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Between Cut and Consent: Indigenous Women's Experiences of Obstetric Violence in Mexico

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During a community workshop in Simojovel, Chiapas, in May 2015, organized by the Organization of Indigenous Doctors of Chiapas (OMIECH), a nongovernmental organization founded in 1984 with the goal of preserving Maya medicine, a dozen Tsotsil women and midwives reflected on the increased medicalization of women's reproductive health. They criticized various government programs that encourage women in Mexico to give birth in hospitals attended by biomedical personnel, rather than at home with Indigenous midwives. In predominantly Indigenous states like Chiapas, women give birth at home with traditional midwives at rates significantly higher than in the rest of the country: 25 to 75 percent versus 4 percent.[1] Indigenous midwives contrasted the treatment women received in public hospitals—where they are alone (no one other than the patient is allowed in the labor and delivery room), undressed, and subjected to multiple forms of touching and cutting—to midwifery care and homebirth, in which women give birth fully clothed, with few or no invasive interventions.[2] The workshop participants also reflected on the mandatory ultrasounds, invasive gynecological examinations, and various blood tests women now have to undergo.

The increased scrutiny to which pregnant women are subjected separates them from their traditional health care providers—metaphorically but also literally, as health centers are often located in urban areas, sometimes hours away from women's villages. Moreover, when conducting research in Chiapas focused on the contemporary changes in the practice of Indigenous midwifery, I found that both Indigenous and

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non-Indigenous midwives and women often associated hospital birth with being cut, whether an episiotomy incision or a cesarean section. "Some women are afraid of going to the hospital," explained Doña Rosa, a renowned midwife in the region, now in her seventies, during the workshop. In Mexico, despite a rise in the number of institution-based deliveries—from 22 percent in 1990 to 73 percent in 2014[3]—health provider discrimination still constitutes a major barrier to quality health care access for poor, Indigenous, and/or Afro-descendant women.[4] She shared one of her strategies for "giving strength" to those who give birth with her:

> I tell her that I know she can [give birth at home]. But that if she thinks she is not able to, then she can go to the hospital. I tell her that I don't like it over there, that it is going to be difficult for her, that it is not going to be the same as at home. I tell her, "You'll get cut and then they'll sew you back up like a rag."[5]

Building on continuous engagement with OMIECH, midwives, and mothers in Chiapas since 2013 and in the light of recent and ongoing debates on obstetric violence in Mexico,[6] I analyze how "being cut" has come to represent Indigenous and poor women's multiple experiences of frustration, mistreatment, and violence during childbirth.

In maternity wards across the globe, the power imbalance between biomedical professionals and their patients shapes women's conditions of consent. In Mexico, historical and institutionalized discrimination towards poor and Indigenous women puts them in a position of acute vulnerability, which adds a layer of complexity to their ability to consent. Some women resist the biomedical model of birth, while others embrace technologies and desire further interventions—a paradox Mexican women express when voicing their ambiguous feelings about "being cut." I argue that obstetric violence cannot be fully understood without examining the conditions that shape women's consent through an intersectional lens.[7]

Coined by law scholar Kimberlé Crenshaw, intersectionality is a tool used to highlight the systemic discrimination created by the combination of racism and sexism. An intersectional approach does not seek to match each social characteristic (such as gender, ethnicity, ability, and the like) with a series of discriminations. In order to determine cases of obstetric violence, an intersectional methodology instead requires that we fine-tune our understanding of women's consent in maternity wards by paying close attention to poor and Indigenous women's accounts of mistreatment and abuse from a wide range of biomedical and non-biomedical personnel.

Obstetric Violence as Gender Violence

Obstetric violence—the physical, psychological, and verbal mistreatment and abuse women experience during childbirth—has emerged as a topic of international concern.[8] While the specific forms of obstetric violence differ, at a global level a rise in intervention rates (cesarean sections, epidurals, and episiotomies) indicates a changing birthing culture and an increased medicalization of women's reproductive health.[9] Rising medical interventions position biomedical specialists as the sole

interlocutors, while marginalizing traditional midwives' expertise.[10] The medicalization of women's reproductive health (through family planning campaigns and the use of technologies in pregnancy and childbirth) also increases the frequency of interactions between women and biomedical providers, involving the question of women's consent with regard to the procedures used. Obstetric violence lies at the crossroads between gender violence and structural violence;[11] violence can arise in interpersonal relations between patients and providers, but is also closely related to the structural conditions under which hospitals are run. Lack of supplies and corruption can have an impact on women's birth experiences, while historical relations between ethnic groups also shed light on the mechanisms of obstetric violence. So far, definitions of obstetric violence—while they are centered on the violation of women's informed consent—have not always considered how women who are already marginalized in society (such as poor women, women of color, and lesbian women) are acutely vulnerable in maternity wards.[12]

In 2016, Mexico revised its Health Law (NOM-007-SSA2-2016), to include "*el derecho de las mujeres a recibir atención digna, de calidad, con pertinencia cultural y respetuosa de su autonomía*" (the right of women to receive quality and dignified care, with cultural relevance and respect for their autonomy).[13] Ten Mexican states have included a definition of obstetric violence as part of the "*Ley General de Acceso de las Mujeres a una Vida Libre de Violencia*" (Law for Women's Access to a Life Free of Violence). However, only the states of Chiapas and Veracruz include the possibility of such violence being brought before the courts in Mexico. In Chiapas, the 2015 reform included up to three years of imprisonment and a fine for any person who does not obtain the patient's informed consent before "*alterar el proceso natural del parto de bajo riesgo, mediante el uso de técnicas de aceleración . . . y practicar el parto por vía de cesárea, existiendo condiciones para el parto natural*" (altering the natural process of low-risk birth through technology to speed the process up . . . and practicing cesarean births when the conditions for natural birth exist).[14]

The issue of women's consent is at the heart of the 2014 Chiapas Obstetric Violence law. What the law does not address however, are the conditions that frame women's consent, and how to treat/punish actions performed with the person's consent, but that are nonetheless carried out violently. The ability to accept, request, or refuse medical interventions is not evenly distributed among women; and women who are socially, ethnically, and geographically marginalized, such as Indigenous women, poor women and women living in rural areas, may face significantly greater challenges in Mexican maternity wards. Discriminatory behaviors in healthcare are deeply ingrained in medical practice, and can include language barriers, condemnation of Indigenous medicine and/or disrespectful remarks, and disregard for cultural differences, such as women being unaccustomed to being naked and insensitivity to the feelings of shame this hospital practice provokes.[15] Such discriminatory behaviors extend beyond cultural disrespect to actual bodily violation: a public report from the National Commission to Prevent and Eradicate Violence Against Women (CONAVIM) reveals that nationally, at least 27 percent of Indigenous women who have been in contact with public health services have been sterilized without their consent.[16]

Indigenous Women: At the Heart of Maternal Health Policies

Worldwide, Indigenous peoples have poorer health outcomes than non-Indigenous citizens within the same countries.[17] In states like Chiapas, in which Indigenous populations make up a high percentage of the total population, poverty and ethnicity conflate, making the Indigenous populations (23% of the total) some of the poorest groups in both the state and the country.[18] Racial inequalities play out at every level of interaction between Indigenous citizens and the state, and while Indigenous women have been at the forefront of social change, during the 1994 Zapatista uprising in Chiapas and in its aftermath they were also the target of institutionalized sexual violence.[19]

In Chiapas, institutionalized ethnic hierarchies between ladinos and Indigenous people were in force well into the 1950s. Historian Stephen E. Lewis reports "rape brigades" of young ladino men who targeted Tsotsil women working in fields around San Cristóbal—crimes that went unpunished.[20] Subsequent indigenist policies aimed at integrating Indigenous peoples into the Mexican nation through health and education assimilation programs have only partially overcome Indigenous men and women's distrust of state structures. After centuries of deception and mistreatment by the local elite, attitudes change slowly.[21]

In Chiapas, contemporary inequalities between rich and poor, Indigenous and ladinos, translate into higher rates of maternal deaths compared with the rest of the country. In 2014, the state ranked second in maternal deaths (77), and the maternal mortality rate was more than double the national rate (68.1 per 100,000 live births), with 70 percent of these deaths occurring in public institutions.[22] To reduce maternal mortality rates, Mexico has developed programs targeting poor women, encouraging them to give birth in public hospitals. The cash-conditional transfer program Prospera (2014–2019) provided women with a monthly stipend on the condition that they carry out their prenatal checkups with a physician and attend a series of monthly talks at their local clinic. While the program has improved maternal health metrics—mainly the diminution of maternal mortality rates—it has also increased the medicalization of women's reproductive health, creating a new "reproductive habitus" that does not include traditional midwives.[23] As research conducted in Chiapas Highlands has shown, Indigenous women are reluctant to choose a cesarean section, but nonetheless they are 40 percent more likely to undergo the surgery: when they report to the hospital at the onset of labor, the medical personnel are more inclined to perform a cesarean section than to have them wait in their homes and come back at a later stage.[24]

In addition to Prospera, another government program has gradually reshaped women's birth experiences and desires over the past decade. Some women still actively seek a midwife in order to give birth in their own homes, but others are drawn to maternity wards where services are free under the universal health insurance, Seguro Popular.[25] In a 2010 report, the National Center for Gender Equity and Reproductive Health highlighted an unintended consequence of Seguro Popular's extension of health coverage to the poorest populations: a saturation of health services has led to low-quality care, which in turn impacts women's willingness to access the health system in the future, even in the case of an emergency.[26] Both Prospera and Seguro

Popular have contributed to the overcrowding of public hospitals, where lack of space and lack of medication, for example, are resulting factors that can partly account for the mistreatment women face. Other structural factors impeding women's access to quality care include institutionalized racism towards Indigenous people. Historically, family planning campaigns have framed poor and Indigenous families as a barrier to the country's modernization, fueling the stereotype that they have "too many children," an attitude that is still deeply engrained.[27]

To encourage women to give birth in hospitals, countries such as Mexico and Guatemala have also invested in workshops for traditional Indigenous midwives—women who became midwives through empirical learning rather than formal educational training. During these workshops, participants are familiarized with the danger signs in pregnancy and childbirth and encouraged to transfer their patients to higher levels of care at the earliest sign of complication.[28] Such policies have resulted in the medicalization of traditional midwifery practices, but have only moderately overcome the fear Indigenous women and their families have of hospitals.[29] Graduates from one of the two state-certified midwifery programs in Mexico are officially licensed to work in public hospitals; however, these number only a few hundred. The certified midwives who I have met were either working in private birth centers or interested in joining one. State-sponsored birth centers have been set up in several municipalities in Chiapas; some are staffed by graduates from professional midwifery schools and are open to women with low-risk pregnancies for prenatal care, labor and delivery, while others are merely places for women to go into labor alongside officially certified traditional midwives.[30] Despite such efforts, the majority of women who give birth outside their homes are attended in public hospitals, where they routinely face mistreatment and abuse from health personnel.[31]

Methods

This article builds on thirteen months (2013–2015) of ethnographic research in Chiapas exploring the contemporary changes in the practice of Indigenous midwifery. Specifically, I engaged in nine months of participant-observation at an intercultural hospital and an Indigenous doctors' organization in the city of San Cristóbal de Las Casas and also conducted interviews with midwives, health and government workers, mothers, and human rights activists in different regions of Chiapas. Participants in this research were recruited through various networks and referrals (members of the Indigenous organizations, private birth centers, public hospitals) until no new information was obtained from further data (saturation). During interviews, I asked open-ended questions focused on the participants' birth stories, their experience with the healthcare system, and, in the case of midwives and health personnel, their training as well.

I rely particularly on data collected during in-depth, semi-structured interviews with nineteen Indigenous and Mestiza women about their experiences with public hospitals in San Cristóbal. This corpus also includes the narratives of thirty-nine Indigenous and non-Indigenous midwives with respect to the treatment that they

and their Indigenous patients received in public hospitals, both as mothers and as midwives. In addition, I draw on interviews with ten workers from the public health sector as well as nineteen medical staff members working in hospitals and rural clinics. Some of them made openly discriminatory comments during our interviews, while others were committed to bettering their practice despite lack of infrastructure and institutional support.

The majority of Indigenous and Mestiza women I interviewed who were originally from Chiapas were from lower- and middle-class backgrounds; those who had moved to Chiapas from other countries or Mexican states were usually upper-middle class. The mothers I met had between one and five children; one-third of the participants had given birth exclusively in their own homes, another third in a medical facility, and the remaining third had experienced both locations. I analyzed my field notes and the interview transcripts using the qualitative data analysis software Nvivo. Given the diversity of the research participants' profiles, I used an inductive approach: I coded transcripts using participants' own words, and followed the emergence of patterns which, aggregated, became categories of analysis. To ensure compatibility between women's stories, I contextualized each transcript and carried out a fine-grain analysis of the context in which these stories were told.

This article first explores women's ambivalence about being cut and then follows four women's narratives in order to illustrate conditions of consent. Taking place at different stages of pregnancy, labor and postpartum, and at different sites of birth, this article discusses the experiences of Alma, an Indigenous woman, in a public clinic; of Inés, an Indigenous woman, and Adelina, a Mestiza woman, when they transferred her from midwife care to the hospital; and of Estela, a Mestiza woman, of postpartum mistreatment. [32] I conducted participant observation when Adelina and Inés were giving birth, was a participant-observer and conducted an interview during Estela's postpartum care, and conducted a long interview with Alma, who was referred to me by a friend. I do not claim with this small sample to provide an exhaustive view of poor and Indigenous women's perception of obstetric violence. Rather, their interwoven narratives shed crucial light on how the interplay of structural violence and daily discrimination impacts their experience of childbirth. The combination of various methods has enabled an interrogation of the nuances of consent, intervention, and violence and a deeper understanding of each of these women's experiences. Other voices of women, midwives, and medical personnel further contribute to the discussion.

Biomedical Authority in Pregnancy Care

Alma, a twenty-five-year-old Indigenous mother who grew up and lived in the outskirts of San Cristóbal, opened our interview by recalling her first birth, "*No, eso no pasa. Las cosas son demasiada rápidas, encima si no llegas a tiempo te regañan. Tuve mi primer parto en el hospital y me quedé traumada*" (No, [that doctors seek women's consent] doesn't happen. In the hospital, things go very quickly, and on top of that if you do not arrive on time they scold you. I was traumatized by my first birth). Alma attributed the various degrading treatments she underwent during prenatal care, labor

and delivery, to her young age (she was seventeen at the time), which put her in a vulnerable position in relation to the medical staff. During our interview in a quiet café of the town, she described feeling particularly humiliated during an ultrasound appointment, eight months into her pregnancy:

> I started to have heavy vaginal discharge so the doctor at my local clinic sent me to the maternity hospital for an ultrasound. The doctor there received me and she said that everything was fine with the baby. But the local clinic doctor sent me back. When she saw me again, the doctor at the maternity hospital said, "let's see, this *señora* here does not seem to understand, let's see, I want everyone to come in." And they made me feel really bad. I lay down again and she did the ultrasound but then with all of the doctors in the room. And she said, "see, the *señorita* doesn't understand, but look, everything is fine, right?" And all the doctors replied "yessss." I felt so bad, I remember I got out of there crying, my mother was holding me in her arms; I was 17 years old.[33]

After this humiliating experience, Alma and her mother went to another hospital, where the ultrasound showed that her daughter presented anencephaly, an acute brain malformation, and that the child would not survive after birth. This experience, and other mistreatments she suffered during labor and delivery, played out in Alma's decision to seek out a midwife in one of the city's private birth centers for her subsequent pregnancy.[34]

Inés, a 32-year-old Chol woman from Yajalón, also described mistreatment during two separate ultrasound appointments. I met Inés in her last month of pregnancy. She had sought out Doña Gabriela, a Tsotsil midwife in her late sixties with whom I conducted participant observation, because she did not want to give birth in the hospital again. Her first child was born by cesarean section six years earlier, and she was afraid of "being cut" again for her second child. Now at full term, she was feeling some pain, so Doña Gabriela requested an ultrasound appointment to check the level of amniotic fluid, which she was able to obtain after pleading Inés' case to the doctor in charge. Doña Gabriela and Inés went in (only one person was allowed to accompany the patient into the ultrasound room) while I stayed in the waiting area with Inés' husband, a thirty-nine-year-old Chol man also from Yajalón, who had moved to San Cristóbal twenty-five years earlier. While we were waiting, he recalled, "At the ultrasound [in another clinic], the *doctora* didn't know [anything]. She told us that the baby would be born in the following days and that we needed to go to the hospital to induce Inés or the baby girl would die. But we refused, so we went home, and every day we wondered, 'Maybe she is dead.' We were scared. They don't attend you well."[35]

When Doña Gabriela and Inés came out, they shared with us that the doctor thought the baby's heartbeat was too high and Inés needed a cesarean section. I inquired which doctor attended them, "The mean one," Doña Gabriela muttered. "He scolded me for always bothering him with my patients." Inés softly added, "And as we came in, he said why do we need an appointment if all we do is waste his time, and that we just come here to dirty his floor" (*Por qué quieren cita si sólo vienen a ensuciar el piso*). Doña Gabriela correlated the doctor's racist comment with the subsequent

diagnosis of fetal distress, explaining that Inés was upset after hearing the comment, which impacted her baby's heart rate.

The treatment Inés received during her appointment not only reveals the racist hierarchy between a male mestizo doctor and an Indigenous female patient, but also the institutionalized racism and sexism present in Mexican medicine. As elsewhere, women in Mexico don't come to childbirth with equal status; pregnant women who depend on Seguro Popular, like Inés, have little choice but to bear such comments. "They don't attend you well," the matter-of-fact understatement from Inés' husband, indicates how they are forced to cope with a situation they do not have the power to change. How, then, can consent be understood when only one option exists? For both Alma and Inés, the ultrasound was a mandatory procedure suggested by their care providers. Their age, socioeconomic status, and ethnicity shaped the way they were treated by medical personnel. Alma's second visit to the maternity hospital was interpreted as a challenge to medical authority. Doña Gabriela's insistence in obtaining an emergency ultrasound for Inés was met with derogatory comments from the doctor in charge.

Violent Cuts: Forced Interventions

Women's and midwives' accounts coincide in describing two specific practices routinely performed without women's consent during labor in public maternity wards: vaginal examinations and episiotomies. Vaginal or cervical examinations are used to measure women's progress during labor, based on the belief that the cervix should dilate at the rhythm of 1 centimeter per hour, a figure recently revised by the World Health Organization.[36] Women described these as uncomfortable and painful, especially when carried out during contractions. Consent was almost never sought, and some instances women were not given any explanation before, during, or after the examination. The Indigenous midwives of OMIECH considered the procedure to be inappropriate: "Women are not hens, I don't need to check if the egg is coming out!" (*No es mi pollo, que lo voy a probar si esta cerca su huevito*).[37] During pregnancy, Prospera's cash transfers are contingent upon mandatory gynecological examinations. For Indigenous women, for whom the conquest of the land was also the conquest over their bodies, these intimate intrusions are reminiscent of colonial practices.[38] During an OMIECH workshop, one Indigenous midwife commented, "*Se siente como que nos pagan para ver nuestro cuerpo*" (It feels as if they are paying us to see our bodies).[39] In Mexico, like other countries of the continent, the development of modern medicine, and of obstetrics in particular, led to attempts regulate traditional midwifery as well as to put the women they attended—poor rural, and Indigenous—under medical scrutiny.[40]

When discussing hospital births, the women I met often referred to episiotomy as the "small cut," as opposed to the "big cut," cesarean section.[41] During an interview, Luz, an Indigenous midwife in her early thirties who trained in one of Mexico's professional midwifery schools, recalled her grim birthing experience at a public hospital, which took place years before she began her midwifery training. Without any warning, the intern who was supervising the birth performed a very large episiotomy, which she

did not consent to and retrospectively feels was unnecessary. Three days later, back in her home, the stitches opened and the wound became infected, leaving Luz in pain: "*"Entonces fue ahí el problema, porque no podía yo ni siquiera sentarme, estuve más de un mes con el dolor, que no podía yo sentarme. Desde ahí me quedé traumada*" (The problem was that I could not even sit down. I was in pain for over a month. Since then, I have been traumatized). Luz vividly related her individual experience to that of other women in public hospitals, concluding her story with, "*Así fue lo que me hicieron a mí*" (that is what they did to me).

Since 1996, the World Health Organization has categorized routine episiotomies as "practices which are frequently used inappropriately."[42] In San Cristóbal's maternity hospital, according to women and the health personnel who worked there, interns frequently performed the procedure instead of doctors in order to improve their skills. Indeed, a retired mestizo doctor confirmed these observations during an interview, explaining that "*quieren practicar*" (the interns want to practice). As an Indigenous midwife, Doña Gabriela can observe on her patients the results of interns' nonconsensual surgical "practice" at this maternity hospital: "*Pero ahora las mujeres mueren. Por eso tienen miedo en la comunidad, no quieren ir al hospital. Porque son practicantes que las atienden*" (Now the women die in the hospital. This is why they are afraid in the village. They don't want to go to the hospital. Because they are attended by interns). This claim resonates with other women's experiences in Latin America as a whole, where many think of hospitals as places where "women die."[43]

A French midwife who had volunteered at a public clinic in the southern region of Chiapas stated that she left the position after two months because she was being reprimanded for not performing episiotomies systematically: "The doctor would come in and say, 'Why didn't you do an episio?' I would answer that that was not how I did things, that the mother and the baby were fine, that they did not need it. But they would argue with me."[44] During this interview, she shared a list of violent practices that also contributed to her decision to leave the clinic: for example, women were being confined to their beds during labor and delivery, babies were taken away immediately after birth, and placentas were being removed manually without anesthesia.

Such experiences of violence circulate among mothers and fuel fear of giving birth in hospital settings. Women who give birth in public institutions often do so at low cost through Seguro Popular and have little choice of opting out, if any. A thirty-year-old Indigenous mother of five living in the municipality of Oxchuc, Chiapas, explained,

> I've never been [to the hospital]. I am scared to go because sometimes the doctors don't attend you well. Yes, I ought to go to the hospital to give birth, but I don't go because I'm scared, as with what happened to that woman. She started to bleed and then she died. This scares me. What if I go there and I start bleeding after they check me? I would have died for just 800 pesos [from Prospera]. That's why I don't want to go.[45]

The interviews of mothers, midwives, and physicians also described harsh verbal abuse in addition to mandatory interventions such as vaginal examinations and episiotomies. For instance, a thirty-year-old Mestiza doctor, who was now working as a lab

specialist in a public hospital, recalled this incident from her time as an intern. "Once I heard a [male] doctor say [to a woman in labor]: 'Really, you were screaming like this when you made it, *cabrona*? So now push!'"[46] As an intern, she was shocked by the older doctor's attitudes and thought his remarks were insulting. As she pointed out, however, other students might imagine this is how patients are supposed to be treated in the delivery room and replicate this behavior. Importantly, the humiliating effect of such comments in a situation where all women are vulnerable—naked, in pain—resonates more deeply with those with additional vulnerabilities: adolescents, non-Spanish speakers, the poor, survivors of sexual violence—characteristics Indigenous women are more likely to share.[47] When the violation of women's consent is so routinely installed, it exceeds the individual relationship between patients and the medical staff. The situation has been institutionalized by a legacy of violation of Indigenous women's rights. Women's attempts at resistance are met with even harsher treatment. This leads some to shy away from hospitals, while others react to reclaim their bodies by demanding interventions.

Choosing the "Big Cut" Cut in Hospital Deliveries

Throughout the world, women's relationship to cesarean sections is ambivalent. Some women choose cesarean section for scheduling reasons, others as a path to upward mobility.[48] In Yucatán, Maya women are talked into cesarean sections by means of various medical arguments, including fear of fetal distress or cephalo-pelvic disproportion,[49] while in France, women of African descent are more likely to undergo a cesarean section regardless of their desires.[50] In my research interviews, some of the women I met shared their fears about the surgery. Doña Gabriela, for example, graphically referred to cesarean section by using the word *abrir* (open), insisting on the violation of women's bodies entailed by the procedure. Doña Felipa, a Tseltal midwife in her seventies from Cancuc, Chiapas, recalled her cesarean section when her last child was born: "I thought I was going to die. I was very sad. I said, 'It's better to die. If they cut me, I will suffer.' I did not want them to operate on me. . . . The surgery is very ugly, because they hurt us, and then the scar takes a long time to heal."[51]

Other women changed their views about the surgery over the course of their labor, as did Adelina, a Mestiza woman and San Cristóbal resident in her late twenties having her first child. Adelina's story illustrates women's ambivalent relationship to "being cut," a metaphor for medical intervention that women both fear and desire. Adelina had sought out Doña Gabriela for two reasons: she wanted to give birth with a midwife and she did not want to have a cesarean section like both of her brothers' wives. Although Adelina herself was born at home in the Selva region of Chiapas, she was the only one of her siblings to choose an out-of-hospital birth, a topic of contention in her family. After a telephone conversation at the beginning of labor, she told me, "My brother says that after the first contractions I will be begging for a cesarean section." That night, after Adelina labored an entire day and evening, Doña Gabriela diagnosed failure to progress and told Adelina and her husband, "*este bebé no quiere salir*" (this baby does not want to come out). Still reluctant to undergo a cesarean

section, Adelina transferred to the maternity hospital. She checked into the emergency room, but less than fifteen minutes later was sent outside to the waiting room because at 7 centimeters, her cervix was not dilated enough (dilation is considered complete at 10 cm). She was told to walk and wait outside the emergency room with an IV. As Adelina reunited with her family, she broke down in frustration and pain, and her mother turned to me saying, "*Ahora sí quiere su cesárea* (*Now*, she wants her cesarean section), while Adelina's mother-in-law added, "We have to take her to a private clinic." Frustrated with the medical service with which she was provided, Adelina and her family considered the public hospital's level of care to be a form of mistreatment and exerted agency in response. Early the next morning, Adelina's daughter was delivered by cesarean section in one of the town's private clinics. Adelina had feared being cut, but during labor came to see it as a form of care.

In 2014, the maternity hospital in San Cristóbal admitted more than 500 patients per month. The majority of incoming patients gave birth in the hospital (325 births per month), but still about 35 percent gave birth elsewhere.[52] Some of the patients transferred to a public maternity ward in another town, while others opted out of the public service in order to give birth at home or else in a private clinic, like Adelina. Because of financial barriers, however, many women do not have this option. Alma shared how, when she was in labor, she had to walk around the public clinic's emergency room in San Cristóbal for thirty-six hours: "They kept telling me, 'Walk, walk,' but it is not easy to walk with IVs on both hands. It hurts."[53]

When Inés entered into labor, it was two days after her upsetting experience with the ultrasound specialist. Throughout her pregnancy, Inés had clearly expressed her fear of being coerced into a second cesarean section, because of her previous birth experience. Her treatment during all of her medical appointments confirmed this fear. Her concern about coercion had led Inés to seek a midwife despite the additional cost (enrolled in Seguro Popular, she could be attended in public hospitals without cost). Inés and Doña Gabriela shared an ethnic identity and a common birth model, although they spoke different Maya languages (Chol and Tseltal/Tsotsil, respectively). With Doña Gabriela, Inés was able to labor alongside her husband, talk on the phone with her family, and try different positions over the course of her labor. At times, Doña Gabriela reminded Inés of her fear of being cut in the hospital to give her the strength to push. Such verbal strategies can of course go awry unless women's answers are given careful attention. At the beginning of labor Inés answered "no" when asked "*Quieres que te corten?*" (Do you want them to cut you?), but after she grew tired she surprised her husband and the midwife by responding "yes." Her reply opened a discussion in which they ultimately decided Inés should transfer to the maternity hospital, where she was immediately admitted. Their daughter was born vaginally less than two hours later.

Because the conversations that occur between Doña Gabriela and her patients allow women to express their fears, these and similar micro-interactions can play an important part in preventing trauma. Inés and Adelina were both able to make their own decisions even if their birth experiences did not follow their expectations. As their stories reveal, it is women's desires and ability to give informed consent that determine whether cases of denial or imposition of interventions during labor can

be considered obstetric violence. As Adelina and Inés' stories also illustrate, despite changes in Mexican maternal health care that are pushing midwives away from their role of primary care provider, midwives often remain women's first choice.[54] For many, they are both familiar and trustworthy—in contrast to hospital birth experiences.

Forced Interventions in Postpartum Care

Estela, a Mestiza woman in her early twenties, struggled to walk on her own as she made her way into Doña Gabriela's consultation room. Her husband, a young man of Indigenous descent, helped her, while her own mother walked behind them, holding their daughter, wrapped in a fluffy yellow blanket. Estela had given birth a week before and was back for a follow-up visit. Doña Gabriela inquired as to why Estela was having trouble walking. "It's the stitches from the hospital," she explained. Estela added that since the birth, her lower abdomen had been hurting a lot and that she had barely been able to walk. Indeed, even though the birth of Estela's daughter had gone well, after delivering her baby and the placenta, she started feeling very dizzy. Her blood pressure dropped, and she feared that she was "going to die." Despite Doña Gabriela's reassurances, Estela's family decided it would be better if a doctor at the maternity hospital checked her. When Estela arrived in the emergency room, the personnel immediately put her on an IV (which bruised both her wrists) and, without informing Estela or seeking her consent, performed a manual uterine revision—a very painful procedure which consists in introducing one's hand into the vaginal cavity in search for residual placenta, a cause of postpartum hemorrhage.

After Estela was stitched up, two government workers entered the room where she and other women were recovering. "They were going from bed to bed, offering [hormonal] implants. They told those who refused the implant that they would not be allowed to leave the hospital."[55] Estela refused at first, but the workers repeated their warning. She agreed to have the implant put in her arm so that she could go home. "There was one *señora* there, I think she was from La Selva [a southern region of the state with a large Indigenous population], who had just given birth to her eighth child, who did not want the contraceptive, so they kept her in."[56] "*La castigaron*" (they punished her), commented Doña Gabriela; Estela and her mother nodded in agreement. Estela then expressed her discomfort with this contraceptive method and Doña Gabriela suggested that she go to a private clinic to have it removed in order to avoid another humiliating encounter. The unwanted procedure caused additional expense for Estela and her husband, who were still in the process of applying to the Prospera program.

Estela's story echoes other cases where contraception is forced on poor and/or Indigenous women, sometimes without their knowledge. This is documented across the Americas.[57] To account for Indigenous women's experiences and the conditions that shape their consent to medical procedures, the concept of obstetric violence needs to be broadened to include consideration of how, historically, their bodies have been targeted for violence. In Mexico in general and in the context of Chiapas' low-intensity, enduring warfare, women who have organized and participated in political struggles

have been tortured, raped, imprisoned, and killed.[58] In lives marked by the intersection of domestic, structural and political violence—what anthropologist and Indigenous studies scholar Shannon Speed refers to as a "dreadful mosaic"[59]—hospitals become places that reproduce violence against these women. The fear of "being cut" encapsulates the physical damage that they may undergo in hospitals, and for some, may even recall the 1997 Acteal massacre in Chiapas, when pregnant Indigenous women were cut open.[60]

Defending Indigenous Women's Reproductive Rights in the Face of Obstetric Violence

The perception of the women and midwives I met was that medical staff violating the Obstetric Violence law acted with total impunity. In particular, Indigenous midwives are often blamed for birth outcomes while they feel biomedical personnel are not held accountable. During an interview, Micaela Icó Bautista, one of the founders of OMIECH, expressed her concern about the differential faced by Indigenous midwives and biomedical personnel with regard to how they are treated in respect of birth outcomes and described the feelings of many midwives about unfair treatment by the hospital staff:

> They say "Never, ever." They never admit that babies die, that mothers die over there [in the hospital]. They put the blame on women, on midwives, because they are Indigenous. . . . The government workers go, "Well, babies never die [in the hospital], never!" No. It isn't true that they don't die, that they don't die in their hands. But they never admit this, because [the doctors] have many rights. Yes, that's why: they have a lot of rights. Because it's legal, it falls inside the law, because they have their degrees, their doctorates and whatnot, everything.[61]

What Icó Bautista terms the different "rights" of medical doctors can impede women's ability to express their anxieties and may also bias the process of collecting informed consent. During a workshop organized by OMIECH with Tseltal and Tsotsil midwives, participants were particularly concerned about lack of informed consent when hospital doctors treated pregnant women:

> Pregnant women . . . don't want to be touched by doctors, because the doctors will tell them that it is better to have a cesarean section. . . . Also, because some doctors don't ask for the woman's or her family's consent. They make decisions on their own, and they perform a cesarean section [without asking].[62]

Indigenous women who were attending another OMIECH workshop reported that some public hospitals provided free transportation only for women agreeing to tubal ligations, yet such transport was not available even in the case of an obstetric emergency.[63] Their testimonies emphasize both the violence in Indigenous women's lack of access to the healthcare structure when they need it and the violence of coercing them into medical procedures. With public policies specifically targeting Indigenous

women to encourage them to give birth in hospitals (disrupting the continuity of care with traditional midwives) and a "mosaic of violence" preventing them from accessing adequate care, Indigenous women's experience of reproductive violence indicates a need to further develop an intersectional definition of obstetric violence.

Towards an Intersectional Approach to Obstetric Violence

Indigenous women's suffering in maternity wards is related to the epidemic of obstetric violence documented across Mexico. However, the discrimination and violence Indigenous women face in clinical settings demands further investigation. While the Mexican state has recognized the specific needs of its Indigenous population and developed cash transfer programs for poor mothers as well as state birth centers, mechanisms deeply rooted in the country's colonial past result in the silencing of women in maternity wards, where, as in other countries, controlling the sexuality of Indigenous and Black men and women formed the heart of the colonial project.[64]

Intimate intrusions on women's bodies disrespect cultural values of modesty, while the Spanish-speaking environment of hospitals reinforces the feeling of isolation of monolingual Indigenous women in labor—without family support, per hospital rules. Despite some committed physicians who train their peers in intercultural health, the scarcity of translators or medical personnel speaking Mayan languages represents a significant barrier to obtaining women's consent. Finally, although forced obstetric interventions are one of the most visible aspects of obstetric violence, other forms of microaggression in public hospitals feed into the continuum of violence and discrimination Indigenous women experience daily, whether they are interacting with interns from other states in their local clinic, bureaucrats who request Spanish-written forms for their children's birth certificates, or racist ladinos in San Cristóbal's tourist center.

The women I interviewed shared their ambivalence about "being cut" if they gave birth in hospital, on some occasions fearing a cut and on others actively desiring such interventions. In addition to understaffing and medicalization, power hierarchies at play between women and physicians in maternity wards contribute to limiting women's agency. Here, I have explored how women's socioeconomic marginalization creates vulnerability, which can make it difficult to obtain informed consent. The fear of being cut does not only stand for episiotomies and cesarean sections, but is also a euphemism for other degrading practices to which (Indigenous) women are subjected, ranging from forced contraception and sterilization to medical neglect that sometimes culminates in death. Thus, while some women eagerly desire a hospital birth, the mistreatment most of them face in labor and delivery rooms counteracts governmental efforts to medicalize childbirth in order to combat maternal death.

In recent years, Mexican professional midwives, trained at one of the country's two officially recognized schools, as well as parents and birth activists, have been insisting on the need to "humanize birth."[65] This approach centers on women's consent, limits interventions to only medically necessary ones, and offers culturally appropriate care. Following the call for humanized birth experiences, private birth centers emerged across the country. Staffed by Mexican and foreign professional midwives, financially

they are out of reach for most of the women covered by Seguro Popular and mostly cater to middle- and upper-class women.[66] In Chiapas, the government has inaugurated several public birth centers through public-private partnerships, each with different characteristics: some are merely a place for early labor before transfer to the hospital, while others are staffed by professional midwives. This strategy still aims at moving births away from the home context and does not account for the variety of midwives' backgrounds. In these "humanized" settings, which are staffed by women who come from other states and do not speak their language, Indigenous women might continue to experience obstetric violence.

Finally, Chiapas has an Obstetric Violence law that aims to improve women's birth experiences, but its narrow definition of obstetric violence does not address the structural causes of women's mistreatment in maternity wards: the lack of space and personnel; obstetricians who lack basic knowledge of rural village life and are at the opposite end of the socioeconomic spectrum from their patients; ingrained racism that affects Indigenous women; and the patriarchal relationships that hold sway in hospital settings. I have argued for a more nuanced understanding of obstetric violence, a definition that would acknowledge the key factor of women's ability and right to decide how they want to give birth and what procedures are performed on them. This more nuanced understanding would also take into account the difficulties women have expressing and making their desires heard, and the problem of both forced interventions and lack of intervention. The World Health Organization recently issued new recommendations criticizing the medicalization of childbirth and emphasizing the uniqueness of each birth.[67] More research on women's intimate experiences of childbirth can illuminate some of the factors behind women's ambivalent relationship to hospitals and bring attention to bear on the unintended effects of well-intentioned development policies.

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Notes

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2. Indigenous midwives use herbal teas and massages and, depending on their religion, spiritual pleading for a good birth outcome. Área de Mujeres y Parteras, *Rescate Del Conocimiento de Las Parteras y Mujeres. Recetas de La Medicina Indígena Tradicional Para Enfermades de La Mujer y Del Recién Nacido*, Boletín 17 (San Cristóbal de Las Casas, Chiapas, MEX: Día Munidal de la Oración; OMIECH, 2004).

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5. *"Hay mujeres que tienen miedo al hospital . . . Le digo a mi paciente: Sí, vas a poder. Pero sino, mejor vete. A mi no me gusta que te vayas, te va a costar, no va a ser igual . . . A cortar y después te costura como trapo."* All quotations are taken from interviews conducted between 2013 and 2015 in San Cristobal de las Casas, Cancuc, and Comitan, Chiapas, Mexico. All interviews in Tseltal were audio recorded; interviews in Spanish were written. Translations from Tseltal are by Mari K'ulub. Unless otherwise noted, all translations from Spanish into English are mine.

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revolution, when slavery was abolished in Chiapas, Indians were still bought, sold, and offered during land selling.] See *El Mandato de los Dioses: Etnomedicina entre los Tzotziles de Chamula y Chenalhó, Chiapas* (San Cristobal de la Casas, Chiapas, and México, DF: Universidad Nacional Autónoma de Mexico, 2005), 41.

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32. Except for Micaela Icó Bautista, all names are pseudonyms.

33. *"Tenía mucho flujo, asi que me mandaron a hacer un ultrasonido en el hospital . . . Me acosté y me dijo la doctora 'Mira tu bebe esta bien, así que vete a tu casa y descanse'. . . . Y voy nuevamente a*

la clínica y me manda nuevamente al hospital. Cuando me pasa nuevamente dice la doctora 'a ver que la señora aquí no entiende, a ver, quiero que pasen.' Entonces me hicieron sentir mal, porque me acuesta nuevamente, me hacen un ultrasonido, pero ya con todo los doctores. Así, y dice la doctora 'miren que la señora no entiende, pero miren: sí o no doctores está bien' y 'síi', todos, 'sí.' Y yo me sentí muy mal, me acuerdo que salí llorando y mi mama me abrazo; tenía yo 17 años."

34. At the time Alma was offered a lower fee for the midwifery care, which she paid in monthly installments for almost a year. She related that a couple of years later her sister-in-law was turned down by the same birth center when she asked for a reduced fee. The woman attempted a homebirth with a traditional midwife who she did not know, but due to exhaustion and mistreatment, transferred to the maternity hospital, where she also reported mistreatment.

35. *"La Doctora no sabía. Nos dijo que iba a nacer en la semana y que había que ir al hospital para inducir sino se iba a morir la niña. No fuimos, regresamos a casa pensando 'sera que esta muerta la niña.' Nos espantamos. No te atienden bien."*

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44. *"Le médecin arrivait et me disait 'Pourquoi tu n'as pas fait d'épisio?' Je répondais que ce n'est pas comme ça que je travaille: 'le bébé et la maman vont bien, elle n'en avait pas besoin.' Mais il me disputait."*

45. *"Nunca fui [al hospital]; me da miedo porque a veces los doctores no atienden bien. Sí, tengo [que ir] pero no llego porque me da miedo, como le pasó a una señora. Empezó a sangrar y falleció la señora. Es*

lo que me da miedo, porque nos revisan y ¿que tal si me empiezo a sangrar? Solo por 800 pesos me voy a morir. Por eso no quiero" (original in Tseltal; translation by Mari K'ulub).

46. "*Me tocó una vez escuchar un médico decir: '¿A poco estabas gritando así cuando lo hiciste cabrona? Ahora ¡puje!*'" "*Cabrona*" is a strong insult with a variety of connotations, including "prostitute."

47. In Mexico, 47% of women over the age of 15 have been exposed to intimate partner violence, a proportion that reaches 62% for indigenous women. Instituto Nacional de Estadística y Geografía, "*Panorama de Violencia Contra Las Mujeres En El Estado de México*," 2006, Mujeres y Hombres en el Estado de México, Estadísticas Sobre Desigualdad de Género y Violencia Contra Las Mujeres (Aguascalientes: Instituto Nacional de Estadística y Geografía, 2013); Claudia Elizabeth Gonzalez Amaya, Arun Kumar Acharya, and José María Infante Bonfiglio, "Gender Based Violence and Reproductive Health of Indigenous Women in Mexico," *Sociology Mind* 6, no. 3 (2016): 107–113, https://doi.org/10.4236/sm.2016.63009.

48. Theresa Morris, *Cut It Out: The C-Section Epidemic in America* (New York: New York University Press, 2013); Elizabeth F. S. Roberts, "Scars of Nation: Surgical Penetration and the Ecuadorian State," *The Journal of Latin American and Caribbean Anthropology* 17, no. 2 (2012): 215–37, https://doi.org/10.1111/j.1935-4940.2012.01223.x.

49. Marcia L. Good Maust, "Making Bodies: Cesarean Narratives in Merida, Yucatan," PhD diss., University of Florida, 2000.

50. Priscille Sauvegrain, "La santé maternelle des 'Africaines' en Île-de-France: Racisation des patientes et trajectoires de soins," *Revue Europeenne des Migrations Internationales* 28, no. 2: 81–100, https://journals.openedition.org/remi/5902.

51. "*Pensé que me iba a morir, me puse bien triste. Hasta dije, mejor que yo me muera. Porque si me cortan yo voy a sufrir, así dije, no quería que me operaran. . . . Pero es muy feo la operación, porque nos lastiman, y luego tarda para que sane la herida*"; original in Tseltal, translation by Mari K'ulub.

52. Instituto de Salud, Hospital de la Mujer, "Boletín Informativo: Violencia Obstérica" (San Cristóbal de Las Casas, Chiapas, MEX: Salud Mesoamericana 2015, September 8, 2014).

53. "*Me decían 'camina camina,' pero es tan incomodo caminar con el suero en las manos, porque te duele.*"

54. El Kotni, "Regulating Traditional Mexican Midwifery."

55. "*Y ahí entraron dos trabajadores sociales, quienes pasaban de cama en cama para poner implantes [hormonales] a las mujeres. Yo no quería, pero nos dijeron que si no nos dejábamos, no nos iban a dar de baja.*"

56. "*Había una señora, creo que de la Selva. Ta tenía 8 hijos. No quiso el implante y la guardaron más tiempo.*"

57. Arachu Castro, "Contracepting at Childbirth: The Integration of Reproductive Health and Population Policies in Mexico," in *Unhealthy Health Policy: A Critical Anthropological Examination*, ed. Arachu Castro and Merrill Singer (Walnut Creek, CA: Altamira Press, 2004), 133–44; Claudia Dreifus, "A Group of Mexican Immigrant Women Were Sterilized Without Their Consent. Can a New Film Bring Justice?" *The Nation*, January 27, 2016, http://www.thenation.com/article/a-group-of-mexican-immigrant-women-were-sterilized-without-their-consent-can-a-new-film-bring-justice-where-the-courts-failed/; Karen Stote, *An Act of Genocide: Colonialism and the Sterilization of Aboriginal Women* (Black Point, Nova Scotia, Canada; Winnipeg, Manitoba, Canada: Fernwood Publishing, 2015).

58. Castillo, "Between Hope and Adversity;" Rosalva Aída Hernández, "¿Del Estado Multicultural Al Estado Penal? Mujeres Indígenas Presas y Criminalización de La Pobreza En México," CIESAS, https://antropologiafractal.files.wordpress.com/2016/01/del-estado-multicultural-al-estado-penal-mujeres-indgenas-presas-y-criminalizacin-de-la-pobreza-en-mxico.pdf.

59. Shannon Speed, "A Dreadful Mosaic: Rethinking Gender Violence through the Lives of Indigenous Women Migrants," in *Working Paper #304, Anthropological Approaches to Gender-Based*

Violence and Human Rights (East Lansing, MI: Michigan State University Center for Gender in Global Context, 2014), 78–94, https://gencen.isp.msu.edu/files/8914/5201/1092/WP304.pdf.

60. Melenotte, "Autopsia de una matanza."

61. *"Dicen 'Nuuuunca jamás.' Ellos jamás dicen que mueren niños, que mueren la mamá allí. Lo echan la culpa a las mujeres, a las parteras, porque son indígenas. . . . El gobierno y sus trabajadores dicen "Nunca muere el niño, nunca." No es cierto si no mueren. Si no mueren en sus manos . . . Pero, no lo dicen. Porque tienen mucho derecho. Por eso: ellos tienen mucho derecho porque está legal, está en la ley, porque tiene su título, tiene su doctorad o no sé, de todo."*

62. Organización de Médicos Indígenas del Estado de Chiapas, "Memoria del Encuentro de Mujeres y Parteras."

63. Área de Mujeres y Parteras, Derechos de Mujeres Indígenas, Talleres de Capacitación Comunitaria, "Programas, Políticas y Leyes."

64. Marcos, "Indigenous Eroticism and Colonial Morality in Mexico"; Roberts, *Killing the Black Body*; Smith, *Conquest*.

65. Zacher Dixon, "Obstetrics in a Time of Violence."

66. Rosalynn Adeline Vega, "Commodifying Indigeneity: How the Humanization of Birth Reinforces Racialized Inequality in Mexico," *Medical Anthropology Quarterly* 31, no. 4 (2017): 499–518, https://doi.org/10.1111/maq.12343.

67. World Health Organization, "Individualized, Supportive Care Key to Positive Childbirth Experience, Says WHO" (news release), February 15, 2018, https://www.who.int/mediacentre/news/releases/2018/positive-childbirth-experience/en/.