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Conflict and Reproductive Health in Urban Chiapas:

Disappearing the *Partera Empírica*

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Abstract

This paper looks at how the unresolved internal armed conflict in Chiapas intersects with existing structural violence manifest in the everyday forms of harassment, abuse, and violence, all of them shaping the fabric of women's existence. This includes both the way they are treated by professionals in the healthcare system and unintended consequences of health policy and initiatives to reduce maternal mortality. I argue it is useful to examine these two factors jointly in order to identify a relationship between armed conflict in rural areas and its indirect costs on the nearby urban environment. I will focus on one main point of discussion: the way a health-policy emphasis on decreasing maternal mortality (as an indirect consequence of the armed conflict) is changing how and where urban women give birth, effectively disappearing the role of the urban 'partera empírica'.

Introduction

Birth is like a battle of the ancient Maya, it's bloody and painful; you either live or die. You must prepare yourselves to do battle!

This was the first time I heard childbirth directly compared to violent conflict.[1] At the time, I was seven months pregnant with my first child and attending antenatal education at my local state maternity clinic for people without health insurance in San Cristóbal de Las Casas, Chiapas. The head consultant doctor was taking the final session of a ten week course that women were obliged to attend in order to receive treatment and attention at birth. Attendance at each session earned me a stamp in my little red book issued by *Seguro Popular* (state health insurance),[2] and a pass to the next health or social care professional in the clinic. This final session focused on the birth, preparing women for the low-resource attention they would receive at the clinic due to the lack of a resident obstetrician or surgery space to perform a caesarean section, if necessary. At this time (2008), the clinic was also undergoing construction works that had temporarily been abandoned due to political and funding complications. After a brief session on how childbirth was managed in the clinic and what was expected of us as patients, we were taken for a tour of the *sala de expulsión* (delivery room) located next to a building site covered in dust and discarded sacks of concrete.

1 This text was developed from a paper titled 'Conflict and Reproductive Health in Chiapas, Mexico: Disappearing the Midwife', originally presented at the Royal Anthropological Institute Postgraduate Conference, University of Kent, UK, September 2012. A version of this paper has subsequently also been translated into Spanish and published as a chapter in the edited collection entitled Imagen instantánea de la partería (see Murray de López 2015).

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

Through this initial experience and contact with healthcare services, I began to learn and investigate more about different antenatal and birth experiences of *mestiza*[3] and indigenous women in the city, and the precarious position of empirical and professional midwifery[4] in urban Chiapas. I noticed that, when speaking to women of different generations, the way they were managing their pregnancies, and consequently their births, was changing as a consequence of greater access to healthcare. Depending on need, women in San Cristóbal were increasingly using the services of midwives and obstetricians in tandem; thus also increasingly choosing to give birth in hospitals because of the negative attitudes that many obstetricians have towards out-of-hospital birth. In the nearby capital of Tuxtla Gutiérrez, clinically managed birth was the norm for all women with (more often than not) an assumption that the birth would end in caesarean section. Whilst many of the women I spoke to were grateful to have access to increasingly free or low-cost healthcare, very few spoke positively about their childbearing experiences in public institutions. Their descriptions of prenatal care and birth stories were often framed by dialogues of life-or-death situations and confrontations with medical professionals. The descriptions of forms of violence in healthcare settings that I heard as a volunteer health worker and in social circles, and then subsequently during fieldwork, led me to reflect on what impact the continuing armed conflict in the rural highlands of Chiapas (FrayBa 2012) was having on everyday lives in nearby cities.

3 Mestiza (mestizo for masculine) is the socially constructed ethnic identity referring to Mexican people who do not identify as 'indigenous' or 'criollo'. The mestiza/o was introduced as an ethnic category in Mexico's post-revolution period as part of a project to forge a new national identity and unite a nation.

4 From this point onwards, I will refer to midwife in the local term of *partera*, full definitions of which will be provided in the following sections.

In this paper, I look at how the armed violence (associated with the conflict) occurring in the nearby highlands (Los Altos) and on the fringes of urban society exacerbates structural violence already prevalent in state health institutions – thereby exposing an intersection of violence trickling down into the interpersonal, institutional, and structural environments in the society as a whole. Analysts of violence and insecurity in Latin America have written in detail about how different types of armed violence intersect to appear in different aspects of the social structure (Krause and Muggah 2007; Sanchez-R 2005). The links between the unresolved armed conflict in Los Altos and various manifestations of structural violence in health institutions (via gender, ethnicity, and class) are often indirect, but nevertheless significant. Both direct and indirect costs have a broad array of social, economic, and developmental consequences ranging from health-care expenditures to lost productivity, increased public spending on security, and an overall deterioration in the quality of life (Krause and Muggah 2007). By taking this into consideration, it can be possible to see where consequences of unresolved armed conflict actually contribute to maintaining existing forms of violence. A focus on gender, class and ethnic inequalities, and on forms of violence in state health institutions, provides a concrete point of analysis to see where economic and political consequences of the armed conflict intersect with existing structural violence, and how this comes to impact on the lives of urban women not directly involved in the conflict.

The Centro de Derechos Humanos Fray Bartolomé de Las Casas (Human Rights Centre Fray Bartolomé; hereon referred to as FrayBa) describes the armed conflict in Los Altos de Chiapas as unresolved and ongoing, resulting in continued violations of human rights and displacements. In their most recent report on the state of human rights in conflict zones of Chiapas, FrayBa stated that acts of violence against individuals 'occur as a result of

generalised violence derived from the effects of the unresolved armed conflict' (2012: 84, my translation). The situation in Chiapas is also described as a 'low intensity armed conflict' (Brentlinger *et al.* 2005: 1002) being fought by the state on three levels: economic, political, and military. The armed conflict has led to a forced displacement of whole indigenous communities and mass migration of families and individuals, of which women, children, and older people have been particularly affected (FrayBa 2012). This has led to a significant rise in population (both transient and permanent) in nearby cities subsequently resulting in increased pressure on public services, particularly health services. State health institutions absorb the extra bodies and must treat them within the existing infrastructure and without necessarily having access to extra resources. State maternity hospitals are principal recipients of the consequences of this increase in general population. As of date, little attention has been paid to the way practices and attitudes of medical professionals are being shaped by these changes and to the impact of the increasingly diverse and complex population on standards of care. Significant changes in women's birthing practices due to population increase in the cities of San Cristóbal and Tuxtla Gutierrez have been highlighted by Zapata Martelo *et al.* (2007). Their article is significant because it notes changes in birth practices of both indigenous and *mestiza* women in the two cities in relation to the consequences of the unresolved armed conflict. Taking the work of Zapata Martelo *et al.* (2007) as a starting point, I argue that health-policy emphasis on improving maternal mortality (as an indirect consequence of the armed conflict) is changing how and where urban women give birth. Furthermore, the role of the urban '*partera empírica*' (empirical midwife referring to mestiza women who are not legitimately recognised by the state as being registered or qualified) who is excluded

from legitimate reproductive-healthcare discourse and practice, is in this respect being disappeared.

In order to develop these arguments, I will draw upon my combined experience as mother and health worker in Chiapas (from 2003 to 2009), two distinct periods of ethnographic fieldwork in the cities of San Cristóbal de Las Casas and Tuxtla Gutiérrez (six months in 2008 and three months in 2011),[5] the growing body of literature questioning obstetric violence in urban Mexican hospital settings (Castro 1999; Castro and Erviti 2003; Castro and Singer 2004; Kendall 2009; Smith-Oka 2012), and upon recent publications on the place of the traditional *partera* in Mexican and Chiapanecan urban birth practices (Carrillo 1999; Davis-Floyd 2001; Freyermuth 2010; Mills and Davis-Floyd 2009; Zapata Martelo *et al.* 2007). During the periods of ethnographic fieldwork, I carried out participant observation with women in antenatal classes, mother and baby groups, and at family celebrations such as baby showers. I also interviewed women in their homes and the aforementioned spaces, collecting pregnancy and birth narratives (forty recorded interviews in total). My target population was working class, *mestiza* women of reproductive age and their families living in San Cristóbal de Las Casas who accessed a mixture of public-health and private services (*parteras*, private gyno-obstetricians, and related services). The capital city of Tuxtla Gutierrez also briefly became a site of my data collection due to some women commuting between the two cities for work and family matters, and therefore receiving antenatal, birth, and postnatal attention in both cities. The closer connection of San Cristóbal, which was due to its vicinity attracting trade and migration flows from rural and conflict zone communities, became

5 The three-month follow up fieldwork was made possible by a Christopher Hale Memorial Fund grant from the University of Salford.

the focus of my research, particularly in relation to the practice of *parteras empíricas*, the continuing prevalence of homebirth, and its importance as a site of clinical transfer from rural communities. I also interviewed five local *parteras* (*empírica* and professional) and two medical professionals. Selected voices of women and professionals will at times be represented in the following discussion.[6]

Intersections of Violence

For the purpose of this discussion, I refer to structural violence as the 'invisible "social machinery" of social inequality and oppression that reproduces pathogenic social relations of exclusion and marginalisation via ideologies and stigmas attendant on race, class, caste, sex and other invidious distinctions' (Scheper-Hughes 2004: 14). The concept of structural violence is useful for analysing intersecting social forces and events (such as ongoing armed conflict) beyond the control of populations and how these forces and events impact on individual bodies. 'Structural violence is violence exerted systematically – that is indirectly' (Farmer 2004: 4), and impacts individuals or groups depending on pre-existing social conditions. Farmer argues that 'factors including gender, ethnicity ("race") and socioeconomic status may be shown to play a role in rendering individuals and groups vulnerable to extreme human suffering' (2009: 21). Chiapas has a high rate of femicide cases,[7] which is increasing every year in both rural and urban areas,

6 All personal and institutional names have been changed to preserve their anonymity.

7 A recently published report indicated that Mexico is ranked the sixteenth place in the incidence of homicides against women globally. According to the report on Femicide in Mexico produced by UNWomen, the National Women's Institute (Inmujeres) and the College of Mexico (COLMEX), cases of femicide in the country have been on a steady increase since 2007 (CEDAW 2012: 6).

and demonstrates – according to CONAVIM (2012) – a social imagination dominated by impunity towards violence against women. In other words, 'structural violence, whether it be institutionalised or mediated by individuals, little by little becomes naturalised in part by public services, family members or individuals themselves. This provides the opportunity to make invisible, minimise or omit situations that create or reproduce violence' (CONAVIM 2012, my translation).

Freyermuth and Argüello (2011) have argued that institutional failure to deal with this phenomenon alongside premature female deaths caused by inequalities in the healthcare system demonstrate structural violence on the basis of gender and ethnicity. In urban Chiapas, where diverse populations of indigenous and *mestiza* women access the same welfare programmes and health services, socio-economic status becomes a chief indicator of who is most vulnerable to structural violence. In the context of this discussion, structural violence in public health institutions throughout Mexico is manifest physically as reproductive rights violations, such as unnecessary caesarean rates, contraception or sterilisation without consent, and refusal of legally approved abortion (Brentlinger *et al.* 2005; CEDAW 2012; Freyermuth 2010; GIRE 2013; Lamas 2001). The abovementioned violations of reproductive rights are understood in the context of this paper as obstetric violence. In Latin American literature (Alemán 2011; Benítez Guerra 2012; Cisneros 2011; Poljak 2009; Villanueva-Egan 2010), reproductive health activism (CEDAW 2012; GIRE 2013), and in Mexican state legislation (the 2009 Law on Access to a Life Free of Violence for Women in the State of Chiapas[8]), *violencia*

8 *Ley de Acceso a una Vida Libre de Violencia para las Mujeres en el Estado de Chiapas*, 23 March 2009, Gobierno Estatal de Chiapas. The law is available at: http://www.cndh.org.mx/sites/all/fuentes/documentos/programas/mujer/5_LegislacionNacionalInternacional/Legislacion/Estatal/Chiapas/B/Ley%20de%20Acceso%20a%20una%20Vida%20Libre%20de%20Violencia%20para%20las%20Mujeres.pdf

obstétrica (obstetric violence) is a widely used and accepted term describing acts and situations that relate to descriptions given by women and professionals in my own research. In Latin America, two models of obstetric violence have been identified: the physical and the psychological. The physical model applies 'when women are subject to invasive practices and given medication when there is no medical justification based on her state of health ... or when the duration and possibilities of a natural birth are not respected' (Villanueva-Egan 2010: 148, my translation). The second dimension is the psychological model of obstetric violence, which includes 'inhumane treatment, verbal abuse, discrimination, humiliation when the woman requests an assessment, or requires attention, or when carrying out routine obstetric practice' (Medina 2009: 3, my translation).

During my field interviews, women described obstetricians and their professional support as overly authoritarian during antenatal and birth situations and/or very soon after birth. Although women describe their experiences as negative, there is a general acceptance that this is what happens in maternity wards. Rosa's narrative is typical of many of the women who have given me their birth stories. As a state government employee, she was entitled to health insurance and was treated within the public health system for government workers (ISSTE) in the capital city. Rosa was thirty years old and a single mother. Her mother accompanied her to the hospital when she went into labour, but was not allowed to be with her in the labour or delivery suite. Only medical staff and other labouring women are allowed in labour and delivery suites of public hospitals. Most narratives revealed that in such spaces, which are dominated by medical hierarchies, physical and verbal abuse was common. In Rosa's words:

> Straight after my son was born, in the moment the placenta came out ... he said, "You, miss, you will die, if you have another baby", at this moment I didn't know what he was talking about ... he said, "We're going to put a [IUD] in", and I said, "No, no doctor", and he told me to decide and, as I said no, he said, "Well, miss, you are an irresponsible girl, you want to bring another baby into this world and to put it into danger", he said, "You are a bad mother because you want to make another baby suffer, did you not see how much you made this one suffer?" ... I didn't understand perhaps in this moment, so I said, "Ok", I just wanted some peace and quiet, so I just accepted it.

The pressure put on women to have IUDs (Intrauterine Device or 'coil') inserted, or to undergo ligation (sterilisation) straight after birth – often prompting haemorrhage and further complications – was a common occurrence in women's descriptions. Family planning was often brought up during antenatal appointments but more aggressively pushed after birth as described by Rosa. Some women explained that they opted for ligation as their birth experience had been so traumatic that they did not want to have any more children. I found this was more common when the birth had resulted in an emergency caesarean section.

Population Control and Disappearing the *Partera Empírica*

> *This morning I was sent to get some routine blood tests ... When I arrived, the corridor leading to the laboratory hatch had been clearly segregated, chairs on one side and a standing queue on the other. I was feeling tired and*

> *sat down in the chair queue. I spent ages wondering what the difference between the queues were as there were other women pregnant and/or with children standing (a mixture of indigenous and mestiza), and some very healthy looking people in the sitting queue (all mestiza). After about an hour, the hatch opened and a lab tech in a white coat shouted that he would begin taking samples from the people on the left (the sitting queue) ... In the end I asked, the person in front why that queue was going first, she pointed at the standing queue and told me, "They are Seguro Popular" (my field notes April 2008).*

There are currently two main programmes running throughout Mexico targeting individuals and families without any health insurance and living below poverty levels. *Seguro Popular* (state health insurance) was created in 2003 and is intended to cover all families that have otherwise no access to healthcare. Health services are delivered through existing state and federal institutions. This means that government employees with health insurance share the same services and personnel with those in receipt of *Seguro Popular*. As demonstrated in the excerpt from my field notes above, this does not equate to parity in the way people are treated within the institutions. A further development programme running throughout Mexico is *IMSS-Oportunidades* (Opportunities, previously known as PROGRESA), a conditional cash-transfer programme that started in rural areas in 1997. Its aim is to improve education, health, nutrition, and living conditions of population groups in extreme poverty, as well as to break the intergenerational cycle of poverty. In the area of health, the programme offers an essential health-care package including pregnancy and delivery care for women enrolled in the programme. Health institutions are responsible for providing delivery attendance in their facilities. Attendance at the health promotion talks and medical checkups are a requirement for being registered on the programme and receiving financial benefits. The *IMSS-Oportunidades* programme disseminates a firm belief in empowering women by recognising

them as responsible financial heads of the household – any financial benefits are given directly to the women. However, with its strict compliance to medical care and training programmes, and its payments in terms of vouchers, *IMSS-Oportunidades* does not translate into women gaining some sort of independence or financial control over their lives. There is also evidence that, whilst improving overall household incomes and school attendance, the programme has been associated with poor health outcomes, and with reinforcing maternal responsibilities as women's primary social role (Barber 2010; Freyermuth 2010; Molyneux 2006). This is made particularly evident in the maternal-health element of *IMSS-Oportunidades*, where the mother receives entitlement based upon the perceived needs of the foetus in her womb and its future as a citizen.

The Mexican government is committed to Millennium Development Goal[9] (MDG) 5, which aims to reduce maternal mortality and increase access to reproductive health services for all women by 2015. Increased access to institutions in urban areas has resulted in a national figure of 94 percent recorded live births in hospital clinics (ENSANUT 2012). In terms of a development model, this is taken as an indication that increasing numbers of Mexican women are receiving skilled assistance at birth and are accessing antenatal care of some form. Alongside the increase in public hospital births, the rates of caesarean section on a local and national level are also rising. According to the department of health statistics, 3.86 million[10] caesarean sections were carried out between 2007 and 2012, 1.74 million of which were

9 The Millennium Development Goals are eight international development goals that were officially established following the Millennium Summit of the United Nations in 2000, once the United Nations Millennium Declaration had been adopted. For a full breakdown of all pre 2015 goals see http://www.un.org/millenniumgoals

10 World Health Organisation recommendations for this period should be around 1.68 million in total or less than 15 percent (WHO 2011).

scheduled and the remaining 2.13 million recorded as emergencies (ENSANUT 2012). Researchers carrying out studies on the growth of birth by caesarean section in developing countries (which include Mexico) recorded no reductions in maternal or neonatal mortality and morbidity when frequency of caesarean section was more than fifteen percent (Althabe and Belizán 2006; Gonzales *et al.* 2013). Studies on the progress of *IMSS-Oportunidades* in Chiapas between 2004 and 2008 report that just over half of the maternal deaths during that period were beneficiaries of the programme (Freyermuth 2009, 2010); the increase in hospital attendance has led to disproportionate rates of surgical interventions during and after birth (Barber 2010; Freyermuth 2010; Zapata Martelo *et al.* 2007), and a non-recognition of traditional midwifery care in the management of pregnancy and birth has left many practising *parteras* out of any serious policy debate and development. There are also disparities between the impact of *IMSS-Oportunidades* in rural and urban areas. Whilst the programme has had some relative success with maternal mortality among the predominantly indigenous rural population, the maternal mortality rates between urban (Ladino and indigenous) beneficiaries and non-beneficiaries is less than 10 percent (Freyermuth and Cárdenas 2009). Also while a reported 50 percent of the state population are in receipt of *Seguro Popular*, the overall maternal mortality rate in institutions is improving at just 1 percent per year (Freyermuth 2010: 2).

The legal stance on attending births outside of medical institutions is complex and often contradictory. In theory, a woman has the right to birth where she chooses; if she wishes to birth at home, she has the option of hiring private services of a *partera*, though legally a birth cannot be planned outside of a medical institution. Where homebirths are recorded, it is done so as if it was an emergency and there was no time to reach a hospital. Women

that birth at home using a local *partera* will take the baby to a public clinic a few days later where it will be registered by a licensed medical professional as a spontaneous birth at home. There are numerous public and private clinics in San Cristóbal de Las Casas and Tuxtla Gutiérrez, as well as two private birthing houses (*casas de partos*) with professional *parteras*. A birthing house does not exist as a legal concept in Chiapas, and therefore de facto birthing houses cannot be registered as places to birth or where births are planned to happen. When births take place in the birthing house, they are registered as home births. The birthing houses are presented as private health clinics that can offer antenatal and other women's health services and they must have a licensed medical practitioner in charge. There remain federal and state legislative contradictions, meaning that birthing houses are never fully legitimised by the state.

The state department of health holds a voluntary register of *parteras tradicionale*s (traditional midwives). All women registered by the state are under the title of *partera tradicional*, though not all women who self-identify as a *partera* in the community are registered, as this is not a legal requirement. It is important to note that midwifery in Chiapas – registered or not – is not recognised as a profession, but rather as a traditional practice. During my fieldwork, I observed three different types of *partera* practising in an urban context: the indigenous *partera* is the woman most likely described under policy initiatives and whom most people (who have no direct experience with the various types of *partera*) associate with the title *partera tradicional*. This image of the *partera tradicional* as an indigenous woman is reinforced by media representations and a development-policy focus on rural midwifery practices and communities. The second and most common type of *partera* to be found in urban barrios is the *partera empírica*. The term *partera empírica* (empirical midwife) is sometimes used to denote those who learned

midwifery either through attending women in childbirth or through apprenticeship to another experienced *partera* (Mills and David-Floyd 2009). The *partera empírica*, who is generally hired via *mestiza* families or close social networks, is the kind of *partera* I encountered most in the barrios of San Cristóbal during fieldwork. Both indigenous and urban *parteras empíricas* use a mixture of traditional and allopathic practices in terms of technique and medicines. As mentioned earlier my discussion in this paper surrounds the disappearance of the role of the *partera empírica* in particular.

Parteras empíricas provide an interesting ethnographic focus for an urban context as they are less likely to be registered, making them difficult to monitor. These women form the ethnographic focus for my argument that this type of midwifery practice is disappearing as access to welfare programmes increasingly requires women to attend institutions for reproductive healthcare. Women hiring a *partera empírica* are – out of choice and social expectations – also more likely to be combining her services with those available in the public and private health system. The third type of *partera* is the more contemporary *partera profesional* (professional midwife) who would attend births at home or in a *casa de partos.* Anthropologist Robbie Davis-Floyd (2001) has previously documented the development of the *partera profesional* and specific midwifery training schools that are creating new generations of *parteras* and working towards a nationally recognised qualification. Hiring of a *partera profesional* is increasingly popular amongst the middle class, as women are more aware of the high risk of surgical intervention in medical institutions. The *partera profesional* will also attend women who have had caesarean sections previously and want a vaginal birth (VBAC – vaginal birth after caesarean); this is not an option for them in public institutions.

The relationship between *parteras empíricas* and medical professionals is often fraught. This is probably emphasised by the fact that they generally only come into contact in case of complications or an emergency transfer from home to hospital. Many women (during antenatal periods) would not tell their gyno-obstetricians or doctors about their seeing a *partera* or plans to birth at home, as this often leads to problems including threats to withdraw treatment in an emergency. In San Cristóbal, attitudes varied greatly amongst medical professionals, depending upon their personal experiences, age and familiarity with the area. Whilst some doctors accepted that women saw a *partera* for antenatal, non-bio-medical interventions, for example a *sobada*,[11] they reacted very differently to the idea of a *partera* attending an actual birth. Many young doctors first came into contact with *parteras* when they were completing their training in more rural locations. Historical attitudes and behaviours of senior practitioners maintain the continuing social and political divide between medical staff and community *parteras*.

Ricardo, a newly qualified surgical doctor, recounted his days as a student in various public maternity hospitals throughout Chiapas, and his contact with *parteras empíricas* in an institutional environment:

> I saw many *parteras* arrive and bring patients in, when they thought or considered that something wasn't right … when they brought women in who had begun with complications or had the risk of complicating, often we [the doctors] wouldn't listen to the *partera*. We would say thank you, but mostly we would tell the women off for going to the

11 A *sobada* is an abdominal and lower back massage also used to accommodate the baby in a more comfortable position during the later stages of pregnancy.

> *partera* in the first place. We would say that if anything bad happened, it was their fault or the fault of the *partera* for not bringing them to the hospital sooner … We didn't let the *partera* accompany the woman, nor did we let her explain what had happened up to that point. Many times, as students we were warned by our superior to not even touch a woman so that, in case it went wrong, we were to blame the *partera* instead. I never witnessed a conversation between a gynaecologist, general doctor or emergency doctor and a *partera*. It was quite the opposite, a total distance … I also heard my service bosses talking against the policies being introduced by state government about training *parteras* and providing them with maternity centres to work in … some of them saw the *partera* as someone who came to trip them up in their work, get in the way or criticise their work as doctors.

Ani (age 27), a federal government employee, provides an interesting case for a generation of women who straddle the divide between traditional and allopathic practices. Due to work and family commitments, she spent her entire pregnancy travelling between the two cities I studied. As a result of her movements, she received antenatal care from various sources – public as part of her employee health insurance, and private as the insurance only covered her for the city within which she worked. Her decisions on where to seek support depended upon perceived medical need, obligation to fulfil health insurance requirements, personal feelings towards services, family networks, and cultural and religious beliefs. She saw a variety of doctors in public clinics, a private gyno-obstetrician in her home city, and a *partera empírica* for the 'things outside of the doctors' knowledge'. Ani was always open with doctors about seeking the services of a midwife, and found their attitudes to be varying:

> I have one doctor who is fantastic, the other who I see in [work city] as part of my insurance, in the regional hospital, she is against you going with a partera ... but when I say I'm going to see a partera, the doctor [in home city], she says, "Go! If it makes you feel better, go and get a massage, no problem."

Ani wanted to birth in her home city to be close to family and so was unable to use her employee health insurance. She planned to have a homebirth using a mestiza *partera empírica* known to her godmother, and to be supported by her mother and aunties. This *partera* charged the average price of around 1,000 Mexican Pesos for her services. When Ani went into labour, the *partera* could not be found and her private gynaecologist sympathetic to natural birth had moved cities. She went to a private clinic so that her mother could accompany her during the birth, and the eventual outcome was emergency caesarean section after six hours of labour at a cost of 30,000 Mexican Pesos.

The high level of scheduled caesarean sections alongside the increase in hospital births (see Zapata Martelo *et al.* 2007 for a quantitative study on these two specific cities in Chiapas) culminates in the *partera* often being removed from the woman's birth plans before the final trimester of pregnancy. The role of the urban mestiza *partera empírica* is becoming increasingly diverted to ante- and post-natal conditions of mother and baby. The mestiza women whom I spoke to often deemed that there are issues relating to either mother or baby that 'the doctor doesn't see', such as *mal de ojo* (the evil eye) or *susto* (frightened by spirits or evil eye),[12] or that they

12 Both *mal de ojo* and *susto* are ethno-theories of illness and causes of illness in babies and young children. They come from a mixed background of indigenous and Catholic beliefs and practices. There are various faith-based and herbal remedies to treat these conditions and local *parteras* are seen as experts in diagnosing and dealing with them. Such ethno-theories are essential to

wished to be reassured with a 'human touch'. Integrating use of both non-allopathic and medical healthcare suggests that many women identify and negotiate support on an individual needs basis. The choice of some women not to tell medics of their alternative support also identifies a level of resistance to authoritative medical knowledge.

Conclusion: Resistance and Unresolved Issues

The women hiring the services of *parteras empíricas* were either in receipt of health insurance connected to their work, eligible for the newly developed conditional cash transfer programme of basic assistance *IMSS-Oportunidades*, or other basic assistance – *Seguro Social*. This meant that by using either form of insurance programme, they were obliged to attend antenatal care and birth in a public institution. Women I met during fieldwork reported attending clinics for care and birth because that was the condition of their health insurance. Those in receipt of basic assistance (*IMSS-Oportunidades* or *Seguro Social*) had to attend all appointments and birth in a designated clinic in order to receive the benefit, and thus make sure that their new born child would have entitlement to basic welfare, which demonstrates the coercive nature of such programmes. This means that, no matter what level or quality of treatment the woman is receiving, she is obliged to attend or be penalised. Many women dependent on this kind of welfare programme do not have the resources to pay a private clinic, though financially they could afford a midwife who is often willing to negotiate for

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understanding women's health and childrearing practices in Chiapas, though unfortunately further discussion is beyond the scope of this paper.

her services. Where there is already a well-documented culture of abuse on reproductive health practices and gendered violence in medical institutions, coercing women into treatment can only encourage further violation without fear of reprisal.

The data I collected during fieldwork supports other qualitative research (see Molyneux 2006; Smith-Oka 2013) demonstrating that increased hospital attendance due to assistance programmes changes many aspects of childbearing behaviour. This includes a decrease in hiring *parteras empíricas* mainly due to an insistence on hospital birth and its associated interventions that require further medical attention (i.e. episiotomies, caesarean wounds). Despite increasing numbers of women now giving birth in hospital who may previously have given birth at home, there were a minority of families in the working class barrios of San Cristóbal who continued to hire a *partera empírica*. These families tend to use a mixed economy of care between public and private institutions, *parteras empíricas* and *curanderas* (herbalists/healers). What is notable about these families is their access to economic resources allowing them to choose a preferred type of attention and their non-reliance on government assisted programmes. In these families, young and new mothers were surrounded by two to three generations of women experienced in birth and maternity that had the confidence to challenge medical professionals claiming that women are safer giving birth in hospital. I encountered many women after hospital births who lamented about not being able to give birth at home with women they trusted. They felt they had no choice, as many *parteras empíricas* had ceased to practice or were no longer alive. As families tended to use the same *partera* that had attended their family for generations, women were reluctant to go to another, unless a close family member had recommended them. These women and their families demonstrate that there is still a need and

preference for giving birth at home with the support of a *partera empírica*, and that this should be taken into account in policy discourse. The overarching aim of policy and development programmes is to improve life expectations for both women and babies. The lack of distinction in regards to the quality of treatment and recognition of the woman's experience has serious consequences in regards to local practices and dominant medical discourse.

In this paper, I have combined analysis of existing literature, my own maternal experience, and fieldwork in urban Chiapas to explore the intersections of existing structural violence that shape the fabric of women's existence, particularly those from working class, low socio-economic backgrounds. This includes how they are treated by professionals in the healthcare system and the unintended consequences of health policy and maternal mortality initiatives. It is useful to examine these two factors jointly in order to identify a relationship between armed conflict in rural areas and its impact on the nearby urban environment. I have proposed the argument that health policy emphasis on improving maternal mortality (as an indirect consequence of the armed conflict) is changing how and where urban women give birth, effectively disappearing the role of the urban *partera empírica* as a central reproductive health and birth provider in the lives of many working class women in San Cristóbal. I propose the notion of 'disappearing the midwife' to describe how a woman's choice in the urban context is increasingly limited to a medical management of her pregnancy and birth – a model that openly rejects midwifery as authoritative knowledge on the subject. By not recognising midwifery as a legitimate form of care for pregnant women, many *parteras empíricas* are disappearing both in social presence and from reproductive health discourse.

About the author

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