

How do people in Kaqchikel Guatemala make decisions when building families?

By

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## Abstract

In Kaqchikel Guatemala, families make decisions about how many children to have when, a process biomedical healthcare providers might call “family planning.” In this dissertation, I present a more holistic model that I call “family building,” based on two years of ethnographic fieldwork in San Lucas Tolimán, Guatemala. Family building in Kaqchikel Guatemala uses the same logics and values as family planning but stretches across the life cycle and includes more family members, incorporating but extending beyond biomedical understandings of health and illness. As an MD/PhD student, I conducted over one hundred interviews and compiled over 3000 pages of notes, engaging in participant observation across biomedical institutions and alongside Indigenous families.

Family building priorities play out in biomedical settings for Kaqchikel community members. From birth to death, women and families creatively manage amidst massive constraint and violence. People’s biomedical care options, limited by structural violence and centuries of colonialism, rely on creativity as families “take advantage” when they can; families also use the Kaqchikel-specific mode of thanksgiving as a way to assure biomedical healthcare. Contraception, a core tool in family building, is a site of tension for Kaqchikel community members who understand that biomedicine is a dangerous site for Indigenous women.

Interviewees explain how contraceptive coercion, documented throughout the 20<sup>th</sup> century Guatemalan Civil War, continues into the “post”-war 21<sup>st</sup> century. Ongoing contraceptive coercion in Kaqchikel Guatemala includes coercion from husbands and mothers-in-law as well as forced sterilization by biomedical care providers in public

hospitals. Violence, long discussed by scholars of gender and Guatemala, remains a constant in many San Luqueños' lives; their family building choices must be made amidst these violences. Sometimes, interviewees show how family building can help transcend family violence. At the end of life, family building priorities continue to shine through in people's biomedical healthcare decisions.

Across the life cycle, Kaqchikel Luqueños creatively use biomedicine as a tool to continue to build their families amidst many constraints. This dissertation contributes to anthropology and public health, specifically family planning research, work on structural violence, and scholarship on reproductive justice.

## Chapter 1: Introduction to family building

Sofía and I sat on her patio on a sunny morning as I asked her about her family. Her five-year-old granddaughter played at our feet, sometimes interrupting to ask if she could have money to run down the street for a *gelatina*, a bite-sized Jello treat. From the outset of our interview, Sofía revealed how the process, and struggle, of continuing to build her family stretched across generations:

“I live here with my five children and my little granddaughter. She’s an only child. The man betrayed her, betrayed my daughter, and then left her with a child. And now my daughter is working to be able to feed her little daughter...she is working in the mountains, it’s men’s work...she thought that he was a good man.”

Sofía related her ongoing endeavor to care for her children within a complex, violent relationship with her husband:

“It’s been a fight, because one must help to be able to continue forward, for my children...he treated me how he treated me, he hit me, he kicked me, he mistreated me, but I said to myself, if I leave, I’m going to leave my children, who will be on my side? A father isn’t the same as a mother, so no, so I said no, I’ll put up with everything just like this. Thanks to God they’re now grown, and I’m still with them, in the fight. It’s a fight...in this way I continue, still fighting, with my children.”

Sofía echoed many interviewees when she explained what public health experts might call family planning decisions in broader contexts of economic struggle and turbulent relationships. She and her husband originally intended to have three children.

“We simply said, always three. Once we had the three, that’s when I got pregnant with the next one. We didn’t say—it wasn’t in the plans.” In fact, this fourth pregnancy was particularly complicated for Sofía: she realized she was pregnant while away from home, working in the fields to make a bit more money for her family. Her husband used this

pregnancy as an excuse for further abuse, accusing her of infidelity, but this moment in their family building process ultimately served as a turning point. “No, I said, just having confidence in God and not blaming anyone. There’s no one else.”

Sofía rejected her husband’s accusations and saw them as part of his pattern of abuse. “If you don’t value me as a woman, no,” she said, articulating her own assertion of worth to both her husband and herself. She began to demand that her husband avoid pregnancy “on his own,” using what public health research would call the withdrawal method: “No more kids, I said... and that’s when I saw the change in him. He had changed. A lot. I said to myself, good, that’s good. Because it’s time, it’s already past time, when he had changed.”

While the fight to raise her children, and now her grandchild, continues, her relationship with her husband has durably shifted, Sofía reassured me. “He has changed, he has changed a lot...slowly. When I realized, he had already changed. I get mad with the children, [but he says] ‘leave them, man, they’re kids, leave it’...he changed slowly, but yes, 17 or 18 years he mistreated me.” Sofía contextualized her own journey as part of a generational shift in gender relations: “A woman today has rights. Before, a man would leave us...now I tell my daughters...look for a good husband, who doesn’t treat you the way your dad treated me.”

### **Family building: a definition**

Sofía shows how family building is a lifelong, daily process of collaborating collectively to create and live within the family people want to have, despite and amidst profound constraints. As Sofía's case demonstrates, Kaqchikel Maya couples have conversations and make decisions about how many children to have and when. In Western medical systems and their colonial descendants, these processes are called family *planning*. The broader process I examine, family *building*, integrates but goes beyond family planning. Unlike the intellectual project that undergirds family planning, family building does not reflect a progress narrative; not every Kaqchikel family aims for some stable "goal" or "plan." Instead, family building is an iterative daily process of enacting. As I will further explain, I focus on the way family building plays out through biomedical decisions, though family building animates many more decisions in Kaqchikel communities.

My understanding of family building grew out of my longitudinal ethnographic involvement, seeing the ways people engaged in everyday and high-stakes decision-making with their families, particularly surrounding biomedicine. I expected to find that Kaqchikel families made family planning decisions more collectively, in a more integrated way, than biomedical practitioners presumed—this was true in many cases. But I did not expect the ways that family building decisions, and their underlying logics and values, continued across the life course in many families, far beyond biological reproduction or lack thereof.

As Sofía's violent and difficult experiences help highlight, words like "building" and "decision-making" fall short of capturing the numerous constraints that many Kaqchikel

women and families encounter within their families. Nonetheless, I chose these terms because they accentuate agency within these structures of constraint, structures this dissertation will enumerate. Reiterating that Kaqchikel people build families, and make family building decisions, despite and amidst these constraints, serves as a throughline, a linguistic reminder that San Luqueño families are more than the sum of the struggles they face.

Sofía's family building experience began long before she and her husband even met. She vividly described the way she and her mother formed a two-parent household for her younger brothers after her father died:

"I was 8 years old when my dad died...we suffered a lot because my mom submitted herself to working in the fields, she made herself like a man, and I, like eight, nine years [old] I was staying in the house, preparing, preparing food...and I had to carry the baby, seven months old, and the other sons, so me, there, with four boys. I had to carry the baby, making food, then I go to bring [food] to my mom at the plantation, because she worked to be able to bring back money...that's how we raised the four boys. Yes. Me and my mom. And we became like a man and woman."

Rather than a set of priorities limited to her own biological reproduction, Sofía described how the responsibilities, skills, and struggles she experienced when first building family as a child continued to animate her family building as she became a mother and grandmother.

### **Specific Kaqchikel family building approaches**

As Sofía begins to demonstrate, the family building I witnessed in San Lucas differed from family planning on three dimensions: the process involved more people within larger kin structures; families took into account the ramifications of these decisions on a broader

group of people; and the time scale considered in the decision-making was longer. This more holistic set of intentions underpinned lifelong family building in Kaqchikel Guatemala.

Family building was not a term I heard verbatim in Spanish or Kaqchikel, but instead a formulation that fit the way San Luqueños described their lives. Family building decision-making stretches across the life cycle, using the same logics that underlie Kaqchikel families' decisions about childbearing, but integrating decisions like where to send their children to school, where to work to make money to support their family, when to throw a big birthday party, how to seek biomedical care for a sick child or elder, how to respond to violence and loss, and what to do at the end of family members' lives. The first three are family building decisions I do not examine in this dissertation; the latter three intersect with biomedicine in critical ways and thus form the subject of my research. The most ubiquitous family building factor that I left out of my analysis was migration: as I had the opportunity to be rooted geographically in San Lucas Tolimán for two years, I focused specifically on the family building and lives of those who lived full-time in San Lucas. Specifically, I studied the overlay of family building within biomedical decision-making in San Lucas, because this was the most analytically rich dynamic I learned about, for reasons certainly connected to my positionality (see Chapter 3).

The underlying logics animating family building decisions varied widely across families, but some themes arose that San Luqueños narrate throughout this dissertation. Kaqchikel identity was more explicitly central for some families than others, but everyone in some way incorporated their ideas of a good Kaqchikel family. Gender norms and the

appropriate, distinct roles of men and women in Kaqchikel families were integral to these decisions, too. Responsibilities of one generation to another, similarly, entered into many discussions. And people's understandings of how to live in a healthy way, amidst a wounded body politic, undergirded many of their family building decisions. Finally, people's relationships with God, Maya deities, and the ephemeral ideals of hope and love shaped how they built their families.

In other words, family building in San Lucas extends far beyond people's decision-making around biomedicine, but I specifically study the overlap of family building with biomedicine. A final logic underlying family building becomes apparent through studying this overlap. Kaqchikel families do not choose to have to navigate structures of constraint at every turn—this is structurally imposed—but since this imposition has lasted centuries, the capacity of Kaqchikel people to build their families amidst structural violence also forms a key nexus of their approach to these decisions.

### **Studying family building extends the anthropology of reproduction**

My dissertation, in addition to drawing from centuries of study in Guatemala (which I discuss in the next chapter), adds to the anthropology of reproduction beyond Guatemala. Anthropologists might see my focus on family building in two ways: as an expansion of the anthropology of reproduction, or as a subset of the broader centuries-old disciplinary focus on kinship structures and community. I see these as one project. Sofía explained her childhood labor raising her brothers, her shifting relationship with her husband, and her

struggles with her in-laws not as distinct phases or aspects of her life, but as overlapping and mutually constitutive. I name this throughline family building. My work contributes to an ongoing scholarly negotiation since the 1980s, when the “feminist critique of the ‘biomedicalization of reproduction’ ...intersected with new directions in the study of gender and kinship” (Andaya and Kotni 2022, 215). Beyond the discipline of anthropology, I present reproductive justice in international perspective as aligned with my articulation of family building across the life course.

In addition to contraception, conception, pregnancy, and birth, the term reproduction, for anthropologists also brings to mind larger cultural flows: Marx’s perspective on economic reproduction through capitalism, and the cultural reproduction of ideas and norms that structure daily lives (Hall-Clifford 2024). Sofía reproduced human life as a mother. She reproduced structures of labor as a worker in the coffee fields, and she also reproduced ideas around gender as a daughter, sister, mother, daughter-in-law, and grandmother. I bring into my discussion the many different meanings and ideas behind the term reproduction.<sup>1</sup> Throughout my dissertation, I focus on life-long family building in my contribution to the anthropology of reproduction.

Anthropologists have studied reproduction since the beginning of the discipline. Some of the pioneering ethnographies that helped establish anthropology as an academic field in part analyzed peoples’ and cultures’ reproduction (for example, Mead 1971). By the late 20<sup>th</sup> century, ethnographers with backgrounds in medical anthropology and feminism

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<sup>1</sup> Another important distinction is between demography and the anthropology of reproduction—while I cannot do that distinction justice here, see Greenhalgh et al. (1995) for more.

called for a new, broader anthropology of reproduction at “the center of social theory, pushing research practices, analysis, and political interventions in new directions” (Ginsburg and Rapp 1995, 15). Instead of, as previously in anthropology, focusing solely on local realities via situated ethnographies, feminist anthropologists wanted the study of reproduction to be informed by political-economic approaches. Scholars advocated a new anthropology of reproduction that should analyze larger, structural factors, “exploring the relation between the corporeal body and the body politic” (Ginsburg and Rapp 1995, 12).

Like many social theorists, anthropologists of reproduction began to draw from Foucault’s concept of biopower, an understanding of the ways in which government power seeps through society’s capillaries into people’s individual actions and bodies, including and especially in relation to sex and sexuality, and therefore reproduction as well (Foucault 1978, 1977; Kaufman and Morgan 2005). Anthropologists have responded to the call for ethnography that sees the body politic in the reproducing body. Diane Nelson, in *A Finger in the Wound* (1999), masterfully showed how the open, unhealed wounds in Guatemala’s body politic in the 1980s and 90s paralleled and caused the ongoing wounding of individual Guatemalan people. Twenty-five years later, I see Kaqchikel people like Sofía continuing to struggle with the cascade of ills caused or exacerbated by the pathologies of the body politic in which they must build their families.

In my ethnography, I aim to draw from these roots of anthropological inquiry while responding to Ginsburg and Rapp’s ever-relevant call to action. Documenting the long reach of the state in women’s lives, medical anthropologists have shown how certain people are encouraged to reproduce while others are “discouraged, stigmatized, deported,

and punished” (Morgan 2019, 113): this is what Shellee Colen, in Ginsburg and Rapp’s (1995) pioneering collection *Conceiving the New World Order*, labeled stratified reproduction (see also Rapp 2001). Indeed, Guatemalans I interviewed echoed anthropology elsewhere, sharing ways they themselves, and larger structures, preferred certain types of Guatemalans to build families over others (Ramos-Zayas 2020).

Morgan and Roberts (2012) extended work on stratified reproduction by introducing the term “reproductive governance.” Anthropologists’ study of reproductive governance has highlighted how state and para-state actors endeavor to control women’s reproduction in order to shape an ideal body politic (Morgan and Roberts 2012, 243). Scholars of reproductive governance across Latin America have pulled together “local moral worlds” and broader scale “epistemic communities” (Morgan 2019, 114). I extend the idea of reproductive governance across the family building life cycle in Kaqchikel Guatemala, while maintaining focus on *how* people build the families they want amidst structural and physical violence.

Reproduction can be violent, in preventable deaths of mothers and babies, in layering of suffering when women cannot access reproductive healthcare due to broken systems, and in the forced imposition of unwanted reproductive biomedicine. Anthropologists of reproduction view women’s reproducing bodies as a lens through which to see these larger forces, which medical anthropologists summarize as “structural violence.” Paul Farmer first popularized the term in medical anthropology, drawing from not just Galtung (1969), Foucault (1978, 1977), and Bourgois (2001) but also liberation theology and popular anticolonial movements (Farmer et al. 2006). In reading Sofía’s story through

the lens of structural violence, factors like colonialism, ethnic violence, misogyny, and neoliberalism reveal themselves to be forces in Sofía's experiences of gender-based violence and poverty, and her ongoing work to build family.<sup>2</sup>

In a defining talk on structural violence, Farmer explained how medical anthropologists should commit themselves to “ethnographically embedding evidence within the historically given social and economic structures that shape life so dramatically on the edge of life and death” (2004, 312). Farmer, exhorting anthropologists to center structural violence in their analyses, consistently returned to embodiment of power: how the

adverse outcomes associated with structural violence—death, injury, illness, subjugation, stigmatization, and even psychological terror—come to have their “final common pathway” in the material. Structural violence is embodied as adverse events if what we study, as anthropologists, is the experience of people who live in poverty or are marginalized by racism, gender inequality, or a noxious mix of all of the above (2004, 308).

Structural violence becomes embedded in the bodies of suffering people. The biologically key moments that make up human reproduction provide anthropologists signposts to identify embodied structural violence. I aim to extend the anthropological gaze across the life cycle, showing how Kaqchikel community members conceive of building family as a lifelong process that carries the same priorities and struggles against structural violence as the more obvious moments of contraception, conception, and birth.

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<sup>2</sup> Lynn Stephen and Shannon Speed's (2021) edited volume, *Indigenous Women and Violence*, details many of the ways that Sofía's story reflects larger patterns for Indigenous women across the Americas. See also Nancy Scheper-Hughes' (1993) important work on structural violence and gender in Brazil.

Anthropologists have long analyzed pregnancy as an opportunity for cross-cultural comparison: Brigitte Jordan's dissertation research resulted in her groundbreaking book, *Birth in Four Cultures* (1978), which presented ethnographic research on and surrounding births in the Yucatan, Holland, Sweden, and the United States. At the time, Jordan's work intervened both in studies of birth in general, where cross-cultural research with an ethnographer present at a baby's delivery seemed far-fetched, and specifically in Mesoamerica. At the time, the only anthropological inquiry into childbirth in the Yucatan ended up in the footnotes of a male anthropologists' work from 1934 (Jordan 1978).

Sofía's experiences of childbirth stretched from biomedical experiences at government hospitals, to delivery at home with a midwife, to a complex experience where a midwife accompanied her to a government hospital, where she was told that the government doctors would not be held responsible for her or her baby's life. Seeing Sofía's experiences of reproduction, and reproductive violence, through an anthropological lens follows Jordan, among others, who positioned biomedicine itself as a worthy object of study. The term biomedicine encompasses not only the clinical practice of so-called Western medicine but also the "hegemonic system orienting research and action, and defining the very nature of the problems" of health and illness that those medical systems attempt to solve (Quaranta 2001). As understood by anthropologists after the 1970s, biomedicine is a cultural system (Nguyen and Lock 2010).

Jordan used comparative approaches to position biomedicine in contrast to "traditional" childbirth and medicine. This related to a contemporaneous movement within medical anthropology to study "medical pluralism," originally defined by Leslie (1980) and

elaborated by Baer (2011). Medical pluralism, the integration of multiple ways of knowing and addressing health and illness, is common across the world. Medical pluralism continues to be a relevant paradigm in both medical anthropology and the qualitative social science of health, including in Guatemala (Chary and Rohloff 2015). However, scholars have also problematized this framework, which tends to compare “traditional” and “modern” medicine, as enforcing hierarchies, essentializing complex interactions, and simplifying community priorities (Penkala-Gawęcka and Rajtar 2016).

Incorporating but no longer focusing on comparative approaches, then, Rapp, Ginsburg, Morgan, Roberts, and Farmer called anthropologists to attend to structure, systematic violence, and governance in medical anthropology. In 2004, a volume titled *Unhealthy Health Policies* brought the anthropology of reproduction into what was becoming known as critical medical anthropology: Ethnographic work explicitly critiquing structures of power that lead to ill health (Castro and Singer 2004). Anthropologists of reproduction found theoretical alliance with other authors in this volume, like Paul Farmer and Didier Fassin, who took the state to task for its role in simultaneously controlling and abandoning people’s healthcare. As rearticulated by anthropologist of medical politics Erin Moore in her talk, “Patient-Activists and the Interembodiment of Chronic Terror in the U.S. Insulin Crisis,” medical anthropologists must “name the policies that make the economic problems that are making the bodies sick” (2023). Much of my ethnographic work similarly shows how states and para-state actors in Guatemala constrain and curtail Kaqchikel family building.

At the same time, some scholars have turned away from more strident critical medical anthropology, resisting positioning biomedicine as a monolithic enemy of people's wellbeing. These scholars, some of whom are physician anthropologists who work clinically, call for ethnography that sympathizes with work and workers in biomedical spaces, while continuing to unpack the epistemologies that empower some biomedical actors at the expense of others (Boudart et al. 2024). "Of course," Kaqchikel Maya physician Waleska López Canu reminds readers, "government health system employees have no say in decision-making or in the design of programs, but they are the ones who must comply with regulations, even when they are not applicable to our communities or our families" (Hall-Clifford 2024, xv). I seek in my ethnography to empathize with both biomedical providers and the families that interact with biomedical systems, acknowledging that in San Lucas, many biomedical practitioners are Kaqchikel people building families too.

### **Beyond anthropology: Fighting for reproductive justice in Guatemala**

Reproductive Justice (RJ) is a grassroots perspective developed by Black women to address reproductive health access in the United States, which is in discussion with but extends beyond academic scholarship. RJ is an applied, activist approach to radically improving reproductive health. RJ promotes "three interconnected human rights values: the right not to have children using safe birth control, abortion, or abstinence; the right to have children under the conditions we choose; and the right to parent the children we have in safe and healthy environments" (Ross et al. 2017, 14). The founding mothers of RJ have

consistently agitated to bring RJ into conversations about national and international population policy (Ross et al. 2017).

Indigenous communities, including groups in the US and Central America, have often found the RJ framework useful in local and global efforts. Indigenous RJ work has included grassroots activism and community-engaged scholarship (Ross et al. 2017; O’Neil 2019). In Costa Rica, El Salvador, and Mexico, for example, Indigenous and feminist organizations have used reproductive justice to argue for changes in law and criminalization of abortion, addressing obstetric violence, and agitating for better social support (“La Pieza Faltante: Justicia Reproductiva” 2018; Prensa Colectiva Feminista 2023).

In Guatemala, my friend, *cómplice*, and mentor Chris Santizo-Malafronti brings the scholarly and activist provisions of reproductive justice to their own experience (2022, 2024, 2025a). Like many gifted Guatemalan storytellers, Chris highlights broader historical patterns of violence against Indigenous families like their own. In paired testimonies, Chris details how an optimistic White American couple in Delaware adopted a baby from Guatemala, and how a young woman with K’iche’ and Mam Maya roots experienced the loss of her child via transnational adoption from Guatemala to the United States. Chris is the transnational, transracial, transethnic adoptee in these testimonies: they use their firsthand knowledge, alongside sociological ethnography, to detail the coercion and violence at the heart of their and other adoptees’ families building and unbuilding around them, as well as revealing where love weaves through those families.

Chris details the myriad facets of intra-war disenfranchisement that overdetermined their biological mother's internal displacement to Guatemala City as a maid in rich homes. The violence within her own overlapping family structures foreclosed a safe, healthy environment for her and, sometime later, her own children. The racial dynamics of the White American family that adopted Chris, in turn, grow from anti-Indigenous yet exoticizing norms in still-colonized North America. Chris's story and scholarship shows that family building is a lifelong process for Indigenous Guatemalans. They also emphasize the reproductive justice rejection of a single nuclear mother-father-child(ren) framing, which fails to capture key family members and community dynamics that shape people's reproductive lives. I foreground Chris's work in the introduction to my dissertation because their systemic analysis, and our friendship, have been fundamental in my own thinking and writing, beyond a single chapter, quote, or citation. Chris's positioned experience also exemplifies the relevance of the study of family building in Guatemala, wherein reproductive justice offers crucial expansion of anthropological scholarship.

Inspired by and indebted to many such activist-scholars, in my dissertation I bring together the anthropology on Guatemala and anthropology of reproduction, using reproductive justice to stretch beyond these rich disciplines. While my writing in this dissertation is focused on establishing my research within the academic discipline of anthropology, my hope for sharing what I learned from community members in two years in San Lucas extends through and beyond the academy. Throughout, I aim to craft a realist anthropological project about family building that sets aside detached arguments about

agency—what it is, whether people have it—to delve into questions about family building decision-making in Kaqchikel Guatemala.

### **Family planning vs family building**

I have contrasted family building, as a lifelong integrated journey, with the family planning featured in biomedicine. To explain my distinction, I need to delve into the anthropology, public health, and global implications of family planning. Family planning projects deploy billions of dollars; these projects affect lives worldwide in ways extending far beyond the biological impact of the contraception they provide. In both the US and Guatemala, the funding of family planning programs relies on metrics based in particular conceptions of rationality and choice rooted in the Western philosophical project (Nguyen and Lock 2010). Quantitative health indicators emphasize numbers over people, systemically excluding some and including others. These priorities make clear that, from the perspective of the state, healthcare succeeds when it produces good metrics (V. Adams 2016). Bringing biopower explicitly into reproductive governance, Murphy (2017) describes an “explosion of techniques for experimental governance that sought to rearrange population through affect and counting for the sake of future economic prosperity” (9).

In the realm of contraceptive use, “unmet need for contraception” is used to rank countries against each other in terms of the corresponding quantitative success of demographic, family planning, and reproductive health projects, thus playing a role in national and international determination of public health funding and programmatic

priorities (Richardson et al. 2017; Cleland, Harbison, and Shah 2014; Khalil and Richardson 2019). Calculating “unmet need for contraception” entails finding the proportion of women of childbearing age who are not currently using a contraceptive method but do not seek a pregnancy in the next two years.<sup>3</sup> Widespread “unmet need for contraception” identifies communities as targets for state or NGO family planning programs.

The concept of a calculable “unmet need for contraception” relies on the idea that women are, at any specific moment, either actively seeking pregnancy (therefore not using any contraceptive methods) or actively avoiding pregnancy (and *should* be using a modern contraceptive method). By this logic, women who wish to avoid pregnancy either currently use a modern contraceptive method, the most biomedically, statistically effective way to prevent pregnancy, or would if they had the requisite education and access. The metric assumes no (rational) woman could fall outside of these categories.

Aiken et al. (2016) explain the compulsory nature of this idea of rationality: “While there is no evidence that planning benefits all women, it has been widely promoted as a universal ideal” (1). Demanding women explicitly and intentionally choose either pregnancy-right-now or no-pregnancy-right-now stems from the compulsory rationalization and medicalization of reproduction (Ginsburg and Rapp 1995). Yet many people fall

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<sup>3</sup> See Khalil and Richardson (2019) for complications of this approach. Some calculations, including that which I have in the past used to analyze quantitative data from Guatemala, include a distinction between modern and non-modern methods. See Hubacher and Trussell (2015) for one definition of “modern methods,” following the Demographic and Health Surveys from which unmet need calculations often draw (10). Population health research makes much of the distinction between modern and non-modern methods (see e.g. Ewerling et al. 2018). See Hartmann (2016) for deconstruction of the assumption that “modern” is better than “non-modern” for contraceptive users. See also Russell and Thompson (2000) for an argument against the use of the phrase “natural family planning” to describe the “non-modern” practices.

somewhere beyond the binary of seeking versus avoiding pregnancy, a state women's health researchers label "pregnancy ambivalence" (Higgins, Popkin, and Santelli 2012).

Women's health providers trained in biomedicine struggle with this ambiguous position. At a family planning conference, one provider said it took her years to learn to respect patients who said they "didn't care" whether they got pregnant (Gold 2017). Biomedicine, with its epistemological reliance on certainty and truth, pathologizes pregnancy ambivalence. This judgment unsurprisingly leads to contraceptive coercion.<sup>4</sup> Provider eagerness to prescribe contraception, which could lead to contraceptive coercion, follows when providers perceive a patient's behavior as irresponsible or not in their best interest.

Previous research has elucidated how healthcare providers pathologize pregnancy ambivalence especially when the pregnant person is Black or Indigenous (Valley et al. 2023). Seemingly interpersonal racism between patient and provider reflects systemic racism, leading to systemic reproductive coercion. This stratified reproductive violence results in "racialized reproductive engineering" (Ross et al. 2017, 186). Racially dichotomized contraceptive coercion has its roots in metrics: In the US, Europe, and across Latin America white(r) communities are urged to reproduce more while governmentalized health programs use metrics to coerce minoritized women into accepting contraception, "punishing women of color through myths about our reproductive

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<sup>4</sup> In previous research, I elucidated patterns that helped me contextualize how biomedicine relates to reproduction globally (Valley et al. 2023). Abortion providers in Wisconsin shared with me that they must explicitly work to fight stigma in their clinics against women who have multiple abortions, a choice often seen as an "irresponsible" result of unmet need for contraception or repeated pregnancy ambivalence.

recklessness in order to maintain the system of white supremacy” (Ross et al. 2017, 186; Ramos-Zayas 2020; L. H. Harris and Wolfe 2014; Nahman 2018). In my analysis, I understand contraceptive coercion as part of a spectrum of structural violence that constrains Kaqchikel family building, in which families must constantly contend with governmental and para-state actors with power over many steps of life-long family building.

Elizabeth F.S. Roberts’ *God’s Laboratory: Assisted Reproduction in the Andes* (2012) examined in vitro conception in Ecuador, another Latin American nation with a history of Indigenous struggle. Roberts found that technologies of assisted reproduction, which have received journalistic and sociological attention in the Global North for abstracting birth from typical family-making patterns, in the Andes reinforced collectivities and religious expectations about conception. “Coming into existence as an IVF baby meant coming into being within a relational network. Like all reproductive endeavors, IVF entailed not only making children but also making and reinforcing relations among adults, and between adults and God” (6). Roberts’ findings underscore why family building is a useful frame in extending the medical anthropology of reproduction in Kaqchikel Guatemala. The “making and reinforcing relations” among children, adults, families, and God I witnessed in San Lucas stretched across the life course. My dissertation structure imperfectly follows the life-long “reproductive endeavor” of building family.

### **Why family building matters**

Overall, this dissertation details how some Kaqchikel Maya Guatemalans in San Lucas Tolimán think about and practice family building. The values and priorities that

underlie specific family planning decisions continued to shape and build family throughout people's lives. And family building in San Lucas is a life-long process that many people participate in, beyond couples of reproductive age. I study family building within the context of biomedical decision-making in San Lucas.

Understanding family building as a lifelong process matters theoretically and practically. Anthropologists have long attended to the dynamics at play across cultures in kinship and family relations (O. Harris 2008; Kistler 2007; Boehm 2012). Anthropologists of reproduction have also attended to the decisions around making new human life as insights into profound questions of agency, culture, truth, and modernity (see for example (Morgan and Roberts 2012; Kaufman and Morgan 2005). However, some anthropology of reproduction ends at contraception, conception, and childbirth. I offer family building as an expansion of this approach. Simultaneously, as an MD/PhD student who worked in Guatemala in both clinical and ethnographic roles, I see practical, applied reasons to create scholarship on family building and biomedicine—understanding consistent factors that underlie biomedical decision-making throughout the life course can help healthcare providers better care for patients.

Honoring family building means unsettling the Western project, dominant since Enlightenment, that tends to think of patients as individual, rational thinkers who make their own decisions in isolation. This understanding motivates the individual patient-provider medical interview, the informed consent form, the physician's presence in a hospital to which a patient must make her way. Articulating family building as a core

priority for Kaqchikel Guatemalans helps destabilize the idea that patients are doing anything on their own.

In San Lucas, families participated in family building while deciding when to have children and how many, yes, but also when celebrating a birthday, gathering clothing for a first communion, debating an uncle's travel to the United States, attending a child's wedding, and finally while deciding how and where a mother should die. I also had the privilege of participating in less remarkable moments of family building: debating the educational merits of watching TV with breakfast when it taught about how families interact; discussing how our ancestors showed up in our dreams while waiting for water to boil; talking on WhatsApp with someone in *El Norte*; and remembering the way a beloved, departed aunt used to scrape her chair when getting up from lunch. San Luqueños' priorities, which innervated their most extreme moments, decisions, vulnerabilities, and joys, also animated the interstitial moments of building family every day. This dissertation features analysis of the most extreme of these cases, where participants articulated distilled priorities around family building via their intersections with biomedical systems. But my analysis of family building integrates Kaqchikel families' everyday moments too.

Rachel Goodman's dissertation on non-governmental organizations and management in India stated: "At its core, this dissertation is about what people want from their lives and how they go about getting it" (2017, 9). My dissertation, while topically distant, has a similar heart. At its core, my dissertation is about *what people want* for themselves, their families, and their health, and *how they make decisions* in order to get

what they want. They go about attempting to fulfill these bodily, experiential, and spiritual wants while building family within and beyond formal biomedical systems.

In the subsequent chapter, I present a few binaries—man/woman, Indigenous/ladino, campesino/oligarch, Catholic/Evangelical—that align with emic categories, internal to San Lucas, and bring out historical context that Guatemalans discuss regularly. The one etic anthropological binary I call upon is the balance between dark anthropology and the anthropology of the good (Ortner 2016; Robbins 2013). As Sophie Chao (2022) details, life in late capitalism for Indigenous people often involves near-constant oppression, dispossession, and struggle against monumental state and capital power. To attempt to temper this ugliness in any way could downplay or excuse these violences. Many American tourists who arrive in Guatemala remark immediately on how “despite everything we have, we are stressed; despite everything people here don’t have, they are happy,” mainly as a reminder to “don’t worry, be happy.” Frankly, I found this to be out of touch with many Guatemalans’ lived realities, and I endeavor not to echo these generalities. Critically sitting with the intersecting and mutually reinforcing violences that San Luqueños managed every day is a core job for me as an anthropological witness.

At the same time, people did, constantly, make and build life and family. Even more stunning to me, every day, the specific people I lived and ate with often maintained a generally sunny affect as they navigated the broken systems that surrounded them. Indeed, even separating out “good” and “dark,” as some anthropologists have done, ignores the way that forces like love and hope are forged within and amidst struggle and violence. Quotidian ways of asserting goodness amidst the bad, like going to the market and calling

greetings to neighbors, often felt to me as an ethnographic participant and observer to be profound interventions. In alignment, then, with the ways of life of Kaqchikel Guatemalans, I must engage with the good, the dark, and the realities that buck that binary in order to be taking seriously the ethnographic truths I learned in San Lucas.

### **Public health imperative for this work**

In addition to contributing to the anthropology of reproduction, as above, and anthropology about Guatemala, which I discuss in the next chapter, this dissertation also contributes to public health. Most urgently, biomedical healthcare providers need to do better by women in Guatemala, including crucially stopping forced sterilizations immediately. My work details many layers of contraceptive coercion in Guatemala today and contributes to ongoing efforts, from local activists to global health scholars, in attempting to disrupt these cycles of violence.

Beyond demanding the end of forced sterilization in Guatemala, I also contribute knowledge and share local wisdom across other facets of public health in San Lucas Tolimán. What I explain in this dissertation is crucial to advancing health for Indigenous Guatemalans. I add to bodies of literature examining what public health scholars call “healthcare seeking behaviors,” highlighting the ways that families continue to build despite and amidst structural violence. Infrastructure improvements alone are not enough: the devil is in the nitty gritty details of care coordination, historical violences, and geography. Programs, providers, and scholars must be alert to the use of “culture” to blame communities or displace responsibility. Healthcare institutions and providers in

Guatemala must be more deserving of respect. Some scholars advocate for training healthcare workers to be more effective at convincing Indigenous Guatemalans to trust them, but this alone will not address the racism and paternalism baked into the system from physician training to patient education. Interventions informed by my dissertation, which could be put into place today across a range of systems, would improve and save lives. I detail my own implementation and public health work in my Methods chapter.

From an epistemological standpoint, this dissertation insists, in line with decades of anthropologists, that San Luqueño women and families should guide how public health responds to their needs. As global public health faces increasing challenges in 2025, we must focus ever more insistently on the needs of Indigenous communities. This dissertation details their expertise, which should guide all public health interventions in San Lucas.

### **Road map of this dissertation**

In this dissertation, I ask how Kaqchikel people make decisions when building families. In Chapter 2, I continue to provide context, introducing the reader to the town of San Lucas Tolimán, engaging with locally relevant binaries to discuss Indigeneity through history. I also review anthropology in Guatemala and how this work fits into that scholarly lineage.

In Chapter 3, I present my methods, explaining how I conducted this study. I then discuss my own positionality. As anthropologists are our own analytic tools, I follow Wendland (2022) in attempting to make myself visible when to avoid it would misrepresent

the ethnographic reality; however, this story is not about me, so I hope to clarify my positionality early on so the rest of the dissertation can focus on the lives of Kaqchikel people and families.

In Chapter 4, I detail how families in San Lucas navigate biomedical healthcare resources. Family building is agentic; community members build their families creatively within structures of constraint. First, then, I sketch the overlapping infrastructures of biomedicine in San Lucas Tolimán, learning from interlocutors how they creatively endeavor within oppressive systems to fight for their families' health.

Chapters 5 and 6 focus on San Luqueños' use of contraception in the context of family building. In these two chapters I ask: How do people building family think about and use contraception? How do systems beyond Kaqchikel families structure their capacity to have children when they want and not have children when they want? Chapter 4 examines these questions by learning from San Luqueños about successes and pitfalls of contraceptive use. Furthermore, in Chapter 5 I present some orientations of Guatemalan and foreign biomedical healthcare providers towards Kaqchikel family building. Some of these powerful actors in providing contraception orient themselves differently than community members who personally contend with biomedical contraception. Chapter 6 continues to examine these tensions at the extremes, presenting and analyzing stories of contraceptive coercion in Kaqchikel Guatemala. Contraceptive coercion, I show, spans individual and systemic forces, showing up in unique ways but contributing to historical patterns of reproductive injustice in Indigenous Mesoamerica.

Much anthropology on Guatemala centers violence as a daily reality and an analytic frame. Chapter 7 engages with this literature directly, asking: Does this frame fit for Kaqchikel families in San Lucas? How do Kaqchikel women and men approach family building within violence, in and beyond their own families? I present stories of physical violence experienced and perpetrated by Kaqchikel San Luqueños and listen to their stories in full. These stories feature both suffering *and* joy, and Chapter 7 asks how anthropology about Guatemala can more holistically capture families' experiences, neither ignoring nor valorizing violence.

Focusing on family building centers the daily decision-making in and beyond health. Some families asked: How do we pay for food? Who is going to work outside the home? Other couples discussed: What contraceptive method should we use? Some interlocutors asked: How do I build a family when the one I grew up in hurt me? Since Kaqchikel family building priorities extend far beyond contraception and birth, I end the dissertation bringing in anthropology on the end of life. Chapter 8 discusses how Kaqchikel families decide what to do at the end of a family member's life. How do engagements with biomedicine at this critical juncture help and hinder family building across the life cycle? I draw on a historical focus in anthropology on the extremes of life. Throughout this dissertation, following Kaufman and Morgan (2005), I see the beginning and end of life as linked moments that reveal patterns that continue throughout the less extreme moments of family building.

## Chapter 2: Situating San Lucas Tolimán, Guatemala

### Place, history, and present

San Lucas Tolimán is a highlands Guatemala town of approximately 15,000 people on the shores of deep blue Lake Atitlán, nestled in the breathtaking scenery between Volcanoes Tolimán and Atitlán (see Map 1). Another 15,000 residents live in the more rural parts of the municipality, also called San Lucas Tolimán, in the hills and valleys outside of town. The majority of San Luqueños consider themselves K'aqchikel Maya, whether they speak Spanish or K'aqchikel, and mothers and sellers chat in both languages as women shop for their families on market days, Tuesday, Friday, and Sunday. The market starts at the central park, a boisterous square block with a basketball court in front of the municipal government building, where the influential mayor and city council preside. Angie, whom you will meet in Chapter 5, often invited me to come along with her family to the park in the evenings. I sometimes asked whether there was a special event, but Angie loved to simply “see who’s around.” Another popular spot for families to pack lunches and run into extended family and acquaintances, the recently revitalized lakefront, is the ultimate destination of the three main roads heading in and out of San Lucas (see Map 2).

Teresa, a community health worker whose son drowned at 17 in the lake, commuted to work using the steepest road into town, under construction when I lived there from 2022 to 2024. From San Lucas, the pickup truck taking Teresa home along this road climbs east and then north around the lake, featuring breathtaking viewpoints and loud trucks puffing black smoke, which also take one’s breath. The San Lucas municipality ends after 20 curvy minutes in this direction, just past where Teresa and her surviving daughters live, ceding

municipal authority to San Antonio Palopó. If she wants to go to a bigger market than San Lucas, Teresa can continue on, where the road heads through Agua Escondida to Godínez. Here, one highway weaves off to take travelers further into the western Highlands, the path to the larger majority-Indigenous cities of Quetzaltenango (familiarily called Xela) or Tecpán (abutting the Kaqchikel precolonial capital Iximche'). Teresa may never travel to these cities, but the physicians that run the San Lucas Mission community health worker program studied medicine in Xela, and patients affiliated with care coordination systems at a different NGO sometimes catch a bus to see an American specialist in Tecpán.

Violeta, a grandmother and expert weaver, lived on the road winding out of town in the opposite direction. When Violeta's family urged her to seek a third opinion about her blood pressure, a process detailed in chapter 8, the bus her son hired headed in the other direction around the lake. The seven family members proceeded along the highway to Santiago Atitlán, towards a different assemblage of biomedical organizations. At the popular hiking spot Cerro de Oro, which some call the sleeping elephant for its humped appearance, the San Lucas municipality ends. The welcome sign to Santiago is in Tz'utujil, the neighboring Mayan language. When people from Cerro de Oro come to San Lucas for medical treatment, providers that speak Kaqchikel can mostly understand them, as they speak a mix between the two languages, living on the border between the municipalities and Maya groups.

The final road out of town passes through most of the San Lucas Tolimán municipality, to the south. Clea, a nurse you will meet in chapters 4 and 5, lives at the other end of the municipality down this road, and commutes to San Lucas to shop at the market,

visit her supervisors' offices, and take her daughter to ride the old, fast, and rickety Ferris wheel set up for the yearly fair. Clea's commute consists of a half hour bus ride, which I also enjoyed most weeks, in reverse direction. The ride abuts coffee plantations, with sightings of the far-away, smoking Fuego Volcano near Antigua, passing villages along ambling rivers, and stopping to pick up workers coming to and from the fields. Traveling from town, this dizzying descent from the *Altiplano* high cloud forests, above 5,000 feet, transitions to the *Baja Costa* ecosystem, with banana and palm as main crops. Where the San Lucas municipality and the Sololá department end near Clea's home, commuters have reached close to sea level.

Workers at the ice cream store where Clea and I sometimes walked on our breaks, the coffee plantations in the mountains, and the banana farms on the coast contend with Guatemala's land policies. Over the last half century, some land holdings have changed dramatically across Guatemala, and perhaps even more starkly in the municipality of San Lucas Tolimán; other patterns have not budged. Estela, whom you will get to know in chapter 6, explained that when she and her husband first married, they lived, like their parents before them, on the *finca* (plantation) where they worked. This coffee plantation followed the *hacienda* model first imposed when Spaniards arrived on Kaqchikel land in the 1500s. Once Central America gained independence from Spain, a slow process of capitalist reconsolidation gave individual landowners, Europeans or those of European descent, increasing control over land once owned by the Crown or Church. While the workers on this land technically were no longer enslaved, they spent many generations like Estela, living in shacks at the mercy of the landowners. Campesinos' agitation for land was

one of many postcolonial grievances that led to the slow beginnings of the 20<sup>th</sup> century Civil War, often called “la violencia” by Guatemalans.

This brutal war, which lasted from the 1960s to 1997, was a generation-defining genocide against Indigenous Guatemalans.<sup>5</sup> In patterns that reverberated throughout Latin America and beyond in the late 20<sup>th</sup> century, Guatemalan guerilla groups began resisting dictatorships that were installed largely through US interference in Guatemalan politics (Sanford 2003; Grandin 2013). The Guatemalan government and army mounted a 36-year counterinsurgency that peaked during the 1980s with a genocide against Maya people in Guatemala (Grandin, Levenson, and Oglesby 2011).

Truth and reconciliation committees in Guatemala after 1997 estimated that 200,000 Guatemalans were killed or “disappeared” in the war, 80% of whom were Indigenous Guatemalans (McAllister and Nelson 2020; Tejada 2023). Between 1 and 2 million Guatemalans were displaced, including many that went into exile outside the country (Tejada 2023). San Lucas itself avoided a massacre, but community members tell of the guerrilla army sweeping in one day in the ‘80s, only to be pushed out by the army the following day. Many San Luqueños, from the influential families that surround the Catholic Mission to villagers in the smallest towns along the road down the mountain, had family members killed or disappeared. The war’s tragedies continue to be impossible to fathom, difficult to talk about, and grueling to study.

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<sup>5</sup>The beginning and end dates of the conflict depend on how you measure; see Fischer (2004) for an argument that the oft-cited 36-year period would be better described as two separate but interlinking conflicts, for instance. Others claim the war is not over at all—see Chapters 6 and 7 for specific ongoing violences in San Lucas.

By writing about postwar Guatemala, I enter into discussion with anthropologists who have struggled for decades with how to write about violence and brutality. Many anthropologists emphasized that publishing ethnographic narratives of violence and loss could help the international community prevent genocide in the future (see Sanford 2003). As the civil war surged, and later as truth and reconciliation committees attempted to sort through massacres, some anthropologists found themselves arbiters of ethnographic truth about this violence (Stoll 1994; Yvon 1996; Sanford 2003). Ongoing struggle over human rights abuses and authoritarianism stretched through my stay in Guatemala, rising to a crescendo during a historic multi-week general strike and shutdown of most roads in October 2023, including blockade of the three roads in and out of San Lucas (Sáenz de Tejada 2024). Indigenous Guatemalan writers and intellectuals have led ongoing processing of the genocide, including through anthropology and testimonies (Montejo and Perera 1987; Macleod 2011; Cumes 2009).

Rigoberta Menchú, a K'iche' Guatemalan activist and writer, achieved both fame and scholarly rebuke from anthropologists for her publication of the genre-defining testimony, *I, Rigoberta Menchú: An Indian Woman in Guatemala* (Burgos 1997).<sup>6</sup> In her Nobel Peace Prize acceptance speech, Menchú argued that her Maya “history is a living history. It has throbbed, withstood and survived centuries of sacrifice. It now comes forward again with strength” (1992). David Carey (2001) built on Menchú’s perspective and that of other *testimonio* writers in his “new historiography of Guatemala,” which centered Indigenous, particularly Kaqchikel, oral traditions (ix). Kaqchikel is one of the “big four”

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<sup>6</sup> I discuss this debate and its implications for the anthropology of violence in Guatemala in chapter 7.

most spoken Mayan languages in Guatemala, or *Iximulew*, some K'aqchikel people's preferred term for their homeland (Maxwell, Brown, and Little 2006).<sup>7</sup> K'aqchikel experts sit at the forefront of Mayan language and Maya activism efforts (Bennett 2017). Carey summarized that "K'aqchikel resilience in the face of natural disaster and foreign intrusion is essential to the maintenance of their cultural, linguistic, and communal vitality" (2001, 153). This daily resilience relies on cosmological balance: K'aqchikel communities historically have oriented themselves "between people and place, between the dramatic and uncontrollable forces of earthquakes and the controllable forces of oppression and exploitation" (2001, xi).

### **Gender and Indigeneity**

The spiritual and political betweenness Carey described has particular interest to anthropologists of gender studying how K'aqchikel people navigate definitions of "man" and "woman" (Sperling and Decker 2017; Emkow 2024). Gender in K'aqchikel Guatemala has long encompassed a thriving set of identities. Before colonization, gender norms in what would become Guatemala looked more nuanced than what imperialism would bring (Cumes 2022). Archaeologist Rosemary Joyce reported that the ancient "Maya understood gender to be more ambiguous and variable than simply a male-female binary" (2011, 26). I follow other anthropologists who argue against stereotypes that Maya communities are by nature, or (a)historically have always been, particularly patriarchal.

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<sup>7</sup> K'aqchikel speakers I have learned from use "Iximulew" (var. Ixim Ulew) instead of Guatemala when speaking both in K'aqchikel and Spanish. Iximulew comes from "ixim" (corn) and "ulew" (earth). "Armita" is another K'aqchikel term to refer to Guatemala, but more often used for Guatemala City.

At the same time, my ethnography showed widespread endurance of violent colonial gender hierarchies within families, communities, and the nation. In San Lucas, as in other highland Maya towns, men are expected to work outside the home and bring their families economic security, while women are expected to care for the home and raise children (Webb 2025). When community members, or global forces, challenge this status quo, some men can respond violently to reassert their dominance (Menjívar 2011; Carey and Torres 2010). This dissertation asks how Kaqchikel men and women build their families amidst strict gender roles and ongoing (post)colonial violence.<sup>8</sup>

Kaqchikel women I have worked with in Guatemala since 2019 have experienced undeniable structural marginalization with reverberating effects on their bodies and lives. I will draw on the rich anthropology about Indigenous women in Guatemala throughout this dissertation. This literature features some dominant threads, including violence (see chapter 7) and maintenance of Maya traditions. For decades, anthropologists have analyzed women's weaving and dress as living Indigenous culture, which expert Kaqchikel women weavers regularly explained to me (R. L. Nelson 2015; Tohver 2006; Prechtel and Carlsen 1988; Hendrickson 1995). Weaving, especially ornate blouses called *guipiles* (*po't* in Kaqchikel), serves Kaqchikel women in many ways at once. The complex designs on the front of a blouse can indicate the weaver's community provenance. In this way, Dolores, a

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<sup>8</sup> I use the word "women" to echo the universal use of gender binaries among Kaqchikel Maya interviewees I spoke with in Spanish or Kaqchikel. Though some in Guatemala identify as transgender or queer (or Spanish variations on these terms), including some friends of mine in bigger cities, I did not interact directly with San Luqueños who openly identified in these ways, and I universally heard binaried gender terms in San Lucas. While I am eager to continue engaging in scholarly conversations about the best way refer to complex identities across cultures, here I will use the words "women" and "men" to follow the speaking and writing conventions in San Lucas.

community health worker you will meet in Chapter 5, could display her ancestral heritage by wearing a *guipil* from where she grew up, before she and her family were forced out by the war. Designing new patterns, integrating high-level geometry, can also display women's creativity and intelligence. Crucially, *guipiles* reliably sell for high prices, often more than \$100 USD, so many families consider them backup savings devices. While women wear them, some daily and others to more formal occasions, *guipiles* can also be strategically sold when a family needs immediate cash. This is particularly useful for families who might not trust or be eligible for formal banking. Finally, women can weave in between other tasks, while their babies nap on their backs, or while chatting with a neighbor (or visiting anthropologist). Weaving serves as an appropriate gendered task that furthers visible Kaqchikel identity and provides economic security.

But rich literature on weaving should not be construed to essentialize women's roles (Femenias 2005; Macleod 2004). Morna Macleod, in her book *Nietas del Fuego, Creadoras del Alba: Luchas político-culturales de mujeres Mayas* (2011), speaks back against simplistic understandings of Maya womanhood and Maya feminisms. Macleod situated her work within a confluence of feminisms. She cited the relevance of African American feminisms from, for example, Crenshaw, hooks, and Collins, in understanding the Guatemalan context (2011, 30). Macleod also dialogued with postcolonial feminist perspectives from, among others, Mohanty, Spivak, Ang, and Abu-Lughod, and transnational Indigenous feminisms from scholars such as Tuhiwai Smith (30). Macleod applied Kimberlé Crenshaw's (1990) theory of intersectionality to the gendered, raced, and classed positionality of Kaqchikel women in Guatemalan society. Crenshaw's original

framing in the United States stemmed from constant “violence against women of color,” also a constant in the lives of many Kaqchikel women (Crenshaw 1990; Menjívar 2014; Stephen 2019; Torres 2018; Yoc Cosajay 2014). In the Guatemalan context, the intersectionality that predisposes women to violence and ill health spans Indigeneity, gender, and class.

### **Economics and Indigeneity**

The violence of Spanish colonialism transmuted to ongoing subjugation of Maya people through economic structures of exploitation. Eduardo Galeano’s 1971 classic text, *The Open Veins of Latin America*, helped bring to cultural consciousness the extraction of Latin America’s resources for rich people’s gain (1997). Presaging widespread critique of “globalization,” Galeano pilloried the International Monetary Fund for being in cahoots with United States imperialism, guaranteeing Latin American underdevelopment could continue to feed American greed. In *Patria del Criollo* (1973), still required reading in many Guatemalan universities, Peláez deconstructed Guatemala’s historical ladino power structures to show ongoing domination from a *criollo* elite that, rather than eliminating colonialism, perpetuated it. In the decades since, powerful interests have made economic inequality within Guatemala even more entrenched, and interrelatedly, relations between the US and Guatemala ever more intertwined. Neoliberalism is the prevailing frame that anthropologists now blame for the inequity of economic opportunity under capitalism.<sup>9</sup> In

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<sup>9</sup> See Greenhouse (2009) for more anthropological context on neoliberalism and Ganti (2014) for some of the risks of for anthropologists in relying on neoliberalism as an overarching frame.

Guatemala, neoliberalist hierarchies play out in the lives of the poor through their relationships with land. While “traditional” relationships with land underlie Indigenous identity, postcolonial land distribution continually reinforces class stratification keeping Guatemala one of the most unequal countries, both by pure economic measures and ethnographic realities (O’Neill and Thomas 2011; Cerón et al. 2016).

Almost all writing on Maya identity I have encountered mentions the centrality of land. Carey’s (2001) oral history serves as an exemplar: “Kaqchikel are teachers, employees, artisans, tradesmen, and factory workers, but in general their work is tied to the land...The Kaqchikel relationship with land and labor is central to Kaqchikel culture. They consider land sacred” (82). The Popol Vuh foundational Maya text describes that Maya people literally come from corn (Colop 2021). Rigoberta Menchú’s Nobel acceptance speech declared: “To us [Maya] Mother Earth is not only a source of ... the corn that is our life, but of so many other things that the privileged ones today strive to possess. The Earth is the root and the source of our culture” (Menchú Tum 1992; Grandin, Levenson, and Oglesby 2011, 511). Indigenous scholars document how oligarchs’ ever expanding cash crops violently usurp traditional communitarian farming methods, often referred to as the *milpa*, or the three sisters in English or Spanish (Barreno 2023). Anthropologist of Mesoamerica Edward Fischer described *milpas* as planted “primarily with maize and beans, with squash, mirlitons, peas, chile peppers, and other plants interspersed” (Fischer 2001, 218). *Milpas* in San Lucas today always center corn, but beans and squash are common co-contributors.

Many families I knew maintained *milpas* as a crucial cultural, economic, and spiritual practice, and the corn allowed mothers and grandmothers to make the food of life, tortillas. In Kaqchikel class and family kitchens, I learned that tortillas have faces like people: different parts of the tortilla are called the back, heart, cheeks, and lips. A well-made tortilla has a clearly distinguishable back vs face: I only rarely achieved this feat. Without entering into debate about the Sapir-Whorf hypothesis, I did find this tortilla anatomy a helpful reminder of the centrality of corn in Maya communities.<sup>10</sup> In Chapter 8, I return to the idea of corn as more-than-human being in Kaqchikel life.

But due to centuries of outsiders using Indigenous labor and land to fill oligarchs' pockets, few San Luqueños can survive selling corn, or even subsist on the harvest of their family's *milpa*. Hence, San Lucas Kaqchikel family life intimately tied to both the booms and busts of the international coffee trade and the rhythms of subsistence agriculture. As climate change worsens, more busts than booms threaten Kaqchikel families' ability to grow traditional crops and survive in coffee-dependent livelihoods (for this pattern in other areas, see Méndez, Flores-Haro, and Zucker 2020). San Luqueños talk openly about climate change and how it destabilizes the rainfall, crop yields, and livelihoods.

Guatemalan families continue to lose their *milpas* due to endless global demand, building since colonialism and speeding through the Anthropocene, for cash crops, particularly coffee, chocolate, bananas, and palm oil. From broccoli (Fischer 2001, 2006) to lobsters (Bourne 2015), *maquilas* (Lugo 2008; de la Torre 2006) to handicrafts for tourists

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<sup>10</sup> The Sapir-Whorf hypothesis, which has many alternate names including “linguistic relativity,” argues that linguistic variation reflects cultural specifics (Kay and Kempton 1984).

(Little 2004), anthropologists have examined the new and enduring ways that capital flows determine Mesoamerican people's livelihoods and lives. These creative ethnographies have contributed to scholarly understandings of globalization as a force in motion in Mesoamerica, while examining the structural violence wrought by the uneven and bordered distribution of capitalism's winnings.

This macroeconomic view helps me understand the histories of unreliable and dismally paid day-labor in coffee *fincas* abutting Kaqchikel communities: "In order to make what is considered an adequate profit, producers," most ultimately supplying either Folgers or Starbucks,

have consolidated holdings while keeping labor costs low through coercive (at best) labor policies. Guatemalan plantations are infamous for employee-recruitment practices in which local labor subcontractors offer modest advances months before the harvest season in return for low-wage contracts (Fischer 2001, 73).<sup>11</sup>

Work in San Lucas coffee plantations was hard to find, dependent on weather, often required commuting, and could not be depended on day to day or season to season.

Especially in the municipality's small villages, women and men would both walk to the fields as they could find work, trying to make ends meet.

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<sup>11</sup> From the traditional economic perspective, and subsequently anthropology that took a political economy approach,

the Guatemalan case may appear to be a textbook study in the structures of political economic dependency that evolved from the colonial encounter...The country is in a structurally weak bargaining position in global commodity markets due to the inelasticity of demand for products such as coffee and the intense competition from other peripheral tropical regions (Fischer 2001, 70).

At the same time, coffee cooperatives are a burgeoning source of local autonomy and economic growth in communities including San Lucas (see Lopez 2024; Krystal 2024). Many coffee cooperatives are mostly Indigenous or Indigenous-run.

Classic anthropological literature reported that in highlands Guatemala in the late 20<sup>th</sup> century, “growing commodification of the indigenous economy tended to disrupt the traditional balance of power between men and women and to erode the social networks that had comprised the collective economic enterprise of family and community” (Foxen 2020, 82). In this dissertation, I analyze individual and community choices around where and how men and women work as part of ongoing family building amidst economic need.

### **Migration and Indigeneity**

As anti-Indigenous patterns of exploitation entrenched in an increasingly globalized world obsessed with lowering costs to consumers in the Global North, economic pressures further increased on Guatemala as it emerged from the war, accelerating an ongoing transformation in Guatemalan cities and towns including San Lucas. Migration boomed: people moved from the countryside to the capital city, and migrated from Guatemala to other countries (Sperling and Decker 2017; Bennett 2017; Foxen 2020; Foxen and Rodman 2012). In particular, men departed Guatemala and set out for the United States.

Much anthropology about the journey from Mesoamerica to the United States has argued against dominant narratives about migration in the US press, politics, and culture. Following Appadurai’s (1996) exhortation to “follow the people” in a globalized world, ethnographers have followed Oaxacan farmworkers (Holmes 2013), Indigenous Oaxacans (Stephen 2007), transnational Mexicans from San Luis Potosí and Zacatecas (Boehm 2012), K’iche’ Maya from Guatemala (Foxen 2020), and the traces of Latin American peoples on the migrant trail to the US (De León 2015). Taken together, this scholarship argues

convincingly that, rather than representing a choice between the US and Mesoamerica, transnationality is a liminal yet indivisible state for migrants and their families. Because of the way the US border increasingly works to violently enforce neoliberal precarity, though, both migrating and staying can have deadly consequences. Anthropology helps readers understand the violence of borders themselves, showing the mutability and intimate implications of such political hard lines (Fassin 2011).

Most Kaqchikel families I knew in San Lucas had a family member, or several, in the United States. Of these families, only a few had family members with stable legal status in the US, sometimes because people had successfully achieved refugee or asylum status during or after the war, or because someone married an American. Despite widespread knowledge that the trip was dangerous and expensive, and regular interaction with people who had been deported, migration was often on the table during family-based discussions about goals and plans. While migrating was difficult regardless, it was much more accessible for those with a bit of money saved than for the poorest, because of the significant investment, including paying for a *coyote* (smuggler) to secure passage. While my ethnography stayed physically rooted in San Lucas, I examine throughout how migration loomed as Kaqchikel people made decisions about how to build their families.

Guatemalan drivers and American travelers, who had seen a bit more of the Guatemalan highlands, agreed that San Lucas had fewer migrants than many other Maya towns. Some towns were referred to as “towns without husbands” because so many men had migrated. Looming unfinished, empty houses, the physical manifestation of their remittances, indicated the simultaneous wealth and abandonment in these towns.

Conversely, men still worked in San Lucas, and while some migrated, fewer did.

Community members explained this by gesturing to the power of tourism around the lake, the accessibility of coffee plantations, and the predominance of the Catholic Mission as a social services organization in San Lucas.

### **Religious identity and Indigeneity**

Jesús, a grandfather, woodworker, and shopkeeper you will meet in chapter 7, took me to meet make an offering to Maximon at the town's Indigenous prayer and cultural center, the *Cofradía*. The status of Maximon in San Lucas, and the Cofradía's cultural position, helps illustrate some of the ways that San Lucas religious life aligns with and differs from dynamics across Guatemala.

Maximon, in anthropological terms, is a syncretic Catholic-Maya deity who, in many highlands communities, takes wood-and-plastic form to physically receive offerings from those in need of his intervention in their lives. Jesús and I watched as a young man tended incense and a central fire made of hundreds of colorful candles, fast-burning symbols of Maya spirituality. A supplicant entered, wearing a red t-shirt and removing his baseball cap in respect. He prayed cyclically in Kaqchikel, for women, for community members in the United States, for family members in nearby towns Patzún and San Lucas Sacatepéquez, and for all people (the word for people in Kaqchikel, "winaqi," can indicate other Maya humans, but also gestures to what anthropologists call more-than-human peoples: the water, the mountains, the *milpa*). Maximon listened to these prayers from his throne with a cigarette in his wooden mouth, as his tenders poured alcohol paid for by the prayer giver

into Maximon's wooden mouth. When Jesús and I left (he was overdue to buy afternoon *cazualeja* bread, and the best place in town tended to run out quickly) I tucked 10 quetzales into Maximon's stuffed leather glove. Maximon leaves his throne during Holy Week, when people dance with him at boisterous gatherings, and when he is strikingly hung from the Catholic Church on Good Friday morning.

When Jesús was young, his grandparents were the guardians of Maximon. In other highlands towns, especially during the war, Indigenous leaders had to hide illicit Cofradías and Maximones from Christian religious leaders' persecution. But in San Lucas, as a component of protracted negotiations between Catholic and Indigenous interests, the Catholic, Minnesotan priest Father Gregory Schaffer bought land for the Cofradía a few blocks away from Jesús's family, giving Maximon an institutional home of his own.

Padre Gregorio may rival Maximon in San Lucas oral hagiography. Now on the Vatican path to sainthood, Father Greg first moved to San Lucas from the New Ulm diocese in 1964 and was buried in San Lucas almost fifty years later. Father Greg oversaw land redistribution, wherein the Mission bought land from plantation owners and provided plots to Indigenous families that used to work that land. This process meant the aforementioned Estela, who grew up as a landless sharecropper on a *finca*, lived in a home her husband owned by the time I interviewed her. Raising money from his home diocese and other Americans, Father Greg began Mission programs that continue to this day, spanning coffee production, house and community center construction, food assistance, an international volunteer program, women's employment training, and a still-growing healthcare program, which I detail throughout this dissertation, starting in Chapter 4.

Catholic leaders and movements played key roles during the war and its aftermath. In the neighboring Santiago Atitlán municipality, an Oklahoman Catholic priest, Father Stanley Rother, was murdered in 1981 by a paramilitary death squad, one of ten priests and thousands of Guatemalans to be murdered that year (Ruiz Scaperlanda 2015). Catholic-led truth and reconciliation committees uncovered evidence of massacres that led to court recognition of genocide against Maya peoples (Crenzel 2010; Sanford 2003; Arzobispado de Guatemala 1998). In San Lucas, accounts vary as to how exactly the Mission oriented itself towards the conflict.

Scholars of religion in Guatemala and across Latin America detail an ongoing, profound shift from centuries of Catholic rule to a growing and diverse Evangelical presence. In David Stoll's pioneering 1990 manuscript, *Is Latin America Turning Protestant?*, Guatemala served as one case study to question whether liberation theology, famously aligned with revolutionary movements across the hemisphere, truly met communities' needs:

When the revolutionary movement was shattered in Guatemala, evangelicals took the opportunity to invite survivors into their churches. In contrast to liberation theology, evangelicals offered to improve one's life through a simple personal decision, to surrender to Christ. That sounded easier than overturning the social order. Evangelicals provided an ideology, not just of political resignation as so often noted, but of personal improvement. They told the poor not to preoccupy themselves with large events they could not influence in direct, obvious ways. Instead, a person was to concentrate on what he could change, such as his drinking habits...In the most difficult situations, calls for revolutionary commitment were not engaging the religiosity of the people and sustaining them through long, hard years of struggle for survival, at least not in the way that evangelical sects could (1990, 314).

In San Lucas, many Evangelical churches did attract overflowing congregations, whose bands rang out day and night. At one housewarming ceremony I attended for a family in a

village perched in a defunct coffee plantation, an Evangelical preacher confirmed: individual men and women should focus on their own sins and their own redemption, not burden themselves with bigger fights for equality.

But San Lucas's Catholic Church seemed anything but retrenched, particularly during community-wide celebrations like Holy Week and the saint day October Fair. In October, Saint Lucas's day shut the whole town down for a week, with vendors where cars usually drive and live band dancing every night. (Evangelicals whose churches forbade them from dancing attended nonetheless to watch the Catholics trade partners and sway.) During Holy Week, artists and families made creative "rugs," decorating the streets using fruits, colored sand, dyed wood, and flower petals. Maximon danced in the *Cofradía* during Holy Week and the Fair. The Mission served as the geographic and emotional center of town on these occasions, from whence statues emerged as groups of catechists paraded up and down the streets to heavy incense. When *bombas* (sound fireworks) exploded from containers painted with the San Lucas Indigenous *guipil* pattern, and Maximon hung yearly from the church, the Catholic-Indigenous syncretism that anthropologists wrote about in the 20<sup>th</sup> century retained much power. I saw families turn to and integrate Evangelical, Catholic, and Maya sources to address illness, poverty, and hopelessness.

### **Anthropology and anthropologists in Guatemala**

Guatemala's history is riddled with US economic, political, and religious intervention, including US anthropologists. As anthropologists have long debated, some of

these scholars have collaborated ethically and foregrounded Guatemalans' needs and preferences; others furthered their own careers at Indigenous Guatemalans' expense (C. Hale 2021; Colom 2022). While I expand on my own positionality as another American anthropologist crafting my career thanks to the wisdom of Guatemalans in Chapter 3, here I briefly review the history of medical anthropology in Guatemala.

Starting in the 1940s, American social scientists flocked to Guatemala to study, in the words of anthropologist Richard Adams, "the vigorous survival of an enormous Indigenous population, which conserves an eminently individualistic and varied culture" (1959, 15; Saravia 2014). According to Guatemalan scholar María Teresa Mosquera Saravia, John Gillin, University of Wisconsin-trained, was the first American anthropologist to study traditional medicine in Guatemala, including early reference to *susto*, a medical condition that continues to affect families in San Lucas Tolimán (Saravia 2014). Adams' prolific research through the 1980s relied on Robert Redfield's premise of folk medicine, a formulation Saravia argues "constitutes the base of all research of an anthropological character performed in Guatemala until the decade of the 1980s" (2014, 228). I refer interested readers to Saravia's detailed timeline of medical anthropology in Guatemala. Underlining the priority of these anthropologists to publish in the United States, rather than Guatemala, Saravia struggled to find several American anthropologists' work in print in the entire country of Guatemala.

In 1950, the founding of the Institute for Nutrition of Central America and Panama (INCAP) established a space of collaboration for Guatemalan and US scientists studying health, including medical anthropologists. I currently collaborate on a project with INCAP,

working with physicians and researchers from both countries, co-led by an American and a Guatemalan. American scholars have worked at INCAP nonstop since its initiation. In the 1970-80s, Sheila Cosminsky's prolific work touched on many of my dissertation's themes: medical pluralism, "illness concepts," the role of food, and the medicalization of birth (Cosminsky 1975, 1977, 2016). At the same time, Guatemalan anthropologists and ethnologists, particularly those based at INCAP and the University of San Carlos, Guatemala's preeminent public university, published studies focused on Indigenous medicine. *Ethnomedicine in Guatemala*, edited by Elba Villatoro, further established medical anthropology in the country and its academic institutions (Saravia 2014; Villatoro 2005 [1984]).

Throughout the political upheaval of the 20<sup>th</sup> and 21<sup>st</sup> centuries, whether anthropologists aligned with or criticized particular Guatemalan governmental administrations, government policy has drawn from anthropology (Saravia 2014). Anthropologists played major roles, as previously mentioned, in uncovering and decrying war crimes during and after the genocide (Stoll 1994; Grandin, Levenson, and Oglesby 2011). These anthropologists were mostly forensic anthropologists, and many Guatemalans associate the word anthropology with the ongoing work to detail violence during the war (Sanford 2003; Saravia 2014). Anthropologists have also played major roles in Mayan linguistics, from the Summer Linguistic Institute, an American evangelical missionary group which was eventually expelled from many Latin American countries, to the current day Academy of Mayan Languages, which agitates for Mayan language

inclusion in governmental and cultural services and played key roles in the Peace Accords (De Lara 1987; Maxwell, Brown, and Little 2006).

Following trends in the field globally, medical anthropologists in Guatemala more recently turned their attention to the crisis of representation and the ethical quandaries facing the discipline (Berry 2024; Colom 2022; Hall-Clifford 2024; Webb 2025). The anthropology of global health has allowed scholars to shift to “studying up” while maintaining focus on the lived experiences of people affected by global health systems (Nader 1972; Hall-Clifford 2024). Scholars critique systems of power that maintain oppression against Indigenous and poor Guatemalans (Hall-Clifford 2024; Berry 2010; Chary 2017; Chary and Rohloff 2015; Yates-Doerr 2015; Driese 2022). In this dissertation, I draw on not just the analyses of medical anthropologists who study Guatemala, but also their intentional, explicit navigation of their own positionalities (see Chapter 3).

Rachel Hall-Clifford, an American medical anthropologist who studies child malnutrition and global health in Chimaltenango, Guatemala, articulated the complex position of visiting applied anthropologists, describing her “productive time...until an adult son of the family” she lived with “was tortured and murdered” (2020, 200). As families built and unbuilt amidst precarity and violence, Hall-Clifford contended with how anthropologists should respond. She concluded that anthropologists working in Guatemala “can be important partners for facilitating ideas and resources with communities,” but should attend to their own positionality, centering the fact that “communities can and do struggle for social justice and achieve their own goals on their own terms” (Hall-Clifford 2020, 201). This aligns with Diane Nelson’s proffered

“methodology of fluidarity” built during several years of fieldwork in Guatemala: “a practice and analytics that combine solidarity—being partial to, as in on the side of, the people I work with—with an acknowledgement of how partial, how incomplete, my knowledge and politics have to be” (1999, 31). I therefore follow the approach of other anthropologists of Guatemala, honoring and thinking about community-based struggle as I analyze the overlap of biomedicine with family building across the life cycle.

### **Chapter 3: Methods**

For 24 months, I conducted dissertation fieldwork in Indigenous Guatemala. Primarily, I lived in San Lucas Tolimán, in the department of Sololá. I rented a beautiful room from a Kaqchikel family with whom I had stayed before; we discussed politics and religion as I attempted to cook tortillas. We watched holiday marches, live and recorded, and many Beatles videos. We celebrated births and birthdays, mourned the losses of family members, sustained each other through bouts of illnesses, and talked through unexpected joys and suffering. Living with this family provided me with safety, laughter, and a helpful place to discuss my questions about health and family building.

Across two years of dissertation fieldwork, I collected data through participant observation, individual and group interviews, and recording and analysis of soundscapes. Throughout my time in San Lucas, I conducted longitudinal, independent research for this dissertation. Simultaneous collaborations with other teams of researchers helped to thicken the data. For example, I worked on a hypertension treatment research study, volunteer medical groups' visits to rural communities, and a cervical cancer screening and treatment project. I first arrived in June 2022, collecting data through my departure in June 2024. Overall, this dissertation draws on interviews or focus groups with 152 people, including 60 healthcare workers, and more than 3000 pages of fieldnotes documenting participant observation.

### **Settling in and initial participant observation**

While I had spent a total of around four months in Guatemala prior, I arrived in the country for extended fieldwork in June 2022. In my first two months, June and July, funded by a Foreign Language and Area Studies fellowship, I focused on improving my Kaqchikel language skills through an immersive Kaqchikel language and culture program based in San Miguel Escobar, Sacatepéquez. When I returned to San Lucas Tolimán, I began preliminary conversations about my dissertation work with community stakeholders. I first met with administrators at the government Centro de Salud and the local non-governmental organization (NGO), Misión San Lucas. I spent significant time at the NGO Hospital Obras Sociales and rural community health program.

From August to December 2022, I also worked as a project assistant on a US National Institutes of Health (NIH) grant piloting a hypertension management program with the NGO's rural community health workers. I shadowed healthcare providers in the NGO hospital and rural pop-up clinics. I attended community and church events. Some weeks I went to three birthday parties, learning intimately the rhythm of these crucial rites of passage and learning how to be useful when my host family put on festivities. I learned to make tamales and failed to learn how to make structurally sound tortillas. I joked with community members in my Kaqchikel, which everyone agreed sounded like it was from somewhere else (I sounded like my teachers from Tecpán and Comalapa, and less like Luqueños). I took public transport, had coffee with colleagues who turned into close friends, and felt homesick. I attended countless clinical, research, and administration meetings and scribbled copious contemporaneous notes. I took fieldnotes daily and

corresponded with friends and colleagues about what I was learning. By the end of my fieldwork, I had filled 23 notebooks and many computer folders, summing to more than 3000 written pages of notes.

### **Interviews about family building**

I conducted formal interviews from November 2022 through September 2023.<sup>12</sup> Most of my interviews were semi-structured and individual, though I conducted group interviews when interviewees preferred. Interviews lasted on average about an hour, ranging from a half hour to three hours. I used snowball sampling, asking all interviewees who else they thought might like to talk to me. Informed consent is crucial in all research endeavors, but is particularly crucial for sexual health researchers, and those affiliated with biomedicine in Guatemala, where decades of evidence shows coercive treatment and research that ignores or parodies informed consent (L. H. Harris and Wolfe 2014; Rodriguez and García 2013; Place, Billings, and Valenzuela 2019; Cerón et al. 2016). I attempted to lead a conversation about informed consent before starting to record, even when interviewees attempted to brush the consent language aside. I explained why specifically I wanted to talk to each participant: perhaps their experience working in healthcare or their other expertise, and always their life within their family.

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<sup>12</sup> The Institutional Review Board (IRB) approval for my dissertation project was University of Wisconsin 2022-0672, and I had funding from the Fulbright-Hays Doctoral Dissertation Abroad Fellowship for much of this time. While my total number of interviews includes other projects, my interviews on family building anchored my fieldwork.

I conducted all interviews in Spanish, even with the roughly half of interviewees who also spoke Kaqchikel. As San Luqueños and Kaqchikel linguists often explained to me, grandparents who were in their 60s and 70s during my interviews had to choose whether to teach their children (in their 20s-40s at the time of my research) Kaqchikel or Spanish at home in the height of the armed conflict. At that time, Kaqchikel was seen as a mark of Indigeneity that would negatively impact children, so most families I talked to who lived in the urban area of San Lucas decided not to teach their children Kaqchikel. This meant that the grandparents talked to each other and their siblings in Kaqchikel, but mixed-generation gatherings proceeded mostly in Spanish. Despite my years of Kaqchikel study, people I had known for years assumed I preferred Spanish, and those who had met me more recently might not know I had studied Kaqchikel at all. I was not confident enough in my Kaqchikel skills to insist on Kaqchikel either. Hence, all of my interviews proceeded in Spanish, sometimes with a few Kaqchikel words here and there.

I prioritized interviewing Indigenous healthcare workers, caregivers, and women, but also intentionally sought out men and non-Indigenous community members in San Lucas Tolimán. I initially focused on interviewing two groups of people: 1) families currently or recently deciding about their own reproduction and 2) those providing care, conceived broadly, for those building families. In practice, these groups overlapped. Quickly, I expanded my interview pool, as I realized that everyone, in some way, contributed to building families. Some of my richest learning came from people whom I would not categorize as “recently deciding about their own reproduction;” these interviewees prompted me to broaden my scope to the entire life cycle. Everyone, in some way, provided

care to those building families, and continued building families themselves, even if they did not have children, or their children were grown or estranged or dead. While I had originally proposed elders and community leaders as supplemental corroborators, I found that these conversations anchored much of my analysis. Still, I emphasized learning the perspectives of women of reproductive age (18 to 55) while honoring the collaborative nature of family building. I spoke to community health workers, physicians, nurses, midwives, and Maya healers, oversampling Kaqchikel healthcare workers, broadly defined. I particularly sought experiences of those who had experience and knowledge in both (nonexclusive) worlds of Indigenous lifeworlds and biomedicine. I sought to maximize diversity across interviewees (including age, marital status, employment, and number of children). While I asked every interviewee their age and work, I included other demographic categories in Table 1 that draw from other ethnographies (Chary 2017; Wendland 2022). I back-populated details I did not ask about explicitly from the body of interviews. Table 2 provides an incomplete list of questions that I used to guide my semi-structured interviews; I have bolded questions that I asked almost everyone. I delineate how these questions relate to each of my main research aims (investigating gender (G), embodiment (E), and power (P)), though I found that conversations transversed these categories.

Table 1: demographics and details of ethnographic interviews about family building

<b>FAMILY BUILDING RESEARCH INTERVIEWEES</b>		<b>52</b>
	Initial individual interviewees	38
	Focus group members (2 groups)	14
<b>INTERVIEWEE CHARACTERISTICS</b>		
<b>HEALTHCARE WORKERS</b>		28
	Administrator (incl accounting, leadership)	4
	Nurse	6
	Doctor	3
	Community health worker	11
	Other (incl educator, translator)	4
<b>AGE</b>		
	Average age	42
	Age range	21-75
<b>WOMEN TOTAL</b>		45
	Married woman	20
	Single woman	25
<b>MEN TOTAL</b>		7
	Married man	5
	Single man	2
<b>FAMILY ROLE</b>		
	Parent	35
	Non-parent	17
<b>PLACE OF RESIDENCE</b>		
	Urban	31
	Rural	21
<b>EDUCATION</b>		
	Beyond early high school	27
	Early high school or less	25
<b>LANGUAGES SPOKEN</b>		
	Kaqchikel speaker	25
	Non-Kaqchikel speaker	27
<b>ETHNICITY</b>		
	Ladino/a	4
	Indigenous	48

Table 2: semi-structured interview questions

Kaqchikel men and women	Healthcare and care providers
<p>What did you learn about reproduction growing up? What do people say about when and how to have children? Who is involved with decisions about what a family should look like? <b>What does an ideal family look like?</b> (G, P)</p>	
<p>Do or should people plan ahead to get pregnant? What do you think women and families should do if they don't want to get pregnant? Who in the community helps people during or after these decisions? What people have expertise about families, and who talks to women or men together or apart? Who do people say should not be getting pregnant or having children? (G, P)</p>	
<p><b>What sorts of conversations do people have when building families?</b> Who is or should be involved? Have you been a part of or witnessed conversations like this? <b>How did you decide what your family would or will look like?</b> How did you feel about these choices as a man / as a woman? Did you ever feel pressured into certain choices? (G, P)</p>	
<p>Have you or your partner ever used contraception? Where did you get this (from a doctor, pharmacy, herbs you picked in the woods, other)? How did you and your partner talk about and decide on using contraception? What did it feel like to use? (G, E)</p>	
<p>For women: Have you been pregnant before? How did you feel during the pregnancy/ies? What felt good? What didn't feel good? For each pregnancy: Did you carry the baby to term? If so, what was labor like? Where did you give birth? How did different parts of labor feel in your body? How did you feel after the baby was born? How did your body recover from birth? (G, E)</p>	
<p>How do you bring your beliefs (religious, cultural, political) into decisions when building families? How do respected leaders in the community (like traditional healers, religious leaders, and physicians) speak about reproductive choices? <b>What would you change about reproductive healthcare?</b> (P)</p>	
<p>Who outside of your family have you talked to about building a family (healthcare providers, religious leaders, elders)? What was that like? (P)</p>	<p>What conversations do you have with patients and in your community about reproduction? <b>What roles do you play in decision-making about family building?</b> (P)</p>
<p>Can you remember specific visits with a healthcare provider about building family (pregnancy, contraception, planning)? What was the conversation like? Did the visit involve an exam or procedure? What did those feel like in your body? (E, P)</p>	<p>Can you remember visits with patients or clients about reproduction (pregnancy, contraception, planning)? What are those conversations like? What visits involve exams or procedures? Can you explain what each of those feel like to you and to your patient? (E, P)</p>
<p>What languages do you speak with healthcare providers? Is there an interpreter? (P)</p>	<p><b>What languages do you speak with patients or clients?</b> Do you have access to an interpreter? (P)</p>

I took contemporaneous notes in addition to recording all interviews. In my focus on embodiment as a way gender and power play out in Kaqchikel families, I attended particularly to the way that participants embodied language during interviews and participant observation, paying attention not just to what people said but how they shared, and what their bodies told me during our conversations. I took notes on interviewees' posture, hand gestures, and where and when they made eye contact. I also documented my own physical experience of the interview—whether I was cold or hot, when I felt my heart speed up during an interviewee's story. This attention allowed me a bit more insight into people's embodied experiences of talking to me about their family building lives.

As the interview process continued, I became more explicitly aware of sound as a manifestation of embodiment, an interembodiment between and amongst people, in the broader, often chaotic sonic context of San Lucas Tolimán. I recorded community gatherings, band rehearsals, and sonically dense streetscapes, in addition to formal interviews. This broader sampling allowed me to analyze my interviews as a broader conversation, not just between me and an interlocutor, but amidst us and the environment, human-made and natural, that surrounded us. This in turn enriched my analysis of family building as a holistic lifelong experience embedded in its many contexts.

Though I found judging “saturation” more art than science, by the end of my formal interview process, I did find that no new major themes emerged, though I found every story to be unique and fruitful.

## Interviews about healthcare

In addition to interviews focused on my dissertation project, my understanding of health and family building in San Lucas Tolimán relies on interviews conducted for two other projects.

As part of the aforementioned hypertension project, in September 2023 I conducted short, semi-structured interviews with patients to evaluate the program.<sup>13</sup> I realized even these short conversations had implications for my broader work on healthcare seeking in family context. These patient interviews averaged 20 minutes in length. Our group also conducted two hour-long group interviews with community health workers (CHWs), one of which I co-led, that similarly added depth to my ongoing dissertation research.

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<sup>13</sup> The IRB for this project is University of Wisconsin 2022-0794 and was also approved by the San Lucas Healthcare Committee, which includes local hospital directors and American NGO board members. Some publications from this project are already available, while other publications are pending or will be written soon (S. Duffy et al. 2019, 2024).

Table 3: demographics and details on patient and CHW interviews

<b>HYPERTENSION RESEARCH INTERVIEWEES</b>		<b>28</b>
	Patient individual interviews	23
	Members of 2 group interviews	5
<b>INTERVIEWEE CHARACTERISTICS PATIENTS</b>		23
	Women	20
	Men	3
<b>COMMUNITY HEALTH WORKERS</b>		5
	Women	4
	Men	1
<b>AGE</b>		
	Average age	57
	Age range	27-82
<b>PLACE OF RESIDENCE</b>		
	Urban	0
	Rural	28
<b>LANGUAGES SPOKEN</b>		
	Fluent in Kaqchikel	25
	Spanish monolingual	3
<b>ETHNICITY</b>		
	Ladino/a	1
	Indigenous	27

The short interview guide for the patient interviews included the following questions:

1. What do you think about the hypertension program?
2. How has the hypertension program helped you to control your blood pressure?
3. Did you previously get treatment for hypertension? What did that look like? How does your treatment in the hypertension program compare to what you did about your blood pressure previously?
4. What about the hypertension program are you most satisfied with?
5. What could we do to improve the hypertension program and better help you to control your blood pressure?

Often, despite the closed-ended interview guide, conversations with patients ranged far beyond these topics.

I also learned a great deal about life and health for Kaqchikel community members by studying medical groups visiting from the United States, who partnered with the rural health program to provide pop-up clinics in the villages surrounding San Lucas. During my time in San Lucas, I spent several weeks, in one or two-week stints, working within pop-up clinics. Mostly, I worked as a medical student, either seeing patients and presenting their cases to supervising physicians or working with more junior students in this capacity. Sometimes, I played more of an administrative role, helping with clinic flow and answering questions about referrals. In the summer of 2023, I had the opportunity to mentor a gifted medical student, Ian Arthur, who also conducted interviews with community members, mostly Kaqchikel women, about healthcare and visiting medical groups.<sup>14</sup>

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<sup>14</sup> The IRB for this project is University of Wisconsin 2023-0369 and was also approved by the San Lucas Healthcare Committee.

These interviews lasted between 20 and 40 minutes. Despite the closed ended structure of the interviews, and the implementation-focused questions, interviewees spoke clearly to many of my own research questions. Ian conducted the interviews with community health worker support, and I led subsequent coding. Though I did not directly conduct the interviews, the collaborators on this project agreed that I should use this data to complement my dissertation work. As above, our group continues to work on parallel manuscripts for a medical audience from this work, but I conducted independent analysis of the transcripts for this dissertation. I supervised the building of the interview guide for this project, summarized here.

What do you think of visiting medical groups? What is the quality of medical attention in these groups? What services do they bring to the community? Why do you think they come? How does it feel to have a group of foreigners in your community? Do they help? Do they cause harm? Compared to other healthcare, how is the quality of medical attention? How do you think these visits affect local medical care? **Have you received care from a visiting group? Can you tell me about your experience?** From one visiting group to another, how does the medical care change?

**In your experience, how is the communication between visitors and patients?** How is communication between visitors and interpreters? What do you think about the amount of time providers spend with patients? When a physician only speaks English, what do you think of the quality of medical care? How about when a patient only speaks Kaqchikel?

In your experience, after the visits, do patients understand what happened during the visit? Do patients continue treatment after the visit? **Is there follow up after the visitors leave?** What illnesses or problems are not treated by the doctors at the visiting clinics? What happens when there's a problem with the medicine or treatment plan after the visiting group leaves?

What benefits do visiting groups have for the community? Who receives these benefits? **Why do people go to visiting groups?** What are some problems with medical groups? What do community members or healthcare workers do every time there's a medical group? What are obstacles for patients that want to attend clinic?

**What suggestions do you have to improve visiting clinics?** How could the visitors be better prepared? Do you think visiting medical volunteer groups should come to this community?

Table 4: selected demographics from visiting group interviews

<b>VISITING GROUP PROJECT INTERVIEWEES</b>		<b>72</b>
	Initial individual interviews total	72
<b>INTERVIEWEE CHARACTERISTICS</b>		
<b>HEALTHCARE WORKERS</b>		27
	Hospital administrator	2
	US group leader	5
	Interpreter	8
	Community health worker	12
<b>COMMUNITY MEMBERS</b>		45
	Women	44
	Men	1
<b>AGE</b>		
	Average age	35
	Age range	20-62
<b>PLACE OF RESIDENCE</b>		
	Urban	31
	Rural	21
<b>EDUCATION</b>		
	Average education	6 <sup>th</sup> grade
	Education range	None to completed high school

### **A note on biomedicine and sampling**

As this distribution of interviews reveals, the vast majority of my interviews explicitly focused on people's experiences with biomedicine, were with people who worked in biomedicine, or both. Correspondingly, I was systematically much less likely to learn from people who interfaced with biomedicine rarely or not at all. My intent in oversampling Kaqchikel healthcare workers was to stay rooted in Kaqchikel people's experiences but turn my analytical lens directly towards biomedicine itself as a cultural force in San Lucas. Readers should therefore understand my dissertation as about family building in the shadow of biomedicine and people's interactions with it. This approach relates directly to the applied, interdisciplinary nature of my scholarship and programmatic work. From an anthropological perspective, while definitionally bounded, my dissertation contributes to anthropology in Guatemala and of reproduction by focusing on how biomedicine and family building relate.

### **Continued participant observation**

Throughout my two years in San Lucas Tolimán, I dedicated significant time to a cervical cancer program I co-led alongside CHWs, especially from fall 2022 to summer 2023.<sup>15</sup> Far from distracting me from my dissertation, the cervical cancer program provided

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<sup>15</sup> The IRB for the original project from which the cervical cancer program stemmed was University of Wisconsin 2019-0380, and the cervical cancer project itself was deemed exempt by the UW IRB as it qualified as a quality improvement and implementation project. This project was also approved, in multiple waves as the project proceeded, by the San Lucas Healthcare Committee.

rich immersion into many of my dissertation research aims. I spent significant time in the NGO hospital, CHW office, and communities developing this project and working with patients. I also learned the intricacies of international healthcare funding flows and advocacy across academic, industry, and NGO norms.

After I finished formal interviews, and wrapped up my work on the above projects, I continued participant observation and expanded my geographical scope while I began analysis and writing. I spent a total of two months in the city of Xelajúj N'oj (Xela, or Quetzaltenango), writing and learning more about Indigenous leadership in Guatemala. I learned especially from Proyecto Linguístico Quetzaleca and Asociación Movimiento Indígena Guatemalteco. In Xela and in San Lucas, in addition to continuing to attend clinical encounters, birthday parties, community concerts, fairs, and religious services, I also sought out women's groups, poetry readings, ceremonial baths, testimonial sharing, and conferences.

Throughout my time in Guatemala, alongside my intensive longitudinal involvement with one healthcare NGO in San Lucas as above, I observed other types of biomedical healthcare across a range of settings, including clinics, training centers, homes, religious institutions, etc. Overall, I conducted participant observation in healthcare provision in five towns in Kaqchikel Guatemala, across three different NGOs and government health centers. I spent about 80 hours in these additional settings, taking contemporaneous fieldnotes. These diverse experiences taught me about the range of possibilities for people seeking biomedical healthcare in Kaqchikel Guatemala, and about the connections and gaps between these possible options.

## **Data analysis**

I transcribed interviews independently using ExpressScribe, software flexible for non-English languages. The majority of my interviews were conducted only in Spanish. For the few with scattered Kaqchikel, I was assisted at the time of the interview by colleagues fluent in Spanish and Kaqchikel.

I coded data using NVivo, identifying recurring themes and those fundamental to research questions. I used a majority inductive approach to coding (Russell Bernard 2017, 460). I revisited codes and interviews, both recording and transcript, as the themes in my dissertation chapters crystallized. I analyzed these themes alongside my fieldnotes. I met regularly with healthcare workers and community members that I trusted to discuss emerging themes and to evaluate my preliminary conclusions. Mostly, I met with these trusted experts one-on-one, informally, and they often provided gentle reframes around my assumptions. One community health worker and dear friend often reminded me, when I was making US-centric assumptions about how people made family building decisions, “things are very different here than what you have there, Taryn,” a point I will return to. I returned to the United States in June 2024, and this member checking continued remotely through my dissertation writing.

## Positionality

Positionality statements have a fraught history in social science. While they have gained popularity in some arenas, including in my MD/PhD program seminars, as novel to some audiences, others believe that they offer the illusion of moral clarity, when in fact positionality is ever-shifting and blurry. My process of being a medical anthropologist, and medical student, in Kaqchikel Guatemala was and remains a constant negotiation rather than a fixed position.

I am a white American cisgendered woman in my early thirties. I am tall, particularly in highland Guatemalan towns with rampant malnutrition (and, debatably, congenitally short stature) (Nagata et al. 2016; Loewenberg 2009; P. K. Smith et al. 2003). Reports differ on whether I am blonde: while among white people in the US my hair is considered some sort of light brown, “canche,” the Guatemalan slang for blond, and “rubia,” describe both my lighter hair and light skin in Spanish. I have a small stud in my nose, rarely wear earrings, and like to pull my hair into a high bun. I share these salient parts of my appearance because I understand these to be the factors San Luqueños notice if they see me walking across the central park in town.

San Lucas is a small town, and despite the encroachment of more cars than the streets can handle, most people still get around on foot. So, plenty of San Luqueños saw me walking to the hospital or dodging tuk tuks on a run. Those who had not met me or heard of me likely associated me with the San Lucas Mission and its American counterpart, Friends of San Lucas. While I detail some of the biomedical healthcare implications of these organizations in subsequent chapters, they play key roles in my positionality in San

Lucas and Guatemala. Friends of San Lucas furnishes the Mission's American volunteer base, often bringing in young women (many of whom more or less match my physical description above) for a few weeks or months on school breaks or gap years. I had no way of ever teasing out how people were perceiving me in a specific moment—as mostly a *gringa* visitor, as the one who had been around the longest, as someone who tagged along with my specific host family, or just as someone wearing weird clothing.

My affiliation with the Mission was long internally inconsistent—while for my main, longitudinal dissertation project I was nominally affiliated with the Ministry of Health Centro de Salud, not the Mission Hospital, my side projects listed above (the hypertension and cervical cancer programs, and visiting group study) all coordinated directly with the Mission. So patients and community members saw me at the hospital, and in rural villages, explicitly representing Mission programs.

When I participated in pop-up medical clinics as a third-year medical student, I established myself firmly not just as a Mission affiliate but as a biomedical healthcare provider. This position gave me unrivaled access and ethnographic insight that I hope strengthens my analysis. At the same time, I could not expect to be seen as anything other than a biomedical provider, even when I sometimes tried to insist that in a particular setting (an interview, a community gathering) I was there only as an anthropologist.

Adding an additional layer of blurriness, Guatemalan medical students work independently before the end of their training. Students in their mid-twenties are as a rule sent to rural Ministry of Health outposts to oversee programs and provide clinical care; while they can reach a supervisor by phone sometimes, community members see medical

students as equivalent to fully credentialed doctors. Indeed, medical students may be the only doctors that many villagers interact with. In this context, a medical student *not* providing medical expertise is odd.

In the United States, however, medical students are rigidly expected not to behave like a doctor, providing independent biomedical expertise, until at least graduating with their MD. At this point, they can begin to be called “doctor,” but they will in most contexts continue to have direct supervision for years. For students like me trained in the United States, medical ethics demand we emphasize our lack of training and independence in interactions with patients. I admittedly err further on the side of hesitancy to express medical opinions, particularly in Guatemala—my father spent his career as a medical malpractice attorney, for one, but more importantly, I am academically and personally aware of the long histories of abuse and exploitation of Guatemalan patients at the hands of doctors in general, and American doctors in particular. Interviewees and I discuss these patterns throughout this dissertation.

I felt ongoing incommensurability between how a typical Guatemalan sees a medical student and what I understood to be my responsibility at my phase of my specific, situated medical training. The blurriness between my medical student and anthropologist roles meant that people may have seen me as more of a healthcare provider (a clearer cut, more visible role) than as an anthropologist. People told me about their lives with this in mind. I represent *gringo* biomedicine, so people’s reflections on biomedicine must have taken this into account. These dynamics could have affected my findings in many directions: people expressed that they could be more open with foreigners about their

medical experiences, and that they trusted healthcare workers to manage sensitive information. Others likely held back their “true” opinions or expressed to me only what they thought I wanted to hear.

Methodologically, to avoid one specific type of coercion, I only asked people if they wanted to participate in interviews outside of contexts of direct patient care, mine or others. More broadly, I considered my ethical obligations as a healthcare provider in training alongside my obligations as an anthropologist at every step, and ethnographic examples will show some outcomes of this approach. I did not do this perfectly, of course. Mentors and friends helped me navigate these struggles, as did the thoughtfulness and advice of interviewees and patients themselves.

My gender also affected my data collection and analysis. I imagine women felt more comfortable talking about intimate topics with another woman, which eased my way.<sup>16</sup> Indeed, though Americans often asked me how I broached such sensitive topics with Indigenous women, most I talked to were forthcoming about the topics I asked about, including contraception and cervical cancer. Their voices rarely lowered, even when we were in spaces where people might walk by; when women did shy away from talking about a topic, I asked if they wanted to change the subject and reminded them we only needed to talk about what they felt comfortable with. As Anita Chary pointed out in her own dissertation, though, my foreigner identity also allowed me to be comfortable speaking relatively frankly with men, access that would likely not be afforded me if I were a Kaqchikel

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<sup>16</sup> Men and nonbinary people have produced great feminist scholarship in collaboration with Guatemalan women (Cuj 2024, 2018; Santizo-Malafrenti 2024; Bevilacqua et al. 2022; Carey 2008).

or ladina woman. And as a woman and medical student, I had access to clinic spaces that might not be accessible to someone without these intersecting identities, particularly obstetrics and gynecology visits.

Beyond but alongside my academic pursuits, my life since I started my MD/PhD program in 2016 has taken unexpected turns. Over the two years I was in San Lucas, like interviewees I learned from, I suffered deaths in my family, unexpected losses, illnesses, heartbreaks, and rays of love and hope alongside. My friends in San Lucas were some of my wisest interlocutors and closest confidants. While the story and argument of this dissertation is not about me, I brought my full self to every interaction. This is the strength and honor of anthropology.

I have identified in many ways with regards to my role as an anthropologist. As an activist anthropologist, I attempted to materially support protesters during the *Paro Nacional* while still aligning with the letter of my requirements as a US federal grantee. As a critical medical anthropologist, I sought to never apologize for broken systems and to speak truth to power when given the opportunity. As an applied anthropologist, I spent countless hours debating the intricacies of specific implementation projects, endeavoring to consistently root myself in the lived realities of patients and colleagues. And yet sometimes I feel that the most meaningful call—not just for me as an anthropologist, but for me as an ethical community member, family member, and friend—is to simply witness with love. As an anthropological witness, additionally privileged through my clinical access and skills, I had the great honor of being alongside San Luqueños as they faced their hardest days, their unexpected hopes, their bodies' betrayals, their most meaningful

losses. However much technoptimistic biomedicine might yearn, however much I might yearn, there is no “solution” to the bigness of feeling that makes up families’ lives. I am certainly not a good enough writer to capture these moments in their entirety. But I hope to nonetheless do some justice to the experiences and meaningful moments I got to witness.

#### Chapter 4: Agradecer and Aprovechar: Families creatively seek biomedical healthcare in San Lucas Tolimán

Tatiana, a 28-year-old woman, narrated her recent ordeal getting treatment for an infected toenail. Despite having finished high school, a rare feat for a woman in her village, Tatiana struggled to find work. So did her family and neighbors. Tatiana lived in a poor, under-resourced community a 45-minute, relatively expensive bus ride away from the nearest town with a market or biomedical healthcare services. She shared how taking advantage of a pop-up clinic run by American visitors helped her heal, and how thankful she was:

I went to a [private] clinic and they were going to charge me 125 (~\$16) to remove my toenail. Not including the medication. In total around 250 (~\$32). And I didn't have that kind of money. The most I'd have would be 75 but I couldn't tolerate the pain anymore. But three days later, the promotor [CHW] came to let me know that a group was coming. Thank God. I went. They gave me some medication to decrease the infection. I couldn't walk because of the pain. But thank God I recovered. It helped me so much. Just the medicine! Because there [at the private clinic] they wanted to take off [my nail] because clearly they just wanted to charge me. More than 250. There at the [visiting] clinic, I just give of my time, an hour. Thank God for you all because I didn't know what to do with that pain. Thank God it's gone now.

Throughout her interview, Tatiana repeated her gratitude to the visiting groups, using “ustedes” (you all) to refer to the visiting group, represented by the young, American, medical student interviewer.<sup>17</sup> Tatiana thanked God, the interviewer, and the group he represented.

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<sup>17</sup> While my colleague conducted this interview, these descriptors applied to me, as well, for all that I intermittently attempted to position myself as an anthropologist in interview encounters rather than a medical student (see methods section). This certainly impacted the double, layered nature of interviewees' *agradecimiento*: expressing their thankfulness to visiting groups also meant performing that thankfulness in my particular direction.

### **Kaqchikel families navigate the structure of healthcare in San Lucas**

Tatiana's expressions of gratitude exemplified common language among San Luqueños accessing biomedical healthcare. A community health worker described how patients engaged with visiting medical groups: "They [patients] are very thankful. They give a lot of thanks because, I'll repeat, they don't have any way [to pay for other care]. So they take advantage and give thanks ("ellos aprovechan y agradecen") a lot when there are groups in the community. They are thankful." Community members and biomedical health workers repeatedly used these two terms when discussing patients' search across biomedical institutions: *aprovechar*, to leverage or to take advantage, and *agradecer*, to give thanks (Kaqchikel *matyoxij*).

I have presented "family building" as a frame through which Kaqchikel community members understand their lives and make practical decisions about biomedical healthcare amidst significant constraints. In this chapter, San Luqueños explain how they work with their families to achieve health. I present evidence of patients using advantage-taking and thanksgiving in an ongoing creative search for biomedical healthcare for their families. In doing so, families navigated the often confusing, constantly expensive assemblage of biomedical institutions in San Lucas: public, para-public, private, charity, and short-term.

Annemarie Mol (2008) critiques the idea of choice, the centrality of neoliberal logics in the experience of "patienthood." Free choice, in Mol's formulation, is an illusion. I offer

evidence that free choice and free will were indeed illusions, and few choices for Kaqchikel families in San Lucas were empirically free. Instead, Kaqchikel families asserted their own agency through building families, deploying their capacities to *agradecer*, *aprovechar*, and engaging with healthcare on their own terms amidst precarity.

### **Limited biomedical healthcare access**

People seeking biomedical healthcare in San Lucas Tolimán today can seek care at government, NGO, and private institutions, with quality of care generally considered to improve along that spectrum. Here, I focus on formal biomedical healthcare and its attendant treatments. I will integrate conversations I had about traditional Kaqchikel medicine, herbal treatments, faith healers, and more throughout my dissertation, but I did not conduct enough research on these systems to be able to paint a comprehensive picture. By outlining biomedical care options and people's experiences with them, I argue against one representation of Guatemala as a place that simply lacks healthcare infrastructure. Instead, I will show how San Luqueños' options are constrained not by lack of concrete infrastructure, but by their inability to access the resources, particularly financial, required to gain entry into the available biomedical options.

Accordingly, biomedical healthcare interventions that only add additional infrastructure, or inject providers into existing institutions, will not improve people's access to biomedical care they want and need. Instead, policy interventions must be locally informed and address practical access to each step along continua of care.

From an anthropological standpoint, I show that the precarity informing people's access to healthcare means they tap into diverse resources to build their families throughout their lives. These resources include willingness, capacity, even eagerness to *aprovechar* and *agradecer*, patterns that shine through in ethnographic vignettes of families seeking biomedical healthcare. Three ethnographic vignettes show a range of access to resources and biomedical healthcare; the differences in these Luqueños' experiences are especially striking because they all live within walking distance of one another in adjacent small, rural Kaqchikel villages. Less-resourced San Luqueños relied more on creative advantage-taking and giving thanks as tools to build healthy families.

### **Clea: layering options towards family building goals**

I first met Clea in 2019, when she was a nurse in training. She has stylish straight hair and a round, inviting face. She understands Kaqchikel, which her mother spoke to her growing up, but blushes when asked to speak. I got to know her better over several years and we became close friends. She is upbeat and loves to take selfies and gossip. She is sweet to older patients and revels in hitting a vein on the first try. She and her husband got married young, after learning about Clea's first pregnancy. Their relationship had significant ups and downs—at one point, she considered leaving him because of how unkind he was being to her—but she still considered him, her daughter, and later her son in every decision she made.

Clea got sick early in her first pregnancy. Her first prenatal check took place in a local Centro de Salud government clinic a ten-minute walk from her house. The public Ministry of Health infrastructure in San Lucas follows the structure nationwide, with clinical healthcare service dependent on the size and catchment area: region, state (department), municipality, town, or village. In the smallest villages in the San Lucas municipality, there was no physical Ministry of Health presence. Once the population of a town reaches a few hundred, they merit a Puesto de Salud (health post), which is intermittently staffed by auxiliary nurses. One level up, Centros de Salud like the one Clea visited have several medications on hand and host medical student doctors a few times a week (see methods section for a description of these medical students' roles). People like Clea come from nearby communities to these health centers, though the hours and staffing are unreliable. In the municipal seat of San Lucas Tolimán, a Centro de Atención Permanente (Permanent Care Center) is said to be staffed 24/7 by professional nurses who can operate independently, and multiple Guatemalan medical student doctors assigned from around the country work here. Staffing was a bit more unpredictable in practice. Patients dropped by for vaccines or prenatal visits, and many medications were regularly available. For specialist care or inpatient medicine, local public centers referred patients to the state, regional, or national hospitals in Sololá, Tecpán, Quetzaltenango, or Guatemala City (see map). In all but some emergency settings, patients were responsible for arranging and paying for their own transport and managing the logistics of the referral.

Clea successfully accessed a local Ministry of Health outpost during her first pregnancy. But she was quickly told to go to the state referral hospital in Sololá, 45 minutes

away, due to complications—she had a gallbladder disease that caused her constant nausea and pain for the first five months of her pregnancy. The doctors at the Sololá referral hospital wanted to see her once weekly through her pregnancy. Unlike some of her neighbors, she could afford the weekly trip because of her father’s income from working in construction the United States and her husband’s reliable job in a factory. But the cheapest way to get to Sololá was by shared pickup truck, and she told me about her weekly bumpy rides, recounting she often vomited on these trips: “That was, oof! I would arrive fainting. It was very difficult.”

She supplemented her government healthcare visits with home visits with a Kaqchikel midwife, or *iyom*, who lived in her small village. The experienced midwife would evaluate the baby’s position by touch and reposition the baby when she was positioned incorrectly. Clea considered the midwife an important complement to biomedical prenatal care through the government health system: “Midwives, they know, they’ve studied, they have knowledge.”

Natural medicine from a local *naturalista*, not biomedical care, ended up solving Clea’s nausea and pain, she told me. She took four plants (ginger, death flower, spearmint, and a purple plant whose name she could not remember), boiled into a tea, every day, and her nausea resolved. She was relieved and grateful to the natural medicine, “because there in Sololá... they told me one time that I was going to have to abort the baby. That they were going to have to operate and take out the baby...but with the natural medicine, it all stopped. I wasn’t vomiting, nothing anymore.”

She also visited a private cardiologist, an hour or so trip outside of San Lucas, who did multiple ultrasounds and confirmed her gallbladder illness. Clea took advantage of any care she could, simultaneously accessing many providers across institutions. She described that these each offered a different set of skills, which contributed to building her family the way she wanted. She commented that generally all healthcare she accessed—public and private biomedical providers, and her midwife and natural medicine doctor—did a good job during her first pregnancy. Her main complaint was that they all told her she was having a son—she was surprised, and so were the doctors, when her baby was born a girl.

During her second pregnancy, four years later, she turned to a different pattern of care: now, Clea had rare formal employment with benefits. She regularly expressed her gratitude for these benefits, most importantly her access to the Instituto Nacional de Seguridad Social (IGSS). IGSS is government-administrated care, but is only available to those who have jobs that comply with stringent government labor laws, roughly 19% of working Guatemalan adults (Gallardo and Isabel 2023). Clea practically lived at IGSS during the first trimester of her second pregnancy—as she described to me, “the same illness came back.” Several times she left work early to take a bus into town to be seen at the IGSS *consultorio*, a large building on the main road out of town. I often knew that Clea was feeling ill not because she told me, but because I, or someone else, saw her walking in or out of IGSS on our own commutes along that main road. IGSS was widely understood to be one of the best healthcare options in town; most who had access used IGSS as their first recourse when a family member was ill. When Clea’s illness took a dramatic turn, IGSS diagnosed her with dengue fever on top of her hyperemesis of pregnancy.

Dengue fever had not historically been a problem in the town of San Lucas. Before 2022, while some people contracted it if they went down the mountain to the *baja costa*, volcanic San Lucas was too high and too cold for the mosquitoes carrying dengue to live. However, over the last two years, thanks to climate change, dengue had become an endemic threat. Dengue's symptoms of shaking fever, debilitating body aches, fatigue, and rashes were bad enough—but in 2023-24, everyone in town quickly learned that it was hemorrhagic dengue that people had to watch out for. If nosebleeds began, families would take out loans or sell off *guipiles* they had in savings to get their child or parent a platelet count lab and, if needed, admittance to a hospital.

Luckily, Clea's dengue resolved without hospitalization. She did pay significant amounts of money out of pocket for labs, because IGSS does not have an in-house laboratory. Across institutions in San Lucas, private and public, laboratory services are almost always paid out-of-pocket, and often in a different location than the direct provision of medical care. Typically, providers write lab orders on a piece of paper for patients and those patients are responsible for finding a private laboratory and paying.<sup>18</sup> Of the dozens of private laboratories in San Lucas, physicians agreed only two or three were trustworthy. Clea ferried back and forth between these laboratories and hospitals during both of her pregnancies, whether getting care through the public hospital in Sololá or at IGSS in San

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<sup>18</sup> Rare exceptions include newer access to point of care testing, as for glucose and HbA1c, in some locations (like Don Arturo's hypertension program in the next section). The NGO hospital has a lab in-house, but it is not always open, and patients do pay out of pocket for these tests as well (as Maricela's family does in this chapter's final example).

Lucas. She expressed gratitude for and took advantage of her education and experience as a nurse to help her navigate the additional burden of laboratory testing.

When Clea had additional concerns, she would send a WhatsApp message to one or two of the doctors she worked with. Creatively taking advantage of informal networks of care helped her feel secure about the treatment she was getting. Clea knew her healthcare access was a relative privilege—from the private cardiologist to the local midwife in her first pregnancy, and from IGSS, due to her formalized work, to the access she had to other physicians in their spare time, during her second pregnancy. Clea, her husband, and her migrant father all had reliable incomes, and Clea knew her health was important. Clea wielded these resources through two successful pregnancies, overcoming significant health challenges in both. Of the examples in this chapter, Clea's resources allowed her the most access to consistent biomedical healthcare. Her nausea resolved once she got past the first trimester of her second pregnancy, and her second child, this time a son, was born healthy and strong at the IGSS hospital.

### **Don Arturo: creatively finding medicine for high blood pressure**

Don Arturo always arrived at the NGO hypertension clinic promptly, with his button-up shirt crisp and tucked in to his slacks, sporting a sprightly straw top hat. He was short and slightly stooped, but walked steadily, with a warm smile and twinkling eyes. When I visited him at home, in a rural community about a half hour bus ride from town, he pulled out small chairs for my colleague and me. Don Arturo appeared younger than his 80 years;

despite seeming healthier than other patients his age, he was no longer working in the fields. His children and their incomes supported him. He spoke to us over the sound of running water from behind him as his daughter washed dishes. At this home visit, as at every clinic visit, Don Arturo greeted us each with his broad smile, thanking us for being there.

Don Arturo first found out about his “pressure” when he woke up in the middle of the night feeling dizzy, feeling as though he was “going in circles in bed” and “going in circles in my mind.” When he described this to me, he let his voice climb from low to high over the one vowel “y,” of the word meaning “and.” He illustrated his dizziness as the tone climbed, the around-and-around-ness spiraling in the sound. “I thought I was going to die, because the feeling was quite odd.” His son “found a car,” meaning he paid the overnight premium to have someone in town drive him to the “parish clinic” (run by the San Lucas Mission). When they took his vitals at the NGO hospital, they told him he had high blood pressure. They prescribed blood pressure medication, which his family paid for out of pocket. His son also paid the cost of the emergency room visit itself, a month’s wages for one of his children working full time.

He finished the pills from that clinic, and “I just kept taking them.” Procuring medication every month demanded considerable creativity. First, Don Arturo’s children paid out of pocket at a local pharmacy, a bit cheaper and much closer than the parish clinic. Then, he said, “I went to the Centro de Salud and they gave me the pills.” But when the “Centro de Salud didn’t have pills, I had to buy them” again, this time from “a young man around here who sells them” at around 10 quetzales per pill. Sometimes, when

visiting medical groups with American doctors came to a nearby community center, Don Arturo went to see them, and they gave him a month or two of free medicine.

As Arturo's case exemplifies, medication provision in San Lucas and across Guatemala is institution-specific and often relies on patients creatively doing their own legwork and then paying out of pocket. "Pharmacies are generally very expensive, so we can't buy our treatment or medicine," a health promotor explained. Sometimes, a patient described, in life-threatening cases they could enter into formal or informal debt with banks or neighbors: "When there's a grave need, sometimes the [owner of a pharmacy will] offer a loan to someone...So we go into debt with that man." Some NGO and private biomedical facilities, like the parish clinic, have affiliated pharmacies; patients weigh whether to fill medications there or shop around for something cheaper. NGO-sourced medications, though somewhat subsidized relative to private pharmacies, were more expensive than, for example, the "young man around here" from whom Don Arturo sometimes bought medicine.

Consistent with variation in price, most medication classes in Guatemala had two or three "quality" levels available: the most expensive, often brand name and imported from Europe or the US, could cost over \$100 USD for one month. Community members widely considered these most expensive medicines to be the highest quality.<sup>19</sup> Patients

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<sup>19</sup> My colleagues and I have found it difficult to ascertain the actual pharmacological quality of these different medicines. In the NIH hypertension study Don Arturo took part in as a patient, and I took part in as a project assistant, we conducted months of outreach to understand whether American-sourced medication was actually higher purity or more effective than the highest quality Guatemalan medicine, or the highest quality tier biomedically different than the second tier. There are no published studies on the quality of the specific medications available in Guatemala. We pursued lab testing for purity, but this would cost thousands of dollars at a US university and still would not necessarily identify the clinical differences among these medications. Therefore, at the time of dissertation writing, that group simply chose to buy and provide the

could sometimes find a middle level, less expensive but lower quality; the lowest level was often available by the pill for \$1-2 USD, but considered low quality. Don Arturo's pills from the "young man" most likely came from this lowest tier.

Patients had to decide not only whether to use family resources to pay for a recommended medication, but also how much they were willing to pay for a medication that might work better than a cheaper option. One healthcare worker explained to me that generally people tried the cheapest medication first; if it did not have the intended effect, they tried the next most expensive. An interviewee named Violeta will explain in a subsequent chapter how taking strong medicines was both a positive, for curative value, and a negative, for the detrimental effects of strong chemicals. Thus, for San Luqueños, it made both economic and medical sense to save the strongest, and most expensive, medication for when cheaper options failed.

One of the few ways patients in San Lucas could access free, uninterrupted medication and ongoing treatment was through programs run by a local NGO hospital, the Hospital Obras Sociales Monseñor Gregorio Schaffer, affiliated with the San Lucas Mission and its American umbrella organization, Friends of San Lucas. To be eligible for these programs, patients needed to have a chronic disease that these programs covered (child malnutrition, diabetes, hypertension, or human papillomavirus) and live in a community covered by the corresponding program. Each program had a slightly different catchment

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highest tier based on local physicians' clear preference among the in-country options. In fact, Guatemalan providers preferred American medications, which Don Arturo was taking at the time of his interview. When the study expanded into a randomized controlled trial, however, it was no longer feasible to bring all the study medications in suitcases as we flew back and forth between the US and Guatemala.

area, stretching just beyond the borders of the San Lucas municipality along the three roads out of town. Medical anthropologists and collaborators globally have documented how patchworks of care provide “enclaves” of biomedical “projectified care”—while some patients can creatively navigate these systems when they are present, and may live longer and better as a result, both these patients and their biomedical providers know the biomedical access is anything but reliable in the long term (Wendland 2022; Whyte 2020; McKay 2018).

In Don Arturo’s case, community health workers from a new, US National Institutes of Health (NIH) funded hypertension program “visited me here” in his home and asked whether he had high blood pressure. They found his record in the visiting medical group electronic management system, from the times that he had sought medication there. “I told them that yes, I had something like that, and so that’s how I entered that program.” Leveraging the new program, he paid about three quetzales for a local bus to nearby monthly hypertension checks, where he received medications. He told me, “I feel happy because everything is free.” His family had shown creativity in taking advantage of any way to get Arturo his blood pressure medication before the program; now, he thanked us profusely, asking “that God bless you. Thank you for the visit.”

Don Arturo’s *agradecimiento* touches a particular, deep history in Kaqchikel Guatemala. “Matyoxiniik,” a spoken ritual of giving thanks, Kaqchikel elders instructed me, should take place before and after any community gathering, prayer, or meeting. Some Kaqchikel community members did this formally, often starting in Kaqchikel, “I give thanks

to the heart of God, I give thanks to the heart of the earth.”<sup>20</sup> Others carried this prioritization of giving thanks into Spanish language occasions, spending significant time before meetings discussing their gratitude to other community members who made their work possible, their ancestors, and everyone in between. Across life in San Lucas, *agradecimiento* took center stage. Don Arturo was one of many who closed out their story by thanking those involved in their biomedical care.

Don Arturo focused his thanks on NGO-based biomedical care. Anthropologists of medicine and globalization have detailed how NGOs, varied as they are in local contexts, play para-state roles. In many contexts, this relates directly to neoliberalization and funding structures that prioritize NGO or public-private partnerships (Pfeiffer 2003). The 1996 Peace Accords mandated Guatemalan state healthcare for all citizens (Cross, De La Cruz, and Dent 2019). In Guatemala, NGOs interact with many parts of public and family life, from economically supporting Indigenous women to providing short-term biomedical care (J. Moore et al. 2017; Berry 2014). Guatemala’s NGO infrastructure in many ways supplants what might be typically considered government welfare responsibilities. Scholars have argued that NGO dominance either created systems in parallel to the government or excused the government from its constitutional responsibilities (Maupin 2011; Rohloff, Díaz, and Dasgupta 2011; Hall-Clifford 2024). These patterns played out in Don Arturo’s healthcare.

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<sup>20</sup> Ninmatyoxij rin chwe Miguel Cuj (I myself thank Miguel Cuj) for a beautiful K’iche’ matyoxinik in an academic setting that reminded me of the importance of bringing (Maya) rituals into (academic) rituals (2024).

Don Arturo interacted monthly with Guatemalan community health workers, nurses, and sometimes one or two American study coordinators. Beyond those who showed up physically at each blood pressure and medication check, Don Arturo's care was asynchronously coordinated by a hybrid, binational assemblage of physicians, care coordinators, community health workers, and funding agencies, all crucial to his continued access to free medicines. This access depended on the continuation of the NIH hypertension project, which has since expanded into a randomized controlled trial. While Friends of San Lucas has historically provided ongoing funding to some projects following university affiliated pilot programs, it was unclear how the San Lucas Mission would afford Don Arturo's care without US university and NIH money. And, at the moment of writing, the future of all NIH funding is uncertain. Nonetheless, Arturo and his family gave thanks for and eagerly took advantage of this biomedicine while it was available.

### **Maricela: high-stakes connections with short-term results**

Gratitude and creativity, frankly, were some of the only resources reliably available to many Kaqchikel families. Many parents in San Lucas told me they did not have enough money to predictably feed their children or themselves. On the backdrop of chronic unemployment and disenfranchisement, rural community members often did not have work; if they could find work, it was unreliable (Moran-Taylor and Taylor 2010; Gragnolati and Marini 2003). A community member explained: "it isn't fixed work, and if it pays, they make 30 to 35 quetzales a day," the equivalent of less than \$5 USD. This work often entailed

day labor at a nearby coffee *finca*, which, in turn, required cooperative weather and soil conditions, transportation to the plantation, enough work to extend to the pool of workers, and an able body to conduct many hours of planting or harvesting in often hot, humid conditions. Most families who sought NGO healthcare did not take for granted even one income; they narrated their poverty to explain why paying for healthcare and its accompanying incidental costs was often unthinkable.

Nelia, a 51-year-old woman who worked in the fields when she could, reported, “sometimes we only eat a tortilla or tortilla with salt” for a meal. Eating a meal of tortillas alone is a widely known mark of dire need in Maya Guatemala, so Nelia likely knew she acknowledged the depth of her family’s poverty. She lived relatively close to town, a 3Q (less than 50c USD) bus ride. Taxis were also available, unlike in some other towns. But even with this proximity, she explained that for her and her neighbors, “when someone has to go to the doctor, there’s a cost.” She summarized the many forces influencing people’s healthcare choices: “There’s no money, and husbands only make enough money to eat. Yes, so, for medicine, nothing. We can’t. It costs a lot. There’s poverty here.”<sup>21</sup>

Maricela embodied how the poverty Nelia described precluded crucial biomedical healthcare for some Kaqchikel families. I first met Maricela when she was 11 years old, at a short-term visiting medical clinic in a hot community salon a half block from her house. In

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<sup>21</sup> She continued: “That’s why one wants to go to the United States.” A nearby community health worker chimed in, laughing, saying to the interviewer: “She wants to go with you!” Anthropologists have written extensively about how unstable working conditions have led Guatemalans to travel to the United States with the hope of establishing temporary or long-term residency and securing more reliable work to send money home to their families (see e.g. Webb 2018, 2025; Boehm 2012; Foxen 2020; Moran-Taylor and Taylor 2010). I do not engage directly with migration in this dissertation, but the power of migration both as a desired future and as a road not traveled was constant through my fieldwork with people remaining in San Lucas.

that clinic, I was serving as a third-year medical student supervisor of more junior students, as well as translating when needed. I had lived in San Lucas for over a year, and felt responsible for urging American healthcare providers, unfamiliar with Guatemala, to incorporate San Luqueños' access constraints into clinical decisions. When the patient line stretched out the door, I took a break from scribbling fieldnotes and saw a patient or two on my own, staffing directly with a resident or attending physician. When Maricela and her family entered, I was seeing another patient across the stuffy room and only learned about her midway through her visit. It would have surprised me at the time that my connection with her family would last more than two years.

Maricela's mother, somewhat distracted by the sniffing younger child on her lap, told a translator, who explained to two first-year American medical students, that Maricela had experienced months of weight loss, anxiety, and palpitations. The medical students, getting clinical credit through the San Lucas Mission's short term medical mission (STMM) program, asked a few questions. Then they stepped away, carrying their notebooks to a resident physician and beginning to tell him about Maricela. A few sentences in, the resident anticipated that this wasn't likely one of the typical patient concerns for pop-up STMM clinics (most commonly respiratory illnesses, gastrointestinal concerns, or musculoskeletal complaints). The resident, continuing up the chain, conferred with an attending physician. At this point, four people had talked about Maricela, but only the attending physician had been to Guatemala before.

The resident explained to his attending physician that the patient was mildly tachycardic with mild exophthalmos and significant diffuse thyromegaly. To non-medical

listeners, this was likely incomprehensible; to the attending, it meant Maricela's heart was working too hard, her eyes were bulging, and her thyroid gland, in the front of her neck, was big and spongy. The physician knew, then, even before the resident explained his diagnosis, that Maricela likely had a condition caused by too much of one of the key hormones in the human body: hyperthyroidism. Untreated, this disease can lead to heart failure or other potentially fatal complications. Treating Maricela would require coordination, so the resident physician turned to me to serve as an ad hoc care navigator.

Maricela's history fit a pattern even the two medical students had seen before: she had as yet only been evaluated by other visiting medical groups coordinated through the same NGO and had not had local medical care because of a combination of poverty and geography. Maricela and her family lived a half-hour bus ride from most healthcare, and Maricela's dad had been out of work for years because of advanced diabetes. His foot ulcers kept him from walking, and he only intermittently had diabetes medication because of its cost. A previous STMM visiting group had made the same hyperthyroidism diagnosis and recommended Maricela visit the national specialist hospital in Guatemala City, but her family did not have enough money to go. Concerned, the resident and I bucked normal STMM procedure and procured a pickup ride to town in the middle of clinic. We withdrew cash from the ATM by the park and bartered with the upscale private pharmacy, paying about \$80 USD for a medicine called methimazole.

We returned to the pop-up clinic and visited Maricela's house, bringing the two medical students along. Chickens clucked in the yard and two additional siblings listened as we explained to Maricela and her family how to take the medicine. I had brought a pill

cutter from town; I had asked my mother to buy one at CVS and bring it to Guatemala on a previous visit in case it might be useful in the hypertension project. We taught Maricela's mother how to use that pill cutter to halve the methimazole, to give to Maricela three times every day. The family thanked us profusely. The resident physician also input a repeat referral into the electronic health record that STMM groups used; hyperthyroidism should be managed on an ongoing basis, and this group was about to leave.

But I wasn't leaving, and I had the experience to doubt that a referral in the STMM electronic system would result in the intensive, ongoing care coordination that uncontrolled hyperthyroidism in a child required. My concern was borne out in Maricela's case by the last group's documented "referral." I could imagine the prior physicians feeling satisfied about making an important diagnosis like hyperthyroidism and sending the referral up the chain. In the United States, this sort of thing often (but not always) works. But higher-level biomedical care and coordination in Guatemala, and in this NGO healthcare system, were much less reliable.

Maricela had only been seen by STMM clinics near her house. Compared to Clea and Don Arturo, who each accessed at least three different sources of biomedical care, did Maricela's caregivers creatively take advantage? Other interviewees' experiences helped show that Maricela's family was indeed utilizing every resource actually accessible to them. One woman in a nearby town explained clearly, "We don't have money to go to a doctor or specialist, truly." Inability to access care because of cost operated on a spectrum, already exemplified in the differences among Clea, Don Arturo, and Maricela—

while Clea had to weigh pros and cons of different types of care given cost, this interviewee, and Maricela's parents, simply could not afford any biomedical care.

"We only hope that God will cure us because there's no money," explained Paola. She was 28 years old. Paola lived in a village of about 800 people that had been relocated by the Mission after a landslide; community health workers considered this the poorest of the 19 small towns where health promoters worked. Paola explained, "We sometimes don't have a way to pay to go to the Centro de Salud. They charge us and sometimes our kids for the transport, and we don't have any way to travel." The bus ride cost 10Q, over a dollar, a price that climbed during and after COVID; whether even the smallest children paid too depended on the moods of the bus driver and his assistant. Transport cost creeping upward was one of the most tangible measures of inflation, while incomes did not increase. For Paola, as for Maricela's family, even if a Centro de Salud would not charge for the visit with a physician or nurse, the travel cost to get there meant it was out of the question. Explained one health promotor about her patients, "if they have money they go, if they don't, they don't."

The prohibitive costs of accessing biomedicine left mothers like Maricela's eager to attend visiting STMM clinics with their families, which do not require transportation, do not charge for care, and provide free medications. "A [public] clinic visit costs 100Q, including the medicine and the trip. It's better to stay at home and not leave. Then when [medical groups] come we take advantage, because it's a great support that they bring medication, vitamins," one mother explained.

Inability to pay especially affected people seeking certain types of healthcare. Specialty care, imaging, or surgery—all of which might be necessary in Maricela’s case—meant a combination of costly transport and unpredictable, expensive care. People emphasized that illness often required many complex steps to be understood and treated. One interviewee linked the expense of care to the ultimate risk of not getting that care: “Someone can’t have a surgery if they don’t have any [money], until they die because who knows what’s going on there, what illness is harming them.” Another interviewee explained, “there are many situations in which children have died for inability to be able to pay for their healthcare.”

Seeking to avoid this outcome for Maricela, I sent a WhatsApp message to the coordinator of the NGO health promotor team, Edwin. Edwin talked with the family; they needed around \$5 USD to transport Maricela and her parents to and from the Mission hospital and pay for her visit. I gave Edwin money from my wallet after a team meeting about the hypertension project; then, I texted a medical student friend who managed the surplus fundraised by the university students before the trip. He refunded me the money via Venmo. At the hospital a few weeks later, a physician, Dr. Elias, saw Maricela and requested she get her blood drawn to see her thyroid levels. The family paid for this at the hospital laboratory with the university funds, too. Dr. Elias saw Maricela’s quite elevated thyroid hormone levels and sent her to Sololá, across the lake, to get an ultrasound. Again, I gave cash to Edwin, who accompanied the family, making it possible for them to take the boat and pay for the private clinic ultrasound in Sololá.

The next time Edwin went to the hospital, he brought the ultrasound report to Dr. Elias. Dr. Elias told me, during a meeting he and I had for a different project, that Maricela's ultrasound showed nodular diffuse thyroid hyperplasia, likely a hyperthyroid condition called Graves disease in English. This could, an online textbook told me, be treated with medication and lab monitoring, radioactive iodine treatment, or surgery. Edwin and I presented these options to the family, who decided they would benefit from talking to a specialist in hormones, an endocrinologist, about which option was best.

Any follow-up visit would require money: Edwin, Dr. Elias, and Maricela's family all behaved as though ongoing funds were dependent on my own individual goodwill. An interwoven dynamic involved Maricela's father, as patriarchal decision-communicator, deferring to Dr. Elias, Edwin, and me about what we thought they should do, with us turning the question back to him.<sup>22</sup> The original endocrinology referrals came from multiple sets of Americans, unfamiliar with Guatemalan systems, imagining an American "gold standard" of biomedical care. At the same time, I believed that an endocrinologist *would* be best at charting a course forward for Maricela; in my eyes, the stakes for her wellbeing were high enough, and the family did actively advocate for that visit.

Maricela's father, Dr. Elias, Edwin, and I therefore performed a four-way dance: Dr. Elias offered the endocrinologist option dependent on funds; Edwin asked me if the funds were available; Maricela's father asked what the doctors recommended; and I said

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<sup>22</sup> This echoed conversations I had while conducting a previous study about patients' preferred methodology of cervical cancer screening—while as an erstwhile qualitative and quality improvement researcher I wanted to know what patients preferred, the patients themselves wanted the best test, and many of them (despite dynamics I examine in other chapters) trusted doctors to tell them what was best (Valley et al. 2024).

Maricela's family should decide what they wanted and the money would follow. I sought the ethical surety of "shared decision-making" as I had learned in a US medical school. Even in the US context, shared decision-making purports to destabilize hierarchical power dynamics that enable physician coercion and abuse, but can function as another manifestation of the neoliberalization of healthcare, romanticizing individual patient choice but stripping expert, interpersonal caring that patients may seek (Mol 2008). But for Maricela's family, decision-making relied entirely on the capacities that seemingly endless funds created. I yearned to remove the money as a variable from consideration, but this was impossible.

Over the next few months, Edwin called me with multiple stumbling blocks—Maricela's dad wasn't at home, then fell sick; later, the family felt they could not make the trip to the referral because the transport cost too much. I repeated that the US university who had seen Maricela could pay with fundraised support. Then Edwin could not reach Maricela's dad again. For a while, Edwin was out sick himself. No one in his understaffed office took over his informal job duties, including following up with patients like Maricela. The busy local doctor who evaluated Maricela had no social work staff to see whether she had completed her referral or to remind her to come in for repeat thyroid testing. This piecemeal struggle to get Maricela care continues through this writing. Whenever she goes without medication, which has already happened twice, Maricela risks death or permanent disability from hyperthyroid crisis.

Though I visited Maricela's family only a few times, I became a key actor in the process of taking creative advantage. I corresponded with friends, family, and mentors in

Guatemala and the US—could my mother pick up a prescription for Maricela before coming to visit me? Did my physician supervisor on a separate project think Maricela should change the dose of her medication before seeing the endocrinologist? Could a different STMM group do a home visit? What were the ethics of continuing to pay out of pocket for Maricela’s care myself when the fundraised amount eventually ran out?

At the time, I thought of this involvement as my obligation as a medical student and community member. I now see that in many ways I was also attempting to *aprovechar*, using some of the same methods I had learned from patients over years in San Lucas—reaching out to my social network, moving money around, searching for deals, engaging with public, private, NGO, and informal care. And my own miscommunications with Edwin and Dr. Elias contributed to gaps in Maricela’s medicine and follow-up. At the same time, I felt distraught that other patients who had not happened upon someone like me would not be able to rely on even shoddy care coordination.

Some organizations in Guatemala have successfully modeled care navigation in cases like Maricela’s, where national-level referral providers and ongoing local care are both necessary (Chary et al. 2018; Austad et al. 2021; Chary et al. 2016; Flood et al. 2017). But few could access consistent care coordination through Guatemalan organizations. Many San Lucas families depended on intermittently present American benefactors (an identity I resisted while inhabiting). More common still was patchy or no access to biomedicine, with family members fighting to *aprovechar* however they could.

Every time I saw Maricela, her parents urged her to tell me how thankful she was. One time, Edwin brought the methimazole to their home and sent me a video. Her dad,

sitting shirtless in the bottom right corner of the screen, states what Maricela should say, and she repeats, standing in the middle of the screen in blue crocs and a shirt featuring Disney princesses. Over the sound of a keyboard from the church next door, she starts: “Thank you, Taryn, for the medicines.” Her dad says: “God bless you.” Maricela says: “God bless you.” Her dad says: “Everything you have done for me.” Maricela repeats: “Everything you have done for me.” Edwin says from behind the phone: “Very good.”

Here, Edwin, Maricela, and her father explicitly performed thankfulness in my direction, suggesting that convincing me of their gratitude was a crucial part of continuing to get medical care to keep Maricela healthy. These affective skills were particularly crucial for Maricela’s family, because of their poverty. In Maricela’s story, giving thanks and taking advantage wove together: they took advantage of any opportunity to give thanks, and those thanks in turn allowed them further opportunities to creatively take advantage.

**Patients must *aprovechar* and *agradecer* even though they know the healthcare on offer is flawed**

Despite the creativity inherent in families’ work to *aprovechar* and the deservingness performed when they *agradecer*, San Luqueños did not ignore the many flaws in their biomedical care. Patients readily acknowledged problems, whether with STMMs, NGO, private, or government care. First of all, care was not reliable or predictable: an STMM was only around when groups were in town, a Puesto de Salud only open when staffed. “An illness never sends a warning when it’s going to come, so [we want] more clinics,” one patient said to a visiting medical student. Some community members could rely on clinics

more than others; community health workers told me they felt that favoritism played a role in which communities got assigned visiting groups and how often. Indeed, some of the 19 Mission health program communities got visited several times a year by American groups and other villages only once or twice.

Even when clinics did arrive, patients seeking to *aprovechar* had to tolerate the drawbacks of each type of care. Sometimes visiting groups gave medical advice that patients found ill tailored for the Guatemalan context. Nelia, who could sometimes only afford tortillas to feed her children, exclaimed, “They tell us we have to eat fruit. Fruit! But if we don’t have money to buy fruit? We don’t buy it.” One woman explained disapprovingly: “They say that the [patient] has to drink sufficient water, has to exercise, and that’s what they say to the patients.” A healthcare worker noted that “there are patients that don’t like when they [STMM providers] say they should go on a diet, because they work, they get hungry, they have to eat.” When patients left clinics without a medication, some felt that they had wasted their time, particularly when the alternative was advice that ignored the realities of their lives.

Bad or unavailable language interpretation also kept biomedical healthcare inaccessible for Maya would-be patients throughout plurinational Guatemala (Cerón et al. 2016; Paulino, Vázquez, and Bolúmar 2019). Patients said language issues were stark at some STMMs, where many STMM visitors only speak English and patients speak Spanish and/or Kaqchikel. One patient described a clinic with no translator present: “Sometimes someone tries to explain [themselves] and if the [person] doesn’t understand, or if they’re explaining to me and I don’t understand, what happens is we just start to laugh. Because

it's *por gusto*, just for the heck of it, we're there wasting our time. They don't understand, and I don't understand anything. And there's not an interpreter." Another explained that she knows community members who only speak Kaqchikel who "have many needs but they don't go to clinic," due to a combination of language barriers and long waits.

Some patients described feeling entirely unsatisfied by the care available at the STMMs: "Some doctors have come, but they don't give us anything other than diclofenac [similar to ibuprofen] and acetaminophen, and people say, 'just for kicks we waited all that time (*por gusto perdí mi tiempo*), if this is what they bring us.'" Patients "get bored" during long wait times. Many mothers emphasized that they felt they did pay for care—not with money, but with their time. This is consistent with anthropological scholarship discussing migrants in Europe and poor women in the United States who paid for healthcare with their time, and may have felt they did not have the grounds to complain about care quality because they received it for free (Huschke 2014; Andaya 2019). Guatemalan mothers paid with their logistical labor, and performances of *agradecer* and *aprovechar*, in addition to their time.

While STMMs had unique drawbacks, public options rarely met patient needs. A mother shared that sometimes "we ask for a loan to pay to travel there [to a public clinic] and they say there's no doctor. We come back [home] with sick kids." But families' dissatisfaction with public options stretched beyond unpredictable hours and unreliable medication availability. Indigenous interviewees echoed sentiments ethnographers and public health researchers have documented across Guatemala: they felt that in the public

health system, “they don’t care about us” (see: Chapter 5; Chary and Rohloff 2015; van Dijk et al. 2013; Cerón et al. 2016).

## **Conclusion**

In this chapter, I have introduced you to families creatively taking advantage of and giving thanks for multiple types of biomedical healthcare. These two interwoven approaches helped families navigate biomedical institutions, and the experiences of illness, with agency despite constraints. As the families’ labyrinthine pathways through biomedicine illustrate, presence of options is not the problem in San Lucas—instead, many families lacked consistent access to any of these options, and quality attention at all.

Families told me the public healthcare system, in particular, was unpredictable. Logistics in most cases were costly and taxing. The many steps of procuring medicine challenged families. Getting medication was often difficult for families like Don Arturo’s, and sometimes impossible for families like Maricela’s. Biomedical care could be violent, as other chapters will show. Accessing non-biomedical care and informal networks could help offset these risks, like Clea’s experience with natural medicine.

As in Clea’s case, some families with relatively more resources achieved somewhat consistent biomedical access and looked back at healthcare experiences positively. But the combination of advantage taking and giving thanks became more crucial for poorer families like Maricela’s. It took creativity and energy for families to navigate any biomedical system, where even low or no cost services were rarely actually free. Deep poverty meant no healthcare for many. Nonetheless, families persisted in seeking good lives, when

possible creatively engaging with biomedicine and giving thanks. In this chapter, I bring *agradecer* and *aprovechar* to the anthropology of biomedical care seeking, while illustrating ways that San Luqueños navigated biomedical care as they intentionally built family across the life cycle.

## Chapter 5: Family building using contraception: community knowledge and biomedical judgment

Sitting at her kitchen table, my friend Angie told me about the collaborative decision-making that helped build her family:

We decided, with... my husband, first to leave a prudent amount of time between the ages of each child, to be able to do some of our things [meet some of our goals] that we needed, in order to bring them comfort, not be without resources either. Therefore, due to that, my children have a time of distance between them...between seven and nine years.

Angie's focus on "comfort," "resources," and the "prudent amount of time" between children exemplified her family's commitment to building intentionally. During this interview, her three-year-old was taking a nap, her twelve-year-old was at school, and her nineteen-year-old was sleeping in after a late band practice. For most of the last twenty years, her sister-in-law has served as an *ama de casa*, housewife, while Angie worked outside the home. The children called both Angie and their aunt "mama." Angie successfully collaborated with her husband, her mother, her mother-in-law, her sister-in-law, and healthcare providers to achieve her ideal time between each pregnancy, prioritizing their children's well-being and the family's economic stability.

I start this chapter with Angie's story because she explains a key success in her ongoing process of family building. She and her family building collaborators wished to achieve a specific "amount of time between" her children's births, and they did so. Angie's experience, and many like hers, reveals that Kaqchikel families regularly do meet their goals. Family building in Kaqchikel Guatemala was not all dire or impossible, and

ethnography offers insights into interwoven successes and challenges. In this chapter, Angie and others will explain the sets of knowledge they engaged with to build the families they wanted.

In deciding how to achieve family building goals, Angie both relied on and produced community-based knowledge about contraceptives. In this chapter, I argue that incorporating community knowledge into contraceptive decision-making is one way Kaqchikel Guatemalans build families within biomedical systems that violently ignore their needs. To show this, I unpack a potent binary among biomedical practitioners in Guatemala, that of the contraceptive “myth” vs non-myth. Though this binary is powerful among those who work in biomedicine, this does not align with Kaqchikel families’ well-informed understandings about contraception. But biomedicine’s conception of the “contraceptive myth” has embodied implications for Kaqchikel families. I follow Wendland (2022) in attending to families’ and biomedical providers’ narratives as inherently “partial,” not to “debunk certain explanations while validating others” but to “explore how these explanations work: what they do and don’t do, and for whom” (4). Understanding experiences like Angie’s alongside healthcare providers’ perspectives on contraceptive use reveals crucial disconnects as well as new ways that biomedical providers, public health practitioners, and medical anthropologists can learn from Kaqchikel communities.

## **Kaqchikel people use contraceptive knowledge to build their families**

### **Angie: intrauterine device (IUD)**

After her first pregnancy, Angie got an IUD placed on the recommendation of a doctor. The story she told me might be interpreted as a three-part story about the risks of IUDs to her body. First, she got pregnant with the IUD in place, an outcome both unexpected and possibly dangerous. She was able to have the IUD removed and the pregnancy was unaffected, but it scared her. Then, she learned that a family member had “a negative experience with the IUD. It ended up ruining or damaging the uterus.” After this pair of scary IUD-related outcomes, she began to warn all her friends not to get an IUD. She said her friends thanked her, saying, “it’s great that you told us. Truly, you realized just in time, and it’s so good nothing worse happened.’ Because they told me that a friend of theirs had the IUD and she got, or it gave her, uterine cancer.” Angie used and shared this community knowledge, incorporating her own experience, to discourage others from using IUDs.

This story stood out to me, in part because of my own training as an MD student. Americans and Guatemalans I worked with in San Lucas talked to me about “myths” around contraception, and I wondered whether Angie’s story fell into this category. To the medically trained part of my brain, defining “myth” was easy: a myth is wrong, because it does not align with the best understood scientific reality. Public health and reproductive healthcare literature seems to use this same formulation. I have found a myth/non-myth binary in research on community ideas about contraception, especially in the Global South

(Russo, Miller, and Gold 2013; Black et al. 2012; Mwaisaka et al. 2020; Gueye et al. 2015; Westley and Glasier 2010; Yee and Simon 2010; Kaur and Blumenthal 2021; Anant, Sinha, and Agrawal 2021; Engelbert Bain, Amu, and Enowbeyang Tarkang 2021; Grimes and Schulz 2011).

Public health frequently invokes this concept of myths around contraception without ever really defining what “myth” means. These papers generally involve a community-based survey or interview project and subsequent publication detailing myths about contraception. Rarely do authors define the word myth explicitly, often pairing “myth” with “misinformation,” or fitting it in a section about “barriers” to contraceptive uptake. I coauthored a paper following this pattern (Valley, Foreman, and Duffy 2022). But my ethnography prompted me to think further about who this construct of the myth about contraception serves, and why.

The questions that motivate my discussion of contraceptive myths are as follows: within my own research on sexual and reproductive health in Guatemala, can I see contraceptive myths in action? How do people who use and do not use contraception talk about their choices? How do healthcare providers in Guatemala interact with community ideas about contraception? And how should researchers, across fields, write and talk about these so-called myths?

Unlike the clarity of publications in biomedicine, most in San Lucas did not divide their information into this binary of myth vs. non-myth. Two more stories, taken together with Angie’s experience above, exemplify what some scholars would call myths about contraception. I will show how these so-called “myths” are in fact useful community

knowledge among Guatemalans. Then, I analyze some Guatemalan healthcare providers' perspectives on these so-called myths. I close by offering ways for scholars to approach ongoing research centering this idea of myths about contraception.

### **Clea: progesterone implant**

For the second story about contraceptive use, I return to Clea, whose creativity and relative access to resources helped her family building during two pregnancies and births. Clea told me that in the ideal family, “we’re all in agreement about our decisions...so that children don’t end up suffering.” After her first child was born, she and her family wanted to wait a few years before she got pregnant again. She said she and her husband “almost always talk about” family planning. Like many interviewees, Clea used the verb “cuidarse” to mean prevent pregnancy, literally to care for oneself. Originally, she “opted for the implant method when my baby was six months old... [I talked] with my mom, she told me that if I did it, it was my decision, and my husband’s. She always supports the decisions we make. We always have to make them [together] the two of us.”

However, after Clea stopped breastfeeding her daughter, she began to experience constant menstrual bleeding, leading to clinical anemia. She implored a doctor friend to take the implant out of her arm between patients one day, avoiding paying for a visit. She found follow-up care for her healing arm by asking a medical student for a favor after hours, because the medical student happened to be working out of a health post where Clea sometimes met with patients. In this way, Clea continued to take advantage of whatever

biomedical healthcare she could access and give thanks to these colleagues and acquaintances.

Some of these providers worked at the government Centro de Salud, which explicitly provided contraceptive services. But others worked at Catholic or ecumenically Christian healthcare institutions. While Catholic Churches and affiliated organizations are sometimes thought to be strictly pronatalist, in San Lucas, as Clea's experience shows, different organizations, providers, and visitors dealt with contraception and reproductive healthcare differently. At the Mission hospital, contraceptives could be prescribed for non-contraceptive indications; as many places in the world, this often allowed providers to obliquely assess a patient's childbearing intentions and provide contraception in practice without explicitly advocating for contraception in theory. And while contraceptive implants were not available in the Mission hospital pharmacy, removing an implant was a favor some Mission doctors would be willing to provide.

Shortly after Clea had her implant removed, we were walking between patients' houses when she confided in me about her current contraceptive plan. She did not want to get pregnant right away, because she felt that her relationship with her husband was in a precarious spot. However, she also did not want to start a different biomedical contraceptive, now that she had successfully had her implant removed. She shared, "I don't want to use injections, because they've told me that they cause a lot of weight gain."

In using the seemingly vague word "they," Clea underlined that community knowledge can be both nonspecific and trustworthy. Behind knowledge from ancestors, scholars and Indigenous leaders rely on Kaqchikel stories starting with "xinwak'axaj" (I

heard) as the most trustworthy (Carey 2001). These stories are not trustworthy because they have specific individual people as their sources, but in fact because they do not. The authority is not one expert but the community at large. Clea's use of "they" referenced a collective gestalt that Kaqchikel families find reliably trustworthy, because this community has Kaqchikel priorities at heart.

After she explained why she wanted to avoid injections, Clea said, "I prefer to take care of myself now." In context, here she means that she will *cuidarse*, avoid pregnancy, without biomedical contraception. In direct conflict with the Western idea of self-care via use of biomedical birth control, *cuidarse* used in this way means practicing self-care by *avoiding* the expected harm of a biomedical intervention. When the implant was working well for her, caring for herself meant using it—when it started causing her problems, and other options carried risks, caring for herself meant attempting to avoid pregnancy by seeking her husband's collaboration and avoiding sex on fertile days. Just after Clea's implant removal, they were not having sex very often because they were fighting. She did get pregnant, a year or so later. Throughout, she prioritized word of mouth wisdom regarding contraceptive options to decide how to proceed in building her family.

### **Government sterilization, a short mention**

Finally, Kaqchikel women and men recounted their concern about any sort of medical treatment from the government, even beyond contraception, for fear of forced sterilization. A friend told me over coffee that "people are worried the government is using

COVID vaccines to sterilize their children.”<sup>23</sup> Others mentioned COVID tests and malaria pills as possible sources of government sterilization. The nurse who runs the Ministry of Health Centro de Salud in San Lucas told me that families resist HPV vaccines to prevent cervical cancer based on similar sterilization fears. Families believed forced sterilization could happen during any pelvic surgery, too, especially Cesarean sections. I discuss people’s experiences with forced sterilization in the subsequent chapter.

### **Contraceptive knowledge**

With these examples, I can imagine the backbone of a paper by public health scholars about false “myths” that reduce contraceptive uptake, following the dominant pattern in the literature. The myths in San Lucas would be: Contraception causes cancer, IUDs damage the uterus, injections cause obesity, and the government sterilizes unsuspecting women. The implication would be that these are false myths that discourage people from using contraception as they, presumably, otherwise should. But there is a problem with this formulation, even from a biomedical perspective: Some contraception does increase the risk of cancer (Gierisch et al. 2013), IUDs can cause uterine emergencies (Heinemann et al. 2014), injections do often affect people’s weight (Oshodi, Agbara, and Ade-Fashola 2019), and the Guatemalan government does regularly sterilize people without their consent (Valley, Foreman, and Duffy 2022; Bailey 2006; Cerón et al. 2016).

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<sup>23</sup> I do not want to suggest that Guatemala is the only place that public health professionals may claim that similar “myths” affect healthcare decision-making; plenty of scholars and communities contest the risks of COVID vaccines. But I focus on the Guatemalan context without invoking comparative approaches because my anthropology is intentionally local, focused on one Kaqchikel community.

Therefore, scholars and healthcare workers who label those stories “myths” are not necessarily judging “validity” from a scientific standpoint. Instead, they judge women’s and families’ choices by matter of degree, as if their risk-benefit analyses does not stand up to scientific muster.<sup>24</sup> For example, an estimated one in 1,000 users have an IUD that either partially or entirely pushes through the uterine wall, and while most perforations do not cause additional complications, some perforated IUDs can damage the bowel or bladder (Rowlands, Oloto, and Horwell 2016). A physician may acknowledge the risk of dangerous uterine perforation with IUD use, but judge that this risk is so rare that it does not outweigh the benefits of the contraceptive method for any given patient. But many women I interviewed, assessing their healthcare options, would not be able to access treatment for a uterine perforation. The quantitative risk of a life-threatening event might not carry the same weight for the doctor as for the patient, who could understandably fear having bowel or bladder damage without reliable access, or any access at all, to follow-up care.

Biomedicine’s definition of correct contraceptive choices is incommensurate with many Guatemalan understandings of good reproductive health. These tensions may not be obvious. Angie spoke highly of improving access to contraception in Guatemala:

Before, there was a lot of fear in women. They asked, what do I do? We would make [contraceptive decisions] in secret. But there are many organizations that have worked, and now it has been implemented that it’s our right to be able to decide when we get pregnant. So now it’s talked about with more safety and with more confidence. People can ask about this, what method are you using. In the Centro de Salud they have access to all of the methods, and women can get checked and see.

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<sup>24</sup> Underlying this disapproval is the idea of gendered compulsory birth control, as Littlejohn (2021) shows, wherein it is socially only women’s responsibility to prevent pregnancy.

Angie's description speaks in favor of government and organizations' work insofar as it gives women the "right to be able to decide when we get pregnant." At the same time, and without articulating a conflict, Angie participates in community knowledge exchange about her and other women's negative experiences with the IUD. Some of Angie's language echoes global rights-based approaches to family planning in the last 30 years (E. O. Singer 2022; El Kotni and Singer 2019). But she also spoke repeatedly of the "risk" of different biomedical contraceptives "adversely affecting" her "organism," as she experienced with the IUD. These conclusions do not align as directly with the way Guatemalan clinicians I talked to oriented themselves toward contraceptive use, which I describe shortly.<sup>25</sup>

Emily Yates-Doerr (2014) described untranslatability in her past work on diabetes in Guatemala as not "just that the meanings of words did not match up, but that the practices in which these words were embedded also followed different logics," which "led to ruptures in communication, confusion and frustration."<sup>26</sup> This churn of meaning and misunderstanding produces all sorts of taxonomic detritus. Is this just another example of how biomedical providers cannot speak their patient's languages? Or is the idea of the false "myth" about contraception more than a simple waste product of this ongoing incommensurability?

To dig deeper, I must begin to explain the context of interviewees' concerns about biomedical contraception, though I will expand and provide further ethnography in the

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<sup>25</sup> Again, biomedical providers regularly acknowledge that contraception carries risk, but I argue that they judge these risks as negligible when compared to their understandings of the stakes of "contraceptive non-use." The subsequent chapter further examines state and para-state entities' vested interests in reproductive governance, control, and coercion.

<sup>26</sup> For a powerful analysis of how women's lived realities in Sololá (across the lake from San Lucas Tolimán) clashed with local and international biopolitical priorities in maternal health, see Berry (2010).

following chapter on contraceptive coercion. Guatemalan reproductive healthcare explicitly continues 500 years of Guatemalan state genocide of Indigenous communities. The state, alongside para-state and international actors, violently governs Indigenous reproduction as part of this ongoing genocidal project, including through rape, forced birth, forced adoption, and murder (Santizo-Malafrenti 2022; Yoc Cosajay 2014; Fulchiron 2016; Hartmann 2018; Bailey 2006; Walsh and Menjívar 2016; Menjívar 2011; Valley, Foreman, and Duffy 2022; Grandin 2013). Women are regularly sterilized against their consent during C sections, an open secret discussed widely among physicians and NGO workers in the highlands. Kaqchikel families in which no one works in biomedical industries are equally aware of historical and current day forced sterilizations in government institutions.

Exemplifying Morgan and Roberts' (2012) theory of reproductive governance, the eugenics goals of the Guatemalan state towards Indigenous women continue to be explicit: Contraceptive control is not a threat, it is a promise, which the government makes good on (Valley, Foreman, and Duffy 2022; Cerón et al. 2016). This is post-war (or mid-war or intra-war) Guatemala where, at the time of these interviews, the government was attempting to overturn a democratic election and criminalizing peaceful protest (Frener 2023; Prensa Comunitaria 2023).<sup>27</sup> A physician who has worked in Guatemala since the 1970s told me that Guatemala is governed by “the same state that perpetrated the genocide but it no longer has to... it accomplishes the same things without it.” One Indigenous friend, José,

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<sup>27</sup> Defining Guatemala's current era means answering the thorny question of what makes war and when it ends (see Fischer 2004; Grandin 2013; McAllister and Nelson 2020).

took this analysis one step further, saying that “the government now is worse” for his people than at the height of the genocide.

For Indigenous people, then, avoiding government healthcare, or government entities in general, is adaptive and appropriate.<sup>28</sup> So when a Kaqchikel woman tells her neighbor something she heard about how this or that contraceptive causes a dire outcome, she warns her also against naïve or nonreflexive (even provisional, one-time-only) trust of the system. The system not just historically, but currently, violently, overrides communities, families, and women themselves to enact reproductive outcomes desired by the state. Neighbors and friends, on the other hand, are trustworthy, mostly aligned on the same side against government overreach and ongoing genocide. As Kaqchikel people endeavor to build their families, they must grapple daily with the pros and cons of engaging in healthcare systems, family relationships, and community processes that may seek to override their own family building goals. Acting upon trustworthy community knowledge in pursuing family building goals through contraceptive use or avoidance is therefore intelligent and informed.

Anthropologists have long documented how reproductive choices reflect cultural wisdom and further community resilience. “The seeming universality of pregnancy,” which “is continuously undermined by its concrete historical and local embeddedness,” explains the very call to study reproduction (Rapp 2004, 49). Literature about traditional birth attendants (TBAs) explicates this throughline in anthropological scholarship; though I do

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<sup>28</sup> Relatedly, Kedron Thomas (2015) explains some of the benefits of avoiding the economic reach of both government and non-government oversight for Maya clothing sellers in the Guatemalan highlands.

not analyze dynamics around TBAs in San Lucas directly, midwives I talked with described ongoing patterns of government absorption and then discarding as Berry (2010) described across Lake Atitlán. Global research involving TBAs, as guardians of local knowledge, can enforce the protectiveness of relying on local contraceptive knowledge in San Lucas.

Rather than positioning TBAs in Mozambique and Guatemala as reproductive caregivers of last resort, both Chapman (2011) and Berry (2010) unpacked families' decisions about where and with whom to give birth, arguing these choices were more related to inadequate, violent healthcare structures than to misguided beliefs. Berry analyzed how state-run biomedicine in Sololá attempted to incorporate TBAs into so-called modern reproductive healthcare in order to cover gaps in underfunded public health systems. Chapman explained how top-down neoliberal approaches to maternal health pushed women away from seeking biomedical healthcare in a structurally violent place. Similarly, Kaqchikel families' wariness about biomedical contraception must be understood in the context of violent neoliberalized healthcare amid structural and government violence.

Fouzieyha Towghi's (2004) worked with Pakistan's *dais* (TBAs) during structural adjustment and governmental incorporation, another setting in which public health beliefs about community approaches to reproduction failed to take into account the intricacies of community understandings and reproductive needs. Towghi problematized the dogma that *dais* in South Asia (and elsewhere) were "substandard, superstitious, and incapable of performing complex tasks" (80). Instead, Towghi's ethnography revealed that *dais* played integral roles in reproductive health, at once key to community expectations around birth

and, depending on the winds of international health funding, intermittently linchpins in governmental interventions into women's health. Towghi challenged the prevailing public health belief that TBAs did not improve maternal health because metrics did not improve when TBAs were present. In a broader sense, this aligns with my findings that locally salient knowledge can contradict biomedical understandings of the "right" contraceptive decisions.

Towghi reminded readers "that local community midwives work in a 'cultural matrix of a social group' in which the midwife and women belong together. Within this cultural matrix, many visible and invisible practices are conducted during pregnancy, delivery, and postpartum by the midwives (who may or may not be allopathically trained)" (88). That is, involving midwives in Pakistan, like turning to local reproductive knowledge in San Lucas, improved women's reproductive experiences. As Angie and other community members revealed, local wisdom regarding contraception is crucial not just despite biomedicine's disapproval: the protection of local knowledge is necessary *because of* biomedicine's violent intentions towards Kaqchikel families.

### **The myth of the myth also does work**

Therefore, what physicians and scholars call "myths" are often in fact reliable, informed community knowledges. But healthcare workers keep talking about myths and blaming them for low contraceptive uptake: I think of this as the myth of the myth. It allows those in biomedicine to restore the epistemological hierarchy, reasserting their position as purveyors of scientific truth. This hierarchy in turn perpetuates structural violence, in the

form of continued reproductive coercion. And this all serves the status quo of bad and absent reproductive healthcare in Guatemala.

In her dissertation about cervical cancer care and suffering in Guatemala, Anita Chary (2017) discussed the idea of “culture” as a scapegoat that (in her study, mostly non-Indigenous) medical professionals use to indemnify themselves. Saying that cervical cancer patients, because of “culture,” did not trust biomedical healthcare served as a convenient reason why women died of cervical cancer at home.<sup>29</sup> But Chary convincingly showed that what killed Guatemalan cervical cancer patients was lack of access to care and lack of quality healthcare itself. This is, to be clear, the state’s fault, not women’s or families’ faults.

But healthcare workers and social scientists in Guatemala reproduce and benefit from this continued belief in “myths.”<sup>30</sup> Blaming myths allows them to elude responsibility or self-involvement in ongoing healthcare violence. Fassin succinctly maps this implication: “In incriminating culture as certain health authorities willingly do, sometimes supported by anthropological data, they are in fact blaming the victims while masking their own responsibility in the matter” (2001, 305).<sup>31</sup> The patterns in Kaqchikel Guatemala go beyond patient-blaming or individual responsabilization. Here, “culture” functions as an

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<sup>29</sup> As much as possible, I use the word “culture” here in its use from my own ethnographic data, not in reference to the ample discussion in anthropology and other fields about this word in theory; see Fassin (2001) for a deeper examination that dovetails with this chapter’s findings.

<sup>30</sup> Yates-Doerr, among other STS and anthropology scholars, discusses how the framing of scientific questions perpetuates inequities in healthcare in Guatemala: “beginning research out of a concern that women were not going to hospitals was itself disquieting...the idea that knowledge can ever be ‘understood’ presumes a stable and correct version of the information itself” (2014, 13).

<sup>31</sup> This formulation and application of the idea of “culture” does not include biomedicine: as other anthropologists have explained, healthcare workers especially universalize biomedicine and hold it apart from both time and culture (Harvey 2011; Taylor 2003; Fassin 2001).

epistemological passive voice. There is no actor in the grammar of culture: neither individual patients nor individual providers, neither specific healthcare systems nor general government structures face blame for poor reproductive health.

The excising of culpability allowed by culture's passive grammar serves larger aims in Guatemalan governance. Aura Cumes, a Kaqchikel anthropologist, echoed my friend José, who said that the government now is worse than during the genocide. Cumes said,

the colonial is not an era—it is not broken. Colonization is not only economic; transforming the economic situation doesn't take away the problem. It's also not solely 'cultural'—the 'culture' is invented through the international market of 'cultural heritage.' The colonial is epistemological, moral, and impregnates our desires and our being. It is a continual domination (2022).

Cumes pinpoints the larger historical forces that animate even Guatemalan physicians' dismissal and scorn of community knowledge as cultural myth. Clea and Angie, through deciding what contraceptive method worked best for them and sharing their experiences and knowledge with friends, pushed back against the prevailing colonial ethos manifested in biomedical hegemony.

Ongoing colonialism in Guatemala, as my ethnography shows, does not require nefarious government plans (though Guatemalans have lived with centuries of those). Instead, as Donatella Di Cesare details in *Immunodemocracy*, the global state of “ungovernable catastrophe” operates through myriad pathways, not depending only on identifiable malicious intent on the part of the state (2021, 31). Di Cesare's explication of power's function, drawing from Agamben's (1995) idea of the “state of exception,” applies to biomedicine's role in Kaqchikel family building. State control over life and death “operates in the background, becoming ever less readable and sinking into the depths of

administrative practice. This does not mean it has lost its importance. The agent of this power is the subaltern functionary, the bureaucrat today on duty” (33). Those bureaucrats can avoid guilt (from themselves or others) by exporting responsibility for any problems with contraceptive use or nonuse to “culture,” which in turn grammatically cannot take or assign blame. Kaqchikel families craft their contraceptive practices in direct conflict with the “depths of administrative practice” that blame so-called myths to avoid culpability.

My ethnographic work found healthcare workers using culture as an intangible offender. When explaining patients’ reproductive health choices, more than one healthcare worker compared Guatemalan culture disparagingly to my US perspective. One Indigenous woman community health worker said to me multiple times, “the culture here is different from what you have there,” often in reference to something dysfunctional in Guatemala. One Guatemalan, non-Indigenous, male physician described Guatemalan culture, in general, as an “archaic ideology.”<sup>32</sup>

A different Indigenous, male physician said that in one workshop, rural community health workers “often mentioned the culture in their communities, their way of thinking...these are ideas people have in their minds, and these are things we can’t correct. And maybe they don’t come [to the hospital] because of their way of thinking.” This physician saw this rural (read, Indigenous) “culture” as unmodifiable. And he designated even the identification of culture as a problem to the Kaqchikel community health workers,

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<sup>32</sup> The physician’s formulation of myth interacts with time here—the word tends to bring up an idea that came from our ancestors, passed along without clear origin. If we wanted to talk about Povinelli’s articulation of cultural tense we could say that biomedicine believes itself to be fashioned in a “faster” zone than the “myths” that exist in some sort of slow Southernly “hora Chapina” (2011).

an additional layer away from assigning responsibility to any actor. Correspondingly, there existed no solution to the problem of culture: “these are things we can’t correct.”

All three of these providers explained that healthcare provision was simply, inexorably obstructed by whatever cultural misconceptions held sway over Maya patients. This formulation reinforces the hierarchy of modernity and power inherent in biomedicine. Lucia Guerra-Reyes documented similar patterns among biomedically trained midwives in the Andes: “Health care workers frequently treated unintended pregnancies as a personal or moral failure on the part of the woman... midwives’ talk of educating was permeated by a sense that their biomedical knowledge conferred a moral superiority, and as such only admitted agreement” (2019, 92). Within this epistemological hierarchy, even when biomedical providers authentically seek what they consider the best health outcome for their patients, coercion makes logical sense. Reyes explained,

the biomedical attitude of superiority was further enhanced by the racial, social, and economic inequalities, which provide context to the medical encounter. Thus, women, and especially indigenous women, were seen as childlike; they cannot, or choose not to, follow the dictates of medical professionals, and as a result, they are inherently more at risk and more risky, or dangerous, for the medical encounter (2019, 92).

Correspondingly, in the Andes and among Guatemalan volcanoes, some biomedical providers acted as though women must be saved from their own culture.

The idea of culture as an actorless but powerful force worked alongside other forces, like street level gatekeeping and administrative silence.<sup>33</sup> Together, these served

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<sup>33</sup> Patients experience these forces differently in different places, depending on their social position, who they know, and what day they happen to arrive (Chary et al. 2016; Lipsky 1983; Mesa 2019; Chary and Rohloff 2022). I cannot further unpack these dynamics here, but hospital ethnography in Guatemala would benefit from further research on this topic.

cohesively to keep patients out of healthcare. Health system rate-controllers are necessary because Guatemalan healthcare systems explicitly cannot provide to all who seek biomedicine.<sup>34</sup> Like biomedical narratives around maternal mortality in the United States and Malawi, biomedical reliance in Guatemala on the explanatory power of culture “seemed to downplay iatrogenesis: the damage we ourselves inflict” (Wendland 2022, 7). Blaming culture meant Guatemalan providers could avoid discussing both the harms that biomedical contraception caused and the harms the health system inflicted upon those seeking contraception in the first place.

A community health worker who worked at an intermittently open *Puesto de Salud* in a village a short tuk-tuk ride from town used to stock contraception through an international program.<sup>35,36</sup> But that funding ran out. When I interviewed her, three Depo-Provera vials constituted the entire monthly contraceptive stock in her community’s *Puesto*. I had to double check I heard correctly. A woman would need one Depo injection every three months to prevent pregnancy. I understand Guatemalan providers’ pessimism about culture in the context of this example. When a provider suggests that women believe untrue myths about contraception to explain low patient uptake, it allows that healthcare worker to skirt the reality that their system is so resource-strapped that only three people in that community could even get contraception. The culture-myth-miasma may serve its own curative process, attending to the provider’s structural violence-induced pain.

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<sup>34</sup> I am indebted to Peter Rohloff for pointing out the spiritual needs of overburdened public healthcare workers (alongside the bad -isms).

<sup>35</sup> She is no longer paid for this work, but once in a while her supervising nurse will give her 50Q (= \$7USD) out of the nurse’s own pocket to thank her for her time.

<sup>36</sup> “Pastillas, inyecciones, el implante, ese cómo se llama, T de cobre, todo.”

## Conclusions

Community knowledge is an adaptive defense mechanism. What biomedical providers think of as “myths about contraception” serve many purposes. Community knowledge helps patients, and the formulation of the “myth” helps providers, survive a violent and resource-scarce healthcare system. In communities where I work in Guatemala, my ethnography shows that the most meaningful barrier to access is contraceptive coercion, in the context of violent reproductive governance. State control over contraception functions alongside resource scarcity at the individual and community levels, long identified in public health scholarship as barriers to contraceptive access, to constrain families’ capacities to pursue their own priorities (Seiber and Bertrand 2002; Valley, Foreman, and Duffy 2022). As in the cases of femicide, climate refugees, and other phenomena of what Anna Tsing (2015) might call the capitalist ruin, the government seems absent, but that inaction serves a distinct purpose. Reproductive governance here functions by way of providing few services, except those that control conception in governmentally approved ways. I propose that public health researchers stop writing about community myths as primary barriers to overcome in the quest for contraceptive uptake.

Applied anthropologists and implementation scientists have argued for education as a solution: educate women about contraceptive safety (Hylton-Kong et al. 2021; Abubakar Kawu et al. 2021), and educate providers about how to talk to patients without being patriarchal or condescending (L. M. Stevens 2018; R. Stevens et al. 2023). But

emphasizing this type of solution is also a settler move to innocence (Tuck and Yang 2012). Simple education only captures the most literal of the young mother's wish to *cuidarse*. One-step solutions targeted at resource-strapped community members do not redistribute resources amidst burgeoning neoliberalism or reckon with genocidal violence during waves of government crackdown.

Guatemalan women I talked to do need wider access to contraception, as much as they need immediate cessation of forced sterilization. But Guatemalan people simultaneously call for reliable access to food and water, a functioning democracy, healthcare in their own languages, humane border policy, dignified homes, abortion legalization, and myriad other changes in line with reproductive justice. Continuing to focus on, study, and discuss so-called myths that purportedly impair women's and families' profoundly limited family building decisions will only further obscure the dire needs that a critical medical anthropology must document and fight for.

## Chapter 6: Contraceptive coercion in Guatemala: an anthropological frame

Guatemalans openly discussed forced sterilization by biomedical providers affiliated with the state. A friend named Sabrina, a community health worker in her early forties, told me her story of contraceptive coercion as an almost casual aside. I was working in her small town alongside an American visiting medical group, mostly in my medical student capacity, and she had seen me provide direct patient care there. She accordingly asked me and a physician supervisor to come to her daughter's home, as her daughter had just given birth, and Sabrina wanted a doctor to check on her C-section wound. Mother and baby were both recovering well, and Sabrina exclaimed how excited and nervous she was to be a new grandmother. As we walked back, Sabrina asked me whether she could tell me about some vaginal discharge that had been bothering her. She said she wanted to talk with me more privately because she had too much *vergüenza* (shame) to be seen at clinic with all her neighbors around.

My supervising physician agreed I would take Sabrina's medical history as we slowly climbed down a hill, switching to talking about flowers when nosy teenaged boys slowly sauntered by, staring. Sabrina told me that her youngest daughter, now 7 years old, had been born vaginally, a normal delivery as Sabrina recalled it. Except, she added, she had a sterilization procedure after the birth. I asked her: "Did you want it?" She responded frankly: "Well, no, but the doctor told me that seven children was enough, so he did it to me."

Kaqchikel Luqueños faced myriad constraints when building families. In chapter 4, San Luqueños explained the overlapping barriers they experienced when seeking biomedical healthcare for their families, a struggle that for many undermined their preferred ways of family building. In chapter 5, women in San Lucas detailed ruptures in their individual and collective family building experiences, when community knowledge supported family building amidst reproductive governance. This chapter engages directly with the most extreme cases of reproductive governance: contraceptive coercion. Despite the matter-of-factness with which San Luqueños discussed their experiences with contraceptive coercion, little scholarship in or beyond anthropology focuses directly on reproductive coercion in Guatemala. In this chapter, I address this gap, focusing on stories of contraceptive coercion from women in San Lucas. I articulate an anthropological framing of contraceptive coercion, including but extending beyond forced sterilization. While San Luqueños like Sabrina told me about their stark experiences of coercion, they identified broader structures of power that underlie contraceptive coercion in Guatemala.

I begin with the definition of contraceptive coercion offered by Leigh Senderowicz (2019, see figure). Senderowicz argued that “all obstructions to women’s contraceptive autonomy should be understood and analyzed as various iterations of the same process: coercion,” showing that contraceptive coercion can be bidirectional and perpetrated by members of systems at several levels (2019, 3). Her model encompasses every instance where a reproducing person is not able to achieve their reproductive goals vis-à-vis contraception. Senderowicz theorized this model from qualitative findings revealing how regional and national targets for fertility reduction ultimately affected patients. These

family planning programs proffered “modern” contraception, which in practice meant most women were only offered “a small range of exclusively hormonal contraceptives,” specifically “contraceptive pills, injectables, and implants” (Senderowicz 2019, 5).<sup>37</sup>

		Has family planning method	
		No	Yes
Wants family planning method	No	[no coercion]	<b>Upward coercion</b>
	Yes	<b>Downward coercion</b>	[no coercion]

Adapted from Figure 1, “Bidirectional conceptions of coercion” (Senderowicz 2019, 3).

In this framing, upward contraceptive coercion happens when a person is coerced into having contraception even though they do not want it. Downward contraceptive coercion, in contrast, happens when a person who wants contraception is coerced into not having it. Sabrina, who was sterilized despite not wanting to be, experienced upward contraceptive coercion. I build from Senderowicz’s model in this chapter, attending to cases where ethnography from San Lucas can challenge the neat fit of this frame.

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<sup>37</sup> Senderowicz does identify that “few women in either the urban or rural areas reported being offered or even told about barrier methods, fertility-awareness based methods, IUDs, or other non-hormonal options” (2019, 5). Therefore, I understand the model to be inclusive of many types of family planning, including those not considered “modern” (see also Russell, Sobo, and Thompson 2000). While the so-called withdrawal method may not fall under specifically biomedical purview, my overall argument in this chapter extends to withdrawal, because patriarchal systems and individual men may not be willing to participate and therefore perpetuate downward contraception.

I extend Senderowicz's binary, cohesive framing to show contraceptive coercion as one specific, crucial nexus of structural violence in the lives of San Luqueños building family. Interviewees told me about occasions when, without their consent or before they realized what was happening, their family building priorities were undermined or overridden. Morgan and Roberts (2012) identify "direct coercion" as one of the "mechanisms" of reproductive governance used to "produce, monitor and control reproductive behaviours and practices" (243). Paying anthropological attention to contraceptive coercion in San Lucas is a crucial part of understanding how Kaqchikel people build families amidst precarity and constraint. In this chapter, four accounts from Kaqchikel women in San Lucas illustrate the multiple levels at which Indigenous Guatemalans' reproductive life trajectories are forcibly interrupted.

Contraceptive coercion in Guatemala has long served as a weapon of genocide. Decades of violence kept Indigenous women from autonomous family building amidst government crackdowns, and this served government goals of both subduing resistance and furthering eugenicist population goals.<sup>38</sup> Scholars have detailed wartime sexual violence in Guatemala, where "the sexuality and reproductive capacity of women gets converted into a field of symbolic, convenient battle" (Yoc Cosajay 2014). During the war, upward contraceptive coercion included forced sterilization and abortion as an act of genocide (Fulchiron 2016; Bailey 2006); this forced sterilization served as a weapon of the

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<sup>38</sup> Taking the longer historical view, the entire project of creating a dominant mestizo or Ladino dominant race and class occurred through rape and forced birth beginning at conquest (D. M. Nelson 1999, 12). The 30-year war and its corresponding eugenicist project in this framing represented not a departure from previous (and subsequent) "peace" but only a shift in tactics at that time.

Guatemalan government to disrupt Indigenous communities' intergenerational resistance (Brett 2016). Paramilitary and military soldiers also widely committed rape, serving as extreme downward contraceptive coercion (García et al. 2016; Martín 2018; Ishida et al. 2011). While very little data exists on the details, many women were forced into pregnancies as a result of wartime rape (Bailey 2006). Community memory of reproductive and gender-based violence has eroded Indigenous communities' faith in government health services (Hartmann 2018; Ishida et al. 2011). The subsequent chapter will discuss gender-based violence more directly, while this chapter focuses on contraceptive coercion, informed by these histories.

Documented accounts of wartime contraceptive coercion fall into footnotes, middle paragraphs, and asides in research reports and papers about broader topics, like sexual violence or the genocide writ large. Scholarship about post-war Guatemala, which I will review alongside ethnographic examples, follows a similar pattern, alluding to and mentioning contraceptive coercion in passing. I contribute an anthropological perspective to public health and global health literature by collating this research in one place and analyzing it alongside San Luqueños' experiences of contraceptive coercion from my own research.

A comprehensive, ethnographic view of contraceptive coercion in San Lucas, from structural forces to individual actors, shows how maximal constraints on contraceptive agency impede the rest of people's family building lives. This chapter therefore contributes to scholarship about contraception as a locus for structural violence, while shining a spotlight on contraceptive coercion hiding in plain sight, impeding Maya Guatemalans from

building their families on their own terms. At the same time, ideas like contraceptive coercion, and other English language social science around reproductive autonomy, tends to take for granted a Western individualized subject who can and should independently decide their contraceptive goals. Identifying coercion, then, means seeing instances where individuals' goals as rights-bearing citizens are disrespected. Listening to Sabrina and the other interviewees who speak in concert complicates this frame. While some, like Sabrina, have an individual goal (or set of possible undefined futures) in mind, others describe collective family building goals with their husbands, children, or others. Therefore, anthropology about contraceptive coercion in Kaqchikel Guatemala must center everyday Maya understandings of family building and understand their responses when factors beyond families' control fracture the family building process.

**Lucía: “I’m sterilized to not have any more family”**

One young Indigenous woman, Lucía, told me tearfully that government doctors sterilized her without her consent in a state hospital far from home while she was unconscious before the Cesarean delivery of her second child:

[The doctors] talked with my husband, and they explained to him ... if he wanted to see me healthy again, that he should decide that they should sterilize me because if not ... with another child, basically I wouldn't survive the operation. And so they told him that they were going to operate so that I couldn't have any more family, and so he said yes. So—I mean I'm sterilized, to not have any more family.

Lucía's final line in this quotation, “para no tener familia,” could be translated as “to not have any more kids.” But I was struck by her use of the word *familia*, so I translated it

directly. Lucía did not only refer to giving birth to a higher quantity of children; her “tener” aligned with the way I came to use “build” in “family building.” In the way Lucía talked about the loss of her family’s reproductive capacity, she suggested the overarching way this affected her and her family’s whole lives.

Lucía’s halting explanation of the day her family building was ruptured implicated both those particular doctors and the Guatemalan Ministry of Health. Examining Lucía’s experience alongside Sabrina’s helps illustrate how individual physicians, government policies, and biopolitical structures conspire to coerce Indigenous families away from their own family building aims.

The language used in biomedicine is one dimension along which patients in Guatemala experience coercion. Many in Lucía’s community prefer Kaqchikel and only have elementary school educations. Therefore, although I did not get to meet Lucía’s husband, my experiences with others and a review of scholarship suggests he might not have felt comfortable communicating in Spanish with Lucía’s physicians. Translators are rare or absent. Compulsory Spanish-speaking in state medical institutions regularly leads Mayan-speaking patients to receive care that does not meet standards for informed consent (Berry 2010; Cerón et al. 2016).

Even if Lucía’s husband spoke Spanish fluently—even if he and the doctors had a conversation in a shared language about Lucía’s options—stark power differentials in Guatemalan healthcare may have precluded true informed consent. Even if her husband had the forthcoming medical procedure “explained to him,” the subsequent line that Lucía’s husband “should decide they should sterilize me” implies that there was only one

real choice for this husband if he “wanted to see me healthy again.” Even if doctors asked her husband outright, in a language he understood, whether they should perform the sterilization procedure during the surgery, he might have felt pressured, or that he did not have a real choice, due to the power of the physicians in the interaction.

Perhaps Lucía would have died that day without sterilization, perhaps not. Perhaps the physicians tied her tubes while she was already unconscious, because they presumed to know what was best for a young Indigenous mother who had survived two C-sections; perhaps they removed her entire uterus, and she otherwise would have died that day. Perhaps both of her C-sections were medically indicated; perhaps she was never offered the option of laboring with her first child or trialing a vaginal birth after C-section with her second, because a C-section was more efficient for the physicians. More important than any of these details is the fact that Lucía herself did not have any say in her sterilization. The effect was coercion: her doctors “spoke with my husband and explained *to him*” the next steps in Lucía’s care. Lucía, for her part, woke up from her surgery and simply “couldn’t have any more family.” Her contraceptive autonomy was taken from her.

In a paper presenting Indigenous people’s experiences of abuse and discrimination in Guatemalan public health services, Cerón et al. provide evidence of forced sterilization similar to Lucía’s experience (2016). A man from Sololá spoke about his wife’s care at the same government hospital where Lucía gave birth and was sterilized. He described that during his wife’s urgent C-section, itself performed “very quickly” and without discussion beforehand, the doctor “also injected her with something to stop her from having more

children.” The man continued, “I got very upset because he should have asked” (Cerón et al. 2016, 5).

Other scholars have emphasized that non-Indigenous healthcare “[p]roviders routinely deploy discourses of negligence and ignorance when dealing with [I]ndigenous patients, rather than inquiring into and acknowledging the constraints of poverty and ethnolinguistic marginalization. Consequently, many patients come to view their relationship with MOH [government] providers as fraught with fear and mistrust” (Rohloff, Díaz, and Dasgupta 2011, 429). This fear and mistrust, as Lucía and Sabrina show, is wise. In both cases, the biomedical provider presumed to know what was best for the Indigenous woman who was their patient and acted directly on this presumption. These individual relationships between patients and providers emerge from histories of violent reproductive governance.

In both Lucía and Sabrina’s stories, the worldwide phenomenon of physicians believing they knew what was best for their patients combined with actual logistical power and institutional approval to enact these state-sanctioned reproductive violences. This additive effect echoes ethnographic findings documenting contraceptive coercion elsewhere in Mesoamerica. Arachu Castro (2004) discussed postpartum contraception in Mexico: While the provision of postpartum contraception (most often IUDs or sterilization by tubal ligation) was not technically incentivized or required by the Mexican government, Castro explained that Mexico’s health system adopted postpartum contraception as part of an international package of maternal health interventions through the International Conference on Population and Development (ICPD), prompted by the 1994 Cairo

conference.<sup>39</sup> For women Castro interviewed, these changes in reproductive governance manifested through biomedical procedures on women's bodies, officially incentivized by the Mexican Program on Reproductive Health and Family Planning.

Castro wrote that in Mexico “international ‘ICPD language’ on reproductive choice and convenience for women...mostly intended to induce fertility decline—a disguised way of exerting population control” (141). While there was no rule that a woman must receive a tubal ligation immediately after her third cesarean section, physicians and patients shared that this permanent procedure was de facto required in Mexican hospitals. If a woman refused, one doctor shared, they would “insist by saying, ‘look, your uterus can burst, and you’ll make orphans of your babies’” (137). This doctor sounded like those who performed Sabrina and Lucía’s sterilizations. Whether threatening some future risk or simply determining that an Indigenous woman’s reproductive days should be over, these physicians may have followed what they believed to be the best medicine. In Guatemalan hospitals, biomedical superiority is rarely questioned (see previous chapter), and women do certainly die in childbirth (Berry 2010; Rööst 2010). These deaths are traumatic for healthcare providers, who may seek to reduce such risks whenever possible (Castro 2004; Guerra-Reyes 2019). But physicians’ individual choices to sterilize specific Indigenous women also often reinforce state-level reproductive health goals by deciding for women and their families.

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<sup>39</sup> Ample evidence in the early 1990s showed that international public health in many ways disempowered reproducing women. Thus, in 1994, global health experts defined a new era of contraceptive provision at the ICPD in Cairo, with the explicit goal of improving women’s autonomy through reproductive healthcare. But the implementation of subsequent metrics often furthered the violence inherent in structures of power, the same issues that the Cairo conference tried to move beyond (Suh 2020; Senderowicz and Valley 2023; Senderowicz and Nandagiri 2025).

Lucía's experience, in contrast to Sabrina's or those of women Castro interviewed, challenges the individual rights-bearing framework that is the subject of contraceptive coercion in Senderowicz's model. Lucía's story differs across two dimensions. First of all, her family building goals, which state physicians nonconsensually foreclosed, were collective: she *and* her husband had their shared desire for "more family" violently interrupted. Lucía did not take issue with her husband speaking as her proxy; instead, her language blamed the healthcare providers for making the decision without involving either of them in a real way. Secondly, Lucía wasn't even present for the moment of coercion: she woke up and her family building goals were already impossible. Lucía and her husband experienced together being set on a life path they would not have chosen for themselves. Lucía described not one bounded event defined by one clinical interaction, but an ongoing tragedy.

This project, overall, is indebted to decades of anthropological thought about reproduction and power. At the same time, anthropology about reproduction can sometimes reify the same notions of a bounded, (neo)liberal subject that ultimately underlie the reproductive violence these works decry. For example, Browner and Sargent's useful chapter, "Reproduction and the State," begins:

In this chapter, we identify the sociopolitical conditions that both enable and impede women's ability to act in their own reproductive interests. We argue that, in today's world, neoliberal policies and the global rise of authoritarianism are the gravest threats to women's reproductive autonomy (2021, 87).

While mapping a very similar argument to this chapter, the authors indicate "women's reproductive autonomy" as the key subject. But Lucía and others' understandings of coercion, consent, autonomy, and resilience reached beyond individual needs or even the

concept of a priori “reproductive interests” or “goals.” Certainly, San Luqueños, especially educated young women, supported and rearticulated rights-based approaches increasingly prioritized in Guatemala since the peace accords (see prior chapter). However, Lucía emphasized not a violation of her individual rights, autonomy, or fixed plans, but the interruption of her and her husband’s possible, imagined or as yet unimagined, life trajectories, within the necessarily communitarian, mutualistic process of family building.

### **The purpose of contraceptive coercion**

Scholars have often presented states as predominantly either pronatalist or antinatalist. Anthropologists have conducted rich ethnography in both contexts. Reproductive governance in Russia and Romania aimed to combat demographic decline (Rivkin-Fish 2003; Pop 2019); conversely, some state structures have pushed long-acting reversible contraception and sterilization, both to meet demographic aims and to comply with family planning organizations’ metrics (Greenhalgh 2008; Senderowicz and Kolenda 2022). In Guatemala, pronatalist forces include Christian churches, both Catholic and Evangelical. Specific ideas about “good Indigenous mothers” forged within Christianity for centuries also carry pronatalist undertones. Antinatalism, on the other hand, comes by way of government forces promoting a Ladino, rather than Indigenous, vision of Guatemala.

In other contexts, like the United States, scholars use the phrase “stratified reproduction” to explain how certain groups of people are encouraged and incentivized to

reproduce while others' reproduction is discouraged or coerced (Rapp 2001; De Zordo, Marre, and Smietana 2022). Reproductive justice and stratified reproduction share a focus on “drawing attention to the persistence of historical patterns of inequality and discrimination in the valuing of some but not other reproductions” (Smietana, Thompson, and Twine 2018, 117).

Stratified reproduction as a mechanism of political power does not always manifest in families' lives in straightforward ways. In Guatemala, as in other contexts including the United States, scholarship shows that the same people may be pressured to have children they do not want at one point in their lives and at another point be unable to have children they do desire. For instance, many prisons in the United States simultaneously do not provide reliable abortion care or safe pregnancy care (Roth 2017). In one community on the road out of San Lucas, two interviewees told me about their reproductive lives: one woman was frustrated that she could not access the long-acting reversible contraceptive she wanted because the understaffed Centro de Salud did not stock it, and another recounted an experience of forced sterilization at a state hospital. The broad strokes of stratified reproduction theory may suggest that Indigenous Guatemalan women would experience antinatalism from the state in a consistent manner. But despite not contributing to one coherent demographic outcome, contraceptive coercion in Guatemala still successfully reinforced broader neocolonial aims.

Elise Singer writes about the centrality of “responsibilización” in Mexican governmental approaches to family planning provision (2017). Healthcare workers scolded women at the abortion clinic where Singer conducted ethnography for not being

responsible enough about preventing pregnancy in the first place. Women had to tolerate this disapproval and promise to be more responsible next time to merit abortion care. Though state-sponsored abortion care is far from available in Guatemala, these cases share the ultimate neocolonial goal underlying much reproductive healthcare: “the fashioning of responsible reproductive subjects is paramount” (2017, 446).

The incoherence in Guatemala results from different actors’ distinct goals vis-à-vis women’s reproduction, varying from Sabrina’s story of the judgment of an individual doctor, to Lucía’s experience with Ministry of Health processes, to other women’s subjugation to their own husbands’ desires. In all of these ethnographic examples, the importance of Maya women’s obedience supersedes any unitary demographic goal. The unpredictability of possible coercion, upward, downward or both, keeps women unsure. This uncertainty incentivizes women, many already resource strapped and overwhelmed, to cede decision-making about their reproduction. Regardless of the direction of the force, Kaqchikel women experienced pressure to perform compliant, governed reproduction that went against their own individual or collective family building wishes.

**Estela: “He didn’t want me to do anything to not have more kids”**

A 60-year-old Kaqchikel woman named Estela helped elucidate the way that seemingly individual forces made up contraceptive coercion that foreclosed women’s reproductive decision-making. She had a strong preference for when to stop childbearing, she told me: “When my son was born who’s 30 now, 31, I said [to my husband] that we

weren't going to have any more kids because it's very costly." At this point, she had three children and told her husband that she wanted to stop because of the cost of childbearing and childrearing.

Interviewees often used the Spanish verb *costar*, literally "to cost," to discuss the difficulties inherent in having children. Children are expensive: Estela's husband worked picking coffee but had "always had problems with his foot" that kept him from working consistently, making Estela particularly concerned about the cost of having more than three children. At the same time, *costar* can also mean "to be difficult," a difficulty that nods to other types of cost: emotional, physical, spiritual.

Estela continued explaining how she tried to convince her husband to have only three children. "The situation is hard, I told him. But my husband didn't want that. I'm not going to be a killer before God, he answered me. And he didn't want me to do anything to not have more kids. So I wouldn't have had the, you know, like six more then—but he didn't want that. I couldn't do anything. Mmhmm. That's why I had those kids I have now."

Estela "wouldn't have had...six more" children if her husband had not asserted his preference, against which "I couldn't do anything." Her language echoed Sabrina's grammatical structure about her sterilization against her wishes: the doctor was the actor in her phrase, "he did it to me." In Estela's case, her husband's seemingly individual desire to have as many children as God wished stemmed from a particular manifestation of male control empowered by a specific interpretation of Christian teaching. In this understanding, any contraceptive method is a sin against God's wishes, and any contraceptive user is therefore "a killer before God."

Aura Cumes identified the ways that the colonial Catholic church historically and currently explicitly aimed to disempower Indigenous people. Compulsory Catholicism attempted to supplant horizontal relationships between masculinity and femininity, elaborated in the Popul Voh, with the hierarchy presented in the bible: God, who is a man, dominates over Adam, another man, who in turn dominates Eve. “One interpretation of the bible,” Cumes reminds, asserts that “women committed the original sin and are worse [than men] in their being,” due to “the word of God” (2022). Accordingly, Estela’s husband’s reference to God while he asserted his decision-making control exemplified the colonial, patriarchal hierarchy governing Indigenous women’s lives, which Cumes argues did not exist in precolonial Kaqchikel communities. Estela’s husband’s insistence on more children, therefore, was structural as much as individual.

Writing an ethnography of contraceptive coercion brings together two seemingly distinct patterns: some women, like Sabrina and Lucía, did not want to be sterilized but were, while systems of power including state reproductive governance, religious hegemony, and patriarchal intimate relationships contributed to women like Estela having more pregnancies than they wanted. Foucault’s idea of biopolitics has been taken up by medical anthropologists in explaining how women’s bodies become sites of contestation where larger political conflicts play out (for example, see Mascia-Lees 2019; Martin 1989). In order for the state to exert control over its citizenry, individual citizens gain recognition and are coopted as objects due to their biological roles: in the case of contraceptive coercion in Guatemala, this includes both Lucía’s experiences at the hospital and Estela’s experiences at home. The common pathway joining Lucía’s sterilization and Estela’s nine pregnancies is

Kaqchikel women's reproductive decision-making being taken from them, via imposed control of colonial power relations.

Catherine Maternowska analyzed the political economy of fertility in her ethnography in Haiti, *Reproducing Inequalities* (2006). Maternowska integrated individual and neighborhood analyses of women unable to advocate for condom use because they "do not have the right" (67). Kaqchikel women I interviewed during my pre-dissertation mixed methods research said the same: while many would prefer to use a barrier method during sex, they simply could not ask their husbands to do so (Valley, Foreman, and Duffy 2022).

Physicians' and husbands' actions stemmed from a set of social structures that incorporated individuals and families into broader state-making projects. In connecting individual-level contraceptive coercion to broader patterns of reproductive governance in Haiti, Maternowska quoted Foucault: "In any society, there are manifold relations of power which permeate, characterize and constitute the social body...individuals are always in the position of simultaneously undergoing and exercising this power" (from Foucault 1980, 93-98). In Foucault's understanding of how hegemonic power operates, individuals (like Indigenous men in San Lucas) can be victims of these relations of power, like Lucía's husband and the man at the Sololá hospital, while also enacting contraceptive coercion against their wives, like what Estela experienced. As Merrill Singer and colleagues reminded anthropologists, "Empirically, of course, social life does not exist on different levels" (1992, 81). Sabrina, Lucía, and Estela experienced all of these forces at once.

Maternowska explained that her work used “locally generated meanings” around contraception to “provide an understanding of how power and reproduction interact as political and economic mechanisms of control at the level of the individual, community, nation state, region, and increasingly the globe” (2006, 42). Following Maternowska, therefore, I offer a final story. Gloria’s embodied experience of contraceptive coercion is not as clear cut as prior examples. But her description of lifelong structural violence shows how the forces Foucault and Maternowska describe coalesced to foreclose Gloria’s capacity to build family as she wanted.

**Gloria: “A woman suffers too much”**

Gloria’s experience of poverty began at a young age, when her father left her mother. “My dad got together with another woman, yes, he went with another woman and left us abandoned...in those times my mom, more than anything, was very poor, and there wasn’t any way to get ahead. I didn’t study.”

In keeping with Senderowicz’s definition that contraceptive “coercion sits on a spectrum and need not involve overt force or violence, but can also result from more quotidian limits to free, full, and informed choice,” Gloria’s whole marriage may have constituted contraceptive coercion:

I was 14. 14 years old. Because for me that was the solution, to get married, because I saw how my mom suffered, but at the end of the day, [it was] even worse...It has cost me...the truth is, I did not know what it would involve, because I was a young girl still, at the age that I was, I never imagined that one would end up suffering more...I was thinking more than anything that he would give me everything I needed, but it wasn’t like that. It wasn’t like that. It was not like that.

Gloria attributed her lack of knowledge about the realities of married life to her mother's own lack of communication and knowledge: "I would ask my mom what life as a woman was like, but the ignorance they had, they never said, they never tell us the truth....she always hid what it was to have a baby, what it was to have a spouse...she always told us—" Here, Gloria took a moment to whisper to her son that he should go watch a YouTube video on his sister's cell phone, shooing him away from the dogs that played around my feet throughout the interview. Gloria returned to talking about her mother's approach to teaching her children about life.

More than anything she told us that when a baby is born, she told us, they say a plane brought him. Or the midwife brought him... When I had my first daughter, I didn't know. I didn't know. Yes, for me, when the pain came on for me, before my oldest daughter, for me maybe there's a medicine for this, so that the baby comes right away, or the pain calms down. But it wasn't like that, and only at that point, then I realized that a woman suffers. Yes, a woman suffers too much.

She endeavored to tell her own daughters what she did not learn from her mother, about the realities of life as a wife and mother: "I tell my daughters...you all have to study... but it didn't end up that way. Instead they got married, they didn't think that way. And they do know what life as a woman is like, but that's the first thing they did."

Her oldest, an 18-year-old with her own baby nearby, soothed Gloria's youngest, a four-month-old, during our interview. Gloria long tried to use contraception. She wanted to stop having children after her second baby, then again after the fifth, but ended up having seven children. Gloria conceived twice while using birth control: once while using injections, once while taking pills. She blamed the injections for a uterine "infection," which

she implied stopped it from working, and simply summarized that her body “didn’t respect what the pill was.”

At the same time as she experienced this downward contraceptive coercion (she could not access successful birth control), she experienced attempted upward contraceptive coercion (providers pushed her towards procedures she did not want). First, after heavy uterine bleeding, doctors “told me that they were going to take out my uterus, because if not cancer is going to spread to it...I asked God many times for him to perform a miracle in my life, because I couldn’t manage the pain and hemorrhaging.” The next doctors she saw then seemingly changed her diagnosis, telling her she had ovarian cysts causing her bleeding. This moment in Gloria’s story highlighted the simultaneous violent presence and violent absence of Guatemalan biomedicine in Indigenous women’s lives. Biomedicine was violently present in making her fear cancer, cysts, and risky medical procedures, but was too absent to provide her reliable biomedical information that she could understand and act on. Indeed, Gloria remained uncertain during her interview, a few years later, whether she still had “cancer” or “cysts.”

While taking contraceptive pills to treat her “cysts,” Gloria got pregnant again, despite believing she was using contraception that would prevent pregnancy. She told her doctors that she wanted to go through the pregnancy, pushing through any implication that she should consider abortion: “I said well, thanks to God, if I’m expecting, I can’t do anything. I can’t have an abortion. Given it’s already happened, I can’t do that. And I left it like that.” In sum, navigating contradictory biomedical diagnoses and proposed interventions, Gloria resisted both a hysterectomy and an abortion.

Before the birth of her last baby, like her father before him, Gloria's husband left her: "He's not with us. We ran into problems...he committed the error of placing another person in between the two of us... psychologically, it affects one. The first days it affected me too much. Yes. But after that, one goes along, getting used to everything that happened, and I got used to it, and thank God that I have made it here."

"Here" nonetheless was a difficult spot. Gloria had not figured out how to pay for one son's medical treatment for his heart murmur. "Including the travel, it requires some 3000 quetzales. And it turns out I haven't found a solution for that. But I am praying to God, I don't know how, but to be able to come out of this. I have to come out. Because I am very worried about his life. Yes. So I say, if he comes out of that, then I'll start to look for my own medicine, to be able to be healthy with them [my kids]. I want to be healthy."

She hopes her daughters can "take care of themselves," making "better" contraceptive decisions, that allow them to achieve the life goals she never could, like "getting an education" and "getting ahead." Two daughters already had children of their own. In summarizing her concerns for them, Gloria also summarized the systemic structural violence that enacted contraceptive coercion throughout her life.

Now I tell them, now you have a baby, you've seen how babies are born, that it's not easy, that being a mother isn't easy. That's how I talk to them now, just stick with one, [let that baby] grow. Because times now are VERY difficult, now is very difficult. Now little kids get sick. And how is she going to feed them? And now the work that a man has, they don't make as much. They make very little. So how are they going to survive? And that's the hardest right now... So how they're going to survive, it's costly, it's not easy. That's why I say to them, now there are so many things for preventing someone from getting pregnant, it's better to put in a Yadel [brand

contraceptive implant] or take a pill to prevent [pregnancy], or there are different methods so that they can take care of themselves.<sup>40</sup>

Gloria's story of contraceptive coercion stretches across different aspects of her life and different actors. Her poverty, isolation, and relationships with her husband, mother, and children joined with specific government healthcare workers to foreclose her reproductive autonomy.

## Conclusion

In this chapter Sabrina, Lucía, Estela, and Gloria explained how contraceptive coercion, a specific salient nexus of structural violence, impeded agentic Kaqchikel family building. Guatemala's government was violently present, preventing Sabrina and Lucía from deciding themselves when and how to "have more family." The government was also violently absent, leaving Gloria unable to prevent pregnancy, pursue education, or understand or treat her own health problems. Biomedical health providers, institutions, and broader government systems, and lack thereof, enacted both upward and downward contraceptive coercion. In the same communities, where men navigated scarce work and struggled to fulfill head-of-household responsibilities, women suffered husbands' patriarchal reassertion of power within their own households. Kaqchikel men themselves, then, also sometimes violently present and absent, also coerced contraceptive outcomes.

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<sup>40</sup> Gloria used the rich-with-meaning *costar* in the same way that Estela had; she also used *cuidarse* similarly to Clea, in the previous chapter.

These four stories together, gathered under the umbrella of contraceptive coercion, fill a gap in the anthropological and public health literature about gender and health in Guatemala. In Lucía's case, she and her husband shared a family building goal, to have more family, which government physicians crushed. Here, government employees could fit Santizo-Malafrenti's (2024) category of "foot soldiers of bureaucracy carrying out cultural genocide." Estela's struggle, on the other hand, was indeed individual, not because contraceptive autonomy is inherently an individual pursuit, but because entrenched power and Estela's husband's religious belief and resulted in his contraceptive coercion against her specific desires.

Anthropology offers a methodological intervention in one aspect of the contraceptive coercion framework: its focus on discrete individual women actors. Some San Luqueños experienced contraceptive coercion against their collective family building goals; other women stood alone in their reproductive desires that coercion prevented them from achieving. These systems are mutually constitutive. As violent neocolonial forces prohibit women and families from building families the way they want to, anthropologists have both the opportunity and responsibility to show how family building gets demolished and how families cope with the aftermath.

## Chapter 7: Violence and family building in San Lucas Tolimán

“I had a lot of problems.” This is how Colibrí, a Kaqchikel woman in her mid 40s, introduced me to her family life. We sat together on a roof overlooking San Lucas on a bright morning. Almost as an aside during the story of how she met her husband, she continued:

I think my problems were emotional, I believe. I lived in a family, one of those with problems, what do they call that?...*Violencia intrafamiliar*. I lived in a, in one, my family was like that. Because, because my dad was very, he was very angry. He was very strict, very angry—

Here she interrupted herself, her sharp gaze catching my eyes, asking me, “Do you want me to tell you my life story?”

“Yes, that’s what I’m here for,” I responded. “If you want to.”

“Yes, I say that I do,” she said.

Throughout this chapter, I will use the phrase “intrafamily violence” to discuss violence within families. While biomedical English-language analyses of violence feature fragmented forms (intimate partner violence, childhood abuse, in-law abuse), Colibrí’s “*violencia intrafamiliar*” captured a more expansive understanding of violence. I do mean all the forms above, and any type of physical violence that one or more members of a family inflict on one or more others. I am indebted to scholars, activists, and practitioners who identify the spectrum of violence as including power and control like emotional and financial abuse in addition to physical and sexual abuse. But in the ethnography in this

chapter, I primarily focus on the physical aspects because this is what people in San Lucas described as violence. Colibrí explained *violencia intrafamiliar*, in contrast to gender-based or domestic violence, as involving more actors across a longer period within families, but she focused specifically on physical violence.

Colibrí experienced intrafamily violence throughout her childhood, and various embodiments lasted throughout her life. She recounted her first few years, when she lived mostly with her grandmother in a rural area outside of town. The first physical abuse she told me about happened when she moved back into her parents' house:

I was accustomed to sleeping with my grandma, she even stroked my hair, and when my sister...she didn't treat me very well, so in the night, I cried. I would get up and go into my parents' room, and I stayed kind of at their feet because they only had a little bed too...and they hit me, they hit me, 'what are you doing here, get out of here to your own room.' And they scolded me and they treated me badly.

Colibrí said this early treatment "stayed with me like a wound."

Then, as she started to go to school, Colibrí realized "my mom had lots of problems with my dad. Because my dad—" she cut herself off again. The wind picked up around us as she continued, telling me in a roundabout way about her father's infidelity.

Here, it isn't like it is in the United States. I know a lot of people from the United States who, for example, don't want to live together anymore, they get divorced, each one goes their separate way... it's as if it's not as important to them. Here, it's not like that. Here, if someone finds out that your spouse was with another, it could get to even being able to kill that person, right, or going to hit them in the street, or throw something at them, something bad, in the street, or they'll wish you ill. Here it's totally different. Here, it's totally different.

Like many Kaqchikel interviewees, Colibrí repeated herself to double down on her emphasis, speaking more power into the words the second time.

And so, back then, my dad hit my mom, he told her, go away, you're useless, why are you here...so when I saw that my dad was hitting my mom, because she was saying

to him, you got together with that woman, and do you think—and my dad hit her, my dad didn't, he didn't—my dad was so *machista*.

Her voice pitched higher as she continued with her story. “He was that super *machista*, that he hit my mom. I watched when he would hit my mom. Then I, because I didn't want him to hit her, I would put myself like that, in the middle, so my dad would grab me like this and *wap*—” She made the onomatopoeic sound of a hit. As she listed what her dad would do, her voice sped up, the tenor of her voice like the motor of a train, ceaseless. “He threw me on the floor, he kicked me, I went around in circles on the floor, and my dad, he hit me. A lot. He hit me so much, my dad did, during that entire time.”

Her father hit her and her mother through the end of secondary school, when she was about 13. Then, when she started having boyfriends, her father's behavior shifted.

My dad would follow me. Or, I mean, I couldn't talk with any of my male friends because if he saw me with someone, he'd hit me. And when I was fourteen, well, I fell in love. And when he saw that I had something like a boyfriend, for example, he'd wait for me in the road. He'd follow the man, and he'd knock him around, and he'd say, I don't ever want to see you with my daughter again. So, the boys, they'd leave and never come back to me. And they'd leave me again. And I'd fall in love again, and my dad, he'd beat them up, and me too, and he'd treat them badly, he'd follow them...when I came home, he'd treat me badly. He'd grab my head, he'd hold me up against the wall and kick me, and he hit me a lot. He was always that way with me. My dad, my dad, Taryn, even ended up—

Here, she paused and started to cry.

He hurt me—until one time he even ended up wanting to rape me. I was suffering through all of this. He touched me. I was scared. I didn't tell my mom. And when I felt like it was a lot, that he was always molesting me and he always wanted to touch me, I did tell my mom. I had to tell my mom, that this is what he's saying to me. I was scared. I didn't want him to hit her, if he was going to hit her, and me.

Colibrí father's abuse worsened through her adolescence, ending only when she got married and moved away. She experienced “a lot of problems,” embodied throughout her

life, which she blamed on this treatment that remained with her “like a wound.” Yet, she stayed in close relationship with her father, who played a central role in her children’s lives, too. She told me her husband did not physically abuse her.

Soon, she wrapped up her story, talking about the end of her father’s life.

But I still love my dad very much. And I think at the core of him he was always sick. I was the one that helped him the most...I visited him in the hospital, and I gave him money. I didn’t even have extra money other than what was keeping my family stable, and I gave it to him, have this, daddy... Sometimes one asks oneself, why did this happen... but my father was a great person. He was a person I really confided in. But I don’t know why...what his situation was that he treated me that way. And yes. Yes, I lived it, and I felt a lot of violence...I learned to be responsible right in the line of fire.

She concluded, “Once in a while it’s good to air these things out, what sometimes one ends up living through, because maybe people look at someone and they seem well, but only the person themselves knows their story.”

Colibrí, like others I spoke with, described the embodied, intergenerational trauma caused by violence. Diane Nelson’s masterful monograph, *The Finger in the Wound* (1999), described Guatemala’s post/neocolonial reckoning near the end of the genocidal war of the 1960s-90s. Indigenous Guatemalans were first colonized by the Spanish, but independence from the Crown did not stop the pillaging of their land. Instead, neocolonial powers like the *criollo* elite, foreign businesspeople, dictatorial governments, and American interests determined how Indigenous Guatemalans got to live (see also Peláez 1973). Nelson, through her vivid primary metaphor in the title, imagined Guatemala as a political body with deep wounds. The neoliberal finger kept the wound open and painful. Indigenous men had few outlets to process disenfranchisement and emasculation at the hands of neocolonial structures: Colibrí’s spoke of her family’s related wound. I continue to

draw on the idea of structural violence, wherein violence is imbricated into the structures and systems in which people live, through both explicit and more subtle mechanisms (Farmer 2004; Benson, Fischer, and Thomas 2008). One of the mechanisms of structural violence is the gendered expression of machismo, as people in San Lucas expressed and described it.<sup>41</sup>

### **San Lucas machismo and violent masculinity**

Colibrí told me that her definition of machismo was a man who says, “the woman exists to be in the kitchen, to make the food, to serve her husband.” As a mother to young men, she intentionally set aside time to talk to her sons every day. “When I return from work, we have hot chocolate together, every afternoon.” Sometimes, in these conversations, she and her sons discussed machismo.

I talk to them about what machismo is like, because we all trust each other a lot, and the good part is that every breakfast, [we eat] together. Dinners, together...so it's there that we talk, conversations, topics come up, or if I see something like machismo, I try to talk about it, so they come away from that understanding... my son, don't do that.

Through open conversation, she hopes her sons will come away from their childhood with a different understanding of how to be a man, how to “choose your partner well,” and how to treat women differently than *machista* tropes.

McAllister and Nelson (2020) recently aggregated research on violence in Guatemala, demonstrating that while the war is ostensibly over, continuing forms of

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<sup>41</sup> For scholarly interpretations of machismo in other parts of Latin America, see great work by Gutmann (2006), Stephen and Speed (2021), and Lancaster (2024).

physical and structural violence define life in Guatemala through a “war by other means.” This involves a country-wide “sense that life is much more dangerous in the postwar context than it has been in the past,” including in Guatemala City, “one of the most dangerous cities on the planet” (O’Neill and Thomas 2011, 2). Violence in Guatemala particularly affects women, who some scholars claim experience a disproportionate burden of gendered struggle (Gibbons and Luna 2015). Quantity of crimes against women, and women’s death rates, continued to climb long after the formal end of the war, with women increasingly “under attack” (Ogrodnik and Borzutzky 2011).

Rogg and Pezzia (2023) documented specific mental health struggles Guatemalan women experienced as a result of gender-based violence. These burdens aligned with some of the problems Colibrí identified in her own life and echoed mental health concerns I heard within clinics. Halvorsen (2014) urged healthcare workers in the US and Guatemala to take into account what she termed a “culture of violence” against women in Guatemala. This ubiquitous gendered violence throughout Guatemalan news and public life, argued Torres (2018), serves to constantly reinforce the centrality of violence in women’s lives. Stephen (2019) concluded that scholars “cannot separate public from private violence and state from non-state actors” in Guatemalan women’s lives, a dynamic San Luqueños also narrated. Carey and Torres (2010) named this a “vortex of violence.” Other scholars demonstrated how violence against Indigenous people in general, and Indigenous women in particular, co-determine Maya resistance and identity formation (French 2010; Salazar 2008).

While I contribute to this anthropology of violence, my ethnography shows that people build their families alongside violence using their own understandings of love. Colibrí intentionally deconstructed machismo for her sons and provided firm, clear instructions to be a different kind of man, exemplifying one form of anti-violent love. Colibrí demonstrated forms of love despite and amidst violence. To discuss the anthropology of violence in Guatemala, I will introduce you to another father and daughter who struggled with violence in San Lucas Tolimán.

### **Wartime masculinity, alcoholism, and recovery**

Jesús, the 75-year-old Kaqchikel father and grandfather who brought me to visit Maximon, captured the social reproduction of this violence from state to family. We sat on his couch, his grandchildren's playful shrieks sometimes audible on the recording. His family's dogs wandered in and out, one settling by my feet. A garden windchime accompanied his voice in a melodious duet. Jesús's stories had a soothing tenor, despite his subject matter. I attributed his ease with storytelling to his decades in Alcoholics Anonymous, sharing testimonials and leading meetings discussing errors of the past and recovery in the present.

Jesús was one of eleven children. He worked with his father in the fields throughout his childhood; his parents took him out of school after sixth grade, once he could read and

write. As a young man, “the time arrived that we had to go to the army, because we had turned 18. We were obligated to give our military service.”<sup>42</sup> But the military

was very hard for us...once I was there, I regretted having left and abandoned my parents, you know. I even sent letters to my dad, asking that he talk with the army bosses, that I didn't want to be here anymore, I want to go back home because I miss my family...and I cried, from sadness and more than that the training we received, very harsh. I cried.

At his request, his parents made the long journey to “the capital city, to talk with the Ministry of Defense... [they said,] ‘Our son, he went to the army, but now he regrets it and he wants to return home.’... ‘Oh, good,’ [the colonel] said. ‘And is he tall, the boy?’ ‘Yes, he’s very tall.’ ‘Ah, damn, it’s worth it because that’s what we need, tall people...he must continue forward because it’s the best place, where they are.’” In this way, Jesús’s sadness and wishes were overridden by the colonel, the manifestation of the patriarchal state, who denied his parents’ request to bring their family back together. In Jesús’s story, this initial violent state coercion shaped his own capacity to perform gender and manifest his feelings.

Jesús was finally granted leave to return home, two years later, over the cultural touchstone of the San Lucas Fair. While most Guatemalan towns have a fair once a year on their saint’s day, San Lucas is well known to have a particularly celebratory approach. For a full week, the fair shuts down the main roads of town, sellers and game purveyors traveling from afar, every night concluding in a live band dance. “That’s when I came back to see my family, but disgracefully, I don’t know if it was from the sadness, or the worry, I began to drink alcohol, you see. I don’t know if it was the happiness, or the emotion, or from all of

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<sup>42</sup> In the 1960s, men were conscripted into military service under Guatemalan law (Batz n.d.)

the things our parents hid from us, that they never told us how life was and all of that, I began to drink that day.”<sup>43</sup> When we visited the syncretic deity Maximon together, described in Chapter 2, Jesús told me he first started drinking at age 10 or 11 while caretaking the saint. Visitors would urge Jesús to drink a little every time they offered Maximon some Quetzalteca, distilled corn liquor available at every corner store.

But during our interview, Jesús attributed the beginning of his problem drinking to the overwhelming set of emotions that hit him upon returning from the army.

When we came back to go out that day, and—I never imagined anything would happen to me. I was drunk one night, my first night of being here in San Lucas. I was quite drunk. But I had a friend, who was kind of my girlfriend. She said, stay here at the house. Don’t go, because you’re very drunk. No, my mom has to be waiting up for me, I said, and my mom is happy because it was my first night of being here in San Lucas, and I have to go...But I didn’t pay attention, where I was walking...I fell down in that same moment. When I got back to my mom’s house, she said, ‘who hit you?’ But no, I fell down all on my own.

Alcohol became a “vice” for Jesús, as for many men in San Lucas. Interviewees, men and women, often described to me how alcoholism, and abusiveness, were rooted in the individual flaws of individual men. Jesús told me his wounds were not caused by a fight with anyone else: “I fell down all on my own.” Nonetheless, he had already explained the context in which he fell: two years immersed in violence in the army, conscripted from his home and not allowed to return to his parents, and the resulting mix of “sadness,” “worry,” “happiness,” and “emotion” that led him to get dangerously drunk for the first time.

His difficulty managing his emotions, he explained, led him to drink; his drunkenness caused visible wounds; then, his shame about showing these wounds in

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<sup>43</sup> Here, Jesús used the same language about his parents not telling him “how life was” that Gloria used in Chapter 6 when discussing her mother’s lack of education about sex and childbirth.

public cut short his ten-day, long-awaited return home. “I didn’t want to spend the fair here in San Lucas because I was embarrassed to walk around in town with my face like that. I turned around, better, I went back again. Only one day was I back here. From there my alcoholism began.” The shame of his wounds transduced itself into the ongoing shame of alcoholism. He opted out of celebrating the Indigenous and Catholic fair in his hometown due to his own pain, visibility, and shame.

Returning to the army after just a day at home, though, did not offer him relief. Upon seeing his wounds, Jesús’s officers penalized him. “They punished me... two weeks of punishment, because they didn’t believe that I had fallen down alone.” He returns to the importance of his falling down “all on my own.” His two weeks of punishment reinforced the violence and cruelty the army was teaching him, but singled him out because of his wounds: “They put shorts on me, barefoot, and they cut off all my hair, and they put on me a 50-pound backpack, to carry it from 4 in the morning to 9 at night.” They forced him to walk miles every day wearing the shameful backpack and outfit. After his punishment ended, Jesús continued to carry a heavy burden of Guatemalan masculinity honed in compulsory army service and shaped by alcoholism. The overwhelming emotions he described causing him to drink, then fall, stemmed from his time in the army, where he was estranged from his family and taught violence as a way of life. Jesús’s alcoholism and violence hurt his family for decades.

He was able to return home after two more years in the army. “They were begging us to stay because the guerrilla had started at that time. But I told them I was very sorry but I can’t, I said, because I have to see my family... right then, I had been back in San Lucas for

one week, when they killed 150 of my teammates.” Having decided to return home when he did saved Jesús’s life; “for me it was a miracle” that he survived. Pulling away with one’s life by chance, or miracle, is a theme in many published wartime testimonials, echoing Jesús’s story. Victor Montejo (1987) escaped from an army kidnapping after watching the village where he taught be systematically massacred. Rigoberto Menchú’s famous testimonial of lifelong violence, punctuated by government atrocities, helped raise international awareness of the genocide (Burgos 1997).

At 22, Jesús returned home and, life miraculously in hand, “was able to start making something of myself,” seeking a career assisted by Father Greg, the priest famed in San Lucas for his charitable work. “But my problem was my alcoholism. That I was never able to leave behind my alcoholism. I worked and I worked, but I was never able to.” Ultimately Jesús did stop drinking, after 40 years of public alcoholism. He told me that “people here in San Lucas up to today still hate me, because they saw the type of person I was. Thrown in the street, like trash. I am not worth anything for people. Even my family, my children, despised me. I wasn’t worth anything for them.”

I learned from Jesús’s daughter that during his heavy alcohol use, he hit her and his other children. She told me in passing that while he was drinking, “it was another story with my dad, a great suffering. That he hit us, that he did everything to us.” While Jesús did not tell me about this directly during his first interview, a few weeks later I stopped at his house on my way home from church. I told him about a family member of mine who was trying Alcoholics Anonymous, and Jesús gave me twenty minutes of loving advice over the counter of his corner store. “You have to encourage him...one thinks about how one treated

their kids, up to hitting them, and feels so bad.” I wrote in my fieldnotes that I might not even have understood this as a reference to Jesús himself, and his own role in intrafamily violence, if I had not heard about his abuse from his daughter first.

In Jesús’s story, I saw gender and state violence manifested in how alcoholism wounded him, and how he externalized his own wounded masculinity as violence against his family. He told me that at 18, he “didn’t know how life was.” After his abrupt conscription to Petén, multiple days travel from San Lucas, he found himself emotionally and geographically isolated from his family of birth. Despite a costly trip for his parents to ask a government colonel that he return home, state structures retained him because of his masculine traits, his height and strength. His first return home on leave was immediately marred by his first night drunk, an inauguration to the physical wounds and emotional shame that would continue for his 40 years of alcoholism. After he fled the fair, returning to the seat of patriarchal masculinity in his army training, the government added insult to his injury when they humiliated him in front of his companions. Finally, though he escaped with his life, he returned home with the “vice” of alcoholism. His actions while in the grips of alcoholism, including his physical abuse of his family, caused him to feel “so bad” as he reflected on them later.

Alcoholism in San Lucas was often an expression of masculine pain and suffering.<sup>44</sup>

Considerable scholarship from Mesoamerica further illustrates a connection between

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<sup>44</sup> I asked multiple people whether women ever became alcoholics, because I never met or heard about a woman who performed public alcoholism the way that Jesús and other recovering alcoholics described themselves. Their descriptions aligned in lockstep with the daily alcoholism I saw on the streets of San Lucas, where men would start drinking outside of small corner stores in the morning and often be drunk, yelling and weaving as they walked down the streets, by early afternoon. The slang word *bolo* rarely took the

men's alcoholism and the wounded patriarchy. Lynne Duffy linked Guatemalan men's alcoholism to "terrible discrimination and oppression" as a result of "colonialization, the most recent civil war, and ongoing oppressive government policies around land" (2018, 442). Macallister and Nelson (2020) called alcoholism a "form of seeking relief" from violence, one of few socially sanctioned ways men can release their emotions (16). Historicizing alcoholism within a critique of capitalism in postcolonial Latin America, Singer et al. explained: "Serving as a valued recompense for the difficult and self-mortifying work undertaken by men, alcohol consumption became culturally entrenched as an emotionally charged symbol of manhood itself" (1992, 87). Learning to kill for the Guatemalan government certainly qualified as "difficult and self-mortifying work" for Jesús, intimately tied up in his masculinity. Another man I interviewed, whose father had been murdered during the war, also struggled with alcoholism. He explained how alcohol use permitted men to process their feelings: "We don't talk about it. We talk about it when we're drunk."

Gender norms in Kaqchikel Guatemala constrained both men's and women's roles in homes, families, and the broader community.<sup>45</sup> The "vortex of violence" that wounds every level of life in Guatemala is itself a gendered violence (Carey and Torres 2010).<sup>46</sup>

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feminine ending. One friend responded somewhat dismissively that sure, she had once met a woman who had an alcohol problem, but most *bolos* were men.

<sup>45</sup> These are not the same as Kaqchikel gender norms: as I discussed in the introduction, Kaqchikel Maya understandings of gender have been torn asunder by hundreds of years of colonialism, and gender as experienced in Kaqchikel Guatemala is crucially a colonial imposition.

<sup>46</sup> I borrow this term from Carey and Torres (2010), who write about femicide in Guatemala. I have written elsewhere positioning gender-based violence along the spectrum that includes the epidemic of femicide in Guatemala, but in this chapter I focus on intrafamily violence as a constraint on family building processes and healthcare decisions, rather than attending to the extremes when women are killed for being women. While femicide is certainly a crisis in Guatemala and across Latin America, interviewees did not bring this up to me during my fieldwork, unlike the other stories I share here.

While men are most often the perpetrators in intrafamily violence, state violence, and what scholars term “new violence,” disproportionately injures and kills men (Benson, Fischer, and Thomas 2008). Scholar of Mexico and migration Deborah Boehm explained how “potential and actualized violence, as well as expectations of gendered behavior” guide “gender relations...Border crossings, position and power within relationships, one’s options negotiating infidelity, intimate violence, and movement itself are gendered” (2012, 107).

Boehm linked gendered violence with unfulfilled requirements of masculinity in San Marcos, San Luis Potosí, Mexico:

Male identity in San Marcos and surrounding communities—which has been defined traditionally through working one’s land and providing for one’s family—is changing significantly. For men who do not migrate, masculinities are often expressed through exaggerated performances of manliness. While “real men” migrate, men who do not may need to prove themselves through hyperpresentations of male identity, arguably a kind of compensation for not fulfilling the expected role of migrating to financially support family. Men in Mexico often put on exaggerated displays of masculinity—including “jokes” about control over women, bouts of drinking, violence against partners and children, fights with other men, and even shootings—in large part because their manhood is threatened (Boehm 2012, 75).

Colibrí’s father’s beatings and stalking and Jesús’s alcoholism and abuse fit Boehm’s frame of “exaggerated displays of masculinity.”

The distinction between “real men” and “men who do not” migrate may not be as salient in San Lucas as in other areas in Mexico and Central America.<sup>47</sup> Nonetheless, the broader patterns of violence from the army, guerrilla, capitalist labor’s presence and its absence, leave men in San Lucas relatively few ways to keep their families financially

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<sup>47</sup> On how migration can function in gendered ways in San Lucas Tolimán, see Sperling and Decker (2017); for other areas, see Popkin (1999). Mexican playwright Salcedo (2015) also dramatized this phenomenon in gendered performance through the character “the chorus of women.”

solvent, understood to be the main role of a good man. When adequately “providing for one’s family” is impossible, “exaggerated performances of manliness” can be a way to attempt to triage the wound of men’s “threatened” gender identity.

While it is crucial to detail stories of violence, most often perpetrated *by men*, and detail the way that this violence stems from and is reinforced by gender roles, I also want to emphasize how these re-wounding experiences affected whole families. It may be tempting to assume that Guatemala’s patriarchy benefits men. But Jesús suffered mightily as a result of his abuse at the hands of the army, abuse he redirected back onto himself through alcoholism and then onto his wife and children. San Luqueños detailed violence as an integral part of the conditions under which they built families, as Guatemala’s wounded patriarchy in turn wounded family members of all genders and ages.

### **Is violence all there is?**

Cecilia Menjívar, a sociologist, has written extensively on violence in Guatemala (Menjívar 2008, 2011, 2014; Walsh and Menjívar 2016). Menjívar’s 2011 ethnography, *Enduring Violence*, asserted that the topic of violence emerged spontaneously and authentically from her Indigenous and ladina research participants: “I did not set out to do research on violence in Guatemala...It was not my aim to look for violence; instead, the women pointed it out to me. It was their own narratives and my close listening to what they were telling me that eventually led me to an examination of violence in their lives” (2011, 16). This is similar to my experience encountering stories of violence despite not asking for

them. People I interviewed intertwined their violent realities with narratives of how they continued building families through love.

I am intellectually indebted to Menjívar's work. Her point that violence shone through in women's own narratives undergirds her argument that violence is the one consistent force across Guatemalan women's lives. Menjívar presented structural violence as a totalizing force in people's lives, manifesting in health, migration, motherhood, in-laws, social class, religion, and gossip. Yet my ethnography suggests that when every aspect of life becomes another example of structural violence, the vibrant, sometimes hopeful, heterogenous fabric of women's lives can get subsumed in the abjectness that violence confers.

But other scholars agree with Menjívar's conclusion that violence is the defining feature of women's lives in Guatemala (see for example Ogrodnik and Borzutzky 2011; Torres 2018; Carey and Torres 2010). Cumes calls violence "the motor of the colonial system... violence against women is a requirement" of ongoing colonization, in which "femininity and masculinity are colonized" (2022). Anthropological focus on violence in Guatemala has a long history. During the thirty-year civil war, which many Guatemalans call *la violencia*, anthropologists curated first-hand narratives alerting the world of the genocide and countering government propaganda. Speaking explicitly about violence was an important step. For instance, Perla Petrich (1999) structured her anthropological history of the Lake Atitlán region by showing that government-presented truths contradicted local perspectives, particularly regarding wartime violence. Virginia Garrard-Burnett (2010) studied religious overtones of the Ríos-Montt dictatorship amidst genocide, finding that the

Evangelical language and pastor-like style of Ríos-Montt's reign provided rhetorical cover for increasing violence to destroy communities under the guise of God-led leadership.

Amidst these government propaganda projects, *testimonios* allowed anthropologists a different route into scholarly and popular press discussions about government violence. Many *testimonios* about violence in Guatemala and other areas of Mesoamerica, written in the same historical moment, help illustrate the primacy of violence in discussions of these regions (Montejo and Perera 1987; Tula 1994; Behar 1994). Rigoberta Menchú's *testimonio* and the subsequent debate stand out as particularly representative of anthropology's use of violence as a single story (Burgos 1997).

Menchú and anthropologist Elisabeth Burgos-Debray published a testimony of Menchú's experience growing up and then resisting government oppression and violence during the civil war. *My Name is Rigoberta Menchú* sparked international awareness of the Guatemalan civil war and its genocidal repercussions for Maya communities. But Menchú, despite worldwide fame, faced criticism from non-Guatemalan anthropologists (particularly Stoll 1994) who highlighted what they saw as errors in her story. This debate has been well-summarized (see Arias 2001), so here I only ask what these tensions say about anthropological perspectives on Guatemala that focus on violence.

Some anthropologists of this period served as arbiters of whether the violence that Menchú described was accurate (therefore debating the *testimonios*' validity as "real" narratives). Victoria Sanford (2003) interviewed Guatemalan government officials as well as community members in her forensic and ethnographic work at the end of the war. Sanford compared ethnographic accounts of *la violencia* with "professional" accounts, including

that of David Stoll, to make her own argument about the role of truth within anthropology.<sup>48</sup> Using this data, she clarified how the Menchú debate revealed “truth-telling” as distinct and, to her, more anthropologically fruitful than Stoll and colleagues’ apparent search for clear-cut “truth.” Sanford clarified that anthropologists’ pushback at this juncture in *la violencia* did not just call Menchú’s narrative into question, but also posited Maya communities’ supposed communist, guerrilla leanings as valid justification for government massacres.

I follow Sanford’s lead when I present Colibrí’s and Jesús’s stories as forms of *testimonios*, which assert the primacy of one person’s individual truth. The role of the ethnographer lies not in aligning some immutable historical fact with people’s words. Instead, I take as given the truth within the stories Colibrí and Jesús shared. Taken together, they underline and renew arguments that the everyday violence Guatemalans experience at home connects to broader political and ethnic violence that continues today.

Anthropologists wrote about *la violencia*’s horrors as well as the multifaceted ways people resisted government genocide (see for example Garrard-Burnett 2010; Grandin 2013; Grandin, Levenson, and Oglesby 2011; Wilkinson 2004; Sanford 2003). While correspondingly violent resistance vis-à-vis guerrilla revolution was forcibly suppressed by the government during the war, scholars borrowed from James Scott’s (2010) analysis of

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<sup>48</sup> This many-sided debate is not just about truth from the Menchú standpoint but also about whether Maya communities were responsible for “provoking” government/army atrocities. I would recommend Sanford’s (2003) chapter 7, “From survivor testimonies to discourses of power,” for a thoughtful analysis.

everyday peasant resistance in Myanmar to argue that Guatemalan poor people's ongoing religious and community endurance also constituted resistance (Stoll 1990).<sup>49</sup>

Even as peace accords pleased international onlookers in the beginning of the 1990s, many scholars concluded that violence had not ended.<sup>50</sup> After the peace accords, anthropological literature continued to focus on how physical and structural violence played out in Guatemalan communities. The article "Resocializing Suffering: Neoliberalism, Accusation, and the Sociopolitical Context of Guatemala's New Violence" (Benson, Fischer, and Thomas 2008) exemplifies an anthropological approach to post-war Guatemala foregrounding the totalizing lens of violence.<sup>51</sup> The authors deconstructed Guatemala's shift from state-sponsored violence to individual culpability: "Guatemala's new violence (e.g., crime, gang activity, and vigilantism) is not the chaos of media accounts but a manifestation of enduring legacies of state violence and the social and economic insecurities brought on by structural adjustment policies" (38). Two parts of this article's approach are common across anthropology about 21<sup>st</sup> century Guatemala. The authors

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<sup>49</sup> Perhaps ironically, Stoll's 1990 interpretation of Guatemalan peasant resistance predated his controversial takedown of Menchú's testimony, published in 1994.

<sup>50</sup> Daniel Wilkinson (2004) concluded his book *Silence on the Mountain: Stories of Terror, Betrayal, and Forgetting in Guatemala* by reflecting on the end of *la violencia* with resignation alongside hope: "Poverty would continue to consume the country's poor. Violence would continue to haunt its political life. But, at the very least, there was reason to hope that the silence of the last century would remain a thing of the past" (359). I believe Colibrí would agree with this conclusion, at least in violence's impact on her own life. Violence haunted both Guatemalan political life and her own childhood and path to womanhood. Nonetheless, she felt comfortable speaking to me about her experience, emphasizing the importance of "airing these things out" in words.

<sup>51</sup> Carey, unlike other historians, wrote very little about memories and reflections on the war, despite writing in the decades just following the peace accords. He explained that he actively avoided quoting anyone speaking about *la violencia* because of the ongoing threat of reprisals and violence to those who express anti (or pro) government views (Carey 2001, 20–21). Though this is a small point, I do believe that this continues to exemplify violence structuring scholarship about Guatemala: by systematically excising any discussion of the war, a relevant sociocultural event ongoing at the time of data collection, Carey still told a story shaped by violence's power in discourses about Guatemalan lives.

argued that 1) violence in Guatemala never ended, just shifted from state-sponsored during *la violencia* to more distributed gang violence, murder, and vigilantism afterwards, and 2) post-war violence was not the fault of individual perpetrators but reflected larger patterns of structural violence for which the neoliberal state held responsibility.<sup>52</sup>

My ethnographic data led me to attend primarily to intrafamily violence instead of focusing on the “new violence” of “crime, gang activity, and vigilantism” (Benson, Fischer, and Thomas 2008, 38). Nonetheless, these categories overlapped. Several months into my stay, a powerful man was murdered in San Lucas, a quite rare occurrence; community members whispered that he and his wife might have been caught up in trafficking women for prostitution, a layering of family roles, patriarchy, and “new violence.”

Another friend told me on a bus one afternoon that her son was in danger because he was causing problems when he drank; a vigilante community defense group delivered death threats to her house. Meanwhile, my friend’s son was also physically abusive to her when drunk. This echoed his father’s violence against her for the first decades of her marriage, though this stopped when she started working outside the home. She faced violence from her son, having put an end to violence from her husband, which her son surely saw as a child. Her son, in turn, faced violence from the vigilante group, which she feared would hurt the whole family. She eventually gathered funds to propel her son into rehab, over a year later. My findings in San Lucas complicate Benson, Fischer, and

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<sup>52</sup> Anthropology about other areas in Mesoamerica also has centered analysis of violence. Despite some consternation about these tropes (see for example Smith’s (2017) comments about violence-ridden depictions of Mexico), much literature has emphasized violence in Mesoamerica (De León 2015; Dixon 2015; Gibbons and Luna 2015; Scheper-Hughes 1993, 1990; Fregoso and Bejarano 2010).

Thomas's template, while still implicating structural violence. Despite offering numerous examples of violence in San Lucas, including many not detailed here, my ethnography affirmed that violence and tragedy were not the singular defining factors in Kaqchikel life.

### **What else?**

I depart from a singular anthropological focus on violence because my interviewees described their lives in more complex and hopeful terms. While not sugarcoating the violence they experienced or perpetrated, interviewees consistently explained the importance of overcoming, fighting on, enduring, and, most consistently, loving their families and communities. I use the word love because this is the word I heard most often, particularly from Jesús, describing how Alcoholics Anonymous helped him rethink his life: "I shouldn't wait for others to give me love, it is said, but instead it is I who is in charge of giving that love to other people...we have to love as God loves everyone."

Jesús cited my own visit to interview him as a manifestation of this love. "For example, you've come here with me because you appreciate me, and I also appreciate you, you see? ... If someone arrives by chance at my house, I feel like God is coming to visit me. Yes! I feel happy, because someone came to visit me, regardless of where they came from." Having suffered the wounds of his army experience, his decades of alcoholism, and the attendant shame and rejection throughout his town, Jesús now embraced his responsibility to keep his doors open to any visitor, and to show love most specifically to his children and grandchildren. "They suffered with me, too...only now are they realizing that, oh, with my

dad, perhaps his suffering wasn't just for the heck of it, but because he had something [wrong with him], meaning everything requires a bit of patience. So that's why now I am demonstrating to them that God is the only one who can make a person change."

In understanding his ability to "change" and prioritize "giving that love to other people," Jesús underlined the human capacity to grow, as manifested by his recovery from alcoholism. He saw the next generation in his family that he helped build as profoundly different from his own. Jesús did not offer love as a salve that remediates the wounds he experienced or caused; instead, love meant a daily approach different from the way he used to live. Similarly, Colibrí continued to experience embodied wounds from her father's abuse, but she simultaneously prioritized teaching her sons about more intentional ways to live to avoid *machista* tropes she grew up with.

Another friend, Carolina, also grew up in a household with intrafamily violence. She drew from that experience daily in her work training women in vocational skills; many times, she explained to me, building economic capacity allowed women to escape violent homes. At the same time, Carolina expressed nuance similar to Colibrí and Jesús. She told me that for her, "an ideal family is an imperfect family." It is important, she explained, "to know how to listen and to know how to accept" others in a family. She expanded upon a common Kaqchikel saying, "jun jolom, jun ruwach ulew." In Spanish, San Luqueños used this too: "una cabeza es un mundo." Literally, this saying means "one head, one world," or "every person is a universe." In counterpoint to Kaqchikel communitarian understandings and emphases on spiritual and more-than-human persons, this idiom underlined individual agency. This saying suggested people cannot understand what motivates others.

I saw how this approach encompassed Colibrí's understanding of her father's violence as an individual problem, in that "at the core of him, he was always sick," and his way of being could not be further explicated. But Carolina used this phrase to bridge the individual and the community, saying, "each head is a world, but if we pull all those worlds close together, we can make something beautiful."

Cecilia Menjívar titled her book *Enduring Violence* because of her interlocutors' constant use of the Spanish verb *aguantar*, which she translated as "to endure." Colibrí and other women in Guatemala did and do endure violence. The wounds of this violence themselves endure. However, love endures too, somehow, as Colibrí and Jesús explained. Kaqchikel people prioritized building the families they wanted by countering intrafamily violence—the manifestation of state violence and misogyny—with love, within their families and beyond.

Interlocutors readily shared stories of violence, including many more I do not present here in an attempt to avoid an objectifying, numbing saturation of violent stories, following Valentine Daniel (1996) and Berry (2010). Beyond intrafamilial violence, people I knew regularly cited their frustration with what they often referred to as either "corruption" or "la situación actual" (figuratively, "what's going on these days," implicitly indicating country-wide dysfunction). San Luqueños gestured to the violence of systems of power. Violence, both intrafamily and structural, constrained their capacities to build families. But instead of violence being the defining frame as some social science posits, San Luqueños emphasized both love and violence in their lives and families. Future anthropology in

Guatemala should continue to grapple with the most ethnographically informed, nuanced ways to avoid valorizing suffering while honoring people's navigation of violence.

## Chapter 8: End-of-life, gender, care refusal, and family building in Maya Guatemala

### Flora: *Primero Dios no es nada*

In the middle of September, during the rainy season, a community health worker and I slid down an uneven embankment to visit a patient named Flora. We were in a small town of about 100 residents, halfway down Volcán Atitlán, between the cloud forest and the coastal rainforest. As representatives of a new healthcare program focused on what global health enthusiasts call “wrap-around care,” we wanted her to get treatment for her recently diagnosed cervical cancer.

Flora was a single mother in her early forties, and she lived in the smallest house on her absent husband’s family’s compound. Her closest neighbor was her sister-in-law, who looked at us curiously as we climbed down the makeshift staircase to find Flora. As the lowest status woman in the household, Flora’s wellbeing was conditional on the positive regard of her in-laws, who in turn were making up, in a way, for their son’s abandonment by housing his wife and children. Flora’s house consisted of one room containing a bed, a table, a dresser with another bed tucked behind it, and a TV playing cartoons, even though there was no child in sight.

Dolores, a community health worker in her fifties with a ready laugh and a colorful *guipil* she wove herself, knew Flora well. On her first visit, in February, Dolores picked up a home testing kit Flora had completed to see if she had human papillomavirus, HPV, the virus that causes cervical cancer. Dolores returned in March to tell Flora her test was

positive, and that a bus would pick her up at the entrance to her village to take her to the hospital for follow-up testing. Flora felt wary about taking time out of her day to go to the hospital, but Dolores convinced her this was important. I met Flora for the first time at the hospital.

In April, we waited for diagnostic results from Guatemala City, where the hospital had sent Flora's biopsy sample. In May, we consulted American pathologists and gynecologists to debate Flora's diagnosis.<sup>53</sup> In June, Dolores came back and let Flora know that her follow-up test was inconclusive. In July, Dolores asked Flora to come back to the hospital to be re-tested, as an American gynecologist promised to bring a sample back with him to the States for a more conclusive diagnosis. Flora said she would try. When Flora did not show up for that chartered bus, Dolores returned to her house. Flora explained that she had not wanted to leave her sons without tortillas, which she woke up every morning to make. She gave her sons tortillas with their breakfast, and they came back at lunchtime on a break from work, when Flora fed them a stew or beans with a new batch of tortillas. So, Dolores brainstormed a workaround with Flora for the repeat exam. In August, Flora returned to the hospital and left pre-cooked tortillas with family members who lived next door. Flora and I talked at length during this second visit, as she nervously waited for the doctor to take her biopsy.

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<sup>53</sup> While my focus in this chapter is on Flora's priorities and decision-making, these delays were not insignificant. We spent much time on Zoom and email debating because Flora's March exam had been quite concerning for cervical cancer, but the pathology did not align with this diagnosis. This disconnect drew us into a longer, ongoing debate about whether to rely on Guatemalan pathologists or attempt to traffic biopsy samples through Guatemalan and American airports on their way to pro bono analysis at American labs.

A few weeks later, Dolores told Flora that her second pathology showed invasive cancer, meaning Flora would need follow-up treatment in the capital. Guatemala City was a five-hour, prohibitively expensive bus ride away, and this kind of medical care was often impossible, unaffordable for poor, rural women.

I had heard about the stress and unattainability of these trips. The bus ride would take a day; the patient and accompanying family members would find themselves at the bus depot in a city everyone agreed was scary; they would have to pay for transport to the hospital and maybe sleep outside, or at a cheap hostel, to be able to line up outside the hospital gates before dawn to get a number; once hopefully granted entry into the hospital, they would check in at a central registration desk, then likely be shuttled by harried staff around the hospital in search of the right department. There was no guarantee that treatment would be forthcoming after such an expensive and time consuming visit; as discussed in Chapter 5, the labyrinth of tasks and unpredictability within referral hospitals functions as de facto triage in the overwhelmed public system (Chary and Rohloff 2022). All told, from bus fees to hostel costs to food, and a likely massive bill from the privately run National Cancer Institute, these costs could take up to a year of Flora's children's earnings. San Luqueños repeatedly told me that the non-medical costs surrounding healthcare were at least as intimidating as the possibility of having to pay for biomedical care itself.

Anthropologists have written about the debts that families enter into in order to be able to seek biomedical care in capital cities in centralized countries; see Anita Chary (2017) in Guatemala and Julie Livingston (2012) in East Africa. But Dolores and I had access to grant funding that promised to pay the transport and treatment costs of any patient

needing specialty care. I had anticipated that our visit with Flora would simply consist of convincing her that she would not have to pay out of pocket—then, I presumed, she would seek additional diagnosis and treatment for her cervical cancer. So, I entered the conversation in Flora’s home eager to share what we knew.<sup>54</sup>

Flora dragged a plastic chair next to the bed to create a space where Dolores, Flora, and I could chat. (Less poor families would have a couch or extra chair.) I sat on the flowered bedspread with Flora, and Dolores sat in the chair. Over the cartoons and chicken squawks outside, Flora began reiterating her story—a tale she had previously told Dolores. Flora was thankful for the help Dolores and I were providing, and she was telling the truth about her gratitude. But she had bled profusely after her last procedure. Worse, she had bled through her clothes in front of her son. This bleeding gave her particular *vergüenza* (shame or embarrassment). When her sister-in-law found out that she had bled like this, she said that she would kick Flora out of her house if something like that happened again.<sup>55</sup> This threat reflected the profound precarity of Flora’s situation: as a single mother relying on her absent husband’s family for housing, she had to show irreproachable motherhood. Bleeding through her clothes caused her discomfort and shame, and her sister-in-law’s reaction threatened Flora’s family’s stability.

“So, thank you very much,” she said to us, “but I’m not going to do any more follow-up.” She gestured to me, saying to Dolores that “she’s already realized that I have a lot of

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<sup>54</sup> I was taking rhetorical shelter in the medical student side of my brain, who wanted to heal but tended to deprioritize deep understanding of patient priorities. I continue to grapple with Flora’s story.

<sup>55</sup> Though I did not attend to this at the time, Flora’s sister-in-law’s response might have had to do with rumors of abortion (see Hinson et al. 2022).

nerves, my nerves get altered.”<sup>56</sup> She thanked me for having been around during her prior exam. “When I was in the exam,” she said, “the little *gringa* encouraged me. And I give many thanks, but I’m not going to do any more follow-up for my case, thank you very much.” She told us she would pray that God would heal her.

Flora’s main responsibility, she explained to us again, was to make tortillas, to feed her children. She had to make sure her sons were well-fed, particularly at the calorically and culturally important midday meal. If Flora left home for treatment in the capital, her sons would be left alone without tortillas for multiple days. And if she had to depend on her in-laws to feed her working sons, they in turn could think ill of her, or kick her out, even if she never bled again. Flora said a few times, “*primero Dios no hay nada*” (God willing there’s nothing).

### ***Violeta: Orando que Dios le cure***

Ten or so miles away, a different mother managed a different healthcare concern. Violeta was a vibrant member of the central San Lucas community in her mid 60s. She was active in her Evangelical church, loved to cook and host birthdays and family events at her house, and entered every room with a wide smile. She lived with her husband on their own compound along one of San Lucas’s main streets. Her family was actively expanding within

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<sup>56</sup> Flora could have simply meant that she got nervous before an invasive pelvic exam, an ordeal that many women I talked to preferred to avoid. But saying “*nervios*” in this way could additionally mean that Flora identified with a life-long predisposition to a broader illness, itself called “*nervios*,” with a broader set of symptoms. In future work, I hope to examine how *nervios* and structural violence work together in women’s lives and how the prerogatives of Western biomedicine affect women who seek treatment for *nervios*.

the compound, a cousin building a house on adjacent family land. Two of her children lived in Violeta's compound with her, and the other three lived within walking distance. She loved doting on her eight grandchildren, the youngest just a baby. She was a prolific weaver, and selling her *guipiles* helped bring money in for the family. Her husband still worked in their families' plots of land most days of the week. With many children working professional jobs, too, Violeta was not as poor as she had grown up.

Violeta's family had long been concerned about her health. She had known about her diabetes and hypertension for years, sometimes going to regular medical appointments and taking pills, sometimes not. In March, around when Flora was finding out about her positive HPV test, Violeta had fainted. Her family brought her to a local private hospital, paying the equivalent of \$700 USD for a few nights' stay and lab testing. The family worked together to gather the necessary funds. Her children had to divert money from other plans—pausing adding on to their houses, deferring working on advanced degrees. As Violeta's health continued to deteriorate, her family continued to endeavor to pay for any biomedical care she sought.

In June, a few months after her original fainting and hospitalization, I sat in Violeta's living room talking with a group of women—Violeta, her youngest daughter, one granddaughter, a cousin, and the cousin's daughter. Everyone was visiting to check up on Violeta and pray for her recovery. They agreed to let me record to conversation and ask some questions about healthcare and their family.

Violeta described her worsening symptoms, her family's decision-making about bringing her to different cities for care, and her understanding of her subsequent

stabilization as a gift from God. She spoke in a quiet voice that crossed registers with a storytelling cadence. Her Spanish was tinged with linguistic shortenings that suggested she, like Flora, was more comfortable speaking in Kaqchikel Mayan.<sup>57</sup> She explained:

I stayed there [at the private hospital] for three days, three nights, but it affected me a lot, it affected me very very much because lots of medicines, they gave me too many very strong ones. And that was the damage to my health, because it was more, more, and that's when my children started communicating more among themselves as siblings: what are we going to do with Mom? Another one of the sisters brought me to Xela, they took me away to Xela. And after Xela, they waited another week, but they saw that there wasn't any result to any of the medicine, and so they took me once more as an emergency to Atitlán. Yes, Taryn, that's how it was. And thanks to God, for me, Christians as we are, we're Evangelical, so sisters from the church were sent to me, and my niece. And God bless her, because she helped me a lot through prayers too. And many sisters came to support me in prayer. And that's why I'm on my feet. And I am happy because God performed a miracle with my health. Yes, Taryn.

Violeta's symptoms worsened after this interview, her legs swelling stubbornly. On a few occasions she lost consciousness at home and her husband struggled to rouse her. Her family brought her back to Santiago Atitlán and consulted multiple physicians in San Lucas. These doctors recommended Violeta see a kidney specialist. Her family gathered funds and transported her to the specialist, hiring a van and driver so that Violeta would not have to brave the bumpy boat ride across the lake during the rainy season. Initially, Violeta's daughter said, the kidney doctor seemed caring and thoughtful, but that same doctor later suggested prohibitive diets and seemed to blame Violeta for her illness. Violeta decided not to see that physician again.

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<sup>57</sup> Nonetheless, as with Flora and Dolores, this conversation proceeded in Spanish. In Violeta's case, part of this stemmed from her own daughter and granddaughter not speaking Kaqchikel. See Chapter 3 for more on interview language in my project.

She did, however, seek continued consults with two physicians in San Lucas, as well as a brother who was a retired Ministry of Health physician and a family friend who sometimes did home visits. Violeta's daughter told me that the family was committed to "not leaving her on her own." This literally meant the family took shifts being at her side around the clock; it also meant that they would help support her through the entire illness, emotionally and financially. As the illness worsened, the challenge brought the family together, Violeta's daughter told me: "That was when we all united more, as brothers and sisters."

By September, multiple doctors had told Violeta that her kidneys were failing. Dialysis, their proffered treatment, would require that same laborious van ride a few days a week, but wasn't out of the question economically for the family. Some doctors suggested dialysis might be a short-term solution, implying that perhaps her kidneys would recover after starting dialysis. Other doctors said nothing about Violeta's expected time frame.

Violeta's family stories and experiences shaped how she saw her ideal future. For example, Violeta's husband had a kidney condition as a youngster, and he was healed by God. The family maintained faith that this might happen to Violeta, too. A fissure arose in the family, though, about the reliability of God's intervention: Violeta and three of her children felt God *would* cure her, while Violeta's husband and two other children felt that God *could* cure her. The latter three argued for dialysis in addition to prayer.

Violeta had a cousin, Irma, whom she called a sister because of their emotional connection. Irma was closer to Violeta than most of her biological sisters—she spent ample time in Violeta's combined kitchen and living room, helping Violeta cook and praying

together. Irma had also had diabetes and hypertension, and several years before had opted for dialysis when her kidneys failed. This turned out to be expensive, painful, and unpleasant. When Irma ultimately died, Violeta blamed dialysis for killing her loved one. Violeta's daughters described how much Irma's suffering and death affected Violeta.

Violeta continued to refuse the intense medicalization of dialysis, despite ongoing family discussions. Her convalescence was punctuated by visits from physicians, faith healers, and *hermanas* from church who prayed over her ailing body. Her family, as promised, never left her to suffer alone, taking shifts by her side day and night. Six months after her initial hospitalization, she died at home of kidney failure.

### **Building family at the end of life**

Flora and Violeta continued using the same frames and priorities when deciding how to die as Kaqchikel women I interviewed used to discuss with their husbands, mothers, and mothers-in-law whether and when to have children. Flora and Violeta navigated overlapping forms of power—biopolitical, ecclesiastical, nutritional, and cosmological—to make decisions about their health and, in the process, continued to construct their identities as women and mothers. When faced with terminal illnesses, told by biomedical healthcare providers they would soon die without treatment, these women refused life-extending healthcare, but not in rejection of biomedicine. Instead, they deployed the tools at their disposal to benefit their ongoing process of building their families as they contended with the end of their own lives.

The clinics and biomedical representatives in Flora's and Violeta's stories represent an assemblage of actors in a "new" Guatemala. The end of decades of war ushered in a flood of NGOs and foreign entities, when "Guatemala became the recipient of a deluge of international development and global health funding" (Hall-Clifford 2024, 8). These actors quickly came to supplement underfunded government healthcare (Maupin 2009; J. Moore et al. 2017). Flora and Violeta engaged with different parts of this assemblage: Flora met with Dolores and me as representatives of a church-affiliated NGO equipped with funds from a US university; Violeta visited a wide range of government, NGO, and private biomedical providers across four municipalities. As Rohloff, Chary, and other authors detailed in *The New Medical Pluralism* (2015), these NGO, private, and public options in Guatemala reflect a socioeconomic reality where responsibility for health and other basic services are shifted to individuals and families in the context of unfettered neoliberal capitalism in the Global South.<sup>58</sup>

Anita Chary, in her work in Guatemala, describes how this "biopolitical regime" that includes global health actors "recognizes the important roles that women play as reproducers and caregivers, and ascribes them legitimacy as a means to an end of ensuring the health, longevity, and productivity of future generations" (2017, 22). Internationally, biopolitical actors from USAID to the central Ministry of Health saw ruling over the bodies of Guatemalan women as the key to a positive Guatemalan future.

The "wrap-around care" project that Dolores and I represented owed its funding to this regime and the underlying assumption that lack of resources drove cervical cancer

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<sup>58</sup> For more on neoliberalism, see O'Neill and Thomas (2011), Kapczynski (2019), and Driese (2022).

care refusal.<sup>59</sup> In other words, NGOs bet that women would opt in to increasingly biomedically intensive care to lengthen their lives and therefore caregiving, if only given the means.<sup>60</sup> But my ethnographic data contradicted these assumptions.

Though Flora and Violeta also primarily identified through their “important roles...as reproducers and caregivers,” their own legitimacy did not rest upon the approval of the biopolitical regime.<sup>61</sup> Maya women carried local responsibilities too: Violeta, like Dolores, was an expert weaver and a Kaqchikel speaker. Women’s roles as keepers and reproducers, not just of children but of Kaqchikel culture, meant that biomedically prioritized expectations of extended life to lengthen caretaking coexisted with locally powerful priorities that Flora keep making tortillas and Violeta keep weaving, that they continue to be mothers and carry on Kaqchikel culture (Carey 2006; Bennett 2015; Ehlers 1991).

Flora and Violeta also explained their reliance on God within and building family. At times, both women expressed their faith that God would cure them entirely—but other times, their words about faith focused more on surrendering to God’s will, for themselves and their families, as wiser than their own. Flora prayed that God would take care of her as

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<sup>59</sup> Wrap-around care in biomedical and Global North social services involves case management that aims to pull together multiple systems that patients might struggle coordinating on their own. The wrapping here could be thought of as a bringing together of wayward bits of an unruly system to create a neater hem. In this way, wrap-around care could hope to address some of the fragmentation and reliance on individual responsibility built into current Guatemalan biomedical systems. However, wrapping around Flora in this way would have also meant enclosing her in a healthcare process. Parts of her life would have to be cut off. Like a serger sewing machine, this wrapping up can prevent fraying, but to do so it must cut.

<sup>60</sup> I made this assumption as I entered Flora’s house, based on a year in Guatemala and a decade of public health classes, and the assumption (and much though not all of my training) aligned with the biopolitical regime itself.

<sup>61</sup> Thanks to Ross Perfetti for asking whether this could align with Audre Simpson’s concept of ethnographic refusal (2014).

she prioritized her sons. Violeta prepared her husband and children for a future without her, reminding them that God would take her when it was time.

In Flora's story, tortillas played an even bigger role than the Christian God. Corn is as important as a deity in Kaqchikel cosmology. In the Popol Vuh, the origin story of highlands Maya peoples, the gods made humans out of one kernel of white corn (Colop 2021).

Tortillas, which women labor over from before dawn and throughout the day, define and sustain human life. A healthy adult man, working in the field, should consume six or so tortillas per meal, Kaqchikel women reminded me. Tortillas make explicit the gendered reciprocity I found constantly alluded to throughout my time in San Lucas, which historians and anthropologists repeat: men farm the corn in the *milpa*, while women make the tortillas, and together, men and women feed their families (Cuj 2024; Wehr et al. 2014; Carey 2001).

In Kaqchikel Guatemala, therefore, tortillas are applied motherhood. Flora's refusal to leave her sons without tortillas was figurative, an unwillingness to stop mothering, but it was also literal: she would not leave her sons without food, without life. And when one of Violeta's diabetes doctors recommended that she cut simple sugars by reducing the number of tortillas she ate per meal, following this instruction would have meant skimming off the very substance of a good Maya life. Corn itself was a more-than-human actor in Kaqchikel family life. In contrast to Foucault's top-down yet diffused biopower, corn served as a biological and cultural staple, an Indigenous, roots-up bio-power, a force defining Maya personhood alongside the structures of churches and clinics.

## Biomedicine at the end of life

Anthropologists and other social scientists have long studied practices, rituals, and conceptions around death and dying, and I show how these decisions constitute family building as actors face, discern, and negotiate dying. Physician anthropologist Scott Stonington, for example, studies the complex choreography at moments of death, in and around Thai healthcare. Stonington conducted this ethnography after the beginning of his own MD training. In the field, he came to terms with his own assumption “that people would frame their understanding of the dying process in terms of a tension between biomedical and other forms of intervention. Instead...choreographing a good death required a mix of biomedical and other solutions...Biomedicine was one of many resources repurposed into a complex strategy” (2020, 21).<sup>62</sup>

Rather than drawing a binary between traditional and modern forms of healthcare, San Luqueños integrated all options available to them, “choreographing” a “complex strategy.” Violeta continued to see doctors until she died, even as she refused dialysis. Medical anthropologists who study dialysis emphasize how access to this extreme biomedical intervention reveals injustices in healthcare and state policies (Hamdy 2008). Stonington discussed how “end-stage kidney failure...is characterized by a kind of waiting that blurs the transition between the debt of life and the last phase” (2020, 75). In Georgia, US, Nolan Kline (2018) analyzed how undocumented immigrants faced exclusion from

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<sup>62</sup> I also get caught up in buying into this binary between biomedical and non-biomedical approaches, needing to constantly revisit interviewees’ words to disentangle my own indoctrinated attachment to biomedicine as the core pole. In previous versions of this chapter, I found myself automatically slotting people like Flora and Violeta into “for” and “against” categories, when their actual family-based decisions showed much more complexity.

state funding for dialysis, resulting in “vulnerable populations living in a liminal space between life and death” (226). Kline draws on Mbembe’s (2019) necropolitics to argue that the political exclusion of immigrants manifests through “medical uncertainty and precariousness” (225). Some of these undocumented immigrants, of course, come from Maya communities. Kidney disease is also increasing in Guatemala and Mesoamerica, driven by a mass influx of processed foods, environmental toxins, and workplace risks (Yates-Doerr 2015; Kierans and Padilla-Altamira 2024; Cerón 2023; Hansson et al. 2024).

Beyond any particular illness, Flora especially drew my attention to the ways in which the “options” biomedicine presents are already foreclosed and incommensurate with Indigenous family building priorities. I believed for months that Flora’s only options were to get healthcare or not, and that she was choosing between a longer life with biomedical intervention and earlier death without it. But Flora opted out of not just the treatment we offered but the entire paradigm defining those as the only two options. Family building, featuring its manifestation in tortilla making, was the future she chose.

Stonington writes evocatively of the “creative improvisation, not always successful” families underwent in order to attempt to fulfill the “potential criteria for a good death” (2020, 66). Both Flora and Violeta creatively thought through the constraints of their diagnoses and opportunities for treatment. They both improvised within these constraints to prioritize continuing to build the families they wished for. Nonetheless, Flora’s constraints were more striking. While she cared for family, few cared for her.

## **“Health” and “Care”**

Who, where, and what sorts of fundamental expectations, goals, and incentives counted as caring to Flora and Violeta? Biomedical providers might cast both women’s decisions as “care refusal.” Scholars of end-of-life contextualize the degree to which people prioritize length of life over quality of life (Russ, Shim, and Kaufman 2005). From critical care to palliative care, systems deploy a circumscribed understanding of what care should look like (Cohn, Borgstrom, and Driessen 2024). These judgments rely on a bounded, culturally specific set of ideas about what types of care, and what kind of caring, matter.

For Flora and Violeta, over the past generation, intensive biomedical healthcare intervention had become a possibility. However, their recent experiences with these systems of care had been discouraging. Flora had experienced vaginal bleeding from her biopsy that had put her material safety, dependent on her sister-in-law, at risk. Violeta’s stay at the hospital exposed her to “too many very strong” medicines, which caused, in her words, “damage to my health.” The care that Flora and Violeta prioritized was not the narrow Western definition of “healthcare,” which they had experienced as overly invasive. Instead, they prioritized caring for their families.

Violeta and her husband, like many Kaqchikel interviewees, practiced biomedical family planning methods. Like Angie in Chapter 5, Violeta explained that she chose the birth timing of her children so that she could care for each one of them as a mother should; she only stopped taking birth control once she felt that the youngest was old enough that she could turn her attention to a next child. Many Kaqchikel interviewees shared this

approach to family planning and child spacing. And Violeta carried this same approach with her as she experienced worsening symptoms from her kidney failure. She wanted to care for her family, and she wanted her family to be “unidos” (united or together). I understood her to mean not just on the same page, in terms of healthcare choices, but that she wanted her family to be literally, physically together—she could not enact the daily role of matriarch from a hospital bed. She had to be at home.

During the six months before her death, Violeta and her family invested time and money in seeking dozens of healthcare providers’ opinions. Violeta’s family’s care decisions might not align exactly with Chary’s (2017) analysis of care shopping as a way of showing love, which could constitute a Guatemalan iteration of Stonington’s (2020) description of the Thai “debt of life.” Violeta’s family’s healthcare seeking seemed to be more about collective processing as a family, and less about repaying specific obligations to an individual ill family member.

Kaqchikel mothers show care materially by making, providing, and sharing tortillas. Flora could not care for her family at all if she chose to travel far away for diagnostic exams, chemotherapy, or surgery. Livingston describes “cancer as something that happens *between* people,” and Flora refused to let cancer happen between her and her family (2012, 3). As mothers, both Flora and Violeta formed the nexus for their families, the place they could return and be nourished, three times a day, without fail. If a healthcare intervention forced them to stop providing *this* care, what kind of health was that?

Across Violeta’s family, many understood health to be a broader concept than just the opposite of biomedical illness. One daughter told me, “health is literally everything.”

This comment can be understood in two ways, as many other observations and conversations helped me to hear. Many interviewees told me one version: “without health, we have nothing,” or “without our health, what do we have?” But Violeta’s daughter’s comment also conveyed that the ontological category of health included “literally everything.” Another member of Violeta’s family, her niece, shared with me that health involved much more than momentary physical sensations: “There are emotional illnesses, there are spiritual illnesses, and there are also psychologically too... there are different types of illnesses.”<sup>63</sup>

Flora and Violeta knew the opinions of multiple providers of a specific kind of healthcare, about what might make their lives last longer. At the same time, they saw their own health, and the care they would give and receive, differently. They did not position themselves against biomedicine as a philosophical or absolute stance. Instead, they availed themselves of this narrow version of healthcare only when it made sense in their ongoing family building.

Flora and Violeta’s decisions evoke healthcare refusal, the biomedical way of framing these women’s choices. According to Sobo, who studied vaccine refusal among American parents, “refusal need not always involve defiance or action-against. It can entail quiet abstention instead. More than that: it can be an affiliative act...vaccine refusal often serves as a declaration of identification with the social setting of import to the individual.

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<sup>63</sup> Thanks to Joyce Lu for reminding me of the synergies between this ethnographic moment and Emily Yates-Doerr’s (2020) critiques of the social determinants of health in the context of non-communicable disease interventions in Guatemala. My role as a clinical interlocutor in these two cases means that I did arrive to these stories with a predetermined idea of “what health is” (Yates-Doerr 2020, 378). I thank readers and interviewees who helped me push back against these normative models foreclosing anthropological analysis.

This kind of refusal is more about who one is and with whom one identifies than who one isn't or whom one opposes" (2016, 345). For parents at a school with high rates of vaccine refusal, "[o]pting out of vaccination was an act of opting in" to the social norms at the school (2016, 346).

Flora and Violeta opted into their motherhood, in their own homes, with their children around them, eating their tortillas together. This "declaration of identification" as a mother feeding her children materially and spiritually mattered the most—much more than seeking the longest possible life. Opting in to the lives they wanted required opting out of healthcare intensification. Or, alternatively, opting into more healthcare would have required opting out of their family building lives. In opting out of the Western idea of (one word) healthcare, Flora and Violeta chose their own understandings of health, as a totality of the things that mattered in life, and care, as they mothered and cared for the families they built.

## Chapter 9: Conclusions

### **Kaqchikel Luqueños navigate constraints while building families**

Family building, as a formulation I develop throughout the dissertation, stretches across the life cycle in Kaqchikel Guatemala. As opposed to family planning, which attends to the decisions around when and how many children to have, family building involves myriad other decisions, big and small: for example, when to throw a birthday party, what medicine to give a sick infant, whether both parents should seek work outside the home, and how and when to die, all incorporating what their own ideal family looks like. Kaqchikel Guatemalans detailed violence and coercion that limited their family building, but San Luqueños nonetheless endeavored to build their families using any tools they could take advantage of, including biomedicine. This dissertation examined the ways that family building happens within and despite biomedical systems in San Lucas Tolimán.

First, people narrated how they navigated biomedical healthcare. Most San Luqueños faced significant difficulty, often unable to access the care they wanted or needed. They used two specific affective tools, giving thanks (*agradecer*) and creatively taking advantage (*aprovechar*), to access what biomedicine they could within structures of constraint. These themes of creativity and thanksgiving amidst precarity resounded in San Luqueños' experiences throughout this dissertation.

San Luqueños used contraception as one tool in building their families. But the way they interacted with contraception reflected and reacted to the ways biomedicine played

out in family building—biomedical institutions offered contraceptive tools many San Luqueños wanted to access, but systems and providers often undermined Kaqchikel families' decision-making, via epistemological supremacy and contraceptive coercion. Analyzing contraceptive coercion in San Lucas connects current work within public health and the social science of family planning to the medical anthropology of family building in Guatemala (Swan, Wasser, and Cannon 2025; Swan and Cannon 2024; Tumlinson et al. 2022; Herrera 2024). Examining the ways Kaqchikel families navigated these dangers while persevering in their family building revealed priorities, such as taking appropriate care of one's body and accessing the best type of biomedicine when desired while avoiding biomedical overreach, that animated decision-making throughout people's lives.

Studying violence shines further light on biomedical decision-making and on the lifelong process of building family for Kaqchikel Luqueños. Stories of *violencia intrafamiliar*, often involving explicit and physical violence, helped reveal some of the ways that post- or intra-war Kaqchikel masculinity can overdetermine alcohol use and violence. At the same time, in the same families, Kaqchikel people stubbornly insisted on love and persevered to build their families. Anthropology of Guatemala has insisted that violence is the predominant frame through which to understand Guatemala's body politic; this orientation can cause scholars to overlook the complex forms of care that Luqueños described.

Examining how women and families reacted to biomedical diagnoses of terminal illness further explicated this overarching focus on family building. Families strategically engaged with biomedicine and continued to prioritize their own family building priorities beyond external strictures or edicts. Kaqchikel mothers prioritized feeding their families

materially and spiritually until the end of their lives. Families creatively took advantage, gave thanks, made difficult decisions, grappled with violence, and contended with death on their own terms, navigating biomedicine in San Lucas and its attendant constraints while building family.

My work contributes to the anthropology of reproduction and social science in Guatemala, focusing on the ways that gender, power, and embodiment related in people's decision-making about building family. Reproductive justice—the scholarly and activist fight for families to be able to have children, not have children, and parent children in safe, healthy communities—remains a vision that I heard echoed, in different words, across highlands Guatemala. I hope my interpretation of family building can serve to extend anthropological work on reproduction, and fights for reproductive justice, across the life cycle.

These analyses further touch on and continue at least a century of anthropological theory around structures, particularly structures in dialectic with human agency. Philosophical literature on structure vs agency notes the fallacies of assuming that either structure or agency can entirely determine human behavior.<sup>64</sup> Accordingly, some anthropologists have moved beyond “agency as argument,” taking individual self-concept and autonomy as given, but power as contested (L. M. Thomas 2016).

As Farmer put it, “the degree to which agency is constrained is correlated inversely, if not always neatly, with the ability to resist marginalization and other forms of oppression”

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<sup>64</sup> For recent work about gender and agency, which I do not cover here, see Diabate (2020) and Mahmood (2009).

(2004, 307). Hence, the question facing medical anthropologists studying reproduction becomes not who has agency but who, and which systems, wield power and how (Fassin 2001). This is especially crucial when oppression causes despair, as Elizabeth Povinelli describes in *Economies of Abandonment*:

The small child's life-as-suffering will drift across a series of quasi-events into a form of death that can be certified as due to the vagary of 'natural causes'...How does one construct an ethics in relation to this kind of dispersed suffering?...Their wellbeing is part of a larger mode of corporeal embodiment in which her carnal misery is a vital organ (2011, 4).

Throughout this dissertation, San Luqueños articulated both the misery and hope in family building. People I talked to simultaneously held individual people responsible for their behavior and identified ways that structures made some decisions impossible. To this end, I follow scholars in avoiding an explicit structure/agency debate, instead studying mechanisms of reproducing biopower through their embodied results (Morgan and Roberts 2012). Future medical anthropology in Guatemala should continue to study decision-making, within and beyond family building, as applied agency.

San Luqueños' consistent reference to the will of God did strike me, by the end of my fieldwork, as much more than fatalistic or resigned to powerlessness. Instead, hope of a better tomorrow, of a God (whether Catholic, Evangelical, or Maya) who looked out for them and would continue to intervene for them, sustained whole families. If I had presented their stories about violence and coercion without communicating the countervailing throughline of hope and praise, I would not be capturing San Luqueños' phenomenological realities of building families. I did not intend to present a redemption

narrative, but instead to faithfully document the experiences of family building that Kaqchikel San Luqueños shared with me.

### **Future directions**

I focused on San Luqueños' experience building families in relationship with the biomedical healthcare system, in large part because this is where I felt my own expertise and positionality allowed me to appropriately analyze and speak. My work dovetails with recent medical anthropology in Guatemala, highlighting the fallacy of "choice" in biomedical healthcare and the legacies of interpersonal and structural violence on people's healthcare seeking, bodies, and lives (Berry 2024; Hall-Clifford 2024).

While most San Luqueño families who contributed to this dissertation engaged in some way with global health systems, this dissertation focuses on their experiences within those systems as much as, or more than, directly turning my analytical gaze on the "ways in which global health—its actors, structures, and systems—perpetuates the challenges it purports to fix," as Hall-Clifford beautifully explicates in *Underbelly* (2024, 13). My positionality during fieldwork, as a primarily independent researcher simultaneously affiliated with several NGO and academic projects, gave me unique insight into these systems. I chose, however, to focus on the agentic family building San Luqueños showed me. I will write more directly about global health assemblages like STMMs and binational NGOs elsewhere. A forthcoming manuscript drawing from some of the data from Chapter

4, on patient perspectives on American visiting medical groups, will jumpstart this future work.

I focused this dissertation on San Lucas, a privilege of longitudinal ethnographic engagement. This means that I will turn to my rich ethnographic data from Santa Lucía Utatlán, Tecpán, Antigua, and Xela in future work. In and beyond San Lucas, several topics interest me: negotiation processes between Guatemalan and American organizations deploying global health dollars and quetzales; the uneven uptake of language around reproductive autonomy by Indigenous women's groups across age and space; Guatemalan labor laws and how they play out in biomedical systems; how Indigenous Guatemalan biomedical healthcare providers see their work and their identities. I anticipate some of my future anthropological work will center global health systems and their discontents in Indigenous Guatemala, even as I continue to work within this system as a future physician and global health researcher.

Kaqchikel and Maya culture, family building, lifeways, and lives have been constantly under threat since colonization. Some scholars have asked if my data revealed an inevitable, ongoing process of *ladinización* (Ladino-ization, the stripping of Indigenous Guatemalans of their Indigeneity). This phrase, and fear, persist, despite Adams' update of the model from the "linear progression" suggested by ladinization to the idea of "coevolution" between Maya and Ladino Guatemalans (Watanabe 2000). Globalization, a popular concept when I first visited Guatemala as a teen in 2008, has been roundly analyzed in the anthropology of Guatemala (Little 2004; Fischer 2001; C. R. Hale 2002). By 2023, I had better cell phone service in most of San Lucas than I do on my US university

campus. This interconnectedness offers hope, for example in the form of mHealth applications and telemedicine, but can challenge Indigenous language and identity in the context of forces of homogenization, like ongoing language death globally (S. Duffy et al. 2019; French 2010; Crystal 2000). Certainly, smartphone access is burgeoning, most interviewees used Facebook, and conspiracy theories spread on WhatsApp. An ongoing project with Nicole Berry, Corinne Hale, and Allie Riechert aims to examine these and other dynamics in the context of misinformation and disinformation in medical settings.

In my future work, I also hope to address Kaqchikel people's relationships with more-than-human persons in family building processes. Relatedly, Kaqchikel families' relationships with the Church and God, as well as the related deity corn (*ixim*), deserve more analysis than I was able to conduct here. Throughout my fieldwork, as mentioned in Chapter 8, interlocutors gestured to the importance of corn, mountains, coffee, and water alongside humans in Kaqchikel families. While this dissertation examined the articulations of family building with biomedicine, leading me to focus on the human body and human systems, I hope my future work will engage more directly with more-than-human persons in family building.

Finally, the anthropology and experience of sound in San Lucas served as an unexpected source of consternation and delight for me throughout my fieldwork. For me, a singer and auditory processor, sound loudly asserted itself as a crucial way Indigenous Luqueños lived and celebrated. Though my aural curiosity echoed through this dissertation, a discrete chapter on sound struck me as discordant with the dissertation's

major themes. Thus, I am excited to pursue this work in the future, and discern its harmonies with the anthropology of gender, reproduction, Indigeneity, and health.

### **Policy and public health implications**

As an MD/PhD student and applied anthropologist, I remain committed to work that bridges theory and practice. My longitudinal implementation work in San Lucas enabled the specific findings of my research, and accordingly, I intend for my dissertation research to be of use in tangibly improving health and healthcare in Indigenous Guatemala and beyond. I do believe anthropology can change and save lives. Findings from this dissertation, drawn from the words and experiences of San Luqueños, can be immediately useful in public and global health. I have attempted to integrate these findings into my own ongoing biomedical work and hope others will as well.

Numerous policy and practice implications warrant attention. Interventions to improve access to biomedical care must address transportation, logistics, and care navigation, in addition to paying for the biomedicine and attendant costs. Local contraceptive knowledge is adaptive and wise, while healthcare worker scorn can drive distrust and worsen outcomes. Interpersonal and systemic contraceptive coercion continues in Guatemala. Violence constrains people's choices, particularly women's, and relates to centuries-long wounded patriarchy. Patients at the end of their lives have diverse priorities, which biomedical providers should respect and enable. Kaqchikel Guatemalans endeavor to build family amidst profound constraints, and do so with dignity and love. This

all plays out in people's healthcare decisions. Anyone who engages with biomedicine, public health, or tourism in Guatemala can share this knowledge and interrupt systems that perpetuate violence.

Biomedical healthcare is far from a monolith, and people who work in health in Guatemala are also people building families. Chapters 4 and 5 featured Clea, a biomedically trained nurse who used community knowledge to inform her contraceptive and prenatal healthcare choices as she, her husband, and her mother collaborated on family building. In Chapter 5, other Kaqchikel biomedical providers expressed suspicion and resignation about the entity "culture," which they presented as both ubiquitous and irreparably misleading. As I have seen repeatedly in my participant-observation, biomedical healthcare providers often engage with patients with the best intentions. These professionals, in Guatemala and elsewhere, would do best to approach the concept of "culture," and its cousin "myth," with awareness and wariness—when providers blame culture or myths for patient behavior, what happens and why? What do these ideas do within therapeutic relationships between physicians and patients, clinics and communities?

Most biomedical providers I got to know in Guatemala found their work profoundly constrained by neoliberal economics and resulting giant workloads from understaffing, corruption, and inequitable educational systems (among other causes). No amount of global health investment in Guatemala could ever compensate for colonialism and forced disenfranchisement. However, post-war, investment skyrocketed, so money is there (for now)—yet global health interventions in Guatemala continue to fall short (Hall-Clifford

2024). As discussed in Chapter 4, while San Luqueños are quite aware of manifold theoretical options, transport, cost, time, trust, logistics, and more keep them from accessing these ostensibly available services. Programs whose interventions involve simply bringing healthcare (starting new programs, building new clinics) are unlikely to meaningfully improve Guatemalans' health. Global health interventions would benefit from further use of anthropological methods like in-depth interviews, participant observation, and long-term community engagement to delineate exactly what resources would be helpful in each particular community. In San Lucas, I found that programs needed to attend to supposedly external costs like transportation, lost work, and seemingly petty charges, in order for biomedicine to be actually accessible to most patients. I intend to continue collaborations in San Lucas, Guatemala, and elsewhere. I hope future scholars also feel called to the day-to-day work of shifting power in biomedical healthcare to Guatemalan researchers, practitioners, and community members.

Anthropologists like me enjoy problematizing global health systems, which we must, because in many cases these systems further inequities and even violence, like the experiences of contraceptive coercion in San Lucas. Regardless of the whims of global health funders, anthropologists must continue to critique global health work by understanding the realities of people whose bodies and lives are affected by these systems. For example, as colleagues and I call for elsewhere, reproductive justice must be the ultimate goal of family planning and related programs, to address the ways that incentives and metrics shape family planning implementation into instrumentalist and coercive practices (Senderowicz and Valley 2023).

This work continues while US politicians ramp up deportations and threaten government funding, including all the sources that allowed me to conduct this research. This challenge, like prior political winds in the Global North, threatens the lives and livelihoods of Guatemalans in the US and Guatemala, who now have their family building even further constrained by an additional set of authoritarian policies governing their lives. Biomedical healthcare workers based in the United States have a unique responsibility to the patients we serve. We must constantly strive to understand their realities, seek to challenge the structures of power that make them vulnerable, and tangibly transfer resources from our institutions to their pockets. I hope my research has made these imperatives clear.

### **Kaqchikel Luqueños fight to build families**

This dissertation documents Kaqchikel people fighting to build their families. Families fight hunger, poverty, illness, genocide, climate change, racism, sexism, and numerous other forms of physical and structural violence. Alongside these constant challenges, Kaqchikel Luqueños presented many ways family building fights succeed. Aura Cumes, the Kaqchikel anthropologist, put this Indigenous resilience succinctly in a talk to my Kaqchikel class early in my fieldwork:

Guatemala is nothing without us; it doesn't exist. We are here without Guatemala. We are good. The most important, the most surprising [part], is that the Indigenous communities have survived. But [in] great precarity. We are immersed in a world that seeks our obedience. We must celebrate the fights: our people continue with their lives (2022).

These fights, San Luqueños building family consistently reminded me, were quotidian and momentary as much as high-stakes and life-defining.

Early in my research, I interviewed Alejandra, who had already become a dear friend. We sat on a back patio on small wooden chairs, a breeze causing the leaves in the nearby garden to whisper. Alejandra was around my age and unmarried, so I would not have interviewed her at all if I only sought out people who fit my initial category of “actively building family.” However, her daily life revolved around what I came to understand as family building: waking up early to make tortillas with her mother, cooking traditional Pepián and Chinese fusion “chomin” for her nieces and nephews, checking on sickly aunts and uncles, instructing me in making tamales at the holidays. Alejandra was unmarried and had no biological children, but the children in her so-called “extended” family called her Mama. Her labor, effort, and love focused on serving her family. I asked her a question I asked everyone—what is an ideal family? She responded immediately, “my family is the ideal family.”

This quick response stayed with me as I learned more about the family Alejandra continued to build over the years—some male relatives’ struggles with alcoholism, people’s experiences of violence, an ongoing debate about whether someone moving to the States could help defray medication and care costs for her aging parents. Her analysis aligned with Carolina’s from Chapter 7: “an ideal family is an imperfect family... each head is a world, but if we pull all those worlds close together, we can make something beautiful.” No Kaqchikel family could avoid the effects of 500 years of violence and the resulting ongoing precarity. Every family that sought biomedicine had to contend with systems that

failed them. And, looking at Alejandra on the patio, remembering holiday meals, children's and older people's birthdays, and laughing and crying in the kitchen together, I agreed.

Alejandra and her relatives had built their ideal family.

## Epilogue

April 2025

In my invigorating dissertation defense, one of my committee members pointed out that, apart from a few mentions, I never engaged with adoption as a facet of family building in San Lucas in particular and Guatemala in general. Though I did not proactively collect data on adoption, it turns out I did have a fair amount of information about it.

I first gestured to one version of adoption in the Introduction, discussing reproductive justice and activism. Adoption served as another axis of reproductive coercion in Guatemala. As has been extensively documented in testimonios (Santizo-Malafronti 2025a) and scholarship (Santizo-Malafronti 2022; Nolan 2024), after the Peace Accords in the mid-1990s, transnational adoption from Guatemala began in earnest.<sup>65</sup> At its height, 1 in 110 Guatemalan children were sent abroad to live with a new family (Santizo-Malafronti 2024). But as many Guatemalan communities knew then, and the international community later learned, forced adoptions, even kidnappings, were common. Women were told their children had died after birth, their signatures were forged, and their babies were sold for tens of thousands of US dollars to eager American families. Trained operators went to Indigenous communities to convince parents that their children would be better off being raised in the States, that they could better support their remaining children with the proceeds. This process made Guatemalan lawyers and government officials rich or richer.

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<sup>65</sup> Chris reminded me to use “transnational” instead of “international,” following critical adoption scholar Eleana Kim. Kim describes how adoptions “have instigated a range of subsequent mobilities—of information, people, goods, and services—from and to the so-called sending and receiving nations that are shaped by (and, in turn, shape) new globalizing trends and transnational processes” (2007, 500).

Chris often talks about seeing ladino Guatemalans around their own age, wondering whether proceeds of selling Indigenous children like them helped furnish those elite Guatemalans' college funds and fancy cars. This industry, a toxic stew of state violence, neoliberal power, and reproductive coercion, continued for decades.

And as Chris's work convincingly shows, adoption in Guatemala "forecloses the possibilities of one family formation, steeped in language, culture, and tradition," as it simultaneously "contributes to the family building goals of other parties" (Santizo-Malafronti 2025b). Adoptive families in the United States, Chris articulates, are not blameless; at the same time, diverse types of families had the capacity to build towards their own ideals by tapping into the international trade in Guatemalan children. Like so much I report in this dissertation, the love present for many in building families and the structural violence underlying who got to make choices and who was coerced—these forces operate simultaneously, and love and harm weave together.

Guatemalan families take part in adoption, too. In San Lucas, the Casa Feliz orphanage, run by the Mission during the years of the war until the last children aged out or were adopted, continues to serve as a narrative touchpoint for community members to discuss family building amidst state violence. One interviewee, Geronima, herself was orphaned during the war. "When I was 10 years old," she explained, "my mother died, and it fell to me to be the mother, for my siblings and for my father. I come from a family of very few resources...five years after my mother had passed, my father died. It was a little bit, very difficult for us." She relied on the generosity of the Catholic Church, as her older siblings could not care for her and her younger sisters. Geronima was present and cared for

children as a teenager, working in the Mission during the earliest days of Casa Feliz, while learning Spanish. She speaks highly of Father Greg:

“The grand love that he brought to me will forever be unforgettable, because for me he was like a father, educating [me], because I didn’t have that, because my parents had so few resources. Even if they wanted to educate us, it was impossible... through all that learning, and suffering, now I can say that all of the experiences have made me feel strong, made me value everything that I now have.”

Geronima got married, but her marriage quickly ended. She has lived for the past 20 years as a single mother with four children. She went on to work with women at a community organization, work that she values highly. She teaches women marketable skills like tailoring, but also shares with women her skills in Kaqchikel weaving and use of medicinal plants. She took classes on violence against women, public speaking, and women’s rights, taking advantage of every opportunity (she used the word “aprovechar,” discussed in Chapter 4).

Geronima used every tool at her disposal to build her family. And with some overlaps with Chris’s story, adoption was a gift as well as a wound that complicated but deepened her family’s story.

“My first son is adopted. He was abandoned by his underage mother. And as I was pregnant with my first child, when my son was born the boy was six months old. So they almost grew up as twins. But I hadn’t said anything to him. I hid this history because—my children were wounded, because their father had left. And if I was going to talk about this, it could be that my sons would also bother him, or make him feel like less. And I avoided that, so four or so years ago, he found out the entire truth. So I had a bit of a problem with that. But thanks to God, now my family is established, he understood, he rationalized. So now we’re living better, because I had big problems with him too. But thanks to God, because of my faith, also, it has helped me a lot to help him understand this reality.”

Geronima then told me proudly of her four children’s successes:

“It was worth the suffering we carried with us, because each one of them, thanks to God, they studied. I have three children that got an accounting degree, and one of my children is a teacher...there is suffering that we have carried, but the same life has taught them to be better, to be an example as well for other young people, because every family lives their own experience.”

Each family’s experience involved difficult choices. Chris’s adoptive parents in the United States and Geronima in San Lucas continued to build their unique families, while the systems of power that created these conditions granted impunity to those who had nefarious interests in children with tenuous ties to their birth families.

After I defended this dissertation, I became aware of a recently published book by Canadian anthropologist Kevin O’Neill, titled *Unforgivable: An Abusive Priest and the Church That Sent Him Abroad* (2025). O’Neill details how a Minnesotan priest known to sexually abuse children was sent to San Lucas while Father Greg was in charge of the Mission. This priest continued his abuse, including “adopting” at least one child while in San Lucas, until he died in 2003. Father Greg was aware that this priest, Father David Roney, had a history of abusing children in Minnesota. Catholic leaders in New Ulm worked together with Father Greg to orchestrate Father David’s “retirement” in San Lucas. Father David lived across the street from the parish school and had unfettered access to children in town, including at Casa Feliz. O’Neill shares the story of the woman, pseudonym Justina, who Father David “adopted.” Justina continues to struggle with her life and identity in San Lucas today. At one point in Justina’s childhood, her birth father briefly attempted to bring her back home with him, until Father David came to their home and took her back to the parish. After his death, Justina was taken in by another San Lucas family, who had also experienced unimaginable violence during the war.

O'Neill's manuscript is a groundbreaking and valuable contribution to the anthropology of Guatemala. It is heartbreaking, too. It details overlapping tragedies: Guatemalan families being torn apart during and after the war; the Catholic Church's international conspiracy to shelter abusive priests and continue to put children in danger; the use of Guatemala as a haven for Americans to commit abuses that were no longer imaginable stateside; continuing subjugation and exploitation of Guatemala and Indigenous families.

I have not addressed this quite difficult topic in this dissertation, though scholars have convincingly argued that "adoption is a reproductive justice issue" (McKee 2018). I can offer this brief epilogue to only encourage readers to explore Santizo-Malafrenti, Nolan, and O'Neill's work, and to acknowledge the many ways that family building can serve as a frame to understand Guatemala's history and present. Indigenous and Kaqchikel family building takes place in dire circumstances, but I return again to Carolina's confidence that "an ideal family is an imperfect family." Families must exert creativity and navigate systems run by people who dehumanize them. And families build and rebuild, loving each other imperfectly, nonetheless.

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## Glossary

Spanish	Kaqchikel	English
	Iximulew	Lit. Land of the corn, fig. Guatemala
	Winaqi'	Lit. People; fig. Kaqchikel people and more-than-human persons
	Xinwak'axaj	I heard
Agradecer		To give thanks
Agradecimiento	Matyoxinik	Thanksgiving, formal thank-you (noun)
Aguantar		To endure
Altiplano		Highlands
Ama de casa		Housewife
Aprovechar	Matyoxij	To take advantage
Asociación Movimiento Indígena Guatemala		Guatemala Indigenous Movement Association
Baja costa		Sea level coastal ecosystem
Bolo		Drunk man
Bombas		Lit. Bombs; fig. Sound fireworks
Bampesino		Peasant; farmer
Cazualeja		Sweet bread, often eaten with coffee in the afternoons
Centro de Atención Permanente		Permanent Care Center (Guatemalan Ministry of Health)
Centro de Salud		Health Center (Guatemalan Ministry of Health)
Cofradía		Indigenous religious center
Comadrona	lyom	Midwife
Consultorio		Outpatient clinic
Costar		Lit. To cost; fig. To be difficult
Coyote		Lit. Coyote; fig. Smuggler in international migration
Criollo		People with Spanish roots who live in Latin America (in Guatemala, the ancestors of Ladino people)
Cuidarse		Lit. Take care of oneself; fig. Prevent pregnancy
El norte	Pa jotöl	Lit. The north; fig. The United States
Familia	Ach'alal	Family
Finca		Plantation

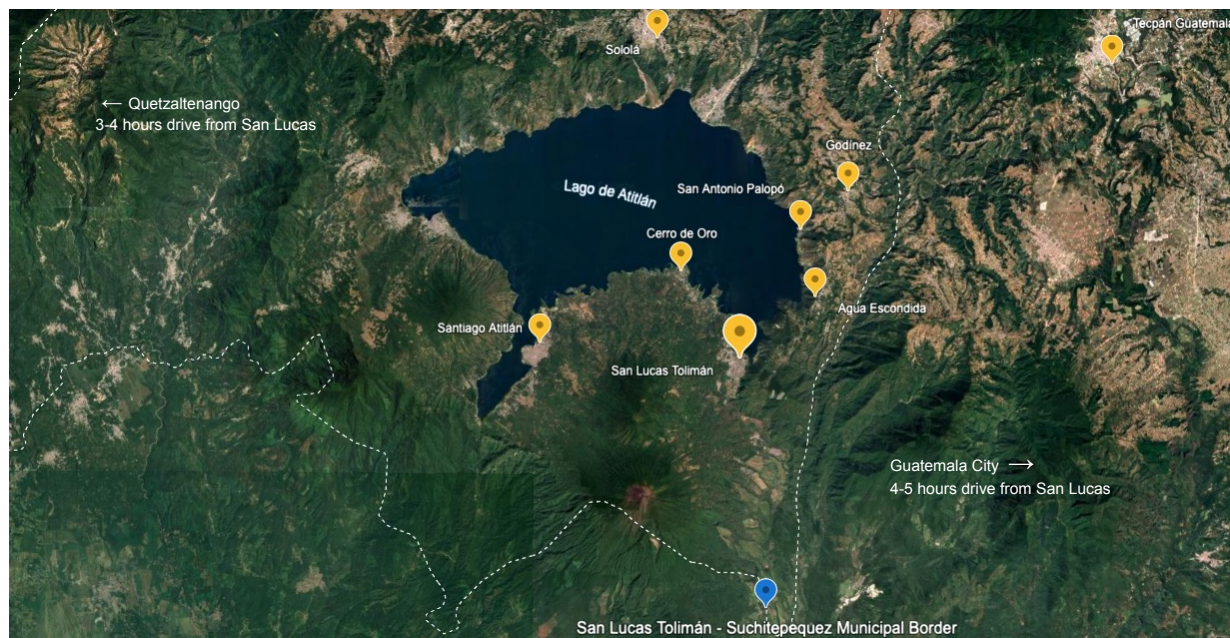
Gringo		American in Guatemala, familiarly (or disparagingly)
Guipil	Po't	Woven blouse
Hacienda		Lit. Large estate; fig. Model of colonial land distribution
Hermanas		Lit. Sisters; fig. Women church prayer partners
Hospital Obras Sociales Monseñor Gregorio Schaffer		Social Work Hospital Monsignor Gregory Schaffer (San Lucas Mission Hospital)
Instituto Guatemalteco de Seguridad Social		Guatemalan Social Security Institute
La violencia		Lit. The violence; fig. The 30 year civil war
Ladinización		Ladino-ization; stripping of indigeneity
Ladino		Non-Indigenous Guatemalans; sometimes aligned with “mestizo”
Machista		A person who practices machismo
Maiz	Ixim	Corn
Maquila		Factory
Milpa	Awän	Community or family plot with corn, beans, squash, and other plants
Misión San Lucas		San Lucas Mission
Naturalista		Natural medicine specialist
Nervios		Lit. Nerves; fig. Illness condition common among women
Padre		Lit. Father; fig. Catholic priest
Paro Nacional		National strike
Por gusto		Lit. For enjoyment; fig. For the heck of it, for kicks
Primero dios		Lit. God first; fig. God willing
Proyecto Lingüístico Quetzalteco		Quetzalteco Language Project (Spanish and K'iche' school)
Puesto de Salud		Health post (Guatemalan Ministry of Health)
Quetzales		Lit. Central American bird; fig. Guatemalan currency. At time of fieldwork, 1 USD ≈ 7.5 Q
Quetzaltenango, Xela	Xelajuj n'oj (k'iche')	Capital city of Quetzaltenango department
Responsibilización		Responsibilization

San Luqueños		People from San Lucas
Susto		Lit. Fear; fig. Illness condition common among women survivors of violence
Testimonio		Testimony
Tuk-tuk		Covered motorcycle taxi, rickshaw
Una cabeza es un mundo	Jun jolom, jun ruwachulew	One head, one world; a head is a world
Unidos		United; together
Vergüenza		Shame
Violencia intrafamiliar		Intrafamily violence

**Acronym list**

<b>Acronym</b>	<b>Meaning</b>
ATM	Automatic teller machine
CHW	Community health worker
CVS	American pharmacy and convenience store
FP	Family planning
HbA1c	Glycosylated hemoglobin; test for glucose levels in the blood over a 3-month period
HPV	Human papillomavirus
ICPD	International Conference on Population and Development
IGSS	Instituto Guatemalteco de Seguridad Social
INCAP	Institute for Nutrition of Central America and Panama
IRB	Institutional Review Board
IUD	Intrauterine device
IVF	In vitro fertilization
MD/PhD	Medical degree and doctorate degree
MOH	Ministry of Health
NGO	Non-governmental organization
NIH	National Institutes of Health (US)
RJ	Reproductive Justice
STMM	Short-term medical mission
STS	Science and Technology Studies
TBA	Traditional birth attendant
USAID	United States Agency for International Development
USD	US Dollars
UW	University of Wisconsin

## Appendix: Maps



**Map 1:** Lake Atitlán and locations mentioned in Introduction; dotted line demarcates Sololá department (copyright Google Earth; annotation by author)

### Travel distances and times from San Lucas Tolimán

Location	Distance km	Time direct drive (boat)	Time bus transport (cost)
Cerro de Oro	7.7 km	20 min	30 min (5Q)
Santiago Atitlán	14.4 km	30 min	1 hr (10Q)
Municipality and department border San Lucas Tolimán Sololá/Patulul Suchitepequez, along main road	15.1 km	30 min	1 hr (7Q)
Sololá	40.1 km	45 min (30 min +15 min bus)	2 hrs (30Q)
Tecpán	43.8 km	1 hr 20 min	3 hrs (60Q)
Quetzaltenango (Xela)	123 km	3 hrs	6 hrs (70Q)
Guatemala City	149 km	4 hrs	6 hrs (60 Q)

