

Power struggle: Indigenous medicines from the Chiapas Highlands, between two worlds

Disputa de poderes: Las medicinas indígenas de los Altos de Chiapas, entre dos mundos

Jorge Magaña Ochoa*

ABSTRACT

The indigenous medical knowledge of the region formerly known as the Chiapas Highlands, now the Tzeltal-Tzotzil region, has been rendered invisible by official scientific-hegemonic medicine and made visible again based on obvious economic advantages that have nothing to do with the recognition of these peoples' fundamental rights, but rather with the Mexican government's search for answers to the conditions expressed in the profound economic, political, and social crisis of the last thirty years.

This work aims to show and reflect on the impact and social dynamics of the health control business, in each of its forms and variations, on the inhabitants, primarily indigenous people, of this region. It aims to demonstrate that the current crisis is temporary, but, above all, it is the manifestation of something much deeper: the economic, cultural, and structural control of indigenous medical knowledge. For this reason, the article explores how sociocultural changes affect social representations of health, illness, and medical care, especially in indigenous communities. Highlighting how some people are abandoning traditional practices but still maintain ancestral beliefs, facing the prevailing challenges of globalization, poverty, and the influence of official, hegemonic, capitalist, and modern medicine.

Keywords: Indigenous medicines, power disputes, medical knowledge, illness and disease, narratives of illness

* Doctorado en Estudios Regionales
Universidad Autónoma de Chiapas
jorge.magana@unach.mx
ORCID <https://orcid.org/0000-0002-9424-2814>

REVISTA TECNOLÓGICA
ciencia y educación
Edwards Deming

ISSN: 2600-5867

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Edited by: Tecnológico Superior Corporativo
Edwards Deming

January - March Vol. 9 - 1 - 2025

<https://revista-edwardsdeming.com/index.php/es>

e-ISSN: 2576-0971

Received: July 19, 2024

Approved: October 10, 2024

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RESUMEN

Los conocimientos médicos indígenas de la región otroramente llamada Altos de Chiapas, hoy región Tzeltal-Tzotzil, han sido invisibilizados por la medicina oficial científica-hegemónica y vueltos a visibilizar conforme a conveniencias económicas manifiestas que no tienen nada que ver con el reconocimiento a los derechos fundamentales de estos pueblos, sino más bien a búsqueda de respuestas, por parte del gobierno mexicano, a las condiciones expresadas en una profunda crisis económica, política y social de los últimos treinta años.

Este trabajo pretende mostrar y reflexionar la incidencia y dinámica social que el negocio del control de la salud, en cada una de sus formas y variantes, golpea a los pobladores, principalmente indígenas, de esta región. Se trata de evidenciar que la actual crisis es de coyuntura, pero, sobre todo, es la manifestación de algo mucho más profundo al control económico, cultural y estructural, de los conocimientos médicos indígenas. Por tal motivo, el artículo explora cómo los cambios socioculturales afectan las representaciones sociales de la salud, la enfermedad y la atención médica, especialmente en comunidades indígenas; resaltando cómo algunos pobladores abandonan prácticas tradicionales, pero aún mantienen creencias ancestrales, enfrentando los desafíos imperantes ante la globalización, la pobreza y la influencia de la medicina oficial, hegemónica, capitalista y moderna.

Palabras clave: Medicinas indígenas, disputas de poder, conocimientos médicos, padecimiento y enfermedad, narrativas del padecimiento

INTRODUCTION

Before beginning the discussion in this article and orienting the reader to the topics that will be addressed—identity, social representation, cultural configuration, social construction, medicine, power, modernity/postmodernity/contemporaneity, and disputed heritage (medical knowledge and expertise)—I would like to make three pertinent clarifications for the reader: First, the reflection presented here is part of a broader project that has been underway since 1998, working to understand the change that has taken place in the medical position and the disputes over power and control of the discourse on health in the region known today as Tzotzil-Tzeltal (Altos de Chiapas), by the mainly indigenous groups that cohabit there. Second, that all the actors and social

agents involved in a social space that shapes its territorialization, even though they can be classified as having a common origin, have patterns of representation around their medical practices manifested in a series of social and cultural elements that form a baggage constructed and appropriated by the social group as a whole in a heterogeneous, historical and dynamic process (Magaña, 2002); and thirdly, that due to the phenomena of “globalization” or “glocalization,” disturbances in the context are affecting the sphere of social reproduction and lifestyles, as well as the basis of the culture with which the collective identifies (Magaña, 2009). We will reflect on how the diverse cultures present in a region influence the exercise of medical practices and representations in situations of interculturality and dispute. The reflection revolves mainly around the construction of medical knowledge, referring to a cosmopolitan environment where tradition and its practitioners have been important factors in the social structure and cultural development. In this sense, when we are faced with the construction of social representations based on the rationality of a specific group (ideas, beliefs, truths constructed, accepted, and shared by the community about the world around them), it becomes necessary to understand the conceptual framework that allows us to grasp this world, as well as the logic with which elements of the various discourses and proposals with which they interact are accepted or rejected (Magaña, 2009). We must therefore be clear that knowledge is produced within a social context, in which the individual agent, when putting their knowledge into practice, interacts within a social structure in which they have been socialized and which enables them to participate in the social construction of representations of their everyday life. Concepts about the cultural process of a people or region are not universal in nature; just as the processes or criteria of rationality that justify them are specific to a semantic context. Such processes and concepts are the foundation of their very knowledge, insofar as they refer to a whole system of socially constructed norms and values accepted in the local context (Magaña, 2009). In this sense, we must be very clear about the spatial location of the research exercise and the contextual reality. Therefore, and in order to situate the reader, we can say about our physical-territorial space that it is a territory in which there have been multiple disputes over medical control and practice, in favor of a hegemonic/capitalist/scientific and official medicine (Magaña, 2002).

MATERIALS AND METHODS

The work that precedes these lines has focused its methodological discussion in general terms on the field of descriptive and reflective ethnography, if we can call it that, whose very quality is the exposition of the “narrative” or “narratives.” In other words, from anthropological studies in health, narrative has become an instrument, or rather a post-structuralist methodological trend in research, which enables us to reconstruct events or experiences based on a person's narrated experience.

Through narrative, aspects such as learning, memory, and the identity of the subject are cultivated. As such, narrative is configured as a metaphor for human thought that

proposes the construction of reality and its interpretation and understanding by the collective (Eroza and Magaña, 2023).

Within indigenous contexts, narratives, experiences, and stories take center stage, as the issues addressed are often very sensitive, highlighting the need to create spaces for listening and reflection in the field of health, especially when health becomes a commodity in dispute and a symbolic struggle for control over its knowledge and practice (Magaña, 2019).

In this case, the production of narratives can be considered a window into understanding the social culture of the actors present in this research work; it is the discourse that organizes everything related to cultural communion and communication with the characters involved in the personal story and in the history of the context in which the narrator's experience unfolds. All of them are convinced of the instrumental meaning of narrative, since it allows them to outline the panorama and environment perceived in relation to the experiences narrated. However, history or narrative is not a copy or, better said, a historical account, but rather a field of study that, through language, frees the emotions of the narrators involved.

Narratives as a methodological tool show us and propose a way of investigating, a way of delving into individual realities and their collective life extensions, a way that makes their appropriation possible. Narrative invites us to understand "Drama," "Social Drama," as proposed by Victor Turner (1974), and the misfortune experienced when expressed by those who bring to life within themselves a suffering that is part of their individual-social self and, I reiterate, of the drama they have experienced.

These possibilities, narratives as a methodological proposal and their construction and/or dialogic constitution, allow us to delve into the analysis of the permanent and dynamic link between cultural visions and the personal experiences of the narrator of their experience and living through broader social processes, in terms of experiences, revealing through communicative action the profuse meanings and diverse roles played by those who narrate. This situation will be objectified in the following lines of this article.

RESULTS

As we all know, both individually and collectively, health is the result of complex interactions between biological, ecological, socioeconomic, and cultural processes that occur in society. Therefore, health is determined by the structure and dynamics of society, by the degree of development of its productive forces, by the type of social relations it establishes, by the economic model, by the form of organization of the State and, finally, by the conditions in which society develops, such as climate, location, and geographical characteristics and, above all, by the natural resources available. The link between health and development is reciprocal and complex; that is, they are complementary concepts. Health is the result of the level and forms of development of

a society, insofar as this determines the limits and availability of resources for the well-being of the various population groups.

The latter, rather than a necessary good, becomes an arena for debate for the very populations targeted by public health policies. For example, according to members of OSECAPIACH/Abejas:

From our experience as health promoters, our foundation has been around for a long time, our organization, now we are a civil association. Before, we had in our minds that we had no education beyond primary school, but from our experience, we thought that health was ambulances or medicine, but later, thanks to other organizations that began to train us, several of us here began to receive training. Due to various conflicts, such as Acteal, as you know, we decided to work as health promoters because there are many diseases in the camps due to garbage and other things that are thrown there. So, the first thing we thought was to form groups... What are we going to do? All of that came about in 1998. That year, diseases such as typhoid broke out, and women had miscarriages due to fear and the conflicts in the community. So we thought about what we were going to do, and we formed groups of young people and started there so that they could get involved. Some were trained and others were used as translators, because in our area we don't speak Spanish, except for Tzotzil, and the doctors were from outside the area. We were the middlemen, translating for the doctors and the patients. We thought that health at that time was medicine (Fieldwork, 2010-2011).

On the other hand, health is an essential condition for social development because of its impact on the individual's ability to work and on the establishment of the climate of stability, tranquility, and social progress that such development requires (Page, 2010-11; Magaña, 2009; Eroza, 2008; Ayora, 2000). Jaime Page goes further, telling us that there are various factors that have had an impact in the short and medium term on the region's medical systems, which he considers to be ethnomedical (2010-11) and which this writer considers to be fragments of medical systems or practices that still survive in the region (Magaña, 2002).

For Page, these factors highlight changing forms of social and economic reproduction among the Maya population in response to growing poverty, the persistent influence of religious groups, political conflict, and migration. This position is supported by the three cases he analyzes: In the case of Oxchuc, he tells us, one can practically speak of the emergence of a healthcare system with abundant elements of biomedical diagnosis and focused on treating illness based on medicinal herbs; while in the cases of Chamula and Chenalhó, there is still a significant presence of an ethnomedical system based on ritual which, although it has undergone important transformations in recent decades, still predominates over others (ibid.).

All of this implies various scenarios of vulnerability, mainly insofar as both communities and individuals are increasingly exposed to the effects of historical and social forces that

are beyond their control. We can speak, for example, of entire communities that have lost their natural resources for subsistence and are disadvantaged in the dynamics of the market economy; processes that entail a latent tension between traditional visions and values of social life and the expectations, particularly among members of the younger generations, to participate fully in the dynamics of modernity...

I feel that government institutions design development strategies, such as Felipe Calderón's Millennium Goals, but I feel that here, when we are in a meeting, it is about supporting communities through communities, not coming from above. For example, the members of Las Abejas who are concerned about their situation—it is difficult, it also involves communication, they go and no one listens to them, So they go and say, 'This hurts, I don't feel this,' but the doctor doesn't understand them because of the language they speak. That's where change has to come from. Doctors need to be taught in different ways so that they can understand, open up new paths so that from there they can promote the development of their community, because I've seen that more opportunities are given to education, and this is done with a distinction between rich and poor. There are many indigenous teachers, people with specialties, but it is difficult for an indigenous person to become a specialist. I want to learn, I want to use it, but they don't because they don't know how, so many die because of ignorance and because they are not treated well (Report, Intercultural Health Forum 2010).

Faced with these kinds of problems, and we must continue to insist, health institutions lack a solid structure of care focused on them, partly because this is a problem that has not been sufficiently visible and, therefore, fully recognized by public health agencies. However, the latter is complicated by the fact that indigenous people have a series of representations and practices around health and illness, which often place the presence of ailments within an interpretive framework whose main references are notions of divine punishment, witchcraft, and spiritual conceptions that account for the constituent elements of the person (Magaña, 2002; Eroza and Magaña, 2010). In this sense, and in relation to the problems of prevention, detection, and care, this means that the search for diagnosis and care takes place through channels that are completely unrelated to those that could be provided by health institutions.

We know that there are a number of deep-rooted problems related to community issues. When the regional hospital, which is not regional but general, was inaugurated, it began operating with 70 beds, and now they realized that they had to hire nurses, and no one wanted to come to San Cristóbal because they didn't want to, but they hired women who knew how to give injections, and these women were racist, discriminatory, and abusive. I saw the social workers, who were also treated very badly. Here, the important things are respect, dignity, and equality. For them, that is quality, but we are seeing it from their perspective, which is why it is an achievement for them. Elsewhere, it is logical to fight against the system in order to enter it. We continue to believe that traditional medicine should be tolerated, but that is not the case. We must understand traditional medicine in order to combine knowledge. Doctors have been taught to cure

diseases, but they are not taught how to prevent them. Everything that is done to prevent or treat a disease is a strategy, a way of fighting a system that serves to see systems and tear them down, our comrades in Oventic of the EZLN and they are not (Report, Intercultural Health Forum 2010).

For researchers such as S. Igor Ayora (2000), the field of debate is manifested in the way that the social political discourse managed by what is considered official Mexican medicine, or in its recognized theoretical conceptualization: Hegemonic Medicine, subsumes and subordinates indigenous medical practice in its regional actions. In other words, for Ayora, the so-called traditional medicine practiced in the region and known as Mayan, due to its roots and cultural-local manifestations prior to the arrival and establishment of allopathic medicine, is a type of medical practice that is accepted as such within the framework of official or modern medicine, as he calls the latter; and that becomes a category that brings together medical practices that have no equivalent in modern medicine.

The researcher argues that, in this sense, traditional and indigenous Mayan medicine is a contemporary product and that official, modern, cosmopolitan, and allopathic medicine validates it as medicine (ibid.). The indigenous practice and knowledge of the healer is subordinated, forcing them to act in accordance with federal and state health regulations and laws.

Some shamans or *iloletik* (as indigenous healers are known in the region), midwives, and other “indigenous” health specialists expressed their feelings to us in the following interview conducted during the 1st Intercultural Health Forum in the city of San Cristóbal de Las Casas, Chiapas, in 2010:

We need to have a health promoter certification that allows us to move around the hospital like doctors or nurses, which was not possible before. Once they have settled the patient in, they make sure they are not left alone in the hospital... But we had experiences where they didn't want to listen to us, we complained to Ms. Lety and they fired them because they didn't want to listen to us, and now there are changes. They were going to give us badges and uniforms, but because of our culture, we would be embarrassed to dress like that in the new hospital. In other municipalities, they treat us well, but based on our experiences with other organizations, they train us. They didn't before, but now they do. The conflict that exists with community health workers or health centers is because they work with official medicine, because they know how to use and administer IV fluids, or because they apply mainstream medicine. but here we had to do this to reduce people's suffering from disease. But it's this whole thing, how can there be such a dominant and oppressive system that in order to be treated, people had to move? We are finally working to change the dominance of these activities. We had to adhere to the model in order to get in, but we have to do even more to be able to say that it is intercultural medicine.

These types of demands and calls for attention are not new. In a state where there is deep inequality in the way health services are implemented, affecting population groups that require immediate service, in addition to other problems that in this specific context are intended to be eradicated:

- a) Misallocation of resources. Public funds are spent on health interventions that are not cost-effective.
- b) Inequality. The poor, especially indigenous people, lack access to basic health services and the care they receive is of poor quality.
- c) In recent years, during the transition to more market-oriented economies, real public spending on health has declined sharply.
- d) The public sector has suffered from severe shortages of medicines and equipment, as well as a lack of the specialized knowledge needed to manage health institutions undergoing change and facing intercultural phenomena.
- e) Misunderstanding of social participation as a contribution to health promotion. In most cases, the concept of participation continues to be based on a vertical relationship, in which traditional instruments of collective participation are increasingly ineffective in gathering citizens' demands, and the limitation is even greater in regions such as ours, which have poorly developed social networks.
- f) The indigenous population living in these regions has traditionally been subject to strong pressures, mostly from national society. Migration, their relationship with the environment, the unequal penetration of capitalism into the indigenous world, the imposition of new religions, and their own cultural dynamics have placed new stresses on the indigenous world (Farías, 1997). At the same time, they have the highest mortality rates and lowest life expectancy compared to any other group, both within the state and nationally.
- g) There is currently significant underreporting in statistics on the most common diseases in indigenous and mestizo communities in these regions, as well as on causes of death, because the health sector does not have sufficient human and material resources to maintain a permanent and efficient epidemiological surveillance system.
- h) Community participation is still very limited because neither the population using health services nor the health sector itself has managed to implement intervention models that do not clash with the cultural structures of the social groups in which health actions requiring the participation of the local population are to be carried out.
- i) The problem of health and disease in the social context of these regions is understood as a matter strictly within the competence of the health sector and government agencies, so that the actions taken by the population to prevent disease and/or restore

health are practically non-existent, insofar as the population sees itself as a passive object of institutional action. Disease prevention and health recovery are not understood by the population as instruments of social and political struggle: Most communities mention that they are not cared for because they do not belong to political parties, ...(Fieldwork, 2010-2011).

As Ayora says, we cannot settle for the simple idea that indigenous people are forced to turn to traditional healers because of their cultural patterns. It is true that there are cultural elements that have great importance and influence on the behavior of indigenous people when solving health problems (Ayora, 2000), but we must bear in mind that the production of practices and patterns of perception and representation of diseases in indigenous contexts marked by situations of multiculturalism generates changes in their meaning, disrupting known signs and symptoms, showing an inability to generate useful interpretative frameworks to explain the conflicting and critical situations of an active illness (Magaña, 2015 [2002]); however, it is also true that many indigenous people prefer to go to allopathic doctors rather than indigenous healers (Ayora, 2000; Magaña, 2002).

DISCUSSION

Knowledge in dispute: between indigenous knowledge and medical knowledge...

Chiapas, the setting for our research

Over the last two decades, the state of Chiapas has faced a number of historical events that have abruptly triggered and/or accelerated multiple social processes. In most cases, given their rapid pace, scope, and complexity, these processes have escaped the attention of decision-makers in the field of social policy. The dynamics of the global era have also contributed to shaping the social landscape of the state.

More specifically, it can be observed that Chiapas has the highest rates of marginalization in the country. In general terms, this means that the standard of living of its population is on the threshold of extreme poverty, with 82% of the population surviving on two minimum wages, more than 42% of the child population suffers from some degree of severe malnutrition, and the epidemiological profile is classified as poverty-related diseases. In addition, it is also noteworthy that the state of Chiapas ranks second in marginalization in the Mexican Republic, and more than half of the municipalities have “very high” and “high” degrees of marginalization (53% and 40%, respectively). According to data presented in the Chiapas Solidarity Development Plan 2007-2012, the state ranks fifth in social inequality in Latin America and among the highest in the world. This situation is aggravated by the impacts of the international economic and financial crisis and by the unequal distribution of opportunities, resources, and power

among groups, social classes, ethnic groups, genders, and individuals in a society where poverty is one of its expressions.

On the other hand, we must take into account that Chiapas is a true cultural and multiethnic mosaic, ranking second among the ten states with the largest indigenous-speaking population in the country, surpassed only by Oaxaca. Throughout its history, this factor has caused its ethnic groups to undergo successive internal transformations, both biological (miscegenation) and cultural, and in their relationships with the different agents of the dominant society, this has led to adaptive changes that have affected their cultural physiognomy and their way of becoming ill and caring for the sick, both in terms of physical ailments and mental health issues.

It should be noted that in Chiapas there is no comprehensive specialized mental health care structure that responds to all the needs of the population. This is complicated by indigenous conceptions of suffering, which often translate into a reluctance to discuss such problems for fear of social shame, understood as suffering rather than as a label or disqualification, as is the case in mestizo urban cultures. (Magaña, 2019:51)

In turn, the emergence of social processes such as the Zapatista movement in 1994 and its direct and indirect effects have led to significant changes in the profile of the various resident populations of the identity. For example, at a certain point, sociopolitical violence played a crucial role in the flow of population movements toward urban centers, which mainly involved the indigenous population. We can also mention the military presence, the magnitude of which served as a trigger for the increase in sex work, which also mainly affected women from poor sectors of the population, particularly indigenous women (Magaña, 2012).

Therefore, in addition to the Zapatista conflict, we can observe that processes such as migration, economic development closely linked to agribusiness, large-scale environmental degradation, modernizing public policies, the deepening of inequalities, technological development, access to global information, illicit economic activities, and in recent years, migration to urban centers in other states but mainly to the United States. Along with all these references to change, however, colonial vestiges survive in Chiapas that also give a unique flavor to Chiapaneca modernity. Regardless of the order in which they are mentioned, all of these factors together have created a new scenario of poverty in which the references of globalization take on many very particular nuances when interacting with a great sociocultural diversity, both in rural and urban areas (ibid.).

In terms of the health of the population, the interaction of all these aspects can also be encompassed as structural violence, which translates into differential forms of vulnerability in relation to different groups and individuals, whose only common denominator seems to be deprivation. Within this context, various health problems can be framed that require urgent attention in the search for solutions: maternal mortality,

child malnutrition, acute respiratory diseases, and acute diarrheal diseases; that is, diseases that are considered preventable in most cases with a simple vaccine, but in this context, the vaccine becomes pure gold, and in recent years, there has been an increase in suicide attempts among young people and children in indigenous populations, not to mention actual suicides (Magaña, 2015).

The impact of all this within indigenous populations is such that it leads to serious fractures in traditional values, which translate into and are related to religious and political conflicts, or to the effects of modernizing trends. These conflicts take place in family, community, and inter-community life and end up placing certain individuals or groups in various situations of vulnerability in terms of health.

Focusing on the region of interest in this proposal, and in addition to the above, it can be said that since 1994, with the emergence of the Zapatista Movement and the problem of religious conflicts (mass expulsions of indigenous populations, for example, in the Altos de Chiapas), there has been a proliferation of conflicts that prevent the conditions for a dignified, healthy, and peaceful life, where there is respect and tolerance for human rights and for the religious, social, ethnic, and cultural diversity of communities. In this regard, we can observe that over the last 40 years there have been significant changes in the Tzotzil-Tzeltal region (Altos) that are not uniformly manifested in the different municipalities that comprise it. State policies toward indigenous communities, the presence of new political groups, the integration of Protestant groups or the Catholic Church itself into the communities, migration in search of work, and the abuse of power by indigenous caciques are some of the factors that have had an impact on the formation of new cultural processes.

These are times of great population movement, of interethnic relations that did not exist before, and of forms of social and political organization that go beyond the limits of the village, the region, and the linguistic group. Changes are observed in indigenous communities that are responses to the influences of the modern world, but which are rather the result of a process of reconstitution and reinvention of ethnic identity in new social contexts. The indigenous people of these regions of Chiapas are more complex than those who inhabit the pages of ethnographies from the 1950s to the 1970s (Magaña, 2013).

Even with the changes that are taking place, a large part of the indigenous peoples retain their traditional forms of political and religious organization. However, although some communities tacitly reject the use of traditional medical practices, for example, in general, the way in which illness is conceived has more to do with the indigenous worldview than with scientific medical practice. Some inhabitants no longer turn to indigenous doctors, but the causes they attribute to their illness are part of what are known as “traditional illnesses” and, in their view, modern medicine is synonymous with drugs (Magaña, 2012 [2002]).

Although indigenous medicine addresses, albeit in a very limited way, the precarious conditions in which the population lives, through specialists who devote much of their time to healing the sick, are recognized by their community, and possess knowledge acquired through the internalization of their daily experiences, death from diseases that in other parts of the world would be preventable at low cost (such as malnutrition, “EDAS” or “IRAS”), in this region, points to economic, infrastructure, and health policy factors, as well as cultural issues and inequalities in gender, ethnic, and generational relations (ibid.).

In general terms, we can say that, since the indigenous uprising in January 1994, there has been a gradual but constant change in the collective perception of health problems as a result of social interaction in terms of injustice and inequality. This has led many residents, and mainly their representatives, to demand greater participation in health recovery and disease prevention processes, with institutional support and recognition (Magaña, 2015).

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