

The importance of midwives in the lives of women in San Juan La Laguna, Guatemala

Esther Geurts and Renate Klijnstra



Utrecht University

The importance of midwives in the lives of women in San Juan la Laguna, Guatemala

Bachelor thesis June 2017

Esther Geurts

4101901

e.m.a.geurts@students.uu.nl

Renate Klijnstra

4083059

b.r.klijnstra@students.uu.nl

Supervisor:

Gerdien Steenbeek



Utrecht University

Source front page: photo from private collection, 05/04/2017.

A comadrona performs a prenatal check at the home of a 4-months pregnant woman.

ACKNOWLEDGEMENTS	5
MAPS	7
CHAPTER 1: INTRODUCTION.....	8
1.1 RESEARCH POPULATION AND LOCATION.....	9
1.2 RESEARCH METHODS	11
1.3 OUR THESIS	13
CHAPTER 2: THEORETICAL FRAMEWORK	15
2.1 INTRODUCTION	15
2.2 GENDER, SEXUALITY, AND MOTHERHOOD	16
2.2.1 <i>Gender</i>	16
2.2.2 <i>Sexuality</i>	17
2.2.3 <i>Reproduction and fertility</i>	18
2.2.4 <i>Reproductive health</i>	19
2.2.5 <i>Motherhood</i>	19
2.3 CARING FOR THE PREGNANT BODY	20
2.3.1 <i>Healthcare systems</i>	21
2.3.2 <i>Authoritative knowledge</i>	22
2.3.3 <i>Pregnancy and birth as medical conditions</i>	23
2.4 PREGNANCY AND BIRTH: CONCLUSION	24
CHAPTER 3: GENDER AND SEXUALITY.....	25
3.1 <i>MARIANISMO</i> AND <i>MACHISMO</i>	25
3.2 FAMILY PLANNING	28
3.3 TABOOS AND IGNORANCE.....	31
3.4 CONCLUSION	32
CHAPTER 4: MOTHERHOOD	33
4.1 “ <i>REALIZARSE COMO MUJER</i> ”	33
4.2 BEING A MOTHER IN SAN JUAN LA LAGUNA	35
4.3 CONCLUSION	37
CHAPTER 5: HEALTHCARE	39
5.1 HEALTHCARE IN GUATEMALA.....	39
5.2 HEALTHCARE IN SAN JUAN LA LAGUNA	40
5.3 STATE-OWNED HEALTHCARE.....	40
5.4 PRIVATELY-OWNED HEALTHCARE	42
5.5 HEALTHCARE PROVIDED BY NGOS	42
5.5.1 <i>Casa Materna</i>	43
5.6 OTHER SUPPORT FOR WOMEN IN SAN JUAN LA LAGUNA	44
5.7 MUTUAL RELATIONS	45
5.8 CONCLUSION	47

CHAPTER 6: MIDWIVES	48
6.1 BECOMING A MIDWIFE: ABOUT <i>DONS</i> AND DREAMS	48
6.2 PRACTICES AND TECHNIQUES	50
6.3 <i>COMADRONAS</i> AS SOCIAL WORKERS	52
6.4 <i>CAPACITACIONES</i>	54
6.5 THE EVOLVING MIDWIFE.....	55
6.6 THE DEVALUATION OF MIDWIVES?	57
6.7 CONCLUSION	58
CHAPTER 7: CONCLUSION.....	60
7.1 FROM WOMANHOOD TO MOTHERHOOD.....	61
7.2 THE CHANGING ROLE OF MIDWIVES	62
7.3 INTERACTION BETWEEN WOMEN AND MIDWIVES	64
BIBLIOGRAPHY	67
APPENDIX A: LIST WITH INFORMANTS.....	78
APPENDIX B: RESUMEN EN ESPAÑOL	80
APPENDIX C: PHOTOS OF SAN JUAN LA LAGUNA	83

Acknowledgements

When we arrived at San Juan La Laguna, we struck up a conversation with two policemen. We told them that we were newcomers, who were highly interested in integrating in the community, and asked them to look out for us during our stay. The policemen told us not to worry. “In this village, you will feel at home. The inhabitants are friendly and respectful, we rarely have to intervene and therefore our work is relatively stress free.” They proved to be right. We could not have wished for a safer and more suitable and agreeable research location.

We would like to thank everyone in San Juan La Laguna who helped us with our research and made us feel at home. There are a few people we would like to thank in particular. First of all, family Sumoza; for treating us as family. You will always have a special place in our hearts. Lacho; for your friendship, and all the cultural experiences you let us participate in. *Casa Materna*; for placing trust in us and allowing us entrance to your beautiful workfield. We believe your power to reach out to the village is amazingly strong. *Oficina de la Mujer*; for getting us in touch with your breathtaking network, and for showing your indispensable work. All the pregnant women and mothers who recently gave birth; for sharing your impressive experiences and for our incredible moments together. The *comadronas*, nurses, and sexual health educators; for showing us your important tasks to assist, heal, and educate the people of San Juan La Laguna.

We would also like to thank our parents; who have supported us throughout this process and who undoubtedly will continue to motivate us to follow our dreams, wherever these may take us. Last but not least, we would like to pay tribute to dr. Gerdien Steenbeek. Due to your constructive feedback, critical comments, thoughtful recommendations, personal guidance, and mental support, we constantly felt challenged and disciplined to get the best out of ourselves.

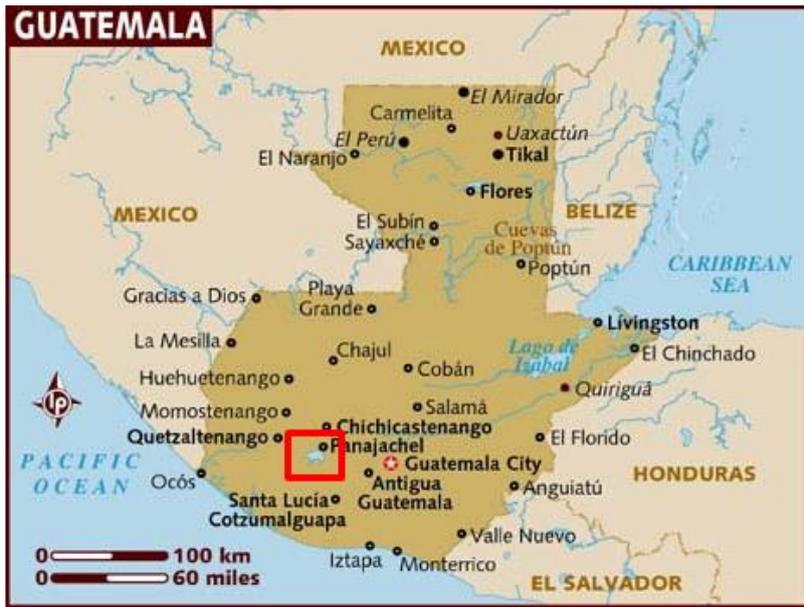
I, Renate, would like to thank Esther; for how we worked perfectly and professionally together, and how you supported me when I was having a hard time during the preparations, in the field, and during the writing process. You were always there to motivate me, and I appreciate your passionate way of working. I am proud of our achievements in our fieldwork, and proud of this thesis, which we accomplished together. Stichting Marjan Rens; for the

financial support. Your foundation does a great job supporting young researchers, who thanks to your financial contribution become more developed and experienced within feminist anthropology.

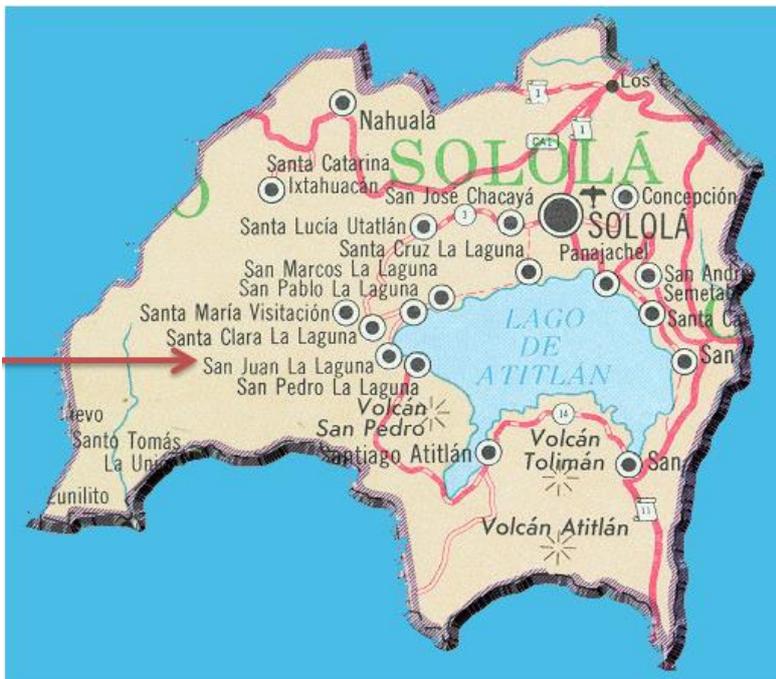
In my turn I, Esther, would like to show my gratitude to Renate; for always being there for me. Whenever I shared my concerns with you, you always made me feel better afterwards. You have helped me grow and become a better researcher. I admire your generosity, passion and commitment. I think that we truly complement each other as a research duo. I could not have wished for a better co-researcher, roommate, travel buddy and ultimately friend to share this great experience with.

¡Qué Dios les bendiga!

Maps



Map 1: Guatemala¹



Map 2: Department of Sololá²

¹ Source: <http://www.lonelyplanet.com/maps/central-america/guatemala/> Accessed on 08/06/2017.

² Source: http://www.jabeltinamit.com/panajachel_atitlan_guatemala/atitlan_region_map.htm Accessed on 08/06/2017.

Chapter 1: Introduction

Esther Geurts and Renate Klijnsra

When the almost 40-week pregnant Josune hurried to the birth centre she did not bring anything with her except for the clothes she was wearing. No money, no food, no baby clothes for the baby who was about to be born. She had wished for her husband to accompany her, but sadly alcohol had taken the better of him. Fortunately, her sister-in-law was prepared to join her. “*Diós mío*”³ Josune whispered, every time a contraction overwhelmed her. When the long awaited baby girl was finally born, it was not Josune who got to hold her daughter first, a quest to take the perfect Facebook worthy photo began while the medical staff took turns in taking different poses with the newborn. Meanwhile Josune was quietly sipping her energy drink, like nothing worth mentioning ever happened...⁴

In recent decades anthropologists have come to understand that birth has become an arena within which culture is produced, reproduced and resisted thus encompassing far more than just biology (Van Hollen 1994, 2).

Josune was able to give birth in a safe environment in a country where maternal mortality⁵ is a big issue. An estimated 110 women per 100,000 live births do not survive⁶. Indigenous women, who not only tend to have low levels of education but also face geographic difficulties in reaching health facilities, have multiple children and give birth at home, are most at risk of losing their lives while giving birth (Radoff et al 2013). As 50-90% of all births occur at home with help of a midwife (Maupin 2008), training programs to “improve” or “upgrade” their knowledge, techniques and practices were implemented in order to decrease maternal mortality. However the maternal mortality rate has not dropped in over 20 years (Chary et al 2013, 853) which suggests that fighting maternal mortality from an exclusively medical point of view does not suffice. As anthropologists we feel providing a more holistic view on pregnancy and birth will be conducive to contributing to the health and safety of (pregnant) women in Guatemala. We will not only look at medical aspects, such as

³ Meaning: “My God”.

⁴ Participant observation Josune 17/03/2017.

⁵ Definition: number of women who die due to childbirth related reasons during pregnancy, delivery, or the 42 day postpartum period (WHO 2004; WHO 2008).

⁶ These women are up to 67 times more likely to die in childbirth than women in the United States. Website: <http://www.casamaternaatitlan.org/> Accessed on 01/06/2017.

healthcare systems and the extensive role midwives occupy, but we also aspire to come to grips with what it truly means to be a woman and become a mother in an indigenous society. We aim to examine how the wellbeing of these women is influenced by their views on sexuality and therefore affects their reproductive health.

In this thesis specialized literature was studied and empirical data were collected during a fieldwork period of two months in the indigenous town of San Juan La Laguna. Our central research question is as follows:

How do midwives and pregnancy-related healthcare interact with the way womanhood and motherhood are perceived and experienced by (pregnant) women in San Juan La Laguna?

By answering this central question, we would like to illustrate that understanding pregnancy and birth from an exclusively medical point of view is not sufficient. We aim to show that it is also important to examine the meaning of womanhood, motherhood and the socioeconomic circumstances women find themselves in during pregnancy. Besides focusing on pregnant women and young mothers, we also focus on midwives. In literature, midwives are often depicted as obsolete, but in this thesis we want to underline the importance of midwives in the lives of women in local communities. So, this thesis will contribute to the already existing body of literature on pregnancy and birth. We aim to pay tribute to the indigenous women of San Juan La Laguna and give them a voice which enables them to tell us what they think, experience and desire. Ultimately, we hope that insight into social and medical aspects from a local perspective may contribute to gaining more insight in possible ways to combat maternal- and infant mortality.

1.1 Research population and location

In late February 2017 we entered San Juan La Laguna, a little town on the shores of Lake Atitlán, Guatemala to conduct anthropological fieldwork. We stayed with an indigenous family who contributed to getting to know the town and its inhabitants. Over time we have met numerous people and with some of them we developed a close relationship.

To “find” pregnant women, newly mothers and local midwives, we started a brainstorm with the help of our host family, hoping to come up with ideas where to start. They introduced us to some women who were pregnant or who had recently given birth and women working as *comadronas*, which is the local name used for midwives. Furthermore,

our host sister, who speaks the local language, accompanied us during our first visit to a newly opened birth clinic, called *Casa Materna*. We think this paved the way for making the managing director more susceptible to cooperating with us. Through *Casa Materna* we could meet pregnant women, be present at prenatal checks, massages and even births. Since *Casa Materna* has only recently started to operate, we are aware of the fact that, if our research had taken place at another moment, be it earlier or later, our results would have been different.

We also visited other organisations which are active or concerned with pregnant women or *comadronas*. One of them was *Oficina de la Mujer*, a governmental organisation which mainly assists pregnant teenagers. Accompanied by women who work for *Oficina de la Mujer* we had access to these young pregnant women. After establishing the first contacts, the snowball method helped us to get into contact with new informants. Building rapport was essential. We tried to achieve that by visiting our informants regularly, accompanying them to activities and by always showing sincere interest in their lives. Trust was needed to allow women to speak freely, especially about sensitive topics. Naturally, the level of rapport and trust achieved varied, but we developed a basic level of rapport with all of our informants.

San Juan La Laguna, as a municipality, has 12,272 inhabitants⁷, which consists of San Juan La Laguna and the smaller villages of Pasajquim, Panyebar and Palestina. In total, we had contact with 21 (2-9 months) pregnant women and women who recently gave birth⁸ in San Juan La Laguna. We also interviewed three (4-9 months) pregnant women from the neighbouring towns of San Pablo La Laguna and San Pedro La Laguna, who use healthcare in San Juan La Laguna⁹. We have had intensive contact with nine of these women. Furthermore, we had contact with six (4-8 months) pregnant women from the *aldeas*¹⁰. So, in total, we interacted with 30 women who were pregnant or recently gave birth.

Ten *comadronas* are known to be active in San Juan La Laguna, two of whom are also certified nurses¹¹. They all became our informants. We also spoke to a *comadrona* from San Pedro La Laguna with many patients. During an extensive visit to the *aldeas* we talked to

⁷ Of which 7,000 live in San Juan La Laguna, interview Gabriela 14/03/2017.

⁸ With a maximum of 5 months earlier.

⁹ The youngest of these 24 women is 15 years old and the oldest 39 years.

¹⁰ Pasajquim, Panyebar and Palestina are locally called the *aldeas*. The youngest of the women is 17 years old and the oldest 29 years.

¹¹ Only registered and therefore certified *comadronas* are legally allowed to attend births. The *Puesto de Salud* in San Juan La Laguna told us that a total of 26 *comadronas* are registered, ten of which are working actively. The other 16 *comadronas* do not attend births regularly or are still in training. Of these ten, the youngest was 37 years old and the oldest 75 years. Their years of experience range from 9 to 45 years.

all five of the *comadronas* working there¹². Lastly, we spoke to medical personnel working at *Casa Materna* and the *Puesto de Salud* in San Juan La Laguna, in Pasajquim and in Panyebar.

During our fieldwork, we were confronted with severe poverty and inequality and we felt we should give something back to the people who helped us in numerous ways. From our host mother we learned what we could bring as an appropriate gift. We gave elementary items like food, drinks, baby clothes, and sometimes a small amount of money, to everyone who helped us. We attempted to minimize the influence that rewarding our informants may have on both our roles as researchers and our collected data by elaborately considering a suitable gift every time we met with an informant. We aimed to find a balance between being objective researchers and being led by our feelings.

1.2 Research methods

In order to collect empirical data we used qualitative research methods, which mainly consisted of participant observation. “Participant observation is a method in which a researcher takes part in the daily activities, rituals, interactions, and events of a group of people as one of the means of learning the explicit and tacit aspects of their life routines and cultures” (DeWalt and DeWalt 2011, 1). By showing our informants that we were more than willing to listen and learn from them, participant observation helped us not only to experience what their daily lives is like, but also to build rapport.

Using participant observation may raise ethical questions in respect to informed consent, which means that people are aware of the fact that they are participating in a research project and subsequently give permission to use the data. When having and recording interviews it is clear to most individuals that their stories will be used, but whenever participating in people’s lives it may be less obvious to the informants that everything is carefully written down right after an activity and may find its way in a report (DeWalt and DeWalt 2011, 214-215). However we tried to tackle this dilemma by always getting out our notebooks when taking part in a participant’s daily life thus emphasising our intentions and roles as researchers.

We argue that participant observation should be seen as an approach rather than a method, because within this approach qualitative methods are used such as interviewing and

¹² Of these five, the youngest was 54 years old and the oldest 85 years. Their years of experience range from 8 to 65 years.

informal conversations. In order to help overcome the insecurities and queries women may have, we made it obvious that we wanted to learn from them what it is like to become a woman and a mother.

During our fieldwork, we visited our informants regularly, on some occasions shortly after having given birth or when celebrating the eighth day after giving birth. We also visited pregnant women and mothers with the sole purpose of having a chat. It is essential to get to know both the *comadrona* and her patient(s), because it has resulted in making our presence during a variety of activities much more acceptable. We witnessed prenatal checks, traditional massages and even births.

Besides having frequent conversations with pregnant women, mothers, *comadronas* and medical personnel, we held semi-structured and open interviews totalling over 50 semi-structured and open interviews. During semi-structured interviews, we had specific research questions and topics in mind to collect more detailed information. We always asked permission to record the conversation for later reference. We also held some open, less formal, interviews. It meant not using our topic lists, nor recording the conversation. To avoid uncomfortable situations and an atmosphere that could be perceived as too formal, we asked open questions and we tried not to take all the initiative during the interviews. As by then we had already analysed data collected up to that point, we had a fair idea of the specific information needed to fill the gaps rendering our topic lists almost obsolete.

Spanish is the official language in Guatemala, but most people speak one of the 21 official Maya languages as their maternal language and Spanish as their second. But in general we noticed that most of our informants were able to converse in Spanish with us confidently. Although not native Spanish speakers ourselves, we feel that because of our extensive preparations including thorough language studies, we did not suffer much from a language barrier. The common local language spoken in San Juan La Laguna is Tzu'tujil, but sometimes our informants spoke Quiche or Kakchiquel. We did not want to exclude women who are not fluent in Spanish from our research as we felt these women deserve to be given a voice too and their information and experiences are important to us. Some of these interviews were conducted with the help of a translator. This translator tended to be a family member of the woman we spoke to but in some cases one of our informants willingly offered to translate. We wrote notes after every single activity and meeting and documented our collected data carefully. We are conscious of the fact that in those cases in which we made use of a translator we needed to be even more precise and considerate since the interpretation of the

collected data could be influenced by the language barrier. In some cases we may have simplified our questions which subsequently could have resulted in the questions being perceived as directive.

We gathered statistical data. Not only did we visit online websites of for example *Casa Materna*, we also visited *RENAP*¹³. Here we collected an overview of all people who are legally domiciled in San Juan La Laguna. With the permission and help of *RENAP*, we collected information about the number of births and the pregnancy-related healthcare women used during giving birth between January 2017 and April 2017¹⁴. The collected statistical data serve to support our findings.

All in all, we used participant observation, informal conversations, semi-structured and open interviews and gathered statistical data. Using these methods we have not only given our informants the opportunity to tell us what they think, but we have also experienced and observed what their daily lives are like. Their perceptions combined with ours has resulted in a detailed and extensive account of the local situation, which is supported by statistical data collected. During the process of data collection we tried to spend as much time as possible with our informants, while during the process of data analysis we tried to look at our collected data without getting too involved and with detachment in order to stop us from being biased and have preconceived opinions.

However, we want to point out that as anthropologists, we are our own research tool and all the information collected, is locally situated. When analysing the data the same applies, because our perceptions and conclusions are filtered by our own cultural lenses and full scientific objectivity cannot be assured.

1.3 Our thesis

Our thesis will start with a literary overview, in which we examine significant literature about pregnancy and birth from two perspectives of subfields within anthropology, namely feminist and medical anthropology. Subsequently, the concepts of gender, sexuality, motherhood, healthcare systems, the authority of knowledge and medicalization are discussed. In the following chapters we will use empirical data to illustrate how these concepts are related to each other.

In the chapters that follow, we present the results of our empirical data collected

¹³ *RENAP*: Registro Nacional de Personas, the National Register of People.

¹⁴ However, this only accounts for the number of registered births during this period. People have two months to register their baby, so it is possible that more babies were born during this period, but were not registered yet.

during our fieldwork and combine them with the theories and arguments found in the scholarly literature. In chapter 3 we discuss how gender and sexuality are interrelated. Male sexuality is celebrated, whereas female sexuality is surrounded by silence resulting in it being a taboo. Consequently women have little knowledge about the workings of their bodies, which affects their reproductive health. The following chapter is concerned with motherhood. Women are able to fulfill God's will by having children, which makes becoming a mother sacred and the societal norm. However, pregnancy must happen within the confinement of a monogamous marriage. Women are either regarded as "good" or "bad" mothers, and often fear a bad reputation. Although being a mother is a more valuable position than being childless, women's economic and social position within society does not grow exponentially when entering motherhood. During pregnancy these women are dependent on healthcare options available to them, which will be discussed in chapter 5. In Guatemala a general distinction can be made between state-owned healthcare, private healthcare and healthcare provided by NGOs. These healthcare organisations do not always work together thus influencing the quality of healthcare on offer. Healthcare is not only offered by formal organisations. In fact, almost all of the women we talked to (also) used the services of a *comadrona*. Chapter 6 is concerned with the work, practices and knowledge of *comadronas*. *Comadronas* offer culturally appropriate care, which matches the needs of (pregnant) women in San Juan La Laguna and therefore is inclusive. We also examine the changing role of *comadronas* within society. According to literature their authority and legitimacy is threatened by medicalization. However, we will illustrate that medicalization has resulted in the increase of knowledge among *comadronas*. Combined with consistently spreading a narrative which underlines their importance, this has led to the maintenance of their authority and legitimacy.

In our final chapter we will conclude that women's own perceptions and experiences of womanhood and motherhood are influenced by norms about gender and sexuality, (lack of) knowledge of the body, social position, economic situation and the care they receive. We also argue that midwives have not become obsolete but, on the contrary, seem indispensable to the women they attend to. A healthcare system which takes into account pregnant women's social position and provides support and education suits their needs best. It is in the interest of both the mothers and their babies to have a healthcare system which is inclusive, accessible and culturally appropriate. Midwives are able to fill this void and provide care which encompasses all these aspects.

Chapter 2: Theoretical framework

Esther Geurts and Renate Klijstra

2.1 Introduction

The birth process is a universal part of human female physiology and biology, but in recent decades anthropologists have come to understand that birth transcends being simply a biological act. Brigitte Jordan describes this process as follows, “birth is everywhere socially marked and shaped” (1997, 1). This is a significant difference with the general mindset of about thirty years ago when most anthropologists had not even considered these topics in a scientific way.

In this chapter we aim to demonstrate that pregnancy and birth transcend biological events. We want to illustrate what this means when taking a closer look at this field. Bodies are shaped by history, culture and society and therefore perceptions about them are constantly changing. This makes the body a social and cultural construction (DeMello 2014). That is why we decided to apply the perspectives of two major subfields within anthropology, namely feminist and medical anthropology.

We will start by analyzing gender, sexuality, and motherhood. Mitchell (1971) once argued that a woman has four oppressions: sexuality, production, reproduction, and the socialization of children. Since only women (and transmen) are able to produce new life, society puts them under high pressure. The processes of sexuality, reproduction, and the socialization of children may be depicted as natural, but are all socially and culturally patterned (Cosminsky 1994). We will illustrate that all of these processes push women in a certain direction.

Subsequently, we will take a closer look at different kinds of healthcare systems. In many societies, different, sometimes even conflicting, healthcare systems may be at play simultaneously. The way in which a particular healthcare system tries to gain supremacy will be discussed later on. Finally, we will see that pregnancy and birth have more and more become part of the medical realm. We will explore the way in which pregnancy and birth are affected by these transformations in more depth.

Summarizing, birth transcends being a biological act and should be seen as culturally and socially marked. This chapter contributes to deepening our understanding of the different social and cultural aspects concerning pregnancy and birth. We will illustrate that both

feminist and medical anthropology show that women are exposed to all kinds of expectations, laws, and social norms within society and its healthcare systems.

2.2 Gender, sexuality, and motherhood (Renate Klijnsstra)

Motherhood, pregnancy and birth should not only be viewed as biological processes, but also as cultural phenomena. To help understand this, gender and sexuality are to be explained as social and cultural constructions. The subfield of feminist anthropology has thoroughly examined these interrelationships. which have led to new insights regarding gender, sexuality, and reproduction.

2.2.1 Gender

Decades before feminist anthropology became a recognized subfield within anthropology, Margaret Mead, one of the most renowned anthropologists, conducted research about what it means to be woman or a man, which turned out to be experienced differently worldwide (Nencel 2007, 91). Her work *The Coming of Age in Samoa* (1928), focused on girls becoming women and was regarded as an illustration which shows that male and female “sex” roles and activities are not universal (ibid., 91). The focus on cultural, instead of biological differences between men and women is still a continuously discussed subject (ibid., 91).

Until the mid-twentieth century, the inherent dichotomies such as male/female and nature/culture, associated sex with one’s activities (Dominguez et al. 2009). According to this static idea, women are childbearers and thus seen as natural creators, to be confined to the private sphere (Ortner 1974, 77; Weiss 1987, 81). Their primary duties are those of being a wife and mother. They are represented as being close to nature as only females are capable of breastfeeding the child leaving room for men to create and sustain culture (Ortner 1974, 77). From the 1970s onwards, doubts about this static perception rose, and feminist anthropologists started to reject the essentialist view suggesting that there is a male and female essence that validates traditional roles of males and females (Dominguez et al. 2009). A need for a new concept originated and the concept “gender” was born. With the application of this new concept the existence of biological differences between men and women is not rejected, but it recognizes the cultural and social construction of beliefs and behaviours considered appropriate for each sex (Lavenda and Schultz 2014, 365). “Gender is constructed through relations, be that between individuals, in institutions, or through identity” (Nencel

2007, 98). Gender identity needs to be distinguished from gender role (Stets and Burke 2000, 997). Gender identity refers to one's internal sense of oneself as male, female or something else (Adler et al. 1992; APA 2015), on which society members decide what being male and being female entails (Stets and Burke 2000, 997). The point at which these internalized gender identities become externalized into a set of expectations is called a gender role (Adler et al. 1992, 185). Thus gender role refers to the cultural expectations as understood by gender classification offered by societal norms (ibid., 185).

Gender is related to power, since the "behaviours and attitudes that societies define as appropriate for women and men can be the cause, consequence and mechanism of power relations, from the intimate sphere of the household to the highest levels of political decision-making" (Koester 2015, n.p.). These power relationships are contextual and change over time and in place (Mohanty 1988; Moore 1988; Scott 1986). Gender is also related to, yet different from sexuality (Shaw and Ardener 2005, 3). In the next paragraph we will explain more about this concept.

2.2.2 Sexuality

Sexuality is a concept that refers to different meanings. Merriam-Webster (2017, n.p.) describes sexuality as "the quality of state being sexual", "the condition of having sex", "sexual activity", "expression of sexual receptivity or interest especially when excessive", and "the sexual habits and desires of a person". Vance shows (2005, 20) that sexuality is more than a biological fact. She notes that sexual acts, sexual identities, sexual communities, the direction of erotic interests, and sexual desire itself are all socially constructed. Even the direction of erotic interest itself, and "sex drive" are constructed (ibid., 20). Vance's definition of sexuality conflicts with the idea that sexuality is innate, a notion feminists have long been arguing about. For years, feminists have been at odds with reigning ideas in society on how to distinguish sexuality from reproduction and women's gendered roles as wives and mothers, and to make clear that "women" and "sex roles" are not universal categories (Greenhalgh 1995; Moore 1988; Vance 2005). Gender identity, gender roles and cultural norms regarding sexuality are contextual and change over time; they highly influence the sexual female body, and therefore women's roles as wives and mothers (Greenhalgh 1995; Moore 1988; Vance 2005, 17). The naturally gendered, female body is in fact a highly socially mediated product; femininity and sexual attractiveness are achieved through persistent socialization regarding standards of beauty, makeup and body language (Vance

2005, 17). In the next paragraph we will explain the deeply gendered and sexualized processes of reproduction and fertility.

2.2.3 Reproduction and fertility

Reproduction is “the process by which new social members are produced; specifically, the physiological process of conception, pregnancy, birth, and child raising” (Birx 2006, n.p.). This biological phenomenon is not culturally universal, nor is it timeless. This concept is, like sexuality and gender, a social and cultural construction.

Reproduction is an example of a deeply gendered process leading to different roles, since only women (and transmen) can get pregnant, bear, and give birth to children (DeMello 2014). Women are affected by fertility decisions in a different way from men, since their fertility span is shorter (Kottak 2008, 225). Males can produce fresh germ cells until their death, in contrast to females, who at birth have been supplied with a set amount of germ cells. Females are productive from an age of 10-15 until approximately an age of 50. During this time span, females are faced with the degeneration of germ cells, of which the non-fertilized eggs get washed away as menstrual waste (Durnell Schuiling and Likis 2011; Martin 1991). Within the concept in which pregnancy is the ability to reproduce, menstruation is seen as a wasteful failure (Martin 1996, 92). In some societies menstruating women are kept from cooking, cleaning, having sex or even being near men (DeMello 2014, 59). This results in a menstruating woman being able to escape her usual role and act without the scrutiny of man (Martin 1996, 101).

The decision to become a mother and birth practices themselves are based on certain conceptions about the body and reflect the continuing change of values and themes of a culture (Cosminsky 1994; Martin 1996; Newman 1975). Some gendered values interrelate with religious ones. Within Christianity, the Virgin Mary is a role model. She is an unremarkable woman, who is humble, subservient and subjective to God while being pregnant (Dillen 2009, 94-96). Mary’s virtues influence individuals and nations, and the manners and morals of society at large (Brownson 2017). Because of her, it is believed that pregnancy is regarded as a goal one should strive for, as long as it is God’s will (Dillen 2009, 99). This led to the use of contraception generally being condemned by Orthodoxy, Roman Catholicism, and Protestantism. However, Christians today are divided about the way they view birth control (Carlson 2007). Consequently women from different credes take measures in line with their beliefs to limit their family size. The so called social management of the

family begins in the prenatal period (Greenhalgh 1995). Whether women opt for hormonal methods, barrier methods, intrauterine device, natural methods or emergency contraception, may depend on and is influenced by different factors like safety, effectiveness, and affordability (Opt 2016). In addition, having freedom of movement, having at least some control in household matters, budget decisions, being involved in family planning decision making, political and legal awareness, fears of domestic and intimate partner violence, among others, might influence the decision making regarding anticonception (Govindasamy and Malhotra 1996 in Do and Kurimoto 2012).

2.2.4 Reproductive health

Not all women opt for anticonception based on a variety of reasons. The majority of pregnancies of millions of women who still become pregnant unintentionally, end in abortion (Glasier et al. 2006). Moreover, hundreds of thousands of people get gonorrhoea, syphilis, chlamydia, or trichomonas infections (ibid.). Also going safely through pregnancy and childbirth is a concern among women worldwide (WHO 2017). Reproductive health, that is to say, health as a state of complete physical, mental and social well-being, which implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so, is often a concern (Glasier et al. 2006; WHO 2017). Besides structural problems, like absent or poor quality of health services, other factors play a role in the affected reproductive health regarding women (Glasier et al. 2006). Conservative political, religious, and cultural forces around the world threaten women's reproductive health and in many countries, debates about issues such as sexual intercourse and sexuality make women feel uncomfortable (ibid.). Lastly, power affects women's reproductive health. "An unequal power balance in gender relations that favours men, translates into an unequal power balance in heterosexual interactions, in which male pleasure supersedes female pleasure and men have greater control than women over when, where, and how sex takes place" (Gupta 2000, 87). Low standards of reproductive health combined with other factors influence the way motherhood is perceived, which will be discussed in the next paragraph.

2.2.5 Motherhood

Although motherhood is a universal phenomenon, the way it is experienced varies worldwide. This relates to age, marital status, sexual orientation, cultural perception (Geist

2013), but also to reproductive health. Most anthropologists acknowledge that motherhood is not restricted to reproduction and the caring work done by mothers. The scope of who engages in mothering is not necessarily the birth mother but could be a nannie, a father, a grandmother (Walks 2010, 3). However, in most societies, women take primary responsibility for infant care (Chodorow 1978, 3; Kottak 2008, 223). This underlines how motherhood is connected to contemporary gendered expectations for women. The “naturalness” of wanting and enjoying motherhood is overshadowed by the force of gender expectations that conflate motherhood and femininity (Ireland 1993 in McQuillan et al 2008, 478). These gender expectations are continuously redesigned in response to changing economic and societal factors. Its meaning varies over time and in place resulting in the absence of one essential or universal experience of motherhood (O’Reilly 2004, 5). However, the bearing and rearing of children as a cultural expectation is so powerful, that motherhood in general is considered as the norm and childlessness as irregular (Ulrich and Weatherall 2000 in McQuillan et al 2008, 478). But the experience of motherhood and mothering is not only seen as being forced on women, but mothering is also seen as female-defined and potentially empowering to women (Rich 1976, 275). This turns motherhood into a social construct rather than a natural product (Chodorow 1978, 14).

Summarizing, the female body is subjected to expectations about how to handle sexuality, reproduction and eventually motherhood. These expectations do not always have a positive influence on women’s reproductive health. In the next paragraph we will examine the ways in which the pregnant body is taken care of and prepared for motherhood.

2.3 Caring for the pregnant body (Esther Geurts)

The pregnant body is attended to in different ways. This is not just limited to physical care but also extends to pregnant women being culturally and socially attended to. We will take a closer look at healthcare systems from a medical anthropological perspective. We aim to demonstrate that healthcare systems and authoritative knowledge tend to steer women in a certain kind of direction which is linked to social and cultural norms within society as a whole.

Medical anthropology is a relatively new domain within the field of anthropology. It is rooted in social and cultural anthropology, but is also connected to medicine and other natural sciences (Helman 2007). In order to demonstrate the scope of medical anthropology Cecil G. Helman (ibid., 1) uses the following definition of medical anthropology:

“Medical anthropology is about how people in different cultures and social groups explain the causes of health, the types of treatment they believe in, and to whom they turn if they do get ill. It is also the study of how these beliefs and practices relate to biological, psychological and social changes in the human organism, in both sickness and health. It is the study of human suffering, and the steps that people take to explain and relieve that suffering” (ibid., 1).

Naturally, medical anthropology entails more than just looking at health and disease. We are particularly interested in health standards surrounding pregnancy and birth. Health standards are culturally constructed and may vary over time and in space (Kottak 2013). Beliefs and practices connected to health play a central role in all human societies. In order to study these beliefs and practices it is necessary to look at health as part of a wider culture (Helman 2007, 7-8).

In medical anthropology the body is regarded as more than just a physical organism shifting between health and disease or its normal state and being pregnant. Beliefs are formed around its structure, its function and its social significance. The way in which an individual thinks about and experiences their body is called “body image”. Our society and background have taught us how to recognize and explain the transformations our bodies go through over time (ibid.).

These transformations entail recognizing and explaining the differences between a young and an aged body; a sick and a healthy body; a fit and disabled body; and a normal and pregnant body (ibid., 19). When people are suffering from physical discomfort or want to be attended during pregnancy, they have a number of options in order to receive help or care. In the following paragraph we will take a closer look at some of these options.

2.3.1 Healthcare systems

“All societies have healthcare systems consisting of beliefs, customs, specialists, and techniques aimed at ensuring health and diagnosing and curing illness” (Kottak 2013, 89). In literature a distinction is often made between “traditional” medical practices and beliefs, and “modern” biomedicine. The traditional system refers to traditional local or indigenous healthcare practices mainly based on a specific cultural background. For ages, these practices have provided healthcare for most of the world’s population. The biomedical system,

however, is based on modern western science, in which ideas about health and illness solely focus on physical and biomedical determinants (Stoner 1986, 44-45).

Traditional healthcare often consists of multiple different systems within one society. In these pluralistic societies, local medical systems have usually thrived side by side for ages (ibid.). Health seekers may use a variety of treatment options simultaneously or in sequence. Thus pluralism should be seen as an abundance of local healing practices and beliefs, rather than separate systems of modern and traditional healthcare (Helman 2007; Stoner 1986).

Although we just concluded that modern and traditional healthcare cannot really be seen as two separate systems, this distinction continues to prevail in academic literature for analytical purposes. We too are conscious of the fact that no true distinction exists between the systems, but in order to make comparisons, it is necessary to hold on to these two systems, without neglecting its interrelationship.

According to Helman (2007, 87-88) traditional healthcare offers several advantages over biomedical health practices. One of these advantages is the involvement of the family in diagnosis and treatment. Attention is not solely focused on the patient, but also on the reaction of family and others to the ill person. Healing often takes place in a familiar setting, such as the home or a religious shrine. The relationship between biomedical staff and their patients however is often unequal because of social class, economic position, gender, educational level and sometimes cultural background. This sharply contrasts with local healers who are part of the same community as the people they assist. Within biomedical healthcare different types of problems are dealt with by different doctors, but traditional healers deal with all these problems at the same time. They often have a single causal explanation and provide explanations which are familiar and relate to the social and supernatural worlds (ibid., 87-88).

Although traditional healthcare may have some advantages over biomedical health practices, these advantages are not always recognized. Biomedical healthcare is often seen as synonymous with modernization and claims to be the sole source of healthcare (Cosminsky, 2001). The way in which biomedical healthcare has acquired such a dominant position is explained in the next paragraph.

2.3.2 Authoritative knowledge

In many situations, different knowledge systems exist side by side and people move fluidly between them. However, one knowledge system often tries to gain legitimacy and authority.

When this occurs, this may lead to the devaluation of all other kinds of knowledge (Jordan 1997). The construction of authoritative knowledge could be seen as an ongoing social process, which constructs and indicates power relationships within a society (Wenger 1990 in Jordan 1997). “The power of authoritative knowledge is not that it is correct, but that it counts” (Jordan 1997, 58).

In the medical field, this process is clearly visible when looking at healthcare systems. The biomedical system presents itself as being the only source concerning health, consequently devaluing the knowledge and practices of traditional health providers (Cosminsky 2001). Berry (2008, 166) states that this often creates a situation in which local understandings are denigrated under internationally approved criteria, which claim to demonstrate good quality of care.

One of the processes through which biomedical health practices have become accepted as authoritative knowledge is medicalization. Gabe and Calnan (1989 in Helman 2007, 164) define medicalization as “the way in which the jurisdiction of modern medicine has expanded in recent years and now encompasses many problems that formerly were not defined as medical entities.” Pregnancy and childbirth are examples of a field which is now included into the medical realm (Jordan 1978). We will further explore the way in which pregnancy and birth are affected by these transformations in the following paragraph.

2.3.3 Pregnancy and birth as medical conditions

Within biomedical healthcare pregnancy and birth are no longer considered as natural processes but have turned into medical conditions, and therefore proper subjects for diagnosis and treatment (Jordan 1978; Martin 1996). The pregnant woman is transformed into a “patient”. This liberates her from all normal responsibilities towards herself and towards others. She is helpless in dealing with the problem and should look for medical help (Jordan 1978, 35). The gap between obstetrical birth cultures and those who use traditional midwives seems to have widened and a possible “culture clash” may occur. This is especially applicable to the western world, where women have communicated discontent with aspects of the medical healthcare. The medical view treats pregnancy as an isolated medical event, separated from the woman’s life experience. This accounts for a possible gap between the woman and the obstetrician in the way they each evaluate the quality of the experience and how they decide who should control the method and the pace of the birth. The obstetrician has specialized knowledge of childbirth, whereas the pregnant woman usually does not.

However, she has the capacity to sense and respond to her body (Helman 2007, 169-173). This “clash” corresponds to the previously discussed concept of the authority of knowledge.

However, in contrast to this technological model of birth, most babies are still delivered with the help of a birth attendant (ibid.). These birth attendants are predominantly women themselves. The knowledge, beliefs and practices are passed on by women, sometimes from mother to daughter and often through apprenticeships (Jordan 1993, 192). Throughout Africa, Asia, Latin America and the Caribbean, birth attendants are found in almost every village (Helman 2007).

2.4 Pregnancy and birth: conclusion (Esther Geurts and Renate Klijstra)

In the introduction of this chapter we stated that birth is not just a biological event but should be seen as culturally and socially constructed. In this chapter we explained what is meant by culturally and socially constructed when looking at pregnancy and birth using concepts originating from feminist and medical anthropology.

In the first paragraphs we discussed gender, sexuality, reproduction, reproductive health and motherhood and their interrelatedness. Gender and sexuality highly influence the (pregnant) body and consequently women are subjected to expectations about how to be a good wife and mother. The intertwining of sexuality and gender has resulted in men being seen as more powerful than women, which subsequently has influenced women's reproductive health.

In the last paragraphs we examined healthcare systems and authoritative knowledge. We demonstrated that power relations are apparent in healthcare systems as well, which are receptive of the authority of knowledge, and thereby seem to force women in a certain direction on how to look after their bodies during pregnancy and birth.

All in all, this chapter shows that within communities pregnant women are subjected to expectations, laws, and social norms; be it through gender norms and taboos concerning pregnancy, through the healthcare systems they are part of or through the eyes of the society they live in.

Chapter 3: Gender and sexuality

Renate Klijnstra

In this chapter we will put gender and sexuality in the empirical context. We will first take a look at how men and women in Latin America are often sexually classified. The popular perceptions about male and female sexuality have far wider ranging social consequences for women than for men. Secondly, we will describe what these gender categorizations mean for the female inhabitants of San Juan La Laguna and how the taboo on their sexuality leads to a lack of knowledge concerning the body.

3.1 *Marianismo* and *machismo*

Gender and sexuality in Latin America are inseparably connected to each other (Melhuus and Stølen 1996, 27). The representation of men's sexuality is different from the representation of women's sexuality (Chant and Craske 2003). If we look at the existing literature about women and sexuality in Latin America, stereotypes have tended to stand out (ibid., 131). Women are often depicted as sexually repressive, self-sacrificing and suffering mothers, whereas sex is only endorsed when linked to marriage and reproduction, and notions of guilt, sin, and restraint preponderate (Chaney 2014, 19; Chant and Craske 2003, 135; Jelin 1997, 76).

In academic literature about gender and sexuality in Latin America, the concept *marianismo*, introduced by Stevens in 1973, is often mentioned (Sanabria 2007, 152). Stevens describes images of the ideal Latin American woman, who is "semi-divine, morally superior to and spiritually stronger than a man" (Stevens 1973, 91). The identity of Latin American women pivots around being a self-sacrificing mother, caring for children, and being subservient to men (Sanabria 2007, 152). Latin American women "are seemingly more than willing to accept the burdens thought intrinsic to womanhood and motherhood" (ibid., 152). *Marianismo* is related to the Virgin Mary, although this relation led to contradictions regarding Virgin Mary as the perfect woman. Sex is necessary for a woman to fulfill her destiny (that is to say motherhood), so the twin ideal of mother and virgin is impossible for a woman to achieve (Chant and Craske 2003, 135).

The counterpoint to *marianismo* is *machismo*, which refers to ideals and practices that determine male identity and masculinity (Sanabria 2007, 152). "The ideal masculine (*macho*)

is fearless, in the face of danger and willing and able to safeguard the well-being and honor of his family, over which he exercises unquestioned authority, especially over women” (ibid., 152). Moreover, the ideal *macho* is publicly heterosexual, with a “natural” and “uncontrollable sexual drive” (ibid., 152), which leads to having numerous relationships with different women, and numerous children (Gutmann 1997, 229 in Nencel 2007, 101). The *macho* is active, and defies passivity, often associated with femininity (Stevens 1973, 90).

Gender categorizations in Latin America are both complex and ambiguous, because “it appears that there are different schemes of evaluation for men and for women” (Melhuus and Stølen 1996, 27). Men are classified according to degrees of masculinity, on which masculinity appears to be continuous, i.e. you are more or less of a man (ibid., 27). On the contrary women are discretely classified according to their moral character, on which a dichotomy exists - you are either a good (decent) or a bad (indecent) woman (ibid., 27).

Navarro (2003, 258) is doubtful whether the models of *machismo* and *marianismo* are applicable to indigenous women, and Browner and Lewis (1982 in Navarro 2003, 258) doubt if these models are not too timeless, static, and unconnected to the varied socioeconomic conditions in the women's lives. The use of the concepts *marianismo* could be problematic, since the universal category of women as self-sacrificing, powerless, dependent, and passive tends to justify the status quo on issues of sex domination and class oppression (Chant and Craske 2003, 15; Moraes-Gorecki 1981 in Navarro 2003, 258). Although it is debatable whether these models of *machismo* and *marianismo* are valid, women in San Juan La Laguna often referred to *machismo*. Whenever we asked the women to elaborate on that, they referred to alcohol problems, jealousy, and the lack of responsibility¹⁵. Especially women who are left by their partners, and who have to carry the burden (namely raising the children on their own, often on a limited budget) blame their situation to *machismo*. Men are often depicted as violent who abuse their oppressive power over women¹⁶. Some women claimed that they obey their partners, for fear of (more) violence or sexual abuse¹⁷.

Pilar, 30 years old, just gave birth to a baby girl, her second child. Her pregnancy was not planned, since her son is still young. Pilar's husband left her only 1.5 weeks before she gave birth. Her husband had been unfaithful for a long time, but Pilar did

¹⁵ i.a. Interview Olivia 02/03/2017, interview Pilar 07/03/2017, interview Ricarda 06/03/2017.

¹⁶ i.a. Interview Gabriela 14/03/2017, interview Hercules 20/03/2017, conversation Pilar 17/03/2017.

¹⁷ Interview Aloise 20/03/2017, conversation Pilar 22/03/2017, conversation Ricarda 10/03/2017.

not have the courage to confront her husband. She was afraid to be beaten, and moreover to be blamed by her family, who already had warned her for the disloyalty of her husband before their marriage. When she finally confronted him with the fact he was having contact with several women, he hit her and left her without the intention to ever have contact with her again¹⁸.

Pilar is an example of a woman who stayed with her unfaithful husband for a long time without complaining about his infidelity. Her anxiety for painful consequences however sadly proved to be founded. Pilar categorized her husband as a *macho*, but trivialized his attitude claiming that “all men from Santa Clara La Laguna act like that¹⁹”.

When women mention *machismo*, the male/female dichotomy and housewife/worker dichotomy are also referred to. Men are economically more autonomous, since women, in most cases, work at home and men have (better) paying jobs; the men work often like sellers, fishers, and farmers, while women who are having jobs, work like laundry women or weavers²⁰. If women live independently, they face economic challenges²¹: in their struggle for achieving more financial security, women sometimes feel forced to stay with their partner no matter what he does or how he behaves. However, many women point out that gender relations are changing, and women increasingly have more rights²².

When women mention *machismo*, the sexual behaviour of men is also referred to. Men are often depicted as hypersexuals, who sometimes want to have “*amantes*²³” besides their wives. Men sometimes believe that after death, God will give them more prestige in heaven when they have multiple children²⁴; this perception seems to be based on the biblical passage of Genesis 1:28, in which God commands human beings to be fruitful (Genesis 1:28). This idea goes hand in hand with the concept of gender identity which claims that men are more masculine when having numerous children (cf. Stets and Burke 2000, 997). On the other hand, women may want to limit the size of their families. Ways and reasons for doing so are discussed in the next paragraph.

¹⁸ Interview Pilar 07/03/2017, participant observation Pilar 17/03/2017, conversation Pilar 22/03/2017.

¹⁹ Interview Pilar 07/03/2017, participant observation Pilar 17/03/2017, conversation Pilar 22/03/2017.

²⁰ i.a. Conversation Casia 13/03/2017, interview Jada 02/03/2017, interview Persy 21/04/2017.

²¹ i.a. Conversation Casia 13/03/2017, participant observation Olivia 07/04/2017, participant observation Pilar 17/03/2017.

²² i.a. Interview Adoración 13/03/2017, interview Valería 10/04/2017, interview Vianca 07/03/2017.

²³ Meaning: “lovers”.

²⁴ Interview Hercules 20/03/2017.

3.2 Family planning

According to the *Puesto de Salud* in San Juan La Laguna, the majority of women plan their families²⁵. The most popular method is an injection of depo-provera, which can be injected by a nurse every one, two or three months²⁶. Other available birth control methods destined for women are a collar to keep track of the menstrual cycle through counting; birth control pills; implants; IUD and sterilization²⁷. The available options to prevent pregnancies destined for men are sterilization and condoms, but these forms are unpopular²⁸.

Medical staff and (sexual) health educators are supposed to educate and inform women about possible methods to limit family size. Regrettably, not all mothers receive the right information to prevent unplanned pregnancies. There is, for example, a perception among women that they cannot get pregnant while breastfeeding. This method is only considered safe if they have not had their menstruation yet²⁹. The *Puesto de Salud* in Pasajquim distributes brochures about this “breastfeeding-menstruation method³⁰”.

Half of our research population in San Juan La Laguna stated not to have planned their pregnancies.

Carrola, 29 years old, 8 months pregnant with her second child: “Planning your family is really important to me, because we are poor, and we do not have enough to give lunch to them [our children]. If we have 2 or 3 children, that is already many to educate and to provide them with everything they need. And then for me, it is very important for the mother to have good health³¹”.

Carrola had her first child at the age of 21. At the time she did not know anything about family planning, and her pregnancy came as a surprise. After she had given birth to her first child, she was informed by a doctor about different methods of anti-conception. She identifies herself as being poor, and therefore she believes anti-conception is needed to not

²⁵ Interview Gabriela 14/03/2017.

²⁶ Conversation Casia 13/03/2017, interview Gabriela 14/03/2017.

²⁷ Interview Hercules 20/03/2017.

²⁸ Interview Gabriela 14/03/2017, interview Hercules 20/03/2017, conversation Rex 08/03/2017.

²⁹ Interview Hercules 20/03/2017.

³⁰ Participant observation *Puesto de Salud* Pasajquim, 20/03/2017.

³¹ Interview Carrola 20/03/2017. Original: “Pues para mi es muy importante planificar, porque somos familias de casos recursos, y no tenemos los suficiente para darle a almorzar. Si tenemos 2 o 3 niños y son muchos para poder crearlos y darlos todo lo que ellos necesitan. Entonces para mi es muy importante igual para que la madre tenga buena salud”.

raise more children than you could take care of. The women in San Juan La Laguna who did plan their pregnancies, did so for a reason too. They pointed out the importance of being able to take care of a child economically and physically³². Witnessing some families in San Juan La Laguna suffering from poverty has helped some pregnant women and young mothers realize the social-economic consequences of having children³³. The women we spoke to seem to adjust the number of children to their means and capability of raising them³⁴. In retrospect Carrola wished she had had her first child at a later stage of life. Her case is not exceptional; the majority of the pregnant women in San Juan La Laguna we spoke with and who already have children believed they were too young when they had their first child. They would have planned and started having children later, had they known about family planning and how tough maternity is³⁵. When asked for more explanation, they refer to their economic situation and their relationship at that time. When we asked for advice about how to prepare for a pregnancy, a stable relationship was named as one of the main prerequisites³⁶. We were advised to discuss pregnancy with a partner before having intercourse³⁷.

Mireya, 21 years old, was pregnant with her first child. Her family-in-law is relatively rich and in direct contact with foreigners, since her mother-in-law has her own weaving institute and guesthouse. She is well educated, verbally strong, and seems to collect her thoughts before speaking. “To be a mother is to plan well. Think about it, analyze it. And also look for a good partner. Because there are partners who do not take responsibility for being with a girl. Then when the girl gets pregnant and the boys don’t want to know .³⁸”

Mireya, mentions that motherhood goes along with the right partner, and a considerate planning. Women who have a partner and planned to get pregnant, sometimes call their baby “a reward” for their relationship³⁹. Although the idealized picture is that pregnancy occurs

³² i.a. Interview Carrola 20/03/2017, interview Jemisa 03/04/2017, interview Laurana 06/03/2017.

³³ i.a. Interview Carrola 20/03/2017, interview Jada 02/03/2017, interview Lorda 03/04/2017.

³⁴ i.a. Interview Carrola 20/03/2017, interview Jada 02/03/2017, interview Laurana 06/03/2017.

³⁵ i.a. Interview Elodia 20/03/2017, interview Kesare 06/03/2017, interview Olivia 02/03/2017.

³⁶ Interview Laurana 06/03/2017, interview Olivia 02/03/2017, interview Pilar 07/03/2017.

³⁷ Interview Laurana 06/03/2017, interview Olivia 02/03/2017, interview Pilar 07/03/2017.

³⁸ Interview Mireya 03/03/2017, Original: “Ser madre es planificar bien. Pensarlo, analizarlo. Y también buscar una buena pareja. Porque hay parejas que no se responsabilizan para ser con chica. Después la chica está embarazada y el chico dice *no*”.

³⁹ Interview Adam 14/03/2017, interview Amina 14/03/2017.

within a marriage, in practice few pregnant women are officially married⁴⁰. When women talk about their experiences regarding pregnancy, they often talk about the lack of a partner (in case of single motherhood)⁴¹ or the presence/good assistance of a partner (if any)⁴².

Some women state that the responsibility to not get pregnant is entirely left to them.

Laurana, 25 years old, 8 months pregnant of her second child states: “If a husband approaches you, you get pregnant. That's why you have to plan⁴³”.

Laurana used to take anti-conception, and candidly shared her experiences with us. She was an exception. Furthermore, her story illustrates that in case of using anti-conception, women are supposed to undertake action, before having sex. The unpopularity of men using anti-conception underlines that men and women are supposed to deal with their sexuality in different ways⁴⁴.

Not only the couple may be concerned with their sexuality. Mothers-in-law exercise an immense influence on women to the point of some of them even forbidding their daughters-in-law to use birth control to prevent them from having sex with other men⁴⁵.

Some women fear that the possibility to get pregnant always remains, even when using contraceptives⁴⁶. There are women who fear the effects of unknown “chemicals”, which, according to some, may result in an infection or a language deficiency of their (unborn) child⁴⁷. The fact that some women experienced gaining weight after using contraceptives may also have contributed to their unpopularity⁴⁸. Women seem to prefer the rhythm (safe period) method, which is widely used among women in San Juan La Laguna

⁴⁰ A difference between “*unidos*” and “*casados*” exists, on which “*unidos*” mean that a couple is together, and only “*casados*” refers to an official marriage; interview Persy 21/04/2017, document analysis *RENAP* 19/04/2017.

⁴¹ i.a. Interview Adoración 13/03/2017, interview Cristiana Lea 20/03/2017, conversation Rosealma 03/04/2017.

⁴² i.a. Interview Laurana 06/03/2017, conversation Mireya 12/03/2017, interview Vianca 07/03/2017.

⁴³ Interview Laurana 06/03/2017. Original: “Si entran un esposo contigo, te quedas embarazada. Es por eso que tienes que planificar”.

⁴⁴ Furthermore, fear about becoming masculine when using anti-conception limits its use in some parts of Guatemala (Dudgeon 2016).

⁴⁵ Conversation Casia 13/03/2017, interview Gabriela 14/03/2017, interview Hercules 20/03/2017.

⁴⁶ Interview Hercules 20/03/2017, interview Jemisa 03/04/2017.

⁴⁷ Interview Hercules 20/03/2017, interview Jemisa 03/04/2017.

⁴⁸ Interview Jemisa 03/04/2017, interview Laurana 06/03/2017.

who wish to plan a family, but who would like to avoid biomedical means⁴⁹. This method is sometimes carried out through using a beaded collar to help counting the days of the menstrual cycle.

During our fieldwork, we often struggled to discuss sexuality and the use of anti-conception with our informants. This is related to taboos which subsequently result in ignorance, which will be discussed below.

3.3 Taboos and ignorance

It was hard to talk about sexuality with our informants, since sexuality is not a subject people easily talk about. On the contrary, the topic of sexuality is surrounded by silence (Steenbeek 1995, 59), whereby “good” women are expected to be ignorant about sex and passive in their sexual interactions (cf. Gupta 2000, 87). The concealment of sexuality in Latin America is highly connected to religion. Catholicism, and nowadays also Pentecostalism, emphasize sex within the confinements of monogamous marriage and denounces contraceptive use (Chant and Craske 2003, 137), which results in the use of anti-conception still being contested (Carlson 2007). According to some Guatemalans, having sex without the aim of becoming pregnant is morally unacceptable (Dudgeon 2016; Fischer and Hendrickson 2003). This is in accordance with gender categorizations, which state that women are classified according to their moral character: there is a fine line between being a decent or an indecent woman (cf. Melhuus and Stølen 1996, 27). Thus, influenced by religion and existing perceptions about morality, sexuality is surrounded by taboos.

Especially teenagers often giggled when we asked them questions concerning sexuality. Giggling was probably just a mechanism for the younger girls to avoid talking about issues they were not knowledgeable about: pregnant women (particularly teenagers) tend to be fairly ignorant about sexuality⁵⁰ and pregnancy can come as a huge shock to them.

When Rosealma (15) did not have her period for three months, she approached her mother-in-law to ask what the cause could be. “You are pregnant”, replied the woman she recently moved in with. Rosealma did not have a clue what being pregnant meant, nor that a baby girl was growing in her womb⁵¹.

⁴⁹ Conversation Casia 03/04/2017, interview Hercules 20/03/2017.

⁵⁰ Participant observation *Oficina de la Mujer* 13/03/2017, 20/03/2017 and 03/04/2017, interview Persy 21/04/2017.

⁵¹ Participant observation *Oficina de la Mujer* 13/03/2017, interview Rosealma 13/03/2017.

In the case of Rosealma, it becomes clear that for some women pregnancy turns out to be a completely new discovery of the workings of their bodies. These women did not have a clear idea about how a woman becomes pregnant and what pregnancy entails⁵². The ignorance and taboos concerning one's sexuality and working of one's body, is part of a bigger problem. Women, like Rosealma, do not have much access to (sexual) education, which affects their reproductive health: for them, it is difficult to be informed about sexual activities, risk reduction or to be proactive in negotiating about safer sex (cf. Gupta 2000, 87). On the contrary men in San Juan La Laguna, who seem to have more chances on education, work, and income, are more autonomous than women. They often seem to have more power and are more dominant in sexual relations: they are the ones who decide when, where, and how sex takes place (cf. Gupta 2000, 88). Women's ignorance concerning sexuality, and moreover their belief in *machismo* and *marianismo*, results in gender inequality, and therefore, influences women's reproductive health.

3.4 Conclusion

As we have seen in this chapter, gender and sexuality in Latin America are inseparably connected to each other. Women are often depicted as sexually repressive, self-sacrificing and suffering mothers, while men are stereotyped as sexually active, violent and irresponsible fathers. In San Juan La Laguna, these different schemes of evaluation lead to an unequal classification: men are classified according to degrees of masculinity, while women are classified by being good (decent) or bad (indecent), with the Virgin Mary as role model. As a consequence, women cannot always talk openly about sex or share information with others due to the taboos on sexuality. Teenagers and young women are ignorant about sexuality. They do not have sufficient knowledge about the workings of their bodies. From conversations we had with women who already had children we learned that they felt they were too young and ignorant at the time they became pregnant. They admitted not to know much about sexuality before becoming a mother. The ignorance concerning the working of their bodies, and the taboo on sexuality, affects women's reproductive health.

⁵² Interview Carrola 20/03/2017, interview Persy 21/04/2017, interview Rosealma 23/03/2017.

Chapter 4: Motherhood

Renate Klijnsstra

Guatemala has the biggest and youngest population in Latin America: almost half of the population in Guatemala is under 19 years old. More than 1 in 5 girls in Guatemala give birth before their 18th birthday (Wings 2015). The birth rate is more than three children per woman and among its rural and indigenous population it is even higher; indigenous women on average have 3.7 children per woman (CIA 2016; Wings 2015). Indigenous women perceive pregnancy as a normal, rather than a pathological life event (Sargent and Rawlins 1991 in Berry 2008). Giving birth is perceived as difficult, but a normal part of family life. Therefore, birth is accommodated into the routines of daily life (Jordan 1983).

In this chapter we will discuss motherhood in Latin America, with the focus on motherhood in San Juan La Laguna. Influenced by Christian religion and myths, motherhood is seen as sacred and something to strive for. Remaining childless is judged and pitied by society. The social pressure on motherhood is strong, but this does not result in mothers gaining a better position within society.

4.1 “*Realizarse como mujer*”⁵³”

Martin (1990, 478) states that women’s connection to childbirth gives them a “unique opportunity to fulfill God’s will” (Martin 1990, 478 in Chant and Craske 2003, 10). This is in accordance with Dillen (2009, 99), who mentions that pregnancy is regarded as a goal one should strive for, as long as it is God’s will (ibid., 99).

Although pregnant women in San Juan La Laguna tend to refer to physical and mental malaise, and all the discomforts that come along with being pregnant (sleeping problems, back pain, vomiting⁵⁴) big smiles appear on their faces, every time they talk about their pregnancies⁵⁵. Usually, they indicate that they are happy to be pregnant and about to become a mother,⁵⁶ even if they have to quit their education or jobs to be able to fulfill the role as mother⁵⁷. Mireya told us that all the suffering during her pregnancy and during childbirth was

⁵³ An expression, which refers to becoming a woman when becoming a mother.

⁵⁴ Interview Juliana 04/04/2017, interview Renata 20/03/2017, interview Ricarda 06/03/2017.

⁵⁵ i.a. Participant observation Diega 08/04/2017, participant observation Mireya 03/03/2017, participant observation Vianca 07/03/2017.

⁵⁶ i.a. Interview Aina Elina 20/03/2017, interview Beatrisa 05/04/2017, interview Carrola 20/03/2017.

⁵⁷ i.a. Interview Diega 08/04/2017, interview Henriqua 13/03/2017, interview Jimena 03/04/2017.

worth it. She had immediately forgotten about the pain she had been going through, when she first had her newborn in her arms⁵⁸. Vianca, who recently gave birth, said to have tears in her eyes when she, after everything she endured, saw her baby for the first time⁵⁹.

Motherhood is regarded as “*parte de vida*”⁶⁰ and to some women, motherhood is the most important event in their lives⁶¹. For indigenous women in San Juan La Laguna, motherhood has even become an innate quality and inseparable from the fact of being a woman (cf. Hernandez and Murguialday 1993, 41). In San Juan La Laguna, pregnant women and young mothers confirm that having a baby gives a sense of being more feminine than without one⁶², because the birth of a child is a privilege to women⁶³. Feeding children, facilitating good hygiene, giving vitamins and proper food, and taking care of a baby is seen as a woman's duty⁶⁴.

According to our informants, womanhood is not only associated with having children, but also with a partner, God and the home. This means that men are predominantly regarded as farmers, and women as housewives⁶⁵. Not every man allows his wife or girlfriend to work outside the house⁶⁶. A woman is expected to wash, to clean the house and to cook⁶⁷. A good woman needs to be a good spouse⁶⁸. By proxy of her husband, she becomes more powerful⁶⁹ and helping him is seen as an obligation⁷⁰. The women refer to God when they talk about how they are able to become not only good housewives, but also good spouses and mothers. They believe God gives a woman the strength to be that powerful⁷¹.

Nowadays, being a woman in Latin America is not automatically limited to motherhood, although this idea is still vivid among Latin American women (Margulis and Urresti 2015). However, the essentializing models of gender and sexuality about the responsibilities of an ideal “mother” or “woman” vary according to contexts and historical periods (Sanabria 2007, 167): for many men and women in San Juan La Laguna, children

⁵⁸ Conversation Mireya 12/03/2017.

⁵⁹ Conversation Vianca 19/03/2017.

⁶⁰ Interview Mireya 03/03/2017.

⁶¹ Interview Elodia 20/03/2017, interview Jada 02/03/2017, interview Mireya 03/03/2017.

⁶² i.a. Interview Carrola 20/03/2017, interview Jada 02/03/2017, interview Ricarda 06/03/2017.

⁶³ Interview Jada 02/03/2017, interview Mireya 03/03/2017, interview Ricarda 06/03/2017.

⁶⁴ i.a. Interview Aina Elina 20/03/2017, interview Aloise 20/03/2017, interview Beatrisa 05/04/2017.

⁶⁵ i.a. Conversation Casia 13/03/2017, interview Jada 02/03/2017, interview Valería 10/04/2017.

⁶⁶ i.a. Conversation Casia 13/03/2017, interview Jada 02/03/2017, interview Valería 10/04/2017.

⁶⁷ i.a. Interview Elodia 20/03/2017, interview Juliana 04/04/2017, interview Renata 20/03/2017.

⁶⁸ i.a. Interview Aina Elina 20/03/2017, interview Carrola 20/03/2017, interview Elodia 20/03/2017.

⁶⁹ i.a. Interview Aina Elina 20/03/2017, interview Elodia 20/03/2017, interview Jada 02/03/2017.

⁷⁰ i.a. Interview Carrola 20/03/2017, interview Jada 02/03/2017, interview Pilar 07/03/2017.

⁷¹ Interview Lorda 03/04/2017, interview Pilar 07/03/2017.

define their lives and identities (cf. Chant and Craske 2003, 14). The social imperative of motherhood is so strong that women who wish to postpone their first pregnancy or choose to remain childless are commonly stigmatized as selfish (cf. Rosero-Bixby et al. 2009, 187). We started to realize the huge pressure women in San Juan La Laguna experience to get pregnant, when they started to share their views on childless women. Based on various conversations, it appeared that women put a lot of pressure on themselves to become mothers. With this social pressure in mind, a pregnancy can feel as a relief. This is in accordance with the theory of motherhood being considered the norm and childlessness an irregularity (Ulrich and Weatherall 2000 in McQuillan et al. 2008, 478). Women who cannot have children, are pitied a lot by other women: for many women being infertile is a great fear⁷². Pregnant women normally go to a doctor or *comadrona* for these “fertility problems”.

After having been married for as short as a period of six months girls in their early twenties already start worrying about not being able to have children.

Mireya (21): “When I discovered my pregnancy, I felt really happy and emotional. It will be my first baby, and after I had seen children of other mothers I said: *Why can't I?* They could (be pregnant), and I was not after one year of trying⁷³”.

4.2 Being a mother in San Juan La Laguna

Once women in San Juan La Laguna have proven to themselves and society that they can get pregnant and give birth to a child with the help of God, they may start worrying about the consequences of becoming a mother again. They may indicate to have a child who is still young and they would rather have waited longer with having another one⁷⁴. Another worry among women in San Juan La Laguna, is their reputation as mothers. In a small village like San Juan La Laguna, women are dealing with interference of the community concerning their pregnancies, families, and their fulfillment of motherhood. This means that women are afraid of the social consequences (gossip, a bad reputation) when they deviate from the norm.

⁷² Interview Jada 02/03/2017, interview Mireya 03/03/2017, interview Ricarda 06/03/2017.

⁷³ Interview Mireya 03/03/2017. Original: “Cuando yo me descubrí que esta embarazada me pone muy feliz y emocionada. Porque es mi primer bebé y también he visto bebés de otras mamás y yo digo: Porque no puedo? Si ellas han podido y nunca estaba embarazada hasta el siguiente años”.

⁷⁴ Interview Pilar 07/03/2017, interview Renata 20/03/2017.

Olivia is a 37-year-old teacher, who recently married for the second time. She already had two children aged 19 and 15, before becoming pregnant. Although she believes that God sent her a new baby, she had not planned this pregnancy. She had not had contact with her two children for a long time, since she decided to marry again and started to live with her 26-year-old husband. She had left her children at her parents' house. Olivia faces many difficulties regarding her 26-year-old husband, who daily succumbs to alcohol. She decided to put the interest of herself and her children first by moving back to her parents, who then took it badly on her. Her family blamed her for the situation she was in, not her husband. After giving birth to her third child, she sometimes suffers from loneliness even though her house is filled with family members all the time.

Olivia is an example of a woman who hardly got any support during her pregnancy. She is seen as immoral, since she chose lust above her children. This results in receiving little if any compassion for her situation. She constantly pities herself while at the same time referring to God's will:

“The third child, such a surprise. I said, I don't know... It is not possible. I could not accept [the pregnancy], because of the alcohol problems of my husband. But after some time, I understood and said *God knows why He sent me another child*. I have to continue and fight for Him. And now I feel more tranquility, I am now waiting for the day [to give birth]⁷⁵”.

We spoke to several women in San Juan La Laguna, who were also regarded as immoral mothers by the community. They too constantly referred to God, and stated that all the suffering just happened to them. This way of thinking allows them to perhaps shirk their own responsibilities and put the blame beside themselves. Although Olivia feels lonely and guilty about her past, she tries to make up for that by being a perfect mother. She achieves this by showing the community that she is even prepared to move in with her parents for the sake of her children.

⁷⁵ Interview Olivia 02/03/2017. Original: “El tercer bebé, una sorpresa. Yo dijo, yo sé... No es posible. No podía aceptar. Por los problemas de mi esposo del alcoholismo. Pero después comprendí, y dije, Dios sabe porque me manda el bebé. Es seguir luchar por Él. Y ahora más tranquila, ahora esperando el día”.

Another example of a woman who did not meet the societal norms is 21-year-old Ricarda:

Ricarda is pregnant with her first child. After being sexually abused by her stepfather and ex-partner (who left her), she does not receive much support from her family and the community. She projects her loneliness on the still unborn child and looks to him for support. “It is like company for life. Moments when one felt sad. For example, when I feel sad or desperate, I cry. Because my life has been like this. But after that, when I am even more sad, my fetus starts with his ribs [in the womb], and then my faith starts. We [both] know the sadness. It makes me laugh and I say: This is my happiness⁷⁶”.

Women in San Juan La Laguna who are single or unhappy in their relationships, indicate that you solely have to think about your child⁷⁷. Their baby becomes their best friend, buddy or distraction⁷⁸. Their loneliness makes place for an object to focus on and embrace. They want to have something in their arms, something of and for themselves, and something to fight for⁷⁹. Ricarda is an example of somebody who complains that she has nobody, except for the still unborn fetus in her womb. She is, like other women in San Juan La Laguna, willing to give everything for her baby.

4.3 Conclusion

When talking about motherhood with women in San Juan La Laguna, the dichotomy between good and bad seems to apply. Women indicate that you are only a good mother, if you can take responsibility for your children. This means that your socio-economic situation should be favorable, you need a suitable partner, and you must provide your child(ren) with the necessary hygiene, protection and food. This explains why pregnant women and young mothers often refer to the health of their children: you must ensure that your child does not get sick and in case this does happen, you must make sure you see a doctor right away⁸⁰. Women are expected to give up everything in order to become a good mother. No one seems

⁷⁶ Interview Ricarda 06/03/2017. Original: “Es como una compañía para toda la vida. Momentos cuando una se sentía triste. Por ejemplo yo cuando me sentía triste, cuando me siento desesperada, me pongo llorar. Porque ha sido mi vida o algo así. Pero después, que estoy más triste, el bebé empieza con sus costillas, empieza me fé, y sabemos la tristeza. Me pongo reír. Y digo: es mi felicidad, digo yo”.

⁷⁷ i.a. Interview Jada 02/03/2017, interview Olivia 02/03/2017, interview Vianca 07/03/2017.

⁷⁸ i.a. Interview Aloise 20/03/2017, interview Ricarda 06/03/2017.

⁷⁹ i.a. Interview Olivia 02/03/2017, interview Ricarda 06/03/2017, interview Rosealma 20/03/2017.

⁸⁰ i.a. Interview Carrola 20/03/2017, interview Laurana 06/03/2017, interview Sara 03/04/2017.

to object to the early age a woman gets pregnant, as long as the community is convinced about her qualities as a mother.

Women are able to fulfill God's will by having children. However, it must happen within the confinement of a monogamous marriage. Although womanhood in San Juan La Laguna is regarded as inseparable from being a mother, women who do not meet the criteria of being in a marriage, will not receive much support during and after their pregnancies. So, although the social impetus on motherhood is strong, the economic and social position of women within society does not grow exponentially with motherhood.

Chapter 5: Healthcare

Esther Geurts⁸¹

“*Knock, knock, knocking on heaven’s door*” blares the radio at a high volume. A woman is lying in bed as waves of pain come and go. She is surrounded by three nurses. Her sister, who accompanied her down to the neighbouring village, is quietly reading a book in a room nearby. Hours pass, but the pain keeps coming. She isn’t making much progress. As time passes, her body becomes motionless. The room around her grows quiet, as all the energy seems to be taken away. The only sounds to be heard are the radio and a nurse popping her bubble gum. At last, a drip is injected, in order to let the exhausted woman regain her much needed strength. As the night grows nearer, her face unexpectedly brightens. Everyone in the room seems to be willing to help her finish the tough job ahead. As the waves of pain become stronger and more frequent, the woman groans and once even screams. She is lifted out of bed by a friendly looking male nurse. While standing on two feet, at last she lets gravity help her. Moments later a hairy newborn cries for the very first time in his life. While looking at all the people present in the room, the now mother of four whispers: “*Gracias por estar conmigo*”⁸².

Mila Vina, unlike many other indigenous women, gave birth in a birth clinic in San Juan La Laguna. In rural areas in Guatemala most births tend to occur at home with a midwife in attendance (Chary et al. 2013; Glei and Goldman 2000). Traditional birth attendants are present at an estimated 50-90% of all births and over 90% in some rural areas (Maupin 2008).

In this chapter, we give an overview of the available pregnancy-related healthcare options in San Juan La Laguna. We will also zoom in on the mutual relations between the organisations. But first, we will look at how healthcare is generally structured in Guatemala.

5.1 Healthcare in Guatemala

In Guatemala, traditional health practices coexist with formal biomedical healthcare, which renders healthcare pluralistic (Glei and Goldman 2000). This is in accordance with the idea that pluralism should be seen as an abundance of local healing practices and beliefs, rather

⁸¹ Paragraph 5.6 was written by Renate Klijnstra.

⁸² Meaning: “Thank you for staying with me”; participant observation Mila Vina 10/04/2017.

than separate systems (Helman 2007; Stoner 1986). Women may use the help of a nurse and a *comadrona* simultaneously. *Comadronas* usually work independently without being associated with a particular organisation. Nurses and doctors are part of the formal healthcare system run by the Public Ministry of Health (MOH) and the Guatemalan Social Security (IGSS). The Public Ministry of Health serves the most impoverished via public health services, while the Guatemalan Social Security (IGSS) serves the working class and their families. Finally, a broad network of private clinics and hospitals led by doctors and nurses services the most affluent in the country (Houston 2001 in Foster et al. 2003).

5.2 Healthcare in San Juan La Laguna

In the municipality of San Juan La Laguna an estimated 420 babies are expected to be born in 2017⁸³. As far as formal healthcare facilities led by the government are concerned, San Juan La Laguna seems no different from any other indigenous town in Guatemala and thus houses a *Puesto de Salud*. When taking into account the presence of NGOs, however, San Juan La Laguna, unlike similar towns, is fortunate in having multiple charity organisations at its service.

This means that women in San Juan La Laguna can choose from a variety of pregnancy-related healthcare options in their hometown. Alternatively, they may also resort to private healthcare services in the neighbouring town of San Pedro La Laguna, be it that these services are very costly and therefore not accessible to everyone. Next to governmental healthcare, private healthcare, healthcare led by NGOs, pregnant women may use the services of the so called *comadronas*. The latter will be discussed in chapter 6.

5.3 State-owned healthcare

Regarding governmental healthcare in San Juan La Laguna, a distinction is made between a *Puesto de Salud*, which is situated in San Juan La Laguna, a *Centro de Salud*, which is situated in the neighbouring town of San Pedro La Laguna and a hospital, the closest being in Sololá. The main difference is that a doctor is only available in a *Centro* and not in a *Puesto*. However, the *Puesto de Salud* in San Juan La Laguna benefits from the fact that it has facilitated a *Centro de Atención Permanente* (CAP) since 2009. This means that a nurse is

⁸³ This number accounts for San Juan La Laguna including Pasajquim, Panyebar and Palestina; interview Gabriela 14/03/2017.

present 24 hours a day, 7 days a week⁸⁴.

Pregnant women can visit the *Puesto de Salud* in order to receive prenatal care, which primarily consists of receiving a series of three vaccinations and monthly prenatal vitamins. It is also possible to give birth here. However, when complications arise it is necessary to refer a woman to the hospital in Sololá, which is owned by the government. Common motives for referring women are when she has reached 40 weeks of pregnancy but has no dilatation or when she has reached 40 weeks of pregnancy but has no contractions. Other reasons to refer are in case of twin pregnancies or premature delivery. When the baby is not in the right position or when a woman suffers from high blood pressure, she should be referred as well. In the hospital of Sololá cesareans can be performed as doctors are on duty here. Women who work for the government usually have a health insurance through which they are able to use the services of certain assigned hospitals.

Olivia is a teacher and therefore has an insurance. However, when she was pregnant she could not go to the hospital in Sololá, she had to go all the way to Guatemala City, because her insurance only covered treatment in this specific hospital. From San Juan La Laguna it takes hours to get there, which may increase the risk of complications⁸⁵.

The hospital generally has more resources than governmental healthcare centres in rural areas. The *Puesto de Salud* only has the disposal of a doppler ultrasound (only features sound), fetoscope (which is a special kind of stethoscope for unborn babies), a device to measure the blood pressure and a device to measure the amount of glucose in someone's blood⁸⁶. As to postnatal healthcare, the *Puesto de Salud* offers vaccinations to newborns. The *Puesto de Salud* employs four auxiliary nurses and four professional nurses⁸⁷.

All state-owned centres and hospitals offer care for free. It must be said, though, that these state-owned centres often face shortages of medically-trained personnel, medication, prenatal vitamins, vaccinations and other basic resources. According to Berry (2008; 2010), women generally have a lack of trust in the quality of care provided.

⁸⁴ Interview Gabriela 14/03/2017.

⁸⁵ Interview Olivia 02/03/2017.

⁸⁶ Interview Adriana 18/04/2017.

⁸⁷ A professional nurse has more knowledge and competencies than an auxiliary nurse, who is more of an assistant.

A pregnant woman named Valería, told us about her inability to receive a prenatal vaccination at the *Puesto de Salud* in San Juan La Laguna, nor at any of the other health centres in surrounding towns. Therefore, she was forced to visit a private healthcare centre. Eventually she had to pay 130 quetzales (about 17 euros) for one vaccination, of which she would need two more⁸⁸.

Mila Vina, the woman we introduced in the beginning of this chapter, had her previous delivery in the *Centro de Salud* in San Pedro La Laguna. A doctor is supposed to be present at all times, but in her case she had no choice but to give birth with the attendance of only one nurse, because no doctor was present⁸⁹.

Although governmental healthcare is free of charge, other structural problems exist which stop women from using them. Transport difficulties, the absence of information regarding the availability of healthcare services and lack of appropriate biomedical providers are some of the problems faced by the rural population (Glei et al. 2003; Kestler et al. 2013). The lack of access to skilled biomedical providers continues to remain geographically concentrated among the poorest women, which underlines the marginalized status of indigenous women and shows the ethnic division in care (Berry 2008; Berry 2010)⁹⁰.

5.4 Privately-owned healthcare

In Guatemala, formal healthcare is partly provided by the government and partly privatized. The closest private clinic is situated in San Pedro La Laguna. The services provided here are usually better than in state-owned healthcare centres, because they do not suffer as much from shortages, they are better equipped and dispose of more and better trained medical personnel. However, Valería's story illustrates that these services are not for free resulting in a lot of people not being able to afford them.

5.5 Healthcare provided by NGOs

Alongside state and privately-owned healthcare centres, two non-governmental organisations are situated in San Juan La Laguna, the first of which is called *Clínica Sanjuanerita*. This

⁸⁸ Interview Valería 10/04/2017.

⁸⁹ Interview Mila Vina 31/03/2017.

⁹⁰ This paragraph was written by Renate Klijnstra (Although governmental ... in care.).

health clinic offers, among other medical services, dental healthcare, mental support and prenatal controls. This clinic is (mainly) sponsored by North-American donations. Its employees are a mix of local and international staff⁹¹. It is not possible to give birth in this facility. For every prenatal control they charge 25 quetzales (about 3 euros). In contrast to the *Puesto* and *Centro de Salud* they dispose of ultrasound, which also shows images. Furthermore, they organise weekly free meetings for (pregnant) women. During these meetings women learn, among others, about the do's and don'ts during pregnancy, but also how to look after the baby once it is born. Some meetings focus on a specific topic such as eating healthily or the importance of breastfeeding. These meetings are, depending on the topic, given by sexual health promoters, social workers or nutrition coordinators⁹².

5.5.1 Casa Materna

Another NGO which is active in the San Juan area is *Casa Materna*. This birth centre is relatively new. Since November 2016, they have been offering prenatal controls and since the 3rd of February 2017 women have been given the opportunity to give birth here. As with *Clínica Sanjuanerita*, this birth centre is founded by and sponsored by North-American donations⁹³. When we visited *Casa Materna* for the very first time on 27 February 2017, they had already attended to 99 women, which seems to imply that a lot of women are using their services. The centre is opened 24 hours a day, 7 days a week⁹⁴. Its staff consists of three nurses and an administrator, who also doubles as a social worker. They do not employ a permanent doctor but occasionally a foreign doctor comes to visit and works voluntarily⁹⁵. During our time in San Juan La Laguna, apart from the local staff, only an American nurse worked here. On Monday and Tuesday mornings and Fridays pregnant women can come to the *Casa Materna* for their prenatal controls. These are accessible for all women, regardless of where they live. When a woman visits for the first time, she will have an intake with one of the nurses. Questions will be asked about the number of children she already has and their ages, when she had her last period, whether she experienced any complications during previous pregnancies, whether she suffers from diabetes or any other possible risks or diseases. Furthermore, the intake consists of measuring glucose, blood pressure, body

⁹¹ Its staff consists of 12 people, of whom three are foreigners.

⁹² Website: <http://www.odimguatemala.org/> Accessed on 28/02/2017 and 18/04/2017, interview Juliana 04/04/2017.

⁹³ Website: <http://www.casamaternaatitlan.org/> Accessed on 27/02/2017 and 07/03/2017.

⁹⁴ Interview Marisol 27/02/2017.

⁹⁵ Interview Luiza 07/03/2017.

temperature and weight. After 20, 28 and 36 weeks of pregnancy an ultrasound is made. During an ultrasound the position of the baby and the placenta are observed. Furthermore the perimeter of the head, the weight of the baby and amount of fluid are measured⁹⁶. As said before, it is also possible to give birth in *Casa Materna*. Mila Vina was one of the women we had contact with, who gave birth at *Casa Materna*. Just like the *Puesto de Salud* they use a doppler ultrasound, fetoscope, a device to measure the blood pressure and a device to measure glucose, but unlike the *Puesto de Salud*, *Casa Materna* owns an ultrasound (with image), a device to measure hemoglobin and extra oxygen. Neither of these organisations owns an incubator. They manage complications in a similar way as the *Puesto de Salud*, by referring women to the state-owned hospital in Sololá. *Casa Materna* will also help women and their families with arranging transportation to the hospital⁹⁷. *Casa Materna* charges a one off fee of 50 quetzales (about 7 euros) in order to register the pregnant women. After registration prenatal controls during all 9 months of pregnancy will be included. When a woman decides to give birth in *Casa Materna* an extra 30 quetzales (about 4 euros) will be charged to cover the laundry costs⁹⁸.

5.6 Other support for women in San Juan La Laguna⁹⁹

Being pregnant and becoming a mother usually means that women should look for care. This may not only entail medical healthcare, but sometimes also social and psychological support. Many pregnant women or women who have recently given birth, face challenges to overcome all kinds of issues, such as alcohol abuse, violence and poverty. The strong dependency on a partner or on family members, makes their lives complicated, especially when those are absent. *Oficina de la Mujer*, an organisation subsidized by the government, offers assistance to support women. They provide information, give sexual education, and organise activities focused on women and their role in society. Although *Oficina de la Mujer* is confronted with limited resources, they try to do everything within their power. During our fieldwork, we worked intensively together with *Oficina de la Mujer* to meet pregnant women and young mothers, to understand their lives and perceptions of motherhood, and to get to know more about the different organisations and caregivers involved in their lives¹⁰⁰. We often visited

⁹⁶ Interview Luiza 07/03/2017, participant observation Olivia 24/03/2017.

⁹⁷ Meeting Luiza, Jonatan and Marisol 18/04/2017.

⁹⁸ Interview Luiza 07/03/2017.

⁹⁹ Paragraph 5.6 was written by Renate Klijnstra.

¹⁰⁰ Conversation Casia 13/03/2017.

their office to keep ourselves updated. One day when we entered the office, the director almost begged us to help out. Rosealma's 18-year-old boyfriend had just drunk himself to death, and they asked us to accompany them to console the teenage girl.

We enter Rosealma's house as we follow her into her room. She is sitting on her bed, almost crying her eyes out. Her house is filled with family members and friends, and every visitor gets a cup of black coffee. She starts telling about her boyfriend, who died less than 24 hours ago after he had been drinking alcohol for three days in a row. The mother of her departed boyfriend comes in to put her one-month-old baby in her arms. Sobbing and howling, she explains that the combination of her bed, the wardrobe, the paintings and her child is too traumatic. The bed is where she found him yesterday after he had announced his willingness to die and where he had been vomiting ceaselessly. At the same time, their daughter had been laying in his arms peacefully. She had a panic attack when she noticed his heart had stopped beating. She gets overwhelmed by emotions when she looks at the wardrobe and starts to describe about what had happened that morning. The family came to remove all his clothes and put them in a coffin for his burial. She said that she had not attended the funeral, since she could not cope with the loss yet. Three ladies of *Oficina de la Mujer*, wipe away their tears. One asks the 15-year-old girl what the future holds for her and her baby. She looks up, is silent for two seconds and starts to weep again¹⁰¹.

This story shows a desperate situation of a young mother. Although *Oficina de la Mujer* cannot offer much financial support, they constantly renew their database and broaden their network to reach out to girls and young women who are in need of emotional and psychological support. In an environment where being a mother is subjected to powerful gendered expectations (Ulrich and Weatherall 2000 in McQuillan 2008, 478) which could aggravate women's lives, an organisation like *Oficina de la Mujer* is a helpful addition to San Juan La Laguna.

5.7 Mutual relations

As our research progressed we got more and more insight into the relations between the different organisations active in San Juan La Laguna. *Casa Materna* told us that they do not

¹⁰¹ Based on participant observation and journal story recorded in Renate Klijnstra's diary 03/04/2017.

work together with *Clínica Sanjuanerita*. However, *Clínica Sanjuanerita* occasionally does refer women to *Casa Materna* and vice versa.

Casa Materna is situated on the first floor of a brand new looking building situated in the outskirts of San Juan La Laguna. The ground floor is not in use. We were told that the *Puesto de Salud* is supposed to move there, but they refuse to do so¹⁰². They do not want to work together with *Casa Materna*, which they regard as a private birth centre. Gabriela, the manager of the *Puesto de Salud*, even blames Luiza, a 37-year-old nurse and *comadrona* working as clinic director at *Casa Materna*, for the recent death of two babies. She even threatens to abrogate Luiza's license, which would make it illegal for her to attend births as a *comadrona*¹⁰³. Gabriela was not alone in accusing Luiza responsible for the death of babies. Multiple stories about Luiza's capabilities were circulating in town. Over time we have developed a close relationship with Luiza, which made it possible to discuss and talk about these accusations. It was true that a baby had died in August, it was the baby of one of her patients. However, this baby, who was suffering from oxygen deficiency, was born in the *Puesto de Salud*. They tried to intubate the baby, without success. Extra oxygen was badly needed, but after multiple calls and visits it seemed that nowhere in the area extra oxygen was at hands. Luiza had accompanied the pregnant woman to the *Puesto de Salud* and tried to help out by calling as many people as possible. Sadly, four hours after the baby was born, it passed away. Subsequently, Luiza was blamed by Gabriela for letting the baby die¹⁰⁴. So, Luiza's competencies and authority have publicly been questioned. Some even refer to her as a student, which emphasizes her supposed inability and deficiency. However, this story is not solely targeted at trying to discredit Luiza. As *Casa Materna*'s clinic director, Luiza has had a central role. So apparently, in attempts to disparage *Casa Materna*, its clinic director Luiza, has become a main target of public slander.

We too witnessed the way in which the *Puesto de Salud* tried to slander *Casa Materna*, when during a regular visit to *Casa Materna*, Hernando, director of *RENAP*, was suddenly present. As it turned out, the *Puesto de Salud*, had emphatically requested *RENAP* to pay a visit to *Casa Materna* in order to check the centre's administration. Fortunately, everything turned out to be well documented. However, if only a slight error were to be

¹⁰² Interview Luiza 07/03/2017.

¹⁰³ Interview Gabriela 14/03/2017.

¹⁰⁴ Interview Gabriela 14/03/2017: We were interviewing Gabriela who, out of the blue, started to tell us stories about the incapacibilities of Luiza; meeting Luiza, Jonatan and Marisol 18/04/2017.

found, *Casa Materna* would no longer be allowed to attend any births¹⁰⁵.

5.8 Conclusion

During pregnancy women are dependent on healthcare options available to them. As we have seen in this chapter, San Juan La Laguna is fortunate to have a range of healthcare options concerned with pregnant women. However, healthcare organisations do not always work together, which influences the quality of healthcare they offer. Ultimately this mutual hostility and jealousy may result in pregnant women not getting the optimal care they deserve.

¹⁰⁵ Participant observation 07/04/2017.

Chapter 6: Midwives

Esther Geurts

In the previous chapter we gave an overview of all the current healthcare options which are available to pregnant women in San Juan La Laguna where in the past a formal healthcare system did not exist. Back then, *comadronas* were solely responsible for the lives of both the mother and the baby. Over time healthcare options in San Juan La Laguna have become more and more available, but this does not mean that the use of *comadronas* is something of the past. On the contrary, almost all of the pregnant women we spoke to in San Juan still use the services of a *comadrona*. Sometimes, they solely use a *comadrona*, but it is also possible to use a *comadrona* and biomedical healthcare at the same time. *Comadronas* are the equivalent of midwives. Some women already have a *comadrona* when they are only one month in their pregnancy, while other women will only use a *comadrona* in the final stages of their pregnancy¹⁰⁶. Usually a *comadrona* will visit a pregnant woman monthly and from the 6th month of pregnancy the visits will increase in frequency¹⁰⁷.

6.1 Becoming a midwife: about *dons* and dreams

One of the main differences between a *comadrona* and a medic is that *comadronas* possess the so-called *don* and medics do not. According to Mayan beliefs everyone is born with a certain *nahual* or Mayan energy. These consist of both positive and negative aspects. The *don* is part of your *nahual* and stands for a specific aptitude¹⁰⁸. Someone could possess the *don* to be e.g. a *curandera* (healer), another possibility is *comadrona*. Someone's *nahual* and therefore *don* is determined by their date of birth. In total there are 20 *nahuales*, of which five carry the *don* to be a *comadrona*¹⁰⁹. It is believed that the *don* is a gift from God. Possessing the *don* is essential when working as a *comadrona*, because it distinguishes them from medics, while at the same time it gives them authority to keep doing their jobs.

No set pattern exists in the way women discover that they are *comadronas*. Some *comadronas* told us that they were born with a white “veil” covering their heads, a “lighted

¹⁰⁶ i.a. Interview Adriana, 02/03/2017, interview Carrola 20/03/2017, interview Olivia 11/03/2017.

¹⁰⁷ This paragraph was written by Renate Klijnstra (On the ... in frequency).

¹⁰⁸ Meeting Leonardo and Javier 10/03/2017.

¹⁰⁹ Conversation Magdalena and Lucrecia 27/02/2017.

candle” or wearing “gloves”¹¹⁰. These are all seen as signs that a baby girl is destined to become a *comadrona*. We also know stories about women being ill and having a lot of health issues¹¹¹. These women would have dreams or visions in which they were told to start working as a *comadrona*.

Doña Milica is 71 years old and has worked for 41 years. She is seen as one of the most respected *comadronas* in San Juan La Laguna. She recalls the clear message in one of her dreams: “If you don’t start working [as a *comadrona*], you will get sick more¹¹²”.

Furthermore, they would have dreams about attending births, how to cut the umbilical cord, what medicinal plants to use, how to perform massages. Some women envision themselves in the houses of the women they help, while others see themselves in a hospital. In Doña Milica’s case deceased *comadronas* would show her how to be a *comadrona*¹¹³. Cosminsky (2001) confirms that being a midwife is believed to be a predestined role, a supernatural gift. Doña Carlota told us that she is able to know exactly when a baby will be born and what the sex will be, because of her dreams¹¹⁴. Midwives usually master the knowledge and practices through personal experience. Midwives who state that being a midwife is their “calling”, often learn “through dreams and visions that reveal the essential techniques, rituals, and meanings of midwifery practice” (Maupin 2008, 366). During our research we have interviewed all of the active *comadronas* in San Juan La Laguna. Almost all of them claimed that they experienced or still experience dreams or visions, in which they learn how to be a *comadrona*. The age at which these dreams start varies, some have dreams starting from an age of 10 or 12 years old, while others have had dreams since they were 30 years old. The frequency is variable, sometimes dreaming daily, while at times having no dreams at all for months. Some *comadronas* only had dreams just before they became a *comadrona* and right after they started working. Other *comadronas* state that nowadays they still experience dreams at times¹¹⁵. Usually soon after someone starts having dreams, she will start to work as a *comadrona*. It is believed that through experience, *comadronas* will master their

¹¹⁰ Interview Anarosa 20/03/2017, interview Elvira 14/03/2017, interview Verda 20/03/2017.

¹¹¹ i.a. Interview Anarosa 20/03/2017, interview Florita 20/03/2017, interview Milica 28/02/2017.

¹¹² Interview Milica 28/02/2017. Original: “Si no vas a trabajar, tú vas a enfermar más”.

¹¹³ Interview Milica 28/02/2017.

¹¹⁴ Interview Carlota 01/04/2017.

¹¹⁵ i.a. Interview Antonia 14/03/2017, interview Carlota 01/04/2017, interview Fatima 15/03/2017.

knowledge, techniques and practices.

All of the active *comadronas* working in San Juan La Laguna stated to work voluntarily, which means that they don't ask money for their services. However occasionally pregnant women will give them a donation in return for their services. This depends on the economic situation of the family of the pregnant women, because some families are very poor and cannot afford to give money. The main reason for working voluntarily is that the *don* is seen as a gift from God.

Doña Carlota is 65 years old and has worked as a *comadrona* since she was 20 years old: "God gave me this knowledge in order to help people, not in order to make money¹¹⁶".

6.2 Practices and techniques

Comadronas offer a variety of services to (pregnant) women. They usually visit the homes of the women they help¹¹⁷. One of their main traits is giving prenatal massages. *Comadronas* are believed to be the only ones who know how to improve, maintain or change the position of the baby through massage and therefore may prevent complications. These supposed abilities are part of a narrative, which strengthens their authority. This is the reason why *comadronas* claim that their hands are very important and serve as the one and only "device" they use¹¹⁸.

Olivia was already 36 weeks pregnant when she came to see her *comadrona*, Doña Luiza. After a prenatal check, Olivia was told that her baby was in the wrong position. Doña Luiza performed a massage in order to get the unborn baby to "dar la vuelta". Olivia is already in the final stage of her pregnancy and therefore the unborn baby is almost fully grown. This complicates the situation making it very hard to turn the unborn baby in the right position. It is a lot easier when someone is only three or four months pregnant. The massage does not have the desired effect. Doña Luiza wants Olivia to do exercises from now on. A bag of ice is placed right where the head of the unborn baby is supposed to be. Subsequently something warm, like a warm cloth, is placed at the bottom of her belly. The idea is that the unborn baby will get cold and

¹¹⁶ Interview Carlota 01/04/2017. Original: "Dios me ha dado esta sabiduría, para ayudar a la gente, no para hacer dinero".

¹¹⁷ i.a. Interview Aletta 17/03/2017, interview Dulcea 20/03/2017, interview Vianca 20/03/2017.

¹¹⁸ Interview Milica 08/04/2017.

seek for some place warm. This will hopefully result in the baby turning down into the right position. Olivia has to repeat this daily. The consequence of the baby not being in the right position, is the risk of having to undergo a cesarean at the hospital. Unfortunately, despite all the hard work, in the end, Olivia had to undergo surgery¹¹⁹.

Most women want to prevent this outcome, because transportation can be very costly and the recovery will take longer¹²⁰. Furthermore, a cesarean results in a woman being away from home for a couple of days. Jemisa, who is pregnant with her third child, told us that she wants to prevent this, because it is her job to look after her family¹²¹.

Comadronas mainly use medicinal plants, which is also part of the narrative which underlines their authority. *Comadronas* do not agree about the right time to prescribe medicinal plants. Some will say that the use of medicinal plants during the pregnancy is dangerous, because the plants may cause abortion¹²². Others have told us that it will not harm the unborn baby, providing that the medicinal plants are combined with proteins, vegetables and herbs¹²³. Chamomile, cinnamon and rue are often used to provoke contractions. *Ixbut* is the name of another plant which is commonly used to improve the quality and quantity of breast milk¹²⁴. Multiple ideas and opinions exist about the use and the efficiency of medicinal plants among *comadronas*. Some *comadronas* use conventional medication when needed. The main reason to use medication instead of medicinal plants, is that although medicinal plants can be very effective, they usually work very slowly. Therefore, in case of emergencies some *comadronas* choose to use medication, because they usually work faster¹²⁵. So, this part of the narrative is not as strong as it used to be, because the use and workings of medicinal plants are more and more challenged by conventional medicine. This corresponds with the idea of authoritative knowledge which states that one knowledge system, in this case “modern” biomedicine, tries to gain legitimacy and authority over the other, which are traditional healthcare practices and the use of *comadronas*.

The use of a *temazcal*¹²⁶, which is a kind of sauna, is widespread and serves different

¹¹⁹ Participant observation Olivia 24/03/2017.

¹²⁰ Participant observation Olivia 24/03/2017.

¹²¹ Interview Jemisa 03/04/2017.

¹²² i.a. Interview Dulcea 20/03/2017, interview Luiza 07/03/2017, interview Milica 28/02/2017.

¹²³ Interview Luiza 07/03/2017.

¹²⁴ i.a. Interview Aletta 17/03/2017, interview Catalina 03/03/2017, visit to Mireya 05/03/2017.

¹²⁵ i.a. Interview Adriana 02/03/2017, interview Catalina 03/03/2017, interview Luiza 07/03/2017.

¹²⁶ i.a. Interview Catalina 03/03/2017, interview Elvira 14/03/2017, interview Fatima 15/03/2017.

purposes. It is commonly used to “*bajar la leche*¹²⁷”, but it can also be used when a woman is 8 or 9 months pregnant. The steam of the *temazcal* will help to deliver the baby more rapidly and gently¹²⁸.

Massages and the use of medicinal plants may also be used to help a woman get pregnant¹²⁹. The belly of a woman who just gave birth may hurt, because of all the air inside. It is the job of a *comadrona* to take care of the newly mother. She may apply a *faja*, which is a kind of belt. This belt, which should be worn for 40 days, is supposed to reduce the woman's abdomen into position¹³⁰. In the postnatal phase, a *comadrona* may also come to wash both mother and child. This usually happens on the eighth day after giving birth or after returning from the hospital. Sometimes a celebration is held on the eighth day during which God is thanked and the family have lunch together¹³¹.

6.3 *Comadronas* as social workers

Being a *comadrona* certainly is not an easy job, because her whole life is adjusted to attending births at any hour of the day. Unlike doctors and nurses, *comadronas* can be called by their patients 24 hours a day and 7 days a week. Whenever a woman is in pain or feels sad, her *comadrona* will come to help her out and to support her. According to Cosminsky (2001) midwives may distract women from physical pain by praying together. So, a *comadrona* does not only have a medical and physical job in attending births and doing prenatal checks, she also has a social role in supporting her patients. Contrary to medical staff, who usually keep a professional distance, *comadronas* have a more personal relationship with the women they attend to. Helman (2007, 87-88) confirms that the relationship between biomedical staff and their patients is unequal, because of social class, economic position, gender, educational level and sometimes cultural background. *Comadronas* visit their patients at home and observe what their home situation is like¹³². According to Doña Luiza, a *comadrona* needs to support women mentally, socially and emotionally¹³³.

¹²⁷ Meaning: “to lower the milk”.

¹²⁸ Interview Elvira 14/03/2017.

¹²⁹ Interview Milica 08/04/2017.

¹³⁰ Interview Kesare 05/03/2017, interview Laurana 06/03/2017, participant observation Mireya 12/03/2017.

¹³¹ This paragraph was written by Renate Klijnstra (Massages and ... lunch together.).

¹³² i.a. Interview Carlota 01/04/2017, interview Fiona 04/03/2017, interview Ricarda 06/03/2017.

¹³³ Interview Luiza 07/03/2017.

We are at the home of Doña Fiona (54), who has been working as a *comadrona* for 30 years. Brisa, who is the fiancée of our host brother and who recently moved in with us, has accompanied us in order to translate. Before we start with the interview, Doña Fiona would like us to pray together first. Doña Fiona is a very religious woman, who refers to God and the Virgin Mary multiple times during the interview. When we ask Doña Fiona if she works voluntarily, she suddenly becomes very emotional. She starts to cry and at first we are not sure why. When she has calmed herself, she explains that she often comes across women who are very poor and do not have sufficient money to buy food. That is why she wants to help. Doña Fiona tells us that she has experienced some difficult times during her life too, such as a miscarriage and complications during pregnancy. She believes that because of these experiences, she is able to understand and therefore help her patients even more¹³⁴.

Besides that being a *comadrona* is a calling, this occasion also illustrates that *comadronas* often hail from the same communities as the women they attend to. Although they share the same background, possessing the *don* distinguishes them from the women they help. *Comadronas* may have found themselves in rough and sometimes similar situations as the women they attend to, which creates understanding and trust.

Another important task of a *comadrona* is educating her patients. They provide advice, especially about what is the right thing to eat and what you can and cannot do (“do not drink alcohol”, “do not walk the streets at night”, “what to do when you suffer from nausea”)¹³⁵.

Furthermore, Doña Dulcea helps her patients with making a “*plan de emergencia*”¹³⁶ in which they state what to do when complications occur. It is helpful to think about who to take with you, how you are going to get to a medical facility, how to pay for transportation and who to approach to look after your children¹³⁷. Some *comadronas* spend a lot of time on informing their patients about the different medical healthcare options available in the San Juan area. They advise where to go to receive vaccinations or prenatal vitamins. A *comadrona* needs to advise her patient to go to a medical health facility on time and often

¹³⁴ Interview Fiona 04/04/2017.

¹³⁵ Interview Adriana 02/03/2017, interview Florita 15/03/2017, interview Rosalia 01/04/2017. This paragraph was written by Renate Klijnstra.

¹³⁶ Meaning: “emergency plan”.

¹³⁷ Interview Dulcea 20/03/2017.

accompanies her patients when needed or asked. Some pregnant women do not speak Spanish, which usually is the main language spoken in health centers and hospitals. A *comadrona* may join her in order to translate¹³⁸. So, a *comadrona* sometimes functions as a bridge between the pregnant women and the modern healthcare system.

6.4 *Capacitaciones*

Nowadays, the use of training programs, locally called *capacitaciones*, has resulted in incorporating midwives more and more into the formal healthcare sector (Maupin 2008). The underlying idea of these programmes is to “improve” or “upgrade” the knowledge and practice of midwives in order to decrease maternal and infant mortality (Cosminsky 2001).

About 15 years ago the *Puesto de Salud* in San Juan La Laguna started with organising *capacitaciones* focused on *comadronas*¹³⁹. After attending a training course, midwives receive a license (Cosminsky 2001). Midwives who refuse to attend regular trainings risk their licenses to be revoked (Acevado-Garda and Hurtado 1997, 319 in Cosminsky 2001). Without being registered it is illegal to attend births and you will not be able to register the baby at *RENAP*¹⁴⁰. This measure has resulted in *comadronas* obtaining a legal position and role.

The *Puesto de Salud* told us that they organise *capacitaciones* monthly¹⁴¹. In San Juan La Laguna a total of 26 *comadronas* are registered. Of these, only 10 are working actively and attending births regularly¹⁴². We spoke to all 10 and asked them about the frequency of *capacitaciones* in the *Puesto de Salud*. They all made clear that this year no *capacitaciones* have been organised (yet). Furthermore, last year only two or three times a *capacitación* was held at the *Puesto de Salud*¹⁴³, who admit that they are sometimes unable to organise *capacitaciones* due to lack of funds. However, according to the *Puesto de Salud* they still manage to organise a *capacitación* almost every month¹⁴⁴.

Capacitaciones are also organised by foreign doctors or nurses. Doña Antonia states that she followed *capacitaciones* from 4 January to 28 May 2016, which were organised by Doña Luiza, former employee of *Clínica Sanjuanerita*, who now works at *Casa Materna*.

¹³⁸ Interview Florita 15/03/2017.

¹³⁹ Interview Adriana 21/04/2017.

¹⁴⁰ Interview Gabriela 14/03/2017.

¹⁴¹ Interview Gabriela 14/03/2017.

¹⁴² Interview Gabriela 14/03/2017.

¹⁴³ Interview Antonia 14/03/2017, interview Catalina 03/03/2017.

¹⁴⁴ Interview Gabriela 14/03/2017.

The teacher was a foreign doctor¹⁴⁵. Doña Rosalia said she occasionally participates in *capacitaciones* organised by *Casa Materna*¹⁴⁶. Another NGO, called Rxiin Tinamet, has been providing *capacitaciones* monthly to *comadronas* for 21 years. However, in the last couple of years only four to five *comadronas* show up regularly during these *capacitaciones*¹⁴⁷.

In general *capacitaciones* focus on how to attend births, how to recognize signs of risks and what to do should complications arise. *Comadronas* for example learn how to cut the umbilical cord and why it is important to wear plastic gloves while examining a woman. Maupin (2008) stresses that traditional forms of education emphasize personal experience and knowledge, whereas training programmes use a model of instruction in which midwives learn via lectures and texts.

6.5 The evolving midwife

In the past neither doctors nor nurses were available in San Juan La Laguna. Back then, *comadronas* were solely responsible for the lives of both the mother and the baby. *Comadronas* were on their own and not adequately prepared for attending complicated births. They did not know anything about dilatation. When pregnant women felt pain, they were told that “*la hora*¹⁴⁸” had come and they just needed to push and push. This sometimes caused the baby to die. However, at present *comadronas* are aware of the “*dolores falsos*¹⁴⁹” which may occur during the final stage of pregnancy. Because of the *capacitaciones* they now know that a minimum of 10 centimeters dilatation is needed before a woman should start pushing¹⁵⁰. Another important change is the use of plastic gloves, which is now widespread among *comadronas*¹⁵¹. So, *capacitaciones* have improved the knowledge and practices of *comadronas*.

Furthermore, pills or vaccinations were not available and prenatal controls were not held. Some *comadronas* were not able to write or read¹⁵². Nowadays, more medical facilities are available in the San Juan area. *Comadronas* can ask for help when complications arise and pregnant women may be referred to a hospital when needed. Doña Carlota states that

¹⁴⁵ Interview Antonia 14/03/2017.

¹⁴⁶ Interview Rosalia 01/04/2017.

¹⁴⁷ Interview Britta 21/04/2017.

¹⁴⁸ Meaning: “the hour”.

¹⁴⁹ Meaning: “false pains”.

¹⁵⁰ Interview Carlota 01/04/2017.

¹⁵¹ Interview Milica 28/02/2017.

¹⁵² Interview Fiona 04/04/2017.

nowadays *comadronas* themselves prescribe prenatal vitamins to their patients as well, because they are aware of their importance to the baby's health¹⁵³.

Some *comadronas* have finished a degree in Nursing. According to Doña Fiona the combination of possessing the *don* and being able to study is the perfect combination, which improves the knowledge of *comadronas* significantly¹⁵⁴. Among the 17 *comadronas* we have talked to¹⁵⁵, three have finished a degree to be a nurse. They combine their work as a nurse with being a *comadrona*.

Doña Adriana is 53 years old and has worked as a *comadrona* and certified nurse for 33 years. In the past she worked at the *Puesto de Salud*, where she combined being a nurse with attending to pregnant women as a *comadrona*. Nowadays she works at the pharmacy owned by her husband, where she also receives pregnant women. When she works as a *comadrona* she works voluntarily¹⁵⁶, when she worked as a nurse she received a monthly salary from the government. Twice we witnessed a prenatal control, during which Doña Adriana visited and examined a pregnant woman. Doña Adriana measured her blood pressure and lifted her eyelid in order to check her eyes. Next, the belly was examined and subsequently measured using measuring tape: “20 *semanas de embarazo*”¹⁵⁷. Within 10 minutes the control is finished¹⁵⁸. Doña Adriana thinks that as a *comadrona* she is more in demand for her nursing background. She possesses knowledge about medicinal plants, but at the same time she is able to prescribe medication when needed¹⁵⁹.

Another example is Julieta, who is a young birth assistant at *Casa Materna*:

Julieta is 19 years old and currently enrolled in a nursing programme. She has the *don* to be a *comadrona* and sometimes experiences dreams or visions. While studying to be a nurse, she has also participated in multiple trainings to learn how to use an ultrasound. This particular course was organised by an NGO located in Santiago

¹⁵³ Interview Carlota 01/04/2017.

¹⁵⁴ Interview Fiona 04/04/2017.

¹⁵⁵ 11 from San Juan La Laguna, one from San Pedro La Laguna and 5 from the aldeas.

¹⁵⁶ Interview Adriana 02/03/2017.

¹⁵⁷ Meaning: “20 weeks pregnant”.

¹⁵⁸ Participant observation Beatrisa 05/04/2017, participant observation Juliana 04/04/2017.

¹⁵⁹ Interview Adriana 02/03/2017.

Atitlán which is connected to *Casa Materna*. Julieta finished the course by attending an exam, which she subsequently passed¹⁶⁰.

Casa Materna stimulates its staff to keep participating in *capacitaciones*, because it is seen as very important to keep your knowledge up-to-date¹⁶¹. These are all examples which show that slowly more and more *comadronas* learn via (formal) education.

6.6 The devaluation of midwives?

In literature a negative picture is presented about the situation in which midwives in Guatemala currently find themselves. The training programmes offered are hierarchical and mediocentric and leave no room for the views of the midwives. The courses are given in Spanish, a language many rural midwives do not speak, while the biomedical providers who teach these courses usually do not speak the indigenous language. In addition, many midwives encountered racism and hostile attitudes during practice (Chary et al. 2013; Cosminsky 2001; Gleit et al. 2003; Maupin 2008). Participation in these programmes has redefined the role of the midwives (Maupin 2008). Midwifery is often seen as a supernatural gift, therefore it is not something to be sold (Acevedo and Hurtado 1997 in Maupin 2008). However, midwifery programmes strongly encourage midwives to increase the prices for their services, which results in the commercialization of their ability. Also, the programmes heavily focus on biomedical causes of maternal mortality (Berry 2008). However, the *comadronas* we talked to did not fully confirm this image. The *comadronas* used to be very content with the *capacitaciones*. However, since two or three years the *capacitaciones* have suffered from a lack of funds and are therefore not regularly organised anymore. Among the *comadronas* no one had encountered racism or discrimination, although the degree of cooperation between *comadronas* and doctors depended on which doctor was on duty. Some *comadronas* confirmed that doctors had encouraged them to ask money for their services¹⁶².

In Guatemala, the formal health system seems to prioritize the value of biomedical health over traditional practices. Cosminsky (2001) and Berry (2008) both show that the process of delegitimization of traditional healthcare is present in Guatemala. The knowledge and experience that traditional midwives possess are devalued (Berry 2008; Cosminsky

¹⁶⁰ Interview Julieta 04/04/2017.

¹⁶¹ Meeting Luiza, Jonatan and Marisol 18/04/2017.

¹⁶² Interview Carlota 01/04/2017

2001). This delegitimization of traditional healthcare is directly related to the legitimization of biomedical healthcare. This is in accordance with the concept of authoritative knowledge (Cosminsky 2001, 350). Nowadays, the knowledge, practice and authority of traditional midwives is being challenged by biomedical health standards (Maupin 2008), which is also visible in San Juan La Laguna, where the capabilities of *comadronas* are sometimes questioned.

Cosminsky (2001) takes a more nuanced stance by stating that on the one hand medicalization may increase the knowledge of midwives in Guatemala, which may eventually empower them, because they will improve the health status of pregnant women. On the other hand, medicalization “may result in midwives losing knowledge, autonomy, self-esteem, respect, and power as they become more dependent upon the biomedical and commercialized health sector” (Cosminsky 2001, 350).

6.7 Conclusion

The *comadronas* we had contact with, feel that, despite the fact that doctors and nurses are now more widely available to the people of San Juan La Laguna, they still are important to the community, “*porque salva vidas*”¹⁶³.

They provide personal services, support and provide education for their patients. Furthermore, it is their job to take women to medical facilities in case of complications. Whereas in the past pregnant women were entirely dependent on *comadronas* during their pregnancies, nowadays more options are available. Doña Aletta feels that at present, *comadronas* have less responsibilities than previously. However, she does not mind, because the presence of doctors has resulted in more assurance for *comadronas*. Whenever complications arise, doctors can help out¹⁶⁴.

Almost all *comadronas* we spoke to, confirmed that the situation for pregnant women is now better than it used to be. They are happy with the presence of medical staff in San Juan La Laguna and their facilities have improved over time. Doctors are able to help whenever complications arise. Furthermore, they use devices during prenatal controls and prescribe vitamins and vaccinations to pregnant women and their babies¹⁶⁵.

The role of *comadronas* is not as badly diminished as stated in some literature.

¹⁶³ Meaning: “Because it saves lives”, interview Adriana 02/03/2017.

¹⁶⁴ Interview Aletta 17/03/2017.

¹⁶⁵ Interview Carlota 01/04/2017.

Comadronas feel that the situation for pregnant women has improved. Their role in this new situation is different from what it used to be. Although pregnant women more and more seem to use medical facilities, most women still have a *comadrona* and with a reason. This has to do with the fact that *comadronas* and medical staff are both able to help a woman, but both in a different way. *Comadronas* perform massages and use medicinal plants, they give mental, social and emotional support. They usually foster close relationships with the women they attend, because *comadronas* are able to relate to them more. Having the *don* to be a *comadrona* gives them authority and is part of a narrative which claims they are the only ones who can perform massages and use medicinal plants. Doctors and nurses dispose of devices, which are important, especially when complications arise. *Comadronas* are still important, but nowadays they (happily) share their authority and role with medical staff.

So, *comadronas* offer culturally appropriate care (cf. Berry 2008) and therefore they offer a healthcare system which is more inclusive. They take into account the position of women in San Juan La Laguna and subsequently offer care which matches the needs of the women they help. Medicalization seems to have resulted in empowerment, because it has thoroughly increased the knowledge of *comadronas*, who in their turn have increased the knowledge of pregnant women. *Comadronas* have maintained their authority by consistently spreading a narrative which underlines their importance and their special abilities.

Chapter 7: Conclusion

Esther Geurts and Renate Klijnsstra

When Pilar gave birth to her daughter nobody except the employees of *Casa Materna* seemed to look after her. They did not even charge her the usual fee of 80 quetzales (about 10 euros), because of the difficult situation she was in. As she lay waiting to go home nobody even came to tell her that she would not go home that evening, but the following day instead. The next day Doña Luiza had to call Pilar's sister to urge her to come pick her up at *Casa Materna*. No one had come to visit her. Eventually, her sister reluctantly gave in and visited *Casa Materna* to take her sister home. Apparently, the fact that it had been Pilar's own choice to leave her former husband, had not had a positive outcome on her family ties. From now on, she would have to get used to doing everything on her own and she would have to fend for herself making a living for her and her two young children. After a week Pilar decided to inform her ex-husband about the birth of their daughter. He vehemently refused to register his daughter, which would mean that baby Risa would only have her mother's last name. This would only increase the feelings of shame as in San Juan La Laguna it is socially unacceptable to only have one last name instead of two. Eventually, Pilar's *comadrona* Doña Luiza had to step in once again. She called the ex-husband and insisted that he should register his daughter as this was his responsibility as a father. Two weeks later Risa was officially registered and at last could start her life with the usual two surnames¹⁶⁶.

This chapter consists of three parts. First we will give a brief summary of the first aspect of our research, which is about the way womanhood and motherhood are perceived and experienced by pregnant women and young mothers. Then, we will have a look at the second aspect, which is concerned with the changing role of midwives and whether midwives have become obsolete or not. Lastly, we will integrate these two aspects and form a final conclusion in which we will answer our central research question, which is:

How do midwives and pregnancy-related healthcare interact with the way womanhood and motherhood are perceived and experienced by (pregnant) women in San Juan La Laguna?

¹⁶⁶ Participant observation Pilar 17/03/2017, visit to Pilar 22/03/2017, 01/04/2017, 08/04/2017 and 19/04/2017.

7.1 From womanhood to motherhood (Renate Klijnsstra)

Pilar's experience is an example of a story which shows the difficulties some women in San Juan La Laguna face. In this thesis we have aimed to give women like Pilar a voice. We intended to illustrate that in order to understand the meaning of womanhood and motherhood, it is important to look at the socioeconomic position of these women, which is influenced by social norms regarding gender and sexuality. These concepts cannot be disconnected from each other. Different schemes of evaluation for the sexuality of men and women, make gender categorizations in Guatemala both complex and ambiguous. The models *machismo* and *marianismo* classify these gender roles, in which men are associated with being sexually active, unfaithful, powerful, and little responsible, while women are associated with being sexually repressed, loyal, powerless, and self-sacrificing with Virgin Mary as role model. The validity of these models, which started to be discussed in academic literature in the 1970s, could be debated. However, many women in San Juan La Laguna often refer to *machismo*, while positioning themselves as powerless in respect to men. They mention men's infidelity, (sexual) violence, irresponsibility towards their children, alcohol problems, jealousy, and their own limited budget. Women like Pilar say to experience *machismo* as a dark cloud hanging over their heads.

The different perceptions of male and female sexuality have led to dissimilar ideas regarding family planning. Some men in San Juan La Laguna seem to believe that after their death they will receive more prestige in heaven if they have been fruitful in life on Earth. However women in San Juan La Laguna often have valid reasons to prevent an unwanted amount of pregnancies: many women are conscious that raising children means that they are going to be the ones mainly responsible for them. The physical and socioeconomic consequences of having children deter women from becoming pregnant (again).

Unfortunately, not all women are knowledgeable about how to prevent unplanned pregnancies, and a pregnancy often comes as a surprise to them. Because of the gendered expectations that women need to be "decent" and therefore sexually repressive, sexuality is a topic people do not easily talk about. This taboo on sexuality makes it difficult for women to be informed about sex, risk reduction or being proactive in negotiating about safer sex. An unequal power balance in gender relations favours men and their pleasure often supersedes female pleasure. All of these factors influence women's reproductive health.

Although knowledge about family planning increases, indigenous women still have a high average of children, with 3.7 children per woman. Motherhood, influenced by Christian

religion and tradition, is regarded as sacred and something to strive for. Moreover, motherhood is often considered as the most important event in women's lives, inseparable from the fact of being a woman, and therefore, identity-defining. Women who (in many cases involuntarily) remain childless, are pitied but also judged by society.

In a small village like San Juan La Laguna, women like Pilar need to develop thick skins in order to be able to deal with interference of the community concerning their fulfillment of relationships and motherhood. They are constantly trying not to deviate from the norm, in order to avoid gossip and a bad reputation. Women want to show the community how much they truly care for their babies, and often mention that they are willing to give everything for their babies. However, women do not always succeed in becoming the mothers the community expects them to be.

The role of a mother in San Juan La Laguna is often overshadowed by the lack or absence of a father. It is hard for them to receive social and economic support during their pregnancies, which results in women having many concerns; for example about how to look after their families financially, what the community will think of them and what the future will hold in store for them. As we could see in Pilar's situation, women are sometimes completely left alone in their hour of need.

In the chapters about gender, sexuality and motherhood, we want to illustrate that understanding pregnancy and birth from solely a medical point of view, is insufficient. What it means to be a woman in San Juan La Laguna, how they fulfill their role as mothers, and the socioeconomic circumstances they find themselves in during and after their pregnancies, contribute to the understanding of pregnancy and birth as a cultural and social construction.

7.2 The changing role of midwives (Esther Geurts)

Long before a formal healthcare system existed, midwives were solely responsible for the lives of both the mother and the baby. Nowadays, San Juan La Laguna is fortunate to have multiple healthcare facilities. However, midwives are the ones who mainly attend to women during their pregnancies, when giving birth and once the baby is born. Nonetheless, in scholarly literature, midwives are often depicted as obsolete and as women of the past. This may suggest that midwives are no longer necessary. Yet, during our fieldwork we have found otherwise.

One of the main aspects that differentiates midwives from medical personnel is that midwives possess the so called *don*, whereas medical personnel studied to obtain the

necessary knowledge. The *don* is regarded as a gift from God and is therefore not a trait to be commercialized. Not only does the *don* distinguish midwives from other carers, it also gives midwives the authority to do their job. The idea that midwives possess a specific gift from God is part of a wider narrative which explains their legitimacy and authority midwives still have. It is believed that midwives learn “through dreams and visions that reveal the essential techniques, rituals, and meanings of midwifery practices” (Maupin 2008, 366). Giving prenatal massages is regarded as one of their most essential techniques, because it is thought that midwives are the only ones who are able to perform these massages. This supposed ability is part of a narrative, which strengthens their authority. Moreover, midwives mainly use medicinal plants. However, this part of the narrative is not as strong as it used to be, because its use and workings are more and more being challenged by conventional medicine, for example every newborn child in San Juan La Laguna gets an obligatory vaccination within 24 hours after its birth.

Nowadays, the use and work of midwives is being influenced by the growing availability of medical facilities. Furthermore, midwives are more and more incorporated into the formal healthcare system, because of mandatory training programs which aim to improve and upgrade their knowledge and techniques. Biomedicine presents itself as being the only true source concerning health, which consequently results in devaluing all other kinds of local knowledge and practices, in this case the knowledge and practices of midwives. This process is a clear example of the concept of authoritative knowledge, further strengthened by the process of medicalization. Many conditions which were formerly not defined as medical entities have become part of the medical realm, resulting in pregnancy and birth now being seen as medical conditions to be addressed by biomedical care.

Naturally, these transformations have influenced the role and authority of midwives, but these transformations have certainly not all turned out to be negative, which contradicts scholarly literature. Since the start of organised training programs, midwives confirm that their knowledge and practices have thoroughly improved. Moreover, the presence of medical personnel has made it possible for midwives to ask for help in case of complications. Almost all of the midwives we spoke to stated that the situation for pregnant women is now better than it used to be expressing their content with the presence of biomedical personnel. It is inevitable that these transformations have influenced the role of midwives. Nowadays, midwives (happily) share their role and authority with medical personnel, which eventually leads to a better quality of care for (pregnant) women in rural areas. We now know how the

role of midwives has been influenced by biomedical healthcare system. We have stated that midwives are still important to local communities. In the next paragraph we want to illustrate what makes midwives important and to what extent they interact with (pregnant) women.

7.3 Interaction between women and midwives (Esther Geurts and Renate Klijstra)

It is common among indigenous women to use the services of a midwife. Midwives usually hail from the same communities as the women they attend to, often sharing the same social class, economic position, educational level, religion and cultural background. Because of these similar backgrounds midwives can reach out to women on a more personal level, whereas medical staff can not, because their relationship with pregnant women is often unequal. Although midwives share the same background, some aspects are apparent which distinguish them from the women they attend to.

In Guatemala women are expected to wash, to clean the house and to cook and thus stay within the boundaries of the family home. Midwives are women themselves, but somehow they do not seem to fit into this description, because they usually work outside of the house. Moreover, women are expected to fulfill God's will in becoming a mother, which means that they will be self-sacrificing mothers, who look after their children. Since a good woman needs to be a good spouse, they should be subservient to men. Although midwives are usually wives and mothers as well, they enjoy a certain degree of autonomy and freedom. On the one hand all women, including midwives, are subjected to certain notions about how to live up to social norms, but what distinguishes midwives from other women is that they possess the *don* to be a midwife. In other words, by working as a midwife they fulfill God's will, because the *don* is regarded as a sacred gift from God. So, midwives find themselves in a grey area between on the one hand being a good spouse and mother and on the other hand working as a midwife.

Because of these similarities in background, midwives have a clear idea about the difficulties women face during pregnancy and after giving birth. Besides offering medical assistance, midwives also provide mental, social and emotional support. Midwives may have found themselves in rough and sometimes similar situations as the women they attend to, which creates understanding and trust. As we have seen in Pilar's case, Doña Luiza is aware of the problems Pilar experiences and tries to find ways to overcome these problems. For example by visiting her at home and by mediating between her and her ex-husband. This also illustrates the authority and legitimacy a midwife holds within the community. Pilar's family

judges her for the bad situation she is in and therefore does not support her. However, midwives will help anyone when needed, no matter how this woman is judged by the community. Midwives also leave room for religion and they may, for example, encourage women to pray when in physical pain.

Women can talk about almost any subject with their midwife, even subjects which are surrounded by taboos and therefore not to be discussed. These taboos have led to ignorance among women concerning sexuality and the workings of the body. Midwives are an important factor in discussing these sensitive topics and educating women about reproductive health, therefore midwives play a major role in fighting ignorance and improving women's reproductive health by informing them about motives and options for family planning.

Besides informing women about sexuality, the workings of the body and family planning, midwives also provide information concerning the availability of healthcare options. Whenever complications arise, midwives may refer a pregnant woman to a doctor or nurse. Moreover, they also encourage and inform women to visit a medical facility to receive prenatal vitamins, vaccinations, prenatal checks or at times to give birth. When asked, midwives accompany their patients to these medical facilities; especially when women are not confident to speak Spanish, a midwife can translate. It seems that midwives act as a link between the women they attend to and the biomedical healthcare options available. We had the chance to speak to some doctors and nurses, which has given us some useful insights into their roles in the lives of women. However, to gain more insight into the relationships between midwives and biomedical personnel more research would be needed. Due to the limited time available to us we felt it was impossible to thoroughly research their experiences, visions and perceptions. Furthermore, we suspect that the relationships between midwives and biomedical personnel is even stronger in the *aldeas*. During an extensive visit to the *aldeas*, we talked to numerous *comadronas* and biomedical staff, who underlined the importance of their cooperation. It seems that because of their remote location, there are fewer healthcare facilities although there are more pregnancies than in San Juan La Laguna. However, more research is needed to understand the extent of their cooperation and its comparison to San Juan La Laguna.

All in all, we have seen that women's own perceptions and experiences of womanhood and motherhood are influenced by norms about gender and sexuality, (lack of) knowledge of the body, social position, economic situation and the care they receive. Furthermore, it has become clear that, contrary to what is being claimed in literature,

midwives are almost indispensable in the lives of women. The way womanhood and motherhood are perceived and experienced by women in San Juan La Laguna interact best when their social position is taken into account and when they receive mental, emotional and social support and education. Midwives cater for all of these aspects by providing culturally appropriate care, which is inclusive and accessible to all women. Midwives play a vital role by contributing to improving not only women's health status, but also the social position of these women. Therefore, it is in the interest of both the mothers and their babies to be able to have access to a healthcare system which is inclusive and which welcomes and appreciates the wide range of services midwives provide.

Bibliography

Acevado-Garcia, D., and E. Hurtado.

1997. *Midwives and Formal Providers in Prenatal Care, Delivery and Post-Partum Care in Four Communities in Rural Guatemala: Complementarity or Conflict*. In: Cosminsky, S. 2001. *Midwifery Across the Generations: A Modernizing Midwife in Guatemala*. *Medical Anthropology* 20, p. 345-378.

Adler, P.A., Kless, S.J., and P. Adler.

1992. *Socialization to gender roles: Popularity among elementary school boys and girls*. *Sociology of education* 65, p. 169-187.

Anderson, M.

2012. *A Special Overseas Retirement Letter Survey*. www.liveandinvestoverseas.com. Accessed on 11/05/2017.

American Psychological Association & National Association of School Psychologists.

2015. *Resolution on gender and sexual orientation diversity in children and adolescents in schools*. <http://www.apa.org/about/policy/orientation-diversity.aspx>. Accessed on 18/06/2017.

Berry, N. S.

2006. *Kaqchikel midwives, home births, and emergency obstetric referrals in Guatemala: Contextualizing the choice to stay at home*. *Social Science & Medicine*, 62(8), p. 1958-1969.

2008. *Who's Judging the Quality of Care? Indigenous Maya and the Problem of "Not Being Attended"*. *Medical Anthropology* 27(2), p. 169-189.

2010. *Unsafe Motherhood: Mayan Maternal Mortality and Subjectivity in Post-War Guatemala*. New York: Berghahn Books.

Birx, H.J.

2006. *Encyclopedia of Anthropology*. Thousand Oaks: SAGE Publications.

Browner, C. and E. Lewis.

1982. *Female Altruism Reconsidered: The Virgin Mary as Economic Woman*.

American Ethnologist 9(1). In: Navarro, M. 2003. *Against Marianismo*. In Gender's Place. Feminist Anthropologist of Latin America, ed. Montoya, R., Frazier, L.J., and Hurtig, J.

Brownson, O.A.

2017. *The Moral and Social Influence of Devotion to Mary*.

<http://www.catholicculture.org/culture/library/view.cfm?id=5860>. Accessed on 10/05/2017

Carlson, A.

2007. *Children of the Reformation: A Short & Surprising History of Protestantism &*

Contraception. <http://www.touchstonemag.com/archives/article.php?id=20-04-020-f>.

Accessed on 10/05/2017.

CIA

2016. *Central America and Caribbean: Guatemala*.

https://www.cia.gov/library/publications/resources/the-world-factbook/geos/print_gt.html. Accessed on 06/12/2016.

Chaney, E.M.

2014. *Supermadre: Women in Politics in Latin America*. Austin: Texas University

Press.

Chant, S. and N. Craske.

2003. *Gender in Latin America*. New Brunswick: Rutgers University Press.

Chary, A., Diaz, A.K., Henderson, B., and P. Rohloff.

2013. *The changing role of indigenous lay midwives in Guatemala: New frameworks for analysis*. Midwifery 29, p. 852-858.

Chodorow, N.

1978. *The Reproduction of Mothering: Psychoanalysis and the Sociology of Gender*. Berkeley: University of California Press.

Cosminsky, S.

1994. *Childbirth and Change: a Guatemalan Study* In: MacCormack, C.P.

Ethnography of Fertility and Birth. 2nd Ed Illinois: Waveland Press.

2001. *Midwifery Across the Generations: A Modernizing Midwife in Guatemala*.

Medical Anthropology 20, p. 345-378.

DeMello, M.

2014. *Body Studies: An Introduction*. New York: Routledge.

DeWalt K.M. and B.R. DeWalt.

2011. *Participant Observation: A guide for fieldworkers*. Plymouth: AltaMira Press.

Dillen, A.

2009. *God heeft je zijn gunst geschonken (LC 1,30): Over Maria en andere moeders*.

Kampen: Klement.

Dominguez, J., Franks, M., and J.M. Boschma.

2009. *Feminist Anthropology*.

<http://anthropology.ua.edu/cultures/cultures.php?culture=Feminist%20Anthropology>.

Accessed on 22/12/2016.

Dudgeon, M. R.

2016. *Conceptions of Contraceptions: Feminist Anthropological Perspectives on Men, Women, and Reproductive Health in Two K'iche' Maya Communities*. In:

Lewin, Ellen & Leni M. Siverstein (eds.) *Mapping Feminist Anthropology in the*

Twenty-First Century. Rutgers University Press ISBN 978-0-8135-7428-8. pp. 126-

145.

Durnell Schuiling, K., and F.E. Likis.

2011. *Women's Gynecologic Health*. Burlington: Jones & Bartlett Publishers.

Fischer, E. and C. Hendrickson.

2003. *Tecpan Guatemala: A Modern Maya Town in Global and Local Context*.
Boulder: Westview Press.

Foster, J., Anderson, A., Houston, J., and M. Doe-Simkins.

2004. *A report of a midwifery model for training traditional midwives in Guatemala*.
Midwifery, 20(3), p. 217-225.

Gabe, I., and M. Calnan.

1989. *The limits of medicine: women's perception of medical technology*. Social
Science Medicine, 28, p. 223-231 In: Helman, C. H. 2007. *Culture, Health and
Illness*. London: Hachette UK Company.

Geist, C.

2013. *Motherhood*. <http://www.oxfordbibliographies.com/view/document/obo-9780199756384/obo-9780199756384-0110.xml>. Accessed on 14/12/2016.

Glei, D. A., and N. Goldman.

2000. *Understanding ethnic variation in pregnancy-related care in rural Guatemala*.
Ethnicity and health, 5(1), p. 5-22.

Glei, D., Goldman, N. and G. Rodriguez.

2003. *Utilization of care during pregnancy in rural Guatemala: does obstetrical need
matter?* Social Science & Medicine 57, p. 2447-2463.

Govindasamy, P. and A. Malhotra.

1996. *Women's position and family planning in Egypt*. Studies in Family Planning.
27(6), p. 328–340. In: Do, M. and Kurimoto, N. 2012. *Women's Empowerment and
Choice of Contraceptive Methods in Selected African Countries*. International
Perspectives on Sexual and Reproductive Health 38(1), p. 23–33.

- Glasier, A., Gülmezoglu, M., Schmid, P., Garcia Moreno, C., and P.F.A. Van Look.
2006. *Sexual and reproductive health: a matter of life and death*. The Lancet Vol 368(9547), p. 1595-1607.
- Gupta, G. R.
2000. *Gender, Sexuality, and HIV/AIDS: The What, the Why, and the How*. Can HIV AIDS Policy Law Rev, 5(4), p. 86-93.
- Greenhalgh, S.
1995. *Situating Fertility: Anthropology and Demographic Inquiry*. New York: Cambridge University Press.
- Gutmann, M. C.
1997. *Meanings of Macho: Being a man in Mexico City*. Durham: Duke University Press. In: Nencel, L. *Chapter 6: Anthropology*. In: Marchbank, J., and Letherby, G.
2007. *Introduction to Gender: Social Science Perspectives*. Harlow: Pearson Education Limited.
- Helman, C. H.
2007. *Culture, Health and Illness*. London: Hachette UK Company.
- Hernandez, T. and C. Murguialday.
1993. *Mujeres indígenas ayer y hoy*. Managua: Puntos de Encuentro.
- Hollen, van, C.
1994. *Perspectives on the Anthropology of the Birth. A review*. Culture, Medicine, and Psychiatry, 18, 501.
- Houston, J.
2001. *Final report: midwives for midwives*. Berhorst Partners for Development, Antigua, Guatemala. In: Foster et al. 2004. *A report of a midwifery model for training traditional midwives in Guatemala*. Midwifery, 20(3), p. 217-225.

Ireland M. S.

1993. *Reconceiving women: Separating motherhood from female identity*. New York: Guildford. In: McQuillan, J., Greil, A.L., Scheffler, K.M., and Tichenor, V. 2008. *The Importance of Motherhood among Women in the Contemporary United States*. *Gend Soc* 22(4), p. 477-496.

Jelin, E.

1997. *Engendering Human Rights in Dore, E. Gender Politics in Latin America: Debates in Theory and Practice*. New York: Monthly Review Press, p. 65-83.

Jordan, B.

1978. *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden and the United States*. Eden Press

1997. *Authoritative Knowledge and Its Construction*. In: Davis-Floyd, R. B., and C. F. Sargent, editors. *Childbirth and Authoritative Knowledge*. University of California Press.

Kestler, E., Walker, D., Bonvecchio, A., Saenz de Tejada, S., and A. Donner.

2013. *A matched pair cluster randomized implementation trial to measure the effectiveness of an intervention package aiming to decrease perinatal mortality and increase institution-based obstetric care among indigenous women in Guatemala: study protocol*. *BMC Pregnancy and Childbirth* 13(73), p. 1-11.

Koester, D.

2015. *Gender and Power*. DLP Concept Brief 04.

Kottak, C.P.

2008. *Anthropology: The Exploration of Human Diversity*. New York: McGraw-Hill.

2013. *Cultural Anthropology: Appreciating Cultural Diversity*. New York: McGraw-Hill.

Lavenda, R.H. and E.A. Schultz.

2014. *Anthropology: What does it mean to be human?* 3rd Ed. Oxford: Oxford University Press.

Margulis, M. and M. Urresti.

2015. *La construcción social de la condición de juventud.*

[http://mountainbike.com.co/wpcontent/uploads/2015/12/mario_margulis_y_marcelo_urresti - la construccion social de la condicion de juventud urresti.pdf](http://mountainbike.com.co/wpcontent/uploads/2015/12/mario_margulis_y_marcelo_urresti_-_la_construccion_social_de_la_condicion_de_juventud_urresti.pdf). Accessed on 23/12/2016.

Martin, E.

1991. *The Egg and the Sperm: How Science Has Constructed a Romance Based on Stereotyped Male-Female Roles.* Signs 16(3), p. 485-501.

1996. *The Woman in the Body: A Cultural Analysis of Reproduction.* Boston: Beacon Press.

Martin, J.

1990. *Motherhood and Power: The Production of a Women's Culture of Politics in a Mexican Community.* American Ethnologist 17(3), p. 470-493 In: Chant, S. and Craske, N.

2003. *Gender in Latin America.* New Brunswick: Rutgers University Press.

Maupin, J. N.

2008. *Remaking the Guatemalan midwife: health care reform and midwifery training programs in highland Guatemala.* Medical Anthropology, 27(4), p. 353-382.

Melhuus, M. and K.A. Stølen.

1996. *Machos, Mistresses, Madonnas: Contesting the Power of Latin American Gender Imagery.* London: Verso.

Merriam-Webster.

2017. *Definition of sexuality.* <https://www.merriam-webster.com/dictionary/sexuality>. Accessed on 10/05/2017.

Mitchell, J.

1971. *Women's Estate*. London: Penguin.

Mohanty, C.T.

1988. *Under Western Eyes: Feminist Scholarship and Colonial Discourses*. *Feminist Review* 61, p. 61-88.

Moore, H. L.

1988. *Feminism and Anthropology*. Cambridge: Polity Press.

Moraes-Gorecki, V.

1988. *Cultural Variations on Gender: Latin American Marianismo/Machismo in Australia*. *Mankind* 18(1), p. 26-35. In: Navarro, M. 2003. *Against Marianismo*. In *Gender's Place. Feminist Anthropologist of Latin America*. ed. Montoya, R., Frazier, L.J., and Hurtig, J.

Navarro, M.

2003. *Against Marianismo*. In *Gender's Place. Feminist Anthropologist of Latin America*, ed. Montoya, R., Frazier, L.J., and Hurtig, J.

Nencel, L.

Chapter 6: Anthropology. In: Marchbank, J., and Letherby, G. 2007. *Introduction to Gender: Social Science Perspectives*. Harlow: Pearson Education Limited.

Newman, L.

1975. *Reproduction: Introductory Notes*. In: Raphael, D. *Being Female, Reproduction, Power, and Change*. The Hague: Mouton Publishers.

Options for sexual health (Opt).

2016. *Birth control options*. <https://www.optionsforsexualhealth.org/birth-control-pregnancy/birth-control-options>. Accessed on 10/05/2017.

O'Reilly, A.

2004. *Mother Outlaws. Theories and Practices of Empowered Mothering*. Toronto: Women's Press.

Ortner, S.

1974. *If Female to Male as Nature is to Culture? In Anthropological Theory*. McGee, J. and Worms, R. California: Mayfield Publishing Press, p. 402-413.

Radoff, K. A., Thompson, L. M., Bly, K. C., and C. Romero.

2013. *Practices related to postpartum uterine involution in the Western Highlands of Guatemala*. *Midwifery*, 29(3), p. 225-232.

Rich, A.

1976. *Of Woman Born: Motherhood as Experience and Institution*. New York: W. W. Norton & Company; Norton Pbk.

Rosero-Bixby, L., Castro-Martín, T., and T. Martín-García.

2009. *Is Latin America starting to retreat from early and universal childbearing?* *Demographic Research* 20(9), p. 169-194.

Sanabria, H.

2007. *The Anthropology of Latin America and the Caribbean*. Boston: Pearson.

Sargent, C. and J. Rawlins.

1991. *Factors Influencing Prenatal Care among Low-income Jamaican Women*. *Human Organization* 50(2): 179-187. In: Berry, N.S. 2008. *Who's Judging the Quality of Care? Indigenous Maya and the Problem of "Not Being Attended"*. *Medical Anthropology* 27(2), p. 169-189.

Scott, J.

1986. *Gender: a Useful Category of Historical Analysis*. *American Historical Review* 91, p. 1053-1075.

Shaw, A. and S. Ardener.

2005. *Changing Sex and Bending Gender*. New York: Berghahn Books.

Steenbeek, G.

1995. *Vrouwen op de drempel: Gender en moraliteit in een Mexicaanse provinciestad*. Amsterdam: Thela Publishers.

Stets, J. E. and J.P. Burke.

2000. *Femininity/Masculinity*. pp. 997-1005. In: Edgar F. Borgatta and Rhonda J. V. Montgomery (Eds.), *Encyclopedia of Sociology*, Revised Edition. New York: Macmillan.

Stevens, E.P.

1973. *Marianismo: The Other Face of Machismo in Latin America*. In *Female and Male in Latin America*. Pescatello, A., ed. p. 89-101. Pittsburgh: University of Pittsburgh Press.

Stoner, B. P.

1986. *Understanding Medical Systems: Traditional, Modern, and Syncretic Health Care Alternatives in Medically Pluralistic Societies*. *Medical Anthropology Quarterly* Vol. 17 (2), p. 44-48.

Ulrich, M., and A. Weatherall.

2000. *Motherhood and infertility: Viewing motherhood through the lens of infertility*. *Feminism & Psychology* 10, pp. 323–36. In: McQuillan, J., Greil, A.L., Scheffler, K.M., and Tichenor, V. 2008. *The Importance of Motherhood among Women in the Contemporary United States*. *Gend Soc* (22): pp. 477-496.

Vance, C.S.

2005. *Anthropology Rediscovered Sexuality: A Theoretical Comment*. In: Robertson, J., *Same-Sex Cultures and Sexualities. An Anthropological Reader*. Oxford: Blackwell

Publishing.

Walks, M.

2010. *Anthropology of Mothering*. In: O'Reilly, *An Encyclopedia of Motherhood*. Thousand Oaks: SAGE Publications, Inc., p. 1-13.

Weiss, P.A.

1987. *Rousseau, Antifeminism, and Woman's Nature*. *Political Theory* 15(1), p. 81-98.

Wenger, E.

1990. *Toward a Theory of Cultural Transparency: Elements of a Social Discourse of the Visible and Invisible*. Ph.D dissertation, Department of Information and Computer Science, University of California, Irvine. In: Jordan, B. 1997. *Authoritative Knowledge and Its Construction*. In: Davis-Floyd, R. B, and C. F. Sargent, editors. *Childbirth and Authoritative Knowledge*. University of California Press.

Wings Guatemala.

2015. *Why Guatemala?* <http://www.wingsguate.org/>. Accessed on 20/12/2016.

World Health Organization (WHO).

2004. *International classification of Diseases, 10th Revision*. World Health Organization, Geneva.

World Health Organization (WHO).

2017. *Reproductive health*. http://www.who.int/topics/reproductive_health/en. Accessed on 19/06/2017.

WHO, UNICEF, UNFPA, and the World Bank.

2008. *Maternal mortality in 1990-2008: WHO, UNICEF, UNFPA, and The World Bank maternal mortality estimation Inter-Agency Group Guatemala*.

Appendix A: List with informants

Adam, 21 years old, recently became father, San Juan La Laguna

Adriana, 53 years old, *comadrona* and nurse for 30 years, San Juan La Laguna

Adoración, 17 years old, pregnant with her 1st child, San Juan La Laguna

Aina Elina, 17 years old, pregnant with her 1st child, Pasajquim

Aletta, 71 years old, *comadrona* for 45 years, San Pedro La Laguna

Aloise, 17 years old, pregnant with her 1st child, Panyebar

Amina, 21 years old, pregnant with her 1st child, San Juan La Laguna

Anarosa, 54 years old, *comadrona* for 8 years, Palestina

Antonia, 75 years old, *comadrona* for 45 years, San Juan La Laguna

Beatrisa, 33 years old, pregnant with her third child, San Juan La Laguna

Brisa, fiancée of Rex

Britta, employee Clínica Rxiin Tinamet, San Juan La Laguna

Carlota, 65 years old, *comadrona* for 45 years, San Juan La Laguna

Carrola, 29 years old, pregnant with her 2nd child, Pasajquim

Casia, director of *Oficina de la Mujer*, San Juan La Laguna

Catalina, 39 years old, *comadrona* for 14 years, San Juan La Laguna

Cristiana Lea, 17 years old, pregnant with her 1st child, Panyebar

Diega, 18 years old, pregnant with her 1st child, San Juan La Laguna

Dulcea, 75 years old, *comadrona* for 25 years, Pasajquim

Elodia, 28 years old, pregnant with her 4th child, Pasajquim

Elvira, *comadrona* for 24 years, San Juan La Laguna

Fatima, 55 years old, *comadrona* for 20 years, San Juan La Laguna

Fiona, 54 years old, *comadrona* for 31 years, San Juan La Laguna

Florita, 55 years old, *comadrona* for 15 years, San Juan La Laguna

Gabriela, manager of *Puesto de Salud* in San Juan La Laguna

Henriqua, 16 years old, pregnant with her 1st child, San Juan La Laguna

Hercules, employee of *Puesto de Salud* in Panyebar

Hernando, Director of *RENAP* in San Juan La Laguna

Jada, 23 years old, pregnant with her 2nd child, San Juan La Laguna

Javier, painter and Maya symbol reader, San Juan La Laguna

Jemisa, 28 years old, pregnant with her 3rd child, San Juan La Laguna
Jimena, 16 years old, pregnant with her 1st child, San Juan La Laguna
Jonatan, nurse at *Casa Materna*, San Juan La Laguna
Josune, 37 years old, pregnant with her 3rd child, San Juan La Laguna
Juliana, 39 years old, pregnant with her 3rd child, San Juan La Laguna
Julieta, 19 years old, nurse and *comadrona* in training at *Casa Materna*, San Juan
Kesare, 29 years old, pregnant with her 3rd child, San Juan La Laguna
Laurana, 25 years old, pregnant with her 2nd child, San Juan La Laguna
Leonardo, owner of garden with medicinal plants, grandson of Doña Milica
Lorda, 28 years old, pregnant with her 1st child, San Pablo La Laguna
Lucrecia, employee at Qo'maneel, San Juan La Laguna
Luiza, 37 years old, *comadrona* for 9 years, working as nurse at *Casa Materna*, San Juan
Magdalena, employee at Qo'maneel, San Juan La Laguna
Marisol, administrator and social worker at *Casa Materna*, San Juan La Laguna
Mila Vina, 29 years old, pregnant with 4th child, San Pedro La Laguna
Milica, 71 years old, *comadrona* for 41 years, San Juan La Laguna
Mireya, 21 years old, pregnant with her 1st child, San Juan La Laguna
Olivia, 37 years old, pregnant with her 3rd child, San Juan La Laguna
Persy, employee of *Ami San Lucas*, San Juan La Laguna
Pilar, 30 years old, pregnant with her 2nd child, San Juan La Laguna
Renata, 24 years old, pregnant with her 2nd child, Panyebar
Rex, host brother, San Juan La Laguna
Ricarda, 21 years old, pregnant with her 1st child, San Juan La Laguna
Risa, newborn baby of Pilar, San Juan La Laguna
Rosalía, 47 years old, *comadrona* for 18 years, San Juan La Laguna
Rosealma, 15 years old, mother of one-week-old baby, San Juan La Laguna
Sara, 23 years old, pregnant with her 1st child, San Juan La Laguna
Valería, 29 years old, pregnant with her 1st child, San Pedro La Laguna
Verda, 75 years old, *comadrona* for 50 years, Pasajquim
Vianca, 33 years old, pregnant with her 1st child, San Juan La Laguna

Appendix B: Resumen en español

Nosotras, Esther y Renate, necesitábamos hacer una investigación sobre un tema específico para terminar nuestro grado en Antropología Cultural y Sociología de Desarrollo. Por eso habíamos preparado una investigación, que resultó en un tesis.

Esther tiene mucho interés en la antropología médica y Renate quisiera especializarse en la antropología feminista. Tuvimos que trabajar juntas, y por eso buscamos un sujeto que consiste en las perspectivas de nuestro interés para que pudimos investigar y realizar apasionadas. Nos hemos enfocado en el embarazo y el nacimiento. Elegimos Guatemala para realizar nuestra investigación, específicamente San Juan La Laguna. Nuestra investigación consiste de 4 partes: el estudio de la literatura sobre nuestro tema, el estudio del idioma español en Quetzaltenango, el trabajo del campo en San Juan La Laguna y escribir nuestro tesis con todos los resultados.

Durante la primera parte, el estudio de la literatura, habíamos leído la literatura sobre los embarazos y los nacimientos, y después podríamos concluir que esos procesos no son solamente actos biológicos. Los embarazos y los nacimientos deben ser vistos como construcciones culturales y sociales. Las teorías de la antropología médica y de la antropología feminista muestran que dentro de las comunidades, las mujeres embarazadas se someten a las expectativas, las leyes y las normas sociales; ya sea a través de rituales y tabúes con respecto al embarazo, a través de los sistemas de atención de la salud y a través de los ojos de la sociedad en donde las mujeres viven. Decidimos enfocarnos en el sistema de atención en Guatemala, lo cual es diferente que en Holanda.

Después de nuestra investigación literaria, fuimos a Guatemala. Nos hemos quedado en Quetzaltenango (Xela) por 3 semanas y fuimos a una escuela de idiomas. Por esta experiencia podríamos conocer a personas guatemaltecas, mejorar nuestro español y descubrir la cultura guatemalteca. Nuestro tiempo en esa ciudad fue una buena preparación para conducir nuestro trabajo del campo.

Nuestro trabajo del campo tuvo lugar en San Juan La Laguna, un pueblo pequeño cerca del Lago Atitlán, que tiene algunos miles de habitantes. Vivimos con una familia guatemalteca, con quien nos sentíamos muy cómodas desde el principio. La familia nos ayudó encontrar a nueva gente, conocer el pueblo y practicar nuestro español. Gracias a la familia Sumoza, nuestro trabajo del campo pudo ser un éxito grande.

Para investigar los procesos "el embarazo" y "el nacimiento", era lógica visitar la Casa Materna en San Juan La Laguna. La Casa Materna es relativamente nueva en el pueblo, pero ya ayudó a muchas mujeres con los controles prenatales y los partos. Desde nuestros primeros días, teníamos contacto con la directora administrativa y el staff que trabajan en la Casa Materna. Siempre éramos bienvenidas para visitar el edificio, para hablar con el staff y las mujeres embarazadas y para ayudar tanto como podíamos. La Casa Materna era un lugar muy importante en nuestro trabajo del campo, porque nos mostró el poder de una ONG, que trabaja profesionalmente. Además teníamos mucho contacto con la Oficina de la Mujer. La Oficina de la Mujer asiste a las mujeres y las chicas y sus familias en San Juan La Laguna y las aldeas (Pasajquim, Panyebar y Palestina, pueblos pequeños que son parte de la municipalidad de San Juan La Laguna). La Oficina de la Mujer nos ofreció la posibilidad de participar en sus actividades. De esa manera podíamos encontrar muchas mujeres, especialmente chicas de una edad baja, que están embarazadas o que ya tienen un bebé. Excepto esas organizaciones, visitamos y trabajamos juntas con otras instancias, a saber el Puesto de Salud, Registro Nacional de las Personas (RENAP), Clínica Sanjuanerita, Clínica Rxiin Tinamet. Estamos muy agradecidas por toda la información, la ayuda y las posibilidades que tuvimos por esas organizaciones.

Una parte muy importante en nuestra investigación, es el trabajo de las comadronas. Las comadronas tienen un papel muy importante en Guatemala, porque asisten a las mujeres embarazadas durante el embarazo, el parto y a veces también después del parto. Aunque el trabajo de los doctores está aumentando en popularidad, las comadronas en San Juan La Laguna todavía tienen muchas pacientes y ayudan a la comunidad desde el principio de las vidas. En Holanda no tenemos las comadronas y por eso estábamos extra fascinadas por el trabajo de ellas. Nosotras tuvimos la posibilidad de hablar con todas las comadronas activas en la municipalidad de San Juan La Laguna, incluidas las 10 comadronas en el pueblo San Juan La Laguna y las 5 comadronas que trabajan en las aldeas. La mayoría de las comadronas en San Juan La Laguna trabaja voluntariamente. Por el don (dado por Dios) y los sueños, las comadronas saben cómo ayudar a las mujeres embarazadas. Hoy en día la educación de las comadronas no es solamente por sueños, pero además por cursos y capacitaciones. Nosotras encontramos a comadronas apasionadas que nos mostraron sus trabajos. Podríamos concluir que el trabajo de las comadronas es muy especial y valioso y que las comadronas hoy en día todavía desempeñan un papel importante en la comunidad.

Para coleccionar información completa, tuvimos que hablar con e investigar las mujeres

embarazadas y las mujeres que recientemente son madres. La municipalidad San Juan La Laguna tiene más o menos 420 mujeres embarazadas por año y por eso no había mucha dificultad encontrar a ellas. Por la Casa Materna, la Oficina de la Mujer, las comadronas, la familia con quién nos vivimos, las mujeres que ya nos conocimos, una tienda con ropa de los bebés, pero además por estar en las calles, encontramos a más de 30 mujeres embarazadas y madres. Fue un placer hablar con ellas, compartir experiencias y aprender sobre los embarazos y los nacimientos. Nos sentimos agradecidas por su apertura, su honesta y todas las amistades.

No fue fácil, pero después de 8 semanas, necesitamos despedirnos de la comunidad en donde vivimos con mucho placer. Fuimos a Holanda para escribir sobre todos los resultados que obtuvimos. Gracias a toda la gente y todas las organizaciones tenemos suficiente información para escribir sobre los embarazos y los nacimientos en San Juan La Laguna. Aunque nuestro tiempo allí fue (en nuestro ojos) demasiado corto, San Juan La Laguna siempre estará en nuestros corazones y esperamos que podamos volver en el futuro.

Appendix C: Photos of San Juan La Laguna



Photo 1: Main street of San Juan La Laguna.

Source: Private collection, 26/02/2017.

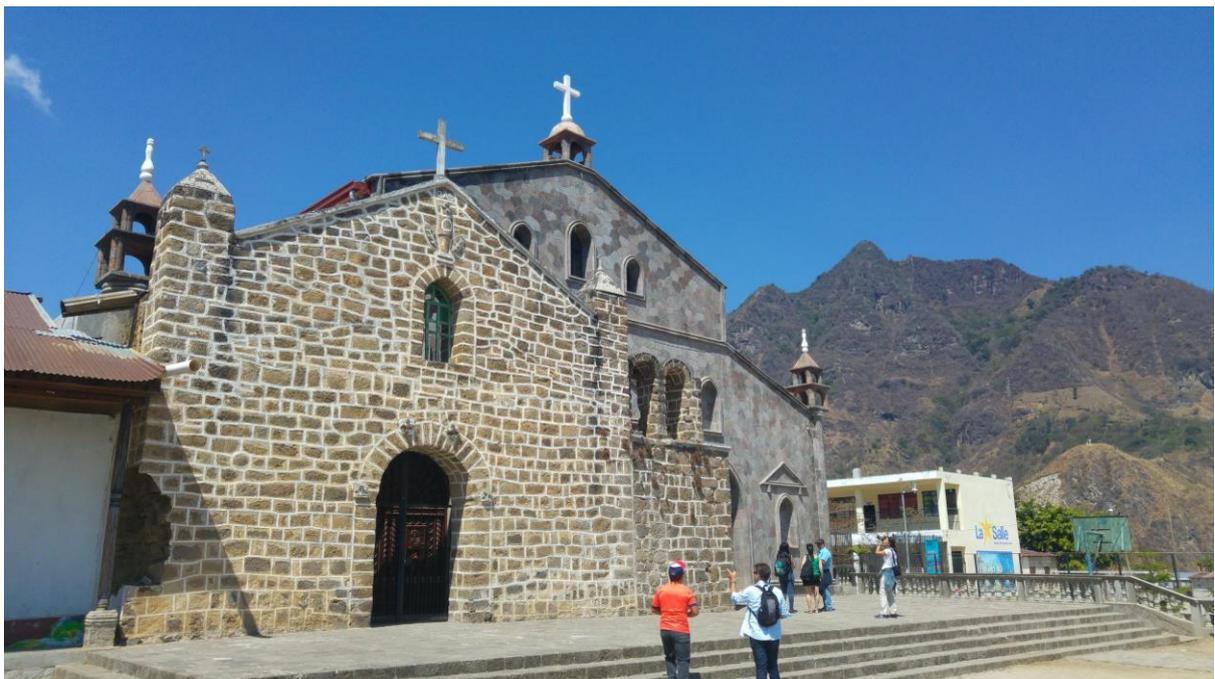


Photo 2: Catholic church, San Juan La Laguna.

Source: Private collection, 27/02/2017.



Photo 3: Down at Lake Atitlán, San Juan La Laguna.

Source: Private collection, 27/02/2017.



Photo 4: *Casa Materna*, San Juan la Laguna.

Source: Private collection, 27/02/2017.



Photo 5: Day trip to the *aldeas*.

Source: Private collection, 20/03/2017.



Photo 6: Esther interviews a *comadrona*, Panyebar.

Source: Private collection, 20/02/2017.



Photo 7: Renate interviews a pregnant woman, Pasajquim.

Source: Private collection, 20/03/2017.



Photo 8: Together with our host family, San Juan La Laguna.

Source: Private collection, 21/04/2017.



Photo 9: Wearing *traje típico* during *Viernes Santo*

Source: Private collection, 14/04/2017