CONJURING EQUITY: NAHUA HEALERS AND THE CULTURAL POLITICS OF INSTITUTIONALIZING TRADITIONAL MEDICINE IN MEXICO

By

JENNIFER LYNN HALE GALLARDO

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To My family
And for my grandmothers,
*Mi mamita, mi estrella*, Esther del Rosario (1920-2012)
and
My nanny, my special, Freda Ruth (1922-2012)
*EPD*, RIP
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This dissertation examines the role of the state-sponsored traditional healer in 21st century Mexico. Based on fieldwork in a rural central Mexican municipality, the study explores everyday interactions between Nahua healers and government workers in a state-sponsored traditional medicine clinic. Tracing the desires, hopes, frustrations, and anxieties of the various actors working in the clinic, I explore how Nahua healers and their mestizo interlocutors are compelled to negotiate new relationships in the context of state multiculturalism and neoliberalism. I argue that the tensions present in the institutionalization of traditional medicine are a product of the contradictions inherent in an official production of social equity that is "conjured" by the state in the name of respecting indigenous medicine.
The first time I met a state-sponsored indigenous healer in Mexico was inside a public hospital. A woman came in asking anxiously whether anyone could cure her son of susto. Known as nemouhtil among the local Nahua population, susto (“fright” or “soul loss”) is a potentially deadly illness in which an animating component of the life force has been separated from the body. Although Mesoamericans have long sought healing for this dangerous ailment afflicting men and women of all ages, most Mexican physicians, like biomedical physicians elsewhere, have typically discounted discussions of susto, considering it outside the realm of biology and relegating it to superstition. At this hospital however, the staff member immediately recognized the woman’s request and sent her to an indigenous healer who was being asked urgently to attend to the life of the child.

With its emergency unit, pediatrician, obstetrician, laboratory, dental clinic and pharmacy, the hospital possessed many of the hallmarks of Mexico’s biomedical institutions. Built in the 1950s in the Sierra Norte of Puebla, it formed part of a wider federal effort to “modernize” rural areas and introduce medical services into indigenous regions. Almost a half-century after it was first constructed the hospital pioneered a new model for healthcare when it invited local healers, historically at the margins of public health, to move their practice inside. When I arrived for the first time in 2004, three-dozen indigenous spiritual healers, bonesetters, and midwives worked at the back of the hospital offering a variety of therapies—from herbal potions for mal aire (bad airs), to sobadas (therapeutic massages) and llamadas (soul retrievals).
After the healer returned from treating the child, I asked the office administration for a consultation with her. Adding my name to the patient log, I followed Doña Ana down the long hallway to a small room at the other end of the clinic. As we walked together in silence, I wondered what to expect from a "traditional doctor" in a 21st century Mexican public hospital, and what she could expect of me, an outsider to Nahua worlds.

Doña Ana sat me down in a chair before a large decoratively carved wood altar arrayed with Catholic saints, cherub angels and a folk art candelabra.¹ Combining Nahuat and Spanish invocations, she lit a candle on the altar, making the sign of the cross over my head as she prayed over me. Then with a cultivated touch, she leaned in and "listened" to something imperceptible to me under my skin. Though I did not yet recognize this healing modality, Doña Ana was pulsando (pulsing), a widespread form of divination and diagnosis in Mesoamerica where the blood is said to speak to the healer and communicate the sickness a person suffers (Huber and Sandstrom 2001).²

Sensing through her fingertips, she asked if I was tired. After a long day of traveling to the mountain town, I admitted I was. “But you have a strong pulso,” she said as she palpitated my wrist, palm, and forearm and “listened.” Detecting my physiological, psychological, social and economic wellbeing, her final diagnosis was that I was paktok (“healthy”, or literally, “happy” [Nahuat]), and that I was doing well, especially in terms of my work.

¹ A stylized version of the more chaotic assembly of household altars I would later find in Nahua homes with their layers of statuettes, faded images and used votives, the altar was a prominent fixture of the traditional medicine clinic.

² Pulsando is considered one of many common traditional indigenous healing practices in Mexico.
While Doña Ana found I was doing well in my work, I wanted to diagnose or assess the role of the indigenous healer in contemporary Mexico. Recently, traditional medicine has become part of the official health strategy in the language of intercultural health (Department of Traditional Medicine 2007). In this research study, I ask: What could it mean for indigenous healers—long considered the nemesis of public health—to ally with the Ministry of Health in a context of neoliberalism? And how does Doña Ana’s presence at a state-sponsored traditional medicine clinic provide a window into the health of Mexico’s relationship with its indigenous citizens under state multiculturalism?

Interculturality in health has become one of the most trafficked concepts among Latin American health organizations today (Lerin 2004). The concept became popular between 1990 and 2000 when The Pan American Health Organization (PAHO)\(^3\) introduced it as part of the Health Initiative for Indigenous Peoples (Ramirez Hita 2008). Its goal was to support the development of alternative health models for indigenous populations of the Americas by “…incorporating their perspectives, medicines and therapies in primary healthcare” (WHO 2003:7; ibid). In Mexico, the notion of interculturality in health has been appropriated by government institutions (Lerin 2004).\(^4\) The mandate of the Ministry of Health’s Department of Traditional Medicine and Intercultural Medicine is described as “fortifying the services of health that are directed to this (indigenous) population, with absolute respect of their culture, by recognizing the

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\(^3\) The regional public health agency office for the Americas of the World Health Organization,

\(^4\) Aguirre-Beltran, one of the earliest applied anthropologists to examine indigenous health defined intercultural health as "complementarity (things that are different from each other but make a good combination) between two health systems (institutional and traditional) that have as their common objective confronting sickness and bettering health in indigenous zones of refuge" (Aguirre Beltran 1996 in Lerin 117: 2004).
participation of the ‘traditional doctor’ in the health of the communities” (Almaguer 2001:3).

This dissertation considers the institutionalization of traditional medicine in Mexico as a key site where tensions between local priorities, national imaginaries, and international discourses are produced. Based on fieldwork in a region that has served as a testing ground for indigenous policies, this study examines everyday interactions between Nahua healers and hospital personnel in a state-sponsored traditional medicine clinic. The study is driven by two concerns: first, to understand how state desires, transnational economics, and biomedical discourses are shaping what counts as traditional medicine in the Sierra Norte of Puebla; and second, to comprehend how Nahua healers and state officials navigate the diverse and not necessarily coordinated efforts to integrate traditional medicine into public healthcare.

A Brief History of Curanderismo in Mexico

Ticitl, ilalix, h'ilol, h-men, ab cut, ah cun and other indigenous healing specialists have long attended to the health problems of Mesoamerican people. 5 However, while discussed today as traditional doctors or practitioners, healers such as Doña Ana are far from being part of an unchanged or homogenous legacy. The so-called ancient healing traditions of indigenous Mexicans have been transformed in the crucible of time and are a product of the syncreticization of pre-Columbian healing modalities with colonial Spanish and African traditions as well as biomedicine (Coronado 2005).

5 No such generic term such as “traditional medicine” existed for the many indigenous medical specialists found in distinct language groups, such as “the Nahua ticitl, the Huastec ilalix, the Tzetal h'ilolje and the Tzotzil h'ilol...the Mayan h-men, the ab cut of the Pokoman, and it's Quiche equivalent, ah cun” (Huber and Sandstrom 2001). Despite its syncretism and variability, the corpus of healing modalities practiced by indigenous and rural people shares many elements in its use throughout Mesoamerica, many of these related to a shared foundation of ontological reference points and meanings rooted in shared life worlds.
Historians write that in the first years after the conquest, Spaniards themselves recognized that Native healers were “doctors in the complete sense of the term” (Viesca Treviño 2001:48). Early records indicate that Spanish colonial officials first considered \textit{indios medicos} or Indian doctors to be “specialists who solved the health problems of their own people” (ibid: 48). One of the first priests in Mexico, Hernando Ruiz de Alarcon, declared that the Nahuatl term \textit{ticitl} meant "what in Spanish is implied by the term doctor" (ibid: 62-63). In a similar vein, Fray Bartolome de las Casas described the original inhabitants of New Spain as having both "physicians" and “great herbalists” (ibid:53).

While the earliest colonial documents refer to \textit{doctores indios} healing Spaniards,\footnote{In a famous case, Hernan Cortes himself wrote of how he and his soldiers were assisted in Tlaxcala by indigenous doctors after being wounded in battle at Otumba (Trevina 2001:49). Native healers assisted Spaniards who became sick in the unfamiliar environment of the lands they had colonized.} it wasn’t long before colonial agents in New Spain began to reason that Indian medicine was for Indians and not for them (Campos-Navarro and Ruiz Llanos 2001). Huber and Sandstorm write that high levels of mortality among Indians from epidemics and particularly the \textit{huey cocolitzli}, or great disease of 1545, led Spaniards to conceive that the physiological constitution of an Indian was different from that of a European (2001). Campos-Navarro and Ruiz Llanos also write that as Indians were accustomed to particular forms of government, dress and food, Spanish officials believed that Indians required medical treatment that was also specific to them (2001). Beginning in the 16\textsuperscript{th} century, Spanish officials assigned Native people to their own hospitals so they could be doctored by Native physicians (ibid).\footnote{When the \textit{Republica de Indios} was established in Tlatelolco, Spanish officials contended that a Native school and Native doctors would be vital to its functioning (Treviño 2001:49).}
Throughout the colonial period, the numbers of popular, non-academic healers continued to be large and they were known to be effective (Ortiz de Montellano 1990). Native healers were considered to have “offered a solution to the majority of the health problems of the population” (Quezada 1991:37). Colonists began to use the term curandero to distinguish medicine of the Empire (which comprised scarce numbers of European medical physicians and medical resources reserved for Spaniards and elites) from the more abundant popular, folk medicine used by the “lower castes” (and by Spaniards albeit more clandestinely (Hall of Mirrors) (Quezada 1991:38). Curanderismo became the catchall name for all Native Mesoamerican practitioners as well as practitioners of African and mestizo (or “mixed”) ancestry (Huber and Sandstrom 2001; Ortiz de Montellano 1990).

In the eyes of the colonial establishment, curanderos were considered inferior to the academically-educated Spanish or Creole physicians. Historian Héctor Jaime Viesca Treviño described the subsequent re-framing and demotion of Indian healers in New Spain as a result of Indians being conquered and culturally devalorized as a people (1987). Spanish officials began to critique Native healers for what they perceived as scientific failings and differences from European principles of healing, which centered on Hippocratic notions of bodily equilibrium (Varey 2000). They also critiqued healers based on their suspected moral failings (ibid). As the Mexican Inquisition grew in fervor (1571-1820), Spaniards thought that indios medicos (Indian doctors) were apt to be pact makers with the Christian devil (ibid).8 Indians were considered prone to immoral

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8 Only a limited number of Indians were subjected directly to the Inquisition. Indians were assigned to a separate status under a special Tribunal where they could be judged by Indians (Viesca Treviño 2001:56-57).
collusions, however, they were not often subjected directly to the Inquisition because of their status as Native subjects (or “children”) of the Crown who needed tutelage against things “the devil made them do” (Lewis 2003).

In the mid-17th century, colonial city councils attempted to regulate practitioners of medicine and to subjugate all non-official medicine including curanderismo on scientific and legal bases (Treviño 2001). The court of the Protomedicato was established by Spanish royalty to supervise the practice of physicians, surgeons, pharmacists, and midwives through their licensure (Treviño 2001). It also collected fines and bribes from the extortion of unlicensed practitioners (Hernandez Saenz 1997). For 200 years, the Protomedicato served as the maximum authority and regulatory body for public health and a focal point for fomenting scientific medicine to the exclusion of curanderos influenced by Native, African, and Spanish folk practices in ways considered uncouth to Spanish notions of science (Campos Navarro 1996).

After Mexico's official birth as an independent nation (1821), positivist science was an essential part of statecraft (Treviño 2001). The emerging liberal government established the College of the Medical Sciences in Mexico in 1833 and the Consejo Superior de Salubridad (Higher Council of Health) in 1841 (ibid). The regime set its sights on reproducing a medical model of curative medicine in vogue in France and the U.S, based on specialty care and hospitalizations (ibid). While the Constitution (1857)

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9 Records indicate that before Independence, curanderos in Mexico City were imprisoned and fined 50 pesos for their first violation and a hundred pesos for repeated offenses.

10 Both of these entities prohibited the practice of medicine by anyone “who did not have a professional degree issued by an institution of higher learning recognized by the corresponding public authorities” (Viesca Treviño 2001:64).

11 The Juarez Reform in 1861 sponsored the building of large public hospitals and the creation of the General Welfare Agency (Dirección General de Beneficiencia). However, the Church maintained its
did not go to the extent of regulating professions deemed to require an academic title, physicians mounted a militant opposition to curanderos (Page Pliego 2002). Despite efforts to regulate medical practice, Indian and mestizo curanderos continued to serve as an important health resource for the republic (Viesca Treviño 2001:64; Campos 2001).

After the Mexican Revolution (1910-1920), state modernization was tied to the healthcare sector (Nigenda et al 2001). Ushering in a language of social rights and the right to healthcare for all, the national healthcare system became part of the new social pact (Horn 1993; Birn 1998). The Ministry of Health installed the bioscientific model as the exclusive basis of public health provision in hospitals and clinics and consolidated its role as the entity officially responsible for the health of Mexicans, excluding everything that deviated from scientific medicine (Nigenda et al 2001; Pozas and Pozas 1976). From the 1940s to the early 1970s, this politics of “neutralization” included the “disqualification, demonization, and persecution” of indigenous healers and their practices (Page Pliego 2002:28). In this context, indigenous and/or popular healers represented the anti-modern and their extirpation, the path to modernity (McCrea 2002).

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position at the helm of most hospitals and dispensaries constructed during the colony, either because Mexico was in an imminent civil war, or because government officials had not yet taken an interest in ill indigent people, and these continued to operate without opposition from state authorities until the start of the Revolution in 1910 (Braquet Marquez 2007). The charge of the Central Welfare Agency was “to centralize the hospital services, organize them, coordinate them, and sustain them through tracts, Donations and products of the National lottery, annihilating the role that the church had in maintaining the medical attention” (Campos-Navarro 1996: 57-58).

12 The Ministry of Health (1937) and the Institution of Mexican Social Security (1947) were intended to institutionalize and unify health and social security but in practice provided a limited set of health and social welfare programs for the population, focusing on the main urban center and those working for industry and services (Moreno 2003).
Starting in the 1930s and 40s, sanitary health units marked the first governmental presence in many rural areas (Birn 1998). Health interventions became an especially important venue for promoting cultural assimilation in the name of modernizing indigenous people and discourses of public health and hygiene provided a language and practice of social control (Burke 1996; Anderson 2006). Citizens were educated to forgo prayers and herbs for the stethoscope and needle (Page Pliego 2002).

The official stigmatization of curanderismo and its association with ignorance or backwardness became a powerful force in the social discretization of healers (Campos Navarro 1996). The government pathologized popular healing practices and regarded them obstacles in the construction of a modern nation-state (Page Pliego 2002). Midwives were especially targeted as dangerous actors, perceived to be a threat to birthing mothers and children and considered “criminals and enemies of society” whose “patients (were) naïve or ignorant people” (cited by Campos-Navarro 1996:63 in Jaime Page-Pliego 2002: 29). Mexican government campaigns kept popular healers at the margins of public healthcare by discrediting their practices and manipulating public opinion about healers (Campos Navarro 1996; Page Pliego 2002). Even so, many Mexicans continued to seek the assistance of curanderos, despite the stigma increasingly attached to their cures (ibid).

A watershed event in global health policy would change the Mexican health sector’s official stance towards indigenous or “traditional” medicine. In 1978, the World Health Organization’s Alma-Ata Convention formally recognized “traditional

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13 Despite the presence of these sanitary units, in rural areas it was well known that most peasants continued to consult both curanderos and midwives. Eventually many curanderos accepted the units, sometimes visiting them as patients or referring patients to physicians (Birn 1998).
practitioners” as potential allies in meeting primary healthcare goals and extending public health services in the global South. It named "suitably trained" "traditional practitioners" as part of the health team for communities (Alma-Ata declaration 1978). In step with global health policy, Mexican healthcare shifted toward emphasizing primary healthcare for all and promoting “community participation” through the dissemination of rural health clinics (Parra 1993). The turn toward traditional medicine was justified by the inaccessibility of biomedical treatment for the majority of rural and indigenous peoples (Estrada 2003).

Beginning in the 1980s, the Mexican government mobilized curanderos like Doña Ana in an effort to expand the coverage of healthcare in rural country sides (Page Pliego 2002; Parra 1993). Toward this end, official discourse began to conceive of "modern doctors and traditional healers shar[ing] a common space" (Nigenda et al 2001:4). Official agents in the national health care system of Mexico (IMSS) and the National Institute for the Indigenous (INI) initiated a plethora of activities aimed at integrating traditional medicine into government health services (Campos-Navarro 1996:68 (ibid). 

During this same period, structural adjustment policies based on aggressive market-oriented economics and finance capital began to dismantle Mexico’s corporate welfare state along with its social protections (Harvey 2007).¹⁴ The model of specialty curative care had come into crisis with the ever-growing disjuncture between the idea of

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¹⁴ Current figures that over 49 million people (forty-four percent of the population lives below the poverty line (Consejo Nacional de Evaluación de la Política de Desarrollo Social, CONEVAL 2009). Public policies intending to compensate for the distortion of Mexico’s market and the extremely wide income gap (of the widest in the world according to the Organization for Economic Co-operation and Development (OECD), have been unsuccessful (Tuiran Gutierrez 2005). In states with the largest concentrations of indigenous people, as much as 75 percent are below the poverty line and 39 percent are defined as extremely impoverished (CONEVAL 2009).
the state as provider and its limits as a corporatist state.\textsuperscript{15} Privatization of healthcare resulted in a disinvestment in the public health sector and medical services especially in poorer states and regions (Laurell 2007). In the context of a crisis in medical attention to rural areas (Page Pleigo 1995)\textsuperscript{16}, traditional medicine was reclassified almost overnight from a vestige of Mexico's archaic past to a valuable resource for the nation-state (Freyermuth 1993; Kohler 1975).

More recently, Indian difference has been re-inserted inside of national discourse as part of an emphasis on the democratization of healthcare. Moreover, the Mexican Constitution has recognized “traditional medical practices” as part of indigenous peoples’ rights to cultural practices (Perez Vasquez 2005). With this, the health sector has resuscitated the idea of bridging biomedicine and indigenous medicine in projects and programs throughout the country. Such is the case of the traditional medicine clinic that is the subject of this study.

\textbf{Embodying the State: Indigenous Healers in Contemporary Mexico}

The complicated nature of engagements between biomedicine and local life worlds of indigenous healing generate innumerable frictions that anthropologists are well positioned to analyze. Unpacking facile assumptions about bounded medicines, scholars have emphasized the way in which all healing modalities are shaped through intersections between local, regional, national and global contexts (Adams 1998; Farquhar 1996; Good 1993; Langford 2002; Langwick 2007; Langwick 2008; Lock 2002; Lock 2002; Lock 2002;)

\textsuperscript{15} Federal retreat in investment in medical care resulted in unemployed medical graduates and large swaths of the population who remained outside of a social security system that covered only full time workers and government employees.

\textsuperscript{16} Mexican officials conceded that it was impossible for academic medicine to attend all of Mexico’s population, especially in the rural areas (Page Pleigo 2002:30).
Scheid 2002; Pigg 1997; Zhan 2001). Going beyond the idea of discrete cultural logics, anthropologists have foregrounded the kinds of historical, cultural, and political networks within which healing practices and healers emerge. What they have demonstrated is that ideas about the mind/body, self, and sickness are never just natural or neutral, but instead are historically produced and contingently embodied.

Anthropologists have also raised over the years about the viability of traditional medicine under orchestrated medical pluralism (Pilsbury 1982; Janes 1999; Feierman 1985; Pigg 1997; Fagetti 2003). While the term “traditional medicine” is misleading, what these heterogeneous healing modalities have commonly shared is a longstanding exclusion from officially authorized practices of state-sanctioned medicine. Traditional medicine as a category of knowledge and practice was forged under modernist epistemes through encounters among biomedicine, statecraft, international development, and global science (Langwick 2010: 232).

Scholars have considered the problematic issue of how to create commensurability between biomedical and traditional healing (Pigg 1997); the subordination of indigenous healing knowledge to structurally dominant paradigms through processes of rationalization based on biomedical or biologist logics (Janes 1999); and collusions among states, markets and scientific standards that marginalize popular healers even as their knowledges become important to the global economy of medicines (Adams 2002). Particularly in Mexico, anthropologists have also demonstrated how the idea of indigenous medical “traditions” serves as a political marker as much as a historical one (Ayora-Diaz 2000; Campos-Navarro 1997;
Freyermuth 1993; Menendez 1994; Modena 1990). Consequently, traditional medicine is entangled in contradictions and frictions that subvert any easy possibility for its integration.

This study provides another reading of institutionalized indigenous healing by focusing particularly on how indigenous healers come to embody “state effects” (Mitchell 1991). Assuming that the “state is not a thing, system, or subject, but a significantly unbounded terrain of powers and techniques” (Arextaga 2003:398), my research is inspired by work that shows how everyday life becomes a domain for the production and reproduction of the state idea (Chalfin 2010; Das and Poole 2004; Ferzacca 2002; Ferguson and Gupta 2002; Navaro-Yashin 2002; Petryna 2002). These effects can be mapped through the idea of governmentality, or the arrays of practices and discourses aimed at ordering and controlling bodies and populations (Balibar 1991; Foucault 1991). Governmentality meets and shapes subjectivities, those complex structures of thoughts, feelings, and reflections (Williams 1978), and in this way state forms can be understood to extend into everyday domains of life (Pizza et al 2009). Healers are thus never separate from state projects but instead are co-constituted together in their desires, discourses, and bodily practices.

In contemporary Mexico, these state forms are deeply influenced by neoliberalism. Neoliberalism is both an ideology and a practice in which the market and free trade are imagined to provide the best possible futures for people, the environment, and nation-states (Hayden 2003). Sherry Ortner describes neoliberalism as comprising two shifts, one which undermines previous safeguards for labor in its relation to capital, and

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17 Scholars have argued that the term traditional medicine circumscribes healers to a second-class status within biomedical hegemony.
another that fosters the idea that government has no place in regulating the economy nor sustaining social safety nets (Ortner 2011). Emphasizing the economic and ideological reaches of neoliberalism in lives today, Harvey’s tongue-in-cheek assertion that “we are all neoliberal now” posits the idea that the world over today is compelled to engage, internalize or otherwise negotiate intimately with the discourses and practices promoted by neoliberal ideology (2007).

Anthropologists have also demonstrated that neoliberalism is not monolithic, and nation-states as well as people continue to be able to exercise agency despite the constraints of the market-driven economies (Chalfin 2010; Mitchell 2004; Roitman 2004).¹⁸ In Latin America particularly, recent scholarship has elucidated the ways in which neoliberalism and multiculturalism have created particularly productive articulations (Hale 2006; Jung 2003; Overmeyer-Velazquez 2010). While previously thought of as antagonistic, or at least, uncanny bedmates, the overlapping timing of Mexico’s neoliberal turn and populist multiculturalism has produced unexpected results. After years of official repression of Indian difference, in the midst of Mexico’s neoliberal opening, in 1992 the government carried out a constitutional reform that for the first time declared the existence of indigenous peoples, guaranteeing respect for their customs as well as mandating the state’s obligation to protect this ethnic diversity (Tully 1995, Speed 2002, Van Cott 2000). Neoliberalism’s ideological emphasis on self-determination and the idea that indigenous peasants could pull themselves up by their

¹⁸ These offer a more nuanced and complicated understanding on the different lived landscapes of neoliberalism. For example, although Brenda Chalfin finds in her study of customs agents in Ghana that they come to embody a neoliberal assumption of “privileging things over persons” in ways that fit well with “the fundamental materialism of neoliberal ideology, she also finds that they are empowered by some neoliberal changes, and are able to effect changes in state sovereignty (2010).
bootstraps by developing enterprising habits dovetailed with the demands for self-determination of populist indigenous movements.\(^\text{19}\)

In order to map the “intimacy of state power” and neoliberal ideology (Pizza et al 2009), in this dissertation I explore the intersubjective engagements between hospital personnel and Nahua healers around the instantiation of traditional medicine as a state object of interest. Focusing on the embodiment of the political, I approach the relation between healers and hospital personnel as one in which they are both “hailed” (Althusser 1969: 41) by discourses on multiculturalism at the same time they are “invited” to become allies for public health.

This invitation is by no means without its terms in that state desires for a particular kind of healer and practice are shaping the kinds of allies and channels for legitimacy healers can call upon. It is also not without its contestations. The desire for a recuperation or performance of “tradition” opens up new agentive imaginaries, as well as new anxieties for healers as particularly situated state subjects. At the same time, the state ideology of multiculturalism has its own effect on state bureaucrats who must navigate state-endorsed projects with all the challenges and ambivalences accompanying their status as mestizo gatekeepers.

This dissertation suggests that nationalist discourses on multiculturalism, and neoliberal ideologies and practices are converging today to produce a particular ethnic variant of “traditional medicine” as an object of government intervention and production.

\(^{19}\) Multiculturalist state ideology formally recognizes language, jurisprudence, and other facets of cultural practice. Among these indigenous usos y costumbres (“uses and customs”) is medicina tradicional indigena (indigenous traditional medicine).
Focusing on a hospital in a region that has served over the last half century as a testing ground for indigenous policies, this dissertation explores the pitfalls and possibilities of institutionalizing indigenous healing practice in Mexico. I argue that the Traditional Medicine Clinic provides a particularly poignant site for reflecting on some of the issues at the heart of indigenous politics. Moreover, this study contends that the cultural politics emerging around indigenous medicine under neoliberal ideology can tell us about what questions for which traditional medicine is being posited as an answer.

**Back in the Clinic**

During almost two years of field research, Doña Ana and other healers in and outside of the institution provided clues to what it meant for an indigenous healer to be affiliated with a public hospital in 21st century Mexico. In fact, Doña Ana began to provide glimpses of these on the very first day. At the end of our appointment, she told me that besides me she had only seen one patient the entire day. Although she had been on call at the hospital since early that morning, ready to offer *medicina tradicional*, barely any patients had come seeking the assistance of a "traditional doctor." On many occasions later, I would sit with healers in the hallway of the clinic, waiting entire days for patients who never came. That there were few patients who actually sought treatment at the traditional clinic was an often-cited complaint of healers who worked there, and they would often express concern that patients would be looking for them at their homes while they were at the clinic. Indeed, as I would come to observe through my participant observation at the hospital, while the biomedical side of the hospital was overrun with patients, the traditional medicine clinic often seemed empty.

In fact, the only days I saw large numbers of "patients" within the traditional medicine clinic were on the days that groups of students or tourists had been invited
from the capital city to tour the premises and to receive "treatments" from the extra healers on call who had been instructed to join that day. These visitors were not the local people for whom the healers had been called to attend, but instead very cosmopolitan clients who could appreciate, at least aesthetically, the (exotic) experience of spiritual cleansings and stories about healers in the clinic. Domestic and international tourists arrived at the quaint mountain town celebrated for its natural beauty and cultural difference. Clinic administrators advertised the services offered by healers at local hotels and negotiated opportunities for healers to appear at festivals and archeological sites. Instead of serving local patients who were seeking their own culturally relevant forms of healing, the traditional medicine clinic was serving as a touristic resource for those seeking exotic otherness.

Extra-local forces are reconfiguring Mexico’s rural landscapes in ways that brought Doña Ana’s practice into new relationships with global capital, cosmopolitan Mexican publics and healthcare reform. Through healers’ affiliation with public health institutions, my study reveals that they are meeting with new challenges and anxieties as they navigate shifting expectations around their role as traditional healers and their own moral prerogatives around attending patients. I found that Nahua healers grappled with the idiosyncrasies and moral contradictions that accompanied a neoliberal paradigm of healthcare and state-sponsored multiculturalism.

Although portrayed in government media as a logical outcome of democratic politics, state responsibility, and multicultural inclusiveness, this dissertation suggests that the institutionalization of traditional medicine into public health comprises an important site of social, political, and ideological struggle. Drawing on the definition of
conjure as “to summon by or as if by invocation or incantation” and “to affect or effect by or as if by magic” (Merriam-Webster 2013), I argue that the traditional medicine clinic conjures up an official production of equitable relationships with indigenous healers "as if by magic." Asking what's at stake for indigenous healers who are recruited to partner with public healthcare, this dissertation studies the complicated ways in which healers---vis-à-vis state recognition and political performances of collaboration---participate in, and are in turn, “conjured up” through official productions of equity that shape how indigenous healing practices come to matter in contemporary Mexico. I argue that the desires and anxieties provoked in subjects inside a traditional medicine clinic demonstrate the tensions inherent in recognizing the brujo permitido (authorized witch) in an era neoliberal multiculturalism (Hale 2006), bringing with these a particular constellation of concerns and conflicted hopes about the role of indigenous healers in the nation-state.

Consequently, in the chapters that follow, I discuss how healers and their interlocutors inside of a traditional medicine clinic have come to embody the contradictions and conflicts of a state-endorsed neoliberal multiculturalism where the neoliberal moment has opened up a space for an unprecedented tolerance for, and mobilization of, cultural difference (Hale 2006). Through interviews with affiliated healers, and physicians, administrators and nurses, I trace the desires, hopes, frustrations, and anxieties of various actors who make the clinic happen on a daily basis. Chapter 2 describes my research process and my negotiation of relationships with state agents and indigenous healers; Chapter 3, “Mexican Statecraft and the Indian Question” offers an important background and context on the racialized violences that
are part of the history of the Mexican nation-state, sketching the historical context of
state power and indigenous people in Mexico; Chapter 4: “Antes No Había Medicina
Tradicional” (Before There Was No Traditional Medicine) details the story of the first
traditional healers’ organization and clinic in the region, narrated through the
perspective of healers who were involved; Chapter 5: “Administering Tradition: Mestizo
Anxieties and the Brujo Permitido” talks about the challenges that state bureaucrat and
physicians who interact with indigenous healers experience as they reconcile
longstanding ideas about Indians with more recent attempts to enlist indigenous healers
as allies for public health; Here, I draw upon Charles Hale’s concept of the indio
permitido, which describes how specific forms of Indian identity and practice are
recognized and celebrated under forms of state multiculturalism as long as they do not
threaten the status quo (Hale 2006); Chapter 6: “They are Eating Us: Moral Crisis and
Racial Belonging” explores how Nahua healers evaluate the moral and social horizons
they feel to be at stake in questions of healthcare through racial constructs; Finally,
Chapter 7 provides a window into how indigenous midwives negotiate the idea of
intercultural healthcare on the ground at the traditional medicine clinic.
Figure 1-1. The Sierra Norte. Photo courtesy of Jennifer Lynn Hale Gallardo.
CHAPTER 2
RESEARCH PROCESS

“Every Neighborhood has Traditional Medicine”

What I didn't expect when I arrived in Mexico City was that it would be more than a layover station en route to the Sierra Madre Oriental. Although during my preliminary visit to the Sierra Norte, the state-sponsored healer, Doña Ana, had found me well and paktok, when I returned to Mexico a year later, I was indisputably sick. While I had planned to depart immediately to make the journey to the small town that would be my field site in the mountainous, indigenous town near the Central Gulf Coast, by the night of my arrival I had fallen ill and was forced to take reprieve in one of Mexico City's urban neighborhoods.¹

The first urban healer who came to my aid was Marina, a 50 year old German woman who arrived in Mexico decades ago as a language teacher and over time carved out a life for herself within the ecologically and health-oriented urban subculture of Mexico City. A friend of a friend, she invited me to stay with her until I regained my strength, generously offering me her extra room where she sometimes treated clients with massage therapy. To survive as an alternative healer in Mexico's urban environment, Marina offered her services as a masseuse as well as taught aromatherapy, conducted workshops on feldenkrais, and sold healthy herbal tonics.

¹ The night before my flight to Mexico, I had called my best friend from high school to let him know of my impending trip only to find out that he was dead, his bereaved mother and sister explaining frenetically that he had been robbed of his young life in a tragic incident in South Florida. I would not make the connection between my despair at this news, however, and the chest congestion, diarrhea and burning fever that would turn into weeks of generalized fatigue, depression and mental haze until multiple urban healers in Mexico City helped me make sense of my symptoms and sentiments.
made from tropical berries.\textsuperscript{2} Generously encouraging me to rest and recover in her home, Marina gave me a refuge in the midst of the busy commotion of Mexico city during what turned out to be an almost two month period of recuperation.

Never guessing that my research would commence with an extended stay at the home of a cosmopolitan healing practitioner, I soon realized that Marina's apartment in a trendy urban neighborhood in Mexico City was at the center of an extended and vibrant urban alternative health community. Through Marina, I soon met various healers, and, unbeknownst to me, in the midst of an impending departure to more faraway places to study the official institutionalization of traditional medicine. It would be within this network of urban healers that I would glimpse the wider context for forces shaping rural medicine in a multicultural state. My immersion in this urban subculture of medicine foreshadowed what I would soon find on the rural mountainside: seemingly remote local healing traditions in Mexico have become inextricability bound to more cosmopolitan ideas that circulate in the name of alternative medicine.

Thus, before I left Mexico City, I had been drawn into a transcultural world of cosmopolitan healing traditions including aromatherapy, floral essences, homeopathic medicine, acupuncture, sweat baths, tinctures, therapeutic massages, spiritual mediums, tarot-card reading psychics, and \textit{Mexica} sweat lodge ceremonialists. A plethora of forms of medical pluralism and healing “traditions” were everywhere evident, to such an extent I began to question the relevance and role of indigenous traditional medicine within Mexico’s diversity of healing modalities. In fact, one day when I was

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\textsuperscript{2} Later I found out that Marina felt a certain kinship with me, having in years prior attempted a master’s program at the same school where I was a visiting scholar in CIESAS (Centro de Investigacion y Estudios Superiores en Antropologia Social). She had apprenticed with a rural indigenous \textit{sobadora} (a popular or empirical therapeutic masseuse), and in her interest in my research I sensed nostalgia for her own research study that was never completed.
}
discussing my proposed research project, an acupuncturist from Mexico City, who considered himself a “traditional healer” in his own right, had objected to the topic, saying “¡Aquí (en Mexico) cada colonia tiene su medicina tradicional!”—“Here every neighborhood has its own traditional medicine!”

The acupuncturist, of course, was right. The reality of Mexico’s therapeutic diversity immediately disintegrated any assumption that would posit one group of medical practitioners, indigenous or otherwise, as having sole claim to Mexico’s patrimony of traditional medicines. Traditional healers abounded on every corner of the city. Figuring out the contours of what made medicine traditional in Mexico during 21st century forms of state multiculturalism would turn into a question haunting me throughout my research.

Finding the Traditional Medicine Clinic

The first time I went looking for the traditional medicine clinic, I asked the security guard in uniform standing at the front gate if he could direct me. With an inquisitive smile, he pointed to the back of the hospital and then opened the large metal gates for me to enter. At the other end of the public hospital was the clinic, a sort of vestibule situated to the back just beyond the ambulance and kitchen. Making my way past the kitchen, the industrial-sized water containers, and the ambulance parking area, where the Virgin of Guadalupe sat silently high up in her niche on one side of the grease-stained lot, I found the clinic situated next to the laundry room at the back of the hospital. A small sign over a doorway marked the clinic: Medicina Tradicional.

The steps led up to a long narrow foyer that was enterable only by passing the door of a room, a room that in later months—during a whirlwind of Ministry of Health bureaucratizing initiative—would come to be labeled on a government office sign: ‘The
Office’. Inside the coordinator for the traditional medicine clinic sat at her desk talking on the phone while a male bilingual assistant typed into the computer at another desk. Dressed in a white lab coat, high heels and her gold crucifix around her neck, something striking in the region’s socio-economic context, Lupita was a middle-aged economist by training who was known to be from a well-off mestizo family; she had only recently been transferred from another clinic in another indigenous town where she held a similar position before being replaced by a Mexican anthropologist. A serious businesswoman who knew how to market the medicinal products as well as the clinic, she worked hard to manage the internal workings of the clinic at the same she promoted the work of the clinic’s traditional doctors to the public.

Greeting me with the formal cordiality that typifies bureaucratic professionalism in Mexican institutional culture, Lupita closely examined the letter I brought from the clinic’s supervisors in Puebla at the Secretariat of Health. After verifying the official request that I be permitted to see the clinic, she quickly directed me to her assistant, one of the two local bilingual Nahua-Spanish speakers working with the coordinator, who are translators formally assigned to assist with the hospital’s large population of Nahua speakers but who spend most of the time doing paperwork in the office (or taking visitors on tours of the clinic).

Moments later, I was whisked through the different spaces that pertained to the clinic, all empty but somehow signaling the material reality of ‘traditional medicine’: a temazcal (sweat lodge), a birthing room outfitted with a special stage and holding bar so indigenous women can give birth in the traditional vertical position, a consultation room featuring an altar space with its saints quietly presiding, a laboratory/kitchen with
various pots and scales and stacks of bags upon bags of dried herbs, a large
cconference room just as empty as all the other spaces, and a sparsely planted and
largely abandoned plot of medicinal plants at the center of the hospital. All of these rooms I am presented as “the traditional medicine clinic” contrasted in
their silence with what seems in practice to be the real center of activity for the
traditional medicine clinic: a space that simultaneously served as the greeting area,
archival database, pharmacy of medicinal products for sale, and a gate keeping place
from which one can observe the comings and goings into and out of the clinic, including
the arrival of patients who are required to register with their name, birth date and
township before they are attended by a healer. It is also within the office that all healers
made known their presence when they come to fulfill their on-call duties, as well as
receive any special orders of the day, for instance, instructions to make a certain
remedy.

At the same time, the Office served in practical terms as the place where
traditional medicine “interrelated” with the different medical and nursing staff of the
hospital3, including physicians who often came for casual chats with the coordinator, or
the head nurse who might be involved in the transfer of a patient (almost invariably from
traditional medicine to the hospital), or the director of the hospital who might touch base
regarding an upcoming visit by hospital supervisors from Puebla.

But all of these things were not part of the tour, which remained confined to the
empty spaces that serve to mark the traditional medicine clinic. After this hurried tour
through the physical installations of the clinic, my guide took me on to meet the director

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3 The gardens had been moved to a gated field just outside the limits of the city.
of the hospital who is in the main building. Leaving the clinic and entering through a side corridor, I was taken into the main hospital, which bustled with activity in stark contrast to the traditional medicine module. Here, there are a cacophony of sounds and sights, of voices over the loudspeaker calling out names, of people in rooms spilling out into the hallways and of even more people standing in long lines that billow out around corners.

Voices called out over a loudspeaker paging from patients to hospital personnel, people sat in chairs lined up and down the hallways, others stood in different lines overflowing out of the corridors. In fact, Nahua patients overflowed the space as women stood chatting, babies nursed, little children leaned up against their grandmothers, old men dressed in tattered clothing look on tiredly, and younger men sharply dressed in contemporary western clothing accompanied their young wives wearing elaborate Nahua kweyits and huipils on the special occasion of their new babies’ vaccinations. These patients were those who had been fortunate enough to arrive early enough to receive a turn, before the limited numbers of turns that day had been exhausted and many others had been turned away.

My presentation to the director of the hospital, a tall blonde woman in a doctor’s coat wearing the same kind of cosmopolitan clothing and cosmetics as the coordinator of the traditional medicine clinic, is brief and again courteous. Back in the clinic, the coordinator invited me to sit as she briefed me on what she saw as an unfortunate degeneration of healers into profit-seekers. Talking to me with an air of almost instantaneous solidarity, she explained with discernible disappointment that medicos tradicionales “must be encouraged to cooperate as a group and share the money that comes in, especially from tourists”. However, this would be the last time Lupita would
candidly share her thoughts about the healers, a *confianza* (trust) that was quickly abandoned the following year when I returned for an extended period of fieldwork under the auspices of a new Ministry of Health administration. It would also be the last time I was invited to linger in the office, the hub of activity it was for traditional medicine, for any extended period of time. Instead, I would, like healers, be relegated to the outskirts of the actual organizational activities of the project, and, along with them, search for signs and evidence that would reveal the dynamics shaping their experience as healers in the hospital.

**Data Collection**

My primary data for this research was gathered during a two-year period in the Sierra Norte of Puebla, with lesser amounts of time in Puebla City and Mexico City. During preliminary research in June-July 2004, I sought out prominent medical anthropologists from *Universidad Nacional Autónoma de México* (UNAM) (Roberto Navarro-Campos), *Centro de Investigaciones y Estudios Superiores en Antropología Social* (CIESAS) (Maria Morena, Sergio Lerin, Jaime Pliego Page), and *Instituto Mexicano de Medicinas Tradicionales Tlahuilli, A.C* (Mario Rojas), as well as visited the Department of Traditional Medicine and Intercultural Development in the Ministry of Health, and the coordinators for the Direction for Traditional Medicine in Puebla’s Ministry of Health.

During this preliminary fieldwork, I also participated in the two-week long traditional medicine course given by the Institution of Mexican Social Security (IMSS) for biomedical physicians in Mexico City, and had the opportunity to observe a day-long cultural sensitivity workshop on “intercultural medicine” given by state-employed anthropologists for rural biomedical physicians in Chiapas. Finally, I also visited two
mixed integral hospitals with traditional medicine in the state of Puebla and gained authorization from administrators at the Ministry of Health in Puebla to conduct a research project at a hospital at the forefront of efforts to provide traditional medicine alongside biomedical services.

Returning to Florida, I wrote a proposal for a research project focusing on the incorporation of traditional Nahua healers into public healthcare and to examine how they negotiated the tensions and contradictions that emerge as part of their more recent inclusion into state projects of traditional medicine. I was awarded a Wenner-Gren Dissertation Fieldwork Grant as well as an American Philosophical Society Lewis and Clark Fieldwork Grant for this research, and between September 2005 and July of 2007, I completed almost two years of fieldwork in the Sierra Norte of Puebla, Mexico. My primary site was the “traditional medicine clinic” of the rural hospital. My first 3 months comprised studying the local form of Nahuatl (Nahuat or macehualtajtol) intensively and developing initial rapport with the tapajtianij (“those who cure” in Nahuat) who were affiliated with the public hospital. Over the remaining 15 months, I collected extensive ethnographic data. I conducted in-depth participant observation at the hospital’s traditional medicine clinic and extensively interviewed Nahua healers and their patients in the hospital and at their homes.

I interviewed hospital personnel at all levels, including supervisors, directors, physicians and staff, as well as project administrators at the hospital and in the Ministry of Health. Eventually I came to access other sites in the vicinity where I could examine parallel processes involved in developing traditional medicine institutionally, including that of an independent traditional medicine organization allied with the Secretary of
Tourism, independent clinics run by traditional indigenous healers, an independent indigenous women’s cooperative hotel that sold herbal remedies, and a local IMSS clinic with a long history of working with midwives. During my research, I talked to dozens of healers who were affiliated with the institution and not, but I worked most closely with 10 at the traditional medicine clinic (4 midwives, 3 bonesetters, and 3 herbalists), accompanying them to their homes and their patients’ homes, as well as conducting participant observation while on-call at the hospital. I photographed and videotaped healers discussing and enacting their practice, and recorded extensive research notes on observed interactions among healers, patients, doctors, and community members. I also interviewed other healers, including healers unaffiliated with the hospital who helped me contextualize the landscape of traditional healing in the region in terms of identity, expertise, and social networks.

**Brujas and Bureaucracies: Negotiating “the Field”**

I entered the world of *tapajtiani* (indigenous healers), hospital personnel, administrators and Mexican anthropologists, understanding from the outset that my project would have to accommodate itself to the possibilities of my relationship to the subjects and phenomena, and would necessarily be facilitated and constrained by these relationships as well as my positioning as a subject. I assumed that my cross-cultural and class sensibilities from being raised in a working class neighborhood in Miami, one generation removed from rural life in both Cuba and Tennessee would help me feel at home among rural people and it did. I realized that this view from somewhere, or “situated knowledge”, necessitated some reflection about where I was standing and how this location would ultimately shape what I was able “to know” (Haraway 1988). In this
section, I discuss how my personal biography, in many ways, facilitated my fieldwork, as well as the moments when it did not.

I assumed my familiarity with not only biomedicine but also with the herbal medicines, prayers and spiritually-based healing rituals that had been part of my Cuban upbringing in Miami would help me feel a level of ease with medical pluralism, and it did. My visits to the homes of family members in Tennessee, sometimes with no or little running water or public amenities, prepared me for feeling comfortable in the starkness that can be rural life. However, rural contexts for me were much more than just to be associated with impoverishment or a lack of material possessions. On the walks we took through the hills and hollers of Tennessee with my father, I also took note of the rich relationships shared by the people there, the camaraderie, and the relations of reciprocity that binded community members and extended family members together in that mountain space. I also took note of another way to exist outside of such commercially-dominated spaces, watching at times while my dad joined my uncles as they “widdled” the day away on the front porch with piles of curled woodcarvings at their feet growing as tangled and large as the stories shared.

My visits with family in Cuba also revealed to me an aspect to rural life and country living I had not predicted before, where living in a rural context was not a detriment but instead provided access to land and animals for one’s own subsistence. Thus I would find my rurally-located family was at an advantage over other members of the family who lived in more dilapidated urban environments, thus providing an interesting inversion of the kind of poverty typically associated with rurality.
Moreover, the stories I had grown up hearing from my paternal grandmother Freda Ruth, whose family had survived in the Appalachians for generations as sharecroppers and laborers, had shown me the dignity of hardworking poor folk. Hearing about how her family strove to keep her healthy in the deep Appalachians with no doctors but plenty of local Native American herbal traditions as well as arguably less salutary remedies based on a “spoonful of kerosene and sugar” opened my eyes to medical pluralism from early on. At home in Miami, I also learned from my maternal Cuban grandmother’s remedios (home remedies), which, depending on the illness, combined Catholic invocations with syncretic healing rituals, plants and prayers and many daily herbal teas.

What I did not expect during my fieldwork was the kind of institutional illiteracy I would experience attempting to undertake a project inside of the health sector, as well as the academic illegitimacy I would encounter in attempting to bridge my own academic formation with that of Mexican social scientists. I also did not foresee my own premeditated rejection of the status symbols that mark a more cosmopolitan subject in Mexico would also create distance between me and my bureaucratic interlocutors. And, very naively in retrospect, I also did not expect that my own identity as a Latina in the U.S. would be completely and hopelessly forfeited in Mexico, while the very problematic politics between the U.S. and Mexico—which I had long defined myself as critical of — would be projected onto my person in innumerable small and something demoralizing ways.

My presence in Mexico was received under very ambivalent sentiments and circumstances. I went overnight from being a Latina and sympathizer of immigrant and
cultural rights in Mexico to being a *gringa* anthropologist in Mexico, with all the hopes and pitfalls that this category brought with it. As an anthropologist now defined by her relationship to the U.S., I inspired both hopes (and sometimes fears) in indigenous healers, *mestizo* hospital personnel, and Mexican anthropologist colleagues alike, as each attempted to ally me to, or divert me away from, their own causes. This meant that for some, I was a person with access to symbolic or real capital that could hopefully effect changes they hoped to see. Healers and perhaps some anthropologists shared a similar desire: that I help bring them more recognition for the work that they do. For some Ministry of Health state bureaucrats, I was someone who might be able to investigate the “truth” about what was happening in the name of traditional medicine at the clinic. While for clinic administrators, I was a meddling foreigner who had come to the wrong place at the wrong time, a time when the traditional medicine clinic was being celebrated in the news again and rising in fame, and at a time when there could be too much too lose to risk an outsider poking around. Underestimating at first what it meant to be a *gringa* anthropologist in a Mexico caught in the grasp of interlocking postcolonial politics, my identity was interpreted through the gridlock of history, and the fantasy of who I was as a person became a screen for different desires emerging from subjects positioned differently socio-economically, and with different things at stake. I would find throughout my fieldwork that I was being marshaled at every turn to build alliances and exclude others, alliances that would inevitably inform the places I was able to access and the data I was able to collect.

**Academic Alliances in Mexico**

For my Mexican colleagues, I represented a graduate student of anthropology from the academic hegemony that is U.S. anthropology. I also represented a kind of
menace, not so much to their person or their careers, but to an ethic of reciprocity and respect in the face of “North Americans who always come, take what they want, and go home” (personal communication, 2005). Academics in Mexico were well versed in the way exchanges between the U.S. and Mexico are most often characterized by uneven flows: where theories generated in U.S. academies (obtaining the scientific authority of “universals”, circulate deeper into Mexico (and very rarely vice versa) while at the same time, Mexico becomes literally, “the field”, the source of raw data for U.S. for anthropologists to mine in the manufacture of their own theories. Conscious of this unequal relationship, I felt it was my ethical imperative to find interlocutors in Mexico with whom to engage in what I hoped would be a mutually enhancing and productive, reciprocal relationship.

However, my search for this kind of relationship proved difficult despite the fact that I had several potential colleagues who were all generously interested in mentoring me. The first I met in a course that I was permitted to observe which was being given to physicians through IMSS as part of a cross-cultural immersion in Mexico’s indigenous tradition. The very accomplished medical anthropologist who was in charge of it was well published in the field of traditional medicine and its institutionalization. I had picked up on a Mexican nationalist sentiment throughout the course, as a reoccurring theme was how Mexico has resisted U.S. imperialism in terms of plant resources and biodiversity, successfully and unsuccessfully over the years, and I think that the fact that I was coming from the United States made it especially problematic for him to be my mentor. From the outset, he was very intent on becoming the chair of my dissertation
committee, and would not accept the idea of even being a co-chair\(^4\) and thus preferred to let me go as a mentee. However, I look forward to working with him in the future, and his wife was very generous with me in her invitations to get to know the urban indigenous movements in Mexico City.

The second in-country mentor who I had the opportunity of meeting and befriending the person who I have continued most in contact with to this date, is Dr. Roberto Melville. A very talented anthropologist from Guatemala, he, in what has been a very infrequent change of roles, had conducted research in the U.S. We often met at CIESAS (Centro Investigacion y Estudios en Antropologia Social) where he helped me become a visiting student, and spent long hours conversing and sharing astute commentaries about world politics. He was a constant source of inspiration as well as mentorship; he however, seemed not to have too much credence in indigenous healing practices or interest necessarily in the politics of these practices, and although he listened very politely to my experiences in the field and my own experiences with non-biomedical healing traditions, I perceived that my subject matter was not necessarily his interest; he has nonetheless graciously served informally on and off as a mentor over the last several years.

Through Dr. Roberto Melville I met another distinguished medical anthropologist, Dr. Sergio Lerin who had experience working within the hierarchies of the public health sector and who opened the doors to me for a number of conference opportunities as well as attempted to provide me recommendation letters through colleagues who worked in indigenous health in the health sector in order to facilitate my study. His

\(^4\) He said to me that “this is why a body does not have two heads” in an anatomically-alliterating argument about why he could not be co-chair on my committee.
specialty was psychological illnesses and found my extended fieldwork in the Sierra Norte of Puebla interesting, especially when it overlapped with his work around alcoholism and intercultural health in indigenous contexts. He encouraged me to generate an “intercultural epidemiology” that would construct equivalencies between symptoms from indigenous folk sickness repertoires with what were imagined to be commensurable diseases in biomedical language. However, this kind of research would have been very difficult to do in the context of my study site in which patients were not necessarily (or rarely if ever) being diagnosed simultaneously or even consecutively by biomedical and traditional doctors. Furthermore, I was more interested in that moment in how indigenous healers and their patients were living out the effects of these larger policies on institutionalizing “tradition”.

Meeting the Healers

Like Mexican anthropologists, the healers in the Sierra Norte I met were also very interested in interacting and exchanging ideas with me. They largely accepted my ambiguous status in their lives, as someone who had come from afar to spend time with them for reasons they did not quite understand, but who seemed to “believe” in their medicine, even requesting consultations as a patient, and someone who seemed genuinely interested in participating in their everyday lives: attending their baptisms, funerals, feasts and other special occasions, and generally making the long trek out to

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5 My intimate exposure to the sickness and suffering of others helped sensitize me to the phenomenological aspects of illness. As the daughter of a mother who somaticized the psychic pain of ruptured ties to her homeland and to her exile in the U.S., I became intimately familiar with the worlds of illness at a very young age. Growing up in the context of my mother’s chronic illness, sickness had become a very palpable and tangible reality for me. Through the experience of her illness, I had learned to be a witness to the suffering of other’s without becoming overwhelmed by the emotional content of that suffering, and in the field, this translated into being able to be physically and emotionally present for sickness and traumatic loss. Furthermore, through my mother’s extended illness, I had become a lay student of herbal and alternative healing. In my quest for healing modalities that could help heal her, I had informally been a student of herbs, homeopathy, aromatherapy, meditation, and massage.
their villages to visit them at their homes. My learning of a very basic Nahuat, however imperfect, greatly facilitated an affinity with especially the older healers at the hospital as they favorably responded to what they had seen in very few Mexican functionaries in their history: a willingness to engage them respectfully as macehual. In the context of a very strong climate of racism against indigeneity or indio-ness in the Sierra, it was well known that even those from those environs who grew up speaking Nahuat and now worked at the hospital as nurses or aids were reticent to speak it. In fact, I had met young Nahua mothers, who had obviously heavily invested in local Nahua fashion (which often amounts to expensive materials and embroidery, one outfit easily costing 100-200 US dollars or more), who told me that they would not be teaching their child Nahua at all. In this context, it was thus all the more significant for healers to witness my eagerness in having them teach me their language, and the fact that I was willing to speak it publically signaled for them a desire to relate in a relationship of solidarity.

Not dissimilar from anthropologists, healers were others who had certain expectations for me. Even after I explained the purpose of my visit—I was conducting a study to understand their experience as healers affiliated to the institution, and the extent to which their roles, practices, and functions had persisted and/or changed in the face of renewed interest by the state in their medicine—there were still many hopes, and in some cases fears, that fell outside of my research prospectus. For example, I overheard that some feared I was just another person who had come to take their herbal knowledge (which is why I purposefully avoided direct questions and inquiries about the specificity of plants), and another told me that they had been told by a mestizo supervisor to “watch out” or else their remedies could be wind up being sold in the U.S.
without their benefit; others however didn’t mind that I learn from their practices necessarily just as long as I was willing to give them credit for it if I ever published a book.

Many hoped that I had indeed come in solidarity with them, and several openly hoped that I had come there especially to rival and supplant the director of the clinic who they felt ordered them around; if not this, they hoped that I was at least there to look out for them and their interests. Still other healers imagined that I was there to learn what they did so that I could become a traditional doctor, which some healers encouraged while others felt threatened by. A few, I came to realize, were hesitant to talk to me, afraid that I would uncover their status as new adepts in “traditional medicine”. Many healers, like many other people I would encounter during the process of fieldwork, felt they had something to be gained and something to be lost in allying with me. A few however mostly younger healers who were closer to my age seemed to already know the drill well, and did not seem to hold very big expectations for my time there.⁶

Being entrusted with their friendship however, I tried my best to reciprocate their kindnesses in whatever way was doable; I also tried to make myself feel more useful and less like a chismosa (gossip), a term that I had heard was used locally to describe the work that anthropologists do (listen to gossip or lies). To help, when I could, I wrote their patients’ names in their notebooks where they were supposed to log all healing activities (an obligation that was often a stressor for illiterate healers who were always in need of this help, especially when their patients were illiterate as well). For a young

⁶ One expressed it in these terms: “We’ve seen many anthropologists come for a few months and go. Many.”
midwife, I helped her review and edit her application for a grant that would have provided her monies to help open her own midwifery training school. For another older midwife, I helped with patients at her house for days on end and sometimes provided support during the labor. For other healers, I introduced them to cheap and nutritional sources that were locally available. And for a younger healer who was deciding to cross the border into the U.S. illegally, I taught him how to use the internet so that he could investigate the dangerous implications of this decision and inform himself on the harsh realities he could face.

For a curandero, I assisted in his teaching of workshops on herbal medicine at a high school and remedios caseros (domestic medicine) for groups of mothers at a community center and helped him give a course in aromatherapy to a group of Totonaco healers at another hospital. While I had expected to learn from healers themselves, I was surprised at how interested they were in learning from me. In one unexpected turn of events, I was invited by the healer Don Placido to give an aromatherapy workshop to a group of several dozen Totonaca healers at another hospital as part his larger presentation on healing and its connection to spirituality and the vital energy of plants. Never expecting to be asked to share knowledge about commodified forms of medicine with indigenous healers, it was then I realized that my introduction to the highly cosmopolitan world of healing in Mexico City was not idiosyncratic; it was in fact part of a lengua franca of forms of alternative healing in Mexico that had in their global circulation become hegemonic, inserting itself into even

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7 For example, water kephir or tibikos.
programs that were ostensibly directed toward developing “indigenous medicine”
healing in the countrysides.

At the same time, I was involved in many of the female gendered tasks involved in
the reproduction of daily life: helping to collect firewood, making tortillas in their
kitchens, cleaning chickens for feast days, and generally sharing food and friendship.
The healers appreciated my down-to-earth sensibilities, finding pleasure in my simplicity
and ability to accommodate myself to the austerity of their lives. This helped to generate
rapport between us, opened up topics of conversation and exchange, and it also meant
that I had the opportunity to get to know their daily existence in a way that many other
Mexican professionals who worked in the area had not. I visited healers’ homes in
remote villages off the beaten path, sat and ate with them simple meals of beans and
tortillas, helped make tortillas over open flames and when I stayed in the rancherias
(dispersed hamlets); I slept alongside the family on their floor mats or wooden planks.
Living in a small apartment rented to me by one member of the hospital personnel on
the outskirts of the main town just above the hospital, my home was also a stopping
post for healers who came by to visit or to rest when I wasn’t spending the day at the
hospital, or riding public transport to their homes, and/or out staying the night at the
houses of hospital affiliated healers.

My interrelations with the lives of healers did not erase the privilege that my rural
counterparts lucidly perceived, and at times, obliged me to acknowledge. On multiple
occasions healers used our rapport as an opportunity to talk about our political-
economic distance and offer a social critique. For example, female Nahua healers
would not let me forget the privilege of my education, which was withheld from many of
them, obligated as they were to work for their families or get married at a young age without having completed primary school. Older generations of female healers, who were illiterate, would often take a moment in our conversations to point out that they had not been afforded the same opportunity to study as I had because of families that compelled them to quit school and labor on the farm or into teenage marriages. Nor would the male healers who hadn’t had the opportunity for at least some or even substantial formal schooling allow me to forget the socioeconomic and political differences that separated us. For instance, they often pointed out that while I was able to visit them in their homesteads, they would never be able to visit me for both economic and political reasons, unless they risked their lives trying to cross the border between Mexico and the United States.

While I was present during many healers’ interactions with their patients, what I was able to actually perceive of their practices, even watching them directly at work on a patient, is arguable; healers had their own subtle ways of negotiating my presence, even when I may not have been completely aware. That there were limits to what an anthropologist would be allowed to know about a healer was also underscored to me by one translator at the hospital who recounted of the way he had served as interpreter for a highly esteemed anthropologist who had written a book for the Ministry of Health on the practices of healers. As he explained, while interpreting for her, the healers told him about what he was permitted to translate or not to translate. And in what I took as a

8 I saw this most vividly through the experience of another anthropology student from UNAM who had arrived to do fieldwork on a similar topic. I invited him to go with me to an interview of a very well known healer who was known as the only clairvoyant affiliated with the hospital and he, using a very different protocol than I did, commenced with a barrage of questions for the healer. At several points, the healer chose to redirect his questions entirely, a maneuver that seemed all the more obvious to me as an external viewer, especially when it came down to asking about items on his altar (such as the headless saint that stood there).
gesture of granting me insider-status as well as keeping me humble, he proceeded to warn me of the same: “just know there are some things that the healers will never tell you” (personal communication, 2007). While this could have been a frustrating experience if my project had been about collecting information on the esoteric nuances of healing, this was very purposefully but not my project’s intent.

Consequently, although healers did not seem to have as much at stake in talking to and sharing their everyday lives with me as some of the institutional actors that I will later discuss, they had also found ways from time to time to let me know when they felt that I had surpassed a limit. For instance, one particular healer who worked in the institution, but who was not necessarily recognized as a healer in her community, used her own clout in the institution to stop me from video recording the entire group at work while they were making remedies in the clinic. By instructing a translator to tell me to stop when at first I didn’t understand her, the recording was abruptly stopped without an explanation, and it was clear that she felt comfortable enough within the institution to protect her own sphere of work. And at other times, when I was negotiating my role as participant observation with another healer, I was dissuaded from my desire to witness his actual healing performance with patients through the explanation that there would be little to learn from documenting his actual practices because “no two healers heal alike” (Placido, personal communication).

Healers best hopes and expectations for me as someone who could “help them” during my time there turned out to be coincident with the timing of policy changes that seemed in some instances to be in their favor. For example, shortly after some lengthy

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9 It has been more interesting for me to think about what this kind of utterance served.
interviews with midwives, who had been telling they felt they deserved more help and compensation for their work, the Ministry of Health promised substantial increases in what they were paid in order to bring in patients to the clinic. Visits from government officials to the traditional doctors’ organization also increased during the time I was conducting fieldwork, and new promises were made to further help the organization.

Engaging the Hospital Personnel

The healers were not alone in entertaining hopes and fears about my presence in the hospital. The coordinators of the clinic, some physicians, the directors of the hospital and the directors of the project at the state level in Puebla (both which changed multiple times while I was there), also had hopes and fears about hosting an anthropologist. My first encounter with the Ministry of Health in Puebla was a very amicable one; the director and co-director demonstrating genuine interest in my proposed research, and welcoming my research project which proposed to document the experience of healers and patients in the clinic and analyze the on-the-ground implications of the recent Ministry of Health policy. With a letter from them in Puebla, the coordinators and bilingual assistants too accepted this project during the phases of my preliminary research, albeit in retrospect with more reserve.

But when I returned the following year after winning funds to carry out the project, the leadership in the Ministry of Health had changed, and so had the climate for a visiting anthropologist in the clinic. My access, which the previous leadership had formerly granted me, was now compromised by these changes. What ensued was an extended deployment of tactics of resistance to my presence at the clinic. For some actors who were comfortably positioned in the hospital but under contracts that had to be renewed yearly, I presented a potential threat as someone who could be too much of
a witness to the daily operations of the much-celebrated clinic. While I naively believed that I could create a project with the clinic collaboratively that could be of use to both the clinic, and to my research, those who ran the clinic had other priorities, which above all, meant making sure I was not going to interfere with the public relations for such a high profile unit. Consequently, the clinic administrators used all the gate keeping strategies that they could to keep me at bay.

While at the very beginning, the assistants to the clinic had accepted and encouraged my willingness to partake in the day-to-day activities of the unit, soon after these possibilities became fewer. At first, I collected signatures from healers who had arrived for their guardia (or thumbprints as it were), helped to label bottles of remedies for the pharmacy, learned to produce capsules of herbs, and sat in on administrative reunions with the healers. In the earliest days, one of the assistants had even taken me on an official visit to the regional pharmacies in the vicinity where I first met several of the affiliated healers. But increasingly in the first months, this kind of participation was discouraged, presumably by the coordinator in charge, and the bilingual translators quickly began to turn more distant and more apprehensive with me.

Under this mounting tension, I continued to seek out authorization for my research study at the clinic. While my first letter of introduction from the Ministry of Health was no longer being granted validity due to the change in command, the coordinator who was evasive with the information about who necessarily had the authorization to grant me permission requested more approvals. My in-country mentor from CIESAS, Sergio Lerin, was able to negotiate a letter for me from Enrique Rios at the federal level, who had previously worked in the area of indigenous nutrition in relationship with the
hospital. But because of decentralization of the healthcare sector, this letter was dismissed as insignificant. When the Ministry of Health officials from Puebla came into town to visit the clinic, the coordinator sent her assistant to tell me that “today the coordinator asks that you not be here because we are going to have a reunion with those from higher up”, thus averting my direct communication with these higher echelons of the Ministry of Health.

My once-authorized yet now-unauthorized status put me in an especially ambiguous position in the hospital. This meant that when healers would invite me into their consultations with patients, or midwives would ask me to be present for a birth, even if patients offered their consent the coordinator could send her assistants requesting very diplomatically that I leave the room, citing stipulations about the privacy of patients and the lack of authorization of my study. At other moments, the coordinator would ask her assistants to call me to her, saying that she needed my proposal yet again, this time to ostensibly present it to another person within the Ministry of Health for approval. At one moment I considered moving my research site to another hospital, but the connections and solidarities that I had already made with healers, who had welcomed me into their homes and into their lives, inspired me to persist.

After a period of time, things stabilized somewhat in the clinic, and I had been present on many long mornings and afternoons with healers while they were waiting for patients to arrive. This changed on the day that I came to introduce an undergraduate student, Natalie, who had volunteered to be my field assistant. After bringing her to the clinic, I was informed that there were yet again more changes in the policy surrounding investigations and that my permission to be in the clinic would be suspended until this
newer protocol is successfully fulfilled (its content would never be specified to me). Seeing that nothing was coming of my intents for re-authorization through the clinic, on several occasions I took it upon myself to make the 8 hour round trip south to the headquarters in Puebla. However, I was never able to see the director (apparently the secretary knew enough from the coordinator of the unit to turn me away), and the day that I finally did meet her in her office (through the help of another anthropologist from Puebla who had an appointment with her), the Director acted disinterested in my project.

Much to the surprise of the healers, administrators treated me as marginally in the clinic as healers many times felt themselves to be. If I passed by the office, I was reminded that the healers “were in the back”. I was permitted to interact with the healers, but there was an unspoken agreement that I would not ask the administration any questions. At other times I was told by the translators that I had “enemies” at the clinic, and on one occasion, shown the santa muerte “santa de la muerta” which purportedly belonged to the administrator in hopes of intimidating me. On other occasions, the coordinator herself would talk about her sangre negra (black blood), as a way to say that she herself was immune to witchcraft. The healers themselves offered me their share of limpias and healing protections for me to cleanse away and withstand what they saw as the negativity and “envy” being directed at me, something that they were sure was due to my solidarity and allegiances to them, or because I was a “reporter” who had come to write down what the institution was doing.

All of this translated into a long struggle for me to conduct my research and gain access to the institution incorporating these healers. That is, until the day that one
physician at the hospital decided that an anthropologist in the hospital could be very useful, especially in light of the project’s mandate that hospital-based investigations take place. While it was obvious that the coordinator did not feel it in her interest that I be there, especially being, as I found out later, that the healers themselves had banded together previously to have her removed from her position, other personnel, and even the director of the hospital, who had much less at stake than her, were interested in exploring what anthropology might be able to contribute to their institution.

When it was finally agreed that the hospital could in fact use a researcher, we conversed about the possibilities of a research study based on the research interests they had. After so many challenges around my presence at the hospital, I was thankful to have an official role (which, like the healers ironically, entitled me to two meals a day) and thankful for easier access to the healers. The politics of officially positioning myself within the institution however also meant my acquiescence in some sense to my own appropriation, and after I left the field, this document came to form the basis for a proposal that won the hospital a very prestigious national prize awarded by the President of Mexico. Not surprisingly, this appropriation did not end here, but continued when I found online the exact language that I had used in my original proposal now being circulated all over the news which pronounced intercultural relations in the health sector not as a question to investigate, but a fact achieved by the clinic.

Positioning as a Gringa Sympathizer

While I had been especially critical myself of the kinds of interlocking colonialisms that sutured Mexico together with the U.S., and had gone to Mexico mindful of these, I was not prepared for the kind of personal affronts that these politics would displace onto my person as I came to represent to the unit administrators the meddling and intrusive
“gringa” and “foreigner” that I had formerly critiqued the U.S. of being. This was a very different experience from Stacy Pigg who talks about being an ethnographer studying traditional healing in her article “The Credible and the Credulous” (Pigg 1996). Where in her case, people were mostly curious about her own interest in indigenous healing; I instead encountered a certain jealousy and suspicion surrounding my interest in indigenous tradition. For instance, this difference from Pigg’s experience is tangible in the statement that one of the assistants’ rhetorically put to a visiting colleague of mine on his first (and only) visit to the clinic, when the assistant asked flippantly: “Don’t you have the same kinds of traditional medicine projects in your country?”

My identity in my field site was also something that was often encapsulated sarcastically by my mestizo landlord and an employee of the hospital, who did not see indigenous people in a particularly positive light, but who would introduce me and my research to Nahua people by saying: “This foreigner is here to steal the knowledge of our indigenous people and take it away with her to the United States.” While he was in all respects saying this in a joking manner, his language calls to mind a history of famous cases of bioprospecting and attempts at bioprospecting in Mexico (Hayden 2003), but moreover, the neocolonial relationship between U.S. and its southern neighbor which, as I was reminded often, was mired in inequality. I could visit Mexico but they would probably never be able to visit me. I think it also had much to do with the particular venue where I was working, which was in a very conservative and rural town that, although increasingly involved in tourism, was still largely mistrustful (and at times resentful) of the opulence of many outsiders. Consequently, I was often reminded by the bilingual assistants of my out of placeness.
especially in both the unit and the country as a whole, being told: “you are a foreigner here, you have no rights, and they can remove you at any time from the country.”

**The Vulnerable Researcher**

In my fieldsite, my body struggled to become acclimated to the exigencies of fieldwork and my psyche to being perpetually “out of place.” An extended quest for my own wellbeing would lead me to seek out medical assistance with an urgency much greater than my curiosity about healing. Various healers would use their own divination methods to diagnose my seemingly unending afflictions in the field. By the end of my investigation, I had been subjected to the interventions of numerous indigenous healers, *mestizo* healers, and biomedical physicians, as well as the diagnoses of other people in the community who all seemed to have contending things to say about why I was sick. As a vulnerable anthropologist and researcher-cum-patient, I became very personally involved in the business of conducting fieldwork, my body/mind another site and vantage point from which to observe what was being wagered for in the pursuit of health in the Sierra. My own vulnerability to such etiological attributions as well as the treatments I was given along the way permitted insights that would have otherwise been missed. My subjectivity as an anthropologist who was sick in the field became part and parcel of my fieldwork. My illness led early on to my forming an alliance with healers who were willing to help me diagnose and treat my symptoms, and take me into their care.

Multiple causal explanations abounded for my illness. However one of the most enduring etiological explanations broke along indian-koyomej divides. According to a few healers, my status as a *koyomej* or outsider to Nahuat worlds made me suspect. Early on during fieldwork, Doña Herlinda came to visit my house and while there,
offered me a *limpia*, cleansing me with an egg and reading the nebulous patterns left by the inside of the egg dropped into a glass of water. She shook her head, telling me, “Oh woman, how much bad airs you have.” Afterwards, she took my pulse and diagnosed that I also had *susto*, telling me that this is why I am so sleepy and despondent-looking. She explained my illness as based on the idea that the other healers were unsure of my intentions and frightened that I was there to take their knowledge. “You are surrounded by *envidia,*” she told me. While she spoke to my about what she perceived as the ideas of “other” healers, I knew that she was also there to confirm my intentions for herself.¹⁰

But my *koyomej* status was doubly-problematic, as I was a foreigner among mestizos as well and thus subject not only to Indian envy, but also mestizo hostility. Doña Esmeralda, who from the outset sensed the hostile environment that was surrounding me at the hospital, one day told me: “don’t worry, you are in your house (meaning the hospital) because we (the indigenous) want you here.” In her view I needed healing to cleanse away and withstand what she saw as the negativity and “envy” being directed at me, and she was sure was due to my solidarity and allegiances with the *macehual*. Viewing my role as someone who was there to support them in solidarity with their grievances with the institution, she was always quick to attempt to heal me, and in the temazcal, while she brushed me with the *temazcalxihuit* leaves, she implored me to pray: "Ask that all that envy that they have for you stays here in the *temazcal,* they have so much envy for you because you hang around with us *macehuales. *" In her mind, it was a struggle that broke along the dividing lines of *macehual* (indigenous) and *koyomej* (mestizo or foreigners).

¹⁰ In the clinic, there was doubt among among macehuales whether I was there to steal recipes. And mestizos had a question whether I was there to steal their traditional medicine project.
The time that I was admitted as a patient on the biomedical side of the hospital lent itself to much reflection on these dividing lines. After I recovered from the uncomfortable experience of being admitted to the biomedical side with its inadequate space for treating patients and its overextended staff which resulted in seeming attitudes of indifference and caustic, I told a midwife Esmeralda about my surprise at the harshness of my experience and she responded in a very serious tone: “Now you can really know what they do to us indigenous”—“Ya puedes saber que nos hacen a nosotros los indígenas.” Other witnesses drew greater lessons from the event. My landlord who helped me be admitted in the first place, and who was witness to what he perceived as a level of neglect during the entire episode of my illness, tells me at first: “You can’t treat the people like that. The place is a “slaughterhouse, there they kill people (like that)”. But then he followed up with a very frank statement of: por algo pasan las cosas, “things happen for a reason” and said “Now you will go to your country and when they are treating Mexicans badly, you are going to tell them what happened to you. Everything in this life is paid for, Todo en esta vida se paga.” In his eyes, that I would be treated harshly like Mexicans were known to be treated in the United States was a form of poetic justice and moral retribution.

11 Later, another Nahua healer, Doña Geneva says, “How good that you experienced it yourself, so that you can see how it is, and why the people don’t want to come here.” Being someone who has trained to give herself injections as a health promoter, Geneva took pleasure in asking me how many “pokes” (piketes) the nurse had to give me to get the IV in, and compassionately shaking her head, commiserated with the pain she imagined they caused when they abruptly and forcefully inserted the needle into my arm.
Figure 2-1. The researcher on public transportation in the Sierra Norte of Puebla. Photo courtesy of Jennifer Lynn Hale Gallardo.
CHAPTER 3
MEXICAN STATECRAFT AND THE INDIAN QUESTION

At the Entrance of the Public Hospital, Huehuetla, Mexico

I can still see him in my mind’s eye. He is standing outside the entrance of the rural public hospital with a man and woman who are also waiting for the truck leaving the mountain town of Huehuetla. Dressed in the gauzy white shirt and ‘calzon’ (pants) of Indian *serranos* (people who live in the mountains), he introduces himself as Antonio. As he speaks, he takes off his hat in the characteristic way that men nod and respectfully remove their hats when they pass the altars that dot the stony pathways through the mountainside. His eyes are young and lively but the sun and elements have worn down his skin, advancing his years. He flashes a shy smile, and catching my eye for a brief moment, we both turn our gaze down towards his rugged string leather sandals and my hiking boots.

He looks up again and tells me about the difficulty of finding a job worth anything in the region, nothing that would pay more than 50 or 70 pesos a day (less than a dollar per hour), and sometimes not even this; “no work to be found anywhere”. In between, he flashes a playful smile, and asks, “And you?” insinuating his interest and causing the older woman and man next to us to giggle, enjoying his subtle interrogation of my personal status. But after each round of laughter, the smile fades as he looks down at the ground, only to begin on a more serious tone, restating the futility of looking for work in the mountain ranges where we stand. “I am going to Puebla,” he says with an air of dampened hope, “I don’t know what I will find there but one must give it good effort, “Hay que echarle ganas.”

I tell him I have come to visit the mountain hospital that we are standing in front of. Only a few years old, it is the first public hospital to have been built in the region. Its bold signage that reads Integral Hospital with Traditional Medicine stands out with its fresh paint against the lush green vegetation densely surrounding it. I ask if he knows this place, and he nods in recognition, saying that “yes, a lot of people go there.”

But he doesn’t have much more to say than this, returning again to the subject of jobs, and explaining the loss of work that came with the fall of coffee prices that had sustained many livelihoods in this Sierra just a few decades ago. Our playful banter aside, I sense a mixture of restless despair and a reluctant surrender to a reality that forces him to leave behind his birthplace and the certainty of no work in the countryside to an uncertain future in an unknown city.

The bus never comes. Although I was told it would arrive by 10 am, my companions seem to know better than this. Finally a small, dilapidated truck pulls up and asks us if we need a ride. It seems that Antonio and I might sit
together in the crowded space of the front cab and continue our conversation. But a uniformed security guard with shiny boots and styled hair comes out from the hospital to ask for a ride and my new acquaintance surrenders his seat to ride in the back with the rest of the campesinos. After riding for 45 minutes, we get off the truck and pay our fare. I shake Antonio’s hand goodbye as we part. He walks off to wait for another ride to continue his journey out of the mountain range towards the capital city and I am on my way to another rural hospital in this mountainous countryside, a countryside that is quickly becoming depopulated due to the emigration of people like Antonio. As my next truck takes off, my thoughts remain with him, another serrano, compelled to leave his village behind in search of way to survive. (Author’s fieldnotes)

Before I ever stepped into a rural public hospital to study the cultural politics of institutionalizing traditional medicine in Mexico, interactions with people like Don Antonio offered poignant windows into the particular contexts that indigenous campesinos in Mexico live today. I went to the Sierra Norte to study the recent revival and reformulation of what had been in prior decades a pioneering example of the incorporation of indigenous healers into a state hospital. While I had set out to examine how micro and macro forces were refiguring the role of the indigenous healer in rural Mexico, what I hadn’t predicted were the kinds of disjointed realities that would make a traditional medicine clinic high on a mountain top such an insightful yet complex locale from which to think about the nation-state’s relationship to its indigenous citizens. Antonio exposed me to broader questions around Indian existence in Mexico at a time of unprecedented cultural recognition and socio-economic marginalization.

While Antonio faced an uncertain future in an unknown city, he was being pushed onto a very well-trodden path that for years have led out of places like the Sierra Norte of Puebla and other indigenous refuge zones (Cohen 2004). Antonio may or may not be the first generation in his family to leave the Sierra, but the region has long been
characterized by temporary and permanent emigration (Gonzalez Marquez 1991).\textsuperscript{1} With too little land to carry out meaningful livelihoods, this trend has only accelerated more recently in contexts of rising food prices, stagnancy of wages, unstable cash crop prices and ecological deterioration (Arizpe 1981) and pressures for people to migrate from indigenous regions have only increased (Burns 1993).\textsuperscript{2} Meanwhile, Mexican state authorities speak of a new respect for Antonio’s culture and a need to provide rural people like him with traditional indigenous medicine.

In order to begin to grasp the cultural and political salience of indigenous traditional medicine in Mexico and a rural traditional medicine clinic serving Nahua people in a high rural mountain town, in this chapter I sketch the historical context of state power and indigenous people in Mexico. The Mexican state was crafted through particular historically-constructed violences to indigenous people that I argue in this dissertation continues to be salient in questions of state multiculturalism. Drawing from Phillip Abrams assumption that the state is “not a thing” in itself, but instead a project of politically organized subjection that masks itself as the state (Abrams 1988), I map the fragmented landscape of powers and techniques that have served to structure the relation between state and civil society, and particularly state-civil society-Indian relations. I argue that understanding the historical nexus of race-making and state-craft is essential in an era where “multicultural” discourses and “intercultural” policies are

\textsuperscript{1}Since 1974, the Sierra Norte had one of the densest populations on the state with 134.7 people per kilometer square (Barrios 1991:14), and average land plot size less than one hectare. For example, in 1955, male laborers from the Sierra de Puebla, would leave during “the hunger” to work as jornaleros in what were 30 ranches of 100 hectares each, planted with coffee (Pozas y Pozas 1977).

\textsuperscript{2}Paradoxically, more tourists come to visit the centers of these kinds of out of the way and “charming” rural places.
today circulating in a vast array of government enterprises including education, law, and healthcare.

While scholarship in Latin America has sometimes privileged analyses of class and ethnicity over race and racism in examining social stratification, I take as a point of departure work by scholars that argues for analyzing indigeniety through the lens of racial relations (Hale 2002; Weismantel 2001; de la Cadena 2000; Warren 2001; Wade 1997). Social scientists have tended to treat indigenous peoples and Afro-descendants very differently, ascribing notions of “race”, “racial stratification,” and “racial discrimination” to the latter, while asserting that the concepts of culture and ethnicity are sufficient for studying the former (Harrison 1995). However, despite the prevalence of ideologies of mestizaje (racial mixing) and racial democracy, racial analysis in contemporary Latin America continues to be a socially salient framework for understanding the “oppressive power relations between populations presumed to be essentially different” (Harrison 1995). As this chapter will demonstrate, these relations have as their founding moment European colonization, where the racialization of indianness became a formative part of both colonization and later of Mexican state-craft.

A Country Founded on Conquest

The ethno-racial politics of Spanish colonization transformed what five centuries ago had been a vast mosaic of hundreds of culturally distinct nations into the largest Hispanophone (Spanish-speaking) country in the entire world today, constituted through and against the original inhabitants. For the first three centuries of Spanish rule,

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3 While some have argued that racism does not exist in Latin America based on the logic that racial groups in the Spanish and Portuguese colony rested less on biological physical features and more on economic class, dress, and education status (Schaefer 2008), a robust body of scholarship has demonstrated that racism in the Americas has historically drawn from a range of cultural as well as biological criteria, including language, dress, notions of civility, and body type (Appelbaum et al 2007).
“colonial governmentality in the Americas successfully articulated processes of exploitation with procedures of cultural formation to produce racial and ethnic differences” (Saldana-Portillo 2002). Although Spanish colonies could not be adequately described as properly modern or capitalist, a colonial modernity was established which depended on the figure of “the Indian” (ibid) and produced a durable template of racialized relationships that outlived Spanish colonialism and had lasting effects on the national imaginary (ibid).

The conquest of Mesoamerica began with the coercive dispossession of previously occupied lands and the enslavement of the original inhabitants. While in the early period of colonialism (16th century) the Spanish Crown shifted to compensating Indian laborers with wages (Lewis 2008:19), even after abolishing slavery there were various legal and extra-legal forms of enforcing obedience and coercing work from Natives (Lewis 2008:19). In order to facilitate social control, a complex socio-racial system of classification, or “caste”, was developed in the 17th century encompassing every aspect of life in the Spanish colonies (Martinez 2002). In the colony, Spanish settlers became instant aristocracy, no matter their parentage or occupations, while original Mesoamericans were lumped into the administrative category of indios, which marked their availability for exploitation (Katzew 1996:3; Saldana-Portillo 2002). Reducing Mesoamericans to an ethnic category attached to labor demands, the Spanish were able to construct a generic “Indian” identity that was constituted against a superior caste status of Spaniard or others (Creole) of “Old World” origins born in the “New World”.4

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4 However, Laura Lewis downplays the “racial” essence of caste divisions, arguing that the process of colonization generated such a myriad number of “go-betweens” or mixed race people, which tended to
The Catholic Church was intimately involved in the Spanish colonial enterprise, and decisions were deeply influenced by the Church, which had been the Crown's ally during the war against the Islamic Moors (Lewis 2008). The Crown had an interest in maintaining the Catholic Church's moral authority in New Spain against the excesses of settlers and facilitated the Church's ideological colonization in the captured territories (Campos-Navarro and Ruiz-Llanos 2001). The Church played an ambivalent role in the colonial effort. On the one hand, it was spiritually charged with the protection of Indians (who they viewed as "minors"). On the other hand, the Church benefited along with settlers from the appropriation of native labor, through which it increased its wealth (Lewis 2008:17). In order to justify divisions of labor and the exploitation of natives, colonists, along with theologians, were deeply involved in producing the ideological justifications necessary to: “demonstrate the natural inferiority of the indigenous people…(and)…make their enslavement both necessary and an act of mercy” (Green 2006:11). In this way, the imperial mandate to exploit and “to protect” was carried out in contradictory and uneven ways, with the thrust of the activity on the former (ibid).

That is not to say that the Church was not also heavily involved in the latter, at least on its own terms. The idea of “protecting” was also manifested through attempts at curbing some of the abusive behavior of colonists and settlers who abused their right to overshadow differences between Indian nobles and mestizos, and generated class antagonisms between Indian nobility and Indian commoners as much as between mestizos and non noble Indians (Lewis 2008:19). However, even if not equated to “race”, her evidence reveals that class divisions were expressed through caste discourse and operated much like racial difference which enacted belonging or exclusion within a hierarchized social landscape. Laura Lewis writes: “In the case of Martin who was a village official entrusted with governing Indians (and who abused of these) generated contradictory claims about his true status. The macehuales claimed he was a mulattoe and should be removed from village, while the Indian elite who backed them underscored how Indian he was. The elite Indians talked about macehuales in ways that depicted them as evil and vile, for instance, they said that the principal plaintiff trying to undermine the governor was “an Indian macegual…rebellious…an instigator of riots throughout the republic” “vile and low” (ibid).
Indian labor in ways that appeared grotesque or excessive to the Church. Some monastic orders were also influenced by the renaissance utopian visions of Christianity and the idea of “protecting” the *indios* while saving their souls. These set out to create humanitarian works in the name of the Church such as charitable hospitals. For example, Franciscans created the first hospital for *indios* in Mexico City as early as 1529 (Campos-Navarro and Ruiz-Llanos 2001). The function of these hospitals was as pragmatic as it was charitable. Economic elites became concerned about the demographic decline of their reserves of Native labor due to epidemics and the recurrent famines that were taking place in the urban centers (ibid) (Campos-Navarro and Ruiz-Llanos 2001).

Thus, as part of the imperial mission, the Spanish Crown thus at least partially justified its sovereignty over the West Indies through an ideological mandate to convert Indians to Christianity (Phelan 1960: 54). Colonial administrators were charged with having to navigate multiple standards, often contradictory and entailing both religious and economic justifications for the invasion of New Spain (ibid). The Crown had to provide for the needs of the colonists to make a profit, as well as abide by their own laws which commanded that all subjects, even "infidels" and especially “New Christians” deserved some measure of protection both in terms of their personal liberty and their property rights (ibid).

Concern for maintaining the lives and health of Native subjects was so important to the crown that the institutionalization of policy around Indian welfare was one of the few areas in which the Spanish Crown was especially clear and concerted:

Looking at the Spanish administration as a whole, one can see no single guiding goal or objective save that tendency common to all
bureaucracies...toward self-perpetuation...(however) a notable exception to the over-all goal ambiguity of the Spanish system is the case of the Church. The spiritual welfare of the natives and colonists was a clear-cut goal from which the Church could scarcely deviate, although various branches of the clergy clashed over the means of reaching that goal (Phelan 1960: 63).

As part of their caste status, Indians were assigned special privileges and obligations which were policed by both the Crown and Church, and detailed the minutia of codified conditions under which Indians rendered labor to colonists (MacLaughlin and Rodriguez 1990). The “spirit and intent” of the Crown’s legislation for Indians “reflected the conviction that the Indians constituted an inferior group in society who…deserved paternalistic protection” (Phelan 1960:54).

Despite the “rights” and “privileges” Indians may have been granted, the imperative to make the colonial mission profitable for colonists’ equated to the tolerance of much exploitation and abuse of natives in practice. Spanish settlers assigned themselves the right to demand their tribute and/or labor if necessary in coercive or violent ways (Saldana-Portillo 2002). Some scholars argue that the purposes of these protective laws were really to monitor the degree of exploitation and tribute that could be (morally and legally) extracted from Indians without killing them (MacLaughlin and Rodriguez 1990). While the extent to which Indians should be exploited in the colony remained up for debate (Lewis 2008: 19), the Crown was successful in establishing and naturalizing the link between economic processes of exploitation and socially-constructed socio-racial ascriptions (Saldana-Portillo 2002).

The hierarchical system of domination of the Indies was supported by the work of early Spanish scientists who created the first “scientific” system of race through astrological notions (Canizares 1999). Born in New Spain (Creoles or criollos) and thus lacking the purity and privilege ascribed to peninsulares (those born in Spain), these
scientists rationalized their superiority to Indians through an embodied distinction: namely their bodies were resistant to the unsalutory effects of the Indies negative astrological configurations (ibid). To establish their own superiority to castas, in the 17th century they developed elaborate racial theories to explain why their bodies did not naturally deteriorate under the negative astrological configurations of the Americas, which had obviously negatively affected the more susceptible Indian and African bodies and destined them to a degenerate and inferior culture (ibid).

Spanish colonialism not only brought with it the construction of new social-racial identities, but it also remade “place” by transforming the territory into the image of Spanish notions of territory and ownership. As a form of social control, the Spanish parochialized the identity of indigenous nations by dismantling their cultural and political organizations, and replacing them with circumscribed and local structures of identification that served colonial governance (Saldana-Portillo 2002). Indian pueblos and religious hierarchies and cargo cults--were shaped and molded in the crucible of colonialism (ibid). Although in pre-contact Mesoamerica, urban and rural communities abounded, the “Indian village” or rural *pueblo* came to stand in for Indian identity in Mexico and Latin America, an ascription that continues today (ibid). These cultural formations would in later years become the quintessential markers of *Indianness*.

Even under the most severe processes that colonization entailed, Indians were also always agents, resisting and usurping Spanish traditions and impositions in creative ways, and maintaining the meaningfulness of their own life worlds. In addition,

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5 With colonialism, came the introduction of economic principles that put a commercial value on the land, undermining indigenous communities through the privatization of property (Garza 2009). The new political and territorial hierarchies created put Indian communities at a disadvantage while Spanish or Creole mayors gained exclusionary access to government authorities (ibid).
Indians as well as Spanish colonists took advantage of the colonial context, when possible. For instance, anthropologist Holly Dygert writes that the figure of the indigenous *cacique* (political strongman) troubled easy simplifications of Indian vs. Spaniard even while the “practicalities of rule shaped the actualization of the colonial caste ideology into a system of governance” (Dygert 2011:40). The colony’s need to bring in enslaved Africans over time to supplant the labor lost in the demographic collapse of Indians “undermined the facile distinctions underlying the dual-republic system” (ibid: 40). A proliferation of caste types and identities thus ensued, including *mestizos* (proceeding from *español* [Spanish] and *indio* [Indian] unions); *mulatos* (*español* and *negro* [African descendant]); and *zambos* (*indio* and *negro*).

Still, as the colony coalesced, a racialized system of privilege and control became ever more entrenched and colonial hierarchies resulted in two oppositionally defined and over determined social groups in colonial Mexico: *indios* (Indians) and *españoles* (Spanish) or *gente de razon* (people of reason). These geo-racial categories were not however stable. Over time, increased mixing and economic growth, cultural considerations gained precedence in marking difference, and a generic distinction of *gente de razon* came to classify those who may have been of “mixed heritage” but had the economic and cultural status to assume privileges over *indios* (Dygert 2011:42). Historian Laura Lewis introduces this more complicated picture of colonial identities by theorizing the intersecting identities that were constructed in this period. She argues:

Colonialism was not a simple question of domination and subjugation. It rather created caste, gender, and class overlaps that made "commoner" Indians more "Indian" and feminized than noble ones, mestizos more "Spanish" than blacks and mulattoes, and it created cultural spaces in which the whole range of colonial subjects--including Indians and Spaniards--identified with "things Indian" as well as with "things Spanish".
Drawing on evidence that considers how people deployed “things Indian” with “things Spanish” especially in the realm of magic, healing and witchcraft, Lewis argues that through the colonization of Indians, the Spaniards ultimately colonized themselves, and ideas of “Spanishness” and “Indianness” became enduring “products of colonialisms complexities” (Lewis 2008:19).

While the story of colonialism is a complicated one, Anibal Quijano contends that colonialism constituted social classifications (albeit unstable as Lewis suggests) that continue to permeate all aspects of social life, producing persisting geocultural identities such as "America" and "Europe" and racialized identities such as "European," "Indian," "African". These deeply racialized categories, he argues are "the deepest and most enduring expression of colonial domination" and colonial enculturation, (Quijano 2001-2: 1). Surviving in contemporary identities as what he calls “the coloniality of power,” Quijano describes the axes of power for colonialism in the control of sexual access, collective authority, labor, subjectivity and the production of knowledge from within these inter-subjective relations. These power relations were intrinsic elements to the construction of modernity that produced a certain way of knowing (and subjugating others) from within the geocultural center of Europe (ibid):

(Modernity is the) fusing of the experiences of colonialism and coloniality with the necessities of capitalism, creating a specific universe of intersubjective relations of domination under a Eurocentric hegemony (Quijano 2000b:343).

Furthermore, this coloniality was not only racialized, but was gendered from the core (Lugones 2008). Not only did Spaniards have the right and access to the labor of Indian men, but they also had the de-facto right to sexual access (and sexual abuse) of Native women (ibid). Racialization became the mode of material and intersubjective
domination, but the gendering of this domination is what made colonialism particularly effective and violent (ibid). *Indios* were excluded from political participation no matter their gender, and through colonialism a new patriarchal-gender system was imposed. Native females and “third” genders were politically disenfranchised politically and dislodged from pre-conquest socialities that were embedded in complementary relationships to their pre-conquest counterparts gendered as males (ibid). Anti-*indio* violence with its gendered, classed, and racialized permutations was central to disenfranchisement a vast segment of the colonial population and was central to the workings of power during colonialism. These foundations for oppressive power were based on race/gender/class antagonisms that would have reverberating consequences all throughout the Americas.

Because of the systematic de-valorization of aboriginal Mesoamerican cultures, their gender and social systems, non-Indians, or American born Spaniards (“criollos”) and people of mixed descent (“castas” or later “*mestizos*”) came to identify with dominant Spanish caste and value European culture as well as non-Indian patriarchal national identity formations (Klor de Alva 1996). Although the hegemonic model of a Eurocentric society would be resisted, usurped, and redeployed for Indians own ends throughout the colonial period, still the colonial race-gender system would set the terrain for subsequent transformations in the development of relations between capital and labor in the independent nation-state.

**Nation-Building and the Discourse of Mestizaje**

The Mexican nation-state is understood to have commenced in 1810 with the war of Independence that ended three centuries of colonial life (Larrain 2005). It is argued that the only “colonized” subjects in Mexico were actually the (non-noble) Indians who
paid tribute and “served primarily as unskilled laborers and providers of foodstuffs for the mines and for the criollos and castas in the cities” (Klor de Alva 1996). At the time of independence, the total population of Mexico is believed to have numbered approximately 6,800,000 people and 54.4% of this population was classified as indigenous (Rosenblatt 1954 [1st ed. 1935]). True to its colonial antecedents, the nation was forged on the grounds of uneven citizenship.

While conservatives and liberals debated whether or not “to maintain structures of power and privilege of Spanish rule” or replace these with “a new model based on the individual liberties of the equal citizen, the rule of law, and the separation of Church and state”, one thing they agreed upon was that indios were not prepared to contribute to the leadership of the modern nation-state (Dygert 2008: 44). While one ideological proposal of government may sounded more progressive than other proposals, especially with its call for the abolition of slavery and equality for all citizens, many Indians equally resisted the measures proposed by the liberals just as they had formerly resisted the conservative power and privilege guaranteed to the so-called ‘gente de razon’ in the colonial era (ibid).

For the newly independent Mexican nation-state, Independence brought with it the determination to overcome the colonial past. Along with this was the new state’s desire to be rid of the trappings of indigenous culture whose socialities and organizational forms served as a reminder of the former colony. Thus, the independent Mexican state

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6 At the onset of independence, only the Catholic Church was capable of pursuing any coherent political project likely to be approved both by landowning elites and the masses (Brachet-Marquez 2007). Consequently, the Church’s dogmas were included in the Cadiz Constitution of 1812, presenting a “fundamental contradiction between a formal declaration of national sovereignty and de facto recognition of ecclesiastical authority over politics” (Villaseñor 1978:32 in Braquet Marquez 2007).
adopted a self-conscious stance of modernization (Brachet-Marquez 2007), which depended on dealing with the *cuestión indigena* or “indigenous question”.

Under the oligarchical state, a fraction of the liberal dominant class proposed equality for all individuals before the law, society and the market while moving to eradicate all “vicious” habits of the Mesoamerican culture present in the population. While the new state did not formally recognize racial or cultural difference, strategies were put in place for a Europeanizing project that had as a goal the ideological and cultural homogenization of all the inhabitants of the country (Page Pliego 2002). The Indian question," a euphemism for what Mexico has long perceived as an "Indian problem" is based on survivals of a social construction of racial and cultural difference that first emerged during the colonial. In the independent Mexican state, inequalities in health, education, and economic and political power became products of the uneven extension of citizenship to Mexican people, wherein indigenous people were excluded from the benefits of national belonging (Barre 1983; Diaz Polanco 1991; Harvey 1997). While Indians were socially defined, they continued to be ascribed to an inferior race that hindered progress (Wade 1997). The government rendered indigenous bodies and socialities to be unfit for the national body, conceiving them along with women, indigenous, blacks, and poor people to be unfit for the rights of citizenship (Nouzilles 2000; Pedraza Gomez 2008).

While it is argued that after colonialism, class status counted for more, Historian Alan Knight contends that ethnic status continued to be an extremely salient dimension of identity. While most Indians were peasants, they were “peasants who suffered a double oppression”: 
as poor peasants, resident peons, and city lumpen proletariat, they suffered an exploitation characteristic of their social class position; and, as ethnic groups in a condition of inferiority vis-à-vis mestizos and criollos, they were culturally oppressed by the carriers of dominant culture, that is, they suffered an exploitation characteristic of their colonial situation. (Knight 1990:78)

Constructed and circulated in popular culture as the quintessential sign of what the country had to overcome, The Indian came to be equated with backwardness and the antithesis to the nation-building (Bonfil Batalla 1996; Garcia Canclini 1995). Their absence of modernity was especially conceived in terms of Indian social arrangements. The ideological goal of modernization rendered indigenous communally organized townships and landholdings as obstacles to a modern nation, for both conservatives and liberals (Bonfill Batalla 1996). The exclusionary nature of Mexican citizenship was founded in the liberal vein of its constitutional rule and the idea of a nation that was ethnically homogenized. The first constitution (1824) left individual states to decide who would be considered a citizen, opening the door for the systematic exclusion of indios, and laws such as the legal code of 1836 “reaffirmed certain restrictions on citizenship for minors, domestic servants, criminals, illiterates” (Staples 2012:6). In a country where many Indians were largely monolingual in pre-colonial languages and illiterate in Spanish, these kinds of laws effectively excluded Indians from political participation (ibid). When the liberals won the power struggle with conservatives and a more liberal constitution (1857) proclaimed citizenship rights to all Mexican males over 18, this ideal was ignored at the expense of Indians (ibid). While liberal ideas were adopted, lay education expanded, democratic forms of government were introduced, and enlightenment ideals circulated, the majority of the people, including indigenous people
who represented about 40% of the population were excluded from political participation (Larrain 2005:73).

“El Porfiriato”

Sixty years after Mexican independence, with the rise of would-be dictator Porfirio Diaz (1877-1880; 1884-1911) Mexico had still yet to be organized politically as a nation-state. While his regime would come to represent “order and progress” to the political elites who had complained of the rampant disorder and misgovernment that plagued the fledgling nation-state, to the masses of indigenous campesinos, the Porfirian state meant repression, deprivation and death. By the late 19th century, Porfirian state-building reinforced the marginalization of indigenous people by assaulting communal political autonomy and imposing the privatization of land. The “architect of modern Mexico”, Porfirio Diaz implemented land policies that resulted in a gross concentration of land wealth (Rummel 1997).

In the transfer of communal lands into private, large-scale production, nation-state building meant mass dislocation and state-sponsored violence against indigenous people, and the massive concentration of land wealth in the hands of mestizos (Rummel 1997I). Five thousand Indian communities were said to have lost their ancestral lands during this time (ibid). Enslavement was also typical among Indians and the poor:

Deprived of land, impoverished and unemployed, the mass of Indians and peasants constituted a huge pool for exploitation. And exploited they were. Always subject to some forced labor since colonialization, under Díaz they became enslaved within a nationwide system of slave (chattel) and indebted labor (Rummel 1997:382).

Porfirio Díaz’s presidency installed a group of modernizing technocrats known as los científicos who set the scientific and industrial agenda of the nation. During a period when ranchers, landowners, and surveyors were consolidating lands that belonged to
indigenous communities, the científicos were given the authority to define the social problems of the nation-state (Page Pliego 2002). These positivist technocrats, steeped in ideas of social Darwinism and European science, were advisors to Porfirio's regime; their “science” produced findings used to justify Diaz’ repressive policies (ibid). The científicos worked together with capitalists to establish authority over official medicine and formulated national campaigns to eradicate diseases—typhoid, rabies, yellow fever, paludismo (malaria)—for those areas important for the economic development model of the regime (ibid).

The Porfiriato’s four-decade regime generated unprecedented economic growth to the nation-state through the diversification of industries, generation of exports and creation of infrastructure; however, the cost was the disenfranchisement indigenous and poor populations through the destruction of communal political autonomy and systematic violence (including murder and massacres) against poor populations. Mexico succeeded in raising its economic status by selling land to large foreign and domestic agrarian businesses. Tensions in the countryside were met by the strong stance of the dictatorial regime meant to maintain control, limit social dissent, and repress peasants. Having achieved a veritable economic “revolution from above” that was premised on desarrollo hacia afuera (outward development), foreign investment, a strong landlord class, and limited political participation” (Knight 1992:103), during the rule of President Porfirio Diaz he did what he could to repress social revolution from below. Elite families came to own haciendas of up to 6 million acres each, while only 5 percent of the rural population and 10% of the indigenous population had any land at all (Rummel 383; Knight 1992). By 1910, one third of the entire population, the majority indigenous, were
forced to work for the criollo (Creole) elite and only 3000 families were owners of half the property in the country.

**Revolutionary Mexico**

The productive but repressive combination of the Porfiriato’s liberal economics and strong-armed politics would ultimately pave the path for its downfall. Nearing the time of Porfirio’s overthrow in 1910, it was estimated that 500 Mexican families controlled approximately 80 percent of the nation’s economy. That same year, the armed uprisings began against the Mexican government, led by revolutionaries who were spurred on by Diaz’s chief political rival, Francisco Madero. “La Revolution” (1910-1920) would erupt as the uncontainable frustrations of masses of peasants—alienated from their land and labor through debt-peonage systems of latifundios (large estates)—burst on the scene only to combine explosively with the frustrations of a growing middle class who demanded more access to political participation. Dramatic in terms of deaths, poverty, and sickness that were left in its wake\(^7\), the ravages of war combined with an emergent nationalism led to the increasing interest of elites and intellectuals in state building strategies.

The Revolution engendered a dramatic shift in the context of state-civil society relationships in Mexico, and ushered in a new era based on revolutionary rhetoric and the institutionalization of social programs.\(^8\) The United States of Mexico’s Constitution

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\(^7\)The revolution was dramatic in terms of deaths, poverty, and sickness that were left in its wake. Rummel puts the number of indigenous dead through slave labor and starvation at 825,000 (IBID).

\(^8\)These programs included an attempt to build a healthcare system that could be considered a public good (Fisk 2000).
of 1917 was the first document in the world to set out social rights, and indeed born as a promise of the revolution. It postulated that social security should be extended to all citizens (Robbers 2007). While far from being realized in its ideal form, especially for rural and indigenous populations, this Constitution guided the spirit of the era, bringing with it the creation of an ample social infrastructure and the emergency of a state-led economy that extended vast social, economic, education, and health services for all Mexican citizens. The Mexican Constitution of 1917 did not however acknowledge the existence of indigenous peoples as distinct groups whose culture and language stood apart from those of people of European descent (Stavenhagen 1992: 437).

While the welfare state was forged in Western Northern Europe as a consequence of decades of struggle by subaltern groups (workers, peasants, women) for civil rights, and along with this public programs to protect families from vagaries of labor market (Brachet-Márquez 2007: 240), in Latin-American states it was a different story due to the inheritance of Spanish colonialism and industrialization which took place under authoritarian, militaristic and unstable regimes. Based in corporatist politics and authoritarian rule, the Partido Revolucionario Institucional (PRI) became a de-facto “benign” dictatorship beginning in 1929 after constructing its political base around interest groups (Dygert 2011). The PRI could count on campesinos who had received land from agrarian reform, and unionized workers who were the product of import-substituting industrialization (Salinas in Wayne Cornelius and Craig 1994: 9). The

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9The force of this new direction was incipient in the Political Constitution of the Mexican United States approved by Congress under President Carranza in 1917 during the Mexican Revolution, the first in the world to set forth social rights and ultimately serving as a model for Germany’s Weimer Republic in 1919 and the Russia’s Constitution in 1918. Article 4 of the revolutionary constitution, for example, stipulated the principles of access to occupational, public, and environmental health.
peasants, the workers and middle classes were organized as social sectors through top-down organizations. These sectors served as base of party support at the same time that they provided points of access to state resources and patronage. The PRI could count on campesinos who had received land from agrarian reform, and unionized workers who were the product of import-substituting industrialization (Salinas in Cornelius and Craig 1994:9).

In Mexico, for example, the land reform accompanied the creation of a national peasant federation, the CNC, and distributed property in many forms. Of these, the distribution of *ejidos* (communally owned land) unwittingly provided the greatest latitude for local indigenous autonomy—they were community based, inalienable, and, while regulated, often beyond state control (Yashar 1997). The agrarian reform built a power constituency, linking elements of the state and civil society in a fashion that was crucial for the political economy of modern Mexico. While the regime painted it as a progressive far-seeing project to return land to the producers, land reform during resuscitated popular discourses and aspirations that had long been in place (Mallon 2003). The PRI “gave itself a highly progressive image, claim(ing) to be heir of the Mexican Revolution” and defining its goal as the “the development to a modern industrial nation” (Meyer 1990:4 in Schulz 2001:295).

**Revolutionary Indigenismo**

As seen previously, the racial, gendered, and class composition of the *patria* or fatherland became a national obsession and a target of statecraft. The desire to shape new kinds of citizens especially in indigenous and rural areas was evident in the policies of this period. Medicine become one way by which state agents mediated and controlled relationships between those subjects of the state that were understood to be in need of
reform. The overthrow of Porfirio Diaz brought the end of oligarchic rule, and with this the rise of the liberal nation-state, the “scientific and industrial goals of the Porfiriato’s liberal positivism persisted” (Birn 1998:49). Thus “elites and revolutionary politicians agreed that trained scientists would lead Mexico’s march to industrialization and economic prosperity”, even while “peasants…seized upon the revolution's promises of improved living and working conditions” (Birn 1998:49).

In the early 20th century, Mexico became the product of a racial project that privileged a fictive national ethnicity fused together with a discourse of racial democracy (Radcliff 1996:34). The revolutionary era institutionalized racial project in the name of statecraft and the idea of a homogenous nation. While in socio-economic and political terms this democracy was otherwise negated, a mestizo identity stood in for the national, counterpoised to the ethnic and culturally-bounded “others”: Mexico’s indigenous, and to a less acknowledged extent African diasporic populations. As noted by Balibar (1991), hybrid identities were idealized as the norm, while identities considered exclusive or of a particular ethnicity were construed as archaic and modern day vestiges of the past.

Through this amalgamation of identities, mestizaje was consolidated as representing perfect citizenship. “Historical indigenismo” gave the Mexican insurgency its distinctive popular character—“an agrarian element and an element of ‘caste’ struggle against Spain” (Díaz Polanco 1997:16). What was most valorized was a mestizaje that incorporated Indian difference as a source of historical and cultural pride but subsumed it into an identity that was greater than its Indian and Spanish parts.
Indians may have been Mexico’s ideal ancestors, but now mestizos were Mexico’s ideal citizens” (Saldana-Portillo 2002: 294-295).

Beginning in the 1930s, the Revolutionary government of Lázaro Cárdenas (1934–40) adopted indigenismo as a strategy for intervening in the so-called "question of the Indian'. Another non-Indian formulation of “the Indian problem”, by this time indigenous people had experienced a long tradition of intervention by "intellectuals, the state or the church" (and) “stretch(ing) back to conquest” (Knight 1990: 77 in Wade 1995: 33). The state endorsement of indigenismo was the product of a long debate, to which "government officials, lawyers, educators, litterateurs, journalists, and clergymen, as well as liberals, positivists, Social Darwinists, and Catholics" contributed (Powell 1968:23). Mexican thinkers spanned the gamut regarding solutions to the "problem", and debated a span of possibilities: from educational, nutritional, economic and spiritual redemption of the Indian, to dismissing this possibility and instead underscoring the irredeemable state of the Indians who were said to hold Mexico back because of their refusal to "separate themselves from their tribal customs to join in the general movement of progress and civilization" (Powell 1968: 27).

It was decided that Mexico’s national-cultural imaginary of modernity, and the efforts to realize it, would thus depend on “not ‘conserving the Indian’, nor ‘indigenizing Mexico’, but instead on ‘Mexicanizing the Indian’ (President Cardenas in Villa Rojas 1976: 11-12 in Page Pliego 2002:26). Mexico would realize its modernity through an “incorporationist” strategy by “accept(ing) its plurality in cultures of origin” and transcending this past “by neutralizing it through mestizaje” (Page Pliego 2002:26). Indigenismo glorified Indian difference (as a cultural formation), but required its
dissolution in the present (Saldana-Portillo 2002). On the whole, indigenistas romanticized the exotic symbolism of Mexico’s pre-Columbian past rather than offer respect to contemporary Indian people (Wade 1995: 32). Claiming that an end to exploitation and true citizenship for indigenous Mexicans could only be achieved through social integration and "acculturation", the official form of indigenismo stressed the assimilation of indigenous people into the nation-state (Guillermo de la Peña 2005).

While after independence the racial order lost much of its official legal basis (Wade 1995:32), during the Revolutionary period the construction of mestizo vs. indio identity continued to be as salient as ever. The desire to shape new kinds of citizens in especially indigenous and rural areas was evident in President Cardenas’ social policies. The Ministry of Public Education (Secretaria de Educacion Publica, or SEP) was of the first to direct indigenista projects in the 1920s and 30s, although the most poor, marginalized indigenous regions in the South of Mexico did not benefit much from “the land, schools, water, tools and credits” distributed by the government in an effort to incorporate indigenous people into dominant national life (Lewis 2008:612). Meanwhile in other places where these ‘modernizing’ policies were more effective, they “destroyed or appropriated much of their culture and subordinated to the state” (Fallaw 1997).

When Cardenas left office, indigenismo fell off the priority list for a few years until 1948 when President Miguel Aleman created a new decentralized federal institution, El Instituto Nacional Indigenista (INI) 1948. As the first director of the Institute, Manuel Gamio, an anthropologist and influential author of indigenismo, became largely responsible for the development and institutionalization of indigenismo as a well-defined state ideology (Gamio 1922; Brading 1988). Only a few years prior the government had
institutionalized the study of Mexican Anthropology (1942), consolidating it as a modern scientific discipline (Krotz 1991). Gamio’s conceptualization in his famous text Forjando Patria described Mexico as backwards, uneducated, poor, and in need of reform (Gamio 1982 [1916]:93-96). For Gamio, the obstacle for the modernization of Indians was not their race but their culture, monolinguism, and religious traditions.

Through INI, anthropologists began to address the colonial legacy of the “Indian question” and his/her integration into post-revolutionary Mexican society. El Instituto Nacional Indigenista inherited some of the previous intellectual trends of the Cardenismo years. However, the impetus was self-consciously placed not on the “incorporation” of Indians, but on their “integration”. The difference was that INI sought to assist in the revalorization of the “positive” elements of indigenous culture (Lewis 2008). INI’s innovativeness as an Institution was due to its fusion of a solid theoretical basis and its model of intervention, which was said to go beyond the conceptions derived from “community studies in order to operate in the framework of a region of intercultural refuge” described as follows:

The region of refuge is the result of the struggle for occupation of the territory between different cultural groups…(they are) regions are regions of refuge because their marginal status and isolation defend them from the aggression of the most developed…in these regions (they) survived because of the geography and characteristics that sheltered them from colonial exploitation…and saved them from extinction, enabling them to preserve the identity of their lifestyles…in greater or lesser degree, as amended by the process of acculturation. (Ibid: 26. [Emphasis added by author] (Aguirre Beltran 1987: 243 in Zolla and Marquez 2004:88)

The “intercultural region” was defined in geographic and ethnic terms as well, where the identities of the two groups were conceptualized as bounded and mapped onto specific spaces:
An intercultural region is a geo-cultural space [that] is a place of coexistence of “two human groups with different ways of life, indigenous and mestizos. The first are part of the majority group of the country and posses a culture that is a regional variant of the national culture; commonly they live in the city that acts like as a guiding group of a wide geographic area that is the hinterland, which contains a variable number of indigenous communities. (Aguirre Beltran 1994 [1955]: 36 in Zolla and Marquez 2004:89)

It is important to understand how the INI conceptualized indigenous “regions of refuge” and the “intercultural region” in order to understand how these definitions ultimately shaped the strategy of Mexican statecraft in the post-revolutionary period. Drawing on the intellectual tradition established by Gamio, which posited education as the pathway out of the Indian’s deplorable condition, and encouraged not racial mixing, but cultural mixing, these Indians of the hinterland could become integrated into national life through (cultural) education. Thus, while a person could be biologically Indian, with the proper cultural education he could be guided to become a mestizo or like a mestizo (ibid), and thus a better national subject and citizen. The ideological strength and influence of this policy would be demonstrated over the years by the government’s success in greatly “decreas(ing) the number of Mexicans previously classified as Indian, and increase those classified as mestizo” (Doremus: 2001: 381).

Rise of Eugenics

During the last phase of the Mexican Revolution, a new form of biopolitics was introduced by Mexican scientists and intellectuals who were particularly interested in the constituents of the national body (Vilella Cortes et al 2011; Stepan 2001; Stern 1999). Eugenics became an attractive social policy in the post-revolutionary climate of

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10INI considered indigenous regions or “refuges” to be those that contained 75% or more speakers of an indigenous language (INI 1994).
socialism, anticlericism, and materialism, and political leaders were open to using science for social reform (Stepan 1991). Decades of debate about how the Indian population could be integrated into the national body and how the health of poor people would best be improved converged with the ideas of eugenics. These ideas, which had already been circulating among socialist strands of European countries, came onto the scene initially in 1910 at the beginning of the Revolution (Stepan 1991). Among Mexican biologists, receptivity to Darwinian ideas combined with concerns for the “Mexican people” (Stepan 1991; Vilella Cortes et al 2011). The scientists were deeply committed to evolutionism and materialism, and believed in the power of science to improve the human lot (Stepan 1991).

Mexican Eugenics covered three main areas including: 1) educational and preventative maternal and child care; 2) the prevention of medical pathologies; and 3) questions of race, which focused on who should be immigrating into the country; and what kind of (racialized) constituents belongs in the national body (Vilella Cortes 2011). So-called European “eugenical feminists” were concerned with healthy motherhood and babies as well as infant and maternal morbidity, and although these kinds of women’s issues were not of interest in most of Latin America, they found their expression in Mexico. In 1921 the Mexican Congress of the Child addressed questions regarding eugenics and reproductive issues (Stern 1999). Among its collective decisions, it voted in favor of a policy that would sterilize criminals and other undesirable populations (Stern 1999).

For many mestizo intellectuals and government functionaries, *indios* were a population to be counted within “undesirable populations” (Vilella Cortes et al 2011). The
Mexican Eugenics society moralized about the social habits that seemed to follow logically from the ideals of eugenics, prompting eugenics to begin to draw boundaries between acceptable and unacceptable behaviors: “These boundaries also separated the poor from the middle class, the manual workers from the elite, and the white segments of the population from the dark” (Stepan 1991:93). Mexican eugenists championed their cause by describing Indians as having “various stigmata of degeneration” that could be attributed to “precocious sexual unions, defective alimentation, alcoholism, and lack of hygiene,” but more than anything, to “custom and ignorance” (Buffington 2000:157).

However, overlapping with more indigenista language of “redemption” of the Indian was the use of more explicitly racialized languages. Mexican medical publications began to link the idea of "racial darkening" to the "irresponsibility of the state" in failing to produce a national population with "desirable qualities" (Suarez and Guazo 2005). While outside of the official state ideology of indigenismo, the idea of “injecting the blood of white settlers” into the indigenous populations was proposed as one way to “redeem” “degenerate and mentally weak” Indians (ibid). Leading Mexican eugenicist Ruiz Escalano described the “preferred weapons” for combating the degenerate nature and culture of indios as being: Hygienic instruction, prenuptial medical certificates, birth control, and rapid racial mixing (mestizaje rapido) (Suarez and Guazo 2005).

While it is difficult to locate figures on the numbers of sterilizations indigenous women and men in Mexico were forced or coerced to have during these years, the commonplace nature of these unconsented sterilizations in Mexico still today (personal communication; Dygert 2011) suggests mestizos were probably highly involved in sterilizing Native women during this period. It also adds evidence to the specifically
gendered, racialized, and classed forms of violence lived by indigenous populations, in this case, through the limitation and control of their reproductive lives. Mexican scientists were able to re-elaborate previously circulating notions of race to justify this level of micro-aggression to Indian bodies. Establishing “new terms by which the internal boundaries between people were to be understood” (Stepan 1991:93) eugenicism operated as part of the colonially power that dominant members of society used to control the original populations of the Americas. At the center of official mestizo social and moral concerns was the question of the “indios”, those indigenous masses whose poverty and marginalization became an obsessive focus of social policy (Stepan 1991:150).

From the 1930-1960s, under an inward looking development strategy, the party ushered in the “Mexican miracle” through its economic base of industrialization via import substitution. This strategy generated a substantial middle class, as well as channeled (or as others might argue, effectively neutralized) the demands of many sectors of the economy, especially the labor sector but also the agrarian sector. The state engaged in redistributive measures and took on the role as proprietor of key industries, such as petroleum, mining, electricity, railway, and banking.

The Revolutionary’s greatest achievement in redistribution was Constitutional Article 27 for land reform. The intention of this reform was to return the territories that had been expropriated from peasants and indigenous people during the primitive accumulation of communal lands during the 19th century (Jonsson 2009). Through the distribution of ejidos (communally owned land), the government formed farming communities and peasant unions with the intention of breaking up the “hacienda
system” or large farms owned by a minority of the population. But it also played a “double political game” with a populism that partially satisfied peasant demands while it defended the interests of the great agrarian bourgeoisie (Pare 1978:26). By sustaining the smallholders and maintaining political control of the rural masses, the Mexican state was able to reproduce previous modes of production in the countryside which depended on “a continuous state of violence, struggle, and (land) usurpation that was typical of the process of permanent primitive accumulation” (ibid).

Land reform provided latitude for local indigenous autonomy—they were community based, inalienable, and, while regulated, they were often beyond state control (Yashar 2005). However, the reform did not have much effect on the Sierra Norte of Puebla as most people had land, although little, or at least access to communal land (Govers 2005). Their struggles tended to be about keeping the land they had from usurpation by local mestizos, and trying to get fair prices for the cash crops they planted in orchards, along with their staple milpas (ibid). They were however affected by what came along with the Revolution in its creation of new forms of state mediation vis-à-vis intermediaries such as caciques (political strongmen) and bosses who were given the job to integrate “the people,” by bringing certain limited benefits to the people, (land, schools, roads, irrigation), these intermediaries often stood in exploitative relationship with Nahua and Totonaca residents of the Sierra. Caciques with ties to the ruling party controlled local political institutions and participated in the illegal expropriation of indigenous lands. Consequently, with the process involved in the revolutionary goal of “forging a fatherland” (Knight in Cornelius and Craig 1994:35), came more possibilities for abuses of power.
After the PRI’s shift to more conservative politics in 1940, a new national policy bias in favor of private agriculture was undergirded by the infiltration of anti-peasant activists within the government apparatus (Fox 1993). Despite conditions of extreme impoverishment and political exclusion (Sierra 2005), indigenous serranos continued organizing in social movements that grew from initial actions to secure land tenure and political power (Ramirez Suarez et al. 1992). Demands included: securing land tenure against mestizo land grabs; demanding cease of exercise of violence with impunity by caciques, militaries and paramilitaries; freedom of expression without fear of assassination, persecution or incarceration; struggles against powerful families in the region who usurped land for ranching and blocked the distribution of consumer goods; and the freedom to produce and commercialize commodities—otherwise blocked by obstacles erected through governmental agencies and commercial merchants and speculators (ibid). Paramilitaries with connections to caciques and state officials violently repressed indigenous efforts to defend economic and political rights (Valle Esquivel 1994).

Through state officials’ collusion with large landowners, the Mexican state “responded to popular demands in the countryside through co-optation and repression” (Servin et al. 2007: 309). Any subsequent protests were conditioned to be "expressed through the state's own institutions of agrarian reform and corporate control" (ibid). The state’s satisfaction of demands through its own institutions served to legitimize and strengthen of the state apparatus and consolidate hegemonic power. The leaders of

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11It is said that purges of INI personnel and those leaders who were suspected to have aligned themselves with indigenous struggles (or who evidenced any kind of progressive pro-indigenous, or seemingly socialist perspective, began in Puebla.
popular resistance movements were compelled to negotiate directly with the state rather than lead actions directly against landowners or businessmen. Their roles were conscribed to two choices: "facilitating agreements at the top levels of the leadership hierarchy" which basically meant co-optation, or resisting negotiations. However, if they resisted co-optation, "they might be murdered (or otherwise removed), thus beheading the organization and undermining its resistance" (Servin et al 2007: 309). It is noteworthy that purges of INI personnel and community leaders who were suspected to have aligned themselves with indigenous struggles (or who evidenced any kind of progressive pro-indigenous, or seemingly socialist perspective) began in Puebla. The regime thus maintained a remarkable degree of stability by meeting some of the demands of the social and political opposition, and co-opting and repressing others (Schulz 2001: 295).

The Neoliberal Turn

In the 1970s global capitalism began to show signs of deep crisis (Meyer 1991). The impact of a U.S. recession on what had been Mexico’s primary market for its exports was coupled with a burgeoning domestic population and evermore public expenditures. Petrodollars had permitted Mexico to maintain high levels of public spending and reduce income poverty through a mixture of interventions in job creation, education and health investment and general subsidies in basic products. By the end of this decade, this scenario led to an exploding deficit and even more borrowing of foreign dollars to stave off social, economic and political disasters. By 1982, the impending economic ruin of the economy could not be avoided any longer, and Mexico declared bankruptcy, unable to pay the massive interest on its debt to U.S. Bankers. Forced to accept conditions imposed by the International Monetary
Fund, the Mexican government accepted the general outline of the “neoliberal revolution” which entailed “…decreasing state intervention in the economy, declining tariffs on trade, and freedom of movement for international capital” (Meyer 2007: 285). The liberalization of trade was put on the agenda by economists who had graduated from Mexico’s top neoliberal economics departments, and who in many cases had advanced training in schools of neoliberal economics of the United States (Babb 2001). A new permutation of a recurrent theme of government recalled the prominence of científicos nation-state building during the Porfirio era. Technocrats, this time economists by training, lead the economic transition of the country. Neoliberally-minded reformers in Mexico took advantage of external pressures, and their own influence within the World Bank, to help move the liberalization process forward domestically (Cronin 1995). Market competition and economic deregulation were championed as the ideology that would lead the path to economic growth.

This era ended one stage of Mexican history and the beginning of another focusing on the premise that social welfare would be the result of economic growth based on private investment. The mechanisms behind this new politics coincided with neoliberal restructuring of Mexico’s economy and what has been reckoned as ‘the end of the corporate state’ (Pastor and Wise 1997). The idea was that the state should withdraw from the economy, and the use of state intervention was only legitimate in solving the social problems amongst the most poor (Laurell 1991:457). The redistributive measures accomplished during the earlier Revolutionary government were eventually reversed under the presidencies of Miguel de la Madrid and Carlos Salinas, after when almost all state enterprises were privatized. As a justification for government
disinvestment in the public sector, the government, which had originally midwifed the redistributive measures, changed its discourse declaring that a “state of (state) ownership” was not a “state of justice” (ibid); privatization was tied to ideas of democratization. The General Agreement on Tariffs and Trade (GATT) and the North American Free Trade Agreement (NAFTA) opened the Mexican market to foreign investment, leading to the outcompeting of domestic producers.

From 1988-1992, Salinas de Gortari implemented a very strategic set of objectives including trying to change the Mexican constitution to open the way for neoliberal policies, particularly in areas that directly impacted indigenous and worker’s groups and the organizations. At the same time, the President launched the concept of “social liberalism,” pledging “equilibrium between state and society, liberty and equality, the individual and the community, social rights and individual guarantees” through a National Program of Solidarity (PRONASOL) which targeted the very poor with direct payments in the form of subsidies (Meyer in Servin 2007: 290). Conceived as a social policy that represented a path to political modernization, the idea was to help those sectors most devastated by the neoliberal reforms (Meyer 2007: 291):

….as the latest in a long line of projects...(it) sought to alleviate the plight of the poor, to burnish the regime’s tainted image, and to strengthen the fraying bonds that tie the rulers to ruled, state to civil society (Cornelius and Craig 1994:45).

In the 1994 election, PRONASOL was delegitimized as a program, but it set a precedent for gaining political quiescence through the basic element of direct payments and continues to survive under different names (later it was called Progresa, and currently is named Oportunidades). This type of program represents a “key element” of modern statecraft and of “papering over the cracks” of social inequality (Cornelius and
Craig 1994:45). But it was not able to paper over the deficit of health services for the Mexican people.

The advanced liberalism of late capitalism, with a policy set to orient the economy to the market, brought health reforms that transformed the predominantly public healthcare system into a market-driven system (Laurell 1991; 2007). Through a complex process intended to obfuscate political resistance, the government opened up healthcare to private insurance companies, health maintenance organizations, and hospital enterprises largely from abroad (Laurell 1991; 2007). These reforms exacerbated health inequalities through the transfer of resources from workers to capital. Although the effect of social policies promoted by International Financial Institutions is said to be “difficult to disentangle from the effects of other neoliberal measures—as well as other historical, social, economic, and political processes—on the huge social and health disparities among and within Latin American countries,” nonetheless the impact of neoliberal policies on health has included a widening of inequalities and the income gap between classes and the dismantling of social protections (Armada et al. 2001).

Neoliberal policy changed the delivery of healthcare in the country. Health reform was part of the structural adjustment process, the broader neoliberal agenda and the social reform of the state that was put into motion after the debt crisis. Structural Adjustment Programs (SAPs) were measures imposed by the International Monetary Fund with the support of the World Bank to stabilize government expenditures. The first major effect of structural adjustment on the health sector was the dramatic decrease in public health expenditure and other social funds channeled through the government
budget (Laurell 2007). The government adopted the World Bank approach to healthcare which stressed "weakening the role of government in the marketplace, enhancing global trade and...creating an infrastructure attractive to foreign investment" (Janes 1999:xx).

The institutionalization of neoliberal policies along with their attendant disenfranchisements, were not met without resistance. As the legitimacy of the authoritarian regime was undermined by its inability to maintain its clientist networks through the selective distribution of benefits to its corporate sectors (military, peasant and popular) the Mexican revolutionary regime effectively ended. A consequence of the dismantling of the revolutionary project was that Mexico’s indigenous peoples lost their access to political institutions and accordingly, their access to participation, representation and resources also declined. Although the benefits of acquiescence to the government in exchange for government subsidies and group representation and participation in government were hardly satisfactory, they did offer some protection against the brutality of liberal economic policies. Without the minimal protections from the compromised form of citizenship, people who had been effectively excluded from enjoying the benefits of full citizenship in particular indigenous communities began demanding the reconfiguration of Mexico’s citizenship regime. Ironically, Mexico’s corporatist structures unwittingly provided autonomous spaces that protected rural indigenous communities from direct state control. The neoliberal policies of the 1990s, which promoted individualized relationships, challenged the indigenous autonomy that corporatism unknowingly fostered. When neoliberalism failed to deliver the promised citizenship rights, the cleavages which broke along racial Indian-non-Indian lines were politicized (Yashar 1997).
One of the most galvanizing events of this period for indigenous rights was the famous Zapatista rebellion that emerged on the scene on New Year’s Day 1994, the same day the North American Free Trade Agreement (NAFTA) took effect as a policy to remove barriers to trade between the United States, Canada and Mexico. NAFTA was the hallmark of Salinas economic liberalization program, with an emphasis on removing trade barriers and tariffs between US Canada and Mexico (Jung 2003). Processes of liberalization and the unfair competition that accompanied “free trade” affected the Sierra Norte of Puebla, which depended on agricultural production. The collapse of the International Coffee Agreement in 1989, when the price of coffee dropped by half and the income of small coffee growers dropped by 70 percent between 1989 and 1993, made the negative impacts of liberalization worse for peasant farmers (Harvey 1994).

As Stahler-Scholk writes, this rebellion of indigenous peasants “did not spring from nowhere”; instead, it was an uprising in Chiapas that represented one manifestation of a very long trajectory of resistance to the impacts of globalization in Mexico (Stahler-Scholk 2004:1). While the rebellion mostly likely emerged from “immediate and concrete circumstances rather than the abstract concept of ‘globalization,’” it is very much the case that the policies and practices which (indigenous and peasants in Chiapas) experienced as affronts to justice and dignity were clearly shaped by neoliberal restructuring” (Gilly 1998: 327-32 in ibid).

The rise of indigenous identity was implicated in neoliberal economic and political initiatives that redefined the role of the state and transformed the revolutionary social pact achieved under President Carranza in 1917 and the first constitution in the world to set forth social rights (Jung 2003). With the insertion of neoliberal ideology against the
backdrop of the demise of the communist bloc, class identities, which had wielded political relevance in an era of standing communist states, lost their political leverage. The concept of the revolutionary peasant and worker to which the post-revolutionary state ideologically owed a certain allegiance, diminished the state’s responsibility to these sectors, and as such the neoliberal era has dismantled capacity to advance activist or political claims through peasant identities. This was not just an effect of neoliberal ideology, but also a challenge to the centralist, corporatist state power, which was infamous for its corruption and sectarian politics, and had lost its moral ground. However, as the government relinquished responsibility for social and economic well-being, the political leverage of class identities (like peasant and worker) diminished (Jung 2003).

Almost simultaneously, the international human rights regime expanded its definition of rights to include not only individual rights in physical and political protection but cultural rights (Jung 2003). In the wake of the Zapatista challenge to the state, the constitution was amended in 1992 to pay homage to the pluricultural characteristics of the nation and guaranteed respect for their customs as well as mandating the state’s obligation to protect this diversity (Tully 1995, Speed 2002, Van Cott 2000). In the wake of these successions, indigenismo of yesteryear, formulated in terms of positive projects of social engineering and assimilation which sought to bring indigenous and the rural poor into greater engagement with the government, gave way to a new neoliberal genre, in which capital sustained culture while inequalities remain entrenched.

While neoliberalization unleashed heterogeneous trajectories and outcomes have been variegated around the world, for indigenous Mexicans, their structural locations
made them particularly vulnerable to the shifts in the global and national economy. The emergence of state-sponsored cultural rights was accompanied by watershed amendments that privatized national resources and opened the way for neoliberalism. Unraveling “the material and institutional bases of the old social contract” (Beaucage in Phillips 1998: 24), indigenous people have suffered disproportionately even while their cultural rights have expanded. Thus despite statist adoption of multicultural ideologies in recent decades, the "Indian question" continues to translate into morbidity and mortality for indigenas at two or three times the national rate in Mexico in a further cleaving of the fault lines that break along ethnicity and class in Mexico. As neoliberal economic and political initiatives redefined the role of the state in the state-civil society relationship, the Mexican government disinvested in public spending that formerly helped provide social protections.

In the context of a history of violence against indigenous people as part of Mexican statecraft, what could it mean then for the Mexican health system to serve indigenous people today when rural indigeneity is equivalent to vulnerability, poverty, and the structural vicissitudes of displacement? What could it possible mean for the state to be offering “traditional medicine” to members of communities left behind by others forced to leave their homes to vie for work in the city? What does it mean for Mexico to be building traditional medicine clinics in areas that are experiencing severe economic depression and depopulation? What was the problem for which the Ministry of Health felt that traditional medicine clinics in rural area could be a solution? The remainder of this dissertation will explore how the traditional medicine clinic is a site where policies directed at the most marginalized indigenous populations reflect the paradox of
neoliberal multiculturalism through its progressive responses to past societal ills that has “a menacing potential to perpetuate the problem in a new guise” (Hale 2006:12).

Antonio exposed me to a broader context in which these “mixed hospitals” abounded. Their lives have been indelibly shaped by contemporary policies that are redefining the roles and responsibilities of the states and the citizens, as well as discourses and practices with precedents under colonialism that have helped structure indigeniety in Mexico. In recent decades, a dramatic deterioration of living standards for millions of Mexicans associated with neoliberal reforms has meant desperate times for a majority of the population, but none more so than for indigenous people. These violences face by these subjects has been both material and epistemic, relegating indios in Mexico to defacto second-class citizenship and a heightened vulnerability to displacement, exploitation, and untimely death due to physical violence or disease. A history of violence against indigenous people has been part of the constitution of the Mexican state and a coloniality of power continues to structure relationships between state and indios today (Quijano 2000).
Figure 3-1. At the home of a healer. Photo courtesy of Jennifer Lynn Hale Gallardo.
CHAPTER 4
FROM MACEHUALTAPAJTIANI TO STATE-SPONSORED TRADITIONAL DOCTORS

Antes No Habia Medicina Tradicional

One morning I went to visit my neighbor, Doña Albita, an older Nahua woman who lived with her husband near the public hospital.¹ Doña Albita welcomed me as she often did with her sweet black coffee in her kitchen of earthen floors, and soon a comadre (godmother) who was running her errands in town joined us, sitting down in the kitchen to converse. After a while she asked Doña Albita who I was and was told in Nahuat that I was studying with the macehualtapajtiani at the hospital. The comadre found this interesting and then in a matter-of-fact tone said: “Antes no habia medicina tradicional” (“in the past there was no traditional medicine”) (personal communication 2005).

When I asked Doña Albita’s comadre why she said that indigenous traditional medicine never existed in the past, she explained to me that the curanderos had gone to the hospital to teach themselves traditional medicine (“se fueron al hospital para enseñarse medicina tradicional”). This notion arrested my attention. With all the discussion I had heard about the hospital respecting local medicinal traditions and offering ancestral medicinal practices to indigenous people, what did it mean that the healers had gone to the hospital to learn? And how did a state hospital become an important site for offering indigenous traditional medicine to indigenous people?

Ironically enough, the notion that medicina tradicional was “at the hospital” permeated local life in the Sierra.² If a person asked about traditional medicine they would often be directed to the Ministry of Health’s hospital. Contrary then to what one

¹ She was one of the few Nahua I knew who lived in the center town instead of one of the many dispersed, outlying hamlets, where the majority of Nahua lived.

² Don Placido told me that he believed that there are more traditional doctors now than ever.
might expect in a region where only a few generations ago physicians, health promoters, and even schools worked to discourage confidence in *curanderos*, the traditional medicine clinic at the hospital was one of the most often cited landmarks in town for procuring herbal remedies or receiving a consultation with a Nahua *curandero* or *tapajtianij*.

This chapter recounts how one state hospital in an indigenous region of Central Mexico helped to put Nahua healers on the map. I focus on a rural hospital with a long history of interaction with indigenous policies to examine how the institutionalization of traditional medicine in Mexico has been reformulated in recent decades. While the hospital has gone through many transformations, each time it has emerged as an innovative national model for the public health sector’s engagement with its indigenous citizens. Drawing from interviews with indigenous healers, physicians, and clinic administrators, I trace the trajectory of the hospital through its various incarnations of *indigenismo* in Mexico. I argue that the traditional medicine clinic and its reformulations comprise an important site of social, political, and ideological struggle for indigenous medicine.

**The Sierra Norte of Puebla**

The Sierra Madre of Central Mexico has constituted a privileged site for testing state policies aiming to westernize indigenous populations (Sierra 2004). It was considered a region of refuge by anthropologist Aguirre Beltran (1973), an "indigenous nuclei whose territories had been established far from power and economic centers" (Valle Esquivel 1994: 56).³ While Nahuas had participated in national life as early as

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³ For many Mexicans the region represents a cultural hinterland in the national imaginary. In fact, when I first arrived in the city of Puebla and told my urbanite female taxi driver where I was going, she looked at
the 19th century, first in a war against the French who had allied with Mexican elites (Thomson 1991; Mallon 2003), and later through the increasing economic integration of the area into the national economy (Beaucage 1974; Lupo 1995), the region was shielded from dominant forms of national culture for most of its history.

After Porfirio Diaz’s rise to national power in 1876, the region was opened to outside economic interests (Stacy 2002). The situation of relative isolation for the Sierra changed dramatically when mestizos and Italian immigrants moved into the humid cloud forest to clear land for intensive cash crops including sugar, tobacco, and coffee (Lupo 1995). Nahuas took advantage of the emerging economic climate to become cultivators and sellers of cash crops on their small plots in addition to their cornfields (Lupo 1995). The region’s influx of outsiders and the reorganization of society led to the adoption by Nahua of mestizo sociocultural and commercial elements (Gonzalez Marquez 1991) and put commercial values on land and labor (Garza 2009).

Nahuas participated in the new economic system while using their agency in various ways to deflect increasing incursions into their life worlds. They supported the municipalization of community when it was believed it could provide a framework for autonomy and self-governing; however, when their own Nahua mayor asked them to pay taxes or provide labor to build roads and public buildings, they resisted (Beaucage 1998). Nahua accepted the privatization of their communal land as a way to secure their

me with an air of disbelief, admitting that she had never been there because it was a place “with nothing there.” Others would tell me that it was a region of “just Indians.” For much of the region’s national history, it was relegated to the kind of place that only social scientists might be interested in.

Historian Keith Brewster writes that: “Lying within a day’s horse ride of the strategic corridor between Mexico City and the port of Veracruz, the Sierra was a highly valued location in times of national turmoil. During the nineteenth century, its valleys offered asylum to political activists escaping persecution on the plains below, while its indigenous communities were coveted as a rich source of military recruits and provisions” (Brewster 2002: 2)

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landholdings, but maintained the idea that it still "belong(ed) to all native communities as opposed to the mestizos illegitimate claim on the land" (Taller de Tradicion Oral 1994: 130-43).

While Nahua leaders displayed a strategic approach toward liberal policies, over time the mestizo elite consolidated their power. They gained large landholdings "through commerce, usury, and/or political manipulation" (Beaucage 1998) and brought the municipal administrative center of the Sierra (equivalent to a county seat) under mestizo control (Sierra 2002). Nahuas retreated to the less accessible and outlying hamlets while continuing to participate in mestizo-dominated political, judicial, economic apparatuses (Beaucage 1998). Mestizos wielded power over commerce by setting prices for crops, controlling the distribution of foodstuffs, and maintaining a monopoly over the access of roads in and out of the Sierra (Pare 1978). Nahua economic activity remained characterized by small-scale agriculture, with land tenure by private land parcels worked by individual families (Rhodes 1999). Eventually mestizos, who remained a minority in the region, came to own over 80 percent of the land and wielded the dominant control over the economic life of the community (Lupo 1995). Socio-economic inequalities thus mapped over ideas of racial and ethnic difference.

In the 20th century, political leaders viewed the region as an embarrassing incompletion of the national project, remarkable more for its “Indian problem” than

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5 When state officials attempted to encourage the growth of mestizo small to medium size landholders Nahuas mounted resistance against coffee planters (Stacy 2002).

6 A form of social control was through the commercialization of religious festivals. Mexican anthropologist Luisa Pare notes that the regional bourgeoisie knew how to incorporate ideological aspects into capitalist development, both to profit from the ideological aspects as to ensure that the system would continue to be reproduced. Nahua came to depend on commodities such as salt and brandy, as well as commercialized products for their religious festivals, and the collusion of mestizo merchants with local officials in coercing Nahua to accept the terms of trade was commonplace (Pare 1978).
anything else. A site for a long standing struggle between government actors, political strongman, and indigenous people, the region became one of the most conflictive regions of the republic (Reina 1979; Tuino 1990 in Esquivel 1994: 62; Servin et al 2007). In the 1970s and 80s, paramilitaries, with connections to caciques and state officials, violently repressed indigenous efforts to assert economic and political rights (Valle Esquivel 1994; Pare 1978: 46). While political strongmen applied extra-official repression to control communal institutions, Nahua people were able to achieve some level of negotiation by co-opting state institutions themselves (Sierra 2005). These negotiations however were limited due to the political and legal subordination of Nahua (ibid).

**Reforming the Region**

It would be well into the 20th century before federal agencies established a presence in the Sierra (Acevedo Rodrigo 2012). Debates about how the Indian population could be integrated into the national body converged with ideas of social engineering. While many elites considered the therapeutic transformation of indigenous “others” into disciplined and productive workers a risky but necessary endeavor (McCrea 2002), government agents considered that the “progress” of the nation-state depended on this assimilation (Villa Rojas 1976: 11-12 cited in Page Pliego 2002:26). Under the ideology of an integrationist *indigenismo*, the state could help “reform” indigenous people into the model of a modernist, *mestizo* citizen, who went to school,

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7 While the Sierra “experienced intense mobilization in the form of land invasions and semi clandestine peasant organizing” (Fox 1993:181-183), it was ultimately "defeated by army occupation" during the beginning of the Portillo administration (Ramos Garcias et tal 1984 in Fox 1993: 181-182).
saw the doctor, worked for wages, and bought their clothing and food, and generally abandoned subsistence and communally based lifestyles (Lewis 2008).

During the 1920s and 30s, the Ministry of Public Education (or SEP, a precursor to Mexico’s Bureau of Indian Affairs) began to build linkages between the federal government and indigenous refuge zones (Lewis 2008; Acevedo Rodrigo 2012). Teachers were sent to begin the task of suturing together national and indigenous life by introducing scientific technologies (ibid). They were encouraged to participate in the routine practices of village life; they vaccinated children, taught beekeeping and the use of fertilizers, and promoted hygiene through the use of individual eating utensils (Acevedo Rodrigo 2012). Forming the first cadre of intermediaries for the spread of dominant ideas, teachers planted the seeds of dominant culture which would begin to compete for cultural authority with local medicines.

In 1949, the creation of Mexico’s bureau of Indian Affairs, the National Indigenous Institute (INI) designed programs of hygiene and vaccination campaigns in collaboration with the Ministry of Health (McCrea 2002). As Director for INI, Biologist Aguirre Beltrán that government authorities should recognize indigenous healing methods and valorize the “positive” elements in order to better serve indigenous regions (Aguirre-Beltran 1963, 1980). However, national ideologies of progress reinforced the desires of academic physicians to eradicate urban and rural curanderos (Page Pliego 2002; Campos-Navarro 1996). Consequently, in the 1950s, as part of a federal attempt to make-over an indigenous zone in its own image of the modern nation-state, a biomedical public hospital was built in the Sierra Norte.
Under the presidency of Lopez Portillo from 1976-1982, the hospital was assigned to the National Indigenous Institute (INI), with the intent of more adequately serving the indigenous population. Mexican intellectuals reformulated “integrative” indigenismo, which had been based on assimilation, and replaced it with a notion of “participatory” indigenismo (Bonfill Batalla 1987:176 in Page-Pliego 2002:29) and “ethno-development” that was imagined to be more adapted to cultural needs (Garcia Ramirez 2001). It was a shift that occurred simultaneously to the strengthening of national indigenous movements throughout the country, which inspired long time indigenous sympathizers and more progressive factions in INI.

As an INI hospital, the mandate of the hospital was shifted to one which prioritized the indigenous population. INI shifted its policy from the condemnation of traditional medicine as superstitious and unscientific to the promotion of the “rescue” and “recuperation” of indigenous medical traditions that were deemed beneficial or benign. It also established a regional health program that promoted the use of both allopathic and indigenous medicine. For the first time the hospital permitted entry of curanderos or midwives at the discretion of families and their patients. The indigenous healers were invited to accompany their patients in the hospital. Beginning in the 1980s, INI also located healers in the countryside's of Mexico to register them, viewing them as potential resources for extending public health.

Registering healers was not an easy feat. Local officials and authorities were in charge of recruiting healers who in many cases were reluctant to participate. Some healers who were firsthand witnesses to this process in the Sierra in the earliest years said they joined the meetings and registered themselves in fear that they might be fined.
if they did not (Panchita personal communication 2005). As another male healer described the process in the following way:

In those years [1980s] the people [the healers] were just starting to be brought together. The government wanted to register all healers, but it didn’t achieve this because many [healers] did not want to. Many did not want those kinds of obligations with the government, to be going to meetings and to talks, etc., and they preferred to work on their own. It was also difficult to identify [who the healers were] as many didn’t want for people to know that they healed others. (Don Fidencio, personal communication)

Local modalities of healing and medicine were widely shared and exchanged in the Sierra to treat ailments such as fevers, empachos, diarrhea, and backaches as well as sustos and other spiritual afflictions. Many people healed their family and friends in their homes. The existence of domestic or household healers who healed but were not considered to be curanderos was common; Doña Justina, a Nahua woman who is part of a woman’s cooperative in the Sierra, told me:

In that time there were more people who dedicated themselves to this [to general household healing]. They didn't distinguish themselves as curanderos; they were people that practiced medicine just for family needs but they didn't do it for others…my mom and my papa they both did limpias to people but they would do it as a favor. They weren’t dedicated to that. (Doña Justina)

Her mother taught her herbalism, and her father was known to cure empachos (digestive disorders) and quedados (people whose spirit had stayed behind in a place because of fright). However, neither were considered curanderos, and it was common to exchange curative and preventative practices steeped in local cultural idioms (such as limpias, or “cleansings”) within an intimate circle of reciprocity based on kin and extended kin alliances.
Curandera Doña Rita, who was one of the founding members of the organization, confirmed this sentiment, revealing additional challenges for women in the Sierra who were not accustomed to leaving their homes to work elsewhere:

At the beginning, really I didn’t want to go to the hospital. I said, what are they going to think of me? And one day I went, and the next day I went, and on the next I went. Someone [gossiped] saying that I was going to see a man over there that was waiting for me. I said to them, “Inform yourself well. We are going to work.”…We went and presented ourselves to the doctor, and they said you will cure in the hospital. I was the first one that used for the first time a room that they had made for us…On a bed of rock [we cured]. I grabbed my tortillas and put some lentils on top and off I went. (Doña Rita, personal communication)

Doña Rita was unsure at first about healing patients in a public space, especially in light of the region’s gender role disparities. However, she persisted, inspired by the service she felt she was providing both to her patients and her fellow partners in the organization, who in some cases had less experience working as healers than she did:

We didn't charge so that people would come. I treated many, many people. And I mentored many healers that wanted to learn. Doña Caro was scared, and I said, “You put faith and you say, dear God, I am going to do this. And he is going to defend you.” She didn't want to, and she said, “Better you do it.” Then, little by little, I went helping, training. She didn't want to at first, but she accepted being a curandera. She became two things; she is midwife and a curandera. (Doña Rita, personal communication)

Other healers were recruited to lead the organization. Doña Barbara, one of a handful of bilingual healers with more advanced schooling and literacy than the rest of her cohorts (who also was from a different region) explained how the INI coordinators recruited her to help them form the organization.

Many times the engineer Javier [from INI] came to invite me. And he used to tell me, “Come, let's go”, and well, he convinced me and I came, because well, he took me to Puebla. He asked me to go with him and do this, and do that, and the other. I didn’t want to join the traditional medicine clinic because I had work at home, but he said, “No, this is good for you.” And he said, “You can learn the scientific names of the plants.” And I used to tell him: “And why do I need that? It’s enough that I know the plants, even if
others don’t.” Then he told me: “This is going to help you a lot.” And that’s how he kind of convinced me….But then [what really convinced her] is that I liked traveling around from place to place (paseando). And there you have me, meeting other people in different places. And I met many doctors that came from other places, allopathic doctors, traditional doctors from other places. (Doña Barbara, personal communication)

The goal was to create indigenous organizations that would work together with INI advisors towards the promotion and local development of traditional medicine. However, it was also very much about politics, as Doña Barbara described regarding constitutional article 4, or the Law of Health which intended to promote the participation of communities, with all their resources, in the care and promotion of health and cure of diseases" and included the incorporation of “indigenous medicine” into the state’s official health sector (Page Pliego 1995):

We didn’t go to talk about medicine, we went there to talk about politics, because, when we were organizing ourselves, it was for the politics. Yes, it was for the constitutional article 4, we went to see President Salinas…I don’t know how many groups [organizations of traditional doctors] were involved because there are many, there were many there. (Doña Barbara, personal communication)

The emphasis on community involvement and cultural rights came together with a neoliberal emphasis on participatory strategies for healthcare, and a gradual disinvestment in healthcare.8 With the assistance of INI, organizations of “traditional doctors” began cropping up throughout Mexico, growing from 2 in 1990 to 57 by 1994. These were formed as independent Civil Associations to be governed by rule of general

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8 Ex-President Salinas was responsible for passing Article 4 of the Constitution called the Law of Health (Ley de Salud) (1984). We can also see the reiteration of WHO's mandate in the words of Salinas: It was necessary to promote a reassessment of indigenous knowledge. Traditional medicine was apt for this purpose because (of the breadth) of data observed and accumulated by the indigenous groups…Naturally, the task had to involve traditional doctors…We believed it was also necessary to encourage contact between practitioners from different regions, not only to compile information, but also to support and promote a nation-level organization belonging to them, which would enable their participation in wider processes relating to medicine and the extended use of their knowledge (Salinas 2002: 727).
caucus and represented through an elected committee. Membership regulations stipulated that to join one had to be an indigenous healer recognized by the community and could not be a professional, or “an educated, degreed, and titled person.”

When INI first organized the healers, their “specialties” were translated into generic categories; just like it was imagined that traditional birth attendants were found in most societies (Pigg 1997), it was also imagined that healers could be lumped into one of three technical specialties: midwives, herbalists (glossed as curanderos), and bonesetters. However, these were not obvious categories for everyone and many healers found it difficult to define themselves or constrain their practice within one category.

INI garnered funding to assist with the expenses of meetings, transport of healers to the hospital, trainings and workshop, and supplies for making remedies. The hospital was renamed a “mixed hospital” and while traditional medicine was offered regularly, the biomedical side of the hospital also received additional support from NGOs (e.g.

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9 In the case of Don Fidencio, he had also been a part of the group of healers that were identified and registered. But the kind of healing that he did was not suited for such categories, nor could he find work all day practicing his specialty. His don (gift) was that of being a twin. Twins have the special capacity to cure what he says is the famous xoxa, although I had never heard of it. As he explained it, “Xoxa is “when one is feeling fatigued and can no longer lift the machete, and later the arm swells and they can’t use it.” When he was a little boy, people would come to his house to ask him to rub them with his saliva, and that’s when he says he realized his don because they did get better (“si sanaron”. However, he like other curanderos with “gifts” that weren’t easily translatable, found no place within the organization to work as a traditional doctor.

10 For example, assuming that a midwife must only concern herself with the process of pre-and-post labor misses the fact that a midwife is necessarily at the same time a curandera, or one who practices the art of the spiritual protection of the patient, as well as herbal healing, and she is often a bonesetter, as well. Most people resolved this tension by practicing one thing at the institution, but healing what they wanted to at home. This was echoed by Doña Paulina when she told me that when she was first registered, the organizers of the traditional healers made her choose one specialty, and she was registered as a midwife only. But she said that she is also a curandera and a bonesetter. Healers’ collective concept of themselves and their work is thus much less rigid than the categorical specializations to which stage agents obligate them, and they have often mention that one of the advantages of participating in the traditional medicine clinic is that they are able to exchange ideas, learn from one another, and expand their own healing repertoires.
National Institutes of Nutrition and Pediatrics) and universities. It was celebrated as a successful intervention in indigenous healthcare and at the same time offered healers the possibility for “modernizing” their forms of medicinal production.

One female healer in her 70s who I interviewed, Doña Petra who was not affiliated with the hospital and preferred to practice as a healer of children’s illnesses independently in her home, recounted teaching officials at the hospital the herbal knowledge that she had learned from her mother. At that time, she washed clothes for the women who had given birth at the hospital but her expertise was solicited from the biologists that had come from Mexico City as part of the IMSS initiative to create a botanical database. In exchange, she was taught how to produce capsules and make other remedies.

I went there [to the hospital] to teach. There was a little grandmother there, I tell you, the little grandmother that was there. The first time that the hospital opened. She had a notebook like this (so thick). And I went to tell her everything, everything, everything. After that she began to work with that information...It’s been a long time now. Perhaps she is no longer there. She had a friendship with me. She was from far away, she came from parriba (‘up above’, the capital). She studied herbs. With this information, they called the rest [curanderos] and started to make the ointments, the capsules. (personal communication, Doña Petra, 2007).11

For some younger healers, they described the hospital as a fuente de conocimientos, a well of knowledge, because of what they could learn there through the biologists, massage therapists, aromatherapists, that have given workshops at Cuetzalan. Another of the more respected healers, Doña Esmeralda, told me that it was “better to be registered” because “we get together and exchange our experiences. If we

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11 The “grandmother” that she is referring to is most likely Abigail Aguilar Contreras. I took a course with Dr. Aguilar Contreras at IMSS in Mexico City that was geared for health providers and where she established a herbarium of medicinal plant samples. With WHO’s first statements regarding the vision of traditional medicine in the 1970s, she and several other scientists became very involved in researching medicinal plants and their ethnobotany all over Mexico.
learn that a particular plant heals, we use it ourselves”; she explains that this was not how it was done in previous epochs; everyone had kept to himself or herself and there was no exchange. She scoffed when she recounted how another healer whom she had encouraged to register with the clinic, said "I don’t want to waste my time, I’ll be in trainings and my patients will be looking for me, and won’t find me (at home). It’s enough with what my father taught me!” Doña Esmeralda found this kind of thinking limited and laughable, repeating again what he said: *Dice basta con lo que le enseno su papa!* “He says it’s enough with what his father showed him!”

In fact, the opportunity to expand one’s repertoires as a healer at the clinic was something often mentioned to me by healers. For example, a 74-year-old healer named Doña Paulina told me one day that she had been a midwife for more than 40 years, and a curandera for only the last two years. Surprised by her more recent entry into curanderismo, I asked her how she had become one at such an advanced age. Having only affiliated with the clinic in the last couple years, she recounted to me with an obvious pride and a big smile that she had become a curandera by observing and learning from her companions in the clinic; they had taught her how to do the spiritual work in the clinic.

This discourse about learning curanderismo in the clinic is something remarkable in light of the official discourse that gets circulated about how healers become healers. The clinic itself likes to highlight how healers learned their trade “from their little grandmothers or grandfathers” or how they were born with a don. But when I ask healers how they came to learn, while many did talk about a family member, or having been gifted with healing, just as many talked about the fact that they started to heal
“from necessity”. Don Rafaels’s mother was a healer, but he himself did not begin to heal until after she was gone, and his children were always falling and needing to be cured of susto. Don Francisco was asked at the age of 40 to do a spiritual calling back of spirit. And Doña Mercedes told me that she learned in the clinic how to give therapeutic massages “por necesidad”; her “gift” comes from her need of doing something to survive economically.

Healers also talked about how important the trainings at the hospital were for their repertoires. In my many interviews with them, healers often mentioned about how much they had gained by participating in the unit, especially during the years when the hospital was under INI. They learned to make capsules, remedies, lotions, syrups, and, through the help of a biologist that was very highly esteemed by the healers, they learned recipes of different herbal concoctions that they had not known before. While they had known how to make pelotillas (little balls of a number of different herbs that are put in the anus as a treatment of susto), or potions to combat mal aire, the biologist taught them how to make warming balms for massaging into twisted muscles, cough syrups, and shampoos to treat problems of the scalp.

One of the younger healers, Doña Cora, talked about what she knew of the history of the organization from the elders. She joined the year after it was established, and had been president in recent times. She recounted that:

In 1990, the organization was initiated. And this is what spurred the work [of healing]. In other words, we still didn’t have any affiliation with the hospital, instead we were working independently, we worked here for many years, 11 years, as the organization of traditional doctors…that is autonomous, in other words, it did not depend on any institution. It was, it is, the SSS, it exists still but is no longer inside of the hospital. (Doña Cora, personal communication)
With the assistance of INI and funding they had acquired through the Kellogg Foundation, the traditional doctors helped to build the unit at the hospital as a place for them to provide therapies, contributing their *faenas* (or volunteer work sessions) to create the hospital’s traditional medicine clinic through their labor.

And then like this, we went little by little working. Instead of giving 20,000 pesos to install water, they [the government] gave us the materials to compose the clinic. Later arrived a project of 120 [thousand pesos] I think, with this we built the traditional medicine clinic. (Doña Cora, personal communication)

Under INI, the explicit outlook was for serving indigenous people and the hospital came to be perceived as truly an indigenous hospital. A mestiza woman, who is a certified midwife herself, told me that she felt that the hospital was truly organized around indigenous people.

With INI it was different. [The hospital] was more open, the nurses were bilingual, and they were all indigenous (Doña Vicky, personal communication).

Doña Barbara explained however that not all healers nor midwives were interested in working at the hospital, especially when they had the conveniences of their respective homes:

In INI, midwives went into whatever part of the hospital they wanted. The doctors attended the births, but we were able to help. Many years ago I was there, but I never attended births, because I don’t like [the setting]. I don’t like to go there, because, why, if here I have space and I have everything, am I going to go there?, If the baby is going to be born, well it’s going to be born in the way to my liking; I’m not going to be listening to what other people say. In the end, I know what I do, and I have a lady who cleans everything, and uses lots of bleach, which disinfects everything, and it’s done! Since I’ve been here, thank God, I've had births, if only 1 per month. (Doña Barbara, personal communication)

Nonetheless, the hospital became a nationally celebrated example of a model of healthcare for indigenous zones. President Salinas de Gortari visited the hospital on
one occasion, promising the creation of similar facilities throughout the country. However, only one other National Indigenous Hospital would be created (in Nayarit), and ultimately the project would come to a halt. National forces were restructuring the possibilities for *Indigenista* projects, and the country’s shift in priorities meant little interest in dedicating funds to the development of indigenous traditional healthcare.

**Neoliberal Disinvestments**

After a concerted effort to develop a regional health plan that would attend to the specificities of the social-economic and epidemiological profile of the Sierra Norte, INI’s health program for indigenous zones remained underfunded and without the regulatory and technical support of the official health system (Zolla and Marquez 2004). By 1994, INI was experiencing the growing inability to fund the project. Governmental funding for the indigenous hospitals and clinics as well as the Traditional Healers’ Organizations began to disappear within a decade of their establishment. Discussion of the importance of these projects continued, but real governmental commitment waned in the context of neoliberal retrenchment in state spending. Cultural rights had emerged alongside the rise of neoliberalism, which meant that while the government was now expected to recognize and uphold rights of indigenous cultural difference, its responsibility to regulate the economy and sustain social programs was increasingly rescinded (Ortner 2011). These initiatives came to be seen as interesting but ultimately inconsequential experiments for indigenous healthcare (Pilsbury 1982).

After almost 10 years of functioning as a National Indigenous Hospital, neoliberal health reform which included the decentralization of the health sector as well as a World Bank funded program for extending coverage of basic health services for the uninsured put the state’s Ministry of Health in a prime position to propose its takeover of the
program. By 1999, the “mixed” cultural mandate of the hospital had been terminated abruptly and the hospital from the National Institute to the Ministry of Health. This presented an abrupt ending for the healers who had been working there, and the new administration displaced the organization of traditional healers from the hospital.

Doña Guadalupe was the first to fill in the silences that lingered uncomfortably in the recesses of the hospital regarding what had happened to the original organization of healers. She told me that although the “partners” (*socios*) or fellow members had contributed the labor to build the clinic and served as the healers, and INI administrators had first told them that this was “their house.” But only a few years later they were told, “It’s no longer your house.”

Doña Rafaela poignantly expounded on the significance of these events:

We worked here [in the space where the hospital is] for many years, 11 years, as the organization of traditional doctors. We worked autonomously as a civil association without depending on any institution. Then there was a change. INI left, the Ministry of Health entered….and the conflicts emerged. …They told us to leave this place, because the land was theirs, even though the construction belonged to our organization. What happened was that the [the land title] was communicated badly in a document. (Doña Rafaela, personal communication)

When the hospital changed hands, it became just another biomedical institution again with no recognition of its particular former indigenous history. Part of the political logics informing this decision was that indigenous people should be served by the mainstream organizations like anyone else. However, the Ministry of Health’s reestablishment of control over the hospital is remembered by healers in terms of emotional hurt and humiliation:

The way we were cast to the side felt very bad. All the work we had accomplished was left [in their hands], and all the efforts of traditional doctors who were advanced in age and had worked so hard [were lost]. We began with nowhere to heal, but all our hard efforts went into creating this
space, sometimes working for weeks in *faenas* [communal labor] abandoning our homes and families [to build the clinic]."...So we left, and this installation went to [the Ministry of Health]. (Doña Cora, personal communication)

Doña Rita, in a very sorrowful expression, told me of the pain that she experienced at that time:

There was a lot of medicine, everything was thrown out—thrown out—thrown out. And the truth is my heart still hurts sometimes [one hand on her heart, the other raised up as if testifying to this pain]. I think it’s not right what they were doing. And when we asked why they were doing it, we were told those were the orders from the superiors. What could I do? I couldn’t fight them, they were really big important people. I am a poor little old lady [*suaca*]. I just said, “God be with them, and may God help my people.” (Doña Rita, personal communication)

From the way that she related it to me sitting in the open room of her house, the memory continued to haunt her in the present.

Nevertheless, she expressed that she was not at all surprised about this sudden turn of face, what for them was a form of betrayal by the health sector, and a failure of the INI advisors to look out for the healers and their needs. In fact, she had foretold this to the Engineer that was in charge of helping them build the traditional medicine clinic at the hospital:

I told the engineer, remember what I had said to you, that one day they were going to take this place away from us. And look what has happened now! [as she says this, she looks me in the eye holding her head sideways with a look of incredulity and holds up her two hands widely to the sky]... I had told him ever since we began to work, “Engineer, why don’t we buy a piece of land on the outskirts and not here, here they are going to push us around.  “Oh Doña Rita”, he said, “you are the only one who thinks of these things because you are old.”  But when the day came, I asked him, ”What happened, engineer, with what I told you?” [*“que paso ingeniero con que le dije”*]. He said, “Well maybe you knew but I didn’t know.” I said to him, “Yes, but look now at all the suffering, where are we going to work? Where are we going to make the ointments, where are we going to make the syrups, where are we going to make the spoonfuls [of medicine]? How are we going to make the capsules and all of that which we sold. The soaps? Where are we going to work?” (Doña Rita, personal communication)
Contrary to the experience of the healers, many of the original physicians did stay on staff. During my research period, Dr. Ignacio gave me insight into how his fellow physicians think about the midwives and how in his opinion many of the doctors who were at the INI hospital thought:

They were all gung-ho about the project, defending it, they put on the [INI] shirt, but when the Ministry of Health came in and said, “We will let you keep your jobs and will even pay you more,” they left their INI mentality behind. Now, the people that they go and have conferences with and circle with, are not other doctors who also work for INI and who are in the same situation they were in (at an indigenous hospital), but located near the headquarters of the Ministry of Health in Puebla, or even as close as [the next closest city], and are more apt to think that everyone living here “wears guaraches”. (Dr. Ignacio, personal communication)

The displacement of the entire organization by one state-run was taken as an especially harsh and hurtful affront. Sent out of the clinic they had constructed collaboratively, this represented a weighty and painful violation. Doña Rafaela further explained what the bureaucratic change meant for the organization, and the assault it was on what they had together as a community of healers:

…It was ugly, because in our same organization we fell apart; it was a horrible conflict because it went out of control…The patients were no longer coming, there was no roll call, there was no medicine…because there was no money to buy the raw materials and the plants. (Doña Rafaela, personal communication)

Doña Barbara, who had left the organization that she helped to found in the first few years expressed not being surprised at this turn of events. She recounted finding few doctors who she felt were true allies, even under INI. She also felt that those few physicians who had aligned themselves with “tradicionales” (“traditionals”) were looked down upon.

Doctor Marco helped us, out of 10 doctors there were maybe two that were in agreement with traditional medicine. They were few in number, and the director felt forced to support traditional medicine, but not really, because
his real interest was the support that arrived for us, because there was money, that was for the sport team of traditional medicine (la partida de medicina tradicional), there was money for traditional medicine (Doña Rita, personal communication)

Entanglements with Global Capital

When Doña Ana studied my pulse on my first day at the clinic, it was not the first time that she had been asked to interpret the pulse of a person who had come from pa’rriba (literally, from “up there” [Spanish]). After the initial abandonment of the special characteristics of the former INI hospital, the office of Planning at the Ministry of Health in Puebla seized on an opportunity to apply for Plan Puebla Panama funding and capitalize on the former project of traditional medicine. In 2002, the government of the state of Puebla proposed the Program of Integral Hospitals with Traditional Medicine (PHIMT). Puebla's Ministry of Health won the bid by submitting a model for a "mixed hospital" based on the previous INI hospital

PPP funded the very needed renovation of the older hospital, and built 5 other new ones based on this model of a principal biomedical center with a traditional medicine unit. Renamed the Hospital Integral con Medicina Tradicional, the project was awarded to the state by Plan Puebla Panama (PPP), a multi-billion dollar development plan. PPP was an ambitious transnational development proposal aimed at laying out the physical infrastructure (highways, air and seaports and energy grids) required for the Free Trade Area of the Americas (FTAA) to operate. Its stated intention was to promote the "regional integration and development" of nine southern states of Mexico and all of Central America and Colombia. Presented by then President Elect Vicente Fox and formally initiated in 2001 as a strategic component of Mexico's National Development Plan, it targeted the “south of Mexico,” or the poorest indigenous regions (beginning in
Puebla state) it proposed economic development for the entire Mesoamerican region and promised “progreso para pueblos olvidados” (“progress for forgotten peoples”).

While the main emphasis of the plan was “to begin construction of great corridors of highways and railroads, of pipelines and electric power lines, of ports and airports, that quickly and efficiently connect(ed) all the development zones from Panama to Mexico and to end the backwardness of the region in order to incorporate it fully in the corridors of world commerce” (Mexican president, Vicente Fox, at the ceremony inaugurating Plan Puebla-Panama, March 2001), the Plan also had allocated relatively small amounts of funding for Human Development projects. The objective, according to the Inter-American Development Bank, was to “take advantage of the human and ecological riches of the Mesoamerican region within a framework of sustainable development and respect for its ethnic and cultural diversity” (IDB 2002). The plan also contained a significant emphasis on tourism development. Coalitions of activists had protested the plan, decrying it as another scheme for multinational corporations to generate profits at the expense of people, the Ministry of Health used the funds to renovate the hospital’s dilapidated structure, purchasing much needed supplies and constructing 6 other hospitals like it in municipalities around the state.

Upon winning a multi-million dollar project, the “mixed hospital” was resuscitated and displaced healers were solicited to come back into the hospital. Later, the Ministry of Health said that they had made a mistake in disbanding the clinic, and hadn’t realized what they were inheriting an indigenous hospital. The new version of the "mixed hospital" looked in many ways similar to the first.

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12 In just the first year, over 10 million dollars were designated to the plan.
Shiny new governmental pamphlets pronounced that the hospital was providing medical attention that was locally determined and “adapted to the traditional medical practices” as well as “cultural patterns” of the indigenous zone it serviced (HIMT 2003). The inclusion of indigenous traditional medicine in the official health sector was expressed as a logical step in the democratization of healthcare. With the funding came the branding of the hospitals and the letters PPP were accompanied by a logo which innovated on the medicine rod of Asclepius by inserting the Aztec plumed serpent Quetzalcoatl in the design. This logo was stamped everywhere in the hospitals, on letterhead, ambulances, lab coats, and on the portfolios of Ministry of Health personnel in charge of administering the projects.

The hospital's acclaim only increased when it won a very prestigious national Ministry of Health award for its work with traditional midwives, placing indigenous midwives and the hospital on the national map again and reinforcing the multicultural achievements of the nation-state.

However, while the new hospital looked very similar to the old one, there were important changes.

And while many still work here, this [situation] is very independent, very separate [from our organization], because here the Ministry of Health rules. Here you cannot say: “You know what? Today we are going to prepare this much [medicine] because a fellow healer needs [our help]. It's not possible. Here you are going to do what the supervisor tells you because they are the ones who order us ["nos mandan"]). Here we are nobody; here you are, in a word, just a laborer. (Doña Cora, personal communication)

While the new MOH hospital had invited healers back, at least initially, they were presented with a challenge to find other healers or to bring back those who had been peremptorily thrown out of the hospital. However, by the time that I arrived on the scene, a number of the original members of the organization were, in fact, back in the
clinic and many new healers had become affiliated. Not all the healers returned, but some did and found a few new perks available because of Plan Puebla Panama’s money. Healers who came to staff the clinic or produce remedies were enticed by the comparatively generous compensation of two meals a day, plus a daily stipend of 70 pesos for transportation costs. The hospital kept the former patient fee schedule of a maximum of 20 pesos per consultation. The project itself meant the channeling of monies into not only traditional medicine, but also into the expansion of biomedical expansion. The funding was mobilized in the name of traditional medicine actually rebuilt and refurbished, entire hospitals in rural zones.

Now they [the Ministry of Health] have their traditional doctors, who are practically the same people but with another name. Here [at the Ministry of Health hospital] there is no organization, you could say it’s now just a group. (Doña Rafaela, personal communication)

While Doña Rafaela’s mention that, under the auspices of the Ministry of Health, healers are now “just a group” might sound like a trivial detail, it provides a clue to understanding what this institutional transformation meant for these healers and the violence implicit in the request for their current participation in the project. From a civil organization recognized by the INI and working within the hospital but retaining an autonomous organizational structure along with a level of self-determination and internal leadership, the organization became, not members, not partners, not even employees, but a “group” subject to the Ministry of the Health as workers who had lost much: their patients, their social formations, their prerogative to self-organize and their resources.

In the transformed relationship to the hospital, the healers still smart from an illegitimate kind of integration in which their autonomy as one of the largest organizations of traditional doctors was usurped. Doña Lina explained that she felt the
Ministry of Health had said, “Get out of the way and lend me your chair so I can sit. And you can go ahead and leave because you are going to get tired standing.” They also smart from losing the sense of self-determination they had:

When we were the [original healers’ organization], we would prepare perhaps 200-300 bottles of remedy to sell, and if a fellow healer was in need, perhaps she was ill and needed help, then we would say, we will sell this for her because she is in need, and we would come to an agreement together in the assembly. Now we cannot do this, because now we are only laborers here, we are not owners…we have no voice because here we are ordered. (Doña Lina, personal communication)

That the institution promised to recognize them, but then did so essentially by appropriating their work as laborers was not lost on the healers. They lost control over the means of their production. They also lost the power to collectively determine what “traditional medicine” they would be producing. With the change in administration came an increasing homogenization or popularization of the medicinal remedies healers would use and the original vision that really they would in fact produce medicine for their local region and medical sensibilities.

There are less medications now. Now there is only made I think 20 products when there was up to 50 products. I don't know what has been done that everything has been modified, I've often said that they should make products, and that the pharmacies continue to function; they no longer function. And there were pharmacies in Tuzmapan, Zoquiapan, and San Miguel I think was the other one, and it looks like they are not functioning because they don't send the medications (Don Alberto).

Don Alberto was referring here to a change in policy that occurred while I was conducting my research around the medicines clinics would produce. All the traditional medicine clinics, despite being in very different regions of Puebla with different medicinal traditions, would make a standard 20 products. Doña Petra, who had originally provided some of the herbal recipes for the initial INI hospital project notes that the quality of what is being produced is suspect.
Now with the Ministry of Health they have really changed. They use just a few classes of the plants that the recipes call for. The *pelotillas* takes 10 classes of plants. I went to the hospital and found out that they are only putting the two *matantzins* and the avocado leaf. But it’s not enough because it also takes mamey, and the other *matanzin*, *estafiate*, all of that. *Mozote*, and two of *epazote*, the purple and the white! (Doña Petra)

When I asked Doña Justina how she saw the project of traditional medicine in the clinic, she told me:

I don’t know, I’m not sure. It’s like they need more. It’s like they have been given the space, but I feel they need more recognition for them, on behalf of the institution. Because many times they [Ministry of Health] only use them to say that they are doing something, but really, not much is done. Sometimes it’s to steal a bit of their knowledge. Perhaps not the people from here, but people arrive that they can do this, and I think that they have done it [stolen their knowledge]… and at least me, coming from Plan Puebla Panama, I would be very distrusting. Because what is the Plan Puebla Panama, where does it come from, what is it aiming at, what do they want, what is their objective? Their object is not to help the people, but their objective is to pull everything they can for themselves, so there is what I say, if really the Ministry of Health would dedicate themselves to coordinate with them, to support, it has been done. But when you mix it with other things, as they say, watch out [be careful], because you are hunting something that is not good. (Doña Justina, personal communication)

Mixing it with Other Things: Healers Hijacked for Ecotourism

One day at a meeting on a Sunday, bored *curanderos* waited as the engineer, Miguel from the CDI, the organization that had in recent years been INI, turned pages and pages of a printed proposal for the eco-tourist-medicine hotel-restaurant-museum-and artisanal-store that he has been working on. He did this as a response to criticisms that more time had passed and nothing had been done towards the Center for the Development of Traditional Medicine for the original organization of traditional healers that had been sent away from the hospital. “Hey! "I’ve been working” he tells the healers. But the healers are tired, and tired of sitting in the unfinished “white elephant”
of a building, someone called it, as roof beams were rotting from exposure to the elements during the three years the project had been abandoned.

After the meeting the engineer asked me for my opinion, and for a moment I see it dawn on him the absurdity of what they have: a humongous half-unfinished building that took hundreds of thousands of dollars to build, while the traditional doctors don’t have money even for the 5-peso truck ride from their communities and must walk for over an hour to attend the meeting. “Who”, I asked him, “ever planned such an enormous building?” He told me it was them, the traditional doctors, who along with the architect designed the building. He adds that now, “They just don’t remember.” The engineer continued to protest that they just don’t remember that they wanted the building like this. But then he confesses that there was an extra 2 million pesos that had arrived to be spent on the Center [on top of the 750 thousand pesos] and that they were forced to make the building even bigger. Only now, they were short several millions of pesos to even finish it.

I listen to him as I wonder whose desires were manifest in the structure of the building. How is a towering and all engulfing concrete structure, whose very structure subsumes local ecologies and imposes itself on the landscape, a center for the development of traditional medicine? And was the plan to partition small, independent rooms for each of the “three specialties” within this huge building, when I often saw healers work together to heal a patient? Finally, how, and within whose imaginary and by whose terms, was this a reflection of traditional medicine, of indigenous culture?

The original traditional doctors’ organization had been compelled to construct another calli or “house” of medicine. Doña Rita described the events that transpired to
me after the traditional healers were removed from the hospital. She said that the engineer told her:

You, Madame, don’t worry; we are going to find a place. We went looking. We went to the municipal president to see if they would give a piece [of land]. (Doña Rita, personal communication)

The architect had shown them the project: “This is how your house will turn out. Do you want it smaller or how do you see it?” (Doña Rita, personal communication).

The engineer told us, “There is enough money, there is enough money.” Through the work of the advisors, the Secretary of Tourism had promised to help them build a space after they lost their space in the clinic at the hospital. Talking to Doña Marina, an older midwife and curandera with long white braids and a pleasant face, she told me that she didn’t understand why they didn’t make the building half the size that it was, leaving the other part, and the second lot of land, with no construction so that they could at least plant medicinal plants. What stood now as the material embodiment of what many recounted as a vibrant organization that began in the 90s was an unfinished construction, strikingly out of place among the much smaller villas surrounding it on a rocky lane several streets above the rural hospital itself. Apparently, with the assistance of the project advisors and the architect, the building imagined by the healers became so enormous that the funds ran out to finish it and the healers were left without a place to heal their patients, and without much hope that they would ever have their own center. For three years the building sat, unfinished, and with no water or bathrooms or proper conditions for its use. Then, during my time there, things started to move again.

A year later, at another meeting inside the windowless monolith of a building the organization’s advisors had come to bring good news about their project’s re-funding. It was announced during this meeting that the Center for the Development of Traditional
Medicine has received new funding. The Secretary of Tourism has promised to help them finish the building and it will take on a new guise, that of an ecotourism traditional medicine resort, complete with restaurant, museum, hotel rooms, and of course, spaces for healers to heal “patients”, those tourists who are seeking traditional treatments. Ironically enough, it was at this same meeting that the healers, as well as myself, first found out about the passing of a law that officially recognizes traditional medicine, Article 2 of the Constitution of Mexico recognized the rights of the indigenous people to “preserve those elements that give them their cultural identity, and purposefully take advantage of traditional medicine.”¹³

The meeting comes to a close and healers called to take a stand and raise an arm in typical national Mexican allegiance as they are praised for the work that they do for their communities as healers. Still it is not understood how healers will continue to “serve their communities” when they are busy making breakfast, or tending beds, or conducting sauna-style sweat baths that serve tourists. The significance of this is not lost on all of the healers, and some sense an inherent contradiction in receiving the news of the passing of the national traditional medicine law and of the decision to turn the building into an ecotourism hotel. This decision was made by the small directorship committee of younger Nahua healers who perceived that the only way that their project of indigenous medicine can go forward financially is to abide by the desires of the funding agencies.

¹³ El Artículo 2 de la Constitución Política de los Estados Unidos Mexicanos, reconoce los derechos de los pueblos indígenas a "preservar todos los elementos que les brindan su identidad cultural, así como a aprovechar debidamente la medicina tradicional". Legislación Federal (Vigente al 30 de noviembre de 2005).
As 65 year old Doña Rita explains, “now that we finally have achieved that which we were waiting for so long, what we have fought so hard to accomplish, now they want to make a hotel out of our center for indigenous medicine.” At a subsequent meeting to discuss the details of the ecotourism project, the organization was told that there can be no midwifery in the building, as that would upset the guests. In addition, there would be no treatment of diseases. During our interview together, Doña Rita turns to me to ask in an incredulous tone:

How are we going to throw away the tapajtianij (indigenous healers) if we are macehualpačti (indigenous medicine) you can’t do that. How can you end the Center of Health and make it so that it goes to serve tourism? And (how can you say) that there be no more macehualpačti, just like the doctor there told us at the meeting: “You all go to your houses if you want to parturear (practice midwifery). If you all want other things, to your houses to go heal. But here of diseases we are not going to speak, of diseases, nothing.” (Doña Rita, personal communication)

Through the story of the appropriation of the INI hospital by the Ministry of Health, and then the transformation of the Center for Traditional Medicine into an Ecotourism Hotel, we get insight into the kinds of relationships that were severed, and reconfigurations that were made, under what is publicized as a further democratization of medicine. Academics have historicized the different incarnations of what is known today as the Integral Hospital with Traditional Medicine, rendering in broad strokes the different stages in the changes of command over the years at this rural hospital, these renditions gloss over the meaningfulness of this regime change for healers themselves, easily eclipsed by the progressive move that is attributed to the Ministry of Health, and later the Secretary of Tourism, in its recognition of the value of indigenous culture.

The displacement of that original group of healers sits uneasily juxtaposed on the inside and outside of a hospital that has established itself as the main loci for “traditional
medicine.” Interestingly enough, at the time that the Ministry of Tourism was celebrating the inauguration of its plan for the ecotourism hotel with a visit from high officials from the Ministry as well as from the CDI, officials from the state government of Puebla, and the municipal president, the coordinators at the hospital clinic became very excited, one of them telling me “what we need to do is turn this hospital into a hotel!”
Figure 4-1. A healer doing a treatment on a tourist who is visiting the area. Photo courtesy of Jennifer Lynn Hale Gallardo.
Figure 4-2. The stalled building project of the traditional healers organization. Photo courtesy of Jennifer Lynn Hale Gallardo.
CHAPTER 5
ADMINISTERING TRADITION: MESTIZO ANXIETIES AND THE BRUJO PERMITIDO

This chapter explores interactions between hospital personnel and Nahua healers around the instantiation of traditional medicine as an object of state interest. Scholars have suggested that “state effects” (Mitchell 1991) can be studied through the mundane spaces in which the state is reproduced (Navaro-Yashin 2002). Going beyond “tangible manifestations in garb of the institution” into the “visceral (habitual, psychic, phantasmatic) effects on subjects of political culture” is a way at getting at how people make the state in everyday life (ibid). In a recent essay on the anthropology of embodiment and the state, Perry and Johannason propose "pay(ing) close attention to bodily based practice of persons and various institutions of the state," to grasp the concrete practices that can point to "how the state is “living” in the practices of everyday life"” (Pizza et al 2009).

In Mexico, cultural rights and neoliberal ideology are inextricable from state-sponsored multiculturalism. The unprecedented recognition of cultural difference has brought with it a particular constellation of anxieties, concerns, and conflicted hopes about the role of indigeneity in the nation-state (Hale 2006). In this chapter, I suggest that mestizo ambivalence (Hale 2006) is present in the way that healers and medical personnel who work for a public hospital experience multicultural neoliberalism. This ambivalence can be glimpsed in the circulation of sentiments in the clinic. I enlist Hale’s notion of the indio permitido (authorized Indian) (2006) in order to theorize tensions in the clinic provoked by the incorporation of the indigenous healer, or el brujo permitido (the authorized witch) into public healthcare. I argue that the traditional medicine clinic offers a window for examining the shifting anxieties under state-sponsored
multiculturalism as expressed and negotiated by state bureaucrats who play an
ambivalent role as mestizo gatekeepers.

Disciplining the Unruly Healer

At 74 years of age, the elderly *huesera* or bonesetter Doña Panchita sat in her
*huipil* (regional embroidered apron) and *enaguas* (skirt) with bare feet in a corner of the
hospital conference room.¹ Tension was in the air. Facing her at the front of the room in
her high heels and *bata blanca* (a white doctor’s coat) stood the mestiza coordinator
who was accusing Doña Panchita of “inventing” the names of patients that had been
written down in her notebook. A few dozen healers sat in silence lined up around the
walls of the conference room listening to the allegation.

Lupita cast sideways glances at her assistants as she confronted Doña Panchita,
saying that an unidentified staff member had denied that Doña Panchita had treated her
nephews. The allegations seemed intended to reinforce a particular ethic that they had
heard before: not to exaggerate the numbers of their patients. Maintaining a notebook
was one of the obligations associated with the clinic; in it healers were required to
document every patient they treated outside of the hospital with the person’s name,
diagnosis and the treatment given.² The accusation was not met silently however; Doña
Panchita sat upright, asserting that she did treat the young men and that if necessary
she would take the coordinator to their house to prove that she had.

¹ Most of the female healers, like Doña Panchita, wore Nahua vestments with an embroidered blouse,
and most of the men wore westernized clothing, sometimes coupled with guaraches, or the rough-hewn
leather sandals worn by local peasant men. A few of the healers wore their blue hospital-issued
windbreakers with the logo of Plan Puebla Panama and the Ministry of Health.

² Healers were obligated to write down all of their healing activities, especially those patients that they
treated outside the clinic in their homes, and on a periodic basis, these notebooks were collected so that
the information could be entered into a Ministry of Health database.
The notebook as a technology of modern surveillance and its subversion by the healer was a microcosm of the larger tensions inherent in a postcolonial moment when indigenous healers were being called upon to perform as allies in the public health sector that in a few instances (such as this state-sponsored traditional medicine clinic) desires their (ever provisional) inclusion. The atmosphere of these sporadic meetings was often tense, and such confrontations between the coordinators and staff were not uncommon. The tension inherent in these encounters pointed to both the urgency of state agents to reform indigenous healers into what they perceive as the proper conduct of a state-sponsored indigenous healer or what I argue is a state idea of an appropriate brujo permitido (authorized witch) and the urgency of indigenous healers to negotiate a space for themselves within state health services.

Drawing on work that theorizes states as that "entire complex of practical and theoretical activities with which the ruling class not only justifies its dominance but also manages to win the active consent of those over whom it rules» (Gramsci 1975: 1765 in Pizza 2009:xx), the political contexts in which the embodiment of the state takes place requires a sensitivity to the "intimacy of state power" (ibid). Government acts "in a mutual intimate dialogue with its citizens" ... "working culturally and sentimentally in order to inform" a certain version of the world “as it should be” (Pizza 2009:xx). In this way, we can think about affective states, or feeling states, not merely as side-effect of neoliberal restructuring, but as "central to facilitating the very transformations that we… set about to study" (Riles 2006).

Hale’s notion of el indio permitido (the authorized Indian) (Hale 2006) provides a useful theoretical lens for understanding the contradictions inherent in institutionalizing
traditional medicine through its indigenous practitioners. The *indio permitido* describes a socio-political subject position, one that Hale suggests is part and parcel of neoliberal’s cultural project in an era of increasing prominence of indigenous rights (Hale 2004). State agents recognize the authorized Indian as an actor with cultural rights, while at the same time constrained to a limited expression of these rights under forms of state-sponsored multiculturalism that do not threaten the distribution of political and economic power.

Because of longstanding semiotic associations between *curanderos* and *brujos* and Indian witches, the state-sponsored healer, as a *brujo permitido*, embodied ambivalent meanings in the clinic. Even the most compliant healer in the clinic was apt to frustrate state imaginings of what a proper *medico tradicional* should be, at the same time reproducing tropes with long histories in Mexico about colonial difference and the ever-present danger of an “unruly native” lurking within even the most noble of *indios*. As such, indigenous healers needed to be ever-watched as they learned to be proper self-governing and legitimate state subjects.

**Administering Tradition**

The place from which healers were most often “watched” and traditional medicine was monitored, was the office. While not part of the official tour on the day I visited the clinic, in practice the front office served as the location from where the clinic was administrated. The office was the main hub of activity, or in the terms of actor-network theory, the “obligatory passage point” —an indispensable node intended to meet the goals of all the other actors involved (Callon 1986). Serving as the principal area through which all activity in the clinic passed, the office was simultaneously the greeting area, the archive for patient data, the pharmacy of medicinal products the clinic had for
sale, and the gate keeping locale from which the coordinators could survey the comings and goings into and out of the clinic. Although healers mostly stayed in the back of the clinic, they reported to the office when they arrived to fulfill their day on duty and reported again before they were dismissed, signing off their work with a signature or thumbprint. The office was also the locale from which healers received instructions to make a certain remedy, or orders to clean any of the rooms, or prepare the altar room by furnishing it with flowers. It was also the place where all patients were required to register before seeing a healer, providing their name, date of birth if known, and name of their community or village.

The office embodied the internal contradictions between a state-mandated respect for “culture” in the back of the clinic, and the governance of that “culture” from the front office. The office served as a kind of liminal in-between space through which biomedical personnel would interface with the traditional medicine program. While the hospital’s mission statement was “to interrelate allopathic medicine and traditional medicine with full participation of their human resources”, the office served as an anxious border territory in which biomedical personnel would selectively interface with the coordinator of the traditional medicine program while largely avoiding the healers in the back of the clinic. While the two sides of the hospital may have been physically connected, in

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3 Most often these interactions were about moving patients into the biomedical side of the hospital.

4 The office often received visits from medical and nursing staff of the hospital, including physicians who came for casual chats with the coordinator, the head nurse who might be involved in the transfer of a patient from the traditional medicine clinic to the main hospital side, and the director of the hospital who might touch base regarding an upcoming visit by hospital supervisors from Puebla. The office was also where the director of the hospital went to touch base with the coordinator regarding committee meetings or upcoming health campaigns.
practice there was a very palpable psychic distance between hospital physicians and healers.⁵

Lupita had her work cut out for her in attempts to justify the existence of the clinic and struggling against a sense of third-class citizenship in the larger hospital. She was a steady presence advocating for more interrelation between the traditional medicine and biomedical “sides” of the hospital, often reminding people they “were one hospital and not two” (Lupita personal communication 2007). Her goal was to demonstrate that the *medicos tradicionales* in the back room, or the *inditos* as many local mestizos “euphemistically” referred to them, were not really the charlatans that many suspected but valuable community actors who could be of service to the hospital.⁶ Attempting to negotiate a viable space for people who were still considered *brujos* by many of her cohorts, she urged healers to participate in the kind of activities the hospital would value:

> Let everyone know we are a part of the Ministry of Health and we are a part of the hospital. We want them to realize it’s not just healing and massaging and fixing bones, but we are also health promoters.⁷

The fact that biomedical personnel had serious doubts about the value of employing healers in a hospital was more than a concern at the local level. It was also a serious concern at the upper levels of management, where the Director of the clinics

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⁵ On one occasion, I watched Don Faustino observe a physician who passed without providing any greeting or acknowledgment. He scrutinized the physician’s every move, watching him pass without taking his eyes off of him. For him, it was a breach of basic human respect.

⁶ All healers associated with the hospital had a letter from their municipal president attesting to the fact that they were recognized in their communities as healers, and this was something was called upon as the evidence that healers were legitimate.

⁷ At one of the meetings with healers, she told them this to encourage them to participate in the National Week of vaccinations, by going out to their communities and enlisting people to take their children to the hospital for their vaccinations.
told me once that she had to struggle in order to channel funds to the project, as her colleagues could not justify payrolls for the healers’ stipends that had been signed with a thumbprint (which occurred in the case of the healers who were not literate). The coordinator’s job thus involved not only convincing employees in the Ministry of Health of the importance of healers, but also increasing the visibility of the clinic locally and garnering interest and clientele nationally and internationally. This work was also important for securing the continuation of funding for the traditional medicine clinic.

In public speeches, Lupita often underscored the quality of healers that she felt that public health sector could most appreciate.⁸ Praising traditional doctors for the “confidence” that their communities had in them, she emphasized the healers’ ability to generate confianza (or trust) in their patients. In this discourse, the traditional doctors were a valuable resource for the hospital because of the trust they were said to inspire in their patients. Often cited as the most preeminent reason that the healers should be included in public health initiatives, it was also something coveted as I came to realize one day when the obstetrician of the hospital told me half admiringly, half begrudgingly that he could give a patient instructions and they would be ignored; however, a midwife had only to tell her patient something and it was taken seriously and done.

While most of the physicians were not convinced of the value of the healers as therapeutic entities, there were some moments when their interest in other healing modalities was peaked. Lupita would advertise the clinic’s services to physicians, making an effort to tell doctors that they should come into the clinic, and after a warm

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⁸ For instance, at a local presentation by the traditional clinic to the larger community during the Annual Health Fair in the House of Culture, the coordinator of the clinic says: “Here we have traditional doctors, to whom (people in the community) give their trust.” (Lupita)
shower, “or a temazcal with simple water”—sans the herbs, they could receive a good massage by any one of three of their “therapists who had taken a massage course and had good hands.”

The Ministry of Health also sponsored workshops on non-biomedical healing modalities for the hospital (such as the aromatherapy as well as Korean acupuncture) that would be repeated twice, once to the physicians and other interested hospital personnel, and another time to the healers. One day after a workshop, Lupita’s exoneration was evident after having convinced more incredulous physicians about the scientific efficacy of non-biomedical medicines. One such physician, after having been invited by Lupita to the workshop to learn about aromatherapy, expressed his pleasant surprise afterwards, saying that he hadn’t expected to find bottles of plant extracts and scientific explanations for aroma-therapeutic processes involved in effects. After having attended the workshop geared for hospital personnel, he told Lupita that he had enjoyed it, and that the reason he had not wanted to come was because he had imagined that it would “just be another discussion about candles and a bunch of little herbs”. Lupita smiled with satisfaction, exclaiming “I told you so!”

In a kind of swapping of imaginaries, Lupita once told me how she has attempted to be more conscious about the contributions of indigenous healers. She told me that her own perspectives of what healers were had evolved with her experience as the coordinator of the clinic, confessing that at one time she too had disregarded indigenous healing. At times, she even made an effort to talk about her own “traditional roots”, disclosing that her own grandmother had been a midwife. Lupita explained how her own perspective on indigenous healers had evolved during her time at the clinic:
I used to think that it was just that [curanderos] give you a limpia, but now that I’ve gotten closer, I realize the importance of the traditional doctors, the traditional therapists. And in talking about these, we would have to specify various things, one of the first is to say, traditional medicine includes bonesetters, curanderos, herbalists, midwives: traditional midwives and empirical midwives, all which are different. (Lupita, personal communication)

Her ability to appreciate the practice of the healers did not come from the scientization or the biomedicalization of their practice, of the kind that has been critiqued in the institutionalization of traditional medicine elsewhere (Janes 1999) as well as in Mexico (Page Pliego 2002). Instead, the value that she projected onto healers, particularly in her esteem the “traditional midwives”, was in contradistinction to “empiricals” (empiricas) those who had learned from courses and professional training instead of having “traditions” passed down to them and learning informally from previous generations. Drawing on a discourse of authenticity, she explained the value of the former over the latter by referencing what she perceived as the affective work of the “traditional” midwives, over the “technical” work of the empiricals.

The traditional midwives are the authentic ones, the ones that work in their communities, and the empirical midwives, are different, they are those that I would classify as knowing how to write, how to put in an IV; they are a different kind of people; they are not the same people as the indigenous ones, because a midwife can be an everyday ordinary person who is trained as a midwife, but this is not the same as a traditional midwife. The traditional midwife is she who goes…nurturing, she is a mother for the patient, with the cravings, she indulges you, she takes care of you, and she takes you to the doctor, all of this. (Lupita, personal communication)

In fact, I heard her comment more than once, that “their traditional midwives” were “not like those who put in IVs; those women are no longer traditional midwives.” She was referring to the women who had been recognized throughout the country as certified midwives and health promoters through their participation in courses that taught them basic medical skills. This idea of a “pure” notion of the traditional,
something uncontaminated by biomedical knowledge and connected to their community
was repeated over to me on many occasions, and by different people, including the
translators and the physicians. I also heard it implicitly stated by the trainers of
midwives. In one certification course preparation, the nurse instructor quickly corrected
herself when she talked about how midwives should offer a consultation to her patient.

You give them a consultation, well no, not a consultation because you all
don't give them a consultation, Instead, what you give them is “attention”
(Nurse, personal communication).

Similarly, the translator Gil on one occasion told me about how much he has
learned from the traditional doctors. In this, he reiterated the prevailing discourse of the
clinic's intention to respect cultural traditions.

We don't take knowledge from them. They stay with their own knowledge. Because there are no two that heal alike, all of them cure differently. For
instance, there are four types of susto and there are different ways of
diagnosing using an egg; some open it, others feel its vibrations, others (do
a limpia) just with a glass of water. (Gil, personal communication)

One particular conversation I had with the translator Gil demonstrated a
particularly adamant stance regarding the idea of the “authentic.”

JHG: How do the traditional midwives detect that something is wrong with
their patient?

Gil: If the woman has preeclampsia, her feet are swollen, or she begins to
see little lights, etc. But the midwives can only detect to a certain point, they
have to know their limits.

JHG: And how is preeclampsia detected?

Gil: Taking the blood pressure.

JHG: So then the midwives can also detect this, if they are trained to take
the blood pressure?

Gil: No, we don't want them to get trained for that, because then they
would no longer be authentic (porque entonces ya no son autenticas). If
they train for that, they aren’t doctors, and if they train for that they will then begin to prescribe, and you lose the traditional.

Interestingly enough, he did not end there, pulling from another discourse that was about validating the midwives’ knowledge, which is now considered the politically correct language, especially in regards to indigenous knowledge. He tells me:

It’s not that they should be trained, because they are already capable. It’s that we must orient them.(Gil, personal communication)

This was the same language that was used when I first proposed my study to the clinic, proposing to look at the transformations of indigenous healers’ ideas and practices in the context of state institutional practice and policy. Lupita became very agitated, and expressed a surprise that bordered on moral indignation that I would even suggest in my study that healers might be changing their practices. Being an anthropologist, she thought that I should know better: the work of a traditional medicine clinic was, of course, not to change their knowledge or practices, but to “respect their culture.” While in previous decades, early indigenista policies encouraged citizens to abandon their prayers and herbs for the stethoscope and needle (Page Pliego 2002), in this moment, I realized the extent to which the cultural rights as human rights language had been internalized, to the point that in that moment, in a swapping of roles, Lupita felt she was being more anthropological and culturally relativist than the anthropologist.

**Healing in the Clinic**

The day I was accompanying one of the younger midwives, DulceMaria, who was making visits to her patients’ homes in town, we found her friend’s father limping in the street in much bodily pain. Apparently Don Lucas’ wife had beaten him up. While male-on-female domestic violence is known to be common in the Sierra, this was the first I would hear about the reverse instance. The man was obviously shaken, badly bruised
and in severe pain. DulceMaria first took him to the IMSS clinic, where she was able to enlist the help of a doctor on staff there. The physician examined Don Lucas and prescribed for him two pain relievers as well as an X-ray to be done at the IMSS headquarters one hour away. Leaving there, the three of us headed towards the hospital, as he wanted a naceptzine to alleviate the pain. He didn’t have money to purchase the medications they had prescribed for him at IMSS and at the hospital he would be able to get medication for a small quota.

When I asked him if was going to get a sobada (therapeutic massage) too while at the hospital, he said he hadn’t thought of it, but then reconsidering the idea, said, “Yes, sobadas are also good.” I introduced him to Don Jose, a bonesetter at the clinic, who talked to him at length about what he was feeling and what he needed before they decided to go into the consultation room. The man confessed right away he was a trabajador de campo, a wage laborer on other people’s farms, and he didn’t have any money. Don Jose said this was not a problem and encouraged him to go inside and lay down on the small bed that was in a corner of the altar room.

Invited to sit in the room as Don Jose treated Don Lucas, and reviewed his body, I stayed there transfixed the entire time, watching the interaction between these two men and the amount of both physical and emotional contact that was shared. With much care, Don Jose calmly addressed all the areas of pain that Don Lucas indicated, checking to see the extent of the injuries. Pressing into the man’s chest and back, and rubbing lightly to diagnose his physical integrity as well as to relieve pain through the application of a hot ointment (pomada caliente), the entire session was strung together by a soft banter, in which they talked about people they knew in common and the
vagaries of life working as a *campesino* (peasant farmer). Don Jose took his time, treating and talking to the man, during a session that lasted close to an hour.

In Don Jose’s treatment, it was hard for me to tell where the emotional ends and physiological begins, especially when it is known that an important component of healing lies in the efficacy with which illness is interpreted. However, these distinctions were very clear to the clinic administrators. An emphasis on the emotional and psychological aspects of “traditional healing” was a way of separating out the spheres of influence in which healers were sanctioned to intervene. This separation of realms relegated indigenous healing to healing the soul.

In fact, I heard Lupita underscore many times the role that traditional doctors’ played, “not by healing the body, but by healing the soul.” As she presented to a group of students that was visiting the clinic: “What we’ve come to understand is that traditional medicine doesn’t heal diseases, it heals the spirit” (*Lo que nos hemos dado cuenta es que la medicina tradicional no cura enfermedades, sino cura el espíritu*). In an interview with me, she explained her understanding of the efficacy of traditional medicine in this way:

I’ve always said that the biggest impact is that they listen, there is not going to be a better cure than that they listen, this is the biggest medicine, that when you are talking about your problems, they are massaging you, they are putting on a lotion, I think this is the biggest cure.. You could go get an injection of I don’t know...whatever you want, but they are not going to give you the tranquility you get when you come here, I have always said this, what happens is that in the area of traditional medicine, they are treating/healing the soul, they are not healing your physical body, and these are the two qualities that should be appreciated: [others] cure the physical and [they] cure the spiritual.

A medical resident had a similar inference to make when said that he thought indigenous midwives were very important for the care of the pregnant women because
they offered a “more human touch.” In the clinic, there was an idea that traditional healers offered a kind of affective labor that was bound up with their tradition (Hardt 1999). While claiming to support and celebrate healers’ traditions, what was in actually supported was the aspect of the traditional that focused on this very real component of healers’ work and the affective labor they provided. However, at the same time, there was a conscious segregating of healers’ practices to what were considered emotional and spiritual realms, and a concomitant denial of their ability to affect physiological wellbeing as well. What I hadn’t heard often discussed by clinic personnel often were instances of healers who helped people not just emotionally but physically.

The Limits of Recognition and Mestizo Ambivalence

While I witnessed many examples of healers having helped people physically and physiologically in addition to perhaps emotionally and psychologically, as in the case of Don Lucas, healers’ interventions into people’s physical wellbeing was very rarely if ever a topic of conversation. Moreover, although Lupita was a very vocal advocate of the good that the traditional healers did, her belief in their work did not extend to validating many of the actual illnesses that healers treated. In fact, I had heard her confide in reporters, correcting them when they asked about “how” healers’ healed particular locally defined maladies by explaining that healers weren’t actually curing things like “cuajo” or “bilis”:

They say “it’s bilis”, but when [the patient] starts to tell them that [they] got angry for this or for the other thing, it’s not that they “gathered up the bilis” [te recogio el bilis], but it was something that you had to get out you emotionally [deshogarte], and they massaged you, and they calmed you…because if you come and say I have bilis and this, yes it’s true, but they [the hospital] will give you an injection, but they didn’t listen to you, they didn’t calm you, and here is the part that I see is really true. [Si es cierto] …There is a psychological part that you have and if you tell the person: “I will cure you, you go with that, but they listened to what
happened to you, you expressed emotion, you cried, and they took away that part, there are things that I myself have not been able to explain, but I have seen improvements, but I don’t know by which way they came. [Lupita, personal communication].

Lupita’s biggest ally in the clinic felt similarly. Dr. Ignacio was a mestizo from the city of Puebla, who had long lived and worked in the countryside. On his own initiative worked closely with the midwives and was one of the few hospital personnel who directly interacted with any of the medicos tradicionales; he also felt that the Ministry of Health needed culturally sensitive health policy in regards to indigenous people and was actively involved in investigating and promoting the wisdom behind some of the practices of midwives, which the biomedical system had previously overlooked, such as birth in a vertical position. However, while we often had long conversations about the idea of the cultural construction of illness, he did not hesitate to tell me he believed little in the business of limpias or “que te pasen un huevo” (that they rub you with an egg) or they give you a “rollo de hierbitas” (little roll of herbs).

Dr. Ignacio also lamented what he felt as the sting of the stigma of working with indígenas saying “the other physicians (at the Ministry of Health) all think that here I wear guaraches to work” (rustic hand-sewn sandals often wore by indigenous people all over Mexico). He told me more than once that he thought the idea of interrelating indigenous healers with biomedical physicians was futile. The only way that he could conceive that mestizos might be interested in taking seriously other healing modalities was if someone like me related it to them: “What we need is someone like you to explain to us, like you who have lived among them (Nahua people), who has been
learning their language, who have been studying what they do.\textsuperscript{9} When we talked about the prospect of institutionalizing indigenous medicine, he brought up the example of traditional medicine in Cuba, saying that the government there was supporting traditional medicine, but that it was “another entirely different matter.” He made the distinction that in Cuba, “they are really scientifically investigating it.” For him, indigenous medicine of Mexico was not on par with these other “sciences”.

Consequently, even though Dr. Ignacio worked with midwives and their patients in the clinics, and often related his own pleasure at finding that a midwife had correctly diagnosed a fetus that was badly positioned, or had produced favorable outcomes through her intervention, there was still the idea that she was still lacking:

Let’s say that throughout the whole world, there are midwives. If you see a French midwife, she is a doctor, and has all the pride of being of midwife. If you see a gringa midwife, she is a nurse that is prepared to be a midwife. They are accepted because [for example] I have my patients and I can recommend them to a gringa midwife with all the confidence that they will supervise well the work of the birth.

However, in the case of indigenous midwives, the doctors had to be confident that they could be entrusted to “know their limits.” The obstetrician in particular took me aside one day to explain they should not allow midwives to become “little doctors” and that this would be harmful to them. Not telling him I had witnessed midwives injecting pitocin (Oxytocin injection to induce labor) and using other pharmaceuticals during some of the births I had seen, I listened as he lamented that the public health sector had already gone too far in previous years, by for instance training indigenous midwives to do “tacto” or feel the size of the cervix when a patient was dilating. He scoffed at how

\textsuperscript{9} Because of my having learned Nahuat and relating to the healers, other hospital personnel to their amusement referred to me on occasion “an indita guera” or light-skinned little female Indian.
this meant that midwives without hygienic conditions in their homes were now infecting
the laboring woman. He also expressed his negative opinion of a traditional midwifery
school that one younger midwife was proposing to a funding agency for indigenous
women (which was ultimately denied). He explained that he thought these things could
not, and should not, be taught outside of formal contexts.

Beyond having their community’s trust, knowing their limits was the main virtue for
which the hospital most praised the midwives for: their ability to trust the midwives to
“know their limits” meant being confident in the midwife’s ability to discern the kinds of
patients they could or could not attend to safely. This list included first time mothers,
older mothers, post-caesarian mothers, or pregnant women who were experiencing the
signs of distress which midwives had been taught. For example, one day, off the
record, Lupita modified what had been her on-record public statements praising, and
enthusiastically championing, the work of midwives. She cautioned me that midwives
should not think that they are too good or think that they do everything right.

Even while promoting healers who worked for her, Lupita remark aloud “they
shouldn’t feel too confident with themselves.” With all the celebration about traditional
healers and their work, she made it evident that she was concerned that the medicos
tradicionales might feel too important, too big-headed or too deserving of rights. This
kind of explicit appreciation for multiculturalism, and simultaneous ambivalence about it
is something that Charles Hale suggestively describes through his concept of racial
ambivalence (2006). In this case, mestizos have their own vulnerabilities and
ambivalences about the practice of indios as healers. Because of the historic and
colonial baggage that carried over into the nation-state about indios there are also distinct limits to the credibility that they can attribute to indigenous people.

When physicians did give credit to the midwives with positive regard, while underscoring how the important role that the institution has had in “educating them”:

The traditional doctors themselves make the difference. Here there is a lot of education and they say progress is the education. I am in agreement, because if you educate the curanderos and the midwives and the traditional doctors [saying]: “you can assist [us but just] up to here, and you know when you can’t anymore,” and this is the part that we have been achieving. It has been a lot of work but it has been understood [by them], and that is why references are being given to the hospital. When they can’t assist, [they say] “I can’t treat or heal them but I brought them so that you can pass them to the hospital”. I think that this is very valuable. [Director Carlos]

The limits of cross-cultural tolerance were brought to bear in encounters with healers whose practices fell outside of biomedicine’s epistemological foundations. For example, the case of the manteadas (or the adjustment that midwives typically do using their shawl in order to help the fetus get into a head down position for birth) was a contentious one in the hospital, and I was present during a couple times when physicians reprimanded indigenous midwives for this practice. Physicians expressed anxiety over the possibility that midwives were intervening directly in pregnancy, but:

the midwives have a point of view that is completely opposite (to that of the biomedical view)…..one must know how to do (the manteada) well (because) without being (sobadas) massaged, the pregnancy suffers more complications. Being the mode of diagnosis the status of the product (fetus), they declare that it is essential for detecting a pregnancy that comes in a different position, like an illness that could produce some setbacks in pregnancy-labor-post-partum (Quattrocchi 2001).

While many Nahua, including those who chose to give birth in the hospital considered the manteadas or therapeutic massages of traditional midwives and curanderas to be an extremely important part of preparing for childbirth and producing healthy children, the physicians’ tolerance of indigenous traditions stopped here. The
burdens of these limits of “recognition” were especially placed on midwives, who were constantly reminded to “know their limits”. Knowing their limits was something inculcated in all the traditional doctors, but none more so than the indigenous midwives, who were constantly reminded of how dangerous their job is and how much is riding on their ability to prevent maternal mortality.

Consequently, while hospital personnel would give lip service to the value of their midwives, it was not infrequently that I observed moments when the midwives felt devalued or disrespected. For some, the feeling was “why do they even have us here if they don’t think we can do the work?” (personal communication, Doña Dominga). For others, it was a general sense that while the biomedical physicians were supposed to be their allies, they often felt misunderstood. Don Ignacio confirmed this foundational and underlying skepticism persisting in the public healthcare system regarding midwives by saying that he knew that in the perspective of public health officials, they considered that if a midwife touched a woman and something later was reported to be wrong with her, the midwife was automatically suspected and blamed for the illness.

Performing Tradition

On a day I was visiting Doña Panchita, a female bonesetter, at her house a few days before she was supposed to go to a national meeting in Metepec, she expressed her resistance to leaving home and conjectured what she presumed was most important about their going to the meeting: she said, “I think that they want us for demonstrating our traditional clothes, because they told us that they wanted us to arrive in our traditional dress,” the same one Doña Panchita wore every day. Healers realized that the administration was interested in having them display the cultural markers appropriate to a traditional doctor, and many times complied with wearing their
traditional dress even if they had never worn it previously. Although I never saw the male healers resort to “traditional clothing” except for the ones who already wore it, I did see female healers dressed, sometimes very uncomfortably, in the kweyits that they had never worn previously. This desire for female healers to mobilize their cultural capital was palpable to even those healers who were accustomed to macehual dress.

The interest of the clinic extended to traditions beyond their dress. Healers were also reminded to perform certain other cultural markers that distinguished them as indigenous healers, namely their religiosity. While every healer I met had a very profound sense of religiosity and tended to their altars at home where their own personal saints were, the coordinator of the clinic expressed frustration that the healers were not tending properly to the altar in the clinic. At many meetings I heard the often spoken reminder and the imploration for healers to bring flowers for the altar. They were also reminded not to stop doing their prayers or providing limpias to their patients, including a pregnant patient who was coming in for a checkup. These were curious requests in light of the countless occasions that I witnessed heavily invested in prayers and attending to their patients with prayers.

At different moments, Lupita also held trainings to have healers practice their interpersonal skills and protocol with patients. Using these trainings, Lupita desired to increase the marketability of healers to their audiences. However, Lupita did not consider these directives to be changes, rather only “improvements” in the quality of care. For example, one day an elderly curandera told me she had learned to more properly conduct a limpia. Doña Fernanda, who had been doing “limpias” all her life, explained to me: “Now we pass the egg directly over the body of the patient, having
them remove their clothing, as we have been taught by the coordinator of the clinic.” Apparently she had been told her that a real *limpia* must be done under the clothes of the patient to absorb the illness.\(^\text{10}\)

The cosmopolitan visions of what traditional medicine should be were circulating ever more deeply in places like the Sierra, where healers were expected to become a part of a growing national imaginary around traditional medicine that has little to do with local realities and contexts.\(^\text{11}\) Considering that healers were being cultivated as a cultural tourism opportunity, is not surprising then that the clinic often talked to me, as discussed earlier, about their desire that healers remain “traditional”, especially in stereotypically assumed aspects of their culture.

**The Altruistic Healer**

One of the biggest concerns for administrative staff, and in fact the first one ever mentioned to me in my initial encounter with the traditional medicine clinic, was the concern that lurking behind every indigenous healer was the potential for a regrettable degeneration and corruption of character that would lead to the desire to heal for profit. On the first day of my visit to the clinic, after my tour with the bilingual translator Victor, Lupita confessed her anxiety about these “profit-motivated healers”, and explained the need to constantly monitor healers to ensure that they were not getting paid ‘too much’ by the tourists. Her concern is that the healers were being lured by less desirable affective states, namely, greed or avariciousness. The danger was especially present

\(^\text{10}\) While I had experienced a few *limpias* in the Sierra in and outside of the clinic, this was the first time I had heard about this requirement, as the *limpias* I had experienced from healers had always been over clothing.

\(^\text{11}\) In another case, a teacher from Puebla, the leader of a group of students who were touring the clinic, asked Gil about the traditional healers and whether they use Bach flowers. No, he tells her. Without missing a beat, she responded, “they should use them.”
for Lupita when tourists would sometimes come in for a consultation and leave a relatively generous compensation with healers who by clinic standards should receive only 20 pesos.

In the clinic, one emotion that administrators attempted to control was that of envy. Lupita often chastised healers for being competitive with, and envious of, each other, something that she mentioned the very first time that she met me when she was lamenting that healers were not more sharing and generous with one another. Preventing competition between healers was seen as a constant problem, a problem which was noted by patients who came to the clinic and were told that a particular healer was not there, or not worth consulting with, as well as being one of the most common reasons expressed to me by healers who were unaffiliated for wanting to remain independent from the clinic. Between having enough patients visit them at their own homes, and knowing the level of competition that occurred inside of the clinic for patients, many healers on the outside of the institution felt that they were better off without joining the hospital. It was thus incumbent on Lupita to ensure that the reputation of the clinic stayed as positive as possible in order to be able to recruit new traditional doctors to work at the clinic.

In a tone that communicated her disapproval, Lupita explained to me that “true” traditional healers were supposed to be “altruistic” in their practice of healing, desiring only the health of the patient. Indeed, one day in the clinic I overheard Don Alberto a bonesetter make a similar statement to the other healers when they were discussing the fact that many considered a quota of 20 pesos per patient to be too little. Don Alberto, mirroring the clinic administrator’s discourse reminded those healers present that they
“were for the health of the people. This could have been said by any number of the multiple healers that I ever observed or conversed with, in which the sense of a healer's duty to serve their fellow human was part of a moral mandate, and anyone that failed to do this was morally culpable (and punishable by God). This ethical duty translated into a regime of gift giving.

In discussing the tapajtiani (Nahua doctors) of previous epochs, before there were doctors, a teacher, Don Hernando explained:

(The tapatianini) didn’t exist like that (in the clinic), they were not in a group. Before, each one had their place…and they healed or they went out to heal others. But each one had their doctor's office in their own house. There were some people that lived from this ("cobran la consulta"). There were others that also knew how to heal but only for the family. Even more, they didn’t even want that it be known that they are a curandero. So then the ones that dedicated themselves to this, they charged. And the ones that would do it only for the family, well the same they didn’t treat (no atendian) other people. And then there were other healers (that healed other people besides the family) that only asked for what the person could give. In other words, they didn’t say pay me 20 pesos or 30 pesos, no. If you want to gift me something, (gift me) what you can. Some continue like this still today. Then they say, pay me what you can, or if they give you a price, it’s low; very few would charge a lot. (Don Hernando, personal communication)

Although Don Hernando was discussing healers in the past, from my observations of healers, they continued to reproduce this kind of service, charging very little or accepting whatever the patient had to give. They also talked about feeling called to serve.

However, upsetting what would seem as an easy fit between administration discourse and the healers own sensibilities, on several occasions I found Don Martinez ranting in the consultation room, sometimes with small crowds around him listening mostly silently, as he said over and over again in a mixture of Nahuatl and Spanish, “Amo conciencia, amo conciencia”, the coordinators have no conscience! How can they
deny us even the minimal amount of compensation for our transportation here?” His counterparts explained to me that they receive no salary and the small amount that they are permitted to charge is not even enough to cover the transportation from their homes in the outlying pueblos to the hospital. Another healer explained the logic of the state agents that run the unit as this: “if we provide them day-old tortillas and a miniscule stipend every 6 to 7 months, they will come and participate in the project”. This logic reflects clearly the assumption that is behind the idea of the corrupt profit-motivated healer: They will accept little, because their nature is to disinterestedly serve others. But the healers themselves continued to challenge the assumption that their services are a public good for the taking, and instead, invoke imaginaries that put themselves on par with the doctors, asking, “what would they do if their biweekly check didn’t come? Would they be so willing to see their patients?

It is evident that state agents here were imagining a certain nature for indigenous healers, i.e., an interest-free aspiration to help others, that is always in danger of becoming contaminated by lucrative desires. What is thus at stake here is the production a particular kind of ‘indigenous healer subject’ with the right kinds of ‘truly indigenous’ desires. Not surprisingly however, this assumption about the altruistic nature of healers is something that circulated not only in the discourse of administrative staff, but was also embedded in the discourse of some of the healers themselves. When I asked him about the 20 pesos that they are permitted to charge for curing inside the hospital space, Don Alberto admits that it is a very minimal amount, and some healers felt that it should be raised to 30 or 50. However, in the same breath, he animatedly expressed, “We are here not to make money, but for the health of the people”.

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Andrea Muhlenbach, in her work on the “moral neoliberal” (2007) discusses how neoliberal regimes depend on the right kinds of motivating sentiments. Unlike other scholars who have addressed the amorality of neoliberal practice, she underscores the kind of incitation toward generative feelings that help reproduce neoliberalism through the shaping of subjects conducive to its reproduction. In the case of the traditional medicine clinic, instead of greed, healers were incited to demonstrate care and compassion for their own people. In this way, healers’ felt that their ethical regimes were being mobilized to serve the purpose of their further marginalization in the name of serving their people. In many cases however, it wasn’t local people who were arriving to the clinic seeking their help.

*El Brujo Permitido*

One day, my neighbor, an affluent mestiza from Puebla City who was doing her social service as a professional psychologist in this countryside heard about my work at the hospital and decided that she will see a traditional healer at the clinic out of her own curiosity. She had been feeling ill, with dizziness and a general malaise, and thought that maybe she would be well served by a *limpia*. She claimed to have little experience with these kinds of treatments, but having felt badly for some days, felt she had nothing to lose and asked me to take her. When we arrive at the clinic, Don Fernando greeted us in the hallway of the clinic, and doing a little dance, announced in his best Spanish, *Yo soy curandero!* (I am the healer!) He was wearing his *calzon* (rustic white cotton pants), blue T-shirt, *guaraches* and a big smile. He sends us for an egg, imploring us to “hurry”!! When she returns from the small convenient store across the street where they sell individual eggs routinely for this very kind of need, he called her to stand by his side and face the glass of water on the altar. Reciting a prayer in a mix of Spanish and
Nahuat, he placed her headband over the glass of water. Then he directed her to say her full name and blow over the water 5 times, which she did awkwardly, unsure of the protocol.

Pulsing her along the length of her arm, he asked: “Has she had headaches?” (She responds that she has.) “Has her vision become blurry sometimes?” (She responds that it has.) “Does she have pain in her chest, and does her stomach hurt sometimes?” (No and yes.) He told her that she had *envidia* (envy) and *mal aire* (bad airs). She asked Don Fernando what this meant, and in his best Spanish he communicated that it is when the person is envious and looks at you with too much desire. He then asked her to sit on the chair, and dragging the egg over her head, face, and neck five times, he alternated his hands on her head while pressing down (Linda later says that she felt that her head was cracking.) Then Don Fernando put the egg on the floor beside the altar, and called her again by his side, praying over her again.

At the end of this process, Linda asked him if he was going to break the egg. She expected he would read it in a glass of water. The translator who was in the room with us, intervened to explain that Don Fernando doesn’t break the egg into a glass as other healers might do for he believes that releasing the contents could be dangerous. Linda however seemed confused and a little let down by not having this last step completed.

With a dearth of local patients seeking “culturally relevant care,” it was incumbent on the clinic’s coordinators to drum up business for the healers. Fortunately, Linda was not the only mestiza with curiosity about healing, and the clinic was evermore trying to enlist tourists or curious non-locals like Linda as patients. There were also visitors who, having heard in Mexico City or the capital of Puebla about the traditional medicine clinic,
were medical tourists of a different kind, coming to the clinic with illnesses that they hoped to resolve at the clinic. While Don Fernando and other healers most often treat patients from their community, they have grown accustomed to treating patients like Linda who increasingly arrive at the clinic out of curiosity. In fact, the only days that I saw large numbers of ‘patients’ within the traditional medicine clinic were on the days that groups of students or tourists had been invited from the capital city to tour the premises and to receive "treatments" from the extra healers on staff who had been instructed to join that day. These visitors were not the local people for whom the healers had been called to attend, but instead very cosmopolitan clients who could appreciate, at least aesthetically, the (exotic) experience of spiritual cleansings and stories about healers in the clinic.

From time to time, the coordinators announced news about they were working with local hotels to promote the clinic. For example, at one such meeting with the spring equinox on the 21st of March approaching, excitedly announced that she had reached an agreement with the Ministry of Tourism that the entire group of healers be permitted to do limpias outside the archeological ruins at a nearby park, something she said was already being done in another larger touristic region. Advising healers of the importance of this upcoming opportunity that could help them widen their market of potential clients, she used the inclusive language of “we” as if she would be healing herself to both encourage and caution healers:

The people there can have their limpias done, filling themselves up with energy (cargandose de energia) and it will be extra money for you all, as we will put our tariffs. But we should do it well so that the people return; we are our own letters of recommendation. Not just because there are many people to attend will we just do it in a rush (no nadamas porque hay
muchos por atender que lo haremos haci de rapidito). (Lupita, personal communication)

At the same time, capitalizing on the cultural capital of the traditional feminine dress, and at the same time referring to a commonly held new age belief in Mexico that on that day one should wear white (ostensibly to absorb the cosmic rays of the sun), she said: “We want everyone with their traditional white clothing so that we can get charged up with energy.”

Still, while Gil may have believed this, there were transformations in the practice of healers that had everything to do with the organization of the clinic. For instance, in one case, two men had come from Mexico City and had just been attended to by Don Francisco. Gil asked them how their experience had been and they said good. The younger man, 31, had come to Cuetzalan specifically looking for a healer. He had seen 5 people die right in front of him in an accident in Mexico City three months earlier, and ever since had not felt well. While visiting Cuetzalan, people had told him about the traditional doctors in the hospital and so he had come with his friend. Don Francisco had diagnosed him with ehecatl (wind) specifying to me that it was asombro. He had told the man he needed 2 more limpias, and the man agreed to take the 6-hour car ride from Mexico City to return on the 29th to see Don Francisco.

In the office, Gil asked Don Francisco what remedies he needed as they had come to the front office after the treatment to buy the products. Although the man needed spirit wine (vinus espiritus), there was none left. The other man needed cough remedy. They ended up buying two remedies at 15 pesos each, an extremely small amount to an urbanite (about a dollar and fifty cents). It is of note that the rise in the clientele of
tourists and outsiders in the clinic has come together with a reconfiguration of the healers’ relationship to remedies. During the time of my research, it was announced that healers would no longer be allotted the 70 pesos per day of stipend that purportedly had covered their transportation costs, but that they would be able to “make up” this difference by selling remedies and potions and syrups. In the world outside of the clinic, this emphasis on selling remedies was not typically regarded as the source of a healer’s income, as patients would give compensation that was all-inclusive, no matter whether they were given a tea to drink or a compress made of plant leaves. However, the shift in clinic policy now created an urgency to push the remedies as commodities, and this shift in policy converged with an increasing amount of tourists and urbanites that visited the clinics expecting such remedies. Consequently, after this policy was implemented, I would come to see healers moving frenetically through the clinic to corral students into the office in order to sell remedies.

**The Scientific Curandero (Healer) and the Professional Brujo (Witch)**

If the authorized Indian holds an ambivalent place as a subject who has a right to be recognized for cultural difference but must not be an unruly ethnic, the *brujo permitido* recalls a legacy of menacing connotations with colonial antecedents that continues to stigmatize *curanderismo* in the popular imagination. In the colonial era, *brujeria* or witchcraft was constructed as an unsanctioned domain of power dominated by Indians, and in contradistinction to the sanctioned power of Spaniards (Lewis 2008). *Brujeria* was strongly associated with Indianness in the colonial caste system, a “politicized contention about power, foreignness, and place”… “coded as blood” (Lewis 2008:19). As members of an inferior caste, it was thought that Indians could be educated into becoming proper subjects of the Crown but because they were vulnerable
to influences of the devil, they were prone to *brujeria* and the use of magic and
witchcraft (ibid). Moreover, the Spaniards considered that the unsanctioned use of
power by Indian *brujos* further justified their domination of Indians (ibid).

These witchy connotations ascribed to Indian people continued after emergence of
the nation-state, when *curanderismo* was conflated with *brujeria*, backwardness and
antagonistic to the modern nation-state. Within Nahua worlds, the word *teixcuepaliztli*
(akin to witchcraft) distinguished between those healers who were socially accepted and
those who were considered false charlatans and deceitful soothsayers, but Indian
healers were known as *tlamatini* (people that are wise and knowing) (Sepulveda y
Herrera 1983). However, Mexican intellectuals and politicians did not make these
distinctions and generally conflated *brujos* with indigenous healers. For example, Lopez
Portillo (long before he became President), wrote in the 1940s that:

(Indian culture) was lame (“coja”, walking with a limp as in deficient or
deformed) from birth; lacking precisely that which is the most delicate of all
cultures” and that this “inferior intellect” made them prone to become
“priests and witches” (Lopez Portillo 1944:159-162) in Korsbaek and

Foreign scholars corroborated the opinion of Mexican intellectuals of the 20th
century, considering *curanderismo* to belong to people who lived in:

Pockets of history…literally in the stone age; speaking only their ancient
tribal language; (and) still conserving their traditions and pagan beliefs and
customs….Among these backwards people could be found the great priest
and witch-doctor of the tribe that function[ed] exactly like their ancestors did
thousands of years ago. (Author’s translation) (Campos-Navarro 1996:63 in
Page Pliego 2002:29)

While this depiction did not accurately represent the syncretic processes that had
produced Mexico’s *curanderismo*, it served to fortify the stigma against *curanderos*, and
conflate indigenous healers with brujería (witchcraft). Part and parcel of “tradicionality” was this tension with healers’ relationship to the occult.

Healers in the clinic were thus expected to remain traditional, but to distance themselves from brujería. However, the most successful healers in the clinic with the greatest draw and the most prestige were a fascinating hybrid of sorts that traversed these boundaries. While the physicians warned against midwives becoming “little doctors” by learning about biomedical interventions and using them to complement their own local healing practices, other healers were respected for these crossings or mimetic anxieties.

Don Placido was a Nahua man who purposefully donned the white calzon that was no longer considered mainstream in the Sierra for men to wear, especially at his relatively younger age of mid-40s. Because of his peculiarity in mobilizing a hyper-Indian identity and self-confidence in his ethnic identity, people often referred to him as “the one in calzon” (or the one in the indigenous underwear, which is the name for the traditional white pants of peasant men from the region). He was unique in that he had his own clinic outside of the hospital, but also participated with the rest of the médicos tradicionales at the hospital.

Don Placido was very conscious of crossing boundaries that clinic administrators did not tolerate others to cross. He proudly asserted, “I am more scientific than traditional.” A graduate of a three-year program in the study of rural medicine as well as the study of herbalism within a professional context, and with degrees and diplomas papering the walls of a private consultation space he rented in town, he was someone with much more professional study, education, and resources than most of the rest of
his companions at the clinic. He was also someone, unlike the other healers in the
clinic, who worked as a healer full time on a team with biomedical physicians for a local
health NGO.

As such, his formal training commanded respect in the clinic, which at times
allowed him to produce his own remedies, something that clinic administrators did not
allow other healers to do (they had to follow the recipes of the biologists). He also had
the singular advantage of coming and going from the clinic as he wished. On one
morning, he told me that he would be leaving the traditional medicine clinic from 10-11
to go to his private office in order to await a patient who was bringing his resultados (lab
reports). Conscious of the differential treatment he received in comparison with the
other healers; he told me later that day that at 2:00 pm he told Edgar he was leaving
without even trying to ask permission. He said that he had seen Doña Paulina ask for
permission to leave early for her Oportunidades meeting which is required for her
governmental assistance, and Edgar altogether denied the validity of her request,
saying, “no es verdad”, (it’s not true), and telling her to stay put in the clinic until 4 p.m.

In the eyes of the mestizos in the clinic, Don Placido may have been an indio, but
because of his educational training and class status, he was able to at least in part
insulate himself from mestizo ambivalence, and was considered an exception to the
clinic’s rule about desiring healers to remain traditional. Because of his formal studies
in medicine, his expertise in medicine was regarded to traverse out of what the
coordinators considered was the domain of efficacy for most healers: the symbolic,
emotional and psychological.
Around the time right before I left the clinic, a new healer was also gaining a devoted following. However, in his case, it was especially for his ability to intervene in the symbolic and esoteric. He was a professional mestizo high school teacher, who was as he told me one day, well versed in “the esoteric” and from Catemako, a place infamous for witchcraft. While since its earliest formations, the traditional medicine organization that started in the clinic had a strict policy against admitting “brujos” or witches to work, Don Anastacio, perhaps because he was a mestizo, was permitted to traverse the boundaries of witchiness. Other Nahua healers in the clinic saw this in a negative light and complained that Don Anastacio was obviously not working with things as they should be, “el trabaja chueco,” he works crooked. This assertion was based on the belief that he was putting curses on people for his clients who sought vengeance. One day I overheard a discussion among the other healers about whether or not he should stay. Doña Esmeralda said, “He should keep coming here with us.”

However, Doña Lucas did not seem so positive about his being there, especially when she says she found out he was permitted to practice more than one of the three specialties at a time unlike the rest of the healers’ restriction to this rule. He was known to do huesero work as well as curandero work. While the coordination knew these witchy side of Don Anastacio, they also knew he had become extremely popular, attracting many patients, and were supportive of his time at the clinic. He soon became the most popular “traditional doctor” in the clinic, with both mestizos and indigenous people seeking him out. In an exposition to high school students, Lupita told the group about Don Anastacio, and said this is the type of healer she wanted: a profesionista (a professional) who at the same time was not embarrassed to be a curandero and “share
his gift because he has a gift!” She also said that she considered Don Anastacio’s presence in the clinic a good sign things were going in the right direction.

**Working in Our Name**

One afternoon in the clinic, two healers on duty began a spontaneous rant about those who “worked in the name of traditional doctors.” Doña Dominga and Doña Ocatlan said “some people work in our name” (*trabajan en nuestro nombre*) and say they are “traditionals” (*tradicionales*) when they are not.” It was a moment I had been waiting for, an opportunity to glimpse how traditional doctors see themselves, and what kinds of significance they had assigned to their institutional affiliation. Dominga and Ocatlan were two curanderas in the Sierra Norte of Puebla working as “traditional doctors” inside of the *hueyi calli*, as they called it: the “big house” of the hospital. They were speaking about those healers who preferred to remain at the margins of the institution, working independently from public healthcare.¹²

Wanting to understand this claim that others fraudulently worked in their name, I asked what the difference was between “those” healers and themselves. Dominga answered without hesitation, showing me her Ministry of Health nametag: “It is that we are registered and they are not!” The other healer, Ocotlan, chimed in: “And we’re even recognized at the international level”, muttering under her breath, “If God would only allow me to live to see this!” Dominga then added “and there are even many books about us already.” Finally, they both expressed pride in being able to boast about how

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¹² On occasion I went to meet and visit with these “unregistered” healers---Doña Petra, who was a very old lady that had specialized in treating child illnesses; Doña Andrea, who was a *curandera* who had achieved much fame through her mother’s own practice before her; Doña Barbara, who was formerly involved with the public health sector but now had a private practice as a midwife, curandera and bonesetter at her house; Don Lucio who was a very well-known bonesetter, herbalist, and spiritual healer in his home village. All of them were very successful and popular healers with a private practice in their own homes, and our conversations were often interlaced with the arrival of patients seeking treatment.
many investigators like myself had come to see them and how they these people “took the tradition from here” *llevaron la tradicion de aca*” to other distant places.

I was intrigued by their statements. The process of registration had nothing to do with the certification of one’s skill or success as a “traditional doctor”, still the idea of being “registered” was used as a credential itself. There was a sense that the recognition of traditional indigenous doctors on a global scale was what was important about their practice, as well as the idea that this recognition was yet deferred. I wondered what Doña Ocatlan was imagining in her “hope to live to see this” as she sat inside of a nationally-acclaimed state-sponsored medicine clinic. In the healers’ assertions were traces of shifts in signs and significations of what it means to be a traditional indigenous healer today. These statements reflected new kinds of imaginaries at work for indigenous healers that situated them in a de-facto alliance with global circuits of “traditional medicine”.

As I have demonstrated in this chapter, the state’s desires for cultural representatives of tradition and multiculturalism, and the healers’ desires for recognition by the state, are brought together in the clinic in an uneasy, but very productive, alliance. For healers, their nametags and paraphenelia such as institutional jackets, were treasured forms of proof, standing in as evidence to substantiate the legitimacy of their practice as healers. And for the Ministry of Health, such things such as photo opportunities with healers were equally productive, standing in for their production of equitable relationships with healers.

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13 The Ministry of Health considers the determination of just who is a “medico tradicional” to be outside of their jurisdiction and instead placed the charge of “recognition” on local communities, or more specifically, the Municipal President’s Office who must sign a letter affirming that the person in question is in fact known and recognized in the community as a healer.
But where were the destitute patients who the project claimed needed culturally relevant care? Most often, they were in the biomedical part of the hospital, or in the outlying villages getting their care from healers in their neighborhood or the next. To access the traditional medicine clinic, community members were called to locate itself within the hospital’s walls, something that often included prohibitive transportation costs for patients. Meanwhile traditional doctors often lived within the same or a nearby community and were available for a house call. And yet, while this funding was invested into the Ministry of Health for a public imagined to be seeking “tradition” because of its low cost and cultural relevance, the content of the traditional medicine clinic’s activities often had very little to do with the traditional if defined as local, popular knowledge. Yes healers did limpias, set bones, attend births, and administer herbal teas, but the emphasis is on the production of sellable remedies that healers are not necessarily accustomed to prescribe and which derive more commonly from commercially sold dried herbs from other regions rather than locally harvested plants.

Moreover, the influence of the national and international tourist sector upon the shaping of what was traditional medicine in the Northern Sierra was evident in the kinds of cosmopolitan desires circulating in its production and consumption. In the clinic, there glossy fliers describing the “ancientness” of healers’ knowledge, meanwhile healers’ practices were being marketed to outsiders as medicine that “heals the soul.” Still, the often-stated desire of the project was on keeping healers “traditional,” especially in stereotypically assumed aspects of their culture. Healers inside the hospital were reminded not to forget the more obvious signs of their “tradition” such as coming to
important reunions in “traditional dress,”, making sure to include prayers in their treatments, and keeping up the altar (intended to emulate their altar spaces at home, a space not considered complete without its fresh flowers and lit candles). Although these traditions were being exalted by the institution as a way of respecting their indigenous public and attending to their community’s cultural needs, they were also being honed for the marketing of Nahua practices in the name of exotic traditions to another public sector, that of tourists seeking to consume “traditional healing.”

Consequently, as the Ministry of Health integrated traditional healers into state institutions in the name of indigenous cultural recognition and respect for diversity, pressures were ever present to shape a particular kind of healer that is translatable and transferable to the setting of a state hospital, while remaining at the same time “indio” enough to nourish a national imaginary that benefits from the legitimization their incorporation into state institutions brings. Struggling to reconcile multicultural doctrines of recognition and respect with biomedical imperatives, administrators and physicians, as well as healers, confronted their own anxieties around traditions as they attempted to navigate the new moral mandates of a late capitalist indigenous policy.
CHAPTER 6
“THEY ARE EATING US”: MORAL CRISIS AND RACIAL BELONGING

Texcuatojxej!

Early one morning I find Doña Panchita alone at the very back of the traditional medicine unit, cleaning up and putting away some pots in the kitchen. A bonesetter who was a founding member of the original traditional healers’ organization was a hard worker. At her 60-something years of age, I had seen her work for hours under the sun in her white kweyit (skirt) and huipil (embroidered blouse), chopping the high grasses around the empty and unfinished building of the organization with only a machete. As one of the more reserved and timid healers I had met in the clinic, she often spared her words when discussing her interactions with others at the clinic. I also knew, as she and other macehual (Nahua or indigenous) told me they did, that she was often “thinking with her heart.”

Touching an open palm to hers, I greeted her with a salutation that is the hallmark of macehual sociality. I had stopped by the clinic briefly to let her know I would not be staying and accompanying her in the clinic’s laboratory as I often had. But after our friendly touch of palms, Doña Panchita suddenly grabbed my arm and pulled me close to her, telling me in a whispering Nahuat: Texcuatojxe! I gave her a puzzled look, not expecting to hear what I thought she was saying to me. Then making as though she was eating her own arm, she mouthed in a hushed but urgent tone: “Nos están comiendo, pedazo por pedazo” (“They are eating us, piece by piece”).

Doña Panchita’s words were immediately arresting. Although she most often exercised discretion in what she communicated, in that momentary lapse she had
abandoned this censorship. Nothing had prepared me for her message cast in the graphic visuals as it was, with a pantomime of her gnawing on her own arm.

The verb for eating in Nahuat is *tacua*, the root *cua* meaning, “to eat.” The word can also take the form of *tecua*…to eat someone.” De Pury-Toumi makes the connection between the Nahua concept of eating or being eaten with destruction, and the end of the world (1997: 91-124). Eating, “if done by ferocious malignant beings, can be a destructive action that endangers the Nahua world that is able to terminate it” (Hooft 2003: 231). Still another derivation of the root, *tekuanime* names beings “like a tiger, a poisonous or otherwise deadly snake, or the Devil, who can eat people and by doing so, destroy them without exception” (ibid).

While at the time I did not realize the historically deep associations her enunciation had in Nahua worlds, Doña Panchita’s enunciation and its manner of dramatic delivery suggested an embodied and visceral morality, dramatically directing my attention to a relationship she perceived to be marked by a semiotics of violence. Although she did not specifically name the subject of her sentence—the “they” of this relationship that she was acting out for me with the gnawing of her arm—it was implied I would know who it was.

What would happen if we were to take Doña Panchita at her word? What if we took her metaphor of consumption seriously as a moral contestation? What if the idea of being consumed provides a vernacular index into more than just the experience of an indigenous healer’s in-corporation into a state project of healthcare, but points to the intersection of ethical regimes, one that “feeds” off another? What if we were able to
flesh out the possible meanings of Doña Panchita’s words by tracing the conditions of their signification?

This chapter considers the intersection of everyday constructions of moral personhood and racial ontology in the Sierra Norte of Puebla. Through morally inflected contestations of the coloniality of power in the clinic (Quijano 2000), Nahua healers and their patients make claims on public healthcare through local idioms of race, class, religiosity, sociality and notions of reciprocity. I argue that in the face of perceived social disintegration, when “long cherished forms of socialities and values are threatened or undermined” (2005:2), Nahua deploy their moral imaginations to make sense of the experience of crisis through a critique that calls attention to longstanding social inequalities and their perceived exasperation in the contemporary era. I argue that the institutionalization of “indigenous healers” under state-sponsored multiculturalism opens up new possibilities for healers, as well as new anxieties.

On Being Fed and Being Eaten: On the Pleasures and Prerogatives of Reciprocity

In order to think through the possible permutations of Doña Panchita’s deployment of a metaphor of being eaten, it is important to become familiar with the symbolic weight of meaning that is conferred to eating and to food by Nahua people. Historically among indigenous of Mesoamerica, the act of eating was embedded in a culture of reciprocity in Mesoamerica: prescribing relations with kin, neighbors, and even further, between families, villages, non-Christian spirits, Christian saints, and the deceased (Gonzalez 2001: 16). In the Sierra Norte, eating as an event continues to reach almost the sacrosanct in everyday macehual sociality, where food is offered and received with much reverence.
I witnessed the centrality of the food that one eats as a morally-laden index in many of my very first conversations with healers in the unit, where the first question perpetually was, “What do you eat at home?” invariably followed by an aghast exclamation: “What? You don’t eat corn?! This reaction is to be expected in light of the fact that maize, first domesticated in Mexico and cultivated over a span of 9000 years, has retained an epic role in defining Mesoamerican conceptions of humanness and civility.) Not surprisingly, when I was offered food, the actual word for food, *tacuali*, was often abandoned for the word that represents both corn and a tortilla, *taxcal*, and it was on a daily basis that I was implored by my Nahua acquaintances to eat *se taxcal* (or “one taco”).

But maize is not just something good to eat—or a sustainer of physical life upon which civilizations have been built—it has also been understood as a sustainer of spiritual life. This crucial food source has been intrinsically involved in Nahua philosophies signaling what it means to be human and how humans *should* be. In pre-Columbian Mesoamerica, reciprocity around exchanging and sharing food worked to build bonds of community far from beyond the family, as one didn’t “break bread with one’s enemy” (Hendon and Joyce 2004:83). On the other hand, food exchanges were also noted as a tool for wielding power. Pre-hispanic elites established their authority over others by demonstrating in particular a generosity with food (ibid). Relationships between both equals and unequals in Mesoamerica involved food exchanges, and “those relations [were] strengthened, reproduced, or subverted based on actions that people [took]” (ibid).
I highlight the conceptualization of these relationships because potent, morally inflected ideas around eating food and the sharing of food have a long history and contemporary relevance throughout Mesoamerica. Motivating these relationships—whether in the strengthening of communal bonds or the exercise of authority over others—was and continues to be an underlying principle of reciprocity. As the representative of food and sustenance par excellence, corn entered Nahua imaginaries as the divine child of a personified living earth, an earth that both gives of itself (in the form of corn), and at the end of human life, takes for its own sustenance. Consequently, important metaphors are linked to the idea of eating in general for Nahua, where eating and being eaten is intrinsic to an existential notion of giving and taking that centers around food: “When one is born, one is said to be food (tlacualī) and when one dies, one is eaten by the earth” (de Pury-Toumi 1997:124). That this idea still resonates with some Nahua can be seen in this contemporary song collected from the Sierra Norte of Puebla (Knab 1987 in Broda 1988:107):

We lie here on the earth (stamping on the mud floor)  
we are all fruits of the earth  
the earth sustains us  
we grow here, on the earth, and flower  
and when we die we wither in the earth  
we are all fruits of the earth (stamping on the mud floor)  
we eat of the earth  
then the earth eats us.

Doña Panchita reiterated this to me one day at her house, when she told me that her father had taught her that whenever her heart was troubled with thoughts, that she kneels down to Tonantzīn, who was the earth, and pound on her with all her might so that she might hear her and help her.
You have to pray to everything you have to pray even to the mother earth, you pray “forgive me mother earth because I am trampling you! and I am making you ugly! dirty! but forgive me because I am your daughter, my father God let me here with you because that is how it should be, but I ask your forgiveness…and…as I was demanding mother earth’s help, my father used tell me, just chat with her (and because he was a little drunk) with all his strength tell me, chat with her! It is necessary for you to implore to her, it is necessary for you to tell her what is your pain, what you are feeling “and that is how you heal yourself, and she [mother earth] is going to defend you and she will give you food and she will take care of everything,” just ask her the mother earth, will give it to you.

Her father’s phrasing of how Doña Panchita should pray portrays a kind of mutual moral obligation to the earth, which echoes a Pre-Hispanic conception of an essential relatedness that is being exchanged, an understanding that suggested that like the earth, man [too] is a plant and as he eats, he shall be eaten. Today this principle of giving and taking, eating and being eaten, lives on as a defining moral compass, where reciprocal exchanges between humans, and between humans and the supernatural are expected, and where the “Nahua sense of obligation to return a favor is particularly apparent” (Taggart 1997:140).

This relatedness encompasses what westerner’s might understand as the spirit world, forces that “exist in multiple, constantly shifting forms that make systematic classification and analysis by outsiders very difficult” (Brady 2006: 42.) Nahua ideas of social behavior and relations with the divine—and the distinction of right and wrong, or in a word, morality—are common themes in conversation. Equilibrium is maintained through proper behavior and immoral acts—such as homicide, adultery, theft, sorcery, and a failure to share with others are moral infringements that can be punished by supernatural beings (Brady 2006; Good Eshelman 1993). Reciprocity has to do with the love and respect that should characterize all relationships including household, kin, friends, human, and supernatural beings (Good Eshelman 1993). Social pressure under
these moral dictums guides giving and receiving between Nahuat—and “human actions that violate reciprocity at any level”...are still considered tlaqtakolli – a concept of Pre-Hispanic origin that departs from the Christian idea of sin, inflicting damage to the cosmic and social order more than just an individual soul (Raby 2007).

With an understanding of the centrality of food as well as the moral axiom of reciprocity, it is not surprising that the exchange of food would mark my engagement with Nahua healers. From the very beginning of meeting Nahua healers at the hospital, their food offerings to me became the initial grounds for negotiating our interaction. One after another healer would invite me to their home to eat, and every day the most common question I was asked upon entering the clinic was when I was going to visit a healer’s home to eat. Additionally, on the many days that I spent alongside healers in the traditional medicine clinic, I was consistently invited to share from their breakfast and lunch plates. Even if I had already been well fed from others’ plates, most would still insist on sharing their food with me, valuable food that they would have otherwise taken home with them. Xitacua, xitacual, “eat, eat!” was the daily imploration.

In order to reinforce the expected moral code, Doña Panchita retold a story to me several times at the beginning of our relationship about what happened when another koyomej (non-indigenous) researcher imprudently declined a food offering. Doña Panchita’s daughter-in-law had prepared a chicken in honor of the researchers visit to Doña Panchita’s house, but the researcher, due to dietary restrictions refused to eat. Doña Panchita’s expressed being deeply aggrieved by this refusal of her offering, and several times retold me how this refusal had made her very sad in her heart, thus causing her anxiety around the prospect that I might do the same to her. Although I had
not first realized the weight of meaning cast upon my reception of the food offered, I came to learn with time that my acceptance of the terms of our relationship involving respect and a sense of mutuality was substantiated by my own willingness to accept what I was offered to eat. This act, together with my efforts at learning and trying to speak to my research consultants in Nahuat, seemed to signal to healers that I was trustworthy and willing to enter into a relationship of reciprocity with them.

At the same time, the healers also seemed to be aware of the fact that offering and accepting nourishment (or any other kind of resource) from strangers can also be a treacherous thing. I gained my first glimpse of this ambiguity very early on in my relationship with Doña Panchita after inviting her to eat at the very beginning of our relationship. I had come across her on the street as I was on my way to lunch at a restaurant known for its low cost meals in a familial atmosphere [the restaurant was literally part of someone’s home]. I asked Doña Panchita to join me for lunch, which she quickly declined, looking down and explaining in a low voice that she had never gone inside (the restaurant), and that in any case she must go home quickly to boil her milk so it would not spoil.

After insisting again, she paused and remained standing in the doorway, until I persuaded her to sit down and rest her belongings. As the sole macehual inside the restaurant where mestizos were eating, she looked around hesitantly and then reluctantly sat down. We ordered what was on the menu for the day, and after the waitress brought out the food, she timidly looked down at the plate, allowing the escape of a soft but audible sigh. Then, as she slowly and hesitantly ate her food, we conversed about her experience as a traditional doctor in the institution. She related the story of
how she had “turned herself in” to the representatives of INI (*Instituto Nacional Indigenista*) who had sent a call out for healers back in the 1980s. She had felt obliged to join as a cautionary move against rumors that she could be fined if she didn’t agree to report herself. In the end, she says, the organizers of the traditional healers organization “deceived her” with a meal and 20 pesos, appropriating the project funds for themselves. Evidencing a sentiment of worry and concern, she sadly told me: “Just like now, I am asking myself how I am going to pay for this food?”

Her reluctance to accept my invitation for lunch might have had to do with hesitation of initiating a cycle of debt with me, at that time very much still a stranger to her, or perhaps a concern that she would not be able to reciprocate equitably. However, the context in which she made this statement also points to a concern that accepting what was to her a generous offer of a meal could be something that could come at the cost of her deception, betrayal or exploitation. In that moment, her reaction laid bare a morally suspect politics that vivified her encounter with yet another koyomej interested in her and her practice of medicine.

Through her hesitation and confession of her concern, Doña Panchita provided insight into another possible relationship in Nahua life worlds, one marked by moral dangers: that of inequitable forms of reciprocity. While reciprocity between *macehual* is part of a cultural imperative, and one is supposed to feed the other, there are moments when this relationship becomes dangerous or unbalanced. Unequal status with koyomej makes reciprocity problematic. This has especially been the case in the longstanding patron-client relationships that were historically established in Mexico between indigenous people and *campesinos* and the landlords or *caciques*. In this
relationship, the latter would obtain obedience, deference, labor or loyalty from the former, whom Doña Panchita characterizes as more maldadoso\(^1\). In the Sierra Norte, this kind of patron-client pattern has marked the relationship between gente de razon ("people of reason") and macehual (Nahua people) at least since the colonial era. On another occasion, Doña Panchita would come to explain the colonial continuities of these categories to me, explaining:

> **Gente de razon** [people of reason], that's what they are called, they are of reason. Like you are "of reason." You are more *maldadosa* than me [someone who does bad things]. You can go and do something to me, because I don't think (Panchita 2006).

Her statement that she could be subjected to something bad “because she doesn't think” (*porque yo no pienso*) indicated a feeling that because I had more studies and education, I could do bad things to her. By this I understand that my possible infringement on an expected moral code of reciprocity and balance is not something that she would expect, and could thus come to surprise (and hurt) her. At another time, Doña Panchita would come to tell me, barely concealing her frustration, that she didn’t understand how gente de razon were even called this ("people of reason") if they were so much more malevolent than the macehual, “son requetemalos” (they [the mestizos] are thricely bad) as she once put it. More often, she refused to converse about these things, or told me “now you have me saying things that I shouldn’t be,” which would be followed by a polite but sudden desertion of the conversation.

**Eating as Health, and Healthy Relations**

In the Sierra Norte, eating, or being able to receive the food that was given, was also an important signifier of health among Nahua. In fact, an important diagnostic

\(^{1}\)They are people who do bad things.
indicator for healers was their patients’ appetite. If a person or child was refusing to eat, this was considered an important sign that they were ill and needed attention. One of the most commonly diagnosed illnesses, susto or the sudden onset of extreme emotion, was suspected in a person who was lacking appetite. This lack indexed the possibility that soul loss had taken place: the animate part of a person had partially disembodied or been “left” behind, taking the person’s vitality and hunger along with it. In fact, healers gauged the efficacy of their own practice around how soon the patient can again be fed and reengage in macehual sociality. When they could say that ya in paciente takuaj taxcal, “the patient already is eating tortilla,” this was a sign that health had returned and their treatment had been successful. Being fed and eating thus indexed and enacted macehual sociality as well as a person’s restoration to health.

Feeding Multiculturalism

With all of the meaningfulness around eating and exchanging food in Nahua worlds, it is not surprising then that in the traditional medicine clinic, one practice that came to enact a cultural politics of inclusion and exclusion within the institution was the offering of food to healers. The traditional medicine clinic provided two meals to each person on call, feeding all the healers during the faenas, or communal work parties, in which a dozen or more healers would participate in daylong shifts of producing remedies and herbal products or other duties. The two meals per day given to healers by the hospital comprised a significant part of the compensation being offered participants of the project. The meal, however, was not an automatic benefit, and the administration of the unit was in charge of listing and authorizing the names for the hospital cooks, who were otherwise preparing patients’ meals. If healers had arrived at the clinic on time and were eligible for a meal, they would pick up their breakfasts or
lunches when they were called (usually around 11 am and 3 p.m. respectively). Sometimes it would be brought to them. On the days of the workshops or work parties, when many healers congregated in the kitchen together, the meal break was especially lively around the big pots of food delivered by the hospital kitchen. The meals were usually always awaited with anticipation, although some days there was a sense of disappointment when the cook had again served koyotaxcal (bread, or literally foreign man’s tortilla) instead of corn tortillas, which were essential to the notion of a proper meal for macehual.

The hospital’s offer to feed healers held an important significance for them. The act of offering food congealed certain recognition by, and a relationship with, the institution. In fact, that the project had offered to feed them breakfast and lunch on the days that they fulfilled their duty harbored on a powerful and culturally-relevant act of inclusion for many, and evidence of the improvement of their situation. “Now things are almost getting better,” one bonesetter told me, being that they received no food in former times when the hospital still belonged to INI. “But just a little bit”, she added. “That they give us food to eat, only in this is it better.” Thus, in spite of the ever-insecure terms of monetary compensation for traditional doctors, the fact that they were offered food was accepted as an ambiguously positive gesture intimating a relationship that at least approximated mutuality.

It was also an act that outsiders considered curious or an odd arrangement. One day, in discussing the traditional medicine clinic, my landlord’s common law wife asked me: “Why do they serve meals to the traditional doctors anyway?” Her husband responded that it was justifiable because the entire hospital was funded due to the
presence of the traditional doctors. Still, at times, the clinic coordinator Lupita threatened to stop providing the food when she thought that healers were complaining too much. Knowing that the previous INI hospital had not offered meals as part of the compensation, she would say in an exasperated tone: “I don’t know why we even give you food! Maybe we should stop!” This kind of threat was perceived as hurtful to the healers; through their acceptance of the food, the clinic had entered into what for them should be a reciprocal social contract.

But not all healers looked well upon the food they were offered in lieu of timely compensation for their participation in the traditional medicine clinic. Some critically questioned the motivation of this policy when they’re promised compensation for their time spent on clinic duty—relatively small pittances for months of work—failed to arrive on time. Thus, instead of an offering to establish an equitable relationship, these healers reinterpreted the hospital’s food as a way for the institution to consume them and their labor. For instance, one of the few midwives from a local community who has long been considered mestizo, Doña Oliva explained her own bad faith of the food being exchanged for the work that she accomplishes in her community; her narrative speaks to the violence implicit in the symbolic gesture of a plate of food that fails to consider the value of the work she carries out, as well as her own need to nourish her family:

I am very sorry if this sounds bad, but for me to become a midwife, I had to suffer a lot, I had to go around [delivering babies] day and night to become a midwife, and then a certified one [with so many courses] worse still, and all just so that they could offer me a few tortillas for my work? Why do they come and concern themselves that we get certified [as midwives]….just to abandon us? They come and they talk pretty, but with their pretty talk I am not going to take home any nourishment to my family (Doña Oliva).

On a few occasions I witnessed healers demonstrating their lack of acceptance of the terms of the relationship with the institution by sometimes refusing to wait on their
meals, which often came late in the day, too close to the 4 p.m. quitting time. I noticed that some healers would become impatient with waiting for food, and would opt out of their meal to go home on time instead. The most critical healers verbalized regret in seeing other healers lured into what they considered inadequate modes of compensation and of false senses of mutuality, critiquing fellow healers for expecting the institution to give them food and complaining when they do not receive it. However, the significance of the project’s emphasis on “feeding” the healers cannot be underestimated; while the clinic coordinators might have felt that they were giving something away for free, for healers, their own moral worlds of reciprocity instilled in them a need to continue being loyal to the clinic and returning to serve on call on the days that they were assigned, even when it was not in the healer’s interest to do so or there were few or no patients in attendance. The clinic had, perhaps unwittingly, shown its “good faith” in offering Nahua healers a meal, and for them this meant returning again and again to carry out their duty to the clinic.

The Moral Domain of Healing

Another domain that was heavily moralized for the Nahua that I interacted with was the domain of illness and of healing itself. As Livingstone writes, "because bodies and the bodily suffering that some impairments and illnesses evidence are social and moral domains, instances of debilities (or illnesses) propel the imagination along moral lines" (Livingstone 2005:19). Moreover, “the ability of the sick, the disabled, the elderly and their caregivers to engage the empathy or interest of others while constructing their own narrative speaks not only to the power of imaginative life but also to the force of moral discourse” (ibid). For Nahua healers, the force of moral discourse was embedded in expanded senses of reciprocity that were not “…abstracted from the whole of life and
instead were a set of collective and private practices that aimed at compensating for disequilibrium by taking away impediments” (Govers 2006: 181). Humans, nature and the supernatural existed and continue to exist in a reciprocal relationship, one that can be disturbed by various kinds of activity, and restored through ritual acts that restore equilibrium (ibid).

The Nahua healers I talked to discussed their duty to serve their fellow humans as part of a moral mandate. Anyone who failed to do this was potentially subject to punishment by God. Doña Adelita, a healer not affiliated with the clinic, told me that she suffered with illness until she responded to the call to be a healer. The illness had her crawling around on all fours for years until she accepted her own healing mission. When she cured herself through the help of supernatural entities which told her what to do, she was instructed to heal others, or else she would grow ill again.

Doña Rosario similarly expressed her resistance to entering the healing profession; however, in her case, she felt a lot of pressure to abide by the gender roles that regarded a “decent woman” to be one who stayed at home with her husband and children. She says she didn’t start out wanting to heal people as she felt it would bring shame upon her family, and her children wouldn’t like other people to find out she was treating sick people outside of her home. People might think that they weren’t taking care of her well enough, that she had to go out of her house to make a living. But her mother told her: “Don’t be scared, this is an inheritance that my grandmother left me, and now I’m leaving it to you.” She felt that ultimately her right decision and morally correct decision in choosing to disobey the gendered roles and heal others at INI’s hospital was confirmed by God, who gave her a healthy and abundant family: “I have 14
children and not a one has died; all of them with life, thanks be to God.” She
consciously continued to honor her commitment to healing, even when her children,
after migrating to the city, bid her to go with them. The excuse she gave them was that
she wouldn’t be able to get used to living in an urban environment. But, she tells me,
confiding: “This was not really why I didn’t join them. I stayed to keep healing people
where I’ve lived all my life. Feeling the weight of a moral obligation, she tells me, “How
could she just leave these people who come looking for her [help]?”

Doña Rosario’s discussion with me about her healing practice was based in her
own ethical moorings. In describing what it takes to be a healer, and how she herself
was able to become one, she explained that “the contact is in the hands”: “Thanks to
God, well I think that [my mother], firstly, gave me her don [her gift]. And secondly:

I don’t get grossed out by any treatment. A women whose feet were going
to be cut off [amputated] came… and I grabbed her foot saying, “Let’s see,
give me your foot and I will wash it here.” I’ll give a good washing with
herbs. And she would tell me, “My daughter, don’t you see how the flesh is
falling off?” I said: “Yes, but I made a commitment to God and if I say to Him
that I will not do what he did [referring to Jesus washing the feet of another
person], then what? I must fulfill this. So no I am not disgusted, I would not
say that it disgusts me, no. But many [people] yes. I have seen my fellow
[healers] who fear [healing others], and so no [raising her hand], they
should be careful [it’s more dangerous] because of the fact that they are
scared of it.

Thus, not being moved or grossed out by a fellow human who may need help is an
important ethical obligation, as it is a kind of reciprocity of mutual respect that comes
with being human.

Healing is also of a highly spiritual nature and moral standard. In describing the
work of her grandmother who was also a midwife in order to explain the legacy that
continues on through her today, Doña Esmeralda related:
My grandmother prayed when they arrived [the babies were born], when she was going to do a *llamada*, when they had *susto*. If they were children she would "call" them with a yellow candle...Today I [follow this tradition] giving them a *limpia* so that God hears me. All my life, I've given *limpias* to my patients, poor things... I give them a *limpia* every 15 days. And sometimes I light the candle here, or if not, I take it with me, I go to the church [in distant villages] to do the *promesa* [a spiritual petition in which the petitioner requests a favor in exchange while committing themselves to an obligatory act of reverence]. I go so God can hear me, because God is watching. If you don't ask, God doesn't give it to you. *La promesa* is this way: For example, if I am going to pray for you, I have to pray and ask the Holy Virgin first, and the Mother Earth, and request she lets you go.. and that she help you with the enemies who are there, so nothing bad comes to you. But you ask for support, you ask for help. (Doña Esmeralda, personal communication)

Religiosity thus characterized Nahua life worlds, and the work of a midwife was not only to help care for the patients and her pregnancy on a physical level, but also to work for the patient spiritually.

Consequently, while overcharging patients was considered abuse, and morally wrong, so was refusing to treat someone. For healers, their practice sometimes entailed putting themselves in the way of danger, especially when illnesses “were bad” or having to do with malevolent forces. While these illnesses could entail putting oneself in danger, healers were compelled to help in whatever way they can. In the following case Doña Rosario explains how she was able to help someone with one of these bad illnesses while still protecting herself:

It’s been a month now since I treated a woman who was mute and something grabbed her. That night, when she was returning from a dinner, she had to pass through a crossroad (intersection of four corners). At that moment, she heard someone who talked to her, and turned around to see. There, *se quedo* [she stayed] and became silent.

Her children came to see me, and they said: “Come see my mother, she is very ill. She has a fever and cannot talk.” I said, “I’m not going to go, but if you like, clean her (*limpiala*) and bring her candle (*veladora*) to me. From right here I will see her.” And yes! She took three days to talk but now she talks. (Doña Rosario, personal communication)
In this case, Doña Rosario knew that going to the lady’s home could put her in
danger, but she was obliged to treat her nonetheless. However, what happened in the
hospital often served as a case in point of moral aggression. As an unaffiliated healer,
Doña Andrea, told me regarding her own imperative to help a person and the difference
she sees between this obligation and what happens in the hospital:

The person is leaving [dying], and if you don’t bring them back, they will go.
And this is what the doctors do, they see someone who is sick, and they
don’t pay attention to them. I’ve seen it in the hospital. We are all persons. I
think no one should humiliate anyone else. You don’t do that. (Doña
Rosario, personal communication)

Thus, while healers were concerned about questions of a moral nature, a critique I
heard often was of the immoral treatment of patients at the hands of biomedical
practitioners in the Sierra.

An example of this “not paying attention,” was told to me by my neighbor, Doña
Albita. When I lived on the outskirts of the city, right above the hospital up the hill, I
would often go to visit Doña Albita, a petite hardworking woman in her 60s. She had
moved from a nearby village and lived in a small partly concrete, partly wooden shack
with her husband near the hospital. I first met Albita and her husband Don Angel
through a social worker, who often went and ate breakfast with her, and who would help
her get the medications she needed from the rural hospital next door. I soon became
an impromptu translator for Albita and the social worker, especially when her husband
was out, as otherwise they could barely communicate. Like most local Nahua women
her age, Doña Albita was almost entirely monolingual in Nahuat while her husband was
fluent in both Nahuat and Spanish.

One day I was visiting, she and her husband had recently come home from the
hospital. They both expressed being tristes (feeling sad) with what had happened that
day, and proceeded to talk about it slowly and plaintively in his heavily Nahuat-accented Spanish. While Don Angel is a very reserved man, who exemplifies the qualities of reserve, aguante (as in holding on and putting up with) or endurance, and an aversion to anger are often valued in Nahuat circles, the way he tells me the story, is much more in the style of a sad lament than a vituperative complaint. He allowed me to turn on my recorder as he recounted the ordeal they had been through in attempting to get a biomedical physician to see Doña Albita at the public hospital:

They didn’t attend us, they didn’t attend the Albita until 5 in the afternoon.” Don Angel then translated to the doctor Albita’s specific complaint, when she told the physician: “I am hungry, it is late, I am hungry, and from 8 (in the morning) until 5, I am here with you all.” Don Angel points to what he sees as the doctor’s inappropriate response to this complaint, saying: “And still the doctor says ‘If you want fast, then why don’t you go to a private doctor’s office?’” Doña Albita contested this logic, explaining what she considers the obvious point the physician is missing. She tells him: Como nikpias tomin, nias particular, amo nikpia tomin, por eso nikan yetok, desde las 8 hasta las 5 nikan yetok. (“If I had money, I would go to a private doctor’s office. But I don’t have any money, that’s why I am there, from 8 in the morning until 5 in the afternoon I was there”). (Doña Albita, personal communication)

Nahua patients are thus expected to wait as they “don’t have to pay.” Doña Albita reminded the physician that she knew very well where she stood, as a patient who would not pay, but she contested the extraordinary amount of time she was expected to wait. Based on Don Angel’s report the visit with the physician only lasted a few minutes, and after the wait, the doctor still did not check her. Albita had not brought her urine for analysis, and thus was required to return the following day for this lab test. He also advised Don Angel that this happened because Albita didn’t understand (Spanish) and thus should be accompanied by someone else who would speak the language. He told Albita: “You didn’t bring it, because you don’t understand,” and she responded, “Yes I understood but they didn’t tell me anything.” Don Angel, then reaffirmed, “She
doesn’t know how to respond, but she understands. If they were to speak *Totonaco* to us, then we wouldn’t understand anything. But those who speak Spanish, we understand most everything.” However, dressed in her traditional clothing and unable to respond clearly to the physician, Doña Albita’s assertion that she had not been given clear instructions was not considered feasible.

Another healer contextualized the kinds of experiences that poor Nahua patients have in the Sierra, bringing attention to what he believed was a motivating factor for mistreatment by physicians:

> What I’ve seen and what they’ve told me is that when one is not paying, there is no interest in the government (doctors) to try to heal them. One goes there with their documents of *seguro popular* or whatever you have, and they know you're not going to pay anything, then since they have other organizations that they can charge money for your work, that's why then they say "No here we won't cure you. We are going to transfer you to some other place." And why do they transfer you? Because they know that the money comes to them."

> And now imagine us. We don't have a government job where they are deducting for insurance, then with more reason they put us to a side. Those are the problems that exist in the government hospitals, because we all stay quiet, and then we try to find some other place where we know that they will attend to us. But even the professionals say, like I say, I have *compadres* [friends; godfathers] that have told me, don't think that because we pay, we are well attended. We get the worse. And we also need to go to private hospitals so that they cure us. (Don Alberto, personal communication)

In this moment, Don Alberto attempted to rationalize what is a moral grievance, by laying the blame on a shared economic struggle.

> Can you imagine?! I see that from all sides its bad. Perhaps it’s bad because of the bad pay that they give to the hospitals, or because of the low salaries that they give, or whatever, perhaps it’s because they don't get paid well, their salary is miserable [*raquitico*] and that's why they treat the people like that. They want to get paid for just showing up to work and not attending the people.
Healers perceived another moral infraction to be the institution’s blindness to the economic conditions of poor people in the remote mountainsides where they lived.

Doña Adelita, a healer who chose not to affiliate with the clinic, sees this kind of routinized ignorance as a form of violence perpetuated against the families who cannot afford to be traveling all over the Sierra to distant hospitals; she calls attention to the fact that she feels that physicians have an idea that the person is terminally ill, but they continue to send them to far off places as a last resort, thereby causing overwhelming stress to the families of the dying who find themselves with very limited resources.

The truth of what happens here is that also the doctors sometimes...they want to say that they know much and well, I will be sincere with you, it appears they even deceive the people. “You have this or you have that”, and we go up till there, and “run, something is wrong”, and sincerely I tell you, something happens far away, and one is without money, shamefully the person comes having to *pedir limosna* [beg] because the doctor, said so. They are seeing already seeing that the person is dying. Why do they send them to another side? And if we are poor people, people who are in need, here of the mountains, the doctor what he should do is tell us that there is no solution, and up to here no more, why do you go far? But no, it has to be attempted, and they throw you to wherever. (Doña Adelita, personal communication)

Doctors are seen as deceptive, and their imperative to continue all measures in order to “save” a patient, even when the patient is terminally ill, in this context is taken as an abuse of authority and a manipulation or deception, whereby the family is left to deal with the consequences of the patient’s removal from their locality when they are in dire economic straits. They transport the patient out but apparently, it costs the family to have to transport them back home for the funeral.

If they see they are not going to be able to cure a sick person, well tell them the truth and let them stay home. Why are they going to send them to another side, how much is it going to be, there is no money now to be going up and down [the road]....To me, personally, it happened, I tell you that it happened to me, because as you now see, I live here, I don’t live in my house, this is a stranger’s house, I am poor, I don’t have anything. The day
that my mother died in truth the doctors sent me, they told me to take her for one day to [the main hospital one hour away]. And what happened? Like now in the morning. No longer was my mother [alive], and I didn't have money, and I didn't have anything to transport her, so now I had to ask for charity to transport her, I had to ask them to give me the coffin so that they gave it to me, for my mother, and the doctor really should have told me that there was nothing to be done, take her to your house...but I tell you the shames [desgracias] truly are like this, the doctors know a lot but they also know, how should I say, perhaps they don’t know the person has many needs, and this is what is sad. They don’t understand that truly the people don’t have money, they think one is pretending, but in reality no, in reality there is not from where we can pull nor how. Perhaps there are people who are barely making it, and then to have to go far, it’s like no [this is wrong]. Doña Adelita, personal communication)

Throughout my fieldwork, I tried to get a sense of how healers and their patients made distinctions between koyomej (or medicine of the white coat) and macehual medicine. Sometimes people would call attention to the fact that allopathic medicine in the Sierra meant medicine de patente (patented medicine) and sometimes they would call attention to the costliness of this medicine. But more than anything, the distinction they would make between koyo medicine and biomedical attention had more to do with moral natures, racialized as macehual and classed as poor.

For instance, after Doña Albita and Don Angel told me about their unfortunate experience in the hospital, they also began to relate to me experiences they had when they had gone to the traditional medicine clinic with Albita a few months previously. They had gone in search of help for the pains she was feeling in her legs. They went three times, which is the requisite number of times many treatments last, three being an important number in Nahuat religiosity connected to the Trinity. Each time they went, they were seen by a different healer on staff. Don Angel remembers going with a woman from a distant village, and another from still a further one “Twenty minutes later,” Don Angel explains, “and we were already home. (We were seen) fast.” He tells me
that the healers were able to alleviate Doña Albita’s pain somewhat, but the jars of ointments that they gave her ultimately did not work. However, Don Angel takes the opportunity to point out something that within his ethical framework made sense to him. When he asked how much the visit would be, each time the healer told him, “Only you know how much you are going to give me.” He then makes a point to ask me, looking for confirmation, “It’s [morally] right like that, isn’t it true?” [es derecho, verdad que sí?]. I tell her, ‘I’ll give you 10 pesos. That’s fine, she says, that’s fine…. Whether you give me or don’t give me [money], I will help you. And she didn’t charge us for the medicine, she gave it to us.”

The power of this story is in the way Don Angel juxtaposes this situation with other experiences with local healers. Albita would commonly take her medicina de patente or allopathic prescriptions, at the same time she would receive treatment from a healer in her former village that worked from his home and made remedies for his patients. She tells me this healer also practiced macehualpajti (indigenous medicine), but okse lado (Nahuat: from the other side, as a way to differentiate it from the hospital.) She would go to this healer, up to 10 times in a row, and each time he would give her medicines. The last time he gave her a big bottle, she said she didn’t know what was in it. Don Angel explains, “Still the gentleman does not say to us how much we will pay. He says, ‘you take it (the medicine). You put it on, and see how it goes’.” Don Angel says the healer explained to them that the pain migrates each time, and she has to keep massaging where it hurts. Doña Albita explains to me, signaling her leg and arm: “When it doesn’t hurt here, the pain goes over there. And when the pain doesn’t hurt there, it goes here.” While dependent on the pastillas or pills of biomedicine, traditional healers
in the region serve not only as another resource for people, but also as an implicit
critique that demonstrates a certain moral lack in allopathic medicine.

Don Alberto underscores this moral lacking, attributing it to a lack of embodied
suffering and compassion, when he says:

The truth is we need our allopathic doctors to have more personal esteem
(for us), to be humane, to be more compassionate with the people. [We
need] them not to feel so superior for their knowledge [superior or stuck up]
or because they are children of the rich, or because they've never suffered.
Because there's many things in life that we learn when we suffer, and we
learn to valorize our brothers, our people that surround us, so it's for the
same reason that we value each other as humans, but there are many
people who perhaps have never lived it.

Attached to this moral lack is the idea that biomedical practitioners are also
marked by avarice, and that the consuming types of relationship which Doña Panchita
described in the hallway of the clinic mark those who find themselves inside but at the
bottom of the institution. The differing ethical regime required of doctors vs. healers is
something Doña Oliva also critiques. She brings up a moral issue of a biomedical
physician she imagines would withhold services before compensation was received,
and compared this to an ethical obligation to which she is held.

If a pregnant woman, has been rape and then badly attended to by her
family, with no social program of assistance, what do I wait for? Until she
can acquire some economic resource to be able to pay me, until then will I
wait? I think not! Because of this need, I think it's very important at an
institutional level that we be recognized through economic compensation,
no matter how little. The physician earns his biweekly paycheck. Two per
month. And I, as a midwife, no one is paying me biweekly, and on top of
this I still have to defend myself [against critiques] that I am a midwife.

The ability of biomedical physicians to treat and care for only those who have
money is scrutinized through a moral politics. The culturally idealized moral obligations
of a masehual healers reflects an implicit critique against kojomej physicians that are
envisioned as knowing how to make a living while being subsidized by the work of
“altruistic” others. This is conceptualized to be in contradistinction to the kind of respectful relationship healers are obligated to engage with others including their patients—the same kind of relationship which puts them in a position in which they are exploitable. It is not without significance to recall the historicity of these relationships and the way that koyomej, or outsiders, received their name: from the word coyotl in Nahuatl, that devouring voracious and moral-lacking animal.

The politics of this relationship is racialized for macehual, who consider their relationship with mestizo people, including mestizo physicians to be one marked by violence. This was revealed one day to me through Don Placido’s very clever play on a term often used to describe biomedicine, medicina de bata blanca, or the medicine of the white coat. While Don Placido, who I have otherwise discussed as the scientific Indian, holds nothing against biomedicine and its possibilities for helping people, and in fact employs it in his own practice, combining it often with herbal medicine and curanderismo or spiritual interventions, he nonetheless critiqued what he saw as a moral character that would define the doctor as human. Playing on the often repeated and status-signaling terminology for biomedical physicians: el doctor de bata blanca (“doctor of the white coat”), in a conversation with me about the nature of physicians, he exchanged the word “bata” (white coat) with the word “pata” (animal leg), signaling the nature of the physician was better described as a “pata blanca” or the doctor of “a white [animal] paw.” Here the idea of the coyote becomes an imaginative moral resource for healers to describe an un-reciprocal and thus immoral, relationship.
Similarly, when describing the differences between *masehual* and *koyomej* medical agents, Doña Panchita points to what comes down for her to a racial difference, the difference between indigenous and non-indigenous people:

I myself feel I am *masehual*. Why? Because I will never refuse you, and if I was going to refuse to give you something, better I don’t offer anything to you… If I know my medicine will help you and you don’t have [money to pay for it], just take it! Later you can come and bring me compensation, or if not, then there it dies”. This is how I tell [my patients], “if you have or do not have, I will treat you so you can get well.

Me: And *koyomej* physicians are not this way?

Panchita: No! When?! They are awake, so they can eat comfortably and well-seated. Not so they would mistreat themselves, nor that they sweat, and neither do they even work. Well, they do work but only their fingers, well-rested with in a cool room [fan or air conditioning on]. There they are, they have to do something so they too will eat. But they know how to get, they know how to take. It’s like the thief, he knows where to scratch. If he doesn’t scratch, he will not eat. (Doña Panchita, personal communication)

Here she is pointing directly to an ethical regime that for her is constructed through a racial-class construct, through her sense of being *macehual*, or a humble person. In another very revealing example, one young male healer, Tino, who had just told me about his plan to begin marketing his diabetes treatment in small bottles with special labels, asks me very nervously,” I am not becoming a piranha too?”, worrying that by wanting to market his products, he might also be engaging in what he saw was a *mestizo* tendency to exploit others.

**Ideals of Altruism vs. Relations of Reciprocity**

Among Nahua, to eat or to let oneself be eaten has been talked about as the destiny of man. In a way Nahua healers are both eating and letting themselves be eaten by participating in state healthcare initiatives that relegate them to the margins, by offering compensations considered small even when compared with the pittances
offered to day laborers in the camps of underpaid fieldwork. Is this what Doña Panchita meant when she pantomimed her arm being eaten by the institution, was she invoking this as a contested destiny, a destiny that is calling her to submit to her own marginal position within institutions who are known to exploit, to take, to consume?

While the clinic constructed healers’ practice in terms of altruism, which they mobilized frequently in order to encourage healers to continue serving “their people,” the clinic’s mobilization of a trope of the altruistic healer was only half the story. Yes, healers worked within a moral obligation to serve, but this obligation existed within a relational context with the expectation of reciprocity, to which the receiving party was morally bound. Theirs was not altruism as much as a recognized co-existence. As Doña Esmeralda explains, “I must help my projimo (my brother, my fellow human), because the day after tomorrow it will be me. Yes, helping them and they too are going to return the hand.”

However, the lack of mutuality which healers perceive in their relationship to the clinic, where they give, and others take with little substantive reciprocity was a source of constant tension. Healers knew there was a debt owed to them. The betrayal of this ethical obligation and a moral trespass are evident in the perspective of Doña Esmeralda, the 60-year old midwife who explained:

The administrators have received their payment, but we have yet to receive anything for our work… If they are there, it is because of us…they need us. And if we have these dones [divine gifts] it is because they are from our grandfathers and grandmothers. (Doña Esmeralda, personal communication)

Doña Esmeralda imagines a chain of linkages that sutures together the object the clinic exploits, their expertise in healing, with the gift that came through their forefathers. This was a gift which belonged to their forefathers, and by extension, to them. In a
sense she is protesting the consuming relationships in which her forefathers are still involved by way of their children who today are not being reciprocated.

This moral trespass is not, however, lost on healers. As *huesero* Don Martinez explained, betraying a feeling of sadness, the project treated them in ways that are less than human. “To them we are like little dogs. By putting down a little bit of food, they know we will come.” In an incisive critique, the invitation to eat insinuates a level of acceptance and recognition but through unequal terms and hierarchical relations of encounter. The opportunity to eat is also the opportunity to be relegated to a corner “like a dog,” and as we shall see, the opportunity to be consumed. Don Alberto alluded to this as well one day when we are waiting for the Ministry of Health directive from the state capital to arrive in their infrequent but often long-awaited visitations to the hospital: “they think we are just *inditos* (little Indians) who don’t know anything, but little do they imagine what we know (about what they do and about what we do).” Even while not unaware of this contradiction, they are compelled to negotiate these relations for their own advantage, however small.

Consequently, Doña Pachita’s articulation about “being consumed” was not met without resistance and moral indictment. Before I arrived at the clinic and even after I left, healers had organized a petition to have the coordinator thrown out. While I was there, I heard rumors that one of the most rebellious midwives had previously confronted the coordinator in her office with a machete, demanding her stipend. A hospital worker who considered the coordinator his ally told me proudly how he very craftily helped her hold on to her job by interceding on her behalf with the Head of the Ministry of Health who allegedly knew nothing about her imminent change. When I
asked what the basis was for wanting to remove her, he told me she had been accused of misappropriating monies. Asking then if he didn’t think this was a good reason to remove her, he responded exasperatedly, “No! Everyone steals!”

Consequently, the bureaucratic duty of the hospital to “feed” its healers, as well as offer them a minimal stipend, was defined very differently from Nahua senses of duty. The hospital made use of a Nahua ethical regime to reinforce its hierarchy. Healers’ autonomy as agents able to enter in reciprocal relationships through their own labor was fragmented vis-à-vis their relationship with the institution and the compromised form of inclusion this entails. As one healer who has renounced affiliation with the hospital explains of the healers’ relationship to the clinic: “they are the quincenas” (literally, period of 15 days, referring to biweekly paychecks). Consequently, the historical social role as caretaker of community wellbeing in a very real sense is translated into paychecks for the clinic administrators, who can then, as Doña Panchita explains, eat well. Thus, for healers, the reproduction of consuming relationships is not isolated from the historical context of contested cultural and racial politics has long formed the fabric of the daily lives between mestizos and indigenous in the region.

As healers take care of fellow community members, subsidizing the care and wellbeing of people who would otherwise not be cared for, their moral compasses are exploited by the interests of an institution in yet another instance of a consuming relationship. The way Nahua heal one another and enter into relationships with others for their own as well as others’ wellbeing, is, as Julie Livingstone has written, “a profoundly moral and historical site” (2005: 19). Certain kinds of relating pose moral problems, and moral conversations about how bureaucracies take advantage of this site
of healers’ own ethical regimes, cause moral dilemmas for healers. In the clinic, these anxieties about moral relating had racial contours. In the context of medicine, they were a common topic of conversation, summed up by statements like Don Alberto’s glib conclusion one day in the clinic that he imagined that they were little Indians who didn’t know better.

In this chapter, I explored the moral order that is being mobilized around state-sponsored forms of multiculturalism. While the links between neoliberalism and moral orders have not often been referenced, Andrea Muelenbach questions the assumption that neoliberalism is incapable of producing "a stable social and moral order of its own," and that these new institutional orders are not commensurable with older orders. When considering whether or not the traditional medicine clinic represents and embodies a new ideology under the current neoliberal regime in Mexico, Muelenbach’s insight is pertinent. Indeed the contemporary situation is not "best characterized as a battlefield with clearly drawn political dividing lines," but, as she aptly states instead, "it is fraught with "new obscurities so opaque" that these lines and what lies on either side of them are difficult to discern (Muelenbach 2012).

The imaginary resources of Nahua are shaped by local moral understandings and priorities as well as circulating biomedical and neoliberal discourses that migrate, implicate and collide with their life worlds. At the nexus of these encounters, healers come to create meaning in contexts that are not only characterized by medical pluralism, but ethical pluralism as well. Healers negotiate the moral and social horizons they feel to be at stake in relationships with their patients as well as with the shifting economic and political contexts around them. I have argued that these moral
frameworks profoundly shape who healers are, and come to be expressed through local racial imaginaries.
CHAPTER 7
MIDWIVES AND THE INTERCULTURAL

The Authorized Witch

One day by sitting at the traditional medicine clinic with Doña Esmeralda, the midwife, a patient of hers, an older Nahua woman, and her daughter from a village an hour away, listened as the midwife eagerly narrated her story. Doña Esmeralda exclaimed excitedly, “Doctora Soñia says I have really done a miracle!,” referring to her patient’s pregnancy and delivery, apparently a complicated one where the doctors had determined she would require a cesarean). Doña Esmeralda expressed visible satisfaction that the doctors had been proven wrong, and she delivered the baby without incident in her home. “They interned her in the hospital for 8 days, but they (the doctors) weren’t going to help her at all” she exclaimed. “Doctora Soñia (the pediatrician) helped me get her out of the hospital. And she lasted another month of her pregnancy!”

Listening as the midwife narrated the story of the successful birth, the daughter asked if I too worked at the hospital. Hearing I was studying the role of medicos tradicionales in the region, she volunteered her own story of the midwife’s efficacy as a healer. Without going into details about the circumstances of her illness, she told me: “I’ve known Doña Esmeralda for a long time now and she healed me. I am healed, thanks to her! It was through a temazcal that Doña Esmeralda healed me. And then she took me to Amatlan to see a doctor.”

Doña Esmeralda’s articulated Nahua medicine and biomedical worlds by skillfully negotiating together her acceptance as a midwife and healer by local Nahua people and

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1 Doña Esmeralda had treated her patient with daily washes of various plants, a treatment that left her patient’s “skin very soft and took everything away” (!Todo se le quitó!).
her skills at navigating the health sector. With dozens of certificates from IMSS and the
Ministry of Health and many years of affiliation with the official health sector, she has
the institutional savvy as well as insider status and personal relationships out of reach of
many local Nahua. At the same time, barefoot in her white *naguas* (indigenous skirt)
and embroidered blouse, she embodies the cultural capital of authentic indigeneity in
rural Mexico and has access to Nahua people in a way the institution would find
enviable. At the intersection of these cultural worlds between Nahua etiologies and
biomedicine, she is considered one of the most “successful” intercultural *enlaces* (links)
in the clinic.²

At the same time, elements of Doña Esmeralda’s practice no doubt frustrated the
public health sector. For instance, something regretted by clinic personnel as well as
hospital physicians was the routine occurrence of births in the homes of healers or their
patients. In her case, the child she recently delivered was born in a small separate
addition that the National Indigenous Institute helped her and other midwives build in
the early 1990s as a more hygienic space to attend births. Along with the temazcal built
on her property, these structures reflected a policy of decentralized indigenous
community healthcare that was imagined to take place “in the community.” However,
since then, the Ministry of Health has encouraged midwives to locate themselves
within the institution. While no official policy prohibits births from occurring in the home’s
of midwives or their patients homes, I found that births in the communities instead of the

² Not surprisingly, times when the traditional medicine clinic was called to demonstrate its work to the
outside public, she was among the first selected by administrators to serve as spokesperson for the
traditional medicine clinic. Putting an indigenous face to the clinic, she was also often recommended by
clinic coordinators for interviews. Charismatic, and able to communicate more effectively than many of her
female cohorts, even in her heavily Nahua-accented Spanish, she seemed to bring together the qualities
that make for a successful *medico tradicional* and was called upon often to evidence the clinic’s
“intercultural” success.”
hospital or clinics were discouraged by the Ministry of Health to such a degree that some midwives in more distant locations—out of reach of the hospital—felt compelled to give up attending births altogether (and remorsefully so). Other midwives, like Doña Esmeralda, were also aware of this informal sanction but chose to attend their patients in their home environment, which they found more conducive to attending labors that at times lasted for days.³

In this chapter, I provide a window into how indigenous midwives negotiate the idea of intercultural healthcare on the ground at the traditional medicine clinic. While Doña Esmeralda’s ability to serve as a cultural broker is the kind dreamed of in earlier decades of community healthcare, this vision has been resuscitated recently under the name of “promoting intercultural health. However, the way this “interculturality” takes place in indigenous regions is highly institutionalized and framed as government-sponsored programs “mixing high-tech with sacred tradition”…. where midwives—often the only people many women trust in one of Mexico’s poorest regions—are helping doctors keep mothers and babies alive” (Reuters 2007). As the principle actors called to perform “interculturality” for the health sector, midwives are asked to proactively mend the relation of “mistrust” that is the legacy of the public health sector’s relationship to rural and indigenous communities. At the same time, they navigate a division of labor which positions them as cultural brokers for public health while inhabiting historically-

³ However, disapproval of this practice manifested as a source of friction every time a midwife had to ask clinic supervisors to sign off on the birth record for an infant born outside the clinic. While midwives, especially literate ones like Doña Esmeralda, were very capable of handling the paperwork required for the state in their own homes, it was still required that they receive a signature from the traditional medicine clinic certifying the child’s birth. Carrying the baby into the clinic in their huacal, midwives would be asked why they didn’t bring their patients into the clinic where physicians could at least supervise the labor and birth process. The midwives who continued to attend children in their homes or the homes of their patients, did so under much disapproval.
constituted vulnerabilities within gender, class, and ethno-racial hierarchies in Mexico (Sanchez Olvera 2009).

**The Making of an Institutional Ally**

On one afternoon, Don Jose found me on the steps of the traditional medicine clinic. He had just returned from a national meeting on traditional and intercultural medicine where he and hundreds of other healers including midwives, hueseros, herbalists, and curanderos convened from all over Mexico at an invitation to the three day conference. I asked him how it went and he responded “mas o menos” explaining further: “I think its good midwives are being promised more recognition, but what about us as curanderos and hueseros? When is there going to be something for us too? Why is everything for midwives?”

Don Jose was speaking as a campesino (peasant) who looked to his work as a huesero to provide additional income to make ends meet in the mountains in Central Mexico. He was also speaking as a medico tradicional who, despite increasing recognition and status for his work, felt disproportionately acknowledged in the larger landscape of traditional medicine policy in Mexico. Apparently at the national meeting, only midwives received promises that their work as agents of health and links to the community would be more recognized and better compensated. Demoralized by what he sensed was an insufficient interest in working with other categories of healers, he confided he felt discouraged that midwives got “all the attention.”

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4 His livelihood depended on cash crops of coffee and allspice and his subsistence crops of maize, but looked to his work in traditional medicine to supplement his limited income. In the Sierra Norte like mostly everywhere in Mexico, these are desperate times for Nahua people, especially as prices of food continue to rise while the market for agricultural products remains unstable.

5 Soon after I left, the hospital won a prestigious national award for the successful program of midwives as allies in the prevention of maternal mortality.
I first realized midwives differential access into wider institutional networks when I first met Doña Geneva, a midwife from a nearby village of mestizos of French descent. The first day we met Doña Geneva was gleaming with pride as she told me she was a midwife who had been in courses in Mexico City and received many certifications from the public health sector, even traveling as far as Cancun for a course. Bubbling over with enthusiasm, and forward in a way most Nahua healers I interacted with never were, she talked about how she wanted to travel to many more places, suggesting she would travel to my hometown of Miami one day if invited her. The expectation of “courses” in faraway places was a reality for midwives in ways it wasn’t for other healers.

What hueseros and curanderos like Don Jose perceived as the unfair opportunities given to midwives were in fact the effects of a longstanding policy in indigenous healthcare that began decades ago. In many ways, the most bruja permitida or "authorized witch" in Mexico has been the midwife. Not only do midwives hold a distinctive place in the national imaginary around traditional medicine, midwives were also the actor first recruited in the name of traditional medicine. A long history of institutional interest in midwives set the state-sponsored midwife apart from the maligned realm of charlataneria (charlatanism) or the realm of brujeria (witchcraft). The reasons for this have much to do with a governmental interest in the management and control of the population within the borders of the nation-state, as well as the biomedical prerogative to consider the work midwives do as something more biomedically relevant than their fellow medicos tradicionales. How their identities became linked to the idea of traditional doctoring is part of a story in Mexico and around the world where midwives

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6 One of the bilingual translators in the clinic told me that “midwives didn't used to be “traditional doctors”, they were something very separate.”
were targeted as crucial actors for bringing rural populations into the fold of public healthcare, as well as promoters of the ideals of hygiene and reproductive control.

As early as the 1930s, the training of midwives was a novel attempt to assimilate traditional health practitioners into the work of rural sanitary units. Although curanderos at this time had been brushed aside as superstitious and superfluous, “empirical midwives”\(^7\), were needed to carry out a service rural health units could not fulfill (Birn 1998). By addressing pregnancy, child health, and midwifery, the public health sector was entering territory previously the domain of women; it justified its trespassing by linking high infant mortality rates (estimated at more than 200 deaths per 1000 live births in the mid 1930s) to maternal ignorance and the “erroneous practices” of empirical midwives, who attended more than 90 percent of births. Even where professional midwives were available, the units complained, “many women, through ignorance or economy, prefer empirical midwives who charge little, creating a grave danger for both mothers and children” (Birn 1998: 57).

Midwives did not restrict their activities to childbirth but offered prenatal and postpartum health advice and herbal remedies, observation of the shape of womb and fetal position, spiritual counseling, massages, steam baths, and assistance with household chores, such as food preparation following childbirth (Birn 1998). Because of this broader role, midwives were also blamed for dangers posed during both prenatal and postnatal stages. Thus, it was necessary to identify, monitor, and train midwives in order to “give them a sense of responsibility and to place limits on their work so they would not threaten the lives of mothers or their children” (ibid: 57-58). Thus, they were

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\(^7\) Empirical referring to those midwives who learned through apprenticeship.
trained by sanitary units each year with sessions “designed to convince midwives to use aseptic methods, employ and disinfect instruments such as forceps, deliver women in a supine position, and limit midwifery to a clinical role, discarding its social and traditional aspects” (ibid: 58).

With the medicalization of childbirth came an instructive to the midwife warning them to recognize their limitations and cede authority to the physician. Although they gained new knowledge of hygienic principles, some merely replaced acceptable local practices with less context-appropriate ones: for example, midwives who typically cauterized umbilical cord with hot blade or flame were taught to sterilize with disinfectants that had to be purchased. While midwifery had been “one of the few prestigious roles afforded rural women; the sanitary units stripped this role of its importance by limiting the social and advisory capacity of midwives and by constructing a dependence on physicians by these once autonomous practitioners” (Birn 1998:58-59). In this way, local knowledge was displaced by outside authority.

These programs were resurrected again in the mid-1970s, the Mexican Ministry of Health and the National Indian Institute (INI) mobilized midwives in the name of attending to several national problems, including, the inability to provide dispersed rural populations with biomedical services of the same quality as those provided in urban areas and the desire to promote family planning programs in rural areas in order to reduce population growth (Parra 1993). While this time the program spoke of respecting the traditional health practices of indigenous people, the goals of the program remained very similar to previous ones: training midwives to refer complicated pregnancies to
state health posts, refer women for sterilization, promote family planning, and promote hygienic measures and vaccination campaigns.\(^8\)

While offered in the name of respecting traditional cultural beliefs, these programs tended to disqualify midwives practices, separating out what was deemed acceptable from the unacceptable. Through trainings of midwives, there was a rationalization and secularization of indigenous medical practices and concepts.\(^9\) The kind of recognition offered Indian medicine was also the kind which selectively valorized components of “tradition” considered worthy of recognition: “traditional and indigenous medicine was reduced to medicinal herbs, stripping all ideological elements that accompanied them” (Campos-Navarro 1996:177). Anthropologist Page Pliego describes it as the “the debilitation of the mechanisms of cohesion founded in the magic and the religion” (Page Pliego 2002).

**Midwives in the Clinic**

During my time at the clinic, a multiple workshops, certification events, ceremonies of honor, were offered or given on the midwives’ behalf. Their participation in these events as well as many public ceremonies became in many ways their work

\(^8\) The impact of these programs is evident in the following statistics recounted in an early evaluation:

By 1985, “rural midwives had referred 50,708 women with problems during pregnancy to the rural clinics or hospitals…sent 55,189 children for vaccination, and referred 30,030 children with malnutrition,” fomenting “the use of contraceptives in rural areas from 5% in 1969 to 27% in 1981, and referring 9600 women for sterilization or IUD insertion (Parra 1993:XX).

Importantly, these projects were part of biopolitical projects that attempted to limit the undesired reproduction of indigenous populations. Unconsented sterilization had never been uncommon in Mexico, but with midwives the hope was that they would be able to gain consent of their patient for contraceptive measures.
alongside attending to their pregnant patients and postpartum mothers. Midwives were also far the most visible traditional doctors in the clinic.

Wednesdays were the busiest day at the clinic because on this day midwives came streaming through the doors with their patients. Some brought one or two gorditas (little fat ones, as midwives affectionately called their patients), others came with more. The clinic’s special interest in midwives was reflected in their appointments with Dr. Ignacio, a physician-obstetrician at the hospital who was considered unique in the Ministry of Health because of his interest in working with indigenous midwives. He justified his interest in midwives (and not other curanderos) by saying that, contrary to other indigenous healers, “at least the midwives are actually doing something… they are catching a real child”.

Of course, the “something” that midwives did extended far beyond “catching a child”. Midwives in the Sierra often got up before dawn to see or fetch their patients and help them comply with the prenatal care standards established by the health sector. Sometimes this entailed traveling to remote communities and walking on trails and roads between coffee plantations and orange groves, on routes which were often muddy and sometimes very steep. As described by a midwife, the women who seek them are sometimes those with little access to biomedical healthcare:

I have had to walk far on foot, and these jobs are almost always at night, and for example, I have had to walk on foot one and a half hours, two and a half hours, in good weather, in bad weather, whatever time it is, and from there, after checking her out, we sometimes ask the husband to take her to the hospital, according to the needs of each pregnant woman. We ask her if she has already been vaccinated, because they are not always women who we know, being sometimes from other places, and have not even had a vaccine, or a consultation with a midwife, let alone a doctor. (Doña Oliva, personal communication)
Waiting with their patients for the obstetrician on staff at the clinic, sometimes they would give up an entire day to sit with their patients and advocate for their turn to be seen. If the patient was considered high risk (because of age, disease, previous cesarean or status of being a first time mother), the obstetrician would perform an ultrasound after the midwives helped their patient onto the table. Standing by the young mother, some midwives looked blankly at the garbled images, waiting to hear the doctors report about the status of the fetus, while other midwives “read” the ultrasound over the doctor’s shoulder in order to confirm for themselves how the “pilitzin” (little baby) was doing (which the doctors refer to as el producto, or “the product”). According to the obstetrician, he was always surprised at how often the observations the midwives made through their own therapeutic prenatal massages were confirmed in the ultrasound images.

The midwives then stood next to their patient who sat at the desk in front of the physician and received instructions about the prenatal procedure to follow. The physician often spoke directly to the patient, who in most cases spoke more Spanish than the midwife (being often a couple generations younger), referring them for additional blood or urine analyses, vaccines, or vitamins. However, it was the midwife who ensured the doctor’s orders were followed. The midwives accompanied their patient to ensure they received their shots or tests or vitamins, only to return later, or if more urgent, on the following Wednesday, with the corroboration of these interventions.

It was common to see midwives with their hands full of instructions and prescriptions walking around with their patients; or hear the midwives explaining to their young patients and male partners in Nahuat that she must have the doctor check her
before going into the *temazcal* (sweatlodge); or watch as midwives departed in regional
trucks with pregnant women for studies at larger hospitals in far off cities such as
Tezuitlan or high-risk deliveries Zacapoatxla. At other times it was the midwives,
discreetly helped wives stay abreast of their birth control. I heard for example, one
midwife remind a young wife when it was time for her next Depo-Provera injection.

I was also with midwives as they supervised their patients for days as the birth
neared, spending sleepless nights and days checking in on their about-to-deliver
mothers. When it was time for the birth, the very infrastructure of the clinic was said to
communicate a state of interculturality because of its platform structure where woman
could squat to have birth in the “traditional” vertical position. Midwives also provided
postnatal and post-partum care for their patients, washing both the mother and the baby
with teas made from different plants for weeks after the birth. Many also worked as
*hueseras, sobadoras, spiritual healers, herbalists, and counselors*¹⁰ as well, and
provided herbal remedies, massages, *temazcales* to help their patients feel more
comfortable and ensure that the child is in good condition.¹¹ In other cases, midwives
helped prevent miscarriages through teas of herbs and *fajas* (girdles). And I observed
how midwives applied the techniques of infant re-animation with much skill, reviving
newborns when there seemed no signs of life.

State officials often discussed the clinic in terms of an achievement in
“interculturality.” The Ministry of Health defines the intercultural during pregnancy,
delivery and post delivery as that which:

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¹⁰ They were also the persons that women turned to in cases of domestic violence.

¹¹ Midwives also provided other things to ensure the health of the baby; I had seen them procure special
foods that the patient cannot afford, but that she has an *antojo* or craving for, in order to protect the child
from suffering a difficult birth because the mother has unmet desires.
Favors the quality of care in a respectful way, horizontally and comprehensive in the context of security and efficiency through the exchange and enrichment between modes of knowledge and practice that allows the woman to be the main actor during her pregnancy and delivery process, eliminating the cultural barriers. This model of intercultural care is the product of interchange and enrichment among diverse models of knowledge and skills recovered and placed to the disposition of the women. (Author’s translation, Ministry of Health 2007)

Biomedical personnel at the clinic were hopeful about what they perceived as the intercultural achievements of the clinics and especially their work with midwives. For example, Dr. Carlos who had worked in the region for over a decade stated:

We have seen many changes. Previously, to have a child vaccinated, which the people sometimes did not want. Now with the midwives encouragement, they bring their children to be vaccinated. And now through the trained midwives, prenatal complications are detected early in the process, and they themselves channel the patients to us. (Dr. Carlos, personal communication).

Speaking of traditional medicine in general, but foregrounding the role and practices of the midwives, he also spoke of the relationships with midwives in this way:

Here…the traditional doctors are still a base, a base of attention for many people, because the customs are still deeply rooted. Here if you walk or you go in a car 15 minutes to whichever community, and the people still follow the curandero a lot, they still have their customs and ways of healing, it’s been many years and the people with much difficulty are going to abandon them. Here in the hospital I think the success has been that the hospital does not have maternal mortality, here or in the community, and this is thanks to the midwives, and the brujos and all of them, because they extract [bring] the people, they check them out and they know that when something is not well, the midwives know that they should come here, not so that we will resolve it for them, because there are many births we don’t even see, well, we don’t see “in parenthesis”, because there is always someone supervising, but they already know that together we can solve the problem, and I think this is fundamental, and the traditional medicine will keep being fundamental (Dr. Carlos, personal communication).

This “togetherness” meant that midwives would be at the service of biomedicine, that they need her to be able to extend their services to the local indigenous population.

The medical doctors I interviewed often reiterated notions they evaluated as “progress”
in relation to the practice of midwives, particularly noting their approval of midwives in
the languages of hygiene and birth attendant protocol. With all the “progress” made
through the education of the midwives, atavistic ideas of “bad practices” continued to be
a specter in the imagination of physicians. For example, Dr. Sonia, a pediatrician
narrates what she believed midwives had been doing wrong in the Sierra:

Before the patients used to come with babies with the umbilical cord cut
with a machete without washing, with razor blades unclean, they would use
the first thing they could find. Or for example, they would put ash on the
navel or use chili. Or sometimes they would put ash on the umbilical cord or
cow manure to make it heal the wound. However, it was found that those
techniques presented premature tetanus in the babies. Then we explained
to them that they need to clean the scissors with alcohol or have a new
razor blade. That changed the perspective because then they did it with a
clean object, and there weren’t infections anymore. So it is good to have
contact with them and train them, to modify their skills, for the betterment of
the health of the patient. (Dr. Sonia, personal communication)

The narrative of midwife, huesera, and curandera Doña Barbara, who was
formerly affiliated with the institution, presents another perspective to the historical
context given by Dr. Sonia. Importantly her narrative calls attention to a kind of
distinctions between midwives that are not elucidated when people who deliver babies
out of necessity in the countryside are collapsed into the same category of midwives as
those who have” inherited” this practice and skill over generations:

From the 80s until now, it was a requisite for the midwives to go to the
courses. In reality…they helped me in some things but others not.

Before I went to the social security, we attended the births and we knew
what we were doing, it's not that we didn't know what we were doing, of
knowing we knew it, and that's why they call us empirical midwives, in the
empirical way [a lo empirical], the way we knew how, and the way we were
taught by our grandmothers to cut the umbilical cord.

But well, in some places, I don't know if it was because of squeamishness,
they used other things, because I was put in charge of supervising
midwives, and to tell them, "no, that's not the way we cut [the umbilical
cord]", because I saw children later that I went to see and they were [ill],
and what did they cut the cord with? From ignorance they didn't know what to cut with because many midwives become midwives because the child is there, is being born, not because this knowledge came from an inheritance, but because the child was thrown [out] and so they cut them, but they don't know with what, and they grabbed the knife, the machete, a chunk of rock, but it's because of the lack of experience, not because, the midwives who we have it from birth [inherited], it's not just anything [it's not just anything anybody knows]. (Doña Barbara, personal communication)

In this narrative, Doña Barbara makes a distinction between the midwives that know, and those called midwives because of the necessity of delivering a child. She critiques the assumption that everyone that delivers a child should be lumped into one category, and points out the differences in experience and knowledge of persons that the health sector might easily group into one category.

**No Little Teas**

The recruitment of midwives as allies for the health sector was accomplished through separating “approved” and “unapproved” practices, which necessitated a cultural politics, one that points to the devaluation of their traditions even while the institution expressed interest in recognizing them. This process of using biomedical standards and priorities to distinguish “traditional knowledges” from condoned practices and prohibitions is a historically rooted one that today lies invisibly at the nexus of the kinds of stresses that midwives experience. In addition, midwives pointed out that they felt the health sector was more interested at first in having them manage the reproduction of women instead of having them treat women with the kind of care that midwives and elder women knew was important for a woman’s health:

There is a sickness that they called it "cachanis" [sp?]....When I attended a labor with my grandmother, the woman had to be carried to bathe in a temazcal, they had to lift her and put her in the door of the temazcal, the women could not stand up before the 8 days from the bed, they were well taken care of, well girdled and then only after they were bathed the next day they could walk very slowly in the house, but to the street they could not go
for 40 days, when they would go to give thanks to God that the child came out well. But now no, now they get up and go. And now they have hundreds of pills. That is the first thing of [the health sector] if you are midwife, it means you will give birth control pills. (Doña Barbara, personal communication)

For Doña Barbara, family planning is what is defined as the proper realm of the midwife practice. The definition of intercultural success promoted in government programs meant that midwives played a pivotal role in attracting the commitment of federal agencies based on their potential for furthering public health goals around family planning. This conflict of interest was eloquently captured by an obstetrician, who framed the challenges of midwives as one in which they walked between “two worlds”:

It is two worlds. The midwives who come and affiliate with ourselves have to have two faces: one in front of the community and one in front of the institution. In the community if they act like allopath, there will come a moment their community won’t accept them. In the community they can speak Nahuat, they can do everything as they do, because that’s how they (the patients) looked for her (the midwife). And in front of the allopathic medicine, today they feel they have to show another aspect to be accepted. It’s not the same. (Dr. Ignacio, personal communication)

For example, although the midwife Doña Esmeralda was lauded by the clinic often as an “intercultural success”, the mode by which she achieved a positive reputation in the public health sector was not looked upon favorably by all. Fellow Nahua midwives, as well as anthropologists I met who also knew Doña Esmeralda, openly critiqued one of the very reasons the midwife was considered such a success at the clinic. Esmeralda had earned the fame of being one of the most productive midwives in terms of the numbers of sterilizations, IUDs and other family planning methods she achieved through her promotion of reproductive programs. While no one framed their comments about her avid promotion of reproductive control methods within a critique of the biopolitical mission of public health in indigenous zones, certainly some
Nahua considered her success in this area suspect even as biomedical physicians at the hospital lauded it.

Thus, while the physician imagined the role of the midwife as that which brokered two worlds, Doña Barbara’s opinion on the possibility for creating mutual respect between biomedicine and indigenous medicine was much less optimistic than those involved as proponents of the traditional medicine clinic. In her view, the traditional doctors were never going to be able to work with the allopathic doctors, because our beliefs and customs they are never going to want. They are never going to want us to give our patients a roll of herbs."

While her training was both with IMSS and INI, she explains the strategies are all very similar, and their desire to promote cultural respect is shallow. For example, the terrain of traditional practices is thus one rife with contentions, even within realms midwives consider key to their work as *traditional* midwives. For instance, the midwives mentioned in several instances they have been criticized for teas they offer their patients. While some had knowledge of these teas from years of experience to know which herbs are suitable for their patients, and many times observed the axiom of not providing teas if the patient was under biomedical treatment, this part of their midwifery care was discouraged. As indicated by a traditional midwife in her words:

They don’t want us to give them the little teas (tesitos), but for us it is important. Some are for pain relief. And some are for the labor. When we are not allowed, we are left with this preoccupation, sometimes they intern them, sometimes they don’t let us care any longer for our people because we give them tea. It has not happened in the unit, but it has in the hospital itself (Doña Barbara).

While these kinds of challenges were never discussed openly to me by any biomedical physician, at times I heard references in low tones to the issue of midwives using teas.
At one point, while I was observing a cesarean section, one of the visiting medical residents asked the obstetrician about what they did in traditional medicine, and was told, “No, the midwives do not administer teas.” But when they come into the doctor’s consultation office with their patients their knowledge-practices were challenged or contested by biomedical staff who interact with healers at the clinic.

Just as there is disapproval of many biomedical on the validity of the teas, the therapeutic massages and *manteadas* are also suspect practices. While the position of some health staff is that these traditions threaten the welfare of the fetus, midwives have a point of view that is completely the opposite; as their way of diagnosing the condition of the *pilitsin*, they argue that it is essential to detect either a pregnancy that is in a different position, as well as any impending complication that might cause some complication either during the pregnancy, childbirth, or in postpartum. Most midwives defy the admonitions of their practice. As one midwife explained to me, “if the pregnant woman asks me as a midwife to *sobar* (therapeutically massage) her, I am indeed going to do it, and I'm going to search the position of the “product” because this is how I can help her.

On another day, while I was accompanying the midwife Doña Paulina with her patient's appointment with the medical resident who has gone to great lengths to question a mother about why her fetus now appears in the correct position for birth, when it hadn't been in the previous checkout. Using a very serious and authoritative tone, he warned both the patient and the midwife about the dangers of the *manteada*. The midwife, who understood Spanish but had difficulty speaking it, said nothing, staying silent with a fixed expression on her face. Like all of her cohorts, I had seen her
conducted *manteadas* many times. Still the informal policy on *manteadas* in the hospital is that they should be strongly discouraged.

There were other ways midwives felt discounted in their knowledge, and misunderstood. When I asked Doña Barbara about the practices the institution had blacklisted as “bad,” she related a narrative about how popular healing practices, which are based on a different epistemology, are met with misunderstanding. Discussing a workshop to which she was invited along with other midwives in Mexico City, she talked about how the officials talked about how it was bad to treat the umbilical cord with spider webs, while another supervisor mentioned specifically the use of cobwebs by midwives as an example of bad practices:

That is why the information is seen badly because they misinform instead of giving the right information,…This misinformation gets all the way to Mexico, and then they say, “don’t do this because it’s bad and has bacteria! But they have never done a real study of what it is that is done, or what the midwives really do, or what they’ve seen. Because I can tell you [what is actually done is different]. But I thought to myself well perhaps it’s the *cuahquixtli* they are talking about, but they don’t put it on the bellybutton, the smoke serves for the healing. It’s to drink so the placenta will come out, the woman drinks it and no one has died from this, because it is the smoke [on the cobweb] that is consumed, it is not the cobweb. The smoke sticks from the residue of what’s left of the smoke, so much smoke it gets stuck up on the ceiling of one’s house. And it hangs there, the black stuff. And that serves us as medicine, and it’s a tradition that has been used, it is not the spider web! But if they don’t know, it’s better if they don’t talk! (Doña Barbara, personal communication)

In Doña Barbara’s opinion, the confusion and misinformation about actual traditions led to erroneous generalizations about the practice of healers and midwives. She continues:

The man who interviewed us yesterday from the magazine said, “I have a lot of technical words, I can’t (understand) you. I told him, “Well then you should first go to the countryside and see how we live and then we can explain to you, because if we are going to say a word, it’s what is done” [it’s not what is said is done].
And if [a midwife] told you [she used] was spider webs, it’s that many call the what the smoke makes on the ceiling “the cobweb”, but its not the spider. The spider is an animal, and the cuahquixtl is another thing, and this is what perhaps I think [they had misunderstood]. It’s not put on the bellybutton of the child, it’s given to drink to the woman when the child does not want to be born, but this was long ago, long ago, although sometimes still it’s used. It’s been some time since I have used it, and I still do use it for other things. The porcupine is still used [in childbirth], izardcuaztle, for that, but it is the bad information that is given, and that’s why they say “don’t believe in it!” but the customs and traditions they are never going to know them until they live them, until they learn them, they don’t know what it is for example, I could be talking to you about a mountain of things, but the situation is not happening. And when the situation arises, I am going to do the same thing. I am going to do something else! I can tell you, I am going to do this or that, but when I'm looking at the patient, I don’t do the same thing I told you. Why? Because at that moment, God is telling me, God is ordering me, to tell me what it is I’m going to do. Then it’s no longer a theory. (Doña Barbara, personal communication)

However, in the case of indigenous midwives, the doctors had to be confident they could be entrusted to “know their limits.” And this is was the quality for which the hospital most praised the midwives for: their ability to trust the midwives to “know their limits” meant being confident in the midwife’s ability to discern the kinds of patients they could or could not attend to safely. This list included first time mothers, older mothers, post-caesarian mothers, or pregnant women who were experiencing the signs of distress which midwives had been taught.

While the biomedical personnel I interviewed underscored their trust that midwives would know their limits, publicly they often focus on the value of the community’s trust in midwives. In this discourse, midwives were deemed to be a valuable resource for the clinic, because of the trust they were said to inspire in their patients. For instance, at a local presentation by the traditional clinic to the larger community during the Annual Health Fair in the House of Culture, the coordinator of the
clinic says: “Here we have people who the community gives their trust” (Lupita, personal communication).

But personnel from the health sector were not the only ones interested in the idea of trust. Midwives also spoke in terms of being able to trust that physicians at the hospital would not “steal” their patients from them. However, while hospital administrators, physicians, and nurses, spoke about the trust the communities had in their midwives, and midwives talked about being able to trust they can now receive assistance from the doctor without having to be concerned he will steal their patient, this notion of trust is a lot more complicated in a place like the Sierra Norte of Puebla.

In fact, while the respect and recognition midwives have in their communities have been productively exploited in recent decades by the health sector, for generations now that same trust has been undermined by discourses that circulated through clinics, and hospitals, and radio programs, about the dangers and untrustworthiness of indigenous midwives. These discourses have had their impact. While the clinic talks about the ‘trust’ of the community in the midwives and praises their affective labor, midwives talked to me about the downturn in numbers of pregnant patients due not only to the impact of family programs, they noted a growing trend for younger patients and more educated patients not to seek out midwives. When I was out and about in the communities I would often ask women about this. Some of the women in full “traditional dress” who barely spoke Spanish—in fact, the very kind of women the health sector imagined would be relying on midwives—told me they did not “sentir confianza”, “feel confidence” in midwives. They said it was better to give birth in the hospital, despite the
infamous horror stories of verbal abuse by the nurses on the biomedical side and the lack of cultural respect. “Es mas seguro,” (it’s more safe) they would tell me.

While in some community clinics in the area, midwives were permitted inside with the biomedical physician assisting a labor, still in other communities there were clinics that chastised the midwives for attending women, and did not permit them to collaborate with the doctor. It was also known that although the policy within the hospital itself did not officially deny midwives access to their patients during labor on the biomedical “side” of the hospital, even some midwives who were well respected as midwives within the clinic quietly confessed to me their experiences with feeling denied entry with their patients. They told me, “Like the midwives who we are, we would like them to allow us into the hospital for delivery” (quisiéramos que nos dejan pasar a la atención del parto).

Despite all the discussion around the positive contributions of midwives within specific frameworks of ‘interculturality’ as respect for traditional knowledge and practices, the relationship of the hospital employees and midwives showed signs of stress and contention. There were many moments during my research when the discourse about a fundamental respect for midwives was laid threadbare. For instance, one day, I find Doña Esmeralda in a rage about her experience with one of the passing physicians at the hospital. She told me one of the reasons she felt she had to pray a lot was due to her feeling of anger towards one particular medical resident:

There is always the temptation someone can make you angry. And so it’s not that way, you have to pray a lot to God. Often the priests say, let the world turn and you keep working in your work, and that’s it. Because I went to tell (the priest) how he chastises me, that piece of junk... He was saying that he was going to run me out of the hospital!
While I was never able to get a sense of the specifics of what had happened to provoke this reaction in Doña Esmeralda, the angst she communicated in this moment was not an uncommon expression. For many midwives I spoke with, local clinics had earned a reputation for threatening their patients with losing their government assistance, or direct governmental assistance for the poor, if the baby was born at home with a midwife, instead of a healthcare institution. I also met midwives who suffered rejection by the staff in their local community clinics, and feeling compelled to cease their practice of midwifery, stopped practicing what they saw as their unsanctioned calling, and focused instead on providing sobadas during the prenatal period and/or serving as laundresses in the postpartum period.

However, in what seems a much more cynical view, Doña Barbara, who no longer participated in the Ministry of Health project, hinted at the kind of frictions experienced by midwives, even while the health sector celebrated their alliance with midwives unproblematically as a *fait accompli*. Her narrative gives us insight into the possible sources of these frictions, as she talks about the rehearsed discourses that the health sector expects from midwives, as well as the content of their ‘intercultural’ contact, which continues to focus only on biomedicine:

If someone comes who wants to let go of some money, well then they [pay attention to us]. They tell us, “you all know what to do, you all talk about what you do… midwives, you say how much we’ve helped you and how we help you.” But when they pay attention to us, the training is all the same: they train you for family planning, about condoms, etc. …how to attend a birth with hygiene, and how to attend the birth with gloves, and cutting the umbilical cord with the disinfected scissors, and they tell you they are going to give you the supplies and they are going to give you the little cords [to tie the umbilical cord].

And then, they ask you: “How is it? [the relationship between midwives and the health sector], and you say "they have helped us” and “the doctor is a really good person.”…They don’t talk about what they really do. [And] it’s
that the information they try to tell us regarding changing our beliefs and customs makes no sense. If the promoter says, don’t believe in this, but if you believe it, you dismiss them as crazy (Doña Barbara, personal communication).

This focus on a very particular notion of the ‘traditional’ led to midwives feeling like they were a kind of split subject, trying to pass for doing what was acceptable while working in the ways they valued. Accepted and praised on some moments, reprimanded in others, this cut down on communication and reestablished hierarchy and the authority of biomedicine.

**Untraditional Traditions**

The traditions that were sanctioned and celebrated in the clinic were ironically also the ones which were in many ways no longer pertinent to the reality of Nahua women. There were moments when the discourse the hospital represented about midwives didn’t match up to the reality of their lives or their current expectations. While physicians I talked to had many critiques of midwives’ “traditions” they had seen or heard about, for example the cutting of an umbilical cord with a machete or the unhygienic use of ash or cow manure on bellybuttons, there were a few traditions that were accepted and promoted in the clinic. Among the most celebrated practices was allowing the birthing woman freedom to move and to give birth in their own clothes. It had been common for women in previous eras to birth in their own clothing with the help of gravity, i.e., in the squatting position. A very colorful painting hung in the clinic hallway celebrating this ideal of a “traditional” birth, with the woman in her own full dress, squatting as she labors over the midwife who is receiving the baby.

A frequent highlight of the tour of the traditional medicine clinic was the platform that sat in the corner of the birthing room which permitted women to simulate this style
of birthing. The metal bars simulated the sash or shawl that would have been wrapped around the inside of a home’s wooden beam, allowing a woman to hold on and bear down. The platform was built for midwives to better be able to access the birthing woman as she squatted, which was imagined to be how indigenous women gave birth. The hospital used these technical adaptations as evidence demonstrating its interculturality and support of native customs for giving birth.

Thus my surprise the day the midwife DulceMaria called me in to the birthing room to see her gordita in labor. I walked in to find a young girl in a worn-out hospital gown laid out horizontally in the bed, her hands pulling the sash around her mother-in-law’s waist as she let out small screams and her mother in law chuckled. DulceMaria pushed down on the girl’s stomach with each contraction. I was surprised to see the girl lying on her back (instead of crouching down or standing) as well as in the hospital gown.

After witnessing this scenario, I asked a midwife about why midwives weren’t following their own tradition that was so often lauded by hospital personnel. Doña Barbara related that tradition had changed due to the changing physical conditions of Nahua women:

It depends on the patient on whether they want to squat or not. It's uncomfortable for the midwife and for the patient to be squatting, because the times have changed. Before there were woman who only squatted and the baby came fast. But [this is not how it is] now. Now labors are more difficult, more complicated, because of change of times and the sedentary life. It’s not like before, where you would see a woman with her big belly carrying wood and water. And still grinding corn; she would feel a pain but not think the baby is coming yet, so she would keep grinding. And then all of a sudden, she squats and the baby comes as if going to the bathroom. Not now. Because they are sitting to watch TV, they are riding the trucks to get around, and not even walking 2 hours in a day, not anymore. (Doña Barbara, personal communication).
In her view, because of the comforts and conveniences available, Nahua women were no longer required to perform as many physically demanding tasks as their older counterparts, and this made their “traditional” practices obsolete for their contemporary bodies.

Midwives and the Not-Yet of the Nation

On one day when I arrived to the clinic, I found the door to the main office of traditional medicine closed. Although it was always kept open so that clinic coordinators could manage the visitors or patients who arrived, on this day it was conspicuously shut. I greeted several of the midwives who were standing in the hall, and then followed Dr. Ignacio into the office after he invited me to join them inside. The office was shockingly cool for a warm summer afternoon in June, a sensation that seemed out of place in a hospital with no air conditioning, and a freshly cut square in the wall betrayed the installation of a new A/C unit. I found the room curiously full of biomedical physicians, assistants and myriad staff, all male except for the clinic coordinator and a young female resident who briefly visited and then hurried out to meet with her patients. With the exception of the traditional medicine clinic’s three member office staff, everyone in the room was personnel who usually stayed on the other (biomedical) side of the hospital. The atmosphere was jovial, and everyone’s eyes were glued to a large television. Originally, the TV had been procured for the clinic's midwives and their patients to watch during their long waits for the obstetrician. However, in a rerouting from its intended purpose, the set routinely sat atop of the file cabinet in the main office broadcasting soap operas for the office workers. On that day, it was broadcasting Mexico playing in the World Cup instead.
Shared camaraderie unfolded inside the office in interaction with the TV set. The onlookers yelled “Mexico!” in an ambience of energized fellowship among a mixed bag of hospital personnel: physicians, health promoters, assistants, and drivers. Everyone roared and cheered and booed in solidarity of nationalist sentiment.

In the middle of all the excitement about the game, there was a light knock at the door, and Edgar arose to answer the call; he cracked the door only slightly open, just enough to converse through the open gap (and just enough for me to see it was the midwife, Doña Mercedes). While normally the midwife would have entered the office to speak to one of the office managers or ask a question, the door remained closed to her as the translator muttered a quick response and just as quickly closed the door. While no one took their eyes off the game to see who was at the door, I sat there in full knowledge of the fact that Doña Mercedes, a fellow midwife who had only moments before urged me with giggling excitement, to accept the obstetrician’s invitation into the office. The midwives wanted to know the score of the game.

Suddenly, watching Doña Mercedes’ being turned away at the barely open door and sensing her eyes meet mine, I became hyper aware of being able to traverse into the center of this privileged communal space, while the midwives outside, with greater interest in the national soccer game, were fielded at the door. In that moment, the team spirit inside the room laid out in contrast the exclusions I knew were happening outside of the room.

While the midwives are celebrated rhetorically as the cultural quintessence of the nation and venerated locally at public exhibitions on traditional medicine, in practice the limits of the nation’s social body were manifested in routine and every day practice.
the inside of the room, the shoed, literate, educated, mostly male and mostly foreign arrivals to this rural outlying, municipality were invited participants to this nationalist communion of sorts. On the other side of that door, those who called themselves masehual, stood outside the door even while they found themselves inside of the institution. The midwives continued to embody the ethnicized and classed Otherness, even within a state project in their name. They continued to be poor. They continued to be illiterate. They continued to be shoeless. And they continued to be indios.

These were in fact the conditions of their possibility as "traditional midwives". An effect of the celebration of the “traditional” depends on the fact there are indias, who are shoeless and poor, and can carry the banner of authenticity in the name of indigenousness. As indigenous midwives recognized by the government, there are certain kinds of positionalities and identities at stake in these configurations of bodies, persons, and agencies. Fields of interlocking colonialisms continue to shape these relationships, reproducing a marginal social location for midwives, even as they enact their agency and mobilize forms of governmental recognition on their own behalf.

As such, while the midwives were curious about the state of their national team in a soccer game, the results were available only through secondhand information from the foreigner among them. While they too may want to know the score, there was a boundary to be kept. That these racialized and gendered others might join the festivities was not even a question: an invisible, but tangible limit held them safely on the other side of the closed door. They came to the door, they knock and ask in low voices, but they are quickly turned back from a barely-cracked door.
After a few minutes of the game, I returned to join two female midwives who were still standing in the empty hallway, just down from the closed door. They invited me to eat with them as their breakfasts were served. We sat in the dim altar room, the lights off, the room warm, the space silent. They shared their tortillas with me and encouraged me to make tacos of the boiled squash on their plates. Back at the TV set, the coordinator and the translators took respite from their game to have breakfast in their dining area. Meanwhile, the midwives continued to wait for their training session. In the end, the training never happened as it got too late in the day and the projector did not work. We couldn’t see the slides the doctor had showed me earlier when he asked me nervously about what I thought he should show them. At that moment, the doctor admitted to me the training was not really a training at all, as his plan was to show a PowerPoint depicting different areas on the biomedical side of the hospital, places that he thought “they should know” about: the pharmacy, the x-ray room, etc.

The irony of "introducing" midwives, most of whom have been working at the hospital for years already, to these spaces through the "virtuality" of digital photographs was not lost on me or perhaps on him either. That these spaces were literally next door but would need to be shown to midwives through pictures, might only be made explicable through the kinds of cultural politics that govern the interactions of biomedical physicians and empirical healers, keeping certain people out of certain spaces, spaces that continue to be overdetermined by constructs of "gente de razon" and "indios." In rural localities where midwives work within the limits and constraints of biomedical hegemony, the indigenous midwife is the indio permitido but in a particularly gendered form of the bruja permitida (the authorized witch).
This *bruja permitida* comes to stand in for notions of equity in indigenous contexts under state multiculturalism even as midwives draw upon state-sponsored intercultural programs as a resource to enact their agency. Hale’s use of Indio, in the concept of “Indio Permitido” contains and reproduces the force of dejection, the inseparability of this ethnic label from a kind of anti-citizen. While the word *indio* is not considered politically correct in public parlance anymore (some mestizos use the diminutive form of *indito* to soften the culturalist and racist overtones that the word carries), Hale’s purposeful use of this word highlights the historical baggage it carries with its colonially constructed semiotics. While the adverb “*permitido*” calls to mind the terms under which an “*indio*” is recognized in the nation-state, the idea of an ‘*indio permitido*’ suggests a subject that must be given permission to exist in the national body, an existence sanctioned on specific terms appropriate to national ideas of mestizo citizenship.

However, while Hale looks at the mestizo imaginaries around this permissible Indian, I consider how midwives embody and enact the tensions of being *an india permitida*, or more exactly, a *bruja permitida*, a “permissible witch.” By recasting Hale’s *indio* with the feminized form of *bruja*, I argue that Hale’s notion of el indio permitido translated into the *bruja permitida* is particularly salient for theorizing the vagaries of being a midwife within Mexican public health sector. Compelled to negotiate a status that is embedded in interlocking colonialisms of which to be a midwife carries the colonial weight of accusations of witchcraft, the “*bruja permitida*” (or the “permissible witch”) in her engagement with the clinic, the rural, indigenous midwife embodies the intersection of gender, class, and race in ways that delimit certain possibilities and
constraints for “intercultural” health. As such, midwives, even those as “successful” as Doña Esmeralda, must walk a fine line between their own patient’s needs and desires, and their role as institutional allies. This is because, from the beginning, the health sector’s interpellation of them selectively entailed accommodating their practices to priorities of a biomedical health sector. This chapter discusses the tensions that envelop midwives roles as they interact with governmental priorities, both resisting and reproducing governmental discourses. Drawing upon multiple vignettes, the chapter offered an ethnographic window into what can be learned from how the traditional medicine clinic is engaging rural indigenous midwives in the name of intercultural public health *La bruja permitida* is useful for theorizing the official production of social equity that a focus on interculturality in public healthcare performs.
CHAPTER 8
CONCLUDING REMARKS

In recent years, the national media published another wave of news reports celebrating the Mexican government’s accomplishments for indigenous people through the institutionalization of traditional medicine. The headlines read: “Traditional medicine, as an alternative for development in Puebla” (Siempre! 2008); “Puebla, spearheading traditional medicine” (Gobierno del estado 2008); and “More than 620 millions of pesos for indigenous peoples” (Eco Diario 2008). La Jornada also announced that soon Puebla “will be the first state in the country to have a hospital where the patients are attended with traditional medicine,” reporting in the same article that the “doctors of the Ministry of Health have fused together ancestral practices with the allopathic ones” (La Jornada del Oriente 2008). All of this press regarding an initiative that has existed for over 20 years points to the way in which the traditional medicine clinic continues to inspire a sort of perennial promise for the nation-state.

This dissertation began from the assumption that the processes at work in the integration of healers into state institutions are reflective of new kinds of answers to the “indigenous question” in Mexico. As in other Latin American postcolonial countries, the challenge for Mexico as a nation-state has been to project an image of evolutionary equality to its European and Anglo-North American counterparts while at the same time claiming legitimacy to sovereignty vis-à-vis its uniqueness and cultural distinctiveness. This distinctiveness has relied on the mobilization of a foundational narrative that celebrates the greatness of the pre-Hispanic civilization, while disenfranchising the descendants of the original peoples in the territory. Disparities in health, education, economic and political power have been a product of the uneven extension of
citizenship to Mexican people, where indigenous people have been excluded from the benefits of national belonging (Barre 1983; Diaz Polanco 1991; Harvey 1997).

Antonio, whom I first met at the foot of a new rural hospital with traditional medicine, is part of this broader context in which these traditional medicine initiatives abound. His and the lives of other serranos have been indelibly shaped by contemporary policies redefining the roles and responsibilities of the state even while continuities with colonialism continue to structure indigeneity in Mexico. In the context of persisting and drastic health inequalities between indigenous and non-indigenous populations, The Ministry of Health has promoted traditional medicine as a health development strategy. The realities of the lives of those who have met with dramatic structural marginalization under the nation-state’s economic and social policies, provoking questions about what it could possibly mean for the state to offer traditional medicine to members of rural populations that have been subject to decades of depopulation and disenfranchisement.

This study suggests that the traditional medicine clinic is emblematic of a reformulation of the state policy of indigenismo, revealing a particularly intimate new chapter in a long history of indigenous relations with the state. Indigenismo in Mexico has a long history of attempting to answer the question of how best to integrate indigenous people into the social, economic and fabric of the nation-state. Now this answer is being reformulated in specific ways. While the traditional medicine clinic's emergence might appear to be a logical extension of the political trajectory of multicultural democratization, this study problematizes the clinic as a space that is being formulated as a socio-political solution to a continuing national problem of meeting the
needs of indigenous citizens under neoliberal economic ruptures as well as anxieties around the government’s growing illegitimacy.

I argue that as Doña Ana studied my pulso on the first day that I visited the clinic, she was being hailed to apply her own cultural capital to the unraveling of former state-citizen pacts under a neoliberal regime. Although healers had first been called to fill in the gaps in healthcare beginning in the 70s and 80s during an incipient unraveling of the welfare state, I suggest that more recently they have been mobilized to ameliorate emerging neoliberal maladies that threaten not only the health of the nation-state’s citizens but also the revolutionary ideals of healthcare for all. In this register, the traditional medicine clinic’s re-emergence can be understood not just a result of multicultural democratization, but as an answer to a national problem specifically rooted in the neoliberal economic and social disjunctions of contemporary Mexico and a growing illegitimacy of the state. Ironically enough, under advanced neoliberalism, indigenous healers have been recruited to serve their communities even as the concept of healthcare as a public good dies (Fisk 2011).

This dissertation has demonstrated that the Mexican government’s constitutional mandate for state multiculturalism and its infusion into healthcare produces a mix of contradictory outcomes. These contradictory and disparate purposes result in “state effects” which can be traced in the day to day tensions and anxieties of the traditional medicine clinic. The incorporation of indigenous healers into public healthcare generates ambivalence and uncertainty, especially in the mestizo mediators who are called to forge alliances with indigenous healers in healthcare. While healers are romanticized and celebrated in public, state officials are faced with a certain disavowal
of their practices behind closed doors and the state officials whose charge it is to promote healers find themselves in increasingly ambivalent positions.

At the same time, healers negotiate these state-sanctioned spaces by transforming and re-interpreting their own practices in light of the tension-rife space opened up through multicultural neoliberalism. While healers receive new legitimacy for their practice, there are also constellations of various publics—government agents, tourists, and new kinds of ‘local communities’—for whom their healing practice must respond. As such, the idea of traditional medicine in the Sierra Norte shape-shifts between different contexts: from popular healing treatments, such as sobadas, tes, recogida de bilis, practiced locally among people with little resources, to million dollar projects of traditional medicine clinics that attract headlining attention, and to ethnic tourism opportunities for people wanting to experience the magic of indigenous healing.

The contested expectations of what a traditional indigenous doctor should be and do in modern-day Mexico create challenges as well as opportunities that healers are compelled to reconcile in their attempt to become institutional allies and proper brujos permitidos. Healers who affiliate with public healthcare not only confront biomedicine’s cultural authority and dominance, but also engage the market-driven forces which compell them to articulate their practices within neoliberal logics. In the midst of the uneven social impacts of Mexico’s neoliberal health reform (Laurell 1991) and the routinization of multiculturalism in a post-Zapatista era (Gilbreth and Obrero 2001), they are compelled to navigate the contingent demands of a Mexican national-cultural politics that recognizes ethnic plurality while privileging certain forms of cultural and healing practice.
With the exception of programs geared towards public health incorporation of midwives, ultimately however, governments have not prioritized investment in efforts to bridge popular and allopathic medicine; notwithstanding the apparent global allure surrounding the idea of institutionalizing medical pluralism, these kinds of projects have not made significant contributions to the health of countries in the global south and scholars have largely declared them unviable for various political, social, economic and ideological reasons (Feierman 1985; Pilsbury 1982; Janes 1999; Lock 1990; Campos-Navarro 1997; Freyermuth 1993; Page Pliego 2002). However, despite the various thwarted attempts, failures, and numerous pitfalls involved in integrating popular healers into public healthcare, attempts to incorporate traditional medicine into government programs continue to stimulate a persistent hopefulness that attracts the attention of international agencies, governments, and urban and rural publics alike.

I suggest that the resilience of the traditional medicine clinic is at least in part due to the state desires to represent more equitable relationships with indigenous people. “Conjuring” this equity through an official production of relationship to indigenous practices through intercultural healthcare—the government projects a relationship of respect to the indigenous populations who are semiotically linked to this idea of traditional medicine. This is evidenced in the language the Ministry of Health used to describe its mandate (Almaguer 2001:3). Instead of foregrounding the idea that there is not enough biomedical attention for all, government attention on traditional medicine through the discourse of intercultural health maintains the notion that it is all about the respect of culture. While many questions remain about what intercultural health really means or how to achieve it among indigenous populations, under neoliberal
multiculturalism (Hale 2006) there is a tendency to consider the conditions of indigenous people solely from a cultural perspective, while overlooking the kinds of economic and political investments necessary for the alleviation of poor health conditions (Hita 2008). I argue then that the promise of traditional medicine, as I have sought to demonstrate in this dissertation, is located in the way that traditional medicine is able to conjure official productions of equity under state endorsed multiculturalism. The question stands as to how indigenous healing will continue to accommodate new publics as local practices are mediated through these national and global discourses on traditional medicine.
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BIOGRAPHICAL SKETCH

Jennifer Hale Gallardo is currently a Social Justice Research Fellow at Saint Louis University in Saint Louis, Missouri. Recently, she held a Derrick K. Gondwe Scholarship in Residence at Gettysburg College in Pennsylvania. She received a Bachelor of Science in environmental studies from Florida International University (in Miami) and a master’s degree in forest resources and conservation at the University of Florida (at Gainesville), prior to becoming a PhD candidate in anthropology at the University of Florida. This research was made possible through the following awards: University of Florida College of Liberal Arts and Sciences Graduate Minority Award, Wenner Gren Dissertation Research Award, American Philosophical Society Lewis and Clark Fieldwork Award, University of Florida Delores Auzenne Award, University of Florida CLAS Dissertation Award.