Shame as a barrier to health seeking among indigenous Huichol migrant labourers: An interpretive approach of the "violence continuum" and "authoritative knowledge"

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ABSTRACT

This article discusses the manner in which social and historical factors impact upon indigenous conceptions of health and health-seeking behaviour, reinforcing their authoritative knowledge about birth and wellbeing. It explores how Mexican indigenous Huichol migrant labourers experience structural, everyday and symbolic violence while away working, and in their home communities. The study was based on semi-structured interviews and observations with 33 Huichol migrant labourers and 12 key informants from the community (traditional healthcare providers), health sector (medical doctors based in the highlands) and tobacco industry (farmers, tobacco union leader and pesticide sellers) during 2010–11. Findings show how the continuum of violence is experienced by these migrants as shame, timidity and humiliation, expressions of symbolic violence that have helped define their tradition of birthing alone and their feeling of entitlement to the conditional welfare payments which sustain their marginalised subsistence lifestyle. This paper proposes that there is a cyclical relationship between structural violence and authoritative knowledge as the former reinforces their adherence to a set of cultural beliefs and practices which are the basis of racial discrimination against them.

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Introduction

The World Health Organisation recognises that indigenous people's health is 'invariably lower than that of the overall population' (WHO, 2013). Indigenous cultures worldwide are unified by experiences of dispossession and colonisation, reflected in socio-economic deficits, a lack of political representation, erosion of culture, dignity, health and wellbeing (Durie, 2004; King, Smith, & Gracey, 2009). These conditions have defined their shared set of epidemiological patterns: in less developed countries high rates of maternal and infant mortality, deaths from preventable infectious diseases and malnutrition, and in the indigenous enclaves of western countries, high rates of cancer, diabetes, alcoholism, depression and suicide (Gracey & King, 2009; PAHO, 2003). The poor state of indigenous people's health worldwide has come as a result of centuries of racial, social, political and economic marginalisation. It is these *structural* inequalities that, to use Farmer's phrase, put people *particularly in harm's way*, and they are violent because they cause illness and a lower life expectancy (Farmer, Nizeye, Stulac, & Keshavjee, 2006).

In this article I illustrate how structural violence operates as a barrier to uptake of health services among indigenous Huichol Migrants and I extend Jordan's concept of authoritative knowledge to describe how this population has developed a set of beliefs and practices about health that are designed to manage the socially problematic aspects of wellbeing, not only with regards to pregnancy and birth, but in a generalised sense to manage their wellbeing when faced with their particular *continuum of violence*.

The concept of structural violence describes how durable and historical social inequalities are embodied as ill health and a generally lower life expectancy. Nguyen and Peschard document the mechanisms through which these inequities are embodied, therapeutic power is legitimated and how collectives respond to misfortune, essentially generating population specific patterns of disease and affliction (Nguyen & Peschard, 2003). These social arrangements are seen as embedded gender, racial, and cultural hierarchies played out though interactions with people or institutions and that cause affliction or harm. Such unequal relationships are forms of what has been termed *everyday violence* (Bourdieu & Wacquant, 2004; Bourgois, 2002; Scheper-Hughes, 1992). Bourdieu examines how social inequalities are embedded generating a set of dispositions 'attuned to the structure of domination of which they are a product' (Bourdieu and Wacquant, p.

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342). These are the foundations of *Symbolic Violence*, evidenced on an individual level as self-blame, shame, timidity and humiliation (Bourdieu & Wacquant, 2004; Bourgois, 2002). Thus, structural violence is experienced by its victims through its various interfaces with other forms of violence − symbolic, everyday, and political (Bourgois, 2002). To bring these and more direct forms of physical violence together Bourgois proposes the concept of a 'continuum of violence', these being inseparable forms with a shared route cause. Different positions on this continuum have been used to explore the relationship between marginalised groups and health and through ethnography to evidence how political, social and economic structures influence people's decisions regarding wellbeing, their use of health services and their understanding of health and illness. Through his work with Mexican indigenous farm labourers in Washington State, Holmes illustrates how structural factors, based largely around racial hierarchy and economic exploitation, generate health problems among indigenous workers, describing how the evidently social nature of their afflictions is unnoticed by health providers who are 'equipped to see only biological and behavioural determinants' (Holmes, 2007, p. 56). Scheper-Hughes' work in Brazilian shantytowns illustrates how structural inequalities are *biologized* into specific illnesses and conditions by the medical profession generating everyday forms of violence that are embodied by mothers and their children (Scheper-Hughes, 1992). Her work documents not only the social origins of morbidity and mortality but also how infant death is parallelled by a set of practices and beliefs relating to motherhood that make sense in their particular context of violence. Ellison describes how structural violence influences the decision making processes of pregnant single women in the USA regarding abortion, adoption and single motherhood. The author describes how everyday forms of violence are explicated in shame and stigma and concludes that to make decisions about their pregnancies these women draw on an authoritative knowledge that is informed by both internal sources and their own experience of symbolic violence (Ellison, 2003).

The concept of authoritative knowledge was first used to refer to the 'set of internally consistent and mutually dependent practices and beliefs that are designed to manage the physiologically and socially problematic aspects of parturition in a way that makes sense in that particular cultural context' (Jordan & Davis-Floyd, 1993, p. 4). Jordan refers to birth as a biosocial phenomenon that is influenced by the 'culture specific social matrix within which human biology is embedded' (p. 3) and the concept is predominantly used to explain how different cultural groups have developed what are effectively survival focussed strategies for coping with it. Other studies with indigenous groups such as the Inuit (Daviss, 1997; Kaufert & O'Neil, 1993) and the Ju/'hoansi (Biesele, 1997) have described the differing ways in which authoritative knowledge is influenced by the particular environmental, historical and cultural characteristic of each group.

It is widely recognised that social groups develop health related behavioural patterns in response to social and environmental contexts (Dein, 2007; Kleinman, 1978; Lock & Scheper Hughes, 1996) and onerous social conditions (Singer, 1990). The onerous conditions that are present during childbirth can lead women to develop birthing and pregnancy related strategies that may in themselves also be considered risky. Such compensatory behaviours and strategies are also generated by the onerous conditions, such as poverty, marginalisation and racism, that are the results of structural violence.

Nguyen and Peschard (2003) review a series of studies which 'sketch the contours of the cultural formations that emerge in settings of extreme inequality and structural violence' (p. 463), noting that the 'cultural dimensions of poverty are no longer viewed *sui generis* but as local attempts to understand, negotiate and even resist global political and economic processes' (Nguyen & Peschard, 2003). What I propose here is the extension of the concept of authoritative knowledge to the onerous conditions within which affliction is embedded and that are the result of structural violence. This internally consistent and mutually dependent set of practices and beliefs develops to manage physiological and social challenges to health and survival in a manner that makes sense in each particular cultural context. In the case of indigenous groups this set of health related practices and beliefs may include traditional ethnomedical practices, themselves also an expression of a resistance to the political and cultural domination that has characterised their particular continuum of violence (Singer, 1990). Rather than viewing a group's specific health related cultural practices from a symbolic and ritual angle as if they were independent of a political-economic context, in the context of structural violence we must recognise their role as survival strategies. Bourgois (2002) proposes that 'treating violence as a continuum moves us away from unidirectional conceptions of causation and process' (p. 223), as is also illustrates by Holmes (2011) in relation to hierarchies of ethnicity among Indigenous Migrant workers in the US. Here I propose that structural violence is in fact the catalyst of a circular dynamic: the (structural) economic, political, racial, gender and social factors that directly impact on the health of Huichol migrants help define and embody their authoritative knowledge about wellbeing. This in turn generates further forms of discrimination and everyday violence against them, in what becomes a cycle of structural violence and authoritative knowledge.

Setting and research methods

The results presented here form part of a larger ethnographic study which sought to explore Huichol/Wixaritari (pural form of Wixárika, the native word for Huichol and terms they use to refer to their own ethnic group) understandings of reproductive health in the context of their lives as migrant labourers. It was conducted over a period of two years in the highland communities of Jalisco state, northwest Mexico, and on the coastal tobacco plantations to which they migrate in Nayarit state. These locations were selected because the Huichol have worked on these plantations for many decades and have a historical and cultural link with the region, and because while they work on tobacco farms they are exposed to large quantities of organophosphate pesticides that are considered harmful to the reproductive process (Gamlin, Diaz Romo, & Hesketh, 2007; Garcia, 2003). The research intended to explore whether migrant workers associated exposure to pesticides with poor reproductive outcomes such as high rates of miscarriage, congenital malformations or difficulty conceiving. What emerged was that women knew very little about reproductive health in a biological sense and were largely unconcerned about the effects of pesticides but did hold a series of syncretic beliefs about health and reproduction that are influenced by both structural and cultural factors.

The Huichol homelands are located in the Sierra Madre Occidental, one the most isolated and marginalised indigenous regions in Mexico. Until the 1960s there were no schools, roads or health centres in the Sierra and they remain one of the least acculturated of Mexican indigenous groups. Today there is a health centre and primary school in each of the main highland towns, a *casa de salud* (health house) in most of the valley communities and a scattering of secondary schools run using the *telesecundaria* system (secondary school classes delivered by a centralised series of television programmes). The entire region is classified by the government as 'highly marginalised', entitling every family to conditional cash transfer payments (CCTs) from the *Oportunidades* welfare programme. So that they can receive these monthly payments they

must comply with a series of conditions including school attendance, attending appointments and talks at clinics, hence the 'conditionality' of this form of welfare (see Smith-Oka, 2009 for analysis of the relationship between indigenous women and this programme). Like most Mexican indigenous communities, the Huichol are essentially subsistence farmers. There are very few paid jobs in their highlands which generate a regular income (Fajardo, 2003). In the sierra towns some families run small shops, but aside from these the only means of acquiring money without leaving their homelands is occasional seasonal and poorly paid agricultural labouring or welfare handouts. The municipality of Mezquitic to which these communities belong politically has an infant mortality rate of 77/1000 (INEGI, 2005), one of the very highest in the country. Official figures suggest that 57% of women and 26% of men in the municipality are illiterate (INEGI, 2005). While education attainment is improving, it continues to be marked by a high degree of gender inequality, particularly in the more isolated communities. Each year around two thousand Huichol migrate to work on tobacco plantations in Nayarit. For up to four months they live with their families next to the tobacco plants on which they are working. The plantations that become their homes for 3–4 months have no running water or sanitation facilities and workers eat, sleep and defecate in the open air.

I initiated this research from both an anthropological and an applied position, but seat myself firmly in the position of critical medical anthropology. This is important as the Huichol are better known for the depth and intensity of their particular set of religious and cultural beliefs, than for the socioeconomic conditions that they experience. Like all other Mexican indigenous groups Huichol life, culture, and the meanings of their existence are intricately interwoven with their system of beliefs, including their medical explanatory model and they are far better known for their rich spiritual traditions than for their marginalisation and unequal relationship with the Mexican state (Liffman, 2011). This spiritual bias is evidenced by the plethora of research on this aspect of their lives and corresponding dearth of socio-political analysis (Neurath & Bahr, 2005; Schaefer & Furst, 1996). In the Huichol world there is no separation between the natural and the supernatural, a characteristic that also defines their beliefs about illness causality. As I will argue in the paper, their adherence to a medical system defined largely by its reliance on supernatural explanations of causality and cure is itself in part consequence of the everyday forms of violence that this community experience. For questions of space the Huichol 'costumbre', as they refer to their particular set of practices and beliefs will not be described further here. Detailed ethnographies and ethnomedical accounts can be found in Fajardo (2007) and Schaefer (2001).

This study used semi-structured interviews, participatory methods and observation to gather ethnographic data over a period of 18 months during 2010 and 2011. The initial population was identified on the tobacco plantations where they were working in Nayarit. Using a combination of opportunistic sampling and informant referral techniques based on initial contacts provided by the National Agricultural Worker's Programme (PRONJAG), I identified 33 migrants from the indigenous Huichol governorship of Santa Catarina, who were working on tobacco plantations during the 2010 picking season. In total I conducted twenty five sets of freelisting exercises and semi-structured interviews with informants. A further eight couples consented to participate in the freelisting activity but declined to be interviewed or were not available. Key informant interviews were also conducted with four medical doctors, four key community members (a shaman, school teacher, the health committee leader and health promoter) and four tobacco farmers (employers). Interviews were conducted either directly in Spanish or with the support of a bilingual (Huichol-Spanish) research assistant. Reliance on an interpreter was the major

limitation of this study. It did however also give the advantage that the interpreters were able to garner a greater degree of trust, and were potentially able to access ideas that may not have been shared with me. Interviews were audio recorded then translated directly into Spanish. Transcriptions were double checked for accuracy. All informant's names have been changed.

All data, including field notes, were stored and sorted using N-Vivo version 9 and analysed thematically. I coded data inductively and deductively, firstly seeking general themes and subsequently to analyse emerging patterns and relationships, generating overarching and sub- themes. This allowed for both a focussed analysis and wider exploration of meanings.

Community approval was obtained through the Governorship's quarterly General Assembly, and formal Ethical approval given by the University College London Ethics Committee. Participant and study information was provided in Huichol and verbal consent was obtained from all participants in the study.

Findings

All of the Huichol families I spoke to talked of using both institutional and traditional health care and most shared a syncretic understanding of health and wellbeing. The Huichol have maintained a dynamic traditional healthcare system which revolves around adherence to a set of practices and beliefs based on a ritual–agricultural cycle and are presided over by mara'akate (shamans). They also use local clinics and hospitals, but while western medicine may cure the illness, it will not treat the cause, this will always be supernatural and any illness treated biomedically will also require a spiritual cure.

Generally the migrant workers I interviewed expressed a generalised dislike and distrust for western doctors, clinics and hospitals, they used the local health centres infrequently and had a poor impression of service provision, as Natalia (F26), a migrant who has settled permanently in Santiago tells me 'they don't treat you well, that's what they're like the doctors here… you go to the health centre and they say 'here we only attend people who are from this region'. How do you say…? Well from here, they don't attend Huicholes, well sometimes they do when they want to'.

The idea that doctors don't attend you or attend you badly was not confined to their experiences as migrant workers. Juana (F56) from the valley community of Taimarita explained to me 'when a person comes who can explain well and attends us well, then maybe, maybe we will go. But it's not like that here, sometimes the doctor gets angry and, well people don't want to go to him'.

Like Natalia, Juana and her family don't like to see a doctor not only because they feel badly treated. While they do not make direct references to racism, they clearly feel that health providers are prejudiced, discriminating against them as an ethnic group (as Natalia commented) and against certain families by denying them medicine or treatment. Juana's son Felipe (27) explains this with reference to the travelling doctor who visits their valley community once a month 'They [travelling doctor and nurse] just go to the clinic, not to our homes, there they attend the people, the ones in charge only look for the people they know, and if they don't like you they say 'there's no room for you here', that's what has happened to my family. Well no one likes my family, I don't know why, they just tell you there is no room for you here. And the doctor comes and he only sees them, not the rest of us'.

The one reason many informants gave for going to the health house or clinic was to be given medicine: medicine for pain, medicine for old age or simply medicine. As Mauricia from the valley community of Cajones tells me 'it's good to go to the health centre to get medicine, but no one else wants to go', or Abelino (M60, valley community -VC) who tells me that he only goes 'when I have pain, to get medicine'.

Many informants expressed a feeling of *entitlement* to medicine, an entitlement that they feel is at times withheld from them unjustly. This attitude is probably an extension of the widespread subservience generated by the particularly harmful strain of welfareism to which Indigenous Mexico has been subjected since the 1980s, one which by providing cash hand-outs as opposed to, for example, community led infrastructure and income generating projects, ensures a corresponding lack of social and economic development. They know they are very poor and see this as entitling them to hand-outs. This dependent relationship also ensures that they susceptible to other forms of economic and political coercion and exploitation −of which they also aware.

Oportunidades

Although in theory every Huichol who is resident in their homelands is eligible for *Oportunidades* CCTs, many migrant families are not enrolled. Several informants complained this was because the conditions attached to these hand-outs require them to make monthly clinic visits, a long trek up the mountain with small children or while pregnant, to listen to health talks that they did not understand and to be told-off for poor attendance, as Juana explained, '*Maybe the wife of Maurillio…no, no, they haven't been getting it for the past year. Nobody here has Oportunidades. They have to go to talks in Pueblo or Colonia and nobody wants to go that far*'. Juana is from Taimarita, one of the most marginalised valley communities, six hours walk from Nueva Colonia, the nearest vehicle accessible town from where *Oportunidades* payments are distributed and talks are held. On the opposite side of the valley lies Pochotita, like Taimarita there are only two people who are employed in this town, the health promoter and primary school teacher, aside from these two people Pochotita is inhabited largely by women and the elderly. I ask Gabriela, the health promoter, whether they receive *Oportunidades* and she tells me '*we don't get any help here*', giving the impression that they feel discriminated against in the valley communities, as if *Oportunidades* was only for people living in the sierra towns. Her tone is one of resentment that they are not being given what is rightfully theirs.

Attendance records for *Oportunidades* talks are kept by the doctor in charge of the clinic and missing talks or appointments can result in families having their payments withdrawn. Dr. Regina had no qualms about *dando de baja* (un-inscribing) families who did not attend the meetings or appointments regularly and no exceptions were made for valley families or migrant labourers for whom is it particularly difficult to maintain their inscription. The doctor certainly identified the entitlement that her patients expressed in relation to welfare and health care. Regina in fact felt that there was a great sense of dependency on welfare and the health clinic and that this had negatively impacted on her patient's self-care practices, making them careless and lazy. She tells me, '*they leave it all up to the ministry of health, this has a negative effect on how mothers care for their children, they are careless, almost half of all appointments are not necessary, they come for anything. The government gives them everything. Food, handouts…there are lots of young women and men who are not in school, lots of unemployment…when it is cold 'Civil Protection' comes with blankets. They know they are always going to get something*'.

Informants from the sierra towns did speak of going to *Oportunidades* talks and appointments but mostly complied with this conditionality under duress and not because they felt the talks and appointments were beneficial. While the conditionality of welfare heightened their sense of entitlement by operating as a form of payment for services rendered (attending health appointments), it also intensified their sense of distrust as they felt they were being judged on the basis of their attendance.

Mauricia was not with *Oportunidades* but gave me her satirical opinion of the obligatory talks: '*sometimes the people who are in the opportunities programme are talked to a lot, and those of us who aren't, I don't think we are told much. And well, I think they mention to them lots of types of illnesses that we can't pronounce and that anyway we have never heard of….*'.

Shame, care seeking and authoritative knowledge

During the two year period of data collection I accompanied three informants to hospitals while they were working on the coast, on each occasion spending a large part of the day waiting in queues and dealing with frontline staff who were generally unhelpful and disrespectful. Bureaucrats who, in the words of the tobacco farmer who accompanied me on these visits '*are not paid enough to smile let alone speak to you politely*'. Poorly paid workers who sought to recover some dignity by exercising the little power they had to its full potential, against those whom they considered to be socially inferior by, for example, controlling access to appointments, ordering patients to wait infinite lengths of time only to be told to return another day or strictly enforcing rules, criteria and regulations. To be able to use their entitlement to free healthcare within ministry of health hospitals patients must first register with the *Seguro Popular*, a *tramite* (bureaucratic procedure) that is in itself complicated for an illiterate monolingual Huichol. Once the paperwork is complete they must queue again to request an appointment with a general practitioner and from there await another appointment to see the specialist they require, a process which may take months. Complicated forms and multiple photocopies coupled with intransigent bureaucrats are the norm in Mexican governmental institutions for any procedure. These days most Huichol have a birth certificate, although often with a fabricated date of birth, since this document is required for every conceivable *tramite*. Very few have a proof of address. Juana gave her place of residence as 'known place within one kilometre of the school in Taimarita'. The Huichol find it shameful to describe the conditions in which they live. They are ashamed to admit that they have no address or that they don't know their date of birth. Contact of this nature with mestizo bureaucrats is always intimidating and exposure to humiliation is another form of everyday violence and a very real barrier to seeking care. The combination of poor Spanish and low levels of education made many of the women I interviewed feel ashamed, and *pena* (shame or timidity) was one of the principle reasons given for not seeing a doctor. *Pena* permeated discussion of using local health facilities and appeared to underlie people's reasoning for not going to the clinic, as is illustrated by the following conversation with Maria (F 26, VC) (I = interviewer)

I: Were you ever seen at either of the clinics, while you were pregnant?

Maria: No. I only go to the clinic to take my boy, so they can check him.

I: Only your son? Have you ever been for yourself?

Maria: No. Only when they come here with the vaccinations.

I: So you don't go to appointments at all?

Maria: Well…who knows, lots of people don't go because they are ashamed.

I: Do you know anyone who does go to the clinic?

Maria: Yes, some go. Some even give birth in the clinics. But those of us who are really ashamed, when are we going to go? And well, sometimes something bad happens to you because you don't go to the clinic…

That the Huichol are *penosos* (ashamed or timid), was a recurrent theme and there was considerable recognition and agreement

that '*this is what we, the Wixárika, are like*', as Sylvia, (F39 VC) explained:

'*Well, yes they tell us that [we should go to for antenatal appointments] but you know what the Wixárika are like, we are ashamed, well I am really ashamed and I don't go, even if they tell us to go….*'

When I enquired *why* they were ashamed this was mostly attributed to feelings of inadequacy, poor Spanish and lack of education or understanding and having to be seen by male doctors. *Pena* can also be translated as timidity or shyness, concepts that, like shame, have their roots in a generalised feeing of social inhibition, nervousness and potentially fear of communicating with others. Although in the majority of cases the context within which it was used more clearly indicated shame or embarrassment, one informant related the question to a more generalised shyness, not wanting to talk about themselves to a stranger, as Mauricia (47, VC) explained '*you know what we, the Wixaritari, are like, we don't want to talk*'.

For antenatal care and birthing this shame is coupled with the humiliation of needing to bare parts of their bodies to healthcare workers and confess to unhealthy cultural norms and practices. Doctor Regina complained that when she asked her patients why they did not eat three times a day and why they shared their homes with animals they would tell her it was their *costumbre*. This she found unacceptable, '*I know they have enough to eat three times a day and they can stop the animals from entering their homes, costumbre is just an excuse*' she exclaimed.

I discussed this issue with Dr. Fernanda, the only Huichol medical doctor in the sierra and while reluctant to disagree with Dr. Regina (her boss) she told me:

'Some of them have and they eat three times, some only twice. These days they grow less maize, men go away to work more and few send money home or only send very little. They leave their wives without money. Now at least there is Oportunidades, but they spend it on alcohol. Here, that's why, because they go out drinking, we have a big problem with the men'.

Birthing

The majority of women I spoke to give birth at home, sometimes accompanied by a family member and sometimes with the presence of a mara'akame. None of these helpers touch the woman's pelvic region while she is labouring and she delivers the baby unaided. This tradition of birthing at home, alone or in the presence of a relative or shaman is accompanied by a series of practices that are designed to make birthing less onerous. These are the practices that have evolved as the AK of this group, in response to the social, cultural and environmental conditions. Most women said that they ate less so that the baby would not grow too big and could be born easier, in particular they avoided eating animal fat. They all saw the mara'akame and fulfilled a specific set of offerings and sacrifices and they could all recite a series of tried and tested birthing positions that work, as Graciela (57, VK) tells me:

'Well, some women are helped when they can't give birth, they are held tightly around the waist and the woman holds on there and can push better, the other way is hold onto a mast [for support]. But I had mine by holding onto a rope [tied to a beam in the roof] when the pains are very close together. I held the rope and when the baby began to emerge I pushed harder. Like that the birth is not difficult, because holding onto the rope you can push with more strength. I just did it like that…'

When there are problems the mara'akame helps. The one physical treatment he does give is to externally turn babies that are not well positioned, but usually a difficult or obstructed birth is treated spiritually, the mara'akame will move aside the gods who are blocking its exit. Graciela explains how he does this:

'If the baby isn't in the right position he turns it. The mara'akame is like a birth assistant and he does the same thing. When the baby can't come out because the Nenekate and Kaka + yarixi (gods) won't let it through, this is when the mara'akame opens the doors, by speaking to them.'

Some women had given birth in the sierra clinics and some had been in Huejuquilla or Santiago when they went into labour and chose to give birth in hospitals but these were a minority, as Hautsima (36, sierra town) told me '*We are ashamed, we don't like anyone to see us*'.

Shame is a big part of a woman's decision to give birth alone. When I asked Olivia (37 VC) where she gave birth she told me, '*Me? Alone. I didn't need anyone, only my old man was with me to pick up the baby*'. I asked her what position she gave birth in and she continued '*Just crouching, it's just that I didn't want anyone to see me…when my first baby was born I didn't even tell my husband until the baby was born… I never said anything to my old man, who knows what he thought…*'.

Many have given birth unaided on tobacco plantations where despite having easy and theoretically cost free access to hospitals, they retain their authoritative birthing practices. Men were also ashamed about the conditions in which their wives give birth, as Felipe explained: '*there are men who complain a lot, but since we don't know how to talk Spanish properly, abandoning our women, and we are embarrassed to ask the patron to take us to the hospital, the baby has to be born like this*'.

Such an event is not uncommon and each of the four farmers I spoke to in Nayarit were able to recall at least one birth in their tobacco fields, Victor and Efrian tell me:

'The woman here, yes, I took them to hospital. But they don't rest or anything. My wife told her to rest, but no, she wouldn't come into the house. You know, they are different, she just waited to give birth then then went off up to the sierra. They are very close to their people who cure them, well so I took them to one of these mara'akame. I took them because he asked me to lend him a bicycle and I said, 'no, I'll take you'. (Victor, Farmer)

'*No, even with me they have given birth*', Exclaimed Efrian. 'There in the field, two women, and when I saw it I couldn't believe it, because sometimes I have been there in the afternoon and the women are up picking tobacco and in the morning there is a baby crying and I ask *caray*! (expression of amazement) What happened? I admire them *caray*! I took her to the clinic, the health centre so they could check her and everything was fine…the husband had cut the umbilical cord, he helps her. No, no! I admire them. Well I think their blood is strong, it means it doesn't affect them, well imagine, with a dirty knife!'

These are farmers who have developed a paternalistic relationship with their indigenous workers over the years. A relationship at times formalised though a godfather/godchild link. While they spoke to me with discretion and some affection for their workers, it was evident in each case that they see the indigenous women and men who work for them as somehow biologically different, describing them as '*more resistant*', with '*thicker blood*', somehow able to withstand the task of giving birth alone in a tobacco field. Ramon who had farmed tobacco for more than fifty years and seen countless women give birth in the field summed it up for me, '*these indigenas they are strong and resistant…they are brutes!*' he tells me. Perhaps unaware that he had likened his indigenous workers to animals.

Discussion

The attitudes, health related behaviours and decisions of these migrant workers are highly influenced by their on-going relationships with the healthcare system, health providers and employers. Relationships that are marked by structural injustices. The subtle forms of racism that are expressed by tobacco farmers are just one of the forms of everyday violence to which Huichol labourers are exposed. The farmers themselves have *naturalised* the racial difference that sets them above their workers, for them it is a natural phenomena, a given biological difference. In turn their Huichol employees have embodied this sense of inferiority, expressing it as shame. In order to avoid confrontations with racism and shameful emotions they make decisions that protect them from these two forms of structural violence (everyday and symbolic): they give birth alone, at home or in the fields, they seek the mara'akame and place offerings to deities in their antenatal period instead of seeing a medical doctor or visiting a clinic. By doing this they subject themselves to an even greater form of violence, the structural form that, directed to them through poverty and marginalisation, exists in the violence of lone birthing in insalubrious conditions –a practice shared by the Rarámuri with whom they share the Sierra Madre mountain range (Chopel, 2013). They also compound the everyday forms of racial violence because by turning to their mara'akame and giving birth in a field they *reinforce* their employer's naturalised belief in racial superiority. Simultaneously these everyday and symbolic forms of violence help ensure the continuity of the Huichol traditional lifestyle and customs including their authoritative knowledge about birth and wellbeing. It is this *world view* or *comovision* and its accompanying set of practices, that continues to generate the racial discrimination that is expressed as everyday forms of violence. Thus we have a cyclic relationship between a set of authoritative practices born of a socio-cultural matrix, and the continuum of violence: structural, everyday and symbolic.

Shame and the violence continuum

For the Huichol *structural* violence is played out through the delivery of health care and conditional welfare payments: the obligation to attend appointments and talks in order to receive the paltry hand-outs that enable them to continue surviving in extreme poverty. *Everyday* violence exists in the power relations and social inequalities that are present in their daily lives. Their relationship with healthcare providers is one of extreme inequality, not only do doctors reprimand them for their 'unhealthy' cultural and social practices they also have the power to deny them their *Oportunidades* payments. As Bourgois explains 'these different expressions of everyday violence then reverberate into the symbolic violence of self-blame and shame' (Bourgois, 2002, p. 223).

It is symbolic violence that becomes a barrier to health seeking among the Huichol. Shame, timidity and humiliation are symbolic manifestations of everyday violence that are the human and lived experience of powerless people within a health, social and political system characterised by structural violence. Pena is also characteristic in a broad sense of the Wixárika relationship with the Mexican state, one that is shared with other indigenous groups (Bartolomé, 1997). It is a response to their position within a social and cultural hierarchy that has economically and socially punished them for their ethnic identity. The *Oportundiades* programme epitomizes this cyclic relationship between institutional and historical structural factors, everyday forms of violence and the self-perceptions of inferiority that are compounded by them. When framed within the continuum of violence it is unsurprising that many women, like Juana, chose not to use the clinic or to receive their *Oportunidades*. Like lone birthing, not seeking institutional

care liberated her from confrontations with her embodied position of social, racial and economic inferiority.

The attitude of entitlement is one more form of symbolic violence. The Huichol feel entitled to welfare hand-outs and medicines because they situate themselves on the bottom rung of the social and economic ladder. This self-humiliation is a product of a state policy which has sought to maintain indigenous groups on the margins of the state yet pacify them sufficiently so to avoid political upheaval (Fernández Ham & Sandoval Arriaga, 2003; Liffman, 2011). Instead of supporting and generating endogenous forms of community development within which the Huichol are able to nurture and sustain a social, cultural and economic structure of their own, they are offered small conditional cash hand-outs. Social development is only available to the extent that this indigenous community are willing to abandon their *costumbre*, their communities, their mountain range and their language.

While there was a strong element of gender related shame, essentially the shame with which women related to health professionals was determined by a self-valuation of racial inferiority and worthlessness, an inferiority compounded and characterised by their experiences of linguistic and economic inadequacy. Bartlett in her analysis of literacy, speech and shame in Brazil draws on Bourdieu to discuss how language ability and literacy act as an embodied form of cultural capital, and Paulo Friere's work on how literary practices shape and are shaped by larger power structures demonstrates how dominant social groups exercise control over linguistic resources and in so doing, regulate access to other resources, in this case the resource is health care (Bartlett, 2007; Freire & Mellado, 1970). Bartlett's 'narratives of shame' in Brazil shows how 'economically produced emotions like shame play an important role in the cultural production of inequality'. The distribution of Spanish proficiency in Mexico reflects social structures of power and also helps reproduce them through the obstacles that it creates. Like the subtle forms of racism used by employers, *shamers* (in this case, health providers) assert or construct their sense of superiority by provoking a sense of inferiority in their patient. Although shame is connected to larger social forces such as race and economic inequality it is experienced as individual and embodied, leading to self-blame.

Conclusions

The Huichol did not exist as a separate ethnic group before the conquest, their's is a culture formed with and within their highland homelands, a region that has offered them cultural and physical protection and facilitated the continued development of their *costumbre*. In 'The Art of Not Being Governed' Scott draws upon the concept of *Regions of Refuge* to redefine the cultural and political development that has taken place within Latin American indigenous regions as 'historical adaptation to political threat', characterised by the rigid kinship arrangements and socio-political centralisation forced *upon* them by the massive population movements and ethnic reshuffling that has taken place since the conquest (Scott, 2009, p. 131). These are communities that developed in response to the widespread violence and ethnocide that colonialism brought and that continues today in the various forms of structural violence I have documented in this paper. This *continuum of violence* has also formed a central role in the development of their authoritative knowledge about wellbeing and reproduction.

As migrant workers the Huichol are particularly vulnerable to everyday forms of violence both while at home in their highly marginalised highland communities and while working as poorly paid labourers. Everyday violence is evident in their relationships with employers and health providers and these migrant workers embody this, expressing it as shame and a self-valuation of racial inferiority. Shame is an embodied form of knowledge, the symbolic

expression of how structural factors undermine agency. By acting as a barrier to health seeking, shame also generates affliction and reinforces adherence to a set of health related practices and beliefs that see illness causality and cure as essentially supernatural. But this deep set cultural matrix cannot be seen in isolation from structural factors. In order to avoid it being reduced to what Farmer et al. (2006) refer to as an 'alibi' for poor health, the continued importance of spirituality within indigenous health must also be viewed within the context of their region of refuge, an element of their cultural and geopolitical resistance to domination by mestizo Mexico. Yet the cycle does not end there. This particular form of indigenous authoritative knowledge about wellbeing, compounds racially and culturally grounded forms of everyday violence. Women who give birth in the fields, take offerings to the sea and are treated by a shaman as opposed to a doctor are seen as racially inferior, backward and primitive, and because they are treated as little better than animals in many of their everyday relationships they avoid these forms of contact, preferring instead to fall back on their own authoritative knowledge and practices.

Acknowledging this continuum of violence as a determinant of the health status of indigenous people must also be accompanied by strategies that aim to address the mechanisms through which it operates. As Holmes has documented in his work with Mexican indigenous migrant workers in the USA, intervening in the education and training of the medical profession so they too are able to recognise and incorporate these determining factors in their own assessments of indigenous health, would be one realistic and achievable strategy (Holmes, 2006; 2012).

On a socio-political level there is need for the formulation of strategies and policy that aim to account for and redress structural barriers. The nature and purpose of CCTs is a central concern that needs to be evaluated ethnographically and re-formulated. Clearly a redistributive form of state help is vital, but this should generate self-sufficiency as opposed to dependency and a culture of entitlement.

Indigenous schools should aim to achieve educational and linguistic equality with mestizo Mexico. As a starting point these could be taught by university as opposed to high school graduates, bringing them into line with the standard of education in Spanish language schools. Finally, health policy could focus on restructuring indigenous health provision on the basis of specific and local health priorities, provided in a manner that is appropriate and acceptable to the population. In terms of maternal health care for the Huichol this might imply the specific training of intercultural midwives who are able to treat both the spiritual and the biomedical. Key to the achievement of any of this is political will, and to impact upon this it is the task of researchers to demonstrate and communicate the ethnographic reality of this full continuum of violence.

Acknowledgements

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