric violence because they have internalized the discrimination of their birthing tactics. Midwives can sometimes perpetuate the violence they experience.

These women are constantly hearing about the dehumanization of women's bodies by state officials and health care officials but they do not sit passively. The following chapter will discuss the forms obstetric violence can take, their methods of resistance, and the obstacles they face when doing so.

Chapter 5: Mayan Women's Activism against Obstetric Violence

Mayan women are frequent victims of obstetric violence in the Yucatan Peninsula. Whether this violence is conducted by health care officials, the state, or even midwives, women are constantly being belittled and criminalized for their birthing choices and experiences. These situations have driven Mayan women to stand up and resist obstetric violence. The following chapter highlights the goals and methods of activism used by Ime, Yuritizi, Itzel, Doña Ake, Irna, Margarita and America. These women fight day by day to end gendered violence.

None of the women I interviewed identified themselves as activists. According to Gitell, Isolda and Steffy (2000), this is common as marginalized women often disregard their actions as political because of their exclusion in political participation. These authors defined activists as those performing activities that change people's lives, better the quality of life in a community, or increase access to institutions. The type of activism women in this research performed was by creating services, changing policy, and community based organizing.

Ime is a 23 year old graduate from the University of Morelos Quintana Roo with a major in Community Health residing in José María Morelos. Besides working in a hostel for students to stay during the school year to continue their education, she is an activist fighting against obstetric violence in her community. Her dedication to bring awareness and change to obstetric violence comes from the fact that Ime has seen this violence occur in her community and its surroundings. Ime is currently directing a short documentary about obstetric violence. She hopes to have film screenings in local communities for both midwives and mothers. The ultimate goal is that mothers be aware and able to identify violence while midwives can stay away from violent "Westernized-taught" birthing techniques. Ime's method of activism involves providing a service to her community. By informing her community, Ime is able to empower them into breaking away from gendered violence. She states the biggest obstacle she faces is the lack of funding to continue her project. Aside from supporting her and the production of her film, Semillas funds also supports her sister while she goes through higher education and is the source of her parents' livelihood.

Ime also stated that it was both a blessing and curse to have deep connections with the

segregated Mayan communities in Morelos. She said she is aware of the privilege it is to be able to go to communities such as X-Querol or Saban and know she will be heard and taken seriously. She says some communities are often hostile towards foreigners because they have been historically marginalized. That is not the case for Ime since she was born in X-Querol and went to school with students from neighboring communities. She acknowledges that as a blessing; however, because people know her and her family she is often subject for gossip. She stated that her activities often hurt her mom the most because she would have to hear from other women how Ime was not being a “decent” woman. Ime, who says she is the oldest person in her community who has not gotten married yet, is often criticized by the communities she visits. They often make fun of her or tell her mother that if she does not hurry into marriage she will be left single and unhappy. Gittel, Ortega-Bustamante, and Steffy (2000: 144.) found that women face a combination of race, class, and gender barriers when actively changing social structures. Their research found that women of color “have limited personal freedom to leave their homes for meetings and community work because of domestic responsibilities and opposition from male partners and husbands” Women in this research often expressed a working environment of racial, ethnic, socio economic, and gendered discrimination.

As mentioned earlier, Itzel works as a masseuse in a hotel in the Mayan Riviera as well as providing massage services to pregnant women. She retired from midwifery after experiencing the hostile environment midwives face in Tulum Quintana Roo. Aside from her jobs she is a Semillas recipient who works towards providing women the opportunity of a safe maternity. Her project consisted of a day-long march in the middle of Tulum that would bring awareness to obstetric violence in the peninsula as well as provide women the tools they need to report such abuses. The march, called “Mi Parto, Mi Decisión” (see Appendix 2) was held on November 29, 2014. The march began in the municipal government building of Tulum, passed the city’s Scotia Bank, and then headed back to the plaza in front of the government building. In the plaza there was music, food and dance. Around the plaza there were tables with different information and services available for women marching. One table had midwives and other experts available to listen to the birthing experiences of women and discuss whether that is considered obstetric violence and how women could recover from post-traumatic stress disorder after experiencing this

violence. Another table gave women the opportunity to leave their testimony with the goal of making their stories public and show how common obstetric violence is. Other tables spread awareness on home births and humane birthing experiences in order to inform women of their options. According to Itzel, around 500 people showed up to march. Yuritzi and Itzel's activism efforts provided services to help victims of obstetric violence, made the violence more visible, and created a space for community organizing.

Doña Ake is an active midwife in Chumbe, Yucatan and the communities surrounding hers. She has been a midwife for around 35 years and through the years has seen varying state interactions. When she became a midwife at the age of 24, the state encouraged midwifery through courses, but since 2008 the state began to criminalize midwifery. During this shift Doña Ake and all the other midwives around her jurisdiction lost support from the Mexican Social Security Institute (Instituto Mexicano de Seguro Social, IMSS) who would provide the necessary documents to assist births. Doña Ake was forced to seek help from the Ministry of Health (Secretaria de Salubridad y Asistencia SSA) to continue in her trade. However, the other midwives, around 70 women, were not able to continue providing assistance during birth after the Social Security Institute let them go. During this shift doctors began to belittle women who chose to see a midwife, state sponsored projects prohibited indigenous women from having home births, and midwifery became criminalized. Doña Ake's vision is to create an association, a union-like group, of midwives that will be protect them from institutional oppression and racism. The association would protect their midwives from judicial prosecution by health care officials and mothers "brainwashed" by their doctors. Doña Ake states that the main goal is to provide women with the opportunity to get humane births at home. She argues that women are brainwashed by health care clinics and given wrong information on midwifery, which leads to women having violent experiences in hospitals. The main obstacle she faces as a midwife is the constant battle she undergoes to have her trade be treated with dignity by hospitals and the state. By providing an association for midwives, she believes she will provide women the opportunity to chose their birthing method as well as protect herself and other midwives from judicial attacks.

Doña Ake states that the main obstacles she faces when organizing is finding an institution that will support her. She is in the process of writing a letter to the Governor of Yucatan urg-

ing him to support them because not only do they keep indigenous traditions alive but encourage health for women marginalized by the state. She argues that unlike doctors from hospitals who are concerned with making money, midwives are concerned in having healthy babies and happy mothers. Doña Ake is organizing a meeting with about seventy midwives in Izamal on November 15, 2015, in order to draft the letter to the Governor as well as begin unionizing. Doña Ake argues that communication with all the midwives she works with is relatively easy because they all know each other and worked together before 2008. Conversely, she says that what is difficult is maintaining communication with institutions. She says several institutions close the door on her, refuse to see her, and do not respond to her phone calls and emails. These are examples of micro-aggressions, personal racist interactions that happen daily and undermines communication (Camara 2002).

Irna Tuz is a Mayan activist funded by Semillas. She lives in Xanlah, Yucatan, a remote community close to several other Mayan communities near the ancient ruins of Chichen Itza. Irna, who has a two year old toddler is constantly battling being a mother and activist in her community. Irna's project with Semillas is to expand information via three distinct target populations. She works with high school students from Chancom and Chikindzonot, groups of women leaders in Chancom, Xanlah, Chanchichimila, Chikindzonot, and Ek-pdz, as well as youth leaders in the same communities. With the high school students, Irna leads workshops on reproductive rights, sexually transmitted infections, healthy pregnancies, and birth control. She gives workshops to groups of women in their workplace, usually suing factories, on topics such as reproductive rights, sexuality, STI's, and human rights. Women in this group are usually twenty to fifty years old. The last targeted group is youth leaders who are usually brought to her attention by teachers and principles. With these students she goes through the same topics but in more detail. The goal for the youth leaders is that they return to their communities and spread their knowledge. Recently she has been working with another group, Hombres Sobre La Tierra, to provide a two month long summer camp for these youth leaders. During the summer of 2014, there were around twenty youth leaders between the ages of 15 and 18. During the first month of summer camp, they learned about gendered issues and sexuality. During the second month, with the help of an actor who volunteers, the participants wrote a play that encompasses everything

they learned. Once the play is completed, they organized trips to their communities to perform. The goal of this is for the students to take what they learned and teach it without seeming condescending. According to Sebastián, the actor who volunteered this summer, through a play people can learn without feeling attacked or patronized. Irna says that these summer camps not only spread information, but they also provide safe and accessible spaces for youth to hang out during the summer without the temptation of drugs and alcohol. Through this program, youth gain social capital by developing a stronger network with kids all around their region. In order to present it to their communities, they have to rely on their cultural and social capital. The participants I met showed great pride in going back to their municipal presidents and convincing them of presenting it in the main plaza or getting the town to provide chairs for viewers. According to Gittell, Ortega-Bustamante, and Steffy (2000) women are able to organize efficiently by relying on their social capital. Social capital according to Bourdieu (2010) is the advantages one has based on the people one knows. On the other hand, cultural capital is the advantages non-financial assets, such as one's traditions, education, manners, etc..., have to obtain social mobility. The participants of this summer camp use their social capital and cultural capital to spread awareness on social issues.

Irna believes her work is crucial because young people are not taught about sex and its consequences, which results in a high rates of teen pregnancies. She also says there has been an increase in the spreading of STI's in her community, but teens are not taught what they are or how to avoid them. According Cantú (2002), since the late 1960s tourism skyrocketed in the Yucatan peninsula, bringing with it a demand for sex work. Cantú states that the Yucatan Peninsula became a tourist favorite to experiment with sexuality and soon became a popular gay destination. The increase in sex work and tourism brought to the peninsula a higher rate of HIV infected people and other STI's. Irna argues that the state has not acknowledged this epidemic as much as it should and continues to push for abstinence rather than implementing more effective policies. According to Irna the workshops for women are equally as important because in these communities older women are held accountable to teach and hold knowledge. By providing her workshops to women workers she is bringing information about people's health to the whole community. She hopes that through these workshops she empowers the community to fight for

human rights such as the right to health, right to life, right of knowledge, and rights to have consensual sexuality. She says that historically, her community has been deprived from these rights because they do not know they have them so how could they demand them. Irna's method of activism consists of providing a service to the public. Her classes about gendered and structural violence empower different populations in order to spread knowledge in her community. She continuously fights day by day to fight against oppression. Although her activism is not explicitly on obstetric violence, during her workshops she does discuss health rights and the right to demand positive treatment in hospitals.

Irna expressed having experienced several obstacles to her form of activism. The first obstacle she faces every day is transportation. These communities are far from any major highway and public transportation is inexistent. Although they are close together as the crow flies, the lack of transportation makes moving between communities inordinately difficult. Another obstacle she faces is being taken seriously by the youth from the high school groups and the youth leaders. She says that speaking Mayan and Spanish helps ease the tension with the youth because they can identify with her. Irna says that if she goes to these workshops dressed professionally and speaking only Spanish, the students disengage. However, when she speaks a combination of Spanish and Mayan and dresses casual the students are more active and accept her. Gittell, Ortega-Bustamante and Steffy (2000) call this the breaking down professional-nonprofessional dichotomies. Valuing the students life experience and communicating bilingually results in a better learning atmosphere. Irna states that she has more obstacles facing the women rather than the youth. Most employers only let her give her workshops once and during their break, so in order to keep bringing workshops to them they have to invite her to someone's home and schedule a workshop. She says it is hard to work around the women's schedule because most of them have children to take care of as well as professional responsibilities. She also says that it is common for women to be prohibited by their husbands to attend these workshops because they argue she "fills their heads up with sex and sin." In Chinquinzonot, she had a women who went to one of her workshops once but never returned because her husband physically abused her as a result. Another obstacle she faces is her fight against religious beliefs that contradict her workshops. Parents complain about her for teaching youth to use contraceptives

because it goes against their religious beliefs. However, she says this rarely happens because parents never talk about sex even if it is to condemn it. Irna also has personal obstacles that prevent her activism. It is common from women activists to struggle in finding childcare or separating themselves from their families (Gittell, Ortega-Bustamante, and Steffy 2000). Irna has to remind herself that she fights to empower so that her daughter lives in a better community. She also expressed fearing her security as Irna is constantly afraid of going to heavy gang populated communities alone without having safe accessible transportation.

Margarita and America are the two activists I interviewed in the San Francisco de Campeche. America, who has a masters degree in poetry, is the founder of an NGO called Red de Mujeres y Hombres Por Una Opinion Publica De Violencia de Genero, which is translated to Center for Women and Men For a Public Opinion on Gendered Violence. Her NGO is fondly called el observatorio (the observatory). Margarita who has a university degree for psychology, works for the observatorio, specifically under the branch of maternal safety.

America began her NGO in 2005 when, as a journalist, she realized that gendered violence was unaddressed in the media. However, in 2010, she understood that increasing visibility to gendered violence was not enough, but that the observatorio had to take an active role in empowering women against gendered violence. The observatorio now works with women for the right to choose, maternal safety, obstetric violence, and human rights.

Margarita works closely with women in bringing workshops on maternal safety and obstetric violence in Tenabo, Calkini and Hecelchakan. She empowers women by teaching them what obstetric violence is, how to identify it, and what to do when victimized by such violence. Margarita connects victims of obstetric violence to free legal council in order to help the victim be compensated for damages. She says that although she has supported many women into taking legal council, it has never been successful because women usually back out. Hospitals are able to get better legal representation and usually blame women for the violence they endure. Women are quick to back out of legal action because court procedures are costly in terms of money and time. According to Bumiller (1987), marginalized members of society are discouraged to pursue legal action because of the power struggle, monetary costs, and the prolonged process. Margarita says that the women she works with are more likely to accept psychological help after suffering

obstetric violence instead of legal help. Margarita says that apart from obstetric violence she also facilitates discussion on other human right violations. Another program she conducts is a puppet show on children's rights for children to learn through interactive visual models. A topic she likes to teach students is on the right to seek and receive information. She also said through the observatorio they hold poetry classes where women who are victims of gendered violence can learn to express their feelings through art. She also enjoys working closely with teen mothers and providing resources for them. A week before I met with Margarita, she planned a workshop for teen moms to learn how to make bread. She says programs like these empowers teen mothers with skills they can use to get jobs and support their families.

Margarita provides workshops to around 200 women in the three different municipalities. She tells several women who live in the community beforehand that she will be going to give a workshop and asks them to invite as many people as they can. According to her it is easier for women who live in the community to invite the community because people trust them. Margarita makes it a point that she invites everyone to these workshops. It does not matter their age, sex, religion, or sexual orientation; what matters is to spread information. A common obstacle Margarita faces when organizing is women not being allowed by their partners or parents take her workshops. Inna mentioned having a similar problem. Margarita says that the observatorio is often signaled as dealing with tabooed themes like abortion, which discourages women from reaching out for help.

According to America, around 30 to 40 percent of the women the observatorio works with are indigenous; therefore she has developed specific guidelines in facilitating workshops with Mayan women. America says that workshops are given in Spanish but highly influenced by Mayan words. For example, when talking about the female body they use "chuchu" instead of breasts. That way workshop attendees do not feel intimidated by words they have never heard and are not necessary. America says she has created strategies for workshops that facilitate discussion through visual learning. The observatorio always tries to bring a big table to every workshop and place it in the middle with malleable materials for women to engage with while listening to the facilitators. America says that the purpose of the table is to make women feel comfortable and at home. Traditionally, America says, women have the most important conver-

sations when working in the kitchen surrounded by other women. By placing a table with buttons, glitter, paint, and paper women can be engaged to the material the same way they are engaged in kitchen gossip. America says this strategy proved successful because women felt more comfortable and would talk among themselves instead of being just passive listeners.

Another strategy that is important when dealing with indigenous communities is to connect what they are learning to their community. America said a good example of this is an exercise they conduct where they represent a female body to a community. Each woman is given a quarter sheet with a female body part. One woman can get one chuchu (breast) while another woman gets the tuuch (belly button) and another gets a vagina. Once everyone has a female body part the women stand up and align themselves according to where their part is in accordance to all the other body parts. The facilitator then asks the women if there is any part of the body that they do not need? Could they live without our uterus? A breast? As the conversation progresses, participants reflect on common sicknesses in the female body as well as the importance of each part of the body. From there, each body part is linked to a human right such as the right to health, the right to maternity, the right to choose how many children to have and when, as well as the right to have humane birthing experiences. At the end, women reflect on how the body represents the community and just as they are a part of the female body they are also part of a greater community. When one part of the body gets sick, the whole body gets sick. When one of the members of the community gets sick, the whole community gets sick. The moral of this exercise is to take care of their health and pressure other women in their community to take care of themselves because in order for a community to be healthy, its participants need to be healthy. America stresses that the observatorio teaches considering ethnic, cultural, and age diversity. She argues that because every community is different, every workshop should be different as well.

According to America women usually respond positively to the workshops and resources available to them by the observatorio. She says this is because they develop a relationship with the women because they continuously come back. Women in these communities are accustomed of having people come, give them classes, promise to return, but then have no follow through. El observatorio makes it a priority to return and build trust with their participants.

America states that her relationship with institutions is a rocky one. On one side, she is known by many people in Campeche as the founder of the observatorio. The government of Campeche supports her and her campaign to end gendered violence. However, the observatorio constantly denounces the government and its institutions for institutional violence. This rocky relationship gives her economic autonomy as well as economic hardships. The state does not provide economic aid to the observatorio, which allows it to be independent from political parties but depend on funding from other NGOs. She says one of the biggest obstacles she faces is to continuously fund the observatorio. Many of the organizations provide monetary aid for specific themes and prevent her from using the money to pay rent, phone bill, and other basic needs. Another obstacle she faces when searching for funds is that several funding agencies only take quantitative data as proof of success. According to Gittell, Ortega-Bustamante, and Steffy, “Sometimes women-led groups are not funded because banks, intermediaries, and other funders often use conventional quantitative measures of success rather than qualitative ones that could best assess comprehensive programs” (2000: 143).

However, according to America the biggest obstacle she faces is getting legal help for the women because women fail to report their abuses. So far the observatorio has brought cases of sexual abuse, torture, and community violence to the Human Rights Commission and/or to the Committee of Reproductive Health of the state. As of summer 2014, they had never been able to take a case of obstetric violence to court. She argues this happens because although they have information of someone who suffered from obstetric violence, they do not have access to the person. Most of the cases they hear about are from word of mouth and do not include the details of the victim, which makes it almost impossible for them to track. However, even when they are able to track a victim of obstetric violence, women often feel that the cost of being part of the legal system is greater than the cost of staying quiet. She also says that it is common for minorities to have a hostile image of the law rather than believe it can protect them (Bumiller, 1987). America also stresses that women do not report obstetric violence because they have naturalized the control and restriction over their bodies. The lack of awareness is a form of violence because women do not know that their rights are being violated therefore cannot defend themselves.

The observatorio also grapples with issues of community violence. According to Amer-

ica, community violence is violence enacted by the community towards and individual. America says that the moment a woman begins to confront the violence she experiences, her own community can exert social pressure undermining her resistance:

Indigenous women in our country are pressured to not denounce when they are victims of some type of abuse, for several reasons. One of these reasons is because it exhibits the community as incapable of protecting its residents, another is because of how it negatively portrays the image of the family among the community. It is not well seen if a woman from a family is victim of violence. Mexico is a chauvinistic country which means if a woman is victimized it affects the social value of the family, not the value of the woman but that of the whole family ¹⁰

America says victims of violence are often expelled from the community, which symbolically removes their Mayan identity. In order for the community to protect themselves from outside law enforcement, they expel the victim from the community. America says she is currently working on a case where a little girl was sexually abused by her schoolteacher in Calkmul. According to the mother of the victim, the whole community knew the teacher sexually abused his students, but would rather stay quiet than be victims of police scrutiny. Since the little girl and her mother spoke up about the abuse, the community insults them and treats them as outcasts. The community itself can be an obstacle towards social change. Molyenau (1986: 285) argues that communities sometimes reject social change “because such changes... could threaten the short-term practical interests of some women, or entail a cost . . . of a loss of forms of protection which is not then compensated for.” America says that if a community supports victims denouncing violence they risk opening their doors to the Mexican police and legal system which reduces the community’s autonomy and power over dealing with their residents. The community then rejects and ignores violence in order to maintain autonomy and keep the Mexican state out of their territory.

¹⁰ “A las mujeres indígenas en nuestro país se les presiona para que no denuncien cuando son víctimas de alguna forma de abuso por varias razones. Una de las razones es porque exhibe a la comunidad por incapacidad de proteger sus derechos y la otra porque tiene un efecto sobre la imagen de la familia en la comunidad. No es bien visto que una mujer de la familia sea víctima de violencia, Mexico es un país de machismo y que una mujer de la familia haya sido vulnerada afecta el valor social de la familia, no la mujer pero la familia.”

To address community violence, the observatorio undertakes various methods of activism. The first is to bring awareness to communities and develop dialogue through community organizing. The second is to provide services for women to fight against gendered violence. The observatorio provides legal and psychological support to victims of violence as well as provides immediate relief for victims. Examples of that immediate relief include finding battered women a home away from their abusive partners to providing women legal support in terminating an unwanted pregnancy. Because in Campeche abortion is illegal, the observatorio funds women who want to legally terminate their pregnancy and accompanies them to Mexico City where it is legal. According to America, as of 2014 eight women from Campeche had legally terminated their pregnancies in Mexico, five of which were sponsored by the observatorio. The observatorio is a local Campeche NGO that provides services and community based organizing that fight against gendered violence.

This chapter has discussed the activism of women who receive funding from Semillas. However, during my research I saw activism from multiple types of people whether they received funding for it or not. Most women engaged in activism one way or another because it seemed like a necessity. It would be disrespectful to not quickly bring up two women, Señora Elide from Saban and Señora Neyi from Xanlah, and their methods of activism.

I was passing through Saban with Ime and a couple of her friends when Señora Neyi heard the car and came running to stop us. She asked us to come in and help her edit an official letter she and a couple of other town members were writing to the head of the Ministry of Health in Quintana Roo. We began drafting their letter at 6 pm and did not leave the community until 1am after having heard countless allegations. The people of Saban have a reputation for not staying silent. A couple of years ago they managed to kick out a state sponsored doctor who would refuse to help complications in birth if the woman had previously seen as midwife. After they kicked that doctor out, the state would only send doctors for two to three months because the state feared the safety of the doctors. However, a year ago Dr. López was sent by the state to work in Saban and refused to leave after a couple of months. According to the women in the room, Dr. López is a great doctor who valued the communities' traditions and had established a personal goal to help Saban reduce their malnutrition rate. Everything seemed to be going great

until the state sent another doctor to work with Dr. López in Saban. According to the community members in Señora Elide's home, the female doctor did not get along with Dr. López and wrongfully accused him of having sexually abused one of his pregnant patients. In order to cover the whole ordeal, the state immediately moved Dr. López to another community. The community was outraged and went to speak to the female doctor to ask her why he had left. When they confronted her she refused to see them and told them she did not talk to ignorant peasants like them. The six people in the room were outraged by the blatant disrespect they were receiving and the lack of information accessible to them. The letter they wrote demanded the Ministry of Health to reinstate Dr. López in Saban and to publicly apologize for having disrespected the people who wanted the truth. I came upon the activism of Señora Elide and those involved in this letter writing campaign by pure luck. It highlights the widespread nature of resistance.

Señora Neyi's form of resistance is not explicitly connected to maternity, but it shows the value women have in their communities. Señora Neyi, who is Irna's mother in law, resides in Xanlah, Yucatan. Xanlah is an extremely tight community where if a house is on fire, the church automatically rings the bells and people run outside with buckets to help their neighbors. Xanlah's population is so connected to each other that they refuse to involve the police during disputes. Señora Neyi says that when justice needs to occur the victim's family speaks with the perpetrator on what they would need in order to forgive. Neyi believes that restorative justice is possible because of the tightness of the community. Neyi's activism involves the empowerment of women and the community. The community survives from men and women working in the milpa (field), foraging, and hunting. For centuries, people who work in the milpa burn it as part of a regime of land management. In the process of burning the milpa, people make coal, which they rarely use. Señora Neyi and her husband realized that in order to survive economically they could sell the coal directly to truckers. Señora Neyi then established a system of buying coal from the community and then selling it to truckers. Her little business made it possible for her home to be the only one in her community to have a private toilet. Señora Neyi has also established a bank for a group of women in her community, a form of grassroots microfinance. She and ten other women meet once a month and work as a bank and support group for each other. Women save \$30 to \$100 pesos a month and give it to Señora Neyi who keeps it safe—protect-

ing the assets from being spent profligately by a drunk spouse—until one of the women needs it to buy a house or start a business. All the women who meet invest in each other’s wellbeing. Señora Neyi, who only has a first grade education, is the center of her community and her activism involves supporting women create their own businesses and empower themselves.

Mayan women all around the Yucatan Peninsula are victims of structural oppression and gendered violence. Their narratives show the constant restrictions they have over their bodies and safety. However, all around the Yucatan, these women show extraordinary forms of resistance. Whether they are mothers, midwives, or activists, women are constantly resisting against all odds. Ime, Yuritizi, Itzel, Doña Ake, Irna, Margarita, America, Elide and Neyi are all examples of strong empowered women who fight day by day to end gendered violence. Their activism takes on various forms, from creating services to changing policy to encouraging community based organizing. The following chapter takes a closer look to try to better understand the variability in their methods of organizing.

Chapter 6: Discussion

The last chapter covered the different activist goals and methods Mayan women in the Yucatan peninsula have when fighting obstetric violence. The variability in their methods highlight the different spaces Mayan women have when organizing. The following chapter will analyze their activism through three themes: structural barriers they encounter, access to capital and the relationship activists have with institutions.

Method of activism based on structural barriers

Structural barriers are an important aspect in organizing. Regarding activism against obstetric violence structural impediments can help decide the method of organizing. These structural impediments can include location, lack of transportation, and economic capital. A common structural barrier is that most Mayan communities are separated from major cities and lack adequate transportation.

Ime mentioned an obstacle women in her community faced when giving birth was the difficulty they had in reaching health clinics. This lack of adequate and accessible transportation is a factor that influenced the methods of activism Ime chooses. Ime is working on a documentary that explains obstetric violence to both midwives and women in order to protect them from partaking in this abuse or being victims of it. Ime stated that making a film was the most accessible medium for her activism because she could spread awareness without physically being there. For Ime, providing workshops was not an alternative because of the lack of transportation accessible around her community. Ime said that not only was the lack of public buses an issue but the roads to get from one place to the next were generally in bad conditions making them dangerous.

Similarly, Irna and Margarita discuss the obstacles they face in organizing workshops on human rights, gendered violence, and health issues because of the lack of transportation. Irna, who worked with women around Xanlah, Yucatan said it was difficult to get women to schedule a workshop with her because communication was hard unless she spoke face to face with them. However, moving from her community to the next took several hours and it sometimes resulted in her being told to come back another day. Margarita from Campeche, had a similar experience

when conducting her workshops. Margarita said women wanted more workshops and she wished she gave more but the lack of accessible transportation made it hard to make more commutes to different Mayan communities. Margarita says that to make sure workshops happened on the days she was scheduled to give them she would contact women leaders from the communities and make them the organizers and inviters. Once participants felt they were committed to the women leaders they were more likely to attend.

Yuritzi Speich and Itzel Catzim lack the common structural barrier of being in a remote location therefore chose their method of activism based on their location advantage. Their activism is located in the Riviera Maya, one of the most tourist filled areas in Mexico. Yuritzi and Itzel organized a march in Tulum on November 29 against obstetric violence. Their march “Mi parto, mi decision” spread awareness on obstetric violence and demanded social and institutional change in supporting women’s choice in getting a humane birth. Around 500 people attended the march that had several tabling organizations that supported humane birthing experiences, tables that provided a space where women gave testimony about their experience when giving birth, as well experts on obstetric violence cases that gave victims of obstetric violence options on what to do.

Their activist goal was to bring visibility to home births and their benefits. Their location was prime in successfully achieving their goals. Because Tulum is a popular tourist location, organizing a march denouncing institutional oppression would bring international notice as well as discomfort to tourists. The method they chose for activism was based on their strategic location, which pressured the state by damaging the tourist economy. This strategy was not used by any other activist interviewed for this research because of the remote location of their communities.

Even more than the lack of transportation, the structural barrier discussed the most was the constant lack of funding women received for their work as activists. The lack of economic mobility restricted most of the women from expanding their work. Women expressed a constant fear of having to give up their projects because of a lack of funding. According to Gittell, Ortega-Bustamante, and Steffy (2000) women organizers often feel that the male-dominated industry to fund social change poses difficulties for women to prove they have technical expertise therefore prohibiting their programs from being considered. This constant economic struggle is experi-

enced by all the activists in the peninsula however some have more economic mobility than others.

America and her NGO was the activism effort with the most amount of economic mobility. Because America funded her NGO ten years ago it had developed certain bureaucratic safety nets to prevent them from going broke. Unlike all the other women activist, America had a bank account specifically for her NGO therefore the funds for her professional life were not the same as those for her personal life. This provided her with the resources to conduct extensive research through questionnaires and interviews to women in different communities and cater her methods to what she saw was the need. The research was conducted every couple of years and had previously been published. Although America enjoys a type of safety net, she did mention several times how much she struggled in getting funding each year. She said one of the biggest obstacles was to receive funding to pay for basic office needs such as rent, phone bills, and supplies.

Structural barriers such as location, the lack of transportation, and economic capital influenced the methods women chose in conducting their activism. Factors outside of their control affected their work as activists.

Capital as a factor for methods used for activism

According to Bourdieu the three types of capital that serve to give certain groups an advantage over others are: economic capital, cultural capital and social capital. America and Irna show the importance capital has in engaging in certain methods of activism. The social and economic capital America has allows her to conduct her activism through her NGO. America has significantly more economic capital and social capital to do the work she does because of her connections with important actors in the capital city of Campeche. Conversely, Irna conducted a certain method of activism because of the cultural capital she has. America and Irna's access to capital dictate the methods they chose to engage in for social change.

America is an indigenous woman from Campeche who through years of hard work was able to create her own NGO in Campeche. In 2005 she began the creation of her organization called Red de Mujeres y Hombres por una Opinion Pública de Violencia de Genero. The goal of her organization is to investigate violence against women and working directly with women in

securing their rights such as the right to choose to legally terminate a pregnancy, maternal safety, obstetric violence, and other human rights.

The institutionalized aspect of America's NGO has given her access to more international economic aid and support. Her economic capital has provided her the opportunity to take classes from indigenous activists and travel in order to perfect her methods in working with indigenous women. Through her extensive education and experiences she has developed a teaching strategy specifically for the Mayan women she uses during her workshops against gendered violence.

Another important capital America has that allows her to be part of the activism she engages in is social capital. According to Bordieu (2010), social capital is the ability to have actual or potential resources, networks, relationships, etc...that can provide an advantage. America's organization not only provides workshops but it also serves as a link between a victim of a human rights violation and the necessary legal actors and steps needed to report it. After several years working on gendered violence, America has developed connections with lawyers, doctors, and other activists and to develop a team to support victims of gendered violence. For example, her NGO provides services for women from Campeche to legally terminate their pregnancies. Through America's relationship with Fondo Maria, her organization is able to fund and accompany women to legally terminate their pregnancies. America says Fondo Maria is a Mexican NGO in Mexico City that provides free and legal abortions to women of lower class. The NGO is located in Mexico City because abortion is legal there. America's social capital provides her organization access to important actors fighting against gendered violence. Margarita, an employee at America's organization, states that the organization gives judicial help to around 300 women a month.

America also has strong ties with politicians. Even though she proudly states and repeats that the association has no political inclinations or receives money from the government. America says that the government supports her work when she is not blaming them for its institutionalized violence. Regardless, she states they respect her work and her cause. America's organization also works closely with the Center of Justice for Women (Centro de Justicia para las Mujeres) that is a state sponsored organization that provides legal assistance to battered women. America's activism is completely different than that of the other Mayan women I interviewed

because of her economic capital and social capital. These capitals provide her with an advantage when organizing for social change.

Apart from economic and social capital, Bordieu (2010) argues that cultural capital provides advantages to those who have it. Cultural capital exists through the embodied state, such as cultural education, and objects, such as cultural goods (Bordieu, 2010). Irna is an example of someone with rich cultural capital which she uses as an advantage in her activism. Irna conducts workshops on human rights such as gendered rights, sexuality rights, and health rights. She provides these workshops to high school students, women leaders, and youth leaders in Chancom, Chanchichimila, Chikindzonot, Ek-pdz, and her community, Xanlah. All these communities are close by in distance but can take up to two hours of transportation because of the lack of accessible roads. Even through the transportation limitations, Irna's community and her extended community exhibited an extraordinary depth in solidarity and connections with each other.

Xanlah and the towns nearby had incredibly rich community connections, people knew everyone closely and cared deeply with one another. According to Neyi the community is so close that they do not need law enforcers, they are able to maintain each other safe. Neyi mentioned how on one occasion a young man came to Xanlah that no one recognized. It took the community less than thirty minutes to spread the word and send a couple of town members to ask the man who he was. It turned out he was running away with a girl from Xanlah but the community found out before the girl did. Señora Neyi says the community is so close together that when mangos from the tree in front of the school started to fall, a committee was developed to pick them up and distribute them to all its residents.

From my observations I understood that Xanlah and the towns near by had an extremely tight and involved community. Irna used this aspect of her community to her advantage. Irna's workshop targets those with most power and vulnerability from her community. Both youth and women are the most common to suffer from structural violence but women are also the center information. Irna says that in order for her information to spread, women need to receive it and share it. Irna uses that community strength to empower Xanlah and its surroundings.

Because Xanlah and its surroundings have a very tight knit community, they are also very protective and exclusive. These communities tend to ignore or completely reject foreigners in the

region. According to Irna, this is because foreigners often come and promise to return but never do. Irna is able to travel among communities knowing people will be more accessible to her because they know where she comes from. The cultural capital Irna's community has provides her distinct tools to conduct her activism.

America and Irna hold different advantages when organizing therefore their activism takes on different methods. America uses her social and economic capital to provide women access to diverse resources. Through Irna's cultural capital she is able to gain the participant's trust in order to fulfill her activist goals. Irna has greater mobility because of the cultural capital she has.

Relationship with institutions as a factor for choosing methods of activism

According to Kate Murray (2012), before the 1970s activism used to consist of people who wanted to challenge mainstream power struggles (2012). However by the 1970s, the actors in activism changed from people wanting to change social order to NGO's, government, private organizations, civil society groups and more who were concerned in policy-making rhetoric. Activism before the 1970s used to be more accessible, inclusive, and have flexible methods of activism. However, since the introduction of new actors in activism older forms of participation have been delegitimized which results in a diminished space for people to introduce and set their own agendas rather than accommodate to the system's set structure (Murray, 2012). Activist movements have moved away from eliminating unjust systems to working with the system in finding possible solutions. Murray states that activist participation is shaped in predictable ways to "mirror bureaucratic structures and reinforce narrow, feel-good norms of 'good citizenship'" (2012, 201). Similar to Murray's research, my research found that in some cases, such as Doña Rafa's activism did become a mirror of bureaucratic organizations. Yet in other cases, such as Sabrina and Elodia's method of activism, their methods took opposing strategies than that of institutional structures. The methods for which activists chose to conduct their activism differentiated by sometimes reproducing "good citizenship" strategies and other times radical strategies.

Doña Ake's method of organizing was by creating an association for midwives in Yucatan that would protect them much like a union. Doña Ake argues there needs to be an institution that

would protect midwives from abuses from doctors, health institutions, and legal processes. Since 2008, Doña Ake says midwives became criminalized and prohibited access to delivering babies. As a result midwives can only legally provide massages. Doña Ake believes that by uniting the midwives around her community, together they can fight against structural violence.

Doña Ake says that government and healthcare officials have a crusade against midwifery and that there needs to be an organization that supports them. Because of the lack of a positive relationship with institutions Doña Ake says she is obliged to create a midwife union that can protect them from further abuses. However, this union-like association takes most of its structure and ideals from already institutionalized unions. To fight the system, Doña Ake wants to join it. Like Murray (2012) states, contemporary activists build their activism by mirroring bureaucratic structures.

However, this is not the case for all the women activists fighting against obstetric violence. Yuritzi and Itzel's method of activism, of marching against obstetric violence in Tulum, is contrary to "feel good" norms and citizenship (Murray, 2012). Their march attacks the government by humiliating institutions in front of tourist rich areas. Their activism does not work within the power structure but rather attacks it.

When comparing both movements, Doña Ake's method of activism has a set long term goal while Yuritzi and Itzel's method of activism is short term. Doña Ake works to create an association that mirrors other bureaucratic structures. She hopes to integrate herself in a system in order to receive protection. Yuritzi and Itzel are attacking the system by humiliating the government. They do not seek integration to the system rather they attempt to break it down.

Chapter 7: Conclusion

This research shows the variability of birthing experiences Mayan women in southern Mexico experience and the variability in their forms of resistance. This research highlights the structural violence suffered by women in regards to maternal health. Authors such as Belli (2013) and Ibone (2013) argue that obstetric violence is a common reality for women around the world and it is violation of their human right for health and an example of gendered violence. The stories presented in this research prove the reality of obstetric violence. These stories also highlight the countless ways Mayan women actively resist against obstetric violence. Through their resistance women met several obstacles. Some obstacles were pushed by their communities such as a lack of participation and the internalization of violence. Other obstacles were structural barriers such as transportation, location, economic obstacles. Their methods of activism differed by the structural impediments they came across, their access to capital, and the relationships they held with institutions. By identifying these obstacles NGO's, the state, and other organizations can adapt their aid to support activism based on the needs of the activists.

The first couple of chapters discuss the current academic research done about obstetric violence, reproductive rights among Mayan communities, involvement of the Mexican state with birthing strategies, and indigenous uprising. These first chapters proved the gap in the academia concerning indigenous women organizing for reproductive rights. It also show cased the lack of research conducted and published in English speaking Academia on obstetric violence. The inaccessibility of information concerning obstetric violence proves the normalization we have of this type of structural violence. My research brings awareness of this gap in the academia and attempts to fill this gap by providing qualitative data of obstetric violence in Mayan communities in southern Mexico. There needs to be more research done that encompass indigenous uprising. The limited amount of published research on indigenous activism is a representation of the historical silencing of marginalized groups from Westernized academia. This is even more true for women. Indigenous women are even less represented in the academia proving the intersectionality of their oppression. This research should serve as an invitation for the academia to be more diverse and include the narratives of those often silenced.

Chapter three discusses the methods I used for obtaining information during my field-

work. This chapter focuses on the different methods used such as semi-formal interviews and focus groups. In this chapter, the nine women participants were briefly introduced to provide a context of their activist work. Finally, possible limitations were also discussed in this chapter. My positionality as someone from the U.S. from a certain class could have been a factor that limited their willingness to share with me. Language was also an issue as I do not speak Mayan. Regardless, the incredible hospitality and openness of the women and men I met in the Yucatan Peninsula reassured me on the validity of my research. However, like in almost all other research, limitations are inevitable.

In chapter four, titled “Definitions and Experiences of Obstetric Violence” I discuss the limited definitions of obstetric violence in the academia. I then proceed to define Obstetric Violence as seen in five Mayan communities in Yucatan, Quintana Roo, and Campeche. Obstetric violence is both defined and experienced differently. Obstetric violence to some women include being sterilized without consent while others argue obstetric violence is being prevented from giving birth at home. Although the definitions are different, all women believe obstetric violence is violence provided by those assisting births that dehumanize women’s birthing experience. This chapter also contextualizes the situations that have pushed women to become activists. According to Pelcastre- Villafuerte et al. (2014), in general indigenous women in Mexico experience triple subordination in the health care system because of their ethnicity, gender, and class. Belli (2013) argues that specifically with obstetric violence, indigenous women are more vulnerable than non indigenous women because of their marginalized status. The stories of obstetric violence and gendered violence these women narrate in this chapter shed light of their subordination as well as their main motivation in ending obstetric violence.

The second half of chapter four, “Definitions and Experiences of Obstetric Violence”, contextualize the situations in which these women experience obstetric violence. This chapter is divided by three different categories of women who experience obstetric violence differently. The categories are mother who experience obstetric violence, midwives who experience obstetric violence, and midwives who perpetuate obstetric violence. The goal of this chapter was to identify the different forms obstetric violence takes depending on the situation of the victim. The section, mothers and women who experience obstetric violence, focuses on providing the testimo-

nies of women who see, are victims of, or hear of obstetric violence. Although midwives are commonly also mothers and women, this section only provides the experiences of activists profiled in this research who are not midwives. The second section is on midwives who have experienced obstetric violence. In summary, they reported that obstetric violence was when the state rejected, criminalized, and belittled midwifery culture. The stories documented in this section are surrounding the current relationships institutions have with midwives and activism. The third section, midwives who promote obstetric violence, makes a more radical claim because midwives are often posed as the solution to getting humane births. This is also a complex claim because most of the activists involved in eradicating obstetric violence are midwives. However, through these interviews we see how midwives often mirror violent tactics of obstetrics from health systems and state sponsored birthing courses. Midwives consciously or unconsciously promote obstetric violence because they have internalized the discrimination of their traditional medical tactics. This chapter explains the different victims of obstetric violence as well as reminds readers how common it is for Mayan women to experience it.

Chapter five, “Mayan Women’s Activism against Obstetric Violence,” profiles the nine Mayan women this research focuses on. The chapter presents the activism work of Ime Cohuo, Yuritzi Speich, Itzel Cazim, Doña Ake, Irna Tuz, America Cassanova, Margarita Pech, Elide and Doña Neyi. The goals, and methods of these women are presented as well as the common obstacles they face. The goal of this chapter is to showcase the incredible resistance of these women and stem away from identifying them as victims.

Finally, chapter six “Discussion” analyzes and compares the methods these activists used for enacting social change. Through their interviews I found that the most important factors that influence the methods these women take for their activism are their structural impediments, their access to capital and the relationships they have to institutions. Common structural impediments activists faced were the remote locations of their communities, the lack of adequate transportation, and a lack of economic support. Mayan women also chose their methods of activism based on the access of capital they had. For example, women with rich connections with their community used their cultural capital to do their activism. Finally, the types of relationships activists and community members developed with institutions affected the type of activism they took. Activ-

ists either took an offensive tactic against the state, which were usually to obtain their short term goals, versus a defensive tactic towards the state, which served better for the activist's long term goals.

The overall argument I found through this research is that obstetric violence is a reality for Mayan women in the Yucatan peninsula and women actively resist through different forms of activism. After understanding the significance of obstetric violence and the resistance of these Mayan women there are certain steps NGO's, governments, and the academia can take to better support their organizing. A simple solution for all of these groups and actors is to acknowledge obstetric violence as a reality. NGO's, government organizations, governments, and the academia need to acknowledge that gendered violence stems from internalized misogyny. Obstetric violence is just another representation of the patriarchal view that women should not and have no control over their bodies.

NGO's and government organizations that fight for human rights and women's violence should also fight against obstetric violence. According to Belli (2013), obstetric violence is a violation of our human rights. The 1993 Vienna Convention on Human Rights declared that humans have the right to health and dignity (Belli, 2013). If NGO's and government organizations acknowledge obstetric violence as a violation of our international human rights they can pressure states to protect the rights of women giving birth.

States also need to acknowledge obstetric violence as a reality whether NGO's and government organizations pressure them to acknowledge it or not. If states acknowledge obstetric violence as a threat in women's health, women can be educated to demand for fair and humane treatment while giving births. States also need to create legislation that protects the autonomy and control of women over their own bodies. According to Pombo (2008), programs created by the Mexican state often impede the empowerment of women by accumulating responsibilities that hold them accountable to the interests of the state and its institutions. The state needs to create programs that grant women autonomy and power to decide over their bodies. Furthermore the state needs to find better and more efficient ways to support midwives. This is important, and of interest to the state, because in some remote indigenous communities midwives are the only health care representatives available to the people. The Mexican government should also protect

and provide economic support to midwives because the state is economically unable to provide health clinics throughout the nation. The state should also provide support to midwives training other midwives. That way midwives are trained on how to safely assist child birth while maintaining their tradition and culture alive. Finally the state should stop criminalizing home births to lower class indigenous women. According to the Vienna Convention of Human Rights of 1993, women should be given the same rights as men regardless of socioeconomic status and race (Belli, 2013). Through this research I found that while home births are becoming popularized by middle and upper class women they are simultaneously being criminalized for indigenous low income women. The Mexican state restricts Mayan women from having home births by criminalizing midwives, restricting the access midwives have to obtain proper documentation, and by forcing women into hospitals through programs like *Oportunidades*. On the other hand, midwives who partner with doctors in providing home births to upper and middle class women are left alone. All women should be treated equal and given the same opportunities to chose where to give births regardless of their socioeconomic background or ethnicity.

Finally, academia needs to expand its research in indigenous movements and obstetric violence. The invisibility of obstetric violence in the academic world proves its naturalization and internalization. Academic research needs to be more diverse in order to be inclusive to the multiple and complex identities in our world. The invisibility in research done on indigenous movements further perpetuates the view of indigenous people as victims rather than survivors. By legitimizing the experiences of indigenous people we are acknowledging the injustices most of society perpetuates.

As this research has shown, obstetric violence contains many dimensions, perpetrators and victims. Obstetric violence has serious effects in women's health and well being and indigenous women are often more vulnerable to this type of structural violence. In the Yucatan Peninsula Mayan women activists are working diligently to eradicate obstetric violence. These women fight day by day to end this type of gendered violence in their communities through a variety of methods such as marches, workshops, and videos. The methods these activists chose to use often depend on the structural barriers they are met with, their access to capital, and the relationships they have with institutions. Their inspiring efforts to create social change in their communities

make it clear that we all have a responsibility to fight for women's right to health and dignity. NGO's, governmental organizations, states and the academia need to better support indigenous women organizing, and in the case of the Yucatan Peninsula, they can start by acknowledging obstetric violence as a reality.

References Cited

- Belli, Laura F. (2013). Violencia obstetrica: otra forma de violacion de los derechos humanos. *Revista Redbioetica/UNESCO*, 4.1, 25-34.
- Bourdieu, P. (2010). The Forms of Capital (1986). In *Cultural Theory: An Anthology*. Wiley Blackwell 81-90.
- Bumiller, Kristin. (1987). Victims in the Shadow of the Law: A Critique of the Model of Legal Protection *Chicago Journals*. The University of Chicago Press, 12.3.
- Camara, Sakile Kai. (2002). Ideological uncertainty: Exploring racism as a social issue in communication.
- Carey, David. (2006). Engendering Mayan history: Kaqchikel women as agents and conduits of the past, 1875-1970. *New York: Routledge*. Print.
- Cantú, Lionel. (2002). De ambiente: Queer tourism and the shifting boundaries of Mexican male sexualities. *GLQ: A Journal of Lesbian and Gay Studies*, 8.1, 139-166.
- Gittell, Marilyn, Isolda Ortega-Bustamante, and Tracy Steffy. (2000). "Social Capital and Social Change Women's Community Activism." *Urban Affairs Review*, 36.2, 123-147.
- Gutiérrez Chong, Natividad. (2010). Indigenous Political Organizations and the Nation-State: Bolivia, Ecuador, Mexico. *Alternatives: Global, Local, Political*, 35.3, 259-268.
- Floyd, Robbie, and Carolyn Fishel Sargent. (1997). Childbirth and authoritative knowledge cross cultural perspectives. *Berkeley: University of California Press*.
- Fried, M. G. (2013). Reproductive Rights Activism in the Post-Roe Era. *American Journal Of Public Health*, 103(1), 10-14. doi:10.2105/AJPH.2012.301125
- Harrold, T. C., Randall, D. A., Falster, M. O., Lujic, S., & Jorm, L. R. (2014). The Contribution of Geography to Disparities in Preventable Hospitalizations between Indigenous and Non-Indigenous Australians.
- Huber, Brad R., and Alan R. Sandstrom. (2001). Mesoamerican Healers. *Austin, TX: University of Texas Press*. Print.
- Icaza, Rosalba, and Rolando Vázquez. (2013). Social Struggles as Epistemic Struggles. *Devel-*

opment & Change, 44.3, 683-704.

- Ibone Otza, F. (2013). PTSD and Obstetric Violence. *Midwifery Today*, 105, 48-49.
- Jordan, Brigitte. (1983). Birth in Four Cultures. *Montréal: Eden Press*, 3. Print.
- Kaplan, T. (1997). *Crazy for democracy: Women in grassroots movements*. Psychology Press.
- Klesner, Joseph L., and Chappell Lawson. (2001). Adios To The PRI? Changing Voter Turnout In Mexico's Political Transition. *Mexican Studies / Estudios Mexicanos*, 17.1.
- Leyva-Flores, R., Servan-Mori, E., Infante-Xibille, C., Pelcastre-Villafuerte, B., & Gonzalez, T. (2014) Primary Health Care Utilization by the Mexican Indigenous Population: The Role of the Seguro Popular in Socially Inequitable Contexts, 9.8, 1-6.
- Morgan, L. M., & Roberts, E. F. (2012). Reproductive governance in Latin America. *Anthropology & Medicine*, 19.2, 241-254.
- Molyneaux, M. (1986). Mobilization without emancipation? Women's interests, state and revolution in Nicaragua. *Transition and Development: Problems of Third World Socialism*, edited by R. R. Fagen, C. D. Deere, and J. L. Goraggio. New York: Monthly Review Press and Center for the Study of the Americas.
- Murray, K. M. (2012). Regulating activism: an institutional ethnography of public participation. *Community Development Journal*, 47.2, 199-215.
- París-Pombo, María Dolores. (2008). Health Promotion and Gender Power in the Oaxaca Mixteca. *Agricultura, Sociedad y Desarrollo Enero-Junio*, 53-69.
- Pelcastre-Villafuerte, B., Ruiz, M., Meneses, S., Amaya, C., Márquez, M., Taboada, A., & Careaga, K. (2014). Community-based health care for indigenous women in Mexico: a qualitative evaluation. *International Journal For Equity In Health*, 13.1, 2-18.
- Pfeiler, B. B., & Hofling, A. (2006) Apuntes sobre la variación dialectal en el maya yucateco. *Península*, 1.1., 27-44.
- Quesda, J., Kain Hart, L., & Bourgois, P. (2011). Structural Vulnerability and health: Latino Migrant Laborers in the United States." *Medical Anthropology*, 339-362.
- Rogoff, Barbara. (2011). Developing destinies: A Mayan midwife and town. *Oxford University Press*.
- Russell Bernard, H. (2006). Research Methods in Anthropology; Qualitative and Quantitative Ap-

proaches. *Altamira press*.

Smith, A. (2005). Native American Feminism, Sovereignty, and Social Change. *Feminist Studies*. 31.1, 116-131

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

Thomsen, Carly. (2013). From Refusing Stigmatization toward Celebration: New Directions for Reproductive Justice Activism. *Feminist Studies*. 39.1,149-158.

Appendix 1

These are some of the questions I used to guide both the focus groups and the unstructured interviews. Because of the nature of the interviews some of the questions were never asked while new questions appeared.

What is maternal safety?

¿Como definen maternidad segura? ¿A que etapa de maternidad se refieren?

What are you organizing for? What are you asking to change or demanding to change and for who?

¿Por que se estan organizando? Que quieren cambiar o demandar y para quien?

What is Obstetric Violence?

¿Que es violencia obstétrica?

What prevents you from receiving or obtaining a safe maternity? Are there cultural/ institutional/linguistic obstacles that prevent you from gaining access to a safe maternity?

¿Que les previene recibir o obtener una maternidad segura? ¿Hay obstculos culturales/ institucionales/linguisticos que no les permite obtener una maternidad segura?

What is the variability of maternal rights and maternal safety within a state, a community, and women?

¿Cuál es la variabilidad en torno a los derechos de maternidad y maternidad segura dentro del Estado, la comunidad y las mujeres?

Have you encountered lingusitic obstacles when organizing for maternal safety? If so, which?

¿Tienen obstaculos linguisticos al organizar por maternidad segura? ¿Si si, cuales?

Have you encountered institutional obstacles when organizing? Do you feel health care institutions cater to your needs? How could these institutions better cater to you?

¿Al organizar por maternidad segura se encuentra con obstaculos institucionales? ¿Sienten que las instituciones de maternidad son hechas para ustedes? ¿Como podrian estas instituciones asistirlas mejor?

Do you face cultural obstacles when organizing for maternal safety? If so, which?

¿Se enfrentan con obstáculos culturales cuando organizan para maternidad segura? ¿Si si, que tipos de obstáculos?

Is your identity as a mother and/or women affect your place as an activist?

¿El ser madre o ser mujer afecta su papel como organizadora? ¿El Ser parte de este movimiento afecta como la ven en la comunidad?

What strategies do you use for organizing?

¿Que estrategias usan para organizar para maternidad segura?

What additional support could Semillas provide you? What support do you need from the state? What additional support do you need to make the change you fight for?

¿Que apoyo podria proporcionar SEMILLAS, el estado, o otras NGO's para hacer cambio para maternidad segura?



Appendix 3





