

### *Abstract*

Women's reproductive health and sexuality is a gender issue that is impacted by factors of ethnicity, socioeconomic status, and culture. Each of these factors represents social negotiations of power that determine a woman's freedom of choice and movement in regards to her health and well-being. By studying women's health, especially reproductive and sexual health issues, in Guatemala I witnessed how this is true for women in Quetzaltenango.

### *Introduction*

"It is culture that marks and gives meaning to certain biological changes. It is culture that defines both health and ill health. It is culture that defines different gender roles for men and women"

-Carlyn Sargent and Caroline Brettell *Gender and Health an International Perspective*<sup>1</sup>

Many feminists argue that as a result of a patriarchal society and the expansion of western biomedicine the woman's body has globally become "medicalized". The politics of a woman's body as defined by culture are mirrored and distorted by the science of medicine and "Very quickly the subjective meanings voiced by women are replaced by a language of objectivity...within the labeling process of 'syndrome' 'symptom' and 'disease.'"<sup>2</sup> The politics of a woman's body is thus defined by the cultural and socioeconomic situation of women in a patriarchal society that has "medicalized" and objectified the female body. Guatemala, a developing nation where patriarchy still has a foothold, presents an interesting perspective on the politics of a woman's body which varies for urban and rural women.

To understand the politics of a woman's body in Guatemala, I began my research hoping to answer the following three questions: First, what are the current health conditions that women

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<sup>1</sup> Gender and Health 12

<sup>2</sup> Gender and Health 5

face in Guatemala, especially in matters of reproductive and sexual health? Second, how does this vary for Ladino and indigenous women? Finally, what effect, if any, do foreign NGO initiatives have on women and perceptions of health and sexuality? The answer to these questions is complex and varies based upon my observations and discussions with local health and health-education professionals. In order to truly understand the meaning of women's health in Guatemala would require further time and research to learn the cultural nuances that depart from my American perceptions of women's health and sexuality. The following report will first, cover the background information upon which my research was built, then, detail my methods, and finally interpret my findings.

## **Background**

As a country roughly the same size as Tennessee, Guatemala is ethnically and geographically diverse. With about 13.6 million inhabitants,<sup>3</sup> the country divides itself into several ethnic representations and languages. According to the most recent 2001 census figures, approximately 60% of the population is ladino, of mixed European and indigenous Mayan descent, with the remaining 40% represented by a range of Mayan ethnic groups that include: Kaqchikel, K'iche, Mam, and Q'eqchi.<sup>4</sup> (Despite the many groups that create the Mayan representation in Guatemala, they are most commonly referred to as *indígenas* in the local Spanish, therefore I will thus use this term to refer to this group throughout this paper). Although Spanish is now the primary spoken language in Guatemala, 40% of the population speaks one or more of the 23 indigenous languages.<sup>5</sup>

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<sup>3</sup> Guatemala Demographic Highlights

<sup>4</sup> Central America and the Caribbean; Additional sources report a more equal representation of Ladino and indígenas, 51% and 49% respectively (Bonillo, Guatemaltecos) A more concrete figure by ethnicity could not be found, but may be a consequence of ethnic switching in which rural-to-urban Mayan report Ladino ethnicity rather than Mayan origins.

<sup>5</sup> Central America and the Caribbean

Guatemala's ethnic diversity is also marked by ethnic conflict and inequality. The ladino population has maintained economic and political power for centuries, while many of the *indígenas* have lived in desperate destitution. The country still suffers the rippling effects of civil war and genocide against the Mayan populations. Despite its difficult and sometimes disturbing past, Guatemala is a beautiful country with beautiful people. The diverse landscape ranging from the hot and impossibly humid coast to the cooler, mountainous western highlands provides Guatemala rich resources and great land for to support its historically agricultural economy. The geography is very important to Guatemala; it cannot be overlooked as a vital part of its economy and history. The landscape is brutal, yet giving. It is very difficult to travel. After one five hour bus ride from Guatemala City, the capital and largest city with approximately two million inhabitants, to Quetzaltenango, this became very clear to me. The mountainous terrain lends to more rural and often remote communities. Slightly more than half of the population (50.5%) lives in rural areas, while the other half (49.5%) live in urban centers such as Guatemala City or Quetzaltenango. This creates even starker differences between the two ethnicities, since Ladinos are often more concentrated in urban areas while *indígenas* live in more rural regions of the country.

### *Why Quetzaltenango?*

Quetzaltenango, commonly called Xela after the original K'iche city name Xelaju (under ten peaks) is a beautiful city located in mountainous and volcanic region of the Western Highlands. As Guatemala's second largest city, Quetzaltenango became a migration center for rural, *indígenas*, especially K'iche *indígenas*, of the Western Highlands. As a result, the city has a unique ratio of *indígena* to ladino inhabitants. With a population of approximately 250,000,

Quetzaltenango it is estimated to be 65% indigenous and 32% ladino.<sup>6</sup> This proportion is unique in contrast to the overall country population distribution that is dominantly ladino with a somewhat smaller representation of often rural indígenas. Urban life and the relative affluence the city provides for many of Quetzaltenango's inhabitants disrupt common distinctions between the two ethnicities.<sup>7</sup> Thus, the population dynamic was fundamental for my research to assess the differences in health between ladina and indígena women.

The city also offered a crucial element to my research in that it has an exceptional presence of foreign and local NGOs due to the numerous Spanish schools in the area. Because Quetzaltenango is a comparatively tranquil and small city, North American and European travelers sojourn in Xela to learn Spanish and opt to volunteer at one of the multifarious foreign and local institutions. Primeros Pasos, a low-cost health clinic, and Nuevos Horizontes, a women's shelter for victims of domestic violence, are examples of NGOs that receive the support of foreign volunteers and foreign funds to offer singular services that cannot thrive in other regions of the country. This provided me with the opportunity to view the way in which NGOs impact women's health and sexuality in Guatemala.

### *Gender, Class, and Ethnicity – Power Relations in Guatemala*

The purpose of my research was to understand the difference between ladino and indigenous women's reproductive health and sexuality and the role of NGOs as a key player in women's health. My findings are complex and varied, yet most importantly I found that the most important negotiator in women's reproductive health and sexuality is power. Power—who has it,

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<sup>6</sup> Oral Source, Antonette Shaw Director of Primeros Pasos; Leonel Andres Valle AGREGUA

<sup>7</sup> Lindstrom 150; Carter 2002, 261; Personal observation; Oral sources

and to what degree—is the greatest influence over the state of a women’s reproductive health and sexuality in Guatemala.

Guatemala has a long history of ethnic and class stratification. Moreover, *machismo*<sup>8</sup> is an undeniable cultural factor that determines the role of women in Guatemala, often doubly disadvantaging indígena women. Evidence of a male-dominated society, in which women are undervalued, is given by the widespread occurrence of violence against women. Dr. Vivana Boj, primary doctor at Nuevos Horizontes, argues that women suffer physical, emotional and economic abuse and the value of women is often denigrated since birth. The Population Resources Bureau (PRB) reports that of a random sample of 1,000 women in Guatemala, 49% reported suffering physical abuse.<sup>9</sup> In 2006, *Prensa Libre* revealed that at least 11 thousand cases of domestic violence were reported by women in the last three years. A more recent article, published in May 2009, questioned the increasing number of women killed at home, expecting that the year 2009 would set a record number for annual domestic femicides in Guatemala. Compared to incidents of the past year, police reports from February to May 2009 showed that 57% of 265 cases of femicide occurred in the home (That is a rate of approximately 1.7 female domestic homicides per day compared to 3 per day in the U.S.; Guatemala is about a fifth of the size of the U.S. in population).<sup>10</sup> The shocking statistics demonstrate how common physical violence against women occurs, especially in the home.

Kishor & Johnson examined the effects of violence on reproductive health and found that no matter economic status, physical violence against women can result in detrimental reproductive health consequences:

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<sup>8</sup> *machismo*- The quality of being macho; manliness, male virility, or masculine pride; the display of this. (OED)

<sup>9</sup> Guatemala Demographic Highlights

<sup>10</sup> Bonillo, “La muerte acecha a mujeres en su casa,”<sup>10</sup>

“Gender-based violence, perhaps the most compelling manifestation of unequal power in sexual relationships, has a multitude of negative effects on women’s sexual and reproductive health...The damage to women’s physical and mental well-being can be greater than the immediate injury and can include depression, anxiety, gynecological problems (for example chronic pelvic pain), miscarriages, and pregnancy complications.”<sup>11</sup>

In order to appropriately examine the reproductive health and sexuality of women in Quetzaltenango, Guatemala, it is imperative to consider the role of unequal gender relationships and the impact it has on the overall well-being of women. The common occurrence of violence against women is part of this power-dynamic, as is the widespread economic disempowerment of women in this country.

Physical violence notwithstanding, many, if not most, Guatemalan women face what Dr. Viviana Boj calls economic violence. The PRB reports that only 23% of Guatemalan women from 1995-2002 have been economically active in comparison to 74% of men who have been economically active within the same years.<sup>12</sup> This does not necessarily mean that women do not work. Women may be obligated to serve alongside their husbands without pay; however a great number of women are responsible for household chores and duties.<sup>13</sup> The result is thus an economic dependence on men that generate greater male authority in the home and community. The impact of women’s economic dependence on men often leads to negative health consequences for women. Marion Carter, when examining male household authority in Guatemala found that a third of the women surveyed reported that their husbands “decided which provider they would see when they were sick,” signifying the level of subordination to men’s

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<sup>11</sup> Kishor and Johnson 195; Carter 2004, 636

<sup>12</sup> Guatemala Demographic Highlights

<sup>13</sup> Carter 2004, 636; Oral Source: Dr. Viviana Nuevos Horizontes

authority in the household. In addition she reported that since men are charged with household income, it is likely that “allocation patterns...ran contrary to the women’s and children’s interests.”<sup>14</sup> Conversely, women who reported earning an income often had greater autonomy in choosing health care providers and managing household resources.<sup>15</sup> The weak economic power of women in Guatemala is disenfranchising, since it limits choices and health care access to what the husband is willing to provide.

The consequences of the unequal power distribution in Guatemala, however, are not limited to gender. Indígenas endure significant economic disadvantage, due to ethnic and class stratification. Social stratification according to ethnicity and class has persisted since Spanish colonization generations ago, causing racism to be a modern-day issue that is undeniable. Guatemala’s most reputable and popular newspaper, *Prensa Libre*, recently conducted a survey on ethnic discrimination in Guatemala and published its findings as a controversial Sunday front-page article. It revealed that a great majority of Guatemalans still recognize racism is still a big problem and enumerated the complexities of prejudice among indígenas, ladinos and garífunas.<sup>16</sup> However, many deny exhibiting racial prejudice at the same time they deny their indigenous roots.

According to the *Prensa Libre* report on racism and stereotypes, indígenas still suffer the most racial prejudice and stereotypes. Common depictions of indígenas include: *bajitos*, *morenos*, y *gorditos* (short, dark and fat).<sup>17</sup> Additional stereotypes criticize the cultural differences and lower class status of the indígenas rather than be based on racial prejudice alone,

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<sup>14</sup> Carter 2004, 641

<sup>15</sup> Carter 2004, 644

<sup>16</sup> Bonillo, “Guatemaltecos reconocen...”; Garifunas represent a very small minority of Guatemalans who are of African descent and have a unique culture and presence on the Eastern coast of Guatemala.

<sup>17</sup> Bonillo “Guatemaltecos reconocen..”

such as the lack of personal hygiene, laziness, conformity<sup>18</sup> and manner of dress<sup>19</sup> My personal observations do not deviate far from these stereotypes, especially after witnessing educated professionals complain that indígenas were slow learners or innately ignorant and that they chose to stay poor rather than work hard for the privileges of clean water and electricity. The greatest cause of the prejudice against indígenas, however, is not the *trajes* (customary wardrobe) that the many indígenas still wear, or the darker complexion, rather it is the provincial life of most *indígenas* that leads to stereotypes of poor hygiene, laziness, and ignorance. Confined to remote regions, without access to running water and with the least public support for schooling and other government provisions, indígenas are subject to prejudice associated with penury.

Poverty affects an enormous percentage of the population. Over 57% of Guatemalans fall beneath the poverty line, and according to *Prensa Libre*, thousands are newly facing such destitution due to the economic crisis and decreased U.S. remittances.<sup>20</sup> Victims of poverty lose the economic power to seek medical attention and to live in healthy conditions. Lack of pure water, poor ventilation, and proper nutrition, the poor of Guatemala face greater risks to their overall health.<sup>21</sup> In addition, Poor women, especially poor rural women, do not have access to health facilities that offer pregnancy services. The following PRB statistics demonstrate the impact of poverty on maternal health. For example, 66% of urban women have births attended by skilled health personnel, while only 30% of rural women have the same provision. More devastating is that only 9% of the poorest women of the population have births attended by medically trained personnel.<sup>22</sup> The multiple disadvantages that most poor, rural indígenas face

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<sup>18</sup> Often indígenas are criticized for conforming to government policies, because the government has been rumored to pay for its supporters especially through bribing indígenas.

<sup>19</sup> Many indígenas, especially women, still wear the traditional Mayan dress called “traje” which identifies them regionally; Bonillo, “Los estereotipos”

<sup>20</sup> Valdez and Figueros 2

<sup>21</sup> Oral Source, Elizabeth Murphy, Antonette Shaw, and Hugo Alvarado at Primeros Pasos

<sup>22</sup> Guatemala Demographic Highlights

on a daily basis in Guatemala create an ethnic and class variation within women's reproductive health and sexuality in Guatemala. To truly understand the state of women's reproductive health and sexuality in Guatemala, one must get to the heart of the power imbalance in each situation that shapes the complex reality of women's reproductive health and sexuality in Guatemala.

## **Methods**

One of the most difficult tasks of my research was defining and understanding reproductive health and sexuality as it related to women in Guatemala, and broadening the scope of my own personal definition as a 21-year-old Latina American. To do so meant discussing this with many individuals – Guatemalan health professionals, American volunteers serving women in Quetzaltenango, and local friends and family I met along the way. With the aid of *Primeros Pasos* and *Nuevos Horizontes*, I was able to get a closer look at women's health issues for women in Quetzaltenango. Each new insight led to the question "Why?" and pushed me to look deeper. However, to truly understand this issue would take further time than merely two months, and would require a more systematic approach to the issue. However, my time in Quetzaltenango was invaluable as was the experience and knowledge I gained while studying there.

For the purposes of this paper I will break my research area of reproductive health and sexuality into the following areas (1) Fertility Control; (2) Maternal Health and Care (3) Sexual Autonomy and Health. Each will be considered within the power dynamics of gender, class and ethnicity. I will also evaluate the role of NGOs in providing services and information for women, and the influence this has over women's health and perceptions of health.

## Fertility Control

An important aspect in women's reproductive health and sexuality is the ability to control fertility. The use of modern contraceptive methods in Guatemala is exceptionally low, reported to be used by only 34% of married women 15-49 years old,<sup>23</sup> but the prevalence of such use varies significantly by ethnicity and location. For example, there is a greater use (47%) of modern contraceptive use among urban women ages 15-49 with only 26% of rural women of the same age range using modern contraceptives. A similar disparity in modern contraceptive use also exists between ladina women (43%) and indígena women (17%).<sup>24</sup> Lindstrom and Hernandez explain the differences: "Cultural and linguistic factors are the principal barriers to contraceptive use in the indigenous population, although access is also a problem in the more remote areas of the country."<sup>25</sup> My personal observations and interviews support this argument for the difference between urban and rural contraceptive use compared to ladina and indígena statistics. Location and ethnicity are important factors that explain the access to information, sexual autonomy and health care options available to women in Guatemala.

The low rate of birth control does not signify women's indifference to or rejection of fertility control in Guatemala; rather, it demonstrates the power imbalance that often leaves women without resources or without choices. The mean ideal number of children for all women ranging 20 to 34 in age was 3.3,<sup>26</sup> yet the average fertility rate is higher for rural women who have 5.2 children on average.<sup>27</sup> At least 28% of women report unmet need of family planning, 15% have unwanted pregnancies, and 17% report mistimed pregnancies. Finally, 31% of

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<sup>23</sup> Population Resource Bureau

<sup>24</sup> Lindstrom and Hernandez 146

<sup>25</sup> Lindstrom and Hernandez, 146

<sup>26</sup> PRB ideal children

<sup>27</sup> Lindstrom and Hernandez 146

currently married women have five or more children.<sup>28</sup> These numbers signify the need for more prevalent family planning access and options for women. In an interview with gynecologist Sofia Albertina Moran of Quetzaltenango, I learned that the greatest disparity between ladino women and indigenous women is not cultural, rather it is relative to location and economic situation. She and Dr. Vivana Boj agree that women in rural locations have less general education, especially about family planning.<sup>29</sup> She expressed concern over anecdotes of rural women having up to 12 or 13 children, without understanding the risks of maternal mortality. Dr. Moran considered maternal mortality to be the number one issue facing women in Guatemala; the PRB reports maternal mortality to be 211 per 100,000 live births for indígena women and 70 per 100,000 live births for non-indígena women. The overall lifetime risk of maternal death in Guatemala is 1 woman in 71, compared to industrialized countries where the overall lifetime risk of maternal death is 1 woman in 4,085.<sup>30</sup> This grave issue is often a result of the lack of resources available in rural and remote regions, especially to women facing emergency complications. For example, only 30% of rural women's births are attended by skilled health personnel, in contrast to 66% of urban women. Too many Guatemalan women, especially rural and/or indígena women are not aware of the high risk of maternal mortality or contraceptive choices that could cut the risks and the costs of having several children.<sup>31</sup> Unfortunately, Dr. Moran commented, even those women who are aware of family planning options do not have the choice to employ them.

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<sup>28</sup> Guatemala Demographic Highlights; "Further data: Total Fertility Rate, Poorest Fifth (lifetime births per woman) 7.6 Total Fertility Rate, Middle Fifth (lifetime births per woman) 5.1 Total Fertility Rate, Richest Fifth (lifetime births per woman) 2.9"

<sup>29</sup> Lindstrom and Hernandez 150-151

<sup>30</sup> Franco de Méndez

<sup>31</sup> "Here in the urban area they are more conscious of family planning and of their own economic needs and of the risks of pregnancy/birth and of diseases. They try to be aware of these things. Also in rural areas, there are some who are equally conscious and others who are not. Some women in rural areas have 12 or 13 children and without understanding the risks of pregnancy." (Dr. Sofia Moran)

While location creates differences between women in Guatemala, the cultural influence of *machismo* impacts both indígenas and ladinas. While some studies have stated that indígenas are less patriarchal than ladinos, others argue that there is more male authority in indígena homes. Dr. Moran, however, indicated that the difference was not necessarily the indígena culture, but the results of poverty that leads to an increase in *machismo*, which has been supported by various studies that exhibit a correlation between greater male authority and penury.<sup>32</sup> *Machismo* plays a significant role in women's fertility control, by economically disempowering women so that she cannot afford her own health options. In addition jealousy and domestic violence negatively affects a woman's decision-making in family planning.

Because most women are dependent upon the income of their husbands, women often must request the support of their husbands in choosing a family planning option. Many interviewees agreed that jealousy often arises when women request to use contraceptive methods, because it suggests infidelity to their partner. This was also supported by Kishor and Johnson who found that women that introduce communication about condom-use and sexuality incite arguments over partner loyalty and imply the woman's promiscuity. In addition, this can lead to violence or threats of violence that discourage women to discuss the topic. Kishor and Johnson drew direct connections between contraceptive use and domestic violence stating that:

“Unintended pregnancy, in part a consequence of non-use or inconsistent use of contraception is positively associated with domestic violence. Women in abusive relationships are much less likely to use condoms than non-abused women and are more

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<sup>32</sup> Carter (male authority)

likely to experience further abuse if they attempt to discuss condom use with their partners.”<sup>33</sup>

Furthermore, while some men may have a greater knowledge and approval of a contraceptive knowledge than might be expected,<sup>34</sup> evidence shows that couples do not always agree about the ideal number of children.<sup>35</sup> Often men favor a larger family size than women, argues Dr. Viviana Bojof Nuevos Horizontes: “She has the children that god sends her according to how many her husband wants.”

Migration, however, blurs traditional differences between urban and rural, ladina and indígena, as rural-to-urban women become more exposed to knowledge of contraception, and sometimes have a greater economic need to limit family size.<sup>36</sup> Lindstrom and Hernandez examined the change in contraceptive knowledge for migrant and non-migrant indígenas and ladinas in rural and urban regions of Guatemala. Their findings demonstrate the rate of increase is slower for rural indígena migrants who are triply disadvantaged due to overall education barriers and a less exposure to contraceptive knowledge.<sup>37</sup> Dr. Viviana of Boj contends that the rural indígena woman is most denied access to general education, because she expected to help out in the home and the cost of education is not considered worth it for a girl who is expected to marry. She adds that the government resources often do not reach indígenas, no matter the gender, in the most remote areas. According to Lindstrom and Hernandez, this lack of education coupled with cultural isolation and linguistic barriers results in difficulty in the acquisition of

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<sup>33</sup> 195

<sup>34</sup> Carter, 2002, 260

<sup>35</sup> Blanc 194-195; Carter 2002, 260; oral source: Dr. Viviana at Nuevos Horizontes

<sup>36</sup> Lindstrom and Hernandez 150

<sup>37</sup> Lindstrom and Hernandez 150

contraceptive knowledge for rural-urban indígena migrants.<sup>38</sup> For this reason, they argue that NGOs specifically target indígenas to increase family planning knowledge among these disadvantaged groups. Despite obstacles to fertility control due to *machismo* in Guatemala, NGOs have been increasing resources for women in this arena and significantly supplement the public services.

Primeros Pasos, for example, is one of the many foreign NGOs in Quetzaltenango who has an express purpose of serving the underserved. Although beginning with children's health services in the rural Palujunoj Valley, the clinic has extended its primary care facility to serve adults as well. As a result, rural indígena women of the valley are empowered by free reproductive health education and resources. Dr. Hugo Alvarado, primary physician at the clinic explains that many of the incoming patients go to the clinic for the sole purpose of contraceptives, especially favoring the three month contraceptive injection. He details that the majority of such indígena women are under the age of 23 and roughly 50% of the women are unmarried while the other 50% are married. This free and confidential resource creates greater economic freedom and reduces the risk of maternal mortality for the women of the Palujunoj Valley. While he said that it confronts some cultural objection, it is less prevalent in the Valley than in other areas of Guatemala. He says that although some women encounter mistakenly jealous husbands, the clinic works to educate about the benefits of family planning and encourages husbands to accompany their wives to the clinic. Unfortunately, many health professionals recognize the lack of women's reproductive health resources in more remote areas of the country, and are more focused in specific practices that do not always encompass women

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<sup>38</sup>Lindstrom and Hernandez 151

specific healthcare. Dr. Moran, for example, is concerned for the lack of prenatal services in rural areas and the shortage of services that can aid women in pregnancy complications.

### **Maternal Health and Care**

Prenatal services are considerably frequent among all women (84%) in Guatemala, with most women having an average of 7.9 prenatal visits.<sup>39</sup> The notable variation among ethnicity and class is often the availability and affordability of a medically-trained health care provider. Most rural and/or indígena women rely upon *comadronas*, midwives who offer prenatal care and attend births.<sup>40</sup> This relates to the previously mentioned risk of maternal mortality that Dr. Moran stated as the number one issue facing women in Guatemala. Since rural and poor women have little choice in prenatal and birthing options, they are at greater risk of maternal mortality. Common reliance upon midwives is exhibited by one survey showing that 85% of rural women had home-births with midwife and/or family assistance.<sup>41</sup>

In the case of maternal health, the *machista* culture manages to cross all class and ethnicity barriers and reach even the most remote regions. For example, men's money management and decision-making authority impact prenatal care and pregnancy in most households. Marion Carter conducted research upon men's role in maternal health, and found that husband's are indeed involved in all three periods-- pregnancy, birth, and postpartum-- of

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<sup>39</sup> Guatemalan Demographic Highlights

<sup>40</sup> Carter 2002, 262; Oral Sources: Dr. Hugo Alvarado and Dr. Sofia Moran

<sup>41</sup> Carter 2002, 262

maternal health, especially through encouraging and funding prenatal care and providing household assistance in the first few weeks after partum.<sup>42</sup> She concludes that the patriarchal system gives men a greater role to play in maternal health, in that they have greater resources to support pregnant spouses. She enumerated contributions such as appropriating funds for prenatal care, arranging maternal emergency transportation, and translation for non-Spanish speaking spouses in hospital settings.<sup>43</sup> In this way, Carter argues, the unequal gender system allows men for men to be involved in maternal health. On the other hand, violence against women works against maternal health, often causing still life birth and permanent physical and psychological damage to women of all classes.<sup>44</sup> Thus, the cultural implications of *machismo* affect all aspects of fertility control and maternal health regardless of class or ethnicity by removing deciding authority and economic power.

Quetzaltenango offered me the chance to more fully understand the way in which migration and ethnic switching influence access to health care and information concerning women's reproductive health and sexuality. Within the city, there is greater similarity between indígenas and ladinas contraceptive use due to the greater availability of resources, education and information. Furthermore, the large number of NGOs specifically serving women in the urban center is an incredible source for women throughout the department of Quetzaltenango, and for especially women who live in the city district. Such foreign and local services include but are not limited to Primeros Pasos, Nuevos Horizontes (women's shelter and free health care provider), APROFAM (the first national organization for women's reproductive health and sexuality) and AMIGAS (a foreign and local women's health initiative). In addition the population ratio of

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<sup>42</sup> Carter 2002, 266-267

<sup>43</sup> Carter 2002, 273

<sup>44</sup> Kishor and Johnson, 294

urban indígenas women skews the typical interpretation of statistics thus far, since so many indígenas belonging to this city have access to low-cost or free women's health care provided by hospitals, private practices, and supplemental NGO services. This indicates that there is not necessarily an ethnic or cultural difference between ladina and indígena women, yet based upon are economic or urban/rural characteristics. Nevertheless, all women regardless of ethnicity, class, or location are subject to the disadvantages of gender inequality by the culturally *machista* society.

### **Sexual Autonomy**

“And also as far as her sexuality, she cannot choose. When she has sexual relationships it is where the man wants when the man wants” – Dr. Viviana Boj, Nuevos Horizontes

Dr. Viviana explains that one of the primary problems facing women in Quetzaltenango and other regions of Guatemala is the increasing spread of HIV and STIs to *amas de casa*. *Amas de casa* is a term that refers to women who manage the household; it is similar in meaning to the English terms housewife or homemaker. According to the Guatemala Ministry of Health, *amas de casa* are one of the number one risk groups for contracting HIV and STIs. Quetzaltenango is among the seven departments that made up 77% of all HIV/AIDS cases in the country.<sup>45</sup> To further understand how this could be possible, I conducted more research into the characteristics of HIV in Guatemala and how imbalanced power relationships can increase the risk for women.

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<sup>45</sup> Guatemala HIV/AIDS :“77 percent of reported HIV/AIDS cases occurred in seven departments: Suchitepéquez, Guatemala, Izabal, Escuintla, Retalhuleu, San Marcos, and Quetzaltenango.”

The PRB reports that HIV affects approximately .8% of the population, which is the same percentage affected globally (.8%).<sup>46</sup> Of the percentage infected with HIV in Guatemala, the most recent statistics show that 42% are women. According to Dr. Viviana Boj, the number of women becoming infected with HIV is increasing, especially among married women. The same trend of increase in HIV incidence among women has also occurred in the United States. Gomez and Marin assert that since HIV is most easily transmitted male to female through heterosexual intercourse, with women having less negotiating power in sexual encounters, “the incidence of AIDS continues to increase more rapidly among women than men.”<sup>47</sup> Further research on HIV and gender power imbalance explains the way in which women are at a great risk for HIV and STI infection from their male partners.

Because women throughout Guatemala are economically dependent upon men, they are more vulnerable to contracting an STI or HIV; moreover, women are encouraged to be sexually ignorant and reliant upon men’s sexual knowledge and desires. Many women are aware that their partner has or will have multiple partners and understand that if a woman does not sexually satisfy her husband, he will look outside the home for sexual gratification.<sup>48</sup> This common understanding among many women, however, does not necessarily encourage sexual protection from STIs and HIV, especially since women are not often aware of such measures or that they are at risk of infection.<sup>49</sup> If a woman is conscious of the HIV/STI risk, she has a hard time negotiating condom use since communication between partners is difficult and may put her in the fire line for physical abuse and/or abandonment.

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<sup>46</sup> Guatemala HIV/AIDs

<sup>47</sup> Gomez and Marin, 355

<sup>48</sup> Blanc 199; Gomez and Marin 355; Oral Sources

<sup>49</sup> Blanc 199, oral sources

In the same way that discussing contraceptive methods raises questions about a woman's fidelity, discussing HIV and STIs has a similar effect. Blanc researched the effect of power on women's reproductive health and found that the lack open communication about sex and sexual health often results in dispute between couples: "When either men or women broach the subject with their partners especially in settings of high HIV prevalence, they risk being accused of having extramarital partners, being promiscuous, or being infected themselves."<sup>50</sup> Discussing sex, condom use, and sexual health is too often taboo between couples with less egalitarian relationships. Additional research of *machista* influences on HIV infection among women exhibited that women who know too much about sex or raise the topic of sex are "viewed as distasteful"<sup>51</sup> and promiscuous, even by their husbands.<sup>52</sup> This leads to less condom use between couples, since women fear discussing the issue. In fact, research suggests that women are more likely to participate in risky sex with their partner to avoid physical harm or abandonment. Economic dependence forces women to continue risky relationships in order to be financially secure, often discouraging women from condom-use and HIV and STI testing. Likewise, economic dependence often leads adolescent and adult women to perform sexual favors for money, increasing vulnerability to diseases.<sup>53</sup> With men negotiating sex, a woman's reputation, and her economic well-being, he has the power to damage her sexual health by removing her sexual autonomy. In cases of domestic violence, the risk is even greater: "HIV positive women were more than twice as likely to report current experience of violence and to report a greater frequency of violent events than HIV-negative women."<sup>54</sup> Kishor and Johnson

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<sup>50</sup> Blanc 193

<sup>51</sup> Gomez and Marin, 356

<sup>52</sup> Blanc 193-194

<sup>53</sup> Blanc 199

<sup>54</sup> Kishor and Johnson 295

enumerate many of the reasons that women who suffer domestic abuse may be at greater risk for STIs and HIV:

“The experience or even the threat of domestic violence tends to limit women’s ability to control when and whether to have sexual relations or to negotiate condom use. Wives of abusive men may be at higher risk of STIs because abusive men appear to be more likely to indulge in other high-risk behaviors that are positively associated with STIs, such as alcohol abuse, promiscuity, and polygamy. Finally domestic violence may also be an outcome of the disclosure of an STI to a partner.”

The role of men’s power as a dominant force over women’s sexual autonomy becomes a negative influence in her overall reproductive health and sexuality. NGOs that recognize the correlation of *machismo* and STI and HIV infection in a Quetzaltenango, a department that encompasses a large percentage of overall HIV infection in the country, are able to further combat the risks women face.

Dr. Viviana Boj at Nuevos Horizontes says that the organization is reaching beyond the women’s shelter and addressing three important women and children’s health issues. Primarily, Nuevos Horizontes is addressing HIV in Quetzaltenango by offering free and frequent testing of HIV for women, especially *amas de casa* who are at greater risk for infection. In addition, Nuevos Horizontes offers *Grupos de Base* a program for abused women who wish to overcome violence and have greater autonomy. The workshops rehabilitate these women and educate them about their essential rights, including women’s reproductive and sexual rights and health. These are important steps to improving the lives and health of women in Quetzaltenango and surrounding regions. Dr. Boj says that the program *Grupos de Base*: not only encompasses health

but self-esteem, psychological problems and women's rights, and legal aide. She says about the program:

“Here we all work together and specialize in our area but we also have our shared project of capacitating women and raising awareness of health issues that affect women. Also with the hope that women will teach their children so that in 15 or 20 years maybe the violence against women here in Guatemala will reduce by at least a small percentage; the violence here is just too common.”

Meanwhile, Primeros Pasos also has a women's health program that encourages women to discuss issues that may be controversial in the home. By reaching out to rural indígenas in the Palujunuj Valley, Primeros Pasos works to improve women's self-esteem, overall health, and civic engagement to encourage positive change throughout the community. By also having sexual education courses for adolescents of the valley, they confront cultural and economic barriers to sexual educations and encourage women's equality and open discussion about sexual issues. Although negotiating the touchy topic of puberty and sexuality within public schools was at first difficult, the clinic was able to implement a positive and reputable program in the schools that will hopefully have a rippling effect through the community.

Witnessing the progress of both organizations' efforts to mobilize women to reclaim their rights to health and autonomy was an exciting experience. I feel fortunate for the opportunity to work closely with them and attempt to understand a vey complex system. While I feel that I would need to spend much more time to fully understand the intricacies of women's reproductive health and sexuality in Guatemala, I am satisfied in what I accomplished thus far. I hope that in

the future I will have an additional chance to look deeper and to comprehend better, so that I can serve these underserved women in the most empathetic way possible.

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