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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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A R T I C L E I N F O

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A B S T R A C T

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 socioeconomic 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

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