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**ORIGINAL RESEARCH**

# Traditional Midwives and Safe Abortion in Southern Mexico Today

# Parteras tradicionales y abortos seguros en el sur de México hoy

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**Abstract**

Medication abortion, using mifepristone and misoprostol, is currently considered the safest method for terminating an unwanted pregnancy. Its primary clinical advantage is that it does not require a hospital setting; trained personnel, such as traditional midwives, are fully sufficient to manage the procedure safely. Through qualitative interviews with 10 trained traditional midwives working with a non-profit organization, this study evaluates the relevance of their role in accompanying women seeking abortions in Chiapas, an impoverished region of Mexico. These midwives are typically women with limited formal education and Christian religious beliefs. They offer highly affordable services characterized by deep empathy, confidentiality, and solidarity, safely administering abortifacient medications to women traveling from various areas across the state. In doing so, they brave social stigma and legal sanctions, as abortion access in Mexico remains structurally limited. This restriction persists despite recent legislative and judicial reforms enacted by the Supreme Court of Justice of the Nation in 2022. Although first-trimester abortion has now been decriminalized in 25 of the 32 Mexican states, access remains constrained, thereby infringing upon the human rights of women who choose to terminate a pregnancy. Ultimately, this study provides empirical evidence of how traditional midwives safely support women seeking abortions, reclaiming healthcare spaces and fostering female autonomy independently of the Mexican state's institutional stance.

**Keywords:** midwives, medication abortion, Chiapas

**Resumen**

Actualmente el aborto con medicamento (mifeprestona y misoprostol) se considera la práctica más segura para interrumpir un embarazo no deseado. Su principal ventaja es que no requiere de un espacio hospitalario y basta con personal capacitado, como las parteras empíricas, para realizarlo adecuadamente. Este estudio cualitativo muestra, a través de entrevistas, a 10 parteras tradicionales debidamente capacitadas por una asociación civil en la realización de abortos con medicamento, su pertinencia en el acompañamiento a mujeres que desean abortar en zonas de Chiapas, región muy empobrecida de México. Las parteras son mujeres con escasa escolaridad, creyentes de alguna religión cristiana, que cobran muy baratos sus servicios, y que, con profunda empatía, secrecía y solidaridad, utilizan adecuadamente los medicamentos para abortar con mujeres que las buscan desde diferentes zonas del estado, arriesgándose al estigma social y a la sanción legal, ya que el acceso al aborto en México es limitado, a pesar de los recientes cambios legislativos y jurídicos realizados por la Suprema Corte de Justicia de la Nación en 2022,[12] a la fecha, el aborto en el primer trimestre ha sido despenalizado en 25 de los 32 estados mexicanos, impactando con ello los derechos humanos de las mujeres que deciden interrumpir un embarazo. No obstante, este estudio muestra evidencias de cómo estas parteras acompañan con seguridad a mujeres que desean abortar, recuperando espacios de salud y autonomía femenina, independientemente de la postura del Estado Mexicano.

**Palabras clave:** parteras, aborto con medicamento, Chiapas

## Introduction

The World Health Organization (WHO) [3] defines the termination of pregnancy, or abortion, as the expulsion of an embryo or fetus at any gestational stage before reaching 22 weeks, classifying it into two distinct types: spontaneous abortion, which oc curs due to physiological causes and stems from issues associated with the general health of the woman, and induced or provoked abortion, which is performed through an external intervention that does not result from natural physiological processes. Currently, two methods are recognized for performing an induced abortion: medical abortion (generally using the drugs misoprostol and mifepristone) and surgical abortion (Manual Vacuum Aspiration, or MVA, as well as uterine curettage or scraping—a practice now considered archaic in modern medical sectors). Medication abortion is currently one of the safest practices for terminating an unwanted pregnancy. It does not require a hospital setting, its costs are relatively accessible, and, above all, it prevents women from being exposed to more invasive procedures such as Manual Vacuum Aspiration (MVA) or curettage. Furthermore, this method offers the advantage of greater privacy, contributing to a less traumatic experience for the women [4] who undergo it, which is why it is recognized as a form of safe abortion.

In contrast, unsafe abortion—according to the World Health Organization (WHO) [2]—is defined as that which is carried out by untrained personnel and in contexts lacking adequate sanitary conditions. This type of abortion represents a significant risk to the health and life of women of reproductive age. Nonetheless, for many women living in highly vulnerable conditions—such as those with low financial resources, minors, those without support networks, or members of indigenous communities—this practice becomes the only viable alternative. The situation is further aggravated in contexts where abortion is highly stigmatized for religious or social reasons.

On the other hand, the decriminalization of abortion at the international level has been widely discussed within multiple debates, including that of the Cairo International Conference on Population and Development in 1995, where the imminent risks and consequences of performing abortions under illegal and unsafe conditions were exposed [5].

In the case of Mexico, the Supreme Court of Justice of the Nation (SCJN) ruled in 2021 that women or pregnant individuals should not be criminalized for undergoing an abortion, nor should those who accompany them or provide assistance during the process, including healthcare personnel. However, this ruling has not been adopted homogeneously throughout the country: only 25 of the 32 federal entities have eliminated legal restrictions on abortion, while the rest continue to regulate it discretionally in accordance with their respective state penal codes. This disparity implies a violation of sexual and reproductive rights, particularly to the detriment of women in situations of vulnerability, indigenous women, children, adolescents, migrants, and those with low incomes. This problem has been documented by Singh et al. [6], who argue that in contexts such as Mexico—where abortion continues to be surrounded by sociocultural stigmas and misinformation—access to safe medication abortion becomes a matter of privilege rather than a guaranteed right.

The drug combination used for medication abortion in Mexico is available in legal support centers for safe abortion (in Mexico City) and is highly restricted in the rest of the country. The advantage of medication abortions according to the WHO [3] is that they can be administered by properly trained healthcare personnel, such as nurses, health promoters, and midwives, which is helping to improve the management of unwanted pregnancy terminations, even in places where such assistance is prohibited [7].

In the case of this investigation (which is part of a larger study [8]), the focus was to document the support provided by traditional midwives [9] for medication abortion in the state of Chiapas. This region in southern Mexico faces severe developmental challenges, bringing together two elements mentioned as preconditions for performing abortions in unsafe situations: first, there is a high degree of social stigma surrounding abortion, and second, 77.1% of the total population lives in conditions of poverty [10], with the

additional factor that 31 out of every 100 births are attended by midwives, in contrast to the national level, which reflects 4 out of every 100 births [11]. Various studies have documented that in Chiapas, it is generally the indigenous, rural, and low-income population that tends to seek healthcare services (not only for childbirth) from midwives as a primary option [1213]. This choice is often a consequence of the lack of access to other health services, where poverty and the vulnerability of healthcare systems intersect with racism and other forms of discrimination. [14]

Nevertheless, traditional midwives (as part of traditional medical systems) have been historically marginalized and undervalued by biomedical medicine. However, their practices are legitimized by the population, which recognizes midwives as agents involved in primary healthcare (including the termination of unwanted pregnancies). Furthermore, although there is a contemporary resurgence of midwifery (empirical, traditional, and professionalized) in Mexico [15161718], the preeminence of midwifery in the country has passed through various stages of inclusion, exclusion, and conflict from the hegemonic perspective of medicine [19].

Some global research [20, 21, 22] has managed to document the damage caused by restrictive measures surrounding abortion, in addition to recognizing the role that traditional midwives have played in providing safe abortion care in non-industrialized countries. In Mexico, only the work of Castañeda and collaborators mentions the role of traditional midwives in terminating pregnancies safely [23].

Therefore, this research investigates traditional midwives interviewed from two regions of Chiapas regarding their experiences in terminating pregnancies with medication, despite the legal risks they face and the opposition within their immediate environments (families, society, and official health services). The objective is to document evidence of other options to improve the sexual and reproductive health of women in situations of vulnerability who require an abortion, guaranteeing their safety.

## Methods

Contacts were available from organizations that worked directly with assistance for the free and voluntary termination of pregnancy with medication and the training of midwives. A work route was mapped out, locating five midwives situated in a border region with Guatemala that we will call A, and five more in the highlands region of the state that we will call B, forming a total of ten participants in this research. These participants permitted the recording of their experiences regarding their work as midwives who know of and use medications for the termination of unwanted pregnancies, following prior informed consent. To understand these practices from a qualitative approach, semi-structured interviews were conducted from the perspective of feminist ethnography [24].

This research was framed from a gender and health perspective, which is one of the most laudable consequences of the impact of feminist theories in academia [25]. We would add that this is also true in healthcare globally, as this approach has enabled analyses that demonstrate the differences but also the inequalities of healing and falling ill between men and women and all their intersections (age, class, ethnicity, religion, educational level, among others). This framework thereby allows for the identification of the diverse needs and processes that women (in this case) face in the care and attention of their own health throughout their entire life cycle [26]. Ultimately, the use of feminist ethnography, the approach from a gender and health perspective, and the analysis of various intersections allowed the authors to carry out research with and for women. This was done with the intention of contributing to the social transformation of unjust, unnecessary, and avoidable health problems, which in themselves are not a pathology, but which violate the right to decide on abortion as a result of the patriarchal system of bodily control over women under a hegemonic, androcentric model of medicine.

In order to safeguard the traditional midwives, the interviews were conducted personally in their workspaces (generally their homes); furthermore, given that the practice of abortion is highly stigmatized and carries a degree of punishability in Chiapas, names were changed and exact locations

were omitted. As part of the initial process, written informed consent was requested from the participants. The fieldwork was carried out from March to July 2018. We consider it pertinent to note that, five years after conducting this fieldwork, it was necessary to corroborate how much conditions have changed so that the midwives of these regions can continue having access to medications and training if applicable. This necessity arises given the state of violence that has been exacerbated over the last two years by organized crime within this federal entity. Although some changes have occurred in the distribution logistics and training surrounding medication abortion, safe and accessible practices for the women of the region have not ceased, as will be detailed further below.

For the purposes of this article, the following research categories were selected: 1) how did they learn to perform medication abortions? and 2) the community perceptions and social consequences of their assistance.

**Study Population**

The interviewees belong to a network of midwives trained to perform medication abortions by a non-governmental organization (whose name also cannot be revealed). They charge very low rates or even offer their services free of charge, depending on their own criteria regarding the financial capabilities of the women who come to them (ranging from pregnant minors to women with many children). In addition to performing medication abortions, the interviewees carry out everything corresponding to the art of midwifery (pregnancy care, childbirth, postpartum care, infant care, and contraception, among others).

Below, Table 1 displays the general demographic data of the participating midwives, illustrating their extensive years of professional experience, their backgrounds, their highly unique training pathways—including through dreams, as noted by other authors [13, 14]—and their religious beliefs.

**Table 1: General characteristics of the midwives participating in the study**

| Name | Age | Zone | Educational Level | Years of Experience as a Midwife | Acquisition of Midwifery Knowledge | Native Language | Religion |
|---|---|---|---|---|---|---|---|
| Doña Isabel | 53 years | A | Incomplete primary school | 20 years | Knowledge inherited from mother-in-law | Tseltal | Catholic |
| Doña Luz | 63 years | A | Incomplete primary school | 25 years | Knowledge inherited from sister | Castellano (Spanish) | Catholic |
| Doña Rosario | 39 years | A | Complete primary school | 16 years | Knowledge acquired through dreams | Tsotsil | Community rituals |
| Doña Josefina | 47 years | A | No formal education | 25 years | Attended her own birth ("empirical knowledge") | Tsotsil | Catholic |
| Doña Antonia | 36 years | A | Incomplete primary school | 12 years | Knowledge acquired through dreams and midwife mother | Tsotsil | Catholic |
| Doña Socorro | 62 years | B | Complete high school | 43 years | Knowledge inherited from grandmother | Castellano / Tojolabal | Catholic |
| Doña Gertrudis | 66 years | B | Incomplete primary school | 45 years | Knowledge inherited from mother | Castellano / Tojolabal | Catholic |
| Doña Angelina | 36 years | B | Complete middle school | 16 years | Knowledge inherited from mother | Castellano | Catholic |
| Doña Lupita | 57 years | B | Complete middle school | 40 years | Knowledge inherited from mother | Castellano / Tojolabal | Catholic |
| Doña Margarita | 59 years | B | Complete primary school | 45 years | Knowledge inherited from grandmother and mother | Castellano / Tojolabal | Catholic |

**Source:** Author's own elaboration based on fieldwork

## Results

In countries like Mexico and others in Latin America, the profession of midwifery does not currently enjoy sufficient prestige [27], and its conditions have become increasingly vulnerable in various parts of the world, as noted by the United Nations Population Fund (UNFPA) in its State of the World's Midwifery report [28]. In light of this, an inquiry was made into how these interviewed women learned to properly perform medication abortions within contexts so adverse for the practice of midwifery.

> **Doña Luz (Region B):** *My sister did do it, but she never talked to me about it... then I started working, and people started coming to me like that, for pregnancy termination. At that time, it wasn't called termination; it was called abortion or "I want to pass it"... suddenly, Doña Bety from an organization showed up, and then she said to me: "I know you are a midwife," and asked if I wouldn't like to try some medications. The termination kit was around 70 pesos 3 USD [29]. "Look," she told me, "I'll leave you two, and if someone shows up around here, let me know." And we stayed in contact with her, and to this day I'm still working with her... The trainings I have received—courses, trainings exclusively on termination—are solely from the non-profit organization.*

This serves as an example of what the World Health Organization is aiming for to combat maternal morbidity and mortality stemming from unsafe abortions [3]: the adequate training of personnel considered non-medical, operating outside hospital settings, who nevertheless act effectively during terminations to guarantee abortion safety with minimal margins of error. Concurrently, for traditional midwives, this approach provides greater certainty in the procedure, blending the use of modern pharmaceuticals with their prior knowledge.

> **Josefina (Region B):** *They looked for me here at my house, and then they started talking to me about that abortion. That was when I remembered everything, because they already used to come looking for me anyway, except I used to use my herbs. So when they gave me the information about the medicines, I felt happier because it was something safer, and that's how I felt encouraged to learn. They explained to me how I had to do it and all about it; even though I don't know how to write, it stuck quickly in my head.*

This midwife narrates how she took ownership of this learning process in a very straightforward manner despite not possessing literacy skills. This underscores the importance of adequate training initiatives that dismantle prevailing myths within the country suggesting that rural, indigenous, or illiterate midwives might jeopardize the life of a woman who seeks an abortion from them—a notion in clear confrontation with studies conducted in Mexico.[30, 31, 32]

In the case of Region A, it was possible to detect how the transmission of knowledge through female genealogy is preserved, being enriched with more modern knowledge from mothers to daughters.

> **Angelina (Region A):** *Well, I have never had training for medication use. I learned because my mother was trained, and I learned from her... everything unfolded after meeting the health promoter; now, if we have any doubts, we call her, but likewise, everything I have learned is with my mother.*

In turn, many women face negative targeting within their own communities when they wish to undergo an abortion, leading them to seek help from midwives in other areas. In both Region A and Region B, the midwives mentioned that they attend to women from different places, both far and near, nationals and immigrants alike.

Nevertheless, midwives are also exposed to community scrutiny regarding the assistance they provide to women who wish to abort. This category is related to stigma, which has been mentioned in other studies [14,21,33] as a social barrier that pejoratively labels both the midwives who terminate pregnancies and the women who turn to them. This was also mentioned by the interviewed midwives, with the exception of what occurs in autonomous zones [34], where a profound respect can be observed regarding the decisions of both the midwives and women's health.

> **Rosario (Region B):** *Up until now, I haven't had problems with anyone for helping women to abort. Here in my community, we have*

> *needs, you see, so there is no problem. Besides, here in my community, it is autonomous, so if we agree to help the woman, we get to do it without anyone bothering us.*

The freedom of action that midwives and women can experience in this type of community is evident, as they are not constrained by cultures filled with prejudices and prohibitions regarding women's decisions over their bodies. On the contrary, in non-autonomous zones, they frequently have to maintain absolute secrecy regarding abortion care—among midwives, within their own families, and in the community in general—to avoid face negative targeting.

> **Doña Luz (Region B):** *It is a closed topic... where I first started hearing about abortion was when an organization's campaign came to the municipal headquarters and they reached an agreement with the municipal president. It's been about 12 years since that campaign came; they invited the midwives, and off I went. That's where they talked to us about termination and mentioned they brought a medication in case anyone wanted to sign up with the people who came. Later, we midwives talked about it, and they said: "No, God forbid, it is a great sin." "But what if a case arrives?" I asked the other midwives. "When that person arrives, I have medication."*

One of the main elements within this narrative, is talking about abortion in a group setting, where independent of each person's beliefs, a space is opened for dialogue. The culture among midwives favors distinct ways of acting and thinking. This dialogue is not easy when it comes to the topic of abortion, because not everyone speaks about it, as it is a "closed" topic, heavily burdened by social weight or stigma.

> **Gertrudis (Region A):** *I do hear people say that there are other midwives who do it, but I never say anything. My family knows nothing because these are very personal things; if they know, I could have problems even with the law.*

Either way, they protect themselves by maintaining secrecy regarding what they do, who does it, and whom they do it for, because they know that the law in Chiapas continues to be threatening in legal terms regarding abortion. This is compounded by the discriminatory and infantilizing gaze that most official health services personnel in Chiapas direct toward traditional midwives [111316].

## Final Considerations

It can be observed that the interviewed midwives recognize their capacity to take ownership of new knowledge in order to offer better care. This is in alignment with the "The State of the World's Midwifery" report [26], which notes that nations require more midwives; in turn, the midwives referred to in that report express a desire to do their work, just like the midwives interviewed in our research.

In this study, some of the midwives mentioned that they used to perform abortions using herbs, but they have identified greater effectiveness in the use of medications, which has allowed them to transition smoothly to this practice. It is evident that to receive training in both regions, the midwives were sought out by a non-profit organization that provided them with information and sold—and continues to sell—the supplies directly to each of their homes. We were able to re-establish contact with promoters from the non-profit organization that primarily supplies them with the medication and provides them with training. In response to our inquiry regarding whether this was being affected—given that organized crime in Chiapas now frequently carries out roadblocks that disrupt communication—we were informed that now, they deliver the kits at more spaced-out intervals but in larger volumes (so that they last for a set period of time), even though they pay for them little by little (for example, when buying batches of 10 in 10).

They receive these packages is via parcel delivery on public transportation whenever there is open passage, and payment is made through bank transfers. This serves as yet another demonstration of the immense ability of midwives to adapt to changes and to the inconveniences presented by their context; and while trainings are now more sporadic and occur in locations with easier geographical access, the non-profit organization has not abandoned these areas. The organization remains fully aware that the need to terminate unwanted pregnancies in a safe manner is a

constant, steady need within the reality of women of reproductive age.

Also notable, peer-to-peer training among midwives in Region B has already begun to take place without the need of intermediation of the non-profit organization. While this does not yet happen in Region A, recent research on tele-abortion and on accompanied abortion (carried out by women who accompany other women and who are not midwives, doctors, or nurses) is making it clear that this can be a widespread practice of this new millennium, regardless of whether it is penalized or not [73536].

Tensions and difficult collaborations between the recognized knowledge base of hegemonic medicine and other types of health knowledge—in this case, that of midwifery [25, 37]—have been widely documented in the contemporary era. Specifically, this study demonstrates how traditional midwives have successfully incorporated pharmaceuticals arising from biomedicine to perform terminations safely. Nevertheless, they did not report a good relationship with the Ministry of Health; in fact, their training regarding medication abortion was provided through non-profit organizations. Is it possible that within the Ministry of Health, personnel are also failing to provide midwives with this crucial training because they are unfamiliar with this type of procedure? Is it possible that the greatest barrier is that the law and culture still penalize abortion in Chiapas, or is it simply part of the lack of recognition between hegemonic medicine and the new practices of midwifery? These questions could give rise to other future investigations.

The gender and health perspective allowed us to clearly frame a broader reality: beyond the nation's need for abortion decriminalization and its widespread availability within health services or clinics (as seen in Mexico City), efforts are needed across the entire territory. At the federal level, the National Center for Gender Equity and Reproductive Health of the Ministry of Health has been working hard since 2022 [38] to implement a technical guideline for safe abortion nationwide. Unfortunately, there is no clear dissemination strategy for these best practices, and there remains a resistance to recognizing alternative care models for sexual and reproductive health. Specifically, institutions fail to recognize that traditional midwives in the studied regions are well-trained despite having low or no formal education. Many of these midwives are of indigenous ethnic origin, their midwifery work yields little profit, the majority profess the Catholic religion, they provide care in non-hospital settings, and the women who turn to them generally belong to highly vulnerable sectors. These findings directly challenge research that seriously doubts their capacity to perform safe abortions [272829], as they execute them with considerable success. This contributes further evidence regarding safe medication abortion in accordance with the WHO [2], a reality increasingly documented with robust empirical evidence in regions where abortion is criminalized or highly stigmatized. [31, 32, 39]

The work of traditional midwives in the specific case of Mexico is of paramount importance given the country's regional and social context, as noted by Berrio [13]. In this sense, it is worth noting that within a restrictive framework for access to safe, induced abortion in Mexico, midwives have had to make their practices invisible out of fear of being penalized or stigmatized by the delegitimization of their knowledge and capabilities. Therefore, training midwives to correctly perform induced medication abortions in the country is not only desirable, viable, and necessary; this research demonstrates—in alignment with previously cited studies [3192032]—that it is entirely possible, safe, and critical. This is especially true for women located in the country's most vulnerable regions, as it reclaims safe, intimate, and reliable healthcare spaces managed among women. This effort must also contribute to restoring dignity to the courageous role of midwives in contemporary Mexico.

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