

Maternal Identity and Family Health in the Sierra

This summer I spent ten weeks volunteering and completing fieldwork for my senior thesis in Gender Studies with the *Salud Materna* (Maternal Health) team at *Compañeros en Salud* (CES). CES is a sister organization of Partners in Health in the Mexican state of Chiapas that works out of a central office in Jaltenango de la Paz and ten rural clinics in the surrounding Sierra Madre Mountains. CES works to bring healthcare to one of the most marginalized populations in Mexico through primary care, surgical referrals, community health worker programs, and other rising initiatives. The maternal health initiative at CES, while relatively new, strives to connect women in the Sierra Madre of Chiapas with respectful and safe birthing practices, prenatal care, and options for family planning. The maternal health team trains student doctors, or *pasantes*, in family planning methods, mentors midwifery *pasantes* in local maternal waiting homes, and recently started recruiting and training community health workers who specialize in maternal and infant health.

Upon arrival in mid May, I was fairly overwhelmed with transitioning into speaking Spanish again (I studied abroad in Puebla, Mexico in Fall 2015) and into the lifestyle of the Sierra. Nonetheless, I felt so welcomed by fellow volunteers living in the CES office in Jaltenango de la Paz and received great support from my friends and colleagues throughout the summer. Upon arrival, my coworkers showed me around Jaltenango, oriented me to the office, and let me participate in training sessions for the bi-annual *búsqueda activa*.

Every six months, Compañeros en Salud conducts a *búsqueda activa*, or an *active search*, which consists of a week of health surveys and referrals in one of the communities where a CES

clinic is located. Because I had minimal experience speaking with people in the Sierra of Chiapas, my supervisor, the coordinator of maternal health, suggested I participate in the *búsqueda* to get better acquainted with the population of this particular community and to practice interviewing such that I would feel more confident in interviews for my own project. With about 10 third- and fourth-year medical students from Tecnológico de Monterrey, a university in Monterrey, Nuevo León, I traveled to Soledad, one of the villages about three hours away from Jaltenango. We traversed from house to house to ask families about their overall health and referred them to the clinic if they presented any symptoms of diabetes, tuberculosis, hypertension, depression, and other illnesses. We also conducted separate interviews for pregnant and postpartum mothers and referred them to the clinic for prenatal care, vaccines, and family planning counseling. This week was integral to the success of my project, as it allowed me to live in one of the CES communities for a week and to get to know some of my coworkers and members of that community.

Throughout the summer, I also attended two of CES's courses in global health, which is primarily geared towards the *pasante* student doctors, although still relevant to my research and volunteer work in maternal health. Each month, we spent several days discussing clinical cases, themes in global health, and other topics pertinent to medical care in Chiapas. For example, we discussed the difference between equality and equity. In achieving *equality*, all parties involved in a given scenario are given the same resources, regardless of their background and/or socioeconomic status. In achieving *equity*, those at the bottom of social hierarchies are given the best or most resources; this emphasis on global health equity at CES stems from co-founder Dr. Paul Farmer's collaboration with Gustavo Gutiérrez and liberation theology. Working with doctors, other health professionals, and students focused on combating structural violence in

healthcare taught me about how to apply what I have learned as a Gender Studies and Pre-Health student into practice.

For about the first month of my summer in Chiapas, I did general volunteer work in the CES office, consisting mostly of clerical work, organizing materials for the maternal health team, and researching community maternal health programs in other countries to inform the development of our own program. Throughout that month, I also worked with my supervisor and the coordinator of maternal health, to narrow the scope and better focus my project goals and specific interview questions. I began this project with the intent to study the rhetoric of national healthcare policy, but ultimately decided to focus on individual constructs of maternal identity and compare those constructions of identity with expectations set by the state through social welfare programs such as *Prospera*.

My supervisor referred me to literature on identity formation, motherhood, and healthcare in Mexico to better focus my project. Drawing on several definitions of identity, within the context of this study motherhood serves as an assumed social necessity towards which women direct their desires, aspirations and intentions as expressed through their everyday actions. This encapsulates the pressure to be a “good mother,” a multi-faceted ideal in the face of extreme poverty and social inequity in the Sierra of Chiapas. Similarly, I investigated the main pillars of *Prospera*, a conditional cash-transfer program very common to families in the Sierra. I hypothesized that maternal identity in the Sierra of Chiapas is inextricably bound to the healthcare and social needs of the family, as identity production impacts one’s desires, ambitions, and living conditions; this is also related to national social welfare initiatives such as *Prospera* that focuses on the economic, social, and physical development of the family but tend

to ignore the social identity of the mother and the ways in which social constructions of motherhood impact the mother's physical and social and emotional well-being.

I also narrowed my inclusion criteria to mothers between ages 18 and 35 with children up to five years of age. I chose this population because they are women of childbearing age, are not minors, and are somewhat "sandwiched" between their parents' and children's generation. I thought that this would show the duality of identity transmission and the ways in which mothers negotiated their desires, their parents' and in-laws' wishes, and the demands of motherhood. The interview is comprised of three sections. The first explores the value of children, the specific responsibilities of mothers in the Sierra, and family values. I asked participants how many children they have, how many they would ideally have, what a typical "day in the life" looked like, and other questions revolving around the participant as a "social mother." The second section asked participants about their physical well being, including their experiences in giving birth, their attitudes on family planning methods, and whether or not they suffered from a chronic illness such as diabetes or hypertension. The third section of the interview asked the participant about their experiences with *Prospera* if they were recipients of the program's benefits.

I conducted the interviews in four different communities where CES clinics are located: Laguna del Cofre, Capitán Luis A. Vidal, Honduras, and Monterrey. As part of further research, I hope to investigate the history of these communities, all of which depend heavily on coffee farms, or *cafetales*, scattered along the mountainside. I completed 40 interviews, though many were not recorded in respect to the participant's wishes. Throughout the interviews, I encountered many cultural and language barriers. Though I did not formally change the interview questions, I often had to modify the ways in which I asked the questions or framed the

interview. I started my study as a nervous researcher but completed the project with more ease in conversation with the women in these four communities. Once I was able to introduce myself in a more casual way while still staying within the original framework of the interview, it became easier to both build rapport and learn from participants' oral histories. For example, one of the questions in the first section asks mothers what values are most important to support a family. The word for values, *valores*, was not common in the region where I did the interviews, and I was more easily understood by using "feelings" or "qualities" of a family in asking that particular question. I would always ask the original interview question, and if they did not understand, I would explain the word using more colloquial terms. Similarly, questions about *Prospera* sometimes made participants uncomfortable, and I did my best to remain cognizant of that discomfort and respectful of a participant's wishes to not answer specific questions about the government-sponsored program. Because I came from a local NGO, members of the community often assumed I was a government worker and that I would take away their membership of the social welfare programs if they spoke poorly of the programs. In these situations I would reassure the participant that their identity and responses were to be kept completely confidential.

Although the title of my project changed throughout the course of the summer, the primary focus remained on the physical and social well-being of mothers and their access to healthcare services in the Sierra Madre region of Chiapas. I am in the process of transcribing and processing the interviews from this summer, as they will inform my senior thesis in Gender Studies. In moving forward, I hope to apply the oral histories of these mothers in the Sierra Madre to the way that community health workers are trained in maternal health. Future research should focus on gendered dynamics for all women within the context of marriage, alcoholism, religion and domestic violence, as all of these phenomena were also common themes in the

interviews. Many myths and fears about birthing practices, family planning, and medicine came to the forefront of these oral histories; by training women from rural communities to accompany mothers and community health workers, we may empower them to balance the need for safe medical care with the local culture of traditional gendered expectations in maternal health.