



4-29-2015

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Family Planning, Pregnancy, and Birth in Guatemala: Maya Women and Modern
Healthcare

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Undergraduate Thesis
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Abstract

Within Maya populations in rural Guatemala, childbearing is considered a sacred and spiritual experience, in addition to a physical one. This country is home to some of the highest rates of maternal and infant mortality in Latin America, along with the largest disparities in health care, primarily between the indigenous Maya and ladino women (Schooley 2009). The use of biomedical reproductive services remains surprisingly low among the Maya, while it is continually rising in the ladino populations. To increase the overall reproductive health care in these indigenous communities, attention must be given to the understanding of Maya's beliefs, therefore enabling quality care to be provided that is culturally acceptable. To bridge this gap between economic, social, ethnic, and cultural differences between the Maya and ladinos, there must be an increase in respect from the ladino population for the Maya's traditional practices and an integration of health care services.

Introduction

Guatemala is a country that is defined by high maternal and infant mortality; it is characterized by some of the highest rates in Latin America. Recent assessment has indicated a maternal mortality rate ranging from 156.2 to 240 per 100,000 births and an infant mortality rate estimated at a range of 41 to 49 per 1000 births, compared to a rate of 30 per 1000 births for the other Latin American countries (Schooley et al., 2007: 412). The statistics are less favorable overall for Maya women, who have national maternal mortality rates that are almost double the national statistics (Schooley et al., 2007: 412). However, the use of biomedical services for pregnancy care remains low; this is especially true in rural areas, where the Maya primarily reside. There are 4.4 million speakers of the Maya family languages in Guatemala, therefore making it the country with the largest number of Maya people (Magnoni, Ardren, & Hutson 2007: 356). The high rates of maternal and child death in this population has led to an increased interest in promoting various family planning services, which has resulted in a more widespread availability of reproductive health services within the areas where the Maya reside. However, resistance to these services is observed in these populations (Ward, Bertrand, & Puac 1992). Refusal of these services is multifactorial, involving health beliefs, individual characteristics, structural disadvantages, and cultural aspects (Lindstrom & Muñoz-Franco 2006). Simply making contraceptives and modern biomedical practices available will not lower mortality rates and improve maternal health within the Mayan population; it requires services that are molded to their perspectives, beliefs, and exhibit a sensitivity to structural issues.

History of the Maya in Guatemala

Lovell argues that native life in Guatemala is regarded as a “heritage of conquest”, which connects the modern-day Maya with their ancestors through the centuries. The Spanish conquest of Guatemala began in 1524 (Lovell 1988:28). The Maya displayed intense resistance, constantly engaged in hostile confrontations with the Spanish troops. The conquest of Guatemala was difficult and long lasting, in contrast with the Spanish conquest of central Mexico, which was accomplished with quick efficiency. The Spaniards were assisted in their conquest by Old World diseases, such as smallpox, measles, and mumps. These diseases are thought to be the single most significant factor in the pattern of Maya depopulation. However, it is not the only factor; intense slaughters, exploitation, abusive treatment, and culture shock all played a role as well (Lovell 1988: 28). Furthermore, Newson argues that there are two other important factors in regard to the nature of the Spanish conquest; the nature and size of the Indian societies, which defined the type of practices used to control and exploit the Maya, and the profitable resources that were present in the areas the Maya resided (1985).

The first decades of the conquest put emphasis on devices such as *encomienda*¹ and *repartimiento*², which enabled privileged Spaniards to receive goods and services from the Maya communities without being given land distribution rights. Not until the exploitation of native labor proved to be an unpredictable source of wealth did the Spaniards use this exploitation as an alternative mechanism of support. The legislation

¹ Forced labored system in which the Spaniards received property rights for Indian labor from the Crown whereby the Spaniards could take tribute from the Indians in forms such as goods, money, metals, or direct labor services (Yeager 1995: 843).

² Forced system of production and consumption imposed by officials of the Spanish crown, compelling Indians to produce goods marketable in the Spanish economy and to purchase expensive, undesired Spanish products (Baskes 2000).

known as *composición de tierras*³ was enacted, which was specifically created to raise funds by selling lands that were thought to belong to the Crown throughout Spanish America. Gaining land and labor to work were strategies that initiated the exploitation of the Maya work force, which had begun to decline in size since the early sixteenth century, with some regions experiencing a loss of 90 percent or more (Lovell 1988: 30).

Spaniards were not drawn to all parts of Guatemala equally. They were concentrated near the colonial capital city of Santiago; the highlands to the north and west were perceived as having little commercial importance, therefore *congregación*⁴ was never as intense in the highlands. More Spaniards infiltrated native communities that were placed around the colonial capital city of Santiago, resulting in a quicker assimilation process and producing a mixture of Maya and Spaniards, also known as ladinos. Native people in the highlands were able to withstand acculturation by being able to hold onto their land, keeping Maya ideas of community organization, and guarding a place they perceived as being their home. The present day Indian community is regarded as “a direct descendant of the reconstructed community of the seventeenth century” (Lovell 1988: 31).

Colonial Guatemala had a native life that was founded on the “dualization of society” (Lovell 1988: 36); the Maya displayed varying levels of submission to serve the Spaniards. Most Spaniards took this submissiveness for granted, believing it was a right that was simply obtained from conquest. Therefore, coexistence under these conditions did not encourage mutual respect. Instead, it cultivated suspicion, distrust, hatred, and

³ Grantees to pay a fee to confirm titles for land holding (Rowe 1957: 181).

⁴ Policy that coerced thousands of native families from their homes in the mountains into new settlements (congregaciones) built around churches located in open valley floors (Lovell 1988: 30).

fear. Subordination was maintained by terror and it must not be underestimated. This was not just a physiological state, but “a social fact and a cultural construction whose baroque dimensions allow it to serve as the mediator *par excellence* of colonial hegemony” (Taussig 1984).

Guatemala gained independence from Spain in 1821 and following the unsuccessful liberal efforts to initiate the United Provinces of Central America between 1823 and 1839, was governed until 1870 by a series of conservative authorities. The liberals returned to power in 1871, led by Justo Rufino Barrios. President Barrios initiated the progression to modernization by promoting foreign investments, and repossessed native land and labor. Decrees were passed that ordered communal land be subdivided among community members, then the privately titled. However, Maya farmers were not always aware of these proclamations, or they did not understand them. Therefore, land that was considered unclaimed by the liberal government was taken by the creoles and ladinos, who were much more fluent in the language of landholding laws than the Maya (Lovell 1988: 38). It is believed that the Maya lost nearly half of the land they originally claimed during the colonial times (Smith 1984: 204). According to Carmack, foreign investments were considered to be so disastrous they initiated a “full-scale guerilla warfare,” solidifying the military’s practice of attacking its own citizens (1983: 242). The ladinos initiated close relationships with national dictators and used these relationships to establish an authoritarian system of government within their communities, using terror as a mechanism of ruling. The structural inequalities that resulted from the ethnic manipulation, caused by foreign investments, are still present in Guatemala today (Lovell 1988: 37).

The only serious governmental attempt to challenge these socioeconomic inequalities occurred from 1944-1954 (Lovell 1988: 42), later deemed the “Ten Years of Spring,” which was initiated by the country’s first democratic elections, which resulted from a coup overthrowing the dictator Jorge Ubico. The army officers who led this coup were committed to ideas of progress and development, which they pursued through economically liberal state policies (Fischer & Hendrickson 2003: 30). However, a CIA-led coup put an end to the Ten Years of Spring after the government of Jacobo Arbenz began to requisition unused lands that were owned by the U.S. based United Fruit Company. This 1954 rebel group pronounced the start of a line of right-wing leaders, mostly from the military, who increased the power within the Guatemalan state by defending the concerns of large landowners. By the early 1960s, guerrilla resistance had broken out in the eastern areas of Guatemala. The army, which was supported by assistance from the U.S., overreacted to these threats and viciously attacked communities, initiating a state of siege where people were incriminated as rebels or collaborators. By 1968, the force of the military increased greatly, overpowering the dawning rebellion. Therefore, the guerillas disassembled and went underground, re-emerging in the mid-1970s in the Indian-dominated highlands (Fischer & Hendrickson 2003: 30).

During the late 1970s and early 1980s, Guatemala was home to a lot of danger and violence, immersed in an escalating civil war between the state and army against many independent guerilla groups (Fischer & Hendrickson 2003: 66). Newspapers inconsistently reported the numbers of bodies that were abandoned, or buried in clandestine graves. The villages in the countryside that were presumed to be involved with guerilla forces were completely eliminated; about 440 burned to the ground (Fischer

& Hendrickson 2003: 66). Therefore, it is understandable that there was a widespread, constant fear in communities around the country; they never knew when a stranger may show up and take a family member away, attack a community, or a bus would be stopped and a “guerilla informant” would walk down an aisle and take people away for “questioning” (Fischer & Hendrickson 2003: 66). In the most savage cases, soldiers would stab pregnant women, slam babies’ heads against a wall, and burn people alive. However, the kidnapers and attackers were usually not clearly identified as guerillas, government soldiers, or members of the paramilitary groups with ties to the government because they all engaged in similar techniques. The Maya were viewed by the army, in concordance with the state, as agitators and therefore, deserving targets for military action. Firstly, those in favor of the violence argued that the modern Maya are direct descendants of the pre-Hispanic Maya, who ripped hearts out of living prisoners and were fearless rulers. Secondly, it was suggested that the Maya Indians are ignorant, too confined to their traditional ways, and easily deceived by the guerilla leaders. Therefore, genocidal slaughters and whole-scale destruction of the Maya was justified as a way to maintain the greater common good. However, among the Maya the reasons behind the kidnappings and killings were very unclear, therefore adding an element of fear to their everyday life (Fischer & Hendrickson 2003: 67).

What these incidences tell us is that the Guatemalan government was intent on ensuring there were no types of community initiatives that would obstruct capitalist development, therefore securing the best native lands and the essential native labor force to further drive the socioeconomic inequalities already present. To guarantee this, the government developed a sense of terror by carrying out premeditated acts of violence; the

Guatemalan government declared war on its own citizens, primarily the indigenous. The widespread and barbarous slaughter claimed the lives of tens and thousands of Maya between 1981 and 1985. The killing of the Maya was effective at traumatizing the survivors into submission, consequently producing fear and suspicion that causes the deterioration of the unification of villages and their compliance (Lovell 1988: 45).

The counterinsurgency experienced in the 1980s, as well as the earlier oppression by imperial Spain, does not represent a victory or a defeat. It does represent, however, intrusions into the lives of Maya Indians, which they have to absorb and somehow respond to in ways that will ensure the preservation of their culture, as well as constructing their own futures with resources that are readily available to achieve their best interests (Fischer & Hendrickson 2003: 67). Although the past weighs quite heavily on the present and life as a Maya Indian in Guatemala is difficult due to these cycles of conquest, it has yet to abolish their culture (Lovell 1988: 47-48).

Today, the Maya inhabit a region that spans almost five hundred thousand square kilometers across four Central American countries, including: Guatemala, Belize, Honduras, and El Salvador. The Maya also live in five Mexican states, including Chiapas, Tabasco, Campeche, Yucatán, and Quintana Roo. Guatemala is home to the largest population of Maya, with 4.4 million, but Mexico comes in second, with 1.87 million Maya. The term Maya refers to speakers of 31 languages that are a part of the Maya family. These people are descendants of the ancient Maya civilization that thrived in prehispanic times. Maya-speaking people belong to a culture that is quite heterogenetic; ethnic consciousness, language, and culture vary due to the different nation states and historic routes (Magnoni, Ardren, & Hutson 2007: 354-355).

The population of Guatemala is composed of the indigenous Maya and the ladino population, which can be defined as people who are of both indigenous and European origins. They view themselves as a part of the national Guatemalan culture, speak Spanish, and wear Westernized clothing. The ladinos dominate the politics of Guatemala, the military, the upper class of society, as well as higher levels of income and education. In comparison, the indigenous Maya are characterized by disadvantages and are labeled as poor (Glei, Goldman, & Rodriguez 2003). The primarily urban residence of the ladino population and the primarily rural residence of the Maya supply an additional dimension. Therefore, the Maya show the classic characteristics of a hard-to-reach population: poverty, rural residence, and low education levels (Terborgh 1995: 143).

- **Demographic health transition**

The concept of the demographic transition essentially states that societies that participate in modernization will progress from a pre-modern pattern of high fertility and high mortality to a post-modern one, in which both of these are low. According to Kirk, the term ‘modernization’ does not have a strict definition and does not necessarily explain the specific causes that result in demographic transition (1996). However, the process of modernization has happened concurrently with these declines in mortality and fertility. Therefore, it is crucial to view the factors that influence this ‘modernization’, therefore defining the causation of the demographic transition. These factors include overall improved standards of living, religious beliefs, increased female education, the acceptance of innovation, and the government.

How does the process of modernization contribute to the decline mortality and fertility rates? The modern mortality decline can be attributed to the reduction in

epidemics by an overall improved standards of living; vaccinations and improved hygiene, improvement of the accuracy of diagnosis and treatment plans, reduction of famines, fewer deaths from wars and violence, and education are all factors. The decline in fertility rates is attributed in the proximate sense to increased contraception use (Kirk 1996: 362-363). However, the use of contraceptives must be preceded by a motivation for birth regulation. These motives are believed to be largely self-centered, involving the high cost of children, their ability to cause stress, the limitation of relaxation and leisure time for the parents, and the fear of obstetrical complications a woman may experience (Kirk 1996: 363).

Lesthaege claims that the difference in fertility levels and the rate at which they change are directly related to differences in religious beliefs and practices and in the degree of secularism, materialism, and individuation (1983). Relating this ideology back to fertility decline: “A fertility decline is in essence part of a broader emancipation process. More specifically the demographic regulatory mechanisms, upheld by the accompanying communal or family authority and exchange patterns give way to the principle of individual freedom of choice, thereby allowing an extension of the domain of economic rationality to the phenomenon of reproduction” (Lesthaeghe 1983). He reports on the decline in traditional religious beliefs and church attendance, in parallel with an increasing emphasis on individual wants, in contrast to community needs. The recent changes of direction towards a preoccupation with individual welfare and self-fulfillment have been associated by increases in pre-marital sexuality and cohabitation, more children born out of wedlock, more divorce, etc., and also further declines in fertility.

Another method that is considered a strategy for reducing population growth emphasizes 'human development', which involves increased education, raising women's status, and the overall improvement of child health. When education equality between the sexes is achieved, resulting in legal, economic, and social equality, the cost of children, making roles other than childbearing more attractive to women. Moreover, reducing child mortality and increasing the factors that improve child welfare have been associated with fertility reduction everywhere (Kirk 1996: 377).

The rapid and extensive fertility declines cannot be explained without the acceptance of innovation; innovation usually needs to be accepted throughout the community before it is widely engaged in. Innovation is not simply an aftermath effect, but an ongoing promotion or obstruction to the practice of fertility control. Historically, diffusion of innovation precedes fertility reduction, and is not simply an adjustment to new socio-economic conditions. An individual's and couple's engagement in family planning can be attributed to the acceptance of innovation, rather than by solely socio-economic conditions. Essentially, fertility control is as much a community decision as a decision of the individual or couple (Kirk 1996: 378). It is highly unlikely that family planning programs are going to succeed within rural populations unless it is through small, primary groups that define the social structure of these villages (Freedman 1987).

The government plays an important role in reducing both mortality and fertility. Reduced mortality rates results from a more active government that provides pure water, vaccination services, control of epidemics and famines, education, as well as other public health measures. The promotion of nationwide peace by reducing warfare has also reduced mortality rates in modern states; through policing there is reduced violence and a

rise in public safety. In addition to mortality, the government's influence on fertility is also just as important. Governmental influence on obligatory schooling has increased the cost of children, as do the laws that prohibit child labor and exploitation (Kirk 1996: 375).

- **Ladino/Maya maternal and child health dynamics**

Guatemala is home to one of the highest levels of health inequalities in Latin America, which can be attributed to the socioeconomic and regional disadvantages that the Maya experience. Language barriers and low education levels among the Maya may contribute to the discrepancy present in women's decision to use, or not use, biomedical reproductive health services (Ishida et al., 2012). In comparison to their ladino neighbors, maternal and child health outcomes are not favorable in the Maya population, and the use of modern health care services is also low (Glei, Goldman, & Rodriguez 2003).

The ethnic differences in maternal and child health are large; the total fertility rate for ladino women was 3.1 compared to 4.5 among Maya women in a 2008-2009 survey (Ishida 2012: 99). Guatemala's total fertility rate, which refers to the number of live births a woman will have through out her lifetime, declined from 1987 to 2002, reducing from 5.6 to 4.4. However, this total fertility continues to be one of the highest in Latin America (Ishida 2012: 99). Correspondingly, Guatemala's annual child mortality rate remained the highest in Central America; the mortality rate of children under five was 33 per 1,000 in the ladino population compared to 51 per 1,000 in the indigenous Maya population (Ishida et al., 2012: 99-100).

The low level of government spending is an important aspect of the alarmingly low levels of maternal and infant health present in Guatemala. The total government

expenses attributed to healthcare is only 28% of all expenses, which is lower than any other Latin American country (Ishida et al., 2012: 100). This has had a negative effect on indigenous Maya, who are immensely poor and live predominantly in rural areas. The ladinos are able to receive healthcare at private clinics and hospitals, which are primarily located in the urban cities, that may be expensive. The Maya generally use government-run health facilities that are free or subsidized, if they use healthcare services at all. The Maya's low socioeconomic status in Guatemala also leaves them at an educational disadvantage, which may also contribute to the lack of patient knowledge and their ability to communicate health concerns properly (Ishida et al., 2012: 100). Due to the violence of conquests the Maya have experienced through out the years, they also tend to not trust the government and have constant suspicions of their motives.

Traditional contraception

In Guatemala, there is a low overall use of modern contraceptives, but usage among Ladino women has increased considerably in the last decade, rising from 22% to 34% of women using contraceptives, with levels of use remaining low among Maya women, increasing from 4% to 6% of women using contraceptives (Ward, Bertrand, & Puac 1992: 59). Many Maya couples attempt to engage in family planning with traditional methods, including the "natural" or rhythm method, abortifacients, celibacy, and postpartum neglect. However, these methods are unreliable, potentially harmful, and socially stigmatizing due to the lack of community acceptance of contraceptives (Metz 2001: 265).

The "natural" or rhythm method is a fertility awareness-based method, whereby a woman will identify her most fertile time within her menstrual cycle, which is a time to

practice abstinence. This method has been indicated as the most acceptable among the Maya, in comparison to modern methods. The effectiveness of this method is highly variable between different cultures and within different couples. When commonly used, this method is considered to only be somewhat effective, but if used correctly and consistently, it is found to be more effective (Burkhart et al., 2000). However, even when couples have more accurate understandings of a woman's cycles, couples must also deal with the irregularities of fertility cycles, which are even more prominent during times of nutritional and emotional stress (Metz 2001). Maya women may experience these kinds of stresses due to the inability to provide food for their children, family, or themselves.

Many of those within the Maya population have little biomedical knowledge in regard to when women are most likely to conceive. Generally, among the Maya, women are considered to be fertile and most likely to conceive before, during, or directly after their menstruation (Burkhart et al., 2000). However, the most fertile time of a woman's menstrual cycle, or the "fertile window", occurs five days before ovulation and one day following ovulation. Therefore, this "fertile window" before and after ovulation is the time intercourse will most likely result in pregnancy, with the variability of a woman's cycle taken into account (Wilcox, Dunson, & Baird 2000: 28). Therefore, most Maya couples are probably practicing abstinence at the wrong times of a woman's cycle and having sex when she is at risk to conceive. The incorrect use of the "natural" or rhythm method is not exclusive to the Maya population; most Guatemalans do not receive the full benefits from this method (Metz 2000: 265).

Some Maya turn to traditional healers to help them prevent pregnancy by inducing menstruation or causing permanent sterilization with herbs, or other techniques.

According to Metz, the most commonly used substance is the avocado pit, which is described as a preventative for pregnancy by some and an abortifacient by others (2001: 265). Other methods used to prevent pregnancy include the use of lemon and vervain (a common herb), and aspirin as a vaginal suppository. Other substances used as abortifacients include soot from cooking, broth from black beans, beet juice, orange leaves with rue, rice with eucalyptus leaves, and a plant that is used to produce purple dye. All these substances and herbs have a coincidental characteristic in common; they all have dark colors that resemble blood (Metz 2001: 265). In addition, the practice of participating in a temascal bath (a sauna used by Maya women for relaxation and medical purposes; usually used after childbirth), integrated with strong massages and various herbal drinks, is also associated with the initiation of an abortion (Ward, Bertrand, & Puac 1992: 63; Metz 2001: 265). There is yet to be substantial proof provided regarding the use of traditional abortifacients and the effectiveness; they may even cause harm to the woman. Some women resort to drinking “poison” to induce an abortion, or try to perform one by abdominal binding, potions, pills, injections, and the insertion of hoses, sticks, and wires; ultimately, leading to serious illnesses or even death (Metz 2001: 265).

Other traditional methods of controlling a women’s fertility include selective postpartum neglect and postpartum abstinence. Selective postpartum neglect might be practiced either consciously or unconsciously. For example, parents tend to give more food and medicine to some children rather than others, which again, may happen unconsciously (Metz 2001: 265). Postpartum abstinence is a very accepted practice. It is widely believed to be a crucial component in women’s health and men who do not respect this abstinence period are thought of as reckless and insensitive towards their

wives. While it is generally accepted that postpartum abstinence should last for around 40 days, it may go on for much longer periods of time. It is believed that the Maya ancestors used to engage in postpartum abstinence for very long periods of time, but the tradition has been altered in current times (Ward, Bertrand, & Puac 1992: 63).

Traditional birthing

Roughly one half of all births in developing countries are assisted by a traditional birthing attendants (Walsh 2006: 148). In Guatemala, it is estimated that 59% of births are attended by traditional birth attendants or unskilled family members or friends. In rural areas, this number tends to rise (Walsh 2006: 148). The most common birth attendant in Guatemala is the *comadrona*, especially prevalent in the indigenous communities of the Maya. A *comadrona* is a traditional birth attendant who may or may not have training in midwifery. These women are typically trusted within the community, are thought to be wise, and to have a calling to be midwives. However, they are usually belittled by the modern health care system due to their gender, ethnicity, and lack of education. They also tend to shoulder all the blame for the high mortality rates in the country by official sources (Walsh 2006).

It is estimated that 75-85% of Maya births occur in the home, with the assistance of a *comadrona* (Schooley et al., 2009: 412). There are three themes that embody the *comadrona*'s importance: sacred calling, sacred knowledge, and sacred ritual. All *comadronas* are called into the work of midwifery through communication from God, or a saint, through dreams or visions. Therefore, this results in the thought that this calling is "sacred." If a woman denies this sacred calling, she will fall ill and become impaired with

some kind of sickness and it is not relieved until she decides to accept the calling (Walsh 2006).

Although most *comadronas* take on the role of a midwife without any formal training, they gain the knowledge of their work through dreams and visions that are described as a direct communications with God. These communications provide information on how to deliver the baby, foretell outcomes of births, and rely various facts regarding the birth. *Comadronas* also describe bodily reactions and functions that can be interpreted as messages from God. If a right eye twitches, this can be interpreted as a normal birth. However, if it occurs on the left side, complications are to be expected. In addition, some *comadronas* gain experience of midwifery at a young age. According to Howell, it may be common for girls to learn the art of guiding women through pregnancy and childbirth from observation, especially if someone close to them is a *comadrona*, such as their mothers. *Comadronas* may also consult each other on difficult cases and learn from each other (Howell & Levi 2008: 8-9).

The act of birth is itself a sacred ritual; *comadronas* prepare for them by praying before they leave their home before every birth. Other similar preparations include burning incense, or going to church and lighting a candle in front of the Holy Virgin to pray for a safe and successful delivery. Once a *comadrona* arrives at the home of the woman in labor, she prays before entering. Upon entering the home, *comadronas* usually continue to pray for up to half an hour, before even having contact with the patient. Many laboring women will engage in these spiritual activities themselves. Many religious artifacts, such as candles and incense, are also brought and set up in the home to create a spiritual atmosphere for the birth. However, some families will create these sacred spaces

themselves. *Comadronas* believe their praying allows God to be able to work through their hands during the birth.

Once the prayers and the sacred space is complete, *comadronas* use their skills obtained through their dreams to aid in labor and delivery. These skills include examination of the mother's abdomen to determine position and size of the baby and a vaginal examination to determine dilation. Through this examination of the role of a *comadrona* in pre-natal care and birth, it is evident that the Maya culture views childbirth as a spiritual event, not simply a physical one (Walsh 2009: 151-153).

Maya perceptions of biomedical reproductive health services

People of all ages usually conform to the norms of their communities. In regard to biomedical reproductive services, the social norm among the Maya is dominated by a strong disapproval of the use due to the desire for large families, religious beliefs, disapproving from community leaders, and widespread distrust of these services. Women and men together share the idea that those who are suspected of using contraceptives are highly judged by their fellow community members (Ward, Bertrand, & Puac 1992). Therefore, those who do use contraceptives try extremely hard to keep it hidden from family and friends. The Maya community is very resistant to the use modern contraceptives and biomedical practices, but what are the underlying reasons?

As previously discussed, the use of contraceptives must be preceded by a motivation for birth regulation. However, the Maya do not usually have motives to have small families and restrict births; the Maya society is primarily an agrarian one. Therefore, large families are considered advantageous and ultimately, the goal. One young, married Maya man indicated that, "Our fathers say we are weak now because we

only have six or eight kids; before it was normal to have 14 or 15 kids” (Ward, Bertrand, & Puac 1992).

One dominant reason for wanting a large family in an agrarian society is the economic security it provides when the parents grow older. There is no welfare system in place within the Maya communities, therefore when the parents become older and unable to support themselves, their children support them with necessary resources. In addition, with strength residing in numbers, the prosperity and strength of the Maya would eventually decline if smaller families became the norm (Ward, Bertrand, & Puac 1992). Some Maya couples lend their children to their childless family members not only to help with labor, but because a house without a child is considered lonely and useless; children make lives meaningful. In addition, rural indigenous communities are characterized by a lack of structured law enforcement. Therefore, Maya community members must rely on family for defense when a confrontation may arise, usually against ladinos (Metz 2001: 264).

Another reason the Maya do not wish to restrict their births is their religion. Within the traditional Maya communities, the Catholic Church is a primary source of family planning information. Premarital classes are given where couples learn that they need to have all the children that God blesses them with. It is a very widespread idea that God decides how many children a woman will have and that she is born with all the children she will bear in her lifetime within her. Furthermore, having children is considered to be the sole reason for human existence and the dominant reason for marriage. Therefore, Maya couples do not get married and just have children; instead they wed in order to have children (Ward, Bertrand, & Puac 1992).

With the Catholic perspective on childbearing understood, it is easy to comprehend why family planning is a form of murder to Maya people. The Catholic Maya community leaders (catechists, pastors, etc.) are widely known for being opposed to family planning services and exhibit distrust for those who attempt to promote it. Therefore, they exert a strong influence on its use by claiming it is a harmful sin. There is an agreement through the Maya population that these services are a sin due to the widespread knowledge of their leaders' perceptions of family planning (Ward, Bertrand, & Puac 1992).

With the Maya occupying more rural areas and the ladinos occupying the urban areas, the spread of family planning programs and biomedical services to rural areas would result in the Maya obtaining better access to these services. There is an overall association with the strength of these programs and the decrease of fertility rates (Kirk 1996: 376). However, the amount of success is also associated with the readiness to adopt contraception, which is measured by socio-economic development, desired family size, etc. (Kirk 1996: 376).

However, it is important to note that in Guatemala, increasing the proximity of biomedical pregnancy services is unlikely to have an impact on its usage by the Maya (Glei, Goldman, & Rodríguez 2003). This may be due to the lack of adequate care in these government facilities, which may be attributed to the low government spending on health care. These biomedical care facilities normally lack trained professionals and important supplies and medicines. The perceptions of poor care, limited hours of service, and lack of confidence in these biomedical services are all proven reasons for not capitalizing on the opportunity to use them (Glei, Goldman, & Rodríguez 2003).

Moreover, the lack of attention paid to the many cultural, social, and structural factors that affect the decision to seek biomedical pregnancy care may hold the key to why the many policies related to the use of health services have proven to be ineffective. Many biomedical providers do not speak any of the indigenous languages, although they are serving mostly the indigenous population. The medical staff has also been known to be condescending and discriminatory towards the poor, and indigenous. Many other social and cultural obstructions play a role in the refusal of biomedical pregnancy care, such as fear of the medical staff (who are primarily ladinos) and embarrassment of being examined (due to the generally male domination over the medical profession) (Glei, Goldman, & Rodriguez 2003: 2449).

The government plays a key role in the emphasis of 'human development', particularly in regard to education of girls and raising women's status (Kirk 1996: 377). It is important to keep in mind that there is a clear relationship between socioeconomic class and measures of wealth and the use biomedical reproductive services. Ladinos occupy the higher social and economic classes, therefore they tend to have a higher rate of use of these services. The increased use of these services is also seen in areas where women that are more educated, which is thought to be attributed to the quality distribution patterns of finances, greater control over these resources, increased freedom in decision-making, self-confidence, and a more active demand for valuable service from biomedical providers (Glei, Goldman, & Rodriguez 2003: 2449). The education of girls has been shown to be a key factor in fertility decline as well, due to the delay of marriage and first births (Kirk 1996: 377).

A widespread acceptance of biomedical reproductive services cannot be explained without the diffusion of new ideas and techniques, especially in areas such as Guatemala with linguistic and cultural areas that differ in levels of modernization. These pathways of diffusion are most likely to flow through friends, neighbors, relatives, and the local community where there is a larger area for common language and culture to establish lines of communication (Kirk 1996: 378). The number and type of social ties that a woman has also plays a role in the use of biomedical reproductive services, by either serving as contacts or by providing necessities, such as money or transportation. It has been shown that having social contacts outside of one's own community, in either a larger urban area or abroad, will increase the chance that a woman will attribute the origin of her illness to the medical causes and seek biomedical health care (Goldman, Pebley, & Beckett 2001).

When discussing family planning and reproduction health care, it is impractical to not note gender roles in the home and the community. Maya men are in almost complete control of decision-making in regards to reproduction. Many husbands feel that it is their right to have sex whenever they feel like it (Metz 2001: 266). It is also very common within the Maya community for men to exert control over family planning. Metz recounted a case where a husband was desperately seeking birth control pills after the birth of his eighth child, with the other seven already experiencing stunted growth, hair loss, and distended stomachs. He was disappointed to learn that these pills cannot simply be taken once, before or after sex. He works at a plantation that is away from home for about half a year and hoped that he would be able to withhold the pill when he was gone, therefore being able to supervise whether his wife was having sex with other men and

getting pregnant by others. As a matter of fact, many health clinic staff members privately confided to Metz and disclosed that husbands questioning of their wives loyalty is a common reason for denying the pill (Metz 2001: 266).

The racist intimidation present between ladinos and the Maya has been a result of the history of discrimination, exploitation, and social exclusion due to the Mayas dress, language, and knowledge. Therefore, Maya often feel uncomfortable about visiting public Ladino organizations such as offices, banks, and health clinics. Moreover, Maya view contraceptives as a way to eliminate Indians (Metz 2001: 266). Indigenous people are also very suspicious of government-run family-planning programs, which they conclude to be the ladinos plot to, once and for all, get rid of the Maya population (Ward, Bertrand, & Puac 1992). Due to the long history of social and political oppression, there has been an overall distrust that the Maya feel towards all outsiders (Terborgh et al., 1995). Finally, the cross-culture gender stereotypes aid in the Maya's distrust. Ladino men think of young Maya women as ignorant, therefore most likely dissolving any confidence they had left to see Ladino health professionals in regard to their sexuality (Metz 2001: 266).

A common opinion among the Maya is that modern contraceptives cause negative side effects (Ward, Bertrand, & Puac 1992: 62). They are chemical means of regulating health, therefore most Maya equate them with poison and danger. Although the potential benefits of contraceptives are recognized within the community, the disadvantages always are considered to outweigh them. One Maya man stated that "having children too frequently causes women to become weak, but this is a minor problem compared to the results of artificial or chemical family planning" (Ward, Bertrand, & Puac 1992). The

most common dangers the Maya attribute to modern contraceptives includes cancer, various illnesses, ability to make a person powerless, clogging the gastrointestinal tract, and the ability to cease menstruation.

The biggest concerns are about the pill (Reddy 2009: 27). The pill is thought to cause extreme weight gain and loss, which is a concern to the Maya due to the factors the community attributes extreme weight changes with. If a woman exhibits a rapid weight change, her peers within the community will be suspicious of contraception use and express criticism. Also, women believe they should not take the pill because they are not receiving adequate nutrition and when someone is malnourished, they are not in the right health state to take it (Ward, Bertrand, & Puac 1992: 62). In addition, there are speculations that the pill is made in the United States, where “many women and children have died from [it]” (Ward, Bertrand, & Puac 1992: 62).

These common forms of distrust present in the Maya communities can be attributed to a history of violence, which has shaped the Maya’s reality today. Life can never be the same for the Maya after all they have experienced; this knowledge that affects all social relations (Fischer & Hendrickson 2003: 97). Although these conspiracy theories of genocides of the Maya may seem paranoid, Fenster claims that this paranoid quality comes from an every day life of vulnerability to danger and violence (Fenster 1999: 112). What middle-class Americans may classify as paranoid is sadly a reality for populations that have a history and current pattern of enduring oppression and racist intimidation (Briggs 2004: 182). According to Briggs, “When people’s lives are threatened by land expropriation, economic oppression, and environmental degradation associated with capitalism, new strategies of governmentality, and widespread death from

both unknown and altogether too familiar diseases, dialogically engaging official narratives and exploring other epistemological and political possibilities provide sites for exploring strategies” (Briggs 2004: 182). In other words, the Maya have a long history of unfair treatment of outsiders, such as the seizure of their land and socioeconomic, political, and structural inequalities, along with new forms of government. With this ongoing oppression and new governmentality, came violent acts against their communities, for unknown reasons. As a result, conspiracy theories are formulated to explain what their government will not. Therefore, the Maya’s distrust of outsiders emerges from the parallels between the “political-economic underpinnings of the distribution of power, wealth, and violence and of the circulation of public discourse” (Briggs 2004: 182).

Reaching the Maya; culturally appropriate health care

Guatemala remains characterized by some of the highest maternal and infant mortality rates in Latin America, and the use of modern contraceptives and biomedical services for pregnancy care remains low. Half of the population of Guatemala is indigenous Maya, therefore there has been a recent increase in the interest to understand the factors that limit the use of these services that may have the ability to decrease the maternal and infant mortality rates.

There has been a progressive increase in the recognition of qualitative research as a mechanism to for designing programs (Ward, Bertrand, & Puac 1992: 64). Many credible insights have been provided from various studies, resulting in an improved understanding of the beliefs and attitudes of the Maya in regard to the issues of family planning and pregnancy care. According to the qualitative research project carried out by

Ward, Bertrand, and Puac, the Maya will not adopt modern family planning and pregnancy care methods in large numbers in the near future (1992: 64). However, this demonstrates the need to modify current efforts employed in Guatemala to make them more acceptable to the indigenous Maya population. Making this possible will involve overcoming social, cultural, political, and language barriers, with a shared mutual respect between the ladino and Maya populations (Glei, Goldman, & Rodriguez 2003).

To be considered credible and reasonable to the Maya population, those within the Maya community should deliver messages about health care and family planning (Ward, Bertrand, & Puac 1992; Terborgh et al., 1995). As members of the community, they experience a high level of trust. In addition, this is also a cost-effective way of reaching indigenous people. Staffing the health post with Maya themselves would eliminate the language barrier when reaching out to the indigenous people. However, due to the many different variations in language within these communities, finding staff who are bilingual and bicultural to provide the necessary training and education to these community members is not always an easy task. Moreover, simply hiring bilingual or bicultural staff members does not assure that there will be enhanced sensitivity to indigenous people's concerns. The bilingual staff is normally urbanized and in some ways, they may dismiss their native culture and partake in the stereotypes of their fellow nonindigenous co-workers (Terborgh et al., 1995: 148). Detecting this, Maya within indigenous communities may have suspicion of these people.

To alleviate these suspicions, it may be helpful to focus more attention on the individuals who play a large role in a woman's decision regarding family planning and health care, such as church leaders, husbands, and community leaders (Ward, Bertrand, &

Puac 1992) .The main providers of family planning services in Guatemala are the Ministry of Health and the Guatemalan Family Planning Association (Asociación Pro-Bienestar de la Familia de Guatemala, or APROFAM). These institutions have begun to educate and train indigenous community leaders in family planning and reproductive health. Then, these leaders convey their advice on various programs and aid in the promotion of program activities. When community leaders are contacted early in program development process, their concerns are accommodated (Terborgh et al., 1995: 149). Although many of these programs have directed their focus on women, it may be helpful and important to involve the men. Men often accompany their wives to health care clinics, which provides an excellent time to provide insight on various family planning methods (Terborgh et al., 1995: 148-149).

Furthermore, the factors that drive modernization, and consequently cause a decline in fertility and mortality, play a role in reaching the indigenous Maya. With an overall improvement of standards of living, which may be induced by a more active government, a decline in infant and maternal mortality among the Maya may be seen. In addition, a more active government contributes to the promotion of obligatory schooling and the outlawing of child labor and exploitation, therefore increasing the cost of children, therefore reducing fertility. As a result, it can be concluded that an increase in overall health and an increase of schooling, especially women's, can aide in fertility and mortality declines. However, the acceptance of innovation among the Maya may serve as a barrier to the rapid fertility declines due to the communities' opposition to modern family planning services. Moreover, due to relation of fertility changes and religious

beliefs, the Maya's strong Catholic influence also serves as a barrier to family planning services due to the relationship between declines in religious beliefs and fertility.

The most important adjustment for reaching the Maya may lie in the process of integrating traditional practices into the formal health care system, instead of simply adjusting and modifying the traditional ways. A combination of methods provided by traditional and biomedical providers to produce culturally appropriate, high-quality services and education is required. With a widespread knowledge of periodic abstinence present within Maya communities, there is hope for the promotion of fertility awareness, therefore making this traditional method more effective (Ward, Bertrand, Pauc 1992: 64).

Conquergood similarly came to the conclusion that combining the recommendations of modern health practices with those from traditional healers was very successful in a Hmong refugee camp. This prevented the program from becoming too one-sided (1988: 82). Conquergood explained that the Hmong refugee camp lacked many things, such as water, housing, and a sewage system, but is very abundant in cultural performances. The Hmong, who have been displaced by war, were trying to regroup what was left of their lives. Therefore, Conquergood believes using the popular theatre component of this Thailand camp would be a good way to diminish the pattern of "experts" delivering health care to the refugees, who were expected to be grateful recipients. Instead of blaming the Hmong for the poor health conditions present, these performances attributed the problem to the environmental setting of the refugee camp. In addition, these performances also did not promote the altering of the Hmong's behavior, instead stimulating the awareness about the health issues present (1988).

The Maya, even among those who experience serious pregnancy complications, trust the care of traditional birth attendants. This implies that outcomes could be improved if these women were able to be placed in closer proximity of biomedical services. However, providing this care closer to women in need is very unlikely to change the rate of use if attention not paid to the other issues, such as quality of care and the various barriers to access. Even if changes in these aspects occur, the differences in ethnicity and education are anticipated to remain (Glei, Goldman, & Rodriguez 2003: 2460).

The integration of traditional birth attendants into biomedical care is regarded as an attractive concept. Bridging this gap between cultures requires training programs that are a mutual learning experience; the providers need to respect the practices of the traditional methods, understanding that these practices have their own potential benefits. Programs would also profit from training that is interactive, rather than a lecture setting. Furthermore, an experienced birth assistant that speaks the indigenous language should be present and provide most of the training (Glei, Goldman, Rodriguez 2003: 2460). Due to the level of pregnancy-care provided by the traditional birth attendants, greater cooperation between these women and biomedical providers would administer the most effective and culturally appropriate care for the indigenous Maya of Guatemala.

Conclusion

Since the 1980s there has been an expanding interest in increasing government and international agency involvement in improving the maternal and child health in poor countries (Glei, Goldman, & Rodriguez 2003). Guatemala is characterized by some of the highest maternal and infant mortality rates in Latin America. Despite these rates, the use

of the government-provided biomedical pregnancy care and family planning services remain very low compared to other countries in Latin America. However, the demographic transition to a post-modern society of low fertility and mortality requires a number of factors related to modernization; overall improved standards of living, improved hygiene, motivation for birth regulation, increased education, improvement of child health, raising women's status, and the role of an active government. With half of the population indigenous Maya, there are various factors that contribute to this.

The cycles of conquest, violence, and oppression the Maya have endured throughout history has left an impact on their everyday lives; there is a legitimized distrust of outsider's motives present within their communities. The Maya also experience a lack of attention to their community's belief system from these government-run agencies in regard to family planning and pregnancy care. The Maya also occupy the rural areas of Guatemala, as well as the lowest education levels and socioeconomic statuses, compared to their ladino neighbors. To make these services more attractive to the Maya population, there must be an integration of quality biomedical services with the traditional beliefs of contraceptive techniques and pregnancy. To achieve this goal, there must be a dissolution of racist intimidation from the ladinos with their mutual respect, along with overcoming the social, language, and cultural barriers.

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