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Fallen Uterus: Social Suffering, Bodily Vigor, and Social Support among Women in Rural Mexico

This article focuses on rural indigenous Mexican women's experiences with uterine prolapse, particularly the illness's expression of social suffering. Drawing on ethnographic research conducted during 2004–2005 and 2007 in a Nahua village in the state of Veracruz, the article analyzes the multifactorial nature of women's social suffering. Results show that the roots of uterine displacement for the women lie in lack of social relations and in perceptions of bodily vigor. Additionally, inequality present in the women's interactions with mainstream Mexico brings into focus the larger structural factors that shape their reproductive health. The implications of research on the effect of social support on women's embodiment of social suffering can extend beyond one illness, linking it to broader issues shaping the health of marginalized populations. [social suffering, indigenous women, reproductive health, Mexico]

The sun warmed the tin roof of Juana's house, inexplicably making it crackle loudly, as though pouring with rain. It was a very hot May evening, and Juana and I sat near her open door hoping to catch some gusts of breeze to dry the sweat trickling down our backs. Juana's second-oldest daughter, Camila, neatly organized her small shelf of precious trinkets as we chatted about Juana's experiences with her seven pregnancies. A garrulous and fast-talking woman whose voice often shifted into a high falsetto when she became animated, Juana spoke about her last pregnancy and the troubles she had experienced. She said:

> I was just walking back [from the clinic]. I did not fall or hit myself or anything. But as we carry so many heavy things. [. . .] It was very hot [. . .] and I felt I was dying. We were walking up the hill and I felt my uterus fall. I could feel the blood come out and it hurt a lot. That is why I went to [the *partera*[1]] over there to cure it. She gave me herbs and thank God I was cured and did not miscarry.

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Referring to *isihuayo* (the Nahuatl name given to a local ethnomedical condition of fallen/displaced uterus), Juana provided an initial glimpse into an indigenous illness that shared many elements with the biomedical condition of prolapsed uterus while also retaining various local elements and interpretations that extended beyond the physical nature of the body. For the women, isihuayo was a symptom of a broader destabilization within their lives—physically through loss of strength and socially through a lack of social support from children—which became expressed bodily in their uterus. This illness frequently shaped women's identities, reflecting their complicated relationship with the broader forces of the Mexican state.

The lives of Mexican indigenous women are marked by hardship. Their bodies need to be able to withstand hard physical labor and a lifestyle of exertion, yet they also must be docile and yielding to state directives—in their various social, political, or medical forms. Among the rural Nahua of eastern Mexico there is a perception of female vulnerability (similar to the Andean notion of *debilidad*) due to the physical make-up of a woman's body, caused through loss of menstrual blood, pregnancy, childbirth, and childcare through breastfeeding (see Larme [1998] and Oths [1999] for examples in the Andes).

Local perceptions see the reproductive life cycle wreaking havoc on a woman's body, greatly affecting her *fuerza*—strength or bodily vigor (see also Tapias 2006). The notion of bodily equilibrium, a balance between the states of hot and cold, is also central to understanding the health of the female body. Women lose heat through loss of blood during menstruation and childbirth, weakening their body and making them vulnerable to other conditions (see Groark 2005; Santos-Torres and Vázquez-Garibay 2003). Furthermore, the lack of social support from kin (Ribera and Hausmann-Muela 2011) and the suffering of living in a society as marginal and alienated (Pylypa 2007) can become expressed in bodily form in a woman's uterus.

In this article, I focus on the ways that older Nahua women (above the age of 45) bodily experience their changing world. Older women are more likely to experience isihuayo than younger women, which is frequently related to the differing degrees of social support they receive. Caught in a system intent on the development of indigenous populations, the older women have an uneasy relationship with larger Mexico. All of them are enrolled in a conditional cash transfer program that requires them to participate actively in biomedical health care centers (Smith-Oka 2009).

For most of these women, the ways of mainstream Mexico (i.e., Spanish, technology, dress, manners, bodily concepts) are foreign. Although they all participate in state development and health care programs, this interaction is not comfortable. In addition, many have seen their children leave the village to find jobs elsewhere, leaving them to care for grandchildren and to perform the many household duties on their own. They see their children leave the community, not only going to a different place but to an entirely different life. Contact between them is often left to the impersonal remittances sent home. The fragility of their bodies and their changing social relations result in what Tapias (2006:400) calls "embodied manifestations of distress."

I extend the argument of other scholars (Rock 2003; Tapias 2006) by showing that social suffering is a bodily expression of people's experiences with macro forces; such suffering goes beyond a straightforward epidemiological disease and becomes an expression of larger issues that shape and constrain marginalized people's health. I amplify these dialogues by arguing that for indigenous Nahua women, isihuayo

is not simply synonymous with prolapse, but becomes a lived expression of their social suffering due to differing degrees of social support.

The framework of social suffering (Kleinman et al. 1997) can explain the connection between women's changing social support, bodily fragility, and their entanglement with the web of the global political economy. Kleinman (2010) suggests that when one applies the framework of social suffering to health issues, it collapses the boundaries between a health problem and a societal problem. Other scholars show that individual suffering and lived experience are shaped by collective frames of reference (Rock 2003:160). For indigenous Mexican women enrolled in large-scale neoliberal economic restructuring programs, they can experience increased anxieties about their autonomy and their responsibility to the country. This embodied manifestation of distress is caused by everyday forms of social suffering (Tapias 2006). Ultimately, the women's ill health is linked to social conflict, economic scarcity, and what Tapias (2006:402) refers to as "failed sociality"—which is when certain relationships are no longer tenable or when one is unable to meet certain societal expectations. Thus, for the marginalized women of this study, they not only contended with large-scale institutional changes but also micro changes such as a decrease in social support, and as such, their health conditions became even more pronounced.

Social support is integral to people's experience with illness. Ribera and Hausmann-Muela (2011) suggest that support is a means by which kin and family in a person's social network can advise and help during times of need. Uchino et al. (1996) take the concept a step further; they emphasize emotional factors and state that the process of social support is when one feels cared for and loved. They show that such support has stress-buffering effects that positively impact health. Clark's (1993) work among Anglo and Mexican American women about their experiences with health issues shows that Mexican women were more likely to rely on female kin for support than on their partners. The support structure for the Mexican American women often resulted in negative gender and spousal relations. Relations with male partners can be extremely complex: Men can sometimes hamper women's reproductive choices (possibly making them more vulnerable to illness); at other times, they may positively influence a woman's health status, allowing her to quickly regain health (Browner 2001).

As I show in this article, social relations clearly shape, and are reflected in, women's health. Although social support is important for people's experiences with other illnesses, it takes on a much more significant role in shaping the course of isihuayo. Isihuayo is not simply a physiological condition but rather a reflection of larger problems women experience at different levels—individual, local, and national. It is illustrative of deeper problems these women (as indigenous, marginalized, and impoverished) face in their daily lives. My work, therefore, provides an important contribution to the discussion of the ways that marginalized populations cope with a changing world. By looking at isihuayo as a local manifestation of the disenfranchisement faced by peasant societies across the world, we can then ask: In how many other societies across the world are some of these bodily expressions of disenfranchisement simply ascribed to local, culturalist explanations rather than to expressions of broader structural socioeconomic forces?

I suggest that the women in my study cope with social suffering not via governmental institutions (which they are forced into) but via their own social networks.

Tapias (2006) points out that when social relations are problematic, they become reflected bodily. Because the women of my study are indigenous, they feel constant pressure from state institutions to conform to mainstream notions of identity. Additionally, social exclusion can become expressed in particular health outcomes, as Spangler (2011) shows in the ways that social and material worlds become incorporated into the self. Thus, the women's experience of failed sociality becomes an expression of their bodily weakness—as reproductive malaise. The women's social disharmony becomes reflected in bodily internalities (i.e., uterine displacement).

Setting and Methods

Data for this article come from ethnographic fieldwork I conducted over the course of 11 months during 2004, 2005, and 2007 in northern Veracruz, Mexico. They are part of a larger research project on the intersection between marginalized women and broader institutions of health and development. The majority of the data came from research in the Nahua village of Amatlán.[2] The Nahua are the largest indigenous group in Mexico—approximately 1.5 million. Ariel de Vidas (2007:4) describes the many social inequities suffered by the indigenous populations of the region as emerging from the quotidian "racist, exploitative, and paternalistic" interactions between mestizo and indigenous populations. Ruvalcaba (1998) states that land tenure remains one of the fundamental problems in this region. In a seemingly contradictory manner, it is also an area where independent indigenous/peasant organizations have acquired (or are striving to acquire) the political strength to peacefully confront the oppression they are facing.

Amatlán has approximately 600 people, most of whom make their living by maize agriculture and small-scale cattle ranching. This particular village has been researched anthropologically for almost 35 years (Sandstrom 1991, 1998; Smith-Oka 2013), so we know a lot about the health system.

I carried out participant observation as well as semi-structured and unstructured interviews with 53 women of reproductive and post-reproductive age (ranging from ages 18 to 73).[3] I focused on reproduction, motherhood, and health care. During many interviews, the women expressed concern about their uterine health, referring to the condition known as isihuayo. Isihuayo was a relatively common complaint, and approximately 20% of the women in Amatlán of reproductive age and above had it at least once in their life (Smith-Oka 2008). About 90% of the women who suffered this condition were above the age of 45 and had on average five children. These are the women I focus on in this article.

There are nine traditional healing specialists in Amatlán—consisting of *parteras* (traditional birth attendants, TBAs), *curanderos* (ritual specialists), and *sobadores* (bone setters). People also have access to biomedical care at local clinics and hospitals in nearby towns. All the women are enrolled in a conditional cash transfer program (Oportunidades). As part of the conditions, women and their families are required to receive health care from clinicians at the medical centers. Clinicians are authorized to supervise women's compliance with the program's conditions, while simultaneously able to extend their own agendas on their patients. If women do not comply with Oportunidades, they risk being removed from the program. This arrangement has

the effect of granting clinicians significant power over their patients' medical lives (Smith-Oka 2009).

I interviewed all nine traditional healing specialists about their practices. I also carried out structured and semi-structured interviews with 11 clinicians (nurses and physicians) at three regional health centers. I analyzed the data using pile sorts and focused coding. I identified data into classified patterns and then combined and catalogued the related patterns into subthemes.

Organ Displacement and Prolapse

Isihuayo is the Nahuatl term used in this region to describe the "female part" (see López Austin 1988 for alternative names used in Nahuatl). The isihuayo is an organ situated in the lower torso of a woman and is believed to have roots radiating out from it. Isihuayo was historically used to describe a specific part of the woman's body (López Austin 1988). However, over the last few years in this region—especially with the contact that the women have increasingly had with biomedicine—isihuayo is frequently synonymous with two other thoracic organs: *matriz* (uterus) and *vejiga* (bladder).

Isihuayo is an ethnomedical category of illness with local cultural and biological characteristics.[4] It is an illness of organ displacement (see Castañeda et al. 1996; Fuller and Jordan 1981; Hinojosa 2008). In this illness category, specific organs or parts of the body shift from their original position and cause health problems. It shares many of the latter characteristics with the biomedical condition of prolapsed uterus (Doshani et al. 2007). The biomedical symptoms for prolapsed uterus include discomfort while urinating, urinary incontinence, constipation, backache, and a lump that projects outside of the vagina (Doshani et al. 2007). One nurse stated, "[Women] have [prolapse] from having too many children; the ligaments begin to come away with so many pregnancies. . . . There is no pain. They feel that something has fallen [inside], or they sometimes feel they cannot urinate or [have] a urinary infection." Prolapsed uterus is a condition identified and treated by biomedicine, but isihuayo differs from prolapse in its etiology and treatment (Smith-Oka 2012).

Abdominal and navel pain are central symptoms of isihuayo—primarily caused by the roots radiating out of the thoracic region (see López Austin 1988:167), which cause pain to envelop the lower body. Enriqueta stated, "It fell a lot when I was pregnant with this [second child]. I could feel it when I moved. I came to Lourdes so she could massage me. That's how it was." Refugio, a very sought-after TBA, confirmed the etiology of isihuayo. She said about one of her patients: "They say she carries too many buckets and containers of water. And she came to me and said she has pain here [belly] and that is why I massaged her." The women spoke of various treatments for the illness, from massages by a TBA, to medicinal plants, to the use of biomedical techniques (medications or surgery). Altagracia, who had experienced such a severe case of isihuayo that she received surgery in Mexico City, commented:

> [Juana] said that [. . .] just by taking a plant she got better. [. . .] But that plant is far away and none grow near here. It is difficult to go for it. Her husband helped her [to get it]. [. . .] She said that just with that she got

> better, that the [uterus] lifted back [into place]. But the doctor says that nothing will cure it; that neither massages nor plants work. [He says] only surgery works.

In the next few sections, I discuss the factors that shaped women's experiences with uterine ill health, highlighting the effects of bodily vigor and social support. The former was often considered an underlying factor of isihuayo; the latter was a contributing force in its prolongation.

Many Mouths to Feed

Clinicians at regional health centers stated that local women who had prolapse developed it because of multiparity (having many children) and because, as one nurse said, "They do not allow [their uterus] to rest; they are constantly using it." The women disagreed with the etiology. Rosario, an energetic woman in her late thirties, scoffed, "They say in the clinic that [it is caused] because they have lots of children one after another, but I don't believe that because my mother had 14 and her [uterus] never fell." Other women, such as Paz, who was younger and slightly more timid about her opinions, said uncertainly, "Who knows? People think that it is maybe because of having lots of children, or because of lifting heavy things. [Or] chopping wood, [or carrying] water. I have not had that." Pausing slightly, she pointed to the house of one of her neighbors and said, "There is a woman over there whose uterus did fall."

Benita, who was in her forties when we spoke, had given birth to four boys. She described the fear and pain she felt during the first birth, but tempered it by describing the joy she felt at her eldest son's achievements in school. She confided that her husband had wanted a girl and had been angered by the series of male children. The anger prompted him to force Benita to receive a tubal ligation. She softly recounted the isihuayo her mother experienced many years before: "[She had it] because of all the *fuerza*—effort—women make. And she endured all that. She had six children."

One of the first women who discussed isihuayo with me was Juana, a cheerful and talkative woman in her late forties, discussed in the beginning of this article. By 2004, she had experienced this condition twice. The first time she was six months pregnant with her seventh and last child. The second time occurred a few months later when she tripped and fell while walking in the fields. Both times she went for treatment with a TBA, who massaged her and prescribed medicinal plants. She firmly rejected going to a biomedical clinic because, as she stated, "Those doctors only write up papers [for you] to be operated, they just operate you and take your uterus; [your body] is no longer the same. The doctor wanted to operate me; he asked me questions about how I became better."

Juana was not originally from Amatlán, having moved there years ago after her marriage to Hilario, an itinerant musician with no rights to agricultural land (a vital source of income and subsistence). Because her oldest children were unmarried boys when she had isihuayo, she could not rely on them for help around the house. Once her children grew, however, Juana's health improved as not only did her younger daughters help around the house, but a daughter-in-law moved in who also became

a very important source of social support. She said, "Now I will look after myself, my children will look after me."

For women such as Juana or Benita, the number of children they had was a blessing but also a means for their bodies to weaken over time. The women's reproduction—having as many children "[as there are] ants," as Altagracia said—contributes to the excessive weakening of a woman's body. With each pregnancy and birth, women's bodies lose strength (Groark 2005)—through loss of blood—and, as one woman stated, "Any little thing will make [the uterus] fall." Daughters were important sources of help even while very young; sons became increasingly important as adults, as in marriage they brought in daughters-in-law who provided valuable help. Such was the contradictory nature of having many children: Though some women had many mouths to feed while the children were younger, all of them expected that as their children grew they would be able to rely on them for help.

Pushing Hard, Lacking Fuerza

Within the region, women were seen to be weaker than men—mostly due to their workload and their reproductive lives. If a woman fell or was physically hurt, energy was believed to travel into her body dislodging her uterus. Lourdes, a hard-working 58-year-old partera and traditional healer, said,

> You see, women are more delicate than men and so any little bump hurts us. [. . .] It's just that we all have a small bone here (touches area underneath the uterus), and if the legs open like this (opens arms wide) after a fall, it will separate and the bladder falls.

The uterus is believed to fall through the space and hang down, causing it to become tired and begin to hurt. Jordan (1993:43) also noted in her research among the Maya the idea of "bones that [open] during childbirth," which might be a similar etiology to the one experienced by the Nahua women of this region. One of the TBAs stated that if a weakened woman continued with hard physical labor, the uterus would likely remain in this state.

Lourdes worked very hard tending her home garden, collecting firewood and carrying water, shucking corn, and walking to nearby villages to attend to patients. A few years before 2004, she was walking back from another village and cut across a cow pasture; one of the cows chased her and she tripped and fell, which caused isihuayo. She said that when she fell she developed *espanto* (magical fright), which was the underlying cause of her isihuayo.

Lourdes was ill for several years and was anxious to find a cure. She said, sadly, "I lack fuerza; I lack vitamins. With so much work one gets tired. I need medicine, a treatment." Lourdes was also borderline diabetic. Because of the diabetes and the lack of fuerza she was more prone to weakness and thus was frequently ill. Her low strength also came from the high amount of energy she expended in her healing practice—walking to other villages (sometimes a day and a half's sojourn) and in the treatments themselves, many of which required her to carry out complex religious rituals that sapped her strength. Her energy and health had declined over the years, which were possibly contributing factors to her suffering from isihuayo later in life.

Carrying heavy loads was believed to weaken a woman's uterus over time—especially during pregnancy and early postpartum. Adela, one of Lourdes's daughters, stated about isihuayo in general, "Because women have a month-old baby and they lift something heavy and [the uterus] falls [. . .] and only a month has passed since they gave birth." Floriana, one of the oldest women in the village, who sadly admitted she gave birth to only one child, concurred that women's work was often the cause of ill health. She stated:

> Some women's uterus falls. It is dangerous. Because they pick up heavy things. They also push really hard (*hacen mucha fuerza*) when their baby is being born. [. . .] The uterus can fall very easily. [. . .] My daughter-in-law had that. [I told her], "Don't lift heavy things. Just chop a bit of wood. If not your uterus will fall. If not, what will we do? [We'll have to go] all the way to Chicón."[5] I tell her that every day.

Rosario's experience mirrored Floriana's comments, as she suffered from isihuayo after the birth of her first child. She said,

> I also had that. [. . .] It was because I exerted a lot of fuerza to push out the placenta, that's why. But I was not ashamed and I told my husband that something had come out and that I could feel it hanging. And we asked a partera to come and she massaged and massaged me and put in some hot oil. And it was very hot, and she would put it on her hands and warm the area. And like that she put [the uterus] back. And it did not happen again. It is not because of having many [children]. It is because [women] do not look after themselves and they carry heavy things.

Altagracia, a 56-year-old woman who experienced several pregnancies, stated during one interview that a woman is expected to rest at least a week after giving birth, to be taken care of, and to receive a postpartum bath to return her strength and counteract the loss of blood (Smith-Oka 2008; see also Groark 2005). The clinicians emphasized that women need rest during the postpartum, though one of the nurses expressed concern that the women did not follow *cuarentena*—40 days of rest. Among the Mapuche of Chile, for instance, the cuarentena is considered a period of fragility during which the woman must maintain bodily equilibrium, abstain from sex, and refrain from arduous physical labor (Alarcón and Nahuelcheo 2008). Not taking care of oneself thus leads to a continued weakening of the body and eventually to conditions such as isihuayo.

Research in the Andes has shown that weakness can be an underlying condition that may lead to illness, similar to stress in the West (Larme 1998:1009). Tapias shows that the underlying constitution of a person can reflect their "past histories of distress and illness" (2006:407). The Amatlán women's past histories of distress certainly play a role in their health. They feel worry and stress from their own lives—the lack of money or lack of land, but they also worry about their children's lives. The multifactorial nature of prolapse is also evident in isihuayo—though in the latter case these factors are both physical and emotional. Although physical factors

might make a woman more at risk for isihuayo, it is the underlying emotional factors that can turn it into a chronic, debilitating condition.

The women who have suffered isihuayo have a labor-intensive life—in all senses of the word. Not only have they given birth various times, but they also work very hard in their domestic chores. Their "techniques of the body" (Mauss 1973:70)—the ways that they use their bodies—create certain physiques and relationships between their tangible, bodily selves and their emotional selves. They, and their bodies, are physically exhausted.

Over the years of knowing Lourdes, I saw her weaken and diminish from being a strong, vital, and energetic woman to a woman whose physical strength dissipated, leading to a series of small accidents—a hot oil burn, a deep cut—that cumulatively added to her heightened sense of weakness. Because of her lack of strength, she was predisposed to suffering from other ailments. This suffering is what Tapias (2006:408) refers to as a "circularity of influence," wherein each bout of illness leaves the sufferer weaker than before, thus more vulnerable to additional health concerns.

Scholars have shown that illnesses of this sort are exacerbated during times of crisis, conflict, or hardship (Henry 2006; Tapias 2006). Signaling "tensions in the social landscape," isihuayo could additionally point to the root causes of the "materiality of poverty" on the women's lives (Tapias 2006:411). Rents in the social fabric for Amatlán women emerge from the social and economic disparity between them and the larger institutions that place conditions over their reproductive bodies. Fleuriet's work (2007:177) among indigenous people in northern Baja California demonstrates the links between the local construction and experience of illness and the larger historical and economic contexts that shape the "experience of being sick, poor, female, and indigenous in Mexico." She adds that physical suffering is frequently tied to cultural identity in an "environment of disparity." Similarly, the women of Amatlán live in such an environment of disparity, where they often bear the brunt of social, economic, and political policies that have historically excluded (or forcibly included) them from participation in the larger mainstream culture (Smith-Oka 2013).

Yearning for a Cure, Lacking Support

All the village women frequently spoke about their support from kin and friends, or the lack thereof. Esperanza was a very gentle and retiring woman in her fifties who had experienced the pain of losing two children—one in infancy to newborn tetanus and one adult son, many years later, to AIDS. She said:

> I dreamed the other day that my [dead] mother came to me. She holds me and tells me, "You will die here because you work too much, while up there [in heaven] it is so nice." But [. . .] I scold her and tell her not to take me and instead to send me someone to help me out.

Ribera and Hausmann-Muela (2011) speak about the importance of mutual support in reducing people's vulnerability to illness. A woman's social support and how much physical labor she did were both integral to her experiences of illness. A

woman who was taken care of by her family after giving birth, who had children to help around the house, and who had help in doing heavy manual housework (such as fetching wood and carrying water) was less likely to suffer from isihuayo than one who did not have support. She was less vulnerable. For Cristina, the mother of five children, "the reason [for getting isihuayo] is not taking care, we have no one to look after us."

Over the years, Esperanza took care of between one and four grandchildren because her children had migrated to other cities to work. She had suffered isihuayo twice. The first time occurred when she was carrying cement in a wheelbarrow when she and her husband were fixing their home. She began to experience lower back pain during this time. Her second bout of isihuayo began mildly in May 2004. It came about from carrying heavy containers of water daily from the nearby well on her head. On both occasions, she treated it by TBA massages and medicinal plants. Refugio, a TBA, stated, "[She] told me that water was coming out and I told her it was the uterus that was coming out." Although the home remedies worked for a while, Esperanza was told at the clinic that she had prolapse and needed surgery. Esperanza could not agree to surgery, however, as this meant no one to take care of her or her family while she was convalescing. Her primary means of social support came from her *comadre*[5] Altagracia, who lived across the street. Though Esperanza began to pay someone to carry water for her, with no other women at home all the housework fell to her.

Cristina, who had a relatively comfortable income from managing the village's only phone for many years, described women's lives the most bluntly. She said:

> It's just that as women we have to do everything, get pregnant and be nauseated for the first few months and when everything makes you feel sick. And [cleaning] the pigsty made me feel so sick. And then in the last [months] it is difficult to stand up and do everything. It is so much trouble. And then the pain of the birth, and to breastfeed, and to get up to change the baby in the middle of the night. Your husband is happily asleep but not you. [. . .] We [women] have to do everything. There is only the condom and the vasectomy for men, but they don't want them. We have to do it if we don't want to get pregnant. And well, one has to satisfy the husband and also not have so many children.

Many of the women who suffered from isihuayo expressed a similar overwhelming sense of lack of support from parents, children, husbands, or other kinsmen. In Juana's case, it was her mother-in-law absence that contributed to her experiencing isihuayo. Her mother-in-law—a traditional source of help for married women—worked in Mexico City as a maid and was rarely around. Thus, Juana lacked the usual female support network available to women in this community, one who she could draw on and rely on during times of illness or crisis. For Lourdes, her daughter-in-law Ofelia was excellent support, particularly in helping her with cooking. But Ofelia also had her own family of four children to feed and look after. Lourdes's sons provided her with some income, especially those working in the city, but she spent much of her time worrying about her youngest son, Samuel, who was still at the university—an expensive enterprise. Esperanza felt that her primary health

problems stemmed from her children—through their presence or lack thereof—and the lack of helping hands at home. She described how her eldest son's lackluster interest in work brought her much grief, stating, "He is no use to me here. He should go away to work but he doesn't want to. I don't know what to do with him. [. . .] When he is far away I don't worry. My head can rest."

Many women believed that isihuayo emerged from reproductive problems. Altagracia gave birth to seven children during her reproductive years. She believed that isihuayo came about from "not looking after ourselves when we are pregnant. We carry many heavy things, because we carry corn and wood, and if the husband is not there then we do it and it harms us." Altagracia and her husband Aparicio had no children at home. All of them migrated to the cities to work. Aparicio additionally had no rights to farmland. His brother conceded him some land to farm on but it was not his officially. He had been an alcoholic for many years and would beat Altagracia, but he converted to Pentecostalism over 20 years ago and became a strict teetotaler. Altagracia had a hard upbringing—her father was abusive and, until he died and she became an orphan, she lived in very wretched conditions. She confided that to this day she still struggled to consider that her home with Aparicio was her own.

Because of her lack of social support, she had no time to rest after birthing her children. She said, "[I should have] rested for eight days. But I could not rest and by four days I was cooking tortillas. With my first three children [I rested] a week. Afterwards no more. I began to work in the kitchen." Esperanza had a similar experience, stating:

> Some women [rest] eight days, others fifteen or a month. But by the next day I was working, as I have no one to help me. [. . .] My mother-in-law could not help. I could barely make tortillas. And I became sick. I felt no hunger and my body began to waste away. My hands were [as thin as] fingers.

Both women developed *necaxantle*—"the weakening disease"—that postpartum women develop with improper rest (Smith-Oka 2008). Additionally, Altagracia lost a child to *tentsocopale*—infant tetanus. She said sadly, "One of my [babies] died with that illness that came. If it gets ill, it does not get better and it dies. Now they are born into the hands of doctors." Her primary worries were about her children. As Aparicio stated, "There in the cities there is much evil." This was a tremendous source of worry to them both.

Gender relations are another lens through which to analyze the relationship between social support and the women's health. Support primarily came from female relatives (daughters or mothers-in-law) and from fictive kin (neighbors, friends). Male kin, especially husbands, also played an important role in support—financial, structural, or emotional. All the women in this study were married; many had companionate marriages. Though the gender domains were quite strict—men in public (fields, politics) and women in private (household)—there was relative gender equality, where the responsibilities and contributions of each gender were equally valued. This relative equality did not mean, however, that women felt entirely supported by their male kin, as they often complained about how much work they had.

Men supported their wives during ill health, either financially or by accompanying them to the clinic/hospital if needed. For instance, Juana's husband, though an alcoholic, was supportive in finding medicinal plants for her. Esperanza's and Lourdes's husbands also supported them emotionally when they were told that they needed surgery. Husbands rarely, however, would help their wives with domestic duties (childcare, laundry, or cooking) if she were ill. That role fell on the female kin. Thus, Cristina's statement that women had to do everything was true, as women needed support from other women in order not to fall ill.

The strength of women's social support also derived from their connection to the village (whether they were born there or had married in), their children's ages and their abilities to help with domestic chores, the presence of a mother-in-law, and the presence of daughters and daughters-in-law. There is strong evidence for the role of familial social support on people's improved health (Ribera and Hausmann-Muela 2011; Uchino et al. 1996). For Juana, her support network, or lack of it, was central in her experience of the illness. Her husband's lack of land and, frequently, any income, meant that the majority of her family's income came from government money as well as money her older children sent from Mexico City. Thus, support was important in shaping her health, especially when her children were younger and she had to take care of them because of her mother-in-law's absence. Though Esperanza was urged by the physicians to get surgery, she chose not to because of lack of female support, which would make her convalescing and recovery period almost impossible. Altagracia lacked the support of her children when she experienced isihuayo for the second time, making it impossible to undergo the treatment. This was not the case in the previous episode, during which she stayed with her children while she convalesced.

As seen from these various women's lives, it is not only the presence of social support that is central to their experience of illness, but also the presence of close emotional ties to these sources of support (Uchino et al. 1996). Ribera and Hausmann-Muela (2011:108) consider such "rich in people" ties as indispensable to the experience of illness.

Suffering in Silence

The women I spoke with frequently mentioned how isihuayo was perceived to be an embarrassing condition; thus, many women avoided treating it until it became painful because they were mortified at the thought of members of their family knowing, especially their husbands. As Rosario said, "A woman I know had [isihuayo] with her first baby. It came out. But she was embarrassed and didn't say anything. And it can't be fixed anymore." Cristina added, "The [treatment] works if you are attended to right away. Some keep silent because they are embarrassed. And only eventually they might call someone to massage them."

Altagracia's problem with isihuayo began when she gave birth to her last child 23 years prior to our interview; she felt her uterus fall but was too embarrassed to tell anyone. She had suffered pain for many years by the time the physician at the clinic diagnosed her with prolapsed uterus and told her to receive surgery in Mexico City. She said, "I didn't want to go but I did, because I had *caída de matriz*. But they did not open my belly; they did it from below. It hurt a lot." In 2005, however, she

had just begun to experience pain again and had once more diagnosed her condition as isihuayo.

In Altagracia's case, she not only experienced several pregnancies and the loss of a child, but deeper causes originated early on in life. She recounted the abuse she suffered as a child at the hands of her alcoholic father:

> When we were young the men were just drunks. And they would fight like dogs, rolling around and beating each other. My father was like that. . . . That's why I say that I grew up as a *borracha* [a drunk]. I didn't go to school and I don't know how to read or write.

Her sense of not belonging and her lack of a mother and of female support during her early married life accumulated in her body, much like an accumulation of heavy metals would. Her suffering became bodily expressed later in life, triggered by the continuous pregnancies with little intervals between.

Women often felt shame at talking about problems of a reproductive nature with others—especially to husbands or children. As Duffy (2005) shows in her work on stigma and shame surrounding AIDS in Zimbabwe, people who suffer from a shameful condition rarely disclose their diagnosis to others. Because most of the women of Amatlán who experienced isihuayo were older, they also had a more traditionally demure attitude to shameful illnesses. This meant that many of them would not speak up for fear of being ostracized by in-laws or other relatives.

For women suffering from isihuayo, the shame associated with it also related to notions of strength and weakness—a woman who was strong and had social support should not suffer from such a condition. The women's feeling of shame thus stemmed from a sense of somehow failing—not having children or support to rely on was somehow a reflection of their inability to keep their family together. Such a cycle of shame and silence could become very damaging to a woman's reproductive abilities and quality of life.

Discussion and Conclusion

This article amplifies the discussion on social suffering by illustrating the role of social support on women's experiences with uterine distress. Isihuayo is an ethnomedical issue, yet reflects broader issues. In contrast to illnesses with a primarily emotional basis, ishuayo is an illness with both physical and emotional causes expressed physically in a woman's uterus. This multifactorial, biological, emotional, and social condition is "rooted in the experiences of rural, indigenous communities" (Fleuriet 2007:157). It also illustrates the ways by which marginalized populations cope with their changing world.

Pylypa (2007:362) states that local discourses on illness can serve two functions: One is a resistance to biomedical hegemony, and the second is a way to "express dissatisfaction with a health care system that is oftentimes disempowering." Isihuayo in Amatlán appears to serve similar functions, whereby women who have suffered this condition express their concerns about the illness while simultaneously scorning biomedical care. The women felt that their bodies were shaped by larger institutional

forces and, as such, were no longer their own. Juana's words above—"They just operate you and take your uterus; [your body] is no longer the same"—illustrates a dual concern: reduced choices over one's own body and its dismemberment and disappearance by others.

A connection exists between women's health and shifting ideas of women's roles in society (Larme 1998). The older, more traditional women who followed local motherhood ideas were likely to experience isihuayo. The younger women, who had fewer children and frequently worked for wages in other regions of Mexico, were less likely to develop the condition. This was not simply because they were younger and their uteruses had not yet had the "opportunity" to be hurt, as many of the older women suffered isihuayo when they were younger. Younger women, significantly, received social support from older women—their mothers, sisters, or mothers-in-law—who provided help in childcare and life in general. Esperanza's daughters often left their own children with her for months or even years at a time, while they worked in *maquilas* on the border. This "socially meaningful strategy" (Leinaweaver 2007:175) of fosterage permitted younger women to earn money while ensuring that their children grew up and developed under the guidance of their own mothers. It also, unintentionally, allowed the younger women to protect their bodies from reproductive harm.

Regardless of whether the women were diagnosed with prolapse, what they suffered from was isihuayo. This illness embedded many more aspects than simply the physical displacement. The women lived isihuayo as an example of their broader issues, not just a biomedical category. Statistics and biomedical models assume that one prolapse is fundamentally like another. But this abstract concept ignores the lived experience of the women. Isihuayo was symptomatic of larger social problems in the women's lives—lack of support, poverty, labor-intensive life, even shame at their family dissolution. Thus, illness cannot be removed from the social context. Rock (2003) states that people's experience with illness should not be separated from collective frames of reference. And, similarly to Rock's research on diabetes among Canada's Cree, my argument demonstrates how distress and duress accompany the falling of a uterus. Within such a system of disenfranchisement, it is thus inevitable that isihuayo would become an expression of a woman's internal lack of strength *compounded* by an external set of forces that intentionally or unintentionally shape uterine health.

Building on the work of other scholars who examine the role of social conditions on women's health (Fleuriet 2007; Rock 2003; Spangler 2011; Tapias 2006), my work deepens this discussion by empirically showing how illness becomes a lived expression of marginalized people's social suffering due to differing degrees of social support. The implications of this study extend beyond the issues of reproduction or the illness of isihuayo given that it answers questions about a seemingly straightforward medical condition and places it in a broader discussion about change, social support, and delivery of health care. The data from this research link to broader social processes that explain how people view illnesses and how social factors shape them. The tensions in the social landscape are lived by these women through their uteruses, connecting their lack of support to a resonance with their broader disenfranchisement.

Notes

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1. *Partera* is the Spanish name for traditional birth attendant.
2. All interviews were confidential and I have used pseudonyms for people and communities.
3. The research was examined and approved by the Institutional Review Board of the University of Notre Dame, Notre Dame, Indiana. I obtained informed consent from all participants before interviewing them.
4. This particular illness is known in other parts of Mesoamerica as *caída de matriz*, *baja de matriz*, or *caída de vejiga* (Cosminsky 2001).
5. *Comadre* is the Spanish term for fictive kinswoman.

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