Caring for Sexuality and Reproduction: Experiencing community based care and state-run health care in a Ngöbe indigenous community in Costa Rica

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This is to certify that to the best of my knowledge, the content of this thesis is my own work. This thesis has not been submitted for any degree or other purposes.

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Abstract

The Ngöbe are an indigenous group that resides in the north of Panama and the south Pacific region of Costa Rica. This thesis uses the ethnographic method to examine indigenous Ngöbe women's practices and experiences of sexual and reproductive health care in a rural community in the southern region of Costa Rica. Indigenous Ngöbe women from El Bajo seek social and medical care practices provided by the community and the state-run health care facility. In their search for well-being, health care seekers consider diverse possibilities within their kin relationships, the community resources, and the state-run health care facility. This thesis also analyses the practices of health care professionals and the subjectivities associated with their work as well as the policies and discourses impacting the state-run sexual and reproductive health care actions, which influences the process of receiving/providing care.

This thesis treats care as a practice that is informed by the logics of relationality and individuality. These logics are located in what Bourdieu terms habitus and as such are related to action and not to conscious reasoning. These logics highlight the individual's relationship to their kin, their community and the environment, as well as the individual's autonomy in relation to society and nature. These logics inform the practices of both health care professionals and Ngöbe indigenous women and, as a result, the two groups display different combinations of these logics which exist in the form of a spectrum. The actors' positionalities play a role in shaping the logics within the structure in terms of gender, ethnicity, class, geographic location, and access to biomedical knowledge. Thus, the logics of relationality and individuality are combined in multiple ways; and in the process of exercising their agency people navigate the spectrum according to their possibilities ―social, economic, etc.― based on their positionality within the structure. This thesis follows a comprehensive understanding of women's exercise of agency through resistance, the inhabiting of norms, and connection and belonging. Consequently, the main focus here is on the Ngöbe women of this community and their experiences and practices of sexual and reproductive health care.

Acknowledgements

During the time of fieldwork, and as is common for many anthropologist, I became friends with several members of the community and I was incorporated into their everyday lives. In the process I was able to understand and recognise —in an intuitive way— what it means to hold and recognise strong relations, which eventually became a strong theme of this thesis. This realisation wouldn't have been possible without the care that the participants of this study and other members of the community of El Bajo offered. I'm deeply thankful to them for trusting me with narratives of their most intimate ideas and experiences, which in many cases were hard to talk about. Even though I can't use their names here, I'm very grateful to the kinship group that took me in and even today continues to support me through this journey.

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To my nuclear family, Mó, pá y má, thank you for being that safe place I can always return to. You have raised me to understand and be thankful for all those relationships that have made my journey possible. By thanking you I hope I am also doing a good job of thanking extended family and our ancestors. I believe it is thanks to this embedded understanding of the importance of family passed on through family narratives and experience that I was able to identify the power of relationships in Ngöbe indigenous women of El Bajo. I know that the possibilities I have had in life have been the result of the care labour of several generations that have shape my understanding of what being a "strong, independent woman" means. I am now certain that my strength is in my relationships to colleagues, friends and family.

I dedicate this thesis to the memory of Martín, and the children of El Bajo who passed away and who are missed every day, and to Tobías, and all those children who thrive in El Bajo.

Acronyms

ADC	Asociación Demográfica Costarricense (Costa Rican Demographic Association)
ATAP	Asistente Técnico de Atención Primaria (Technical Assistant of Primary Care)
CCSS	Caja Costarricense del Seguro Social (National Social Security Fund)
CENDEISSS	Centro de Desarrollo Estratégico e Información en Salud y Seguridad Social (Centre for Strategic Development and Information on Health and Social Security).
EBAIS	Establecimiento Básico de Atención Primaria en Salud (Basic Establishment for Comprehensive Health Care)
FDA	Food and Drug Administration
HCF	Health Care Facility
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
HPV	Human Papillomavirus
IDB	Inter-American Development Bank
IICA	Instituto Interamericano de Ciencias Agrícolas (Interamerican Institute of Agricultural Sciences)
IMAS	Instituto Mixto de Ayuda Social (Mixed Social Assistance Institute)
INAMU	Instituto Nacional de las Mujeres (National Institute of Women)
IUD	Intrauterine Device
IVF	In Vitro Fertilisation
IVM	Invalidez, Vejez y Muerte (Disability, Old age and Death)
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex
OCIAA	Office of the Coordinator of Inter-American Affairs
PAHO	Pan American Health Organisation
PANI	Patronato Nacional de la Infancia
PHC	Primary Health Care
PPFA	Planned Parenthood Federation of America
SEM	Seguro de Enfermedad y Maternidad (Disease and Maternity Insurance)
STD	Sexually Transmitted Disease
UNICEF	United Nations Children's Fund
USA	United States of America
USAID	United States Agency for International Development
WHO	World Health Organisation

Glossary

Ngöbere

Bule	Swollen abdomen.
Kakwete	Ngöbe rite of aggregation.
K¢ teri	Ngöbe rite of reclusion.
Ngöbe(s)	Indigenous group residing in the north of Panama, south of Costa Rica.
Ni Brare	Men.
Ni merire	Women.
Sulia(s)	Preferred Ngöbe term to refer to a non-indigenous person.

Spanish

Adaptándose	Adapting.
Aguantaba	To put up with (indicative imperfect).
Amar	To love.
Biombos	Payments received by medical doctors to perform surgeries ahead of schedule in the public sector.
Bribri	Indigenous group in the South Caribbean side of Costa Rica.
Celar	A strategy to control a partners' actions. Verb form of *celos*.
Celos	Jealousy.
Chacara(s)	Woven bags.
Cochinada	Uncleanliness. Word used on objects, places and actions.
Cuidar	To care.
Cuidarse	To take care of oneself.
Disfrutar	To enjoy.

Equilibrio	Balance.
Esposa	Wife.
Esposo	Husband.
Estar antojada	To crave.
Juntarse	To come together or to join. Use to refer to de facto unions.
Machista	Sexist attitudes.
Marido	Husband. Most commonly used to refer to a man in a de facto union.
Mujer	Woman. Use to refer to a woman in a de facto union.
Parteras	Midwives.
Pulseador	Hardworking.
Querer	To love, to want or to like.
Reclamaba	Complained (indicative imperfect).
Relacionándose	Relating.
Separarse	To separate or divide. Use to refer to a partnership break-up.
Tonta	Fool.

Spanish Phrases

Lo bonito no se come	Pretty can't be eaten (you can't eat pretty).
Toda esa chiquillera	All those children.

Table of Contents

Table of Figures

List of Tables

Chapter One: Introduction

Everything is related, but above all and more importantly, relating (relacionándose), looking for the proportion, oscillating between affinities and repulsions, adapting (adaptándose), be they facts, thoughts, animals, rivers, people, etc. (Favela, 2014, p. 49).

As we walked to her plot to harvest the corn Lucina[1] talked to me about her past. She was currently in her sixties and was a very independent woman that had been providing for herself, her children, and grandchildren since an early age. Lucina valued hard work and talked about the hardships she had endured in order to feed her family. She had been a coffee picker, a maid, a door-to-door seller, and a peasant[2]. She had had several partners throughout her life. In those partnerships, she had experienced neglect and physical abuse. These experiences had influenced her decision to fend for herself and her children. Her reproductive life had also been difficult, losing four of her eight children during childbirth. As we walked home, carrying the harvested corn in large *chacaras* ―woven bags― that Lucina had made out of plastic rope, it was clear we were carrying her world. The product contained in the *chacaras*, and the *chacaras* themselves represented the labour she had been performing throughout her lifetime in order to care for her kin and for herself.

During the time I spent with Lucina, hearing stories about her life and the lives of those she cares for, I learned about the practice of weaving *chacaras*. This practice is mainly a female activity that still has relevance in women's lives in El Bajo. The modern *chacara* is made out of several materials, from natural

1 All names used in this thesis are pseudonyms ―more about the use of pseudonyms in the methodology section of this chapter. See appendix A for more information on Lucina.

2 In this thesis, I use the term peasant to refer to those who engage in agricultural labour as a form of livelihood. Peasants of El Bajo use the product of their labour mainly for their own consumption, and a small amount to exchange for other goods or currency. As peasants from other parts of the world, peasants of El Bajo also engage in wage labour when available/necessary. Even though I do not engage with the body of literature on peasantry in this thesis, I acknowledge the efforts made by theorists to understand the complexities and diversity of those who have been associated with this category (Bernstein, 2000; Escobar, 2012; McMichael, 2008; Morton, 2007).

fibres to plastic rope and cotton or acrylic yarn. They come in many different sizes to carry crops, children, cell phones or paperwork. Women use many different weaving technics, from crochet stiches to basic weaving with a homemade needle to weaving with their bare hands. Many women's stories involved the presence of *chacaras* in which children slept, crops were carried for long distances or valuables were kept. *Chacaras* are used by both men and women and in many instances, they hold the things they perceived as most important to them. One can find their income (cash currency), the insurance card, and their cell phones. A *chacara* as a metaphor is thus a net that holds a world. If the Ngöbe world is understood as a *chacara*, then it is possible to say that every thread represents the elements that make up the Ngöbe experience. Consequently, every weaving of the threads represents a point of encounter between several elements. That is to say that every knot explains part of their existence.

I conducted this research in a Ngöbe indigenous community located in an indigenous territory in the southern region of Costa Rica. This is a community of no more than 500 inhabitants that has a mixed composition of indigenous and non-indigenous people. This exploration concentrated on hearing the stories of women like Lucina and other Ngöbe indigenous women residing in El Bajo, the community where research was conducted. I believe that El Bajo was at an interesting moment in their history when I started the research. For the past three decades, El Bajo had been experiencing a steady transformation spurred on by a growing interaction with government institutions, mass media communication, the education system and the labour market. Lucina's experience was a great example of this increasing interaction that had moved her into different labour practices inside and outside of the community. These transformations had subsequently motivated intense conversations about what it means to be Ngöbe, and how this was different for men and women in the community. In these conversations loyalty to Ngöbe lifestyles and to kinship relationships were at the centre. Partnership formation was also a debated topic filled with arguments related to what men and women expected of the opposite sex. In this process men and women categorised experiences in terms of their association with Ngöbe or Sulia ―non-indigenous― experiences, and in relation to what was positive or negative according to the different perspectives. These discursive practices

were ultimately trying to define what is acceptable and beneficial for the community as a whole, albeit from different viewpoints, male or female, from different ages.

In this thesis, I concentrate on the knot that weaves together the different care practices that women perform and/or access to achieve sexual and reproductive wellbeing. These threads are formed by their actions at the community and at the Health Care Facility (from now on HCF) levels. Thus, I concentrate on a particular set of relationships between the indigenous Ngöbe of El Bajo and the Costa Rican State. The community and state-run health care centre contexts are shaped by different structures that influence the actors' habitus, which are characterised by the logics of relationality and individuality. The resulting practices reflect these logics in the form of a spectrum that sometimes is closer to relationality and sometimes to individuality.

Theoretical Framework

In this dissertation, I argue that Ngöbe indigenous women from El Bajo partake in state sponsored as well as indigenous care practices in order to experience sexual and reproductive well-being. These women access care mainly in the community, through kinship support and Ngöbe beliefs, and the HCF. These two contexts, separated by an 8km gravel road, provide different forms of care that women access according to several factors that hinder or enhance their exercise of agency. Some of the factors impacting on women's decision are their immediate needs, the available services, the sociocultural meanings attached to these services, and the economic resources available to them, among others. Additionally, women also provide care to other women in the community, particularly to those with whom they share kinship ties. In this process, social and medical care practices and beliefs interact and get articulated in different ways according to the options provided by the state-run HCF and the community's social and economic dynamics. Such interactions are influenced by discourses and policies that impact the existing socioeconomic and political inequalities.

The exploration and analysis of the sexual and reproductive care practices performed by and accessed by indigenous Ngöbe women from El Bajo are aided by scholarship produced by anthropologists,

medical anthropologists, and indigenous and feminist scholars. I bring together the anthropological work on care, and on sexuality and reproduction with the contributions of indigenous and feminist scholars. I am particularly interested in identifying the intersecting structures impacting on the life of indigenous people, particularly indigenous women. I see these scholarship efforts as equally invested in acknowledging the diversity and complexity of human communities while at the same time recognising the global forces influencing them. Nevertheless, I value the work of indigenous scholars as the most suitable to explore the experiences of the Ngöbe participants in this research. I use Bourdieu's theory of practice and particularly the concept of habitus to tie these strings together in a way that allows me to deepen my understanding of the care practices analysed here.

Alongside the notion of habitus, I highlight the logics of relationality and individuality. These two logics are at the centre of the practices and experiences of the actors in this research. They are of great relevance to the understanding of agency examined here, which I understand as the actions performed by an individual vis-à-vis his/her relationships to others (Mallett, 2003; Wardlow, 2006), whether they are power relationships or relationships of care and reciprocity (Weir, 2013). Both these logics informed the actors at the state and community levels. Therefore, the use of these logics is non-specific to a setting or a group of people. Here I follow other anthropologists who have identified both logics in a world impacted by modernity (Hirsch, 2003; Hirsch et al., 2009; LiPuma, 1998; Rebhun, 2002; Wardlow, 2006), but that still relies heavily on kinship, connections to land, and community relationships.

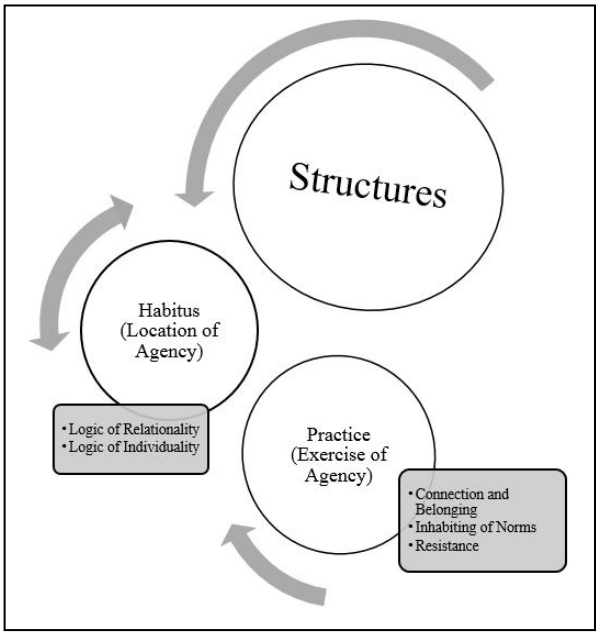
Practice and experience are also incorporated as two important elements within the work of feminist and indigenous scholars (Abu-Lughod, 2006; Cumes, 2014; Marcos, 2014; Moreton-Robinson, 2013; Welch, 2013). These two elements have been highlighted in this thesis to identify the everyday knowledge of women in relation to their sexual and reproductive well-being. Following medical anthropology scholars (Briggs & Mantini-Briggs, 2016; Menéndez, 2005; Mol, 2008), I look at care as a process in which health care seekers considered a diversity of possibilities within their kin relationships, the community resources, and the state-run HCF to attend to particular situations in their search for well-being.

Habitus and Agency: The Logics of Individuality and Relationality

In his influential book *Outline of a Theory of Practice*, Bourdieu (1977) formulated his concept of *habitus*. The habitus is a set of principles that sit between the historically informed structures and people's everyday activities. This set of principles or dispositions guide people's practice and are at the same time influence by it. Thus, the habitus nature is one of *"a practical logic rather than a conscious reasoning"* (Samuelsen & Steffen, 2004, p. 5). Furthermore, this practical logic responds to the social arrangements that have been historically constituted in their dialectical interactions with the habitus. For the purpose of this research, I identify two main logics associated with the indigenous Ngöbe women's and health care professionals' practices: relationality and individuality. Here, I follow Mol (2008) by using the term logic as one related to *"what we do"* (p. 7). Thus, logic is understood as the things we do and how they make sense even if the actors involved are not conscious of its coherence. Therefore, the logics of relationality and individuality associated with the actors from El Bajo and the state-run HCF are the elements informing the practices that will be analysed in the following chapters —see Figure One.

The individuality logic, which has been highlighted as a characteristic of modernity, emphasises an individualised self, characterised by internal attributes of autonomy and self-determination (Cordova, 2004; LiPuma, 1998; Welch, 2013). This is a logic that sees the individual as detached from the world and others. The relationality logic, strongly associated with indigenous groups all around the world, links the individual with kin, community and environment, stressing the community membership as constitutive of the self (Cumes, 2014; Favela, 2014; Marcos, 2014; Moreton-Robinson, 2013; Weir, 2017). In relationality, the individual is in constant relation

Figure One: Relationships and Interactions of the Different Theoretical Aspects



with the world and others. Thus, these logics that are embedded in the habitus of the agents described here, are dispositions driving people's actions in compliance with a set of structures. These dispositions are not rules but a set of tendencies that guide actions. Furthermore, the reproduction of the habitus allows for the introduction of variation. However, these new elements are not completely free but conditioned by the existing social organisation.

Even though the logics of relationality and individuality seem to be incompatible, in reality there is interrelation between them. These logics are representative of the different structures that make up the complex reality of the two contexts that are being analysed here. Thus, each of these logics is not exclusive of one or the other context, on the contrary they manifest in the form of a spectrum. As expressed by LiPuma,

> *"It would seem rather that persons emerge precisely from that tension between dividual and individual aspects / relations. And the terms and conditions of this tension, and thus the kind (or range) of persons that is produced, will vary historically" (1998, p. 57, emphasis in original).*

I follow LiPuma's view of these two logics, which he defines as dividual and individual and I, following Moreton-Robinson (2013) and other indigenous scholars, call relationality and individuality. Therefore, when understanding the practices and interactions at both the community and the HCF levels, I see relationality and individuality in tension with each other.

The habitus, as described by Csordas, finds its *operative locus* (2011, p. 138) in agency which is exercised through practice. In terms of the logics of individuality and relationality, Weir (2013) suggests that agency is perceived differently according to each of these logics. Weir agrees with Mahmood's criticism of the feminist understanding of agency that highlights the *"[…] desire for autonomy and the ability to resist and subvert norms"* (p. 121) as the necessary conditions for action. For Mahmood, agency can also involve the *inhabiting* of norms. Nevertheless, Weir also criticises Mahmood's approach to agency as still characterised by a model that emphasises on individuality. She points out that under this model all social norms are oppressive. Thus, a paradox emerges —the *paradox of subjectivation*—, in which agency is only achieved through the resistance or inhabiting of norms; the same norms that oppress us. Agency

within this model can only be understood through the binary of subordination and resistance, and thus, through relations of power. Weir suggests that agency can be perceived differently through a relational understanding. This indicates that individuals are subjected to a diversity of relations, and not only to relations of power. Other forms of relationship that individuals come into are those of care and reciprocity. According to this view, agency can be conceived *"[…] as a practice of connection and belonging"* (p. 128). These connections include *"[…] relations to [one]self, to [our] bodies and actions, […] to others"* (Weir, 2013, p. 134) and, I will add, to the environments in which we establish these connections. Furthermore, Weir stresses that a relational understanding of agency also benefits from the paradox of subjectivation by reminding us that *"[…] it is precisely the norms that subordinate that are also those that enable"*. Hence, the exercise of agency, is also hindered and driven by interdependence with other beings.

Considering LiPuma's (1998) understanding of the dividual/individual, relational/individual, the two forms of agency discussed by Weir (2013) are at tension. Therefore, I am neither disregarding the relations of power, nor ignoring the relations of care and reciprocity that women from El Bajo experience. Furthermore, because women[3] constantly find themselves within power structures, in their communities and outside of them, the agency they exercise in relation to connection and belonging is limited. Nevertheless, connection and belonging play an important role for Ngöbe women who find both a source of strength and an oppressive force in their identities as indigenous peasant women. These women constantly negotiate this contradiction in their everyday practice. Finally, as this ethnography shows, actors in both El Bajo and the HCF exercise agency through subordination, resistance, connection and belonging. The exercise of agency depends on the actors' positionality within and understanding of the different structures. Therefore, indigenous Ngöbe women from El Bajo, for example, were more able to exercise their agency through subordination and resistance at the HCF; in the community, they had better access to connection and belonging as well as subordination and resistance.

3 Men are also embedded in this power structure. However, their positioning in their communities and outside of them is different from women's positioning. Even though they also experience intense forms of oppression, they still enjoy privilege positions within their communities.

Inequality and Oppression: Intersectionality and *epistemic advantage*

Indigenous Ngöbe women perform their agency at the intersection of multiple structures. In their communities, they deal with particular gender and sexuality arrangements that impact on their world view and lifestyle. Additionally, they interact with the views of the Costa Rican patriarchal and heteronormative society that in some ways echo the organisation of gender and sexuality in their own communities (Mohanty, 2003). As a community, indigenous Ngöbe people also exist within a racialized and capitalist society that manifests in their own community, in nearby communities, and in the Costa Rican society as a whole. These structures of gender, sexuality, race and class assign privilege to specific identities, creating inequalities and forms of oppression (Collective, 2014; Gines, 2011; Hill Collins & Bilge, 2016; Marcos, 2014). They are the result of a long historical process which has been strongly impacted by the power of colonisation (Lugones, 2010; Marcos, 2014). At the institutional level, women in this study also interact with a particular structure that reproduces the gender, sexuality, race and class arrangements and favours biomedical knowledge production (Briggs & Mantini-Briggs, 2016; Espinosa Damián, 2014; Hill Collins & Bilge, 2016).

Feminist scholars have pointed out the importance of recognising the experiential knowledge of women from diverse backgrounds, dealing with many structural elements and exposure to multiple forms of oppression (Hill Collins & Bilge, 2016; Marcos, 2014). According to Narayan (2004), groups in marginalised conditions are considered as having an *epistemic advantage* over the dominant groups, because they are knowledgeable of their own reality and have knowledge about various aspects of the dominant groups' reality. Thus, the marginalised groups *"[…] can operate with two sets of practices and in two different contexts; [t]his advantage is thought to lead to critical insight because each framework provides a critical perspective on the other"*(p. 221). Thus, indigenous Ngöbe women's exercise of agency is informed by their understanding of both the social arrangements at the community level and at the HCF level. Latina feminists, such as Lugones and Anzaldua, among many others, have also pointed out this ability of multiplicity granted by the many different identities that women inhabit according to the contexts and circumstances in which they find themselves (Ortega, 2016). Indigenous Ngöbe experiences

demonstrate their abilities to navigate institutional and community contexts. Their understandings are based on their knowledge of these spaces and on the negotiation of their many identities as indigenous Ngöbe poor women. In their communities, Ngöbe women have a general understanding of their reality and access to abundant knowledge about their cosmology, which is provided by elder women; at the HCF these women have limited biomedical knowledge, and limited access to sources of information to enhance their knowledge.

The interactions at the HCF put Ngöbe women at a disadvantage when faced with agents in more privileged positions. Thus, even though these women are skilled at navigating the structures, they still find themselves in difficult circumstances that impact their well-being. At the community level, even though their positions as mothers, elders or leaders might allow them more agency, they are still faced with disadvantages as a result of the gender structure. For example, women are generally the primary carers of children, elders, sick or disabled members of the family, which in many ways impacts on their agency.

Within the institutional context, actors are also organised in hierarchical positions that impact on their agency. Following the anthropological literature analysing the state and its institutions (Fassin, 2015; Sharma & Gupta, 2006), this thesis looks at the state-run health care in Costa Rica through the everyday practices of health care practitioners. I am interested in understanding the health care practitioners' perceptions of both the institution they work for and the women from El Bajo seeking health care. Furthermore, I pay particular attention to the employee's subjectivities and the resulting actions (Biehl, Good, & Kleinman, 2007). The aim is to understand the state through the work of health care professionals. Here I follow Fassin (2015), who states that in order to decipher the workings of the state, it is necessary to account for both policies and the work of individuals on the ground.

Furthermore, Fassin states that it is through the analysis of institutions that it is possible to connect *"the macrosocial level of public policy and […] the microsocial level of individual practices"* (Fassin, 2015, p. 7). Following this line, the macrosocial level is composed of both the influences of bilateral and multilateral organisations, the state's discourses, rules and laws, and the claims of civil society at the national level. These aspects are analysed here in relation to the microsocial level. This level is multilayered

since it includes the subjectivities of health care practitioners in different hierarchical positions according to their access to biomedical knowledge, and the indigenous women from the bordering rural community of El Bajo.

Sexuality and Reproduction: Care and Well-being

As previously stated, a main concern of this thesis is to understand the care sought and experienced by indigenous Ngöbe women in order to achieve sexual and reproductive well-being. Anthropological studies concentrating on sexual and reproductive health have, for the most part, divided these two aspects of health care. Studies on sexuality became increasingly relevant since the 1980s, after the unfolding of the HIV/AIDS epidemic (Hirsch et al., 2009; Parker, 2009; Vance, 1991). Anthropological research on reproduction has also been prolific for the past three decades, and has been particularly impacted by the development of reproductive technologies and its effect in social dynamics (Browner & Sargent, 2011; Layne, 2014). Despite this evident division in anthropological scholarship, I have incorporated both in following Ngöbe women's care practices identified in El Bajo. I use the term sexual and reproductive health even if indigenous women from this community have only recently interacted with it. I do this with the intention of teasing out the points of interaction and degrees of articulation between the care provided at the community and kinship levels and the care provided at the state-run health care system. Nevertheless, I am well aware that the priorities at the community level and at the HCF level vary, and that sexual and reproductive well-being and care are, at times, conceptualised differently.

Indigenous Ngöbe women's sexual and reproductive practices are intimately linked, since an essential part of becoming a woman is to bear children. Their sexual and reproductive care practices are also interrelated, since they are not only associated with bodily care, but also strongly attached to caring for their kin. Here I understand sexuality as:

> *"[…] experienced —even formed— in social matrices, through organizing sets of public meaning, and within a history. Sexuality manifests not (just) as personal experience but also as a*

set of public, shared cultural beliefs about the practices and consequences of sexual behaviour" (Pigg, 2012, p. 328).

This comprehensive appreciation of sexuality involves not only the practices and discourses around sexual behaviour, but also its constitutive process and the outcomes of this behaviour. Reproduction as one of the consequences of sexuality is social and therefore historical, but it's also political (Ginsburg & Rapp, 1991), since it has an important impact in the community's understanding of what it means to be Ngöbe and what it means to be a Ngöbe woman. Women's agency in El Bajo is impacted by their sexual and reproductive lives. In this sense, care practices performed for achieving sexual and reproductive well-being are at the centre of community life and are constantly debated.

Sexual and reproductive well-being was expressed in a diversity of ways in the different contexts that indigenous Ngöbe women inhabit, from personal bodily sensations to the well-being of others around them. Michael Jackson (2011), in his study of the notion of well-being in Sierra Leone, emphasises the plurality of understandings around this concept. He contrasts the use of the word in developmental discourses against the idea that well-being is intersubjective. Jackson highlights three aspects of well-being,*"[a] sense of hope, […] a sense that one is able to act on the situation that is acting on you […][and] a sense of being-with-others"*(p. 184). This understanding of well-being echoes women's narratives of care seeking, in the sense that these three aspects are considered in their practice. Furthermore, Jackson's emphasis on the relational aspects of well-being is connected to care as a practice that is performed in relation to others. Whether the logic behind the practice of care leans toward individuality or relationality, as I argue here, social interaction is always necessary. Even when we practice self-care, being-with-others weighs on the decisions we make and the outcomes of that practice. Hence, I concentrate here not on well-being, but on care as a practice to achieve it.

I understand care as a series of practices that find their logic in the habitus' dispositions. These dispositions are the result of the influence of diverse structures at the community and at the HCF level. Following Mol (2008) and Menendez (2005), care can be seen as a process in which several actions take place. Care seeker and care provider undertake these actions. These two agents engage in practices that are

meant to provide a particular outcome that is perceived as warranting well-being. For both Mol and Menendez, care is mainly axiological and it is only possible to understand it through the actions constantly performed by agents. On the one hand, Menendez is particularly interested in following the health seeker's journey. The author considers this journey as especially informative due to the diversity of avenues a health seeker agent follows. In his view, it is only through this journey that we are able to identify the diversity of care practices that individuals make use of and that are available to them. Mol, on the other hand, is interested in practices of care and self-care in institutional settings. Briggs and Mantini-Briggs (2016) criticize Mol's placement of *"the clinic as the site where the 'logic of care' unfolds"* (p. 5), and suggest that Menendez's argument reinforcing the labour of lay people outside of the clinic as fundamental to care, is a more accurate characterization.

In this thesis, I follow Menendez's (2005) line of reasoning, while at the same time acknowledging the importance of the HCF as the place where a particular set of care practices are provided. The process of care followed by indigenous Ngöbe women showed that sexual and reproductive care are found in a diversity of settings and performed by a diversity of actors. Women were at the centre of this study not only as health seekers, but also as health providers. Thus, I coincide with Menendez's and Briggs and Martini Briggs' (2016) analyses of care practices as labour. In this way, I recognise the value of the work performed by lay people, such as the women participating in this study, as well as the work performed by health care professionals. This shows that the care practices that are associated with a woman's sexual and reproductive well-being dwell in the fabric of formal and informal social and economic arrangements.

The process of interaction between health care professionals and indigenous Ngöbe women is characterised by tensions visible in the care practices. Indigenous women, due to their particular positionality in terms of gender, class, and ethnicity, are able to see the many structures that inform their dispositions. They are knowledgeable of their own cosmology, and out of necessity they know about many of the values informing the health care professionals' morality, and the basic structure of the state-run health care institution. They also understand bureaucracy and its needs, even if they don't agree with it and many times decide not to deal with it. This is evident in the way they articulate existing dispositions with the

practices promoted by the state and from their recognition that their knowledge is deemed inferior and subordinated to other forms of knowledge, like the biomedical knowledge that health care professionals claim as their own. Thus, care practices as women experience them, and as health care professionals understand them are many times in tension. However, women are now able to explain many of the sexual and reproductive health care practices promoted by the state in terms of both a relational, community based logic, and an individual, biomedical driven logic.

Place, Temporality and Change

El Bajo and the HCF are at the centre of this ethnography as places inhabited by individuals with diverse worldviews and lifestyles. This exploration of women's care practices is grounded in their *emplaced*[4] experiences across generations (Casey, 1996). Thus, change is contingent on the inhabiting of places where care practices occur and on the passing of time perceived in different generations of indigenous Ngöbe women. Thus, following Casey (1996), *"[t]ime and history […] are so deeply inscribed in places as to be inseparable from them"* (p. 44). Throughout this ethnography, I move to different places incorporated in the narratives of the indigenous women. Their stories of sexual and reproductive care are always interrelated with their being in either the community, the places they have migrated to, the HCF, or the different hospitals in which they have accessed care; this aspect of place is therefore highlighted throughout this dissertation as part of women's experiences.

The indigenous Ngöbe women from El Bajo were constantly reaffirming their relation to land. Women leaders highlighted land ownership as one of the most important elements impacting their general well-being. Thus, place is not only relevant as the site containing history and experience, but is important in the sense that it is political. Place gathers things, experiences, relationships and practices. Additionally, knowledge production is only possible in place (Casey, 1996). Hence, place as a category is also political (Escobar, 2001; Harcourt & Escobar, 2005). Highlighting the importance of place in care practices is a way

4 As Casey (1996) points out, the human experience is never without a place.

of recognising women's connection to land and their strategic use of state resources to ensure the continuation of the Ngöbe experience in a place they recognise as their own.

Methodology

As it is true for most anthropological work, the initial plan for fieldwork is transformed through the process of interacting with the communities we study and the participants collaborating with our research. This dissertation has been transformed by the ideas and concerns shared by the people living in El Bajo and the ones working in the HCF. Even though the plan for fieldwork remained mostly unchanged throughout the 12 months spent in the southern region of Costa Rica, the initial research questions and topics of interest were slightly modified by the richness of the ethnographic material found and the participants own appreciations of their reality. I highlight four aspects of the methodology. First, I consider four central moments taking place during the first few months of fieldwork that shifted my interest to some of the elements that I exhibit here. Second, I talk about my positionality, in line with my interest of resorting to intersectional theory as central to understanding indigenous Ngöbe women's experiences. Third, I overview the activities undertaken in the field to gather the data. Finally, I summarise the actions taken to analyse the empirical material.

From Everyday Conversation to Drafting an Ethnography

From the moment the fieldwork started, my assumptions about El Bajo started to shift to more complex understandings of this reality. Initially, I had imagined an isolated community with a homogenous composition and limited access to state-run services. Even though there is some truth to my initial assumptions, the reality is much more complex. These encounters with the fieldsite, together with later analyses of fieldnotes and a continual reflexion on the experience of doing ethnography transformed this research and the analysis that follows. Four events/conversations have particular importance in this process of shifting from a proposed research to the tangible ethnography. Thus, recalling a Ngöbe woman community leader evaluating her culture, an indigenous woman talking about her interactions with a health

care professional, a conversation with a non-indigenous member of the community about his perception of the indigenous community, and my first experience walking to the community, became central to this project. These events/conversations offer the perspectives of the main actors involved in this ethnography: indigenous Ngöbe women, the state-run health care system and its employees, the non-indigenous population of El Bajo, and myself, the researcher. These four events/conversations took place early in the process of fieldwork and I have returned to them in several drafts of the dissertation to try to explain the reality of El Bajo and the elements that hold real importance to the Ngöbe women of this community.

Talking about 'good' culture 'bad' culture

Early into the period of fieldwork I engaged with Cora in a conversation about *'good'* culture and *'bad'* culture. This conversation was prompted by a community meeting in which female and male members debated what was appropriate Ngöbe behaviour. For Cora, some aspects of Ngöbe lifestyle were negative for women. She pointed particularly to the practice of polygyny as a negative practice that places women in a subordinate position. However, during the process of fieldwork, other women presented contrasting ideas about *'good'* culture and *'bad'* culture. Along the same lines, in community meetings, in house kitchens and throughout walks, people raised the question of what were acceptable Ngöbe *traditions*. For Ngöbes, the word *tradition* seemed to refer to a number of practices, beliefs and values that were most representative of their ethnic group's past experiences. There was also a concern for what they, both men and women, were willing to include in their daily lives as part of their ethnic heritage. In many cases, the assessment of desired *traditions* varied according to the individual's perception of the *tradition* and to what was required of them to preserve it. These practices, beliefs and values included many daily activities and ideas associated with agriculture, religion, education, gender, sexuality, and health, among others. The reflections about *tradition* became part of the discussions about being Ngöbe in the Costa Rican context. Thus, the discussions were politically charged and reflected forms of oppression and inequality that this population experienced on a daily basis.

Contesting the ATAP's point of view

During a conversation I had with Celia, a woman in her early 40s, who has been using state-run health care services since she was in her mid-teens, she told me her views on the work performed by the Primary Health Care (from now on PHC) professional visiting the community (Arturo)[5]. She talked about a conversation she had had with him in which she suggested to Arturo that if he was promoting birth control pills and injections among girls (girls who had already had a partner or that had had a child), he should also promote condom use among boys. According to her account of the story, Arturo replied by saying that providing condoms to boys would spoil them. In his view, they should wait until they got married to have sexual relations and in the mean time they should concentrate on studying. Celia said she argued against this by saying that boys and girls got desires just like anyone else and that they should have the necessary information to take care of themselves when they experience these desires in order to prevent pregnancies and STDs. To bring her point across, Celia reminded Arturo about the contradictions of his own personal life. This was a commonly used mechanism among women in the community. The close relationship between Arturo and the community allowed women to use this mechanism. He had been born and raised in El Bajo and many members of his family still lived there. This meant that even though he was a non-indigenous man, he knew the community very well and people in the community knew him.

From a self-identified white man's perspective

During the first few weeks of fieldwork I lived with a non-indigenous family while I organised the rest of my stay in an indigenous household. The several conversations I held while living with this family were very informative of the indigenous / non-indigenous (Ngöbe / Sulia) relationships in the community. One recurrent aspect of these conversations was the distinction between disorder and order. One day while looking at a forested hill in front of their house, Tomás, a self-identified white man[6] who had lived in the

5 ATAP is a Spanish acronym that stands for Technical Assistant of Primary Care.
6 By self-identifying as white, he echoed the national imaginary that claims a strong European heritage. In this way, he participates in the continuous process of concealing the diverse composition of the Costa Rican population (Townsend-Bell, 2014).

community since he was born, talked about the thickness of the natural forest in the area where indigenous people live. He pointed out that it was a disorderly area. In his view, trees should be planted in an organised fashion. He also considered that the area around the house should be cleared. The fact that he was unable to see the houses of the indigenous people from afar seemed to frustrate him. As I came to realise, for him and for other non-indigenous people in the community and in nearby communities, indigenous life is characterised by disorder. In their view, the disorder extended to other aspects of their lifestyle, like the way they kept their houses and surrounding areas, but also the way they formed and dissolved partnerships and how they raise and care for children. Through this conversation, I was able to identify a difference of worldviews, which is impacted by the logics of individuality and relationality but in different measures. Consequently, for non-indigenous people, an orderly life was characterised by a proper distinction between the individual and nature, where nature could be associated with dirt, sex, forest, etc. Under this framework, indigenous people were seen as a cohesive community that was closely intertwined with nature.

Walking in and out of El Bajo

In an attempt to gain knowledge through experience I visited El Bajo for the second time on foot. I had been there before while working for a local state institution a few years back, but could remember little about the place or the journey. El Bajo is located only eight kilometres away from the nearest town, but walking there involves a steep climb under intense heat. This initial walk a few days before officially starting the fieldwork was meant to provide an insight into women's struggles. However, the subsequent 13 months would prove, their reality was much more complex. Later on, when I talked about this first trip to El Bajo on foot, most women were unable to understand the reasons why I had subjected myself to this walk. I came to realise a few weeks into the fieldwork that indigenous (and non-indigenous for that matter) people from El Bajo, had access to some transportation options. Most of these options were private and therefore involved payments of, sometimes, large amounts of money. Nevertheless, transportation in and out of the community was an important asset that people were willing to invest in for the right reasons. What this new knowledge proved to me, was the importance of the monetary economy for the community

of El Bajo. Even though I don't emphasise the economic aspect of living in El Bajo, this knowledge placed the importance of paid labour, welfare, and other monetary transactions, such as loans or credit in sharper perspective. These aspects were important in many of the processes described, from partnership formation to hospitalised births.

These events/conversations revealed the complex composition of the community that involved the interactions between indigenous and non-indigenous people, government employees and other non-indigenous actors from other communities. This initial realization transformed the indigenous territory into an ethnically, socially and economically diverse environment. The dynamics between the individuals of this community showed inter and intra ethnic tensions that revealed a plurality of lived experiences and values. Furthermore, at times the interactions were cohesive in a way that showed the community as a whole in a harmonious environment. The regular interactions with government employees proved complex, the agents at times subordinating and sometimes resisting actions, along with practices that sought to enhance their connections and belonging. These stories form the background of this ethnography of care practices while simultaneously incorporating the elements of gender, knowledge production, class and ethnicity.

Positionality

I was born in 1982 in one of Costa Rica's third level hospitals in the capital, San Jose. My mother's narrative of my birth is filled with references to the medicalised nature of birth in Costa Rica at the time. That same year, Amelia, an indigenous Ngöbe woman that is now in her late 40s and is the mother of eight and grandmother of nine, gave birth to her first son in her home with the assistance of her mother. This fact is important to me because it shows the distance between my personal experience and the experience of the indigenous Ngöbe women I worked with. Additionally, many other facts separate us. As a single childless woman in her thirties I am an oddity to women in El Bajo. Indigenous women from this community highlighted these aspects of my experience during our interactions. Other aspects highlighted were the colour of my skin, my level of education, and my urban affiliation. All of these elements were identified by these women and recognised by me as privileges within the structure of the Costa Rican society.

I reflect on the aspects of difference and the shared experience of living in the Costa Rican society following an anthropological tradition of reflexivity among Latin American scholars (Guber, 2004; Guevara, 2004; Krotz, 2010). It is important for me to mention these aspects in this thesis for two main reasons. The first, is to highlight the fact that I don't speak for Ngöbe indigenous women, I merely recount the stories they kindly shared with me and contrast them with other experiences around the world and with a theoretical framework that, in my opinion, does justice to the complexity of their reality. The second, is to point out some of the elements that inform our understanding of each other. These elements sometimes benefited the process of gathering information and sometimes worked against it. For example, certain Ngöbe women refused to talk to me or interact with me either because they felt their Spanish was not fluent enough or they felt I was a threat to their way of living. At the same time, many other women felt at ease while narrating their stories based on the fact that I was an outsider.

A significant limitation of this research was my inability to communicate in the Ngöbe language. Even though I made a few attempts to learn it, I was unsuccessful. This prevented me from talking to some of the senior women in the community who could only speak Ngöbe and to women who for one reason or another avoided talking in Spanish. My lack of knowledge of the Ngöbe language limited the amount of information I could gather from informal conversations, as well. My language limitations allowed women from El Bajo to share with me only what they wanted to share. I had to ask what people were talking about and I had to solicit their opinions on matters that happened around the community, like the formation or termination of partnerships. In asking, however, I recovered interesting information that I have contrasted in this dissertation with the observation of practices and the information that was volunteered by some of the community women.

In spite of the restrictions posed by the language barrier, I was able to form trust relationships with many of the women. This allowed me to engage in formal and informal conversations with them about trivial and relevant topics on a daily basis. Of great relevance were conversations in which Ngöbe women, across ages and with different appreciations about what it means to be a woman and what it means to be

Ngöbe, expressed their hopes for their future and the future of their community and their kin. Many of these conversations are at the heart of the thesis.

Ethics Procedures

The nature of this research project had important ethical implications. I was not only gathering information about personal issues through interviews and observation, but I was also working on gathering information from medical files. Furthermore, the fact that the research was conducted with indigenous people and that some of the participants were underage girls added complexity to the project. As a result, the research project was subjected to two ethics application procedures. Here I will offer an overview into the administrative procedures I followed to obtain approval from the University of Sydney and the Costa Rican ethics authorities. I will also explain some additional measures I took to conduct the research in an ethical manner.

The process began when I obtained approval from the University of Sydney Human Research Ethics Committee (HREC). This application was approved on the 11th of December of 2014, Protocol number 2014/870. This process was followed by the initial contact with representatives from the state-run health care system. The contact was first established through the local clinic where I was advised about recently approved regulation on biomedical research in the country[7]. This prompted the process of a second ethics application to the Centre for Strategic Development and Information on Health and Social Security (CENDEISS for its acronym in Spanish). This application was approved on the 27th of April 2015, Protocol number R014-SABI-00070. In order to approve the research project, it was necessary to seek the support from the local director, the doctor assigned to the Health Care Facility where the research was going to take place, and one other employee who would support the researcher. All the actors were informed about the details of the research project, including the review of the medical files, and they all agreed for the research to take place. The fieldwork started in May of 2015 after the ethics review processes from all institutions were complete.

The administrative process of applying for ethics approval in Costa Rica was complex, due to the recent ratification of the law, the nature of the research, and the characteristics of the participants —indigenous women, potentially pregnant or breastfeeding, in some cases underaged and in most cases with experiences of sexual or domestic violence. In order to obtain approval, I was advised to make changes to the research project particularly with respect to underage girls' participation and the use of information from medical files. However, it was my firm belief that in order to have reliable information about the

[7] The Law of Biomedical Research Regulation #9234 that had been approved in the second trimester of 2014.

reality of the sexual and reproductive health practices sought by women in the community, I had to work with women from a broad age range and with information from many sources. My own insistence and the added administrative complexity delayed the process of fieldwork by three months to obtain all the necessary ethics approval.

The initial administrative process had little implications at the community level. Contrary to my own concerns, women at the community were neither intimidated by the consent forms nor did they attach any particular value to them. The participants would listen patiently to the verbal explanations of the informed consent and quickly sign to put the paper away. The community members in general and the participants in particular seemed to be more reassured by our constant interactions, the proximity of my residence during fieldwork, and the access to my contact information once I left the field. This demonstrated that the processes for regulating research, while serving an administrative purpose, are not sufficient to satisfy the necessary conditions to conduct ethical research. In the communities where research is conducted we, as researchers, need to find ways to establish trust with our informants and to offer them simple and viable avenues to express their concerns and dislikes about our academic labour. This is a relational process that expands beyond the completion of the research.

To establish trust in the health care facility and the community, I initiated the process of seeking consent by approaching respected public figures, like health care employees in higher administrative positions or democratically elected community leaders. At the health care facility, I held meetings with the director of the state-run health care system, Doctor Arturo Lothrop Saballos, at the county where research was going to take place. Other employees at the administrative level, such as the head of nurses, approved the project and made the necessary arrangements to allow my work in the Health Care Facility. I also had the support of the assigned doctor at the Health Care Facility, whose name won't be disclosed here to maintain his anonymity.

Employees working at the Health Care Facility and participating in this research were informed about the nature of the research and their verbal consent was requested and obtained after the director's permission was corroborated. Throughout the process of fieldwork, I received the collaboration from these employees in the form of informal conversations and formal interviews. Written consent was obtained before conducting the formal interviews and both the participants and the researcher kept a signed copy of the document.

At the community, the fieldwork started by approaching community leaders, many of whom were also participants in this research. I requested consent from two community organisations (the Development Association and the Women's Association). Both organisations discussed the risks and benefits of the research and consented as long as the research participants gave individual consent and results of the research were communicated to the community once the research was completed.

Once I had the consent from community leaders I sought the consent of individual participants. At the community, I visited the houses of participants once or twice to talk to them and to explain the characteristics of the study and what was expected of them. Instead of seeking consent right away I always left promising to come back to find out if they were still willing to participate. Women who were asked to participate and refused, expressed their refusal in subtle ways —like not being present at their houses at an agreed time— or direct ways —like explicitly expressing their refusal.

On the day of the interview, informed consents were provided in Spanish and Ngobe in writing and a verbal form, and every participant signed a copy of the consent form and retained the identical copy for their reference. In the case of underage participants, two documents were signed, an informed assent by the participant and an informed consent by the legal guardian of the participant. Information about the interview and research process was discussed with both parties. During the interviews, participants were constantly reminded of their right to refuse to participate at any time in all or some of the components of the research. After the interviews were conducted and during the rest of the fieldwork process I reminded the participants of their right to refuse further participation in the study, particularly when comments about their life story were brought up; nevertheless, none of the participants refused further participation.

Through the process of discussing and signing the informed consents, participants were advised that they were also consenting to give access of their medical files to the researcher. It was explained to them that the information was going to be used in a non-identifiable form. All of the participants consented to giving access to their medical files[8]. In some cases, I was further reassured about their full awareness of what I meant by getting access to these files when they requested me to provide them with information about their diagnoses or treatments once I gained access to their files.

As a result of the complexity of the ethics process, both administrative and on the ground, and due to the sensitive nature of the research I was concerned about women's explicit willingness to participate. Thus, I was constantly seeking cues for either consent or dissent. For this reason, I started conducting interviews only six months after I arrived in the field. During those first six months I mentioned to several women about my interest in conducting interviews with them. Some of these women refused the interviews early on, others considered the possibility and, once they had made up their minds, they continued to affirm their consent to participate. I considered their openness to talk about personal and intimate experiences and the details provided as a form of consent, in addition to their signed forms. Similarly, interviews in which women shared limited information was considered a form of dissent and therefore a cue to moderate the

[8] The informed consent of 65 people whose medical files were also reviewed was not sought because the information was gathered in a non-identifiable form with the intention to use it for statistical purposes only. However, this information was never used even if it was helpful to confirm the patterns of male and female use of the medical services and sexual and reproductive health services that women pursued.

questions. Thus, it was through paying attention to subtle cues and/or shows of trust, along with the administrative procedures already described, that I validated my approach to ethics concerns.

Ethnographic Fieldwork

The ethnographic fieldwork was divided into two main stages according to the two settings that were explored. The first stage concentrated on the community and in particular on spending time with female participants interested in narrating their stories. The second stage involved a period of everyday interactions with employees at the HCF along with the examination of a sample of medical files from the community and formal interviews with health care professionals. Both stages were guided by an ethnographic approach in which I immersed myself in the everyday activities particular to each context to gain a deeper understanding of the experiences of its members (DeWalt & DeWalt, 2011). Formal and informal conversations were prioritised in both contexts, particularly when participants sought them. I use pseudonyms to refer to the participants in this research to protect their identity. I also make vague references to the exact location of the community and the EBAIS where the study was conducted. Even though many of the people I talked to were willing to express their opinions and talk about their stories in public, I believe that their privacy should be respected.

First Stage

The first stage was developed over a period of nine months. This stage can be divided into two periods. The initial period lasted six weeks in which I resided with a non-indigenous family while I searched for an indigenous household as host. This initial period provided an insight into non-indigenous members of the community and their perceptions about El Bajo as a place, as a community and as an indigenous territory. At the time, I recorded the daily activities of non-indigenous families and became acquainted with both indigenous and non-indigenous members of the community. Once I moved into an indigenous household, I engaged in more lengthy and in-depth conversations with members of the community that eventually resulted in the recruiting of participants for the study. To get to know the community I began

every day walks to the school, where I collaborated in different activities. This allowed me to meet men and women from the community, who eventually got accustomed to seeing me regularly.

I conducted semi-structured interviews[9] with a total of sixteen indigenous women, three indigenous men, five non-indigenous women, and one non-indigenous man —see Table One. These interviews concentrated on building a time line and emphasising on important events like partnership formation, social interactions within the community, health care seeking activities, and in the case of women experiences of pregnancy and birth. The participants were selected considering: their age, the area where they lived in the community, and their willingness to participate. The intention was to have a wide range of experiences from indigenous women of different ages and belonging to different kinship groups. Even though I concentrated on indigenous Ngöbe women participants, the interviews with non-indigenous women provided valuable information about the general organisation of the community and served as a point of comparison between the experiences of Ngöbe and Sulia women. The interviews with men were conducted with the intention of getting insight about their perspectives and experiences, and they ways in which they are different from those of women. I also gathered interesting data from interviewed indigenous men and non-indigenous women about their perceptions of indigenous women's sexual and reproductive practices. Overall, the interviews conducted were a way of submerging myself into the experiences I was observing in everyday life while living in El Bajo. I also engaged in spontaneous and detailed conversations with at least three young Ngöbe women who were not formally interviewed. These women were family members of some of the participants in this research, and all three of them lived in the same sector where I stayed during the fieldwork. At least two other women were approached, but they rejected the interview based on the fact that they didn't feel comfortable talking in Spanish and they were not willing to talk in front of an interpreter.

9 See appendix B.

Table One: Community Participants' General Characteristics

Interviewee	Approximate Age	Ethnicity	Sex
Lucina	58	Indigenous	Female
Cora	53		
Adela	51		
Amelia	50		
Carmina	47		
Penelope	41		
Celia	41		
Paola	40		
Emelina	38		
Rosa	35		
Rebeca	26		
Rosibel	25		
Sara	20		
Noelia	19		
Nadia	16		
Evangelina	15		
Benjamin	25		Male
Mateo	55		
Augusto	56		
Marta	55	Non-indigenous	Female
Marisela	40		
Adina	50		
Teña	50		
Mariana	22		
Tomás	60		Male

The interviews conducted were enriched by the conversations with other men and women in the community and by the interactions with state employees at the elementary and high schools. During most of these conversations school teachers sought to instruct me on what they perceived was the Ngöbe and the dynamics of the community. Even though some of this data were misleading, it allowed me to engage in

conversations with Ngöbe indigenous people and discuss their views on different issues from politics to sports to religion and the history of their community.

Second Stage

The time spent at the HCF was short and divided into many activities. Overall I worked at the HCF from Monday to Friday for three months. The first five weeks were spent in each of the five services or tasks performed in the facility. I spent time with the receptionist, the nurse, the two PHC professionals, the pharmacist and the three pharmaceutical assistants, and the physician. During the remaining seven weeks, I worked on reviewing the medical files of the 25 participants. This information was used to corroborate dates, events and procedures narrated during the interviews. Additionally, I gathered data from 65 people from the community to identify trends in the services accessed at the HCF.

During the seven weeks after the initial period of acquaintance, I conducted semi-structured interviews[10] with health care professionals at the HCF. I also contacted health care professionals working at the hospital to get a better understanding of the experience of birth. I selected the state employees based on their participation in the delivery of sexual and reproductive health care assistance and their possibilities, in terms of time, and willingness to participate. These interviews provided a great deal of detail about the indigenous people's perceptions on accessing the services. Finally, I interviewed a few other state employees, two of them were interviewed while conducting fieldwork in the community, to understand some of the procedures in relation to sexual abuse and welfare. The professionals consulted and their institutions are condensed in Table Two.

10 The questions for these interviews were designed according to the professional's role within the health care system. They were mostly open-ended questions about their tasks, their relationships with the indigenous community and their relationships with co-workers. These interviews included follow up questions to better understand their work and views.

Table Two: State Employees Participants' General Characteristics

Professional	Institution	Sex
Receptionist (Networks)	Health Care Facility	Male
Nurse		
Pharmacy Assistant		Female
Primary Health Care Professional		Male
Physician		
Physician	Hospital	Female
Nurse		
Social Worker	Child Protection Agency	Male
Teacher	Ministry of Education	Female
Teacher		Male
Physician	County Clinic	Male
Physician	Ministry of Health	

Most of the interviewed employees were either from the county or from other rural areas in Costa Rica. Additionally, most of them had been working for several years in the county and had had many experiences working with the indigenous and non-indigenous populations of the area. Many other conversations were held with employees from these and other institutions. These informal conversations corroborated some of the general statements gathered in the formal interviews. Additionally, these conversations enriched the existing knowledge about the institutional culture in the county.

Data Analysis

I analysed the data gathered using the QSR International's (2015) Nvivo 11 software for qualitative data analysis. I used this software to create nodes or categories based on the fieldnotes. These nodes highlighted the data that were relevant for the focus of this research, sexual and reproductive health care practices. Additionally, I created nodes for data that were recorded on fieldnotes and that gave a holistic idea of what it means to live in El Bajo and to be indigenous/non-indigenous in this context —such as

economic subsistence, leisure activities, and water sources, among others. A central element in this process of coding was to get a sense of what indigenous, non-indigenous and health care employees thought of themselves and of others. For example, indigenous people's opinion of their own ethnic group was coded with two nodes: 'indigenous' and 'insider views'. Other categories included 'non-indigenous', 'institutional employees' and 'outsider views'. Furthermore, categories to analyse the shared ideas about sexuality and reproduction were also coded with particular attention to elements like 'menstruation', 'birth', 'sexual practices', 'sexual beliefs', 'partnerships', and 'jealousy', among others. These categories were very important especially in their relationship to the other categories like 'health', 'risk' and 'violence'. Through this coding, I was able to identify the participants' varying ideas about sexuality and reproduction, or about the sexuality and reproduction of those who were perceived as others.

The process of data analysis that I followed was slightly different for the interviews. First, the interviews were transcribed by an assistant[11]. Second, I undertook a process of active listening to identify details associated with tone of voice, particular silences or the interactions that the women and I established. Third, I coded the interviews using Nvivo, highlighting experiences of partnership formation and care practices associated with sexual and reproductive health such as prenatal control[12], diet and mobility during pregnancy, home birth and hospital birth, contraception, and STD screening. Even though the use of the Nvivo software proved to be useful when analysing the interviews, the most enlightening process was that of actively listening to the interviews.

Finally, after some consideration, I decided to use the data gathered from medical files only to corroborate findings based on fieldnotes and interviews. Although these data are rich and informative, it only provided a limited understanding about women's experiences. Thus, the analysis presented here concentrates on the narratives of women and the observations of their daily interactions.

11 An anthropology student. Her participation in the research was cleared with the ethics committee at the University of Sydney and the one granting approval in Costa Rica. She signed a confidentiality agreement that binds her to safeguard the identity of research participants. Research participants were information about the research assistant's participation in the research in a verbal and written form in Spanish and Ngöbe, and were given the option to consent or not to her participation.

12 Prenatal control, also referred to here as prenatal care, are monthly appointments with the doctor at the HCF in which women are examined to determine if the pregnancy is advancing as it should. Common medical practices during these appointments involve: monitoring the growth of the foetus and the heartbeat, interviewing the woman to identify discomfort or signs of early labour, scheduling blood tests, and prescribing supplements.

Thesis Outline

This dissertation is divided into a Background Chapter, three main parts consisting of two chapters each and a Concluding Chapter. Chapter Two offers a general description of the fieldsite and the everyday dynamics. I emphasise the diversity found within the community and on the complexities of interethnic relationships. The aim of this chapter is to provide some context into the everyday life in El Bajo and the struggles experienced by the population. The first part is divided into two chapters —chapters Three and Four. In part I look at the encompassing experience of partnership formation and the fluidity of sexual practices. These chapters concentrate on identifying care practices that are socially-based and that enhance women's well-being. These social care practices also impact on women's access to medical care practices.

The second part includes chapters Five and Six. These two chapters provide a general overview of the state-run health care system and the general reality of sexual and reproductive rights in Costa Rica. In Chapter Five, I concentrate on the history of the health care system in Costa Rica and its organisation today. In Chapter Six, I identify the structures organising sexual and reproductive health care practices at the institutional level. In both chapters, I refer to aspects influencing the provision of services at the local level, like moral views influencing health care professionals' subjectivities.

The last part includes two chapters, Seven and Eight. In these I concentrate on the points of articulation between the care practices at the community and the HCF level. I engage with sexual and reproductive health care practices that have become part of the experience of indigenous women of El Bajo and that have been articulated or are in the process of being articulated with their existing habitus. I pay special attention to the ways in which indigenous Ngöbe women's sexual and reproductive health care practices today echo or are in tension with the practices in the past. I point to the practice of care performed by professionals at the state level whose dispositions respond to multiple structures —religious, institutional, global, among others. While examining these care practices, I will emphasise the relational or individualistic logics they reproduced.

Chapter Nine summarises the main findings of this research. In this chapter I highlight connections between the theory I used and the empirical material I gathered. I also show some of the most important aspects impacting on women's interactions with their community and the state-run health care system. By doing this I aim to show the most important aspects shaping the sexual and reproductive health care of indigenous Ngöbe women from El Bajo. Additionally, I reflect on the limitations of this research to suggest new lines of inquiry.

Chapter Two: Background

Cora is an indigenous community leader who has been involved in community projects for more than a decade. In many of our informal conversations she was quick to mention the elements she considered most important to ensure the well-being of her community. The ownership of land was among the most important topics, along with the political role of women and the education of younger generations. Cora was also very critical of government employees and the institutions they represent. She mostly criticised their resistance to visit and get to know the community and its members, and identified this resistance as a lack of commitment and laziness. Overall, Cora was very aware of the inequalities she had to face as an indigenous woman in her community and outside. As such, she was protective of certain aspects of the Ngöbe lifestyle, even though she was aware that this lifestyle allowed men more agency than it allowed women. Nevertheless, she knew that outside the community men also experienced many of the oppressions Ngöbe women were subjected to, especially those related to ethnicity and belonging to a rural community.

Along the same lines, national and international social scientists have been pointing out for several decades Costa Rica's persistent inequalities in terms of ethnicity, gender, and geographical locations (Guevara & Bozzoli, 2002; Guevara & Vargas, 2000; Molina Jiménez, 2002; Sandoval, 2002; Townsend-Bell, 2014). In relation to the indigenous populations, Guevara and Vargas have pointed out that to tackle these disparities it is essential to consider the deficits in terms of income, health and infrastructure that these populations face. Additionally, these communities lack legal resources, and the socio and political recognition that would allow them to make autonomous choices about the form of development they would like to encourage in their territories (Guevara & Vargas, 2000). The existing inequalities are then coupled with a paternalistic approach to development that undermines the abilities and values of the indigenous population. This paternalistic approach is also intertwined with negative views about ethnic groups that are perceived as deviant in relation to an idealised Costa Rican identity, seen as ethnically white, educated, and egalitarian (Jiménez, 2005; Molina Jiménez, 2002; Sandoval, 2002; Townsend-Bell, 2014). The Costa Rican state's actions are, for the most part, directed at correcting these differences through interventions

that seek a more homogenous composition among the population. In this process, the education and health care systems play an important role along with the state's welfare programs (Guevara & Bozzoli, 2002; Townsend-Bell, 2014).

In this chapter I emphasise the meaning of belonging to place and what it entails within the Costa Rican context. Furthermore, I highlight the significance this sense of belonging has for members of El Bajo. This aspect is in direct connection to the social and familial relationships and the shared life conditions that make up the identities of its members (Hill Collins & Bilge, 2016). I distinguish between those who self-identify as Ngöbes, also referred to as indigenous, and those who self-identify as Whites, also referred to as non-indigenous or Sulias[13], and their interactions. The location of the community and its ethnic distribution becomes salient, not only in visual terms, but also in the ways that social, economic and political experiences of indigenous and non-indigenous men and women are different. I highlight some of those differences, and similarities, with the intention to provide a clear context of the experience of living in El Bajo. Following Casey (1996), I see place as a reflection of historical processes that occur at the local and national levels. Through an analysis of place, I identify some of the inequalities that are relevant for analysing the sexual and reproductive care practices that are explored in this thesis.

In the analysis of place I present a preliminary approach to the aspect of gender in El Bajo. In order to address women's struggles I go beyond the idea of gender as a social construction (Beauvoir, 1989; Connell, 1987; Scott, 1999; Weeks, 2002) to include the power structures put in place to organise social relations (Lugones, 2008; Stolke, 2004). According to Stolke, sexualized bodies and naturalized social identities are co-produced. Thus, indigenous Ngöbe women not only face the struggles associated with their ethnicity and vulnerable economic situations, but also have to deal with difficulties imposed based on their gender identity —difficulties that they find within and outside their community. A major difficulty involves balancing their ethnic identity in the face of social, economic, political and cultural transformations. In this process, women negotiate their different affiliations while at the same time supporting the changes that they

13 The preferred Ngöbe term to refer to the non-indigenous population.

consider will bring them better conditions. This process of balance and negotiation is highly debated among men and women in the community, further intensifying their struggle.

The Landscape

For more than half a century Costa Rica has been renowned for its political and economic stability (Molina Jiménez & Palmer, 1998; UNDP, 2011). As far as international evaluations go, Costa Rica has been placed in the 69th position (HDI of 0.766) among the countries with a high Human Development Index (UNDP, 2015). Nonetheless, Costa Rica's population is highly unequal and those inequalities can be perceived in geographic, ethnic, and gender terms, being the disparities in rural areas and among minorities the most severe. For example, the 2013 State of the Nation Report notes an increase of income inequality in Costa Rica, and places the country as the only one in Latin America that reports an increase in the Gini Coefficient (0,518 in 2012) during 2001 and 2011 (Estado de la Nación, 2013). In 2016, the National Household Survey reported a further increase from 0.516 in 2015 to 0.521 in 2016. The same report showed that inequalities were even more severe in the bordering areas of the North Caribbean and South Pacific regions (0.529 in 2016) (ENAHO, 2016).

The social and economic stability and the benefits that Costa Rica has enjoyed have not been equally distributed, negatively impacting women, rural populations, indigenous communities and migrant populations. The South Pacific region of Costa Rica, known as "La Zona Sur," is an example of this reality. This region has been one of the most neglected regions in the country (MIDEPLAN, 2013). The community of El Bajo is located within this region in a county that is rated in the lowest 15 percentile (MIDEPLAN, 2013). This county faces deficits in terms of education[14], infrastructure and access to health care[15]. The community experiences these and other inequalities.

14 The illiteracy is 4%, 1.6% higher than the rate for the country (INEC, 2011).
15 The health care coverage is still low, 84.3% (INEC, 2011), and the HCFs have a deficit of adequate equipment and specialised personnel.

The Road and the River

The community of El Bajo, as both members of the community and outsiders call it, is situated at the base of the Costeña mountain chain. The community has a secluded dimension based on its geographic location and the limited road infrastructure. However, it is relatively close to an important urban area of the county, only eight kilometres away. Both the community's isolated location and the poor road infrastructure can be traced back to various historical elements; one of the most relevant being the government's persistent neglect of rural areas in general and indigenous territories in particular throughout almost 200 years of independent life (Palmer & Molina Jiménez, 2004)[16]. Alongside these historical elements, the characteristics of the mountainous terrain impacts directly on the poor quality of the road. Road conditions are shaped by steep hills, closed curves and narrow stretches that are exacerbated by the slippery material used to pave it. The material is mostly crushed limestone found in nearby formations. The heavy rain, common throughout eight months of the year, not only washes the material away but also causes mudslides on the walls adjacent to the road. Therefore, the road needs constant repair that is only possible through the involvement of both the local government and members of the community.

The journey from the nearest urban area to El Bajo has four main sections. The first is a two kilometre plain stretch that runs across one of the most populated neighbourhoods of the city. The gravel road crosses through the village to then run parallel to the Corredores River for a long stretch. The second section is shorter, but it's the hardest section to navigate, either on foot or by car. This section is composed of mainly crushed limestone and has many hills and very risky curves. This section ends at an area called 'the rest' located at the highest section of the slope. Once at the top, the third section begins. Here the limestone road continues for another three to four kilometres, first with a discrete fall that levels itself off for a few meters, until it meets a couple of hills right before the first and only intersection of the journey. Further along the road on a straight line is a small village, inhabited mainly by non-indigenous people and a couple of indigenous families. Turning to the right at the intersection, the last section of the trip to El Bajo

16 Other important historical elements are the displacement of indigenous people during the conquest and colonization of the continent to mountainous areas of the, at the time, province, and the development of the banana industry in the southern region, which further contributed to the mobilization of the indigenous population into more secluded areas (Palmer & Molina Jiménez, 2004).

starts, still paved in crushed limestone, but now moving down the slope all the way until it meets the Corredores River again.

Once in El Bajo the road branches off into three more sections. The first section crosses the river to arrive at the elementary and high schools to then continue up the hill into one of the most populated hamlets of El Bajo. During the dry season, it is possible to access the area by four-wheel drive vehicles. The second branch crosses the river again, further up, to move into another section of the community that is located in the plain fields and is mainly inhabited by non-indigenous people. Another branch of the road leads to the land of a female-headed household, who identifies as non-indigenous. The road finally moves up the hill to the land of the Savedra family. This last section of the road has had very little maintenance in the past decades and is mostly used to travel on foot or by horse[17].

For most people in El Bajo, the road is a commonly used part of the landscape that is travelled both on foot and by car. The road not only connects the community with the local and global realities, it also connects many other elements in the community. It is in constant interaction with the river and with the surrounding natural landscape like trees and earth formations that impact on its effectiveness. This also means that the road needs constant repair, which creates conflict between the community and the local government as to who is responsible for providing the resources and labour to fix the problem. Thus, the many issues the community faces when they travel on this road result from the existing political and economic structures as much as they are the product of the unpredictable behaviour of the river and streams that cross it.

The river in El Bajo is as much a part of the setting as it is a part of its members' livelihood. It is seen both as a resource and as a risk. The constant flow of water provides the inhabitants of El Bajo with enough supply to meet their needs (consumption or otherwise). However, this constant availability becomes a cause of concern when the rainy season starts and the negative effects of excessive water flow on infrastructure and the population's livelihood emerges. El Bajo's river system is composed of one river and

17 These last two sections of the road are outside the limit of the Indigenous Territory, but they only have access through this road.

four streams. The Corredores River flows along a valley where most of the community's infrastructure is located. This river starts at the Costeña Mountainous Chain and ends at the Colorado River, in the plains west of the mountainous formation, about 15 kilometres away from the community. In El Bajo, four streams that also begin at the Costeña Mountainous Chain feed the Corredores River. The characteristics of this hydrographic system make the lowlands of the community vulnerable to floods during the rainy season (CNE, 2003, 2008; IFAM, n.d.). These floods have had notable negative effects on the road and housing infrastructure in the past few years. Some of the streams are particularly dangerous for pedestrians due to their unpredictability and the lack of infrastructure to cross them. In addition to the river and streams, the community has many springs that supply water for human consumption.

In El Bajo, water formations seem to be everywhere. This is a condition that is not shared with neighbouring communities where the availability of water is scarce. These communities are located in highlands and, though exempt from the risk of flooding, they have to endure the difficulties of having limited access to water. For the inhabitants of El Bajo, water is not only available, it is also abundant and of good quality. This resource has impacted on the everyday lives of people in El Bajo. Many of their daily activities are in constant interaction with different water sources. In terms of its integration with the community, the water system in El Bajo is an important element of the landscape. A walk around the community implies the crossing of the river through diverse structures, from swinging and cement bridges to wooden boards, or rocks. Water is readily available for cleaning and cooking and due to the regularity of rainfall in the region irrigation is not a common concern.

The road and the river are two essential elements for the community in terms of the resources they provide. They are also a cause of concern. The road needs constant maintenance to ensure its usefulness. The river embodies a number of risks in spite of its benefits. Thus, the road and the river are also important in symbolic terms. The road is symbolic as a link to national and international spheres. It is also perceived as necessary to ensure their subsistence and well-being, especially in relation to the changing consumption patterns. The river is symbolic in political terms, since it represents a resource that is associated with the land and the rights of indigenous people to decide over their territories. It is also symbolic in terms of the

ideas or risk/benefits that are associated with water sources. The road and the river are ultimately two ever present elements in the community and, therefore, both are places for social interactions.

Two Communities, One Territory

The relationship between indigenous and non-indigenous inhabitants of El Bajo is generally harmonious. These two groups interact on a daily basis and in some instances members of both groups have established interethnic ties of friendship. Additionally, there are at least two interethnic couples in the community that maintain good relationships with both groups. Notwithstanding, there are important differences between these two groups that point to the coexistence of two communities in the same territory. Members of both groups were conscious of these differences and made reference to them on a regular basis. For an outsider, this distinction was visible after a few continuous interactions. El Bajo illustrates the complexity of interethnic coexistence taking place in several communities of Costa Rica. These interactions were not generally violent, which is not the case in all the indigenous territories in the country. The complex relationships taking place in El Bajo are the result of a combination of factors, among them historical global processes —most importantly colonialism and neoliberalism— and a persistent national identity based on the idea of whiteness and homogeneity.

The Non-Indigenous Settlement

Along the road, the non-indigenous population or Sulias spreads all the way to the mountains, almost connecting with the Panamanian border. Their proximity to the road can deceive unfamiliar visitors who might interpret the community's composition as mainly non-indigenous. There are five distinguishable clusters of houses along the road that group several households of one or two families. Adjacent to these clusters there are several farms owned by the same non-indigenous families. This means that with the exception of one area where an indigenous family lives, the area near the road is mostly owned by non-indigenous people. Furthermore, they have easy access to the community infrastructure —the elementary and high schools, the football field and the church. Meanwhile, the indigenous population has to cut through

the land of non-indigenous people to access these community buildings and the road. This reality is a point of friction between both groups and although there have not been violent incidents, there have been events in which discomfort on both sides has surfaced.

The Indigenous Settlement

The Ngöbe population is mainly located in three sectors on the mountains that surround the small valley. Each sector is represented by particular familiar relationships that to some extent are related to the first Ngöbe settlers in the area. Each sector has at least 10 closely located households. All three sectors are located in mountainous areas with rough terrains that make both agricultural activities and mobility difficult. Land in these sectors is also distributed among several families that form one or two kin groups. Elias, a man in his 70s who has lived all his life in El Bajo heads the first sector. He has extensive knowledge of Ngöbe practices and still observes many of these practices through his diet, his religious beliefs, and his agricultural activities. He lives with his partner and is surrounded by two of his daughters, grandchildren, great-grandchildren and a couple of other close relatives. Cordelia, who represents the second kin, lives near her two daughters and runs the second sector. Her two sons only spend time in the community seasonally.

The second sector is located on the mountains south of the football field across the river. There is a core of seven houses and then three smaller clusters of three houses each to the south, the east and the west. This sector includes members of two distinct kin groups. The heads of both kin are widowed women. Inés and Leonor, the two surviving wives of a polygynous relationship, head the first kin. They are sisters and are surrounded by their daughters (six of them, three each), and some of their sons. Isabel heads the second kin. She has children both nearby and further to the east and west of her house. The last sector is the biggest and the more complex in terms of kin groups. This sector starts close to the elementary and high schools and extends all the way to the mountains. Even though it might be possible to divide this sector into two, there are kinship relationships that suggest the existence of only one. It seems more likely that the people living closer to the elementary and high schools settled there with the intention of having better

access to the road. Many of the people located in this area are related to Augusto. The sector has at least 15 houses. The houses in this area tend to be bigger and the families inhabiting them are also more numerous than in the other sectors. This sector is also followed by other clusters of houses that extend all the way to another ethnically mixed community in the same territory.

The Housing Infrastructure

Beside the differences in location, there are also differences between the structures of the houses of non-indigenous and indigenous people. As is common in rural areas in Costa Rica, the houses of the non-indigenous population have a cement base with a polished floor. The upper walls are mostly made out of wood. The preferred material for the roof is corrugated zinc steel, which is sometimes painted. In all cases but one, the houses are owner occupied. Most homeowners built their houses over a long period of time, following income fluctuations. The government's housing program provided a few of the houses of the non-indigenous population. These are similar to those provided to the indigenous population.

Previously, the indigenous population lived in wide huts built at the ground level, and made out of wood and other materials found in the surrounding areas. As recently as one or two decades back it was still common for extended family to share this type of home. However, this has changed radically, as a result of the availability of government housing projects that facilitate building materials and qualified labour to construct houses throughout the territory. The most common design used by government house projects is a wooden house built on woodpiles and with corrugated zinc steel roofs and consisting of two or three rooms. Some have a living room that is also meant to work as a kitchen. More recent designs exclude the living room but allow an open area between the rooms that is generally used as a sitting place. The kitchen and bathroom are kept outside the house on two separate sections. The indigenous people themselves build these structures since the government-funded houses don't include these structures in the design. The kitchen area is on the ground level and the roof is a continuation of the corrugated zinc steel roof. A division made with natural materials allows for the kitchen to be half enclosed. All indigenous houses use wood stoves to cook and lack refrigeration. Most houses also have a sitting area next to the

kitchen where both, members of the family and visitors, can sit to eat and/or chat. The toilets use dry handcrafted systems and are generally a few meters away from the house. There are also a few cement houses at the ground level that include a water toilet that is for the most part never used[18]. Finally, there are a few self-made houses, built on wooden piles and with corrugated zinc steel roofs. These houses are very similar to the government-funded houses, but they are generally bigger.

Lifestyle Changes

Like the road, the river and the infrastructure, El Bajo is a community in a constant process of change. These changes are the result of both internal and external forces. Among the most noticeable forces are access to health and education among other government services, and new consumption patterns motivated by increased participation of indigenous people in wage labour. Anthropologists all around the world have been reporting on this same pattern (Besnier, 2011; M. Hunter, 2010; Wardlow, 2006). Small changes like the channelling of water toward the households have also strongly impacted the lifestyle in the community. Furthermore, the availability of solar panels providing a few hours of electricity a day, have also motivated the expansion in the use of telecommunications. In a way, the access to these services has been made possible as a result of the improvement of the road that allows easier transportation of materials in and out of the community. Thus, although the road is not in the best condition, it is a central element in facilitating the interaction of the community with other contexts.

The many changes that the community has been experiencing are modifying their way of life, impacting on the worldviews of its members and their general well-being. Notwithstanding these changes, the inequalities experienced by these communities have not been resolved. Even if some of the changes described here are having positive effects in the population, there are still many shortcomings to overcome. Some of the biggest challenges are associated with basic services, like effective water systems and constant

18 Water toilets are not used mainly due to two reasons. First, even though welfare houses generally include toilets, they don't include the septic tank which requires construction materials and expertise to be build, making it difficult for most families to afford it. Second, even if most houses have access to water through an artesian water system, the flow of water is not regular which impacts in the toilets functioning.

availability of electricity. In terms of employment and access to health care, indigenous communities in general and El Bajo in particular experience difficulties. Furthermore, the indigenous territory where El Bajo is located has a larger dependent population in relation to other areas of Costa Rica —3.2 children per women in contrast to 2.3. The illiteracy rate, 7.7%, is 5.3% higher than the rate for the country. Furthermore, the average years of schooling for the territory is six years, while Costa Rica's average years of schooling is 8.7 (INEC, 2013).

Economic Transformations

A decade ago the trip to the nearest city to bring groceries and other supplies was done mostly on foot. Many people remember the strenuous walk and some talk about the particular dangers that lone women had to face. In the last decade there has been regular use of a car service that offers a return trip on Mondays and Fridays for ₡2000 (around AUD$5). This service has been one of the factors impacting on the expanded consumption patterns of people in the community, transforming their diet and everyday practices. These changes are also taking place in other Ngöbe communities of Costa Rica (D'Ambrosio & Puri, 2016). Particularly telling is the use of purchased rice[19] instead of cultivating and peeling rice for self-consumption as it used to be the norm. Other crops such as beans and corn are still produced in the community. The use of oil and salt, and the high consumption of sugar stand out as recently incorporated practices. Many of these changes have also been influenced by the increasing participation of indigenous people into the labour economy.

A few decades ago, Ngöbe men and women from El Bajo started to work consistently in tasks mainly associated with domestic services and agricultural work. An important activity is coffee picking during the harvest season that prompt many to migrate temporarily to other counties around the country to obtain wages that will support their activities throughout the year[20]. The forms of migration observed in

19 The time and labour involved in cultivating and peeling rice is another factor influencing Ngöbe indigenous people's decision to buy rice. Rice is an important product in indigenous, and Costa Ricans in general, diet and is consumed in high quantities.

20 In the southern region of Costa Rica there are two counties with a coffee tradition. Due to the lack of coffee plantations in the nearby areas and the cost of transportation in an out of the community, people from El Bajo working as coffee pickers are forced to move out of the community during the coffee season.

this context are both the product of capitalist dynamics enforced by neoliberal policies that promote forms of mass production requiring low wage labour. In the case of Costa Rica, extensive agricultural practices for the production of bananas, coffee, and palm oil are some forms of production in which the population of El Bajo has participated. There are a few exceptions to this movement pattern among indigenous Ngöbe families of El Bajo, but overall temporary labour migration is a regular practice. These labour practices provide access to currency that motivates many to consume a wide range of products, from electronic devices to construction materials - products that were not used in the past.

Interacting with the State

Alongside changes in consumption patterns and working conditions, members of the community of El Bajo also started to interact on a regular basis with public employees in search of different services. Most interactions take place in the nearest urban area which hosts many of the public and private sector offices and offers a variety of business activities. Men and women travel to this city in search of a wide range of services from cell phone plans to welfare services to health care[21]. More recently some of them have become public employees, working at the pre and primary school and high school and in other institutions in urban centres close by. The education system in particular has become an important source of income for several families in the community.

The school dynamic is not strange to the majority of the community since the school[22] was established around the 1970s. Both Ngöbes and Sulias recalled the shed where they used to have lessons for a few years before the first school building was constructed. Recently, no more than ten years ago, this school building was abandoned and a new elementary and a high school were built. These two main buildings are located a few meters east from the Corredores River. They have walking access through a

21 Chapters Five, Seven and Eight offer a comprehensive review of the health care system's reforms, the services it offers and the interactions with the community.
22 In Costa Rica elementary schools are in charge of seven years of education from pre-school to year six. High school education includes five more years before students can apply to continue their education at a university.

swinging bridge[23] that crosses the River, followed by a path parallel to it. These structures provide the community with a comfortable and safe place for education and other community activities like meetings or celebrations. Nevertheless, the rainy season still impacts on educational activities since the programs get modified according to the weather conditions[24]. In spite of the seasonal difficulties associated with school attendance, education is still an important part of the community's dynamic. Even though community leaders and teachers consider that parents and children are not placing enough emphasis on education, the conversations and interactions I had indicated the contrary[25]. However, the understanding about what it means to prioritize education varies among the population.

Both the elementary and high schools fall into the category of rural institutions, according to the organization of the Ministry of Education. The elementary school has three main teachers to assist students in seven grades. Three other teachers work part-time and support the development of the school with lessons on Ngöbe language, culture and special aid. Four out of the six teachers identify themselves as Ngöbe, and two of them live in El Bajo. The high school has a larger body of full-time teachers, five in total. The lessons are divided between the subjects of Spanish, English, Math, Science and Social Studies across five grades. The school principal runs the high school and is responsible for administrative tasks. The principal and three of the teachers are non-indigenous individuals from the neighbouring county; the other two are indigenous individuals living in El Bajo. Indigenous women run the kitchens of both the elementary and the high schools. Their work is essential to the workings of the community. As it was explained to me on more than one occasion, the only daily meal that children and adolescents get is the meal they eat at school. Additionally, school attendance is a source of income for many families, since most of the children receive a small scholarship from the government —around ₡20.000, AUD$50/month— to ensure they continue

23 The good condition of the bridge, however, is the product of recent repairs that were incited by a visit from the Minister of Women's Affairs during the Laura Chinchilla government.
24 In 2014, the river breached its banks moving dangerously close to the high school. In 2015, due to the effects of the hurricane Otto, classes were suspended for several days due to the risk of rising water in streams caused by abundant rainfall.
25 I constantly heard mother's talk about the importance of allowing their children to access education. Mothers would walk their children to school on a regular basis, to allow them to attend and make sure they were safe. Furthermore, mothers who had daughters with children would care for the grandchild in order to allow their daughters to attend school.

their education. The stipend increases as the student moves into high school and into the last years. Being at the centre of everyday life, the elementary and high schools organise the daily routines of the community.

Access to Water

The development of handcrafted water systems is an important transformation that has made an impact in the community's activities. This change was facilitated through inter-neighbourhood collaborations. Members of El Bajo have taken advantage of the many springs around the community to provide households with water for human consumption. However, the infrastructure for such water systems is precarious, doesn't have purification systems, and tends to fail regularly. Thus, the El Bajo water formations, and the infrastructure surrounding them are both a resource and a concern. Notwithstanding, the water systems used to distribute this resource in the different settlements has made housework easier, eliminating the task of fetching and transporting water. However, it has not eliminated certain practices like washing clothes or bathing by the river. Thus, the streams that flow through the mountainous formations of the community provide the different sectors with enough water for cleaning activities and entertainment. These activities are generally carried out in the company of close family. Most times going to the river is a gendered activity in the sense that groups will be formed by either men or women. However, it is also common for partners and their children to go to the river together.

In terms of food preparation, the water systems are of great importance. They provide a fairly constant access to water. However, because the system might experience a few interruptions during the week, it is still a common practice, especially among the indigenous population, to store water in several containers, generally referred to as gallons due to the size of the bottle. In the house where I lived for seven months, there were between ten and fifteen gallons of stored cooking water. There were also around three bigger containers used to clean dishes and for bathing, although people generally drank this water too. Health care authorities have been voicing their concerns about this practice on two bases. The danger of reproduction of microorganisms that threaten the health of the population, since containers are most times refilled without being thoroughly washed. Additionally, authorities are concerned about previous

substances being stored in the containers, like oil and cleaning products, and the effects they might have on the population.

Electricity and Telecommunications

Access to electricity in the form of solar panels have provided community members with enough power to charge cell phones or watch television for a few hours a day. The government's electricity company provides the solar panels at a low monthly charge. The non-indigenous population has access to constant electricity services through the cable network running along the road. However, access to the electricity service might not be an advantage when there are not enough resources to pay for the service. Access to solar panels is fairly recent, no more than five years ago, and is accompanied by the consumption of electronic devices, such as televisions and smart cell phones, and the increased access to cell phone coverage. Most households in El Bajo have regular access to television programs. The preferred programs are the news and Latin American telenovelas (soap operas). Furthermore, the increased access and use of cell phone devices is a process that is having strong effects on the population. For example, access to cell phone coverage and the use of smart cell phones is transforming the processes of partnership formation by allowing young people to communicate on a regular basis for a few months before establishing a formal relationship.

Even though many other changes could be analysed here, the ones presented above were the most salient. Some of these changes have impacted the interactions of people among their kin or neighbours that continue to produce important transformation, like the development of community organisations. Furthermore, these changes are also the result of struggles within the community and between the communities and other organisations. Although it is impossible to foresee the consequences of some of these changes, it is possible to assume that aspects of indigenous life, such as their health conditions or the use of language, might rapidly be affected. In terms of sexual and reproductive health, many of these

changes[26] have motivated heated discussions about gender, sexuality and partnership formation that will continue to impact the community.

Social Interactions

The composition of the indigenous territory where El Bajo is located is not different from other indigenous territories in the country. Most of these territories were created in 1977 when the current Indigenous Law was approved. According to the law, the Costa Rican government was responsible for initiating a process of compensation of the non-indigenous population that had settled within these territories before the law was created. However, the process of compensation has not been implemented. Thus even today, most of the Indigenous Territories have important percentages of land occupied by non-indigenous residents (Mackay & Morales Garro, 2014). At the beginning of this century, in 11 of the 23 territories, the percentage of land owned by non-indigenous families exceeded or was the same as that owned by indigenous people (Guevara & Vargas, 2000). By 2014 the ownership of the land was still an issue showing limited improvement in some territories and some setbacks in others. Consequently, the indigenous ownership of the land is still 50% or less in at least half of the now 24 territories (Gómez-Meléndez, González-Evora, García, Espinoza, & Solano, 2014)[27]. This situation is characterised by constant tensions between indigenous and non-indigenous groups that in some territories has escalated into violent events (Mackay & Morales Garro, 2014).

El Bajo is located in one of the most densely populated counties[28] of the Southern Region, with 1.025%[29] of Costa Rica's total population (INEC, 2015b). The indigenous population within this county represents only 5.2% of its people (INEC, 2011), most of whom belong to the Ngöbe indigenous group. The county has a total of three indigenous Ngöbe territories that border with Panama. El Bajo is located within one of these territories, a few kilometres away from the border toward the northeaster limit. The

26 Chapters Three, Four, Seven and Eight will concentrate in the analysis of some of these transformations.
27 Now twenty four after the restitution of China Kicha as an indigenous territory in 2001 (Mackay & Morales Garro, 2014).
28 Costa Rica's politico-administrative division includes seven provinces, which are divided into 82 counties and 484 districts. Often a division into six regions is favoured over the province division to facilitate institutional work.
29 48,307 people in 2015 (INEC, 2015b)

territory has 1,494 inhabitants of which 40.83% are Ngöbes and 59.17% are non-indigenous (INEC, 2011). The ownership of the land corresponds to 50% indigenous and 50% non-indigenous in this territory (Gómez-Meléndez et al., 2014). There are several other indigenous territories in neighbouring counties that are also Ngöbe. However, a larger proportion of the indigenous Ngöbe population lives in the northern region of Panama. In the following section I concentrate on the social interactions within the community that further exemplify indigenous Ngöbe people's exercise of agency in the face of the inequalities they experience.

Interethnic Interactions: Shared Places

The geographic and social separation between the indigenous and non-indigenous communities limits the frequency of their interactions. Although house visits occur, they only account for a small amount of interethnic interactions. Therefore, activities around education, political organization, entertainment, and religious events are central to these mixed interactions. The shared infrastructure, like the elementary and high schools, becomes the place where both communities meet. These exchanges, characterised by group segregation and formal interactions, are further proof of the community's fragmentation.

A significant place of interaction is the football field that stands between the road and the river, a short walk to the North from the old school. The football field is a meeting place for many in the community. Both men and women use the field during weekly football matches where both indigenous and non-indigenous play, usually forming ethnically specific teams. Men organise games twice a week, while women play less regularly. The field is also the scenario for Sporting Events where the community's football teams compete against teams from other communities around the area. These events are of great importance to the indigenous community; they are mostly organised by indigenous community leaders to generate funds for different projects. The events are also a place for social interactions mainly around entertainment but also related to courtship and conflict resolution. Some of the main activities, besides the football matches, are the consumption of alcohol, and the interactions with members of other Ngöbe and Sulia communities around the area. These events are also a good platform for the study of gender relations,

since they are attended by many in the community, from a wide range of ages, forming many relationships, and displaying a wide variety of gender performances. Furthermore, during these events conflicts arise in more violent ways when alcohol is involved. Observed tensions at sporting events sometimes escalated based on collective memory around interethnic fights, use of weapons, and the consequences of physical injuries suffered by members of both communities.

Religious activities, of different creeds, are an important aspect of the community's everyday life and are mostly developed in shared buildings. The cemetery, as an official setting, is a common place for everyone in the community. Both indigenous and non-indigenous families have loved ones that have been buried there. The religious practices involved in the burials vary greatly, but this is still a shared place where both groups accompany each other in the rituals. In terms of places of worship there are two recognized churches: the Catholic Church and the Evangelic Church. The Catholic Church's building is rarely frequented since mass services are scarce and in many cases only held in the neighbouring community's Church, where both indigenous and non-indigenous population participate. The Evangelic Church is located near the high school and holds gatherings twice a week. Participants are also a mixed group of people with a majority of indigenous members. In addition to these churches, the indigenous community holds religious celebrations that are only open to indigenous people, some of the participants also attend catholic and evangelic services. These activities are of a religious/healing character and have their roots in the Mama Chi religious cult that developed in the 1960s among the Ngöbes living in Panama (Young, 1971). These activities are performed during many hours of the night and are performed every two to three months, particularly in two private houses belonging to two of the most prominent religious leaders of the community.

A quick look at the geographic distribution of the population within the territory provides evidence of the population's fragmentation. Even though these two populations endure similar inequalities based on some shared conditions, the conditions of the indigenous population are more severe. These conditions are mostly related to ethnic discrimination that has forced the indigenous community to inhabit the most sequestered areas of the community and has impacted on their land ownership. Furthermore, these

conditions are also associated with the inequalities in terms of class that affect both indigenous and non-indigenous members of the community. In relation to gender Nögbe women find in El Bajo the central locus for the experience of inequality that later in life expands in terms of its location and intensity.

Political Activity and Women's Participation

The most basic political organization within the Costa Rican government is the Development Association. The Association leadership is determined by popular vote and they are in charge of mobilizing people toward social, economic and political activities that enhance the community's development. These associations are branched out into committees or smaller associations, like the Women's Association or the Sports Committee, that manage and develop projects related to different interests; from sports and entertainment, to water systems, education and agricultural projects. These organizations in many cases are also in charge of conflict resolution and they generally administer governmental resources to develop small projects. They are also the basic units making claims to the local government for the development of infrastructure, and the improvement of existing structures. The members of the community are grouped in two different Associations, one formed by indigenous people, and the other formed by non-indigenous people of El Bajo and the neighbouring community. Meetings are held separately, with limited participation of one or two representatives from the other group. Most of the indigenous organizations' meetings are held at the school. The non-indigenous organizations utilize the buildings in the neighbouring community or private structures owned by its members. Because of the community's mixed composition, the actions developed by either association impact on the wellbeing of both groups and ultimately require the participation of members of both organisations.

Political participation among the members of the community of El Bajo was fairly common. Both indigenous and non-indigenous members got involved in activities directed at improving the well-being of the community. Through different organisations and in regular conversations the inhabitants of El Bajo laid out their views about the right way to approach the issues that, in their opinion, needed to be resolved. In the process, indigenous and non-indigenous people exposed their ideas about each other and about the

performance of different community leaders within and outside their own ethnic groups. Nevertheless, these interactions are not conflict free. Members of the community assessed those members of the community who were involved in the associations in terms of their gender and their ethnic and class identities. They were also ranked according to their achievements or lack thereof. Given that El Bajo is part of an indigenous territory and that indigenous leaders are, for the most part, in charge of the organisation of the community, the non-indigenous parties are more inclined to criticise the decision-making process, and the length of time invested in each project. A common complaint expressed by non-indigenous community leaders was the indigenous leaders' incapacity to exercise enough pressure before the local government. In their opinion indigenous leaders needed to be more vigorous and systematic in their approach to develop projects that were most urgent, particularly those related to infrastructure, which impact on the non-indigenous community's livelihood.

Noticeably, indigenous Ngöbe women were politically active in many community organisations, while non-indigenous women avoided participation. Thus, indigenous women exercised a more complex political agency —which I will argue was based on connection and belonging— than non-indigenous women, who claim to lack the necessary knowledge and courage to get involved. Most organisations within the indigenous community had at least one or two female members. Almost half of the members of the Indigenous Development Association were women. Additionally, one of the strongest organisation in the community is the Women's Association which has strong links to several governmental institutions, among them the National Institutive for Women, the Ministry of Cattle Raising and Agriculture, the Ministry of Health, and the National Institute of Learning. Even though the leader of this association was constantly complaining about women's lack of interest and limited participation, its members continued to gather for meetings and, even though slowly, performed many tasks to develop different projects. Women's active engagement with political activity was also characterised by internal and external struggles. Frictions among members of kin groups or between kinships were common and many provided evidence of the different views about what it means to be a Ngöbe woman and what it means to be a community leader.

This rivalry showed profound differences in women's views about the future of the community and of the Ngöbe lifestyle.

Cora, the indigenous community leader coordinating the actions of the Women's Organisation, was emphatic about the importance of working with the women of El Bajo. Her political practice had been enhanced by the support of government organisations and by her own identity. She was outspoken about the significance that her condition as a female belonging to the indigenous Ngöbe ethnicity and her land inheritance bear. Her connection to other women in the community, through their shared experience and common struggles, and to the Ngöbe group was central to her political labour and highlighted her motivation. This was true for other women in the community, such as Rebeca, who amidst her desire to lead a life in which she could prioritise her individual goals, was clear about the importance of women's political commitment to land, kin and community.

This strong sense of belonging and connection was not present among non-indigenous women, even if they had an unconditional commitment to their families. However, this commitment didn't extend to land and community in the way indigenous women's engagement did. Non-indigenous women not only did not talk about the importance of the land they inhabited, but they were also outspoken about their willingness to leave if the government expropriated their property, and expressed their reluctance to get involved in community activities. This was observed during a community meeting in which members belonging to the all-male water committee were stepping down to allow other members from the community to take over the task of maintaining the system in good condition. After a few other men nominated themselves for the posts, the president of the committee suggested one of the women join the committee as well. There were at least four women present, half of the amount of males participating in the meeting. However, none of them agreed to getting involved. Two of them referred to their lack of writing and mathematical skills needed to take over the tasks required —for example writing letters, keeping the meeting minutes, or the balance sheets—, and lack of knowledge about plumbing —required to keep the water system in good condition and to repair any damage. The other two women refrained from coming up

with excuses for not agreeing to participate. Even though these women had legitimate reasons for not participating, it is also true that indigenous women face the same limitations.

Conclusion: Connection to Land

For indigenous Ngöbe people, the notion of *place* is deeply incorporated into not only everyday practices, but also into their sense of belonging and ultimately into their identity. Though the ways both indigenous and non-indigenous people inhabit place are similar, there are important differences given by their relation to nature and the ways in which place is associated with their indigenous identity. On the one hand, non-indigenous people understood land as a means of producing a livelihood. The organisation of the community was strongly associated with an approach that favoured economic development. As such, non-indigenous people in the community favoured living close to the road and engaging in economic activities like cattle-raising and the cultivation of products like palm tree oil as a way to respond to market demands. Even though they recognised the importance of caring for their environment, they saw a clear separation between humans and nature that was not highlighted by the indigenous population. For non-indigenous people, nature was something that needed to be managed in order for it to be productive. Thus, non-indigenous land was characterised by the elimination of forest in favour of pastured lands, palm tree oil plantations and crops planted in threshing grounds.

On the other hand, even though indigenous people were also in the process of incorporating some ideas associated with the intensive use of natural resources, they still valued a diversified agricultural practice. The land was seen as a resource that could provide them with several products necessary for their daily consumption. Furthermore, indigenous Ngöbe still considered the presence of forest areas in the community as important for their lands, their water sources and the livelihood of their communities. Women in the community were particularly concerned with the intensification of economic activities that took advantage of natural resources like wood, land and water. Furthermore, they were witness to changes in the environment that have impacted their everyday activities; for example, the disappearance of freshwater prawns as a result of the pollution in the river has impacted their diet.

The many struggles men and women face in this context are directly or indirectly linked to everyday conflicts for land and resources. These conflicts are associated with the different views that indigenous and non-indigenous people have over the use of land, and to the lack of autonomy indigenous people have over their territories. As well, the oppressive structures operating in the national and local context impact the different experiences of being socially recognised men and women in relation to ethnic background and socioeconomic status. Though women's belonging and connection to land and community is central to their exercise of agency in the political and social spheres, it is this very identity that places them in a position of oppression and inequality in the different contexts they inhabit. The experiences of belonging and connection, and oppression and inequality impact the transformations identified in their sexual and reproductive care practices. These practices respond to the continuous process of seeking well-being, and the continuous transformation of this notion.

Part I: Gender Structure, Partnerships and Sexual Practices

The debates about socio-economic transformations in El Bajo involved concerns about its effects on Ngöbe ideas and practices around sexuality and reproduction. These concerns were related to their identity and their constant exploration of what it means to be Ngöbe. As is common in other indigenous communities in Latin America, indigenous women from El Bajo placed a high value on the experience of partnership formation and the subsequent experience of reproduction. Latin American scholars have called attention to the idea of complementarity as central in the lives of indigenous communities (Loría Bolaños, 2000; Marcos, 2014; Segato, 2012). Indigenous ontologies identify strength in the notion of duality which is *"[t]he supreme cosmic organising principle"* (Favela, 2014, p. 37). However, this complementarity does not always promote equity since male / female relationships in indigenous communities operate under structures of power.

Marcos points out that indigenous activist women use the term *equilibrio* ―balance― to advocate for equitable relationships between men and women highlighting indigenous ideals of duality and complementarity. This call for equity is part of women's actions aimed at resisting the structures informing their habitus. By relying on indigenous ontologies to find balance in their relationships with men, indigenous women are exercising their agency through connection and belonging. Women in El Bajo are involved in the process of defining what it means to be a Ngöbe woman and what are the characteristics of Ngöbe lifestyle. Through this process women are attempting to reach a balance while at the same time they are becoming more aware of the inequalities to which they are subjected.

In El Bajo, debates around the current state of gender structure confronted men and women with different ideas about the way partnerships ought to be complementary in order to achieve balance. These discussions were commonly associated with the formation and dissolution of partnerships, reproductive practices, and men's and women's roles within the household. Indigenous Ngöbe women's views about the right way to achieve a state of balance were based on experiences of gender inequality in their communities. Ngöbe everyday life is characterised by a binary division of sexual differences. Lugones (2008, 2010)

considers this division a colonial imposition. Nevertheless, I follow this binary division due to its common use within the population of El Bajo and to its importance among different indigenous groups in Latin America (Favela, 2014; Marcos, 2014; Segato, 2012). Furthermore, throughout the fieldwork process there was no evidence to suggest a non-binary gender division, which means that the male / female division was already part of the habitus impacting on practices of partnership arrangements.

In El Bajo, heterosexual unions, including polygyny, were the only accepted form of partnership arrangement. Thus, it is possible to talk about a *compulsory heterosexuality* (Rich, 2002) in El Bajo, where same sex sexual relationships are not considered appropriate. The concept of *compulsory heterosexuality* was developed by Adrianne Rich in the 1980s to refer to the imposition of heterosexual practices on women. She also referred to the ways in which lesbian practices had been ignored or labelled as abnormal (Rich, 2002). In El Bajo, this is true not only for women but also for men. Nevertheless, sexual expressions were diverse and took place inside or outside of a partnership. These practices were not free from judgement, and particularly in the case of same sex practices, they were not accepted and were considered the result of Ngöbe people's interactions with Sulias[30]. Amongst gender structure articulations, sexual violence was an encompassing experience.

The gender structure that prevails in El Bajo also promotes a homosociality. Even though I acknowledge the value of more complex understandings of these terms, I mainly use homosociality to talk about the bonds established between people of the same sex (Hammarén & Johansson, 2014; Sedgwick, 2015)[31]. These divisions across gender are being transformed as women are now engaging in activities that were generally expected of men. In order to understand these changes I take advantage of Peter Wilson's concepts of *respectability* and *reputation* (as cited in Rebhun, 2002). According to Rebhun, Wilson

30 The subject of same sex was not explored in depth with non-indigenous people mainly, for two reasons. First, throughout fieldwork I concentrated on exploring aspects of sexuality and partnership formation among indigenous Ngöbe with the intention of understanding the complexities of this practice. Second, as fieldwork went on, I interacted more with indigenous people than with non-indigenous people and this resulted in my having less opportunities of identifying comments about same sex partnerships among the Sulia community. Nevertheless, based on recent elections, same sex partnerships in rural communities of Costa Rica are not accepted as a legitimate form of partnerships mainly for religious reasons. The election results of February 2018, showed a strong preference for the Restauración Nacional party ―a political party associated with Evangelical/Pentecostal beliefs and campaigning mainly through their opposition to marriage equality, among other sexual and reproductive rights. (Arguedas Ramírez, 2016)― took the lead, with overwhelming support from rural communities in the coastal provinces of Costa Rica (Alvarado Murillo, 2018).

31 It is possible to identify the discontinuity between homosociality and homosexuality analysed by Sedgwick (2015) in male-to-male relationships in El Bajo. It is also possible that the continuum that the author refers to in terms of female-to-female relationships is also present in the community. Nevertheless, such an analysis requires further research about these practices and people understandings of them.

suggested these two terms to replace the commonly used *shame* and *honour*, widely-used in Mediterranean settings (Jankowiak, Nell, & Buckmaster, 2002), which didn't seem appropriate to characterise the experiences of men and women in the Caribbean. Thus, Wilson associated respectability with female attitudes that seek to comply with the social norms in order to obtain respect from her community. Reputation was associated with male attitudes that conversely were looking for status through reproductive and drinking abilities, land ownership, and being obeyed by others, especially women. Rebhun agrees that both respectability and reputation are more appropriate concepts to analyse Latin American contexts. Nevertheless, she also agrees with feminist scholar's critical evaluation of Wilson's categories, which points out that women are also interested in their status in the community and therefore the concept of reputation is also useful to understand women's actions. Thus, I use the concepts not as gender specific, but as mechanisms used by women to negotiate and navigate the gender structure.

The processes of beginning, maintaining and ending partnerships are shaped by the gender structure at play. In this process women enact their agency and in the process practices of self-care and care performed for/by others come to life. These care practices reveal the inequalities women experience, while at the same time display the support and solidarity to which women have access. The practice of care in the context of partnership responds to both the existing dispositions and to new views about women's value within their communities and their rights as human beings. The acknowledgment of the importance of Ngöbe care practices is the product of a dialectical interaction between the recognition of women's rights ―introduced to the community by governmental institutions, mass media communication, and the process of education― and Ngöbe women's awareness of the existing relational practices that enhance women's well-being.

Processes of partnership formation and dissolution are strongly influenced by kinship relationships. This influence can be analysed from the perspective of relational autonomy, that recognises women's embeddedness in social relations (Nedelsky, 2011; Welch, 2013) while at the same time *"[…] distinguishing between supportive and oppressive relationships"* (Weir, 2013, p. 140). Here, I look at the actions performed through supportive relationships as care practices. These care practices, require an

exercise of agency based on connection and belonging. Additionally, women involved in care practices exercise agency through subordination and resistance since partnership formation and dissolution in El Bajo take place within power dynamics that result in oppressive experiences for women. Thus, the narratives included in these two chapters unveil the tensions between subordination and resistance to the gender structure, while at the same time resorting to existing bonds of kinship and gender solidarity to achieve well-being.

I use Jennifer Johnson-Hanks' (2002) concept of *vital conjunctures* to analyse women's narratives. This concept is useful because it highlights the unstipulated process of partnership formation that most women from El Bajo experience, and the subsequent impact it had on their futures. Johnson-Hanks states that this concept,

> *"[…] refers to a socially structure zone of possibility that emerges around specific periods of potential transformation in a life or lives. It is a temporary configuration of possible change, a duration of uncertainty and potential" (2002, p. 871).*

The experiences of partnership formation and dissolution have this effect of *potential transformation* for women in El Bajo. This means that once women start this process they experience a series of transformations that might have many different effects in their lives. A new partnership might be the beginning of their reproductive lives and a long relationship, or it might not. These experiences not only had a strong effect on women's lifestyles, but also demanded the exercise of agency through different mechanisms, whether they were compliance and resistance to the oppressive aspects of the gender structure, or views of connection to kinship and community. Johnson-Hanks places the vital conjunction in *"[…] the context of action"* (2002, p. 871), and in direct relationship to the habitus. For the author, the conjuncture is precisely situated in the dialectical process that takes place between habitus and practice, where the first one is nourished and the second one enacted.

In Young's (1971) ethnography, marriage among Ngöbes is described as a structured ritual in which men from two different kin groups exchange their children to form new partnerships. After men agree on the exchanges a series of activities take place to formalise the unions. Even though these types of structured

arrangements are known by many and have been practised by some, women's narratives place emphasis on the experience of forming a partnership and not its structural elements. Thus, a woman would mention, for example, how her partnership was part of an exchange arrangement between two families. However, her intention was not to point to a recurrent or well-established Ngöbe practice, but to highlight the compulsory nature of the union. In a similar way, women talk about residential practices. The Ngöbe community where Young (1971) conducted his fieldwork placed virilocality as the ideal form of residence for new couples. As well, he talked about uxorilocality and neolocality as common. In El Bajo, there is a mixture of these forms of residence being uxorilocality prominent in two of the three sectors of the community. The recurrence of uxorilocal residence becomes relevant as a care practices in which kin groups offer women protection and stability. Therefore, I follow women's narratives and only point to the structural aspects that were highlighted by them[32]. That being said, I do refer to the patterns I identify throughout the narratives to highlight those experiences that are relevant to Ngöbe women.

I chose to talk about partnership formation instead of marriage for mainly three reasons. First, in El Bajo, partnerships are fluid in the sense that many men and women have several partners throughout their lives. There are a significant amount of long established relationships in the community, but they do not account for all the diversity of experiences that are taking place. Second, even though it is possible to identify patterns in the process of partnership formation described by the participants, there is also a lot of variation; especially for subsequent partnership, the arrangements are informal, unstructured, and may not involve permanent cohabitation. Third, men and women in El Bajo didn't use the word marriage or divorce to talk about their partnership formations. They were inclined to use the verb *juntarse*, which literally means to come together or to join, or *separarse* which means to separate or divide. Women mainly use the Spanish word *marido* that although can be translated into spouse or husband, is commonly used to substitute the word *esposo* which denotes a formal marriage, through either legal or religious rituals. Men used the word

32 Young's (1971) informants were male and he was mostly interested in understanding tradition. He refers to different practices as traditional practices and is concerned about the frequency of certain unions. Therefore, even though exceptions were present in many of the experiences he observed or was informed about, he was more interested in identifying a pattern. I am more interested in the specificities of the experiences of women. Therefore, even though some generalizations are mentioned, I try to recreate the diversity of experiences to have a better idea of the different ways in which one can be a Ngöbe woman in El Bajo.

mujer, which can be translated as woman or wife, to refer to their partners in substitution for the word *esposa*. Even though researchers have talked about the use of the term marriage as a process and not just an event (Bledsoe & Pison, 1994; Parikh, 2015), I believe that the process of partnership formation in El Bajo can be better explained by avoiding this term.

In the following two chapters, I explore the gender dynamics in the Ngöbe community of El Bajo, followed by the processes associated with beginning, maintaining and ending partnerships, and the sexual practices taking place in the community. Through the analysis of these dynamic, processes and practices I have identified care practices associated with sexual and reproductive well-being. These phenomena display existing dispositions associated with the gender structure. At the same time, the current context of accelerated socio-economic transformations has an impact on women's experience of partnership formation that influences their agency in this process and creates transformations at the structural level. These types of transformation impacting on partnerships, marriage and sexual practices have been common through time and in other places around the world where values and practices are constantly being shaped by social, economic, political and religious factors (Hirsch & Wardlow, 2006; Hirsch et al., 2009; M. Hunter, 2010; Juárez, 2001; Padilla, Hirsch, Muñoz-Laboy, Sember, & Parker, 2007; Parikh, 2015; Rebhun, 2002; Wardlow, 2006).

In their narratives women acknowledge changes in their habitus that are associated with the tension between the logics of relationality and individuality. For example, they express their desire to protect their daughters from bad experiences and in the interest of doing so they allow more flexible partnership arrangements for them. In this way, the processes of partnership formation and dissolution are being influenced by the Ngöbe gender structure and new gender ideals that are the product of their own experiences and views disseminated by governmental institutions, media, and consumption patterns, among other factors. In the next two chapters I present several narratives that illustrate the experiences of Ngöbe women, the transformations that they have identified and the many ways in which they continue to influence their reality.

Chapter Three: Gender Structure and First Partnerships

At 13 years of age, Penelope, an indigenous woman, wasn't thinking about finding a partner[33]. She had started to hold conversations with boys and liked one in particular, but her imagination wasn't going further than the occasional talk. She already had her menarche and her mother was aware of that. Thus, her parents were concerned about her regular interactions with this one boy, and pressured her to choose between him and their choice of a partner. According to Penelope, Ngöbe courtship is different from other forms of courtship in Costa Rica, where a couple has a relationship for several months or even several years that stands between friendship and partnership[34]. She explained that the Ngöbe custom called for the formal establishment of a household once a couple was formed. Furthermore, a couple is formed through a first formal contact that can last a couple of months in which a boy that has shown interest, visits a girl's house and they get to know each other. Later on, the relationship escalates to a sexual relationship to then change into a partnership when the couple becomes official and moves in together. Even though sexual intercourse might start previous to cohabitation, the union is only formal once the couple starts living together and/or have a child together[35].

Due to the limited options her parents gave her, Penelope chose to form a partnership with the boy she liked. She told me he wasn't too keen to formalise a relationship so soon but he nevertheless did. Soon after they moved in together, Penelope fell pregnant with her first child. However, complications while in childbirth along with the difficulties of accessing hospital care resulted in the death of the new-born. After this experience, and due to the fact that there was no strong bond between her and her partner, she decided to end the partnership. Penelope explains that they had trouble since the beginning —he was abusive— and after the death of their child she made up her mind. Her escape was orchestrated during a political protest

33 For general information about the participants mentioned in this chapter see appendix A.
34 This form of courtship may or may not respect the Catholic requirement of virginity before marriage, but it is assumed that during this time the couple doesn't live together. However, there are no in depth studies about courtship in Costa Rica that could offer reliable information to do a systematic comparison. The five non-indigenous women interviewed in El Bajo, also displayed a variety of experiences, some of which were similar to the ones shared by Ngöbe women.
35 Many couples in the community lived together in the house of either parents and some were able to build a household of their own. The building of a household was usually something that happened some years after the couple had been together. Women were also free to reside with their parents if they wished to do so, they might then visit their partner regularly or their partner might visit them.

that indigenous groups from all over Costa Rica took to San Jose to demand their right to citizenship. She participated in the march and when she was in San Jose, she managed to convince a non-indigenous woman to help her escape her partner's watchful eye. She ran away with a Sulia man she had been communicating with through his sister. The courtship experience was, therefore, brief and mediated by a third person.

In this chapter I first look at the gender structure and the aspect of homosociality in order to further understand the practice of partnership formation and its association with the practice of care. Penelope's story is used as a good example of the underlying gender structure in the community of El Bajo. Although currently parents have less active roles in their children's partnership formation, the starting age and male and female interactions at the beginning of a partnership are fairly similar. Thus, many elements of the gender structure organising men's and women's everyday life present in Penelope's experience still remain. In this context, male / female interactions during puberty continue to be understood as processes of partnership formation. This is particularly true if we consider the importance of homosociality among indigenous people in El Bajo and its association with Ngöbe views about the proper way in which non-kinship relationships between men and women should take place.

Gender Structure

In El Bajo, the gender structure is strongly influenced by a *compulsory heterosexuality* and homosociality that organises Ngöbe social relationships and permeates their sexual experiences. This means that heterosexual relationships were the norm in terms of partnership arrangements and homosocial practices the norm in terms of social everyday interactions. As Penelope's experience shows, partnership formation is for women a process directly related with menarche and thus, with reproduction. Most of the interviewed women in El Bajo started their partnership relationships a few years after they had their first period, with the exception of three women, and in at least five of these cases; they were strongly encouraged by their parents to establish a formal partnership. The homosocial context highlighted the division of household tasks and leisure activities among people of the same sex. This organisation of everyday activities intensified the concerns around girls' casual interactions with members of the opposite sex.

Nevertheless, this same homosocial atmosphere provided the environment for same sex experiences to take place, particularly among men. Even though these experiences are part of the diverse ways in which Ngöbes express their sexual desire[36], they are not accepted as forms of partnership.

Here I consider heteronormativity and homosociality as two organising principles of the gender structure. These two principles find their relevance in the social organisation of labour and the everyday social interactions among people in the community. Even though some of the practices associated with this form of organisation are no longer central to Ngöbe people's experiences, they continue to be present both in conversations and everyday interactions.

Heteronormativity

Le Carrer's (2010) ethnography shows how the binary division of sexual difference is present in the Ngöbe language and cosmology. According to the author "…the women are *ni merire* and the men *ni brare*" (p. 50 own translation). Le Carrer further characterizes this binary division when she explains the puberty rituals that took place in Ngöbe communities until the 1930s, in the case of male rituals, and the 1980s, for female rituals. In El Bajo, there was no evidence to suggest these rituals would still be in place. However, Cora made reference to learning about some aspects of the ritual while she lived in Panama. About it she said:

> *They put them [the women] on a circle of leaves in the floor for the days of her first period. She is not allowed to go out during the day. At night and in the early morning (before the sun was up) they took her to the river and the grandmother told her about the things she had to do, how to behave […] [This process involved the pulling] of her ears and [constant reprimands]. They will tell her she has to be brave with the house work and stay with only one man […] They said it was very hard for the girls to stay in one place in the house, while menstruating […] As*

36 I explore this aspect of Ngöbe sexual practices at the end of Chapter Four.

soon as [the girl] was done [menstruating] they will make her clean the whole house to teach her to be brave (Direct quote from fieldnotes).

Neither Cora, nor her sisters ever participated in the ritual, but their mother did. During this conversation they expressed their disapproval of this practice and, while living in Panama, Cora had opposed to having her oldest daughter go through it.

Based on Le Carrer's (2010) ethnographic evidence, the puberty rite described by Cora only preserves very basic aspects of this complex ritual. The Ngöbe female puberty ritual includes three phases: rite of reclusion —*kȼ teri*—, liminality, and rite of aggregation —*kakwete*. The entire process can take up to a year, with the liminal phase being the longest one, two to 12 months. The phase of reclusion relates strongly to Cora's explanation about the rite in which the girl's relationship with the household changes radically. This phase of the ritual, which extends for four days and the morning of the fifth day, involves nightly trips to the river and the isolation within the household throughout the day out of the sight of the other members of the family. The liminal phase involves an outside-in —*dehors-dedans* (p. 272)— experience, in which the girl's every day experiences are transformed by the ritual, vis-à-vis her interactions with the family and with her own body. For the last phase of the ritual the girl is removed from the household for one to three days to a house within the vicinity and then reincorporated after a journey that moves her over through the river and around the house to end with a dance and the reincorporation of the girl to the household as a marriageable woman (Le Carrer, 2010).

In El Bajo, the Ngöbe female rite of puberty described by Le Carrer, has disappeared. All the interviewed participants and several other women talked about the lack of guidance being provided during their menarchy. However, women were perceived as entering their marriageable state soon after their menarche,[37] as Penelope's and many other partnership formation stories show. The experience of menarche narrated by women in El Bajo points to the existence of a strong silence as the substitute of the puberty ritual. This silence not only meant that women would go through this process alone and sometimes in fear,

37 This practice is in conflict with some of the aims of health care institutions.

but also that they had to figure out the right way to care for their bodies during those days of the month.

Adela offers an exception to the silence described by other women,

> *Well, when I came on with that I was scared, I said to my mom: - I came on with this!, and my mom grabbed me by the ears, she grabbed me like this: - You have to learn this, that should make you feel embarrassed when you come on with that! […] And my mother would say to me: "This doesn't just happens once," she told me, "this happens every month," she said to me, "you have to take care of yourself! she says. […] - You have to take care of yourself, by not talking to man, - she says - that when you are like this you do not say anything! But after [I turned] 12 years, a year after, […] she gave me away to a man.*

Regardless of the absence of the ritual, Adela was paired with a man close to a year after she had her menarche. This seems to correspond to the length of the rite of puberty described by Le Carrer (2010).

Carmina on the other hand, stated:

> *I wasn't going to get an explanation, see, […] always we, the indigenous people, sometimes are embarrassed to tell the family [...] Take for instance me, I have my granddaughter in the house, I'm not telling her that when one has the period this is what happens, I'm ashamed to say so myself. Neither did my grandmother ever told me that when you're going to be like this, this is the purpose, she never told me; nor was my mom going to tell me […]*

The exceptions to this silence were the women who obtained information from other sources. In the case of younger women schooling has had a great impact in their access to information about the menstrual experience. Among older women, the exceptions to the silence where those whose sisters helped them navigate this change in their bodies by explaining the frequency of this event and the ways in which they were supposed to manage it.

According to Le Carrer (2010), gender division in Ngöbe culture manifested itself in the puberty rituals. These rituals were intended as a process of separation of boys and girls, who up until now had been allowed to share time-space. This separation involves the incorporation of new ways of living for both boys and girls that are dissimilar in terms of movement. The male movement involves a round trip from the home

to the place where the ritual is held and back again. This is a cyclic temporality that will later be reproduced in daily life. The female movement drives her away from the home into the home of her husband. This movement represents a linear temporality. Thus, this is an outward movement that will only allow her to return to her parent's home for short periods of time (Le Carrer, 2010). Le Carrer dwells on the meaning of the rituals and its significance in terms of the union of a man and a woman. However, based on Young's (1971) ethnography and on the ethnographic data gathered in El Bajo, it is possible to identify a return home movement performed by several women, that might or might not move outwards again.

Nevertheless, introduction to the phase of reproduction hinted by menarche is still very important in El Bajo. Although there are exceptions, and in recent years more and more women continue to postpone their first child, the participation in the act of procreation is of great importance for Ngöbe women. No woman over 25 years of age was without a child in El Bajo. Le Carrer (2010) talks about the emphasis the ritual of puberty placed on procreation. About it she states *"the girl is associated with the vegetable, with the moisture and oriented towards the production of sprouts"* (p. 295 own translation). According to Le Carrer, this new growth is representative of the child she will be able to procreate once the last of the three puberty rituals comes to an end and she is deemed ready to be married.

Homosociality and Mobility

Ngöbe everyday experiences are characterised by an emphasis on homosociality. Men and women are generally in charge of different activities concerning the household. Even though these activities show a cooperative spirit among the genders, they are mostly gender specific. For example, men will generally bring the firewood for the stove, but women will do the cooking. These tasks are shared in a way that everyone will get to participate during the week. About the gender division of labour Young (1971) states:

> *In [Ngöbe] society, greatest emphasis is placed on sex as the basis for division of [labour]. Nevertheless, the distinction between male and female tasks is not rigid. There are some tasks, which are considered to be exclusively in the male or female domain, and in the normal course of events these tasks are performed by members of the appropriate sex. But expediency*

> *frequently blurs the boundaries. […] People do not necessarily enjoy performing work that should be done by the opposite sex; in fact, they generally complain about it(p. 154).*

Young's observations are valid for El Bajo as well, in which men and women will do the necessary work, but will always prefer to act according to the division of labour.

The gender division of labour is structured in a way that most of the tasks developed by women are shared with members of the same household; men's tasks, however, are developed in a wider collaborative sphere that will include members of the same kin, but belonging to different households. Men's tasks also require for them to move further away from the home, which makes them more mobile. This was also observed in relation to leisure activities. While women developed more of these activities within the hamlet, where most of the inhabitants were kin; men were more prone to enjoy leisure activities in public spaces (like the football field) and other hamlets. During the 12 months I lived in the community, it was common to observe men, organised in kin related groups, visiting other hamlets or even other communities.

These practices seem to relate to Le Carrer's description of the rites of puberty and the differences between boys' and girls' rites,

> *Separation induces, as we noted, two opposing and complementary movements. The young boys leave the house and the family residence area to live together in the "village of guro", where their male relatives have come and where some continue to come. The nubile girl stays in her family home always surrounded by family (2010, p. 293 own translation).*

Even though the people in El Bajo have no recollection of performing puberty rituals in the past, male and female attitudes still correspond to the social organisation promoted in the rituals. Thus, dispositions around gender divisions are still performed in everyday life, in the use of language and the values of members of the community. Nevertheless, and as expected, these practices have been undergoing a process of transformation that is shifting and reorganising the social composition of the community.

For the past couple of decades, women have started to occupy public spaces in a more prominent way, and at the same time are developing more mobile lives. For example, according to several women in the community and the principal of the high school, football matches among women were more common

at the time that I did fieldwork than they had been a few years back. Nonetheless, they were still less frequent than male football matches that took place once a week and in summer even twice every week. Accordingly, men in El Bajo were more likely to participate in leisure activities at the river in the company of other male participants than were female members of the community. Even though women also spent time by the river, it was most times accompanied by the task of washing clothes. Moreover, women that participated actively in sporting events, living mobile lives at late hours of the night and engaging in interactions with male members of the community were generally a topic of gossip. These women exercise their agency by resisting the imposed idea of respectability and engaging in practices that were mostly used by men to enhance their reputation.

In El Bajo, women navigated and negotiated these two categories of respectability and reputation by getting involved in activities that were previously characterised as male specific. Even in their households, women who had little or no help from male members of their kin, performed activities assigned to men. This contributed to their reputation as independent hardworking women that were able to fend for themselves and other women and children. In a way, by building their reputations, women were also enhancing their respectability. Thus, women who were able to fend for themselves and at the same time were mobile and engaging in drinking activities, were confronting the gender structure through everyday practices.

Women's new found access to the public sphere and mobility also implied that they were more active in political activity, not only engaging in political organizations, but also participating in government funded and run fora and activities. On the one hand, these changes are the product of women's personal experiences and the extent to which they have been faced with the task of providing for their families. On the other, the transformations have been influenced by the work developed by government organisations such as the National Institute of Women (INAMU Spanish acronym). These two situations create a dynamic interaction between women and the governmental apparatus that provides welfare in exchange for women's participation in their initiatives. Even though women complain about the government's lack of commitment

to their political agenda and the instability of welfare programs[38], these spaces represented an opportunity for women's voices to be heard, even if the expected results were never fully realised.

Beginnings

A woman first partnership represents a *vital conjuncture* in the sense that this experience impacts on the rest of her sexual and reproductive life (Johnson-Hanks, 2002). The bonds that are formed in these first relationships are generally very strong, particularly when a child is conceived. However, before the partnership is consolidated and even during the first years of cohabitation, the possible outcomes of the relationship are uncertain. Thus, people only identify a partnership as established when it responds to existing dispositions like child bearing or consistent cohabitation. Penelope's experience, for example, was ambiguous due to the death of her child. This experience was also charged with much grief and anger in a way her experience with her second partner was not. Nevertheless, this was a vital conjuncture for her, one that motivated her to run away from her partner and as a result also away from her kinship. Thus, the outcome of this first partnership impacts on women's quality of life. In many cases, it is the beginning of a life under physical and emotional abuse; other women are able to maintain relationships that are closer to what anthropologists have called a *companionate marriage* (Hirsch, 2003; Hirsch & Wardlow, 2006; Hirsch et al., 2009); an idealised form of partnership based on the *"... mutual recognition of individuality, and the intimacy created through it"* (Hirsch & Wardlow, 2006).

This vital conjuncture is also a turning point in which women are sometimes faced with jealous partners that limit their exercise of agency, or supportive relationships in which they are able to pursue other interests such as studying or working outside of the household. For most women in El Bajo the first partnership is also the start of their reproductive lives, which in many cases represents the beginning of their interactions with the state-run institutions. Thus, first partnerships are important turning points in

38 The welfare programs were dependent on the change of government and the availability of resources. Many women in the community got temporary access to welfare that extended for three months once or twice a year. The rest of the year, women had to find other ways to access resources to provide for their families.

which women enter adult lives. In this process of becoming an adult, women also become carers of others around them and of themselves. And in this process of caring for others and for themselves women engage in an exercise of agency that interacts with a social structure that in some ways they seek to preserve and in others reject.

Of Male Dominance and Sexual Violence

Carmina, an indigenous woman born in Panama, was only 12 or 13 years old when her mother organised her first partnership. Based on the way she narrated the story I could tell it was a bitter memory. I had to ask a lot of questions to get the details of this arrangement since she only referred to general ideas. Her final narrative came to the following:

> *As soon as I was in third grade at school, my mother handed me over to a boy… [he] was 17 or 18 years old… I didn't want to get together with him… but it was part of an exchange… for me to be with the brother of my sister-in-law… first, he wanted to take me far away, but I didn't want to get together, firstly the man came two times, three times, and I didn't get together with him, I didn't want to… until finally, I had no option but to go with him… [my mother and grandmother] insisted that I had to get together with that man, because if I didn't, if I wasn't going to fulfil my obligations to him, I was going to go away with someone else, and then, they wouldn't take care of me, that is what they said, so I fulfilled my obligations to them.*

As stated at the beginning of this section, Carmina's experience resembles in many ways Young's (1971) account of partnership arrangements. However, in Carmina's narrative, her perspective is at the centre, emphasizing family commitments as the force driving her final actions.

The parents' concern, in many of the narratives, was related to the possibility of their engagement with an undesired partner, as Penelope's story shows. This concern assumes that sexual desire starts shortly after a girl's menarche. In Carmina's case, her mother framed her actions in terms of care. For her, providing a suitable partner for her daughter was a form of securing her place in the social structure and preventing a pregnancy outside of marriage. Nevertheless, this form of care didn't allow Carmina to achieve well-being.

On the contrary, Carmina was convinced that the only way in which she could enjoy the care of her kin group was if she exercised her agency through subordination. This was a vital conjuncture that ended up tying her to an abusive man for several years before she could resist her situation. Thus, Carmina's case presents a condition in which her own connections and sense of belonging is what ultimately oppresses her. Here it is clear that not all practices of care bring well-being, since some of them are directed at preserving the existing structure by limiting the possible negative effects. That is to say that the gender structure that oppressed both Carmina and her mother operated through power relations that limited their possibilities for action. Carmina's mother was exercising her agency through subordination as well. Thus, ensuring Carmina a place in the social structure was a way to care for her. In a way, she was concerned about her daughter's respectability.

The stories of arranged partnership belong to women in their late 40s or 50s. They all eventually left their partners, two of them soon after the relationship had been established. In the case of Carmina, she had a longer relationship with her former partner and had five of her six children with him. She eventually left him due to his constant physical abuse. Later I will show how the exercise of agency through the mechanism of connection allowed Carmina to end this relationship.

Sara, a 19-year-old girl, also had her first sexual experience at the age of 13. A man, twice her age, was pursuing her. At the time, she didn't have any knowledge about sexual intercourse or pregnancies. About the formalities around her first short-lived partnership arrangement she said,

> *He first told me that he was going to ask my mother for permission; I told my mother that he wanted to talk to her. She then told me that it was fine to talk to him if I wanted to, but that she didn't want me to get together with him too quickly. So I told him that it was fine, and so he started to go to the house and we were talking, but he then wanted to take me with him quickly.*

Notwithstanding the previous formalities, for Sara (as well as for Carmina) the partnership arrangement felt more like an obligation to family than an actual desire to be with a man. He had used Sara's respect for her mother to force the partnership by saying that her mother would be upset if she didn't comply. Sara knew he had lied and so she said "*before I didn't know how to think well since I turned 18 years old I started to*

think". This was for Sara a moment of transformation that she highlights as the end of her childhood and beginning of her adult life. Thus, this experience had made her understand men's strategies to deceive women, as well as to have a first encounter with her sexuality.

Besides Sara, Nadia also felt deceived by the first man she had been sexually active with. These girls, in contrast with the previous group of women, were still very young —in their mid to late teens— at the time of the interview. Their experiences, as well as the ones of the three women in the previous example, indicate a form of sexual violence, in which an older man takes advantage of a younger woman to engage in a sexual act she is not willing to perform and whose implications she is not aware of. In this case, their connection to their mothers and other members from their kin group, such as siblings, allowed them to end the relationships not long after they started. These girls also exercised their agency through resistance by rejecting their partners once they realised they had been deceived. Thus, connection to and support from their kinship was an important force enabling them to make decisions.

The extreme version of this type of experience was the one of Evangelina. She was the last woman I interviewed; she is also the youngest among the participants. She was three years old when she started to be inappropriately touched by her stepfather and later on forced to have intercourse with him. This form of interaction lasted for almost 10 years and there was a child conceived and born as a result. This, as well as the other forms of forced unions described in this section, cannot be labelled as courtship or even as forms of relationship since women expressly described them as impositions, obligations and rejected them as forms of partnership. Even though in some cases the dealings lasted for long periods of time, the women themselves eventually terminated all of these exchanges, in most cases with the support of their relatives, and in the case of Evagelina also with the support from state institutions. In four out of the six cases, the forced partnerships lasted only months. In the case of Carmina and Evangelina it lasted years.

<u>From Paper Notes to WhatsApp</u>

Rosa is a talkative and opinionated woman in her early 30s. She was detailed in the telling of her narrative and unconcerned about the way in which she expressed her ideas. Rosa was always happy to talk

about her partner, an unusually tall and physically strong indigenous man. It was clear to me she thought about her relationship as a partnership in which her voice was as important as his. As I got to know them better, and in spite of their age difference, I could see that they made most of the decisions together and shared many of the burdens and responsibilities of adult life. This seemed to be a characteristic of their relationship since the moment they met and liked each other. In relation to this first encounters, Rosa said:

> *We meet at a meeting I attended when I was 18 years old… I saw him when he was reading a speech in the middle of a room, it was when I first saw him… After that, we started to talk and like each other… I had never been so in love with anyone before…*

Rosa's mother, however, wasn't too happy to find out her daughter was interested in courting a man 10 years older than her and already involved with another woman. Rosa's father had established a polygynous relationship and had neglected Rosa's mother and siblings. This experience created Rosa's mother's concern about this possible union.

At the beginning, and for some time, Rosa and Marcos exchanged letters through Rosa's brother-in-law. Rosa then acted on her desire by resisting her mother's disapproval. Thus, through paper notes she was able to interact with Marcos outside of the limits of a formal relationship, which allowed them both to get to know each other better. It was also the only possible way, due to the fact that they lived far away from each other and had very few opportunities of getting together in an informal setting. Eventually, after ending his previous partnership, Marcos went to talk to Rosa's mother, and although she was resistant to let the relationship continue, she gave in and they started the period of visitation. One year later, they were having sex, and soon after they formalised the relationship establishing themselves in a new household near Rosa's mother's house.

The use of cell phones and social media as a form of interaction has also impacted the way in which partnership arrangements are organised in El Bajo, offering more possibilities for girls to interact with boys in an informal way and then make decisions. This practice is accompanied by mothers' and other kinship members' concerns for girls getting involved too soon with a particular boy. This concern is motivated by their desire to see girls finish their schooling. Thus, there are ambiguous views of cell phone use as an

important skill, but also as a distracting and potentially disrupting tool. This was also true for non-indigenous girls.

Even though most of the interviews with younger girls didn't mention the cell phone as a means to establish a courtship, this was confirmed through participant observation. Most of the girls attending high school had a cell phone available to them, and even though the institution had limited access to wireless internet, it allowed the exchange of WhatsApp text messages. Through Valeria, I heard some of the possibilities of engaging in a conversation with a potential suitor using the cell phone. She commented that a girl might meet a boy at a sporting event and exchange contact details to later engage in conversation prior to the boy's formal request to the girl's parents. Another option is to meet the boy through another WhatsApp friend, generally a relative, who introduces the couple via text message. Finally, a girl could also meet a boy through a WhatsApp group chat created by a friend or relative. During a conversation with Noelia, who was originally from a Ngöbe community in a neighbouring county, she told me the following:

> *When I was 15 years old, I meet him through the cell phone… I already had a phone and supposedly he sent me a message by mistake… and then we started to send text messages and he liked me and I liked him. So we started to exchange messages and one day we decided to meet.*

Therefore, the cell phone is allowing girls to expand the pool of possible suitors to boys living in faraway communities.

The use of cell phones during courtship has also allowed girls to get to know the boys courting them better by having unsupervised and extended conversation. However, this type of communication also presents some risks that come from exchanging information with an unconfirmed recipient. Text message exchange with boys introduced by relatives is a safer option for girls but as the example of Noelia shows, there are many other possibilities of meeting someone through text messages. These new forms of courtship also raise concerns among parents. Going back to the first narrative in this chapter, Penelope's parents were concerned about her involvement with an unapproved partner and because of that, they pressured her to establish a formal and approved partnership. In Noelia's case, her mother concern was her education:

> *Later I told my mother I had met a boy that liked me, and my mother told me that if that was so, I could then talk to him but that I shouldn't think about having kids… She told me I was too young and I couldn't take care of children yet and that I had to study, the most important thing is that I had to study and once I had finished high school I could then think about living together with a partner.*

This concern was shared by many of the mothers in the community. The priorities, then, had changed and promoting education was becoming the best way to care for their daughters and to secure their well-being. Notwithstanding, partnership was still very important; the women that had managed to complete their education were soon pressured into forming a partnership. Rosa is a great example of a woman who prioritised her education and soon after established a partnership.

Even though the examples presented here show that there are important transformations in the way courtship takes place in El Bajo, there are also important continuities. Overall, women's exercise of agency is becoming more complex with an important use of resistance and connection when formalising the partnership. Mothers caring for their daughters' interactions with men are encountering contexts in which girls have many more options to interact with boys and engage in informal relationships before making decisions about formalising the union. However, the care that mothers provide also shows an important use of agency through connection. Mothers also rely heavily on their own experiences when caring for their daughters' well-being.

Chapter Four: Partnerships, Endings and Sexual Practices

Carmina ended her first relationship to end the physical and emotional abuse she had been experiencing for almost two decades. She first went to her mother's house, since her mother had advised her before that the best way to protect herself was to return to her kinship household and only visit her partner occasionally. But Carmina wanted to end the relationship for good and thus she had decided to start a relationship with another man from her community in Panama. Before she had made up her mind her sister approached her and courted her, offering her to become her partner's second female partner. Carmina's sister promised to care for her and her family. She also promised her freedom, since her partner wasn't the jealous type; but most of all she promised her zero violence. Carmina's mother didn't agree with the union, but Carmina still decided to take her sister's offer and move to El Bajo in Costa Rica. The practice of sororal polygyny was not strange to people in El Bajo. By the time, Carmina arrived to live with her sister and her partner, there were at least a couple of examples of this type of union in the community. Adela, Carmina's sister, was true to her promise of non-jealousy and zero violence, but Carmina felt disappointed by her sister and partner's inability to provide for her and her children.

Carmina's dissatisfaction with both her partnership arrangements was motivated by experiences of violence and lack of care. Contrastingly, she talked about a sense of agency facilitated by the agreement she had in her new partnership. About it she said:

> *In that sense, I'm well… now I'm relaxed, as I told you, when he goes he doesn't have any right to ask me what I am going to do or where I'm going to go, he doesn't have any need to ask me that, this is as I always say to him, and also if he wants to go, I don't have to ask any questions, that is the agreement we arrived at…*

Even though Carmina felt frustrated by the way both of her relationships had turned out, she was also satisfied with some of the advantages this new partnership allowed her. She was involved in the community's political organisations and was able to come and go as she pleased. However, she was always concerned about making ends meet and constantly in search of resources to support her family. She talked

proudly about her children and motivated them to continue their education and to seek new opportunities, even if this meant they had to move away from the community.

In this chapter I explore three elements of women's experiences, within and outside of partnerships, two of which are present in Carmina's story. First, I examine two forms of partnership formation that are common in El Bajo: monogamy and polygyny. Carmina exemplifies both of these forms of partnership. Second, I look at the process of ending a partnership with special attention to the main reasons to dissolve it and its acceptance within the community. Carmina's experience of physical and emotional abuse is a well-known cause of partnership dissolution that is well accepted and fosters kinship support. Third, I look at sexual practices both within and outside of partnerships. I am particularly interested in identifying the ways in which these practices correspond or contradict the gender structure. Here I also point to care practices that come to life both within partnerships or in the processes of ending a partnership.

Partnership: Social arrangements

Partnerships in the community took two basic forms: monogamy and polygyny. Fluid as relationships are in El Bajo, they are generally monogamous. I would use this terminology to refer to arrangements where both men and women expect exclusivity out of their relationships. However, this doesn't rule out infidelity, which is a regular practice of human sexual activity. Infidelity, however, is not polygyny. A polygynous relationship in El Bajo is one in which the man is open about his association with two or more women and, whether or not the women in the relationship are in agreement with such union they comply with it. This description of polygyny might sound very similar to one of infidelity. Thus, for the sake of clarity, I will resort to the element of secrecy[39] in formal settings, as the one element separating infidelity from polygyny.

Out of the 16 indigenous women interviewed 15 have been in a monogamous partnership. The length of such partnerships varies considerably. Seven of the women in this study have had more than one

39 Secrecy means, here, that even if everyone knows about this unofficial relationship, men will deny it in formal settings. This might not be true in informal conversation where the relationship might be assigned to the infidel some status.

partner throughout their lives. Four out of the 16 women had also been in polygynous relationships. However, at least half of the women I interviewed had had some close encounter with the practice of polygyny through either their parent's polygynous relationships or by rejecting or engaging in this practice. At the time I did my fieldwork, most people I talked to would not agree with this practice. However, four or five decades ago this was still a common practice, only mildly contested. To illustrate the arguments in favour of and against polygyny in El Bajo, I look at narratives of two pairs of sisters that have experienced this type of union.

Even though I emphasise the complexities around partnership arrangements in the community, these complexities are not exclusive to the Ngöbe population. In fact, many Ngöbes were quick to point to the recurrence of infidelity among Sulias when the topic of polygyny was raised. They used to say —whether they agreed with this practice or not— that Sulias also had polygynous relationships, the only difference is that they were not honest about it. Some women went so far as to say that all men are promiscuous and that there was nothing that could be done about it. In many ways, this assumption framed the way relationships were established in the community, where infidelity and jealousy were constant interacting elements between couples.

Monogamy

Rosa had been in a relationship for 15 years when I first meet her. She was in her mid-30s and had only birthed two children. As previously mentioned, she first established a relationship when she was in her late teens, early 20s, with a man more than 10 years her senior. Her initial thoughts about him portrayed a very respectful man. When I asked about his fidelity, she stated *there is no faithful man like him*; she said she was sure of it. She reciprocated by being faithful herself. Notwithstanding, she also identified and expressed her discomfort with his shortcomings. To begin with, she felt a lot of pressure to perform sexually with him. She said, she would have liked for him to seduce her into having sex and not just to expect for her to perform.

In terms of communication, Rosa associated the success of their relationships with their ability to talk to each other. However, she also talked about how this was only achieved through 15 years of work to strengthen their relationships and come to agreements. She said that to achieve a good communication she had to bear instances of physical and emotional violence. Even though, she emphasized his ability to recognise his shortcomings and to work through them. She stated she once told him "*either you change, or it's all over. Even if I still have feelings for you, but the way we are living is better not to be, either you change or this is over*". She then added that he used to be a very sexist man ―*machista*. She felt she had changed him and because of that, she was able to enjoy a lot of freedom. Furthermore, she was proud of their relationship, even if she complained about some of his ways. She described their relationship as a mixture between intellectual and physical chemistry and a lot of hard work. Ultimately, she was interested in establishing a companionate marriage. To do this, she had to navigate this relationship by means of resistance at times and also through subordination. Rosa was acting with the intention to preserve her relationship and at the same time stand her ground to be able to pursue her other interests, such as her education. Her relationship, nonetheless, was also rooted in their connection through their children and the work they put into the land they own.

Celia also talked in a manner that showed her desire to have a companionate marriage. However, her situation was different from Rosa's. Even though she reported still having feelings for her partner, he had been unfaithful to her on several occasions. They had been together for more than two decades and had six live children. She, as did Rosa, described her partner as a sexist ―*machista*― man, but claimed that he had changed and now he helped regularly with the housework. But when it came to fidelity, Celia said she was hurt by his continuous involvement with other women. She said she had never been a jealous woman but due to his actions, she had changed. Thus, she used resistance as a way to exercise her agency. In this way, she would refuse to comply with household duties and on one occasion she had cast him out of the house. In Celia's case, their connection through their children and the labour they had put in their land was an element that limited her options, hindering her agency.

To explain her situation, she referred to the way the interaction between jealousy and infidelity worked for other couples. She gave the example of her grandparents; about them she said:

> *... my grandfather complained [reclamaba] a lot to my grandmother…and she complained [reclamaba] to him too... she used to tell him that he must have had a lover, that he had liked another woman… at that time of their youth, and even when old, they still fought.*

Thus, in Celia's opinion, jealousy and fear of unfaithfulness was a common cause of quarrel between couples. She mentioned how jealousy was a two-way street. Men used to fear unfaithfulness as much as women did. During my stay in El Bajo, I heard of many women complaining about their partner's jealousy. In many cases women's mobility was constrained by their partner's jealousy, confining them to their homes and close surroundings. This element of jealousy, however, was never extended to men, since they were generally able to move as they wished, and they did.

For Celia "[...] *no man is faithful to a woman* [...] *the woman that tells me 'my husband is faithful to me', that is a lie"*. She, however, never spoke about women's unfaithfulness. She did, nonetheless, state that she had never been unfaithful to her partner. Out of the 16 interviewed women 13 are currently in a relationship; of those 13 women, I asked 10 of them the question "*have you ever been unfaithful to your partner?"* Four of those women openly admitted to having been unfaithful to their partners, five responded they had never been unfaithful and one gave an uncertain answer.

Emelina was one of the women that admitted to having been unfaithful on two occasions. She and her partner Roger had been together for almost 20 years. When questioned about infidelity in their relationship she said that they both had been unfaithful. He had been in a relationship with her sister for about two years, and he had also had sporadic encounters with other women outside of the community. Emelina talked about her unfaithfulness as a way to retaliate against her husband's infidelity. But she also mentioned *"[...] men like it when they are unfaithful, but they don't like it when we do the same"*. She had to experience this first hand since her husband started to beat her when he found out. He was eventually forced to stop when family members intervened. Emelina mentioned many times that she used to be the kind of woman who put up with ―*aguantaba*― her husband's mistreatment, but she was no longer like

that. Thus, her argument was different from Rosa's and Celia's. Emelina was the one that had changed in the relationship.

Rosa, Celia, and Emelina had only had one formal arrangement in their lives. They had in common an ability to accept their partner's shortcomings and to endure different forms of abuse in favour of their families' economic and social stability. In this way, they experienced their connections as an aspect limiting their ability to act. This was a common experience for many of the interviewed women. However, there were also several cases of women who rejected unions where they were mistreated —Penelope, Adela, and Carmina are all examples that have been mentioned. Therefore, women's exercise of agency through connection to their children was both the reason for staying in a relationship or for leaving a partner. The element that women seem to ponder was that of the conditions under which their children and themselves would be better cared for. Important health factors such as putting themselves at risk for STDs were, in most cases, not considered. Their sexual well-being was at risk.

Beside infidelity and violence, women mentioned the inability to support a family as a negative characteristic in a partner. Not all women talked openly about their partner's role as a provider. But some women did talk about what was expected of a partner in their community. Emelina, for example, mentioned that one of her sisters left her former partner for a younger man. She talked about her father's disagreement with her sister on the basis of her partner being a "*brave man, a hardworking (pulseador) man*". Thus, even if a man was unfaithful or at times violent, these failings could be overlooked if the man was hardworking. This idea was further supported by Celia's argument, that all men were unfaithful, including Sulia men. Thus, men's labour of care was mostly framed in terms of economic support. Other responsibilities, such as emotional support and respect for women's well-being were not as highly regarded as their ability to maintain the economic stability of a household.

The best example of a monogamous long lasting relationship in El Bajo is the partnership of Cora and Amelia's parents. They had been together for more than half a century. He was characterised by his daughters as a sweet and hardworking man that never hurt his wife. As for infidelities, the subject was never talked about. Both sisters also agreed that their mother was a complicated woman; they justified her as

having had a very hard life. When she was very young, she had been handed over to a man who already had several female partners, and who was very violent with her. The fact that their father had accepted their mother even if she had already been with another man, elevated their father into an even higher social status.

Polygyny

Some of the first Ngöbe indigenous settlers in El Bajo had polygynous relationships. Cora and Amelia's grandfather came to El Bajo with his two female partners. Their mother, before getting involved with their father in El Bajo, had lived in Panama where she was in a relationship with an older man who had several female partners. Similarly, Paola's father had been in a sororal polygynous relationship with her mother and aunt until he died a few years ago.

Even though the appreciation of polygyny in the community is mostly negative, there are a few people who agree with the practice. Augusto is one of them. He has been a community leader for several decades. However, his leadership has always been controversial. He has been severely criticised particularly by some of the female leaders I interviewed. Augusto used to frame his positive appreciation about polygyny in terms of the importance of preserving the Ngöbe lifestyle; by doing this, he placed this practice in direct confrontation with the Sulia way of life. His father had been in a polygynous relationship himself, and ever since Augusto started his first partnership he had expressed his interest in having more than one female companion. His second partner Lucina, the sister of his deceased former partner, left him because he tried to formalise a polygynous relationship by including another woman into their union. Augusto finally settled into a relationship with Adela after having had three other partners. Adela agreed to incorporate another female into their relationship when they had been together for about 15 years. Augusto explained their arrangement the following way:

> *... I wanted to have another woman because if the family got sick or if there is work, then we have someone to care for the family… if I have to go to work, then she would be alone, so she needed to have some company… I use to tell her I wanted to have another woman, she answered:*

-Another woman I don't accept, but my family I can accept if she is my sister or my niece… so that we are the same, with the same ideas…

During my interview with Carmina, Augusto's version of the story was confirmed. Adela didn't directly mention their arrangement, but she talked about the correct way to establish these unions. She said that this was not an arrangement that could be negotiated by the man alone. Both women had to agree to the union and they both had to have a conversation about the terms of this agreement. She concluded, "[…] *the point is that there has to be an understanding between the couple and the other"*. Adela, unlike many other women in El Bajo, had a strong personality. She had resisted her family's choice of a partner when she ran away from him shortly after the union was established. She had chosen Augusto as a partner when she asked her brother to talk to him and ask him to take her to Costa Rica. In her day-to-day interactions, she also stood out as an energetic woman. She was regularly laughing and talking out loud, and it was common to see her on her own at community events, in town, or fishing. However, not all women had a say when it came to their partner's choice of a polygynous relationship.

Cora's case illustrated a different experience of polygyny. She was the oldest of three daughters. She started her first relationships at 16 and lived in Panama with her partner for six years. Sometime after they moved back to Costa Rica, Cora's partner got involved with Amelia. When I asked Cora about the extent of her knowledge about this relationship, she told me he had told her. She said she didn't agree with the relationship but she felt unable to resist the arrangement because she had many children and felt incapable of caring for them on her own. He was also constantly pointing out that she wouldn't be able to get another partner if she left him. Thus, Cora saw subordination as the only way to act in her situation. During an interview, Cora told me she was a fool ―*tonta*― for accepting the situation. Besides her informed fear of fending for herself and her kids, she had strong feelings for her partner, she commented she *thought he was the sun*, meaning she adored him. She used to describe her former life as domestic: spent cooking, washing clothes and weaving *chacaras*. She attributed the strong sense of agency she emitted and her commitment as a community leader to the tragedy of her husband's death.

Amelia, on the other hand, talked about Cora's partner's insistence to get involved with her. She said he had talked about this since he first started his partnership with Cora. Even when Amelia established her own partnership with another man, Cora's partner insisted on formalising a union with the two sisters. He was finally able to make arrangements once Amelia's partner left her to establish a union with Amelia's younger sister. At the time, Amelia had had four children with her former partner. Amelia commented on Cora's partner insistence,

> *He used to tell me that Cora knew…, and Cora used to come here with him and in front of Cora, he used to sit next to me to talk to me. As I always told you, people from the past were very [sexist] machista… Until finally I agree to get involved with him…*

There was, then, no open discussion between the two women about the relationship. The union never involved cohabitation, but they lived close to each other. Cora explained that her partner used to tell her she was first. Amelia confirmed this by mentioning that he never really cared for her and her children, he only provided for Cora's family.

The tragic end of this complex set of interactions occurred on a regular afternoon, in which the two men met by the river in an isolated area not too far from their house, and fought. This fight had no witnesses. It ended when Amelia's former partner killed Cora's partner with the machete he was carrying to farm the land. He took the blame and was sent to prison. This tragic incident left all three women caring for their children alone, nine fathered by Cora's partner and six by Amelia's partner.

This was an important event in the community. While conducting fieldwork I heard several versions of the story. There was one that suggested Amelia's partner was jealous of Cora's partner's involvement with Amelia. Another version, supported by Amelia, highlighted the rivalry between these two men was because of Cora's and Amelia's younger sister. This last version assumed that Cora's partner wanted to establish a sororal polygyny with all three sisters.

The stories of Carmina and Adela, Cora and Amelia offer similarities and some contrasting views. In fact, both Adela and Cora were protagonists in different community discussions about the practices of polygyny. On the one hand, Adela's arguments highlighted some of, what she considered, were positive

aspects of polygyny, such as sharing the work load at home, strengthening their kinship relations, and expanding their care network. Cora, on the other hand, argued that this practice was disrespectful of women's autonomy and benefited only men. These narratives show differences in women's exercise of agency. Cora and Amelia consider the inhabiting of norms as the main mechanism driving their agency. Nevertheless, Amelia pointed out her resistance to mould some of the terms of these arrangements. She said that even though she was pressed into a polygynous relationship, she was able to set some boundaries. As she explained,

> *I told him, 'I will accept, but with one condition that I will never leave this house to go with you. I am going to tell you that I am always going to live with my father and I will never leave here again'.*

In that way, she was able to stay at her parents' house, keeping hers and her sister's household separate. Adela and Carmina describe a more active involvement in which they set the terms of the arrangement. For example, Adela's resistance to accept a woman outside her kin group as the new partner left Augusto with limited options. Carmina, conversely, talked about acting against her mother's wishes to form the union.

The evidence suggests that in practice these arrangements are not uniform, as Adela and Augusto declared. The distribution of responsibilities and resources was not perceived as equal in either case. This challenged the perceived advantages of the arrangement for women. Amelia talked about not being rewarded for her labour in the fields. Carmina also complained openly about the distribution of resources. About this she said,

> *Well for now I'm fine because he does not mistreat me, he does not hit me, the man does not hit me. But only, only sometimes bothers me … as yesterday we discussed with him for this: he does not help me with food, this bothers me, it bothers me when we discuss this. He says he does not have children, he has nothing, and knowing very well … And even my sister offered me that the man was going to buy half and half, now I really need half of the food and he never gives me anything, that's why I'm always talking to the man about this…*

For both Amelia and Carmina, the unequal distribution of resources represented a broken promise. This was also a breach in terms of care since women in El Bajo considered the provision and distribution of resources as an important element in a partnership. In their view, these resources had to be enough for both the woman and her children, whether or not these were the man's children.

The data I have available are insufficient to outline a more comprehensive view of the experiences of Ngöbe women around polygyny[40]. Nonetheless, this is still a living and contested experience in El Bajo. Discussions about polygyny in El Bajo were always framed in terms of identity. Indigenous people's arguments against the practice pointed to the importance of eliminating practices that were perceived as detrimental for women and thus for Ngöbe people in general. Cora stated that this practice highlighted that *[Ngöbe] women don't have the same value as men*. Those advocating in favour of polygyny used Adela's arguments, mostly associated with enhancing women's access to care, in relation to the importance of preserving the Ngöbe lifestyle. During these discussions Adela also adopted the human rights argument and framed the practice as their own right to self-determination. She also emphasised that women's agreement was the necessary ingredient for such a union to take place. Adela also pointed out to me, at no point can you say 'this is wrong', you can't say that because that is our culture, it is an agreement and an agreement that we establish in our own language. Through these discussions women were both arguing the importance of resisting and inhabiting the Ngöbe lifestyle in their attempt to reclaim their connection and belonging.

Endings

The end of a partnership is an important event in the life of a woman. Thus, ending a relationship was as much a vital conjuncture as a woman's first partnership. Once a woman had made up her mind she was faced with the task of fending for herself and her children. In order to make a decision, women took several factors into consideration, such as kinship support, access to land, and available means to support

40 The subject was explored respecting the participant's willingness to talk about it. Many of the informants didn't want to go into details or didn't want to talk about it at all and I didn't press them. Furthermore, there were several other relationships where polygyny was practiced, but the women involved refuse to be interviewed. Thus, having only two cases means that there are many details of the experience that I didn't get to know about.

their family. Even though women in El Bajo are knowledgeable about agricultural tasks, like growing beans, rice and corn, they require the support of other members of the family to be able to attend to these tasks. Women are also in charge of caring for the household which involves not only cooking and cleaning, but also taking care of farm animals, like chickens, gathering water and not long ago peeling rice. Therefore, ending a relationship means they acquire new responsibilities on top of the ones they already have. In the process of decision-making, women would consider their parents and kinship support, especially in terms of the provision of land and shelter. The age of their children and the ways in which they can contribute, either as support in the field or doing wage labour, is also important. Women would also take into account the possibility of entering a new partnership. Recently they have also relied on the government's welfare.

In El Bajo, both men and women used the act of *celar* as a strategy to control their partners' actions. People in El Bajo ―and in general in Costa Rica― transform the Spanish noun for jealousy (*celos*) into a verb (*celar*). Thus *celar*[41] are people's actions as a result of their distrust of their partners' fidelity, whether these actions are complaining, controlling or mistreating their partners. This strategy was widely-used by men. Patriarchal explanations of infidelity argue *"[a] man's reputation […] is determined to a large extent by the behaviour of his close kin […]"* (Jankowiak et al., 2002)[42]. This argument holds true for El Bajo where men's jealousy can easily turn into emotional, sexual and physical violence. Nevertheless, women also care for their reputation due to their partner's indiscretions. The difference between men's and women's use of jealousy is that women put themselves at risk when using this strategy, since violence can also be triggered by women's jealousy.

The act of *celar* in combination with violence can be the main cause for ending a relationship[43]. Thus, jealousy plays more than a marginal role in women's decision-making process. However, not all women experiencing violence due to their partner's jealousy ended their relationship. For example, Emelina was the victim of physical abuse due to her partner's jealousy after her infidelities, but she didn't end the

41 Here I talk about the instances in which this device was used by couples. However I also heard this expression being used to refer to other relationships, like the one between mother and daughter.
42 An example of men's pride in association with infidelity and jealousy can be found in Senior and Chenhall (2008). For women's understanding of men's jealousy see Senior and Chenhall (2012).
43 But jealousy alone was not a reason women will use for ending a relationship.

relationship[44]. Consequently, persistent physical abuse was highlighted as the only direct cause to end a relationship. Other types of endings involve a more complex argumentation that includes different forms of emotional abuse and lack of economic stability. In many cases, economic and emotional factors were weighed together with a man's desire to form a polygynous relationship. This was a circumstance in which women were not judged for ending a relationship.

Feelings of Jealousy Transformed into Violence

Carmina was constantly experiencing her partner's jealousy through her first partnership arrangement. Once they got together, he started to control her and wouldn't allow her to visit her family. At the beginning of their relationship, he was concerned she was not getting pregnant right away. According to Carmina this frustrated him, so he would engage in sexual relationships with other women to prove he could procreate. Later on, once she finally got pregnant, he accused her of carrying someone else's child. This taunt was on-going throughout their relationship; she said that

> *... he always said the same, all the children that I had with him, he said that they were not his… [the first one] was the child of a school teacher, [the second one] was his brother's child, that is what he used to say…*

He imagined she got involved with male neighbours around them and was physically violent toward her because of it. He even suggested their fourth child was the result of Carmina's relationship with her brother. Thus, the feelings of jealousy extended to the woman's own kin, claiming she was engaging in incestuous relationships. Carmina stated that this accusation, along with his constant mistrust made her particularly angry and caused her grief.

Additionally, he used to interpret Carmina's interest in spacing their children as an attempt to prevent him from fathering children. Thus, both his feelings of jealousy and his interpretation of her use of

44 In this case the abuse did stop after several family members of Emelina's partner intervened.

avoidance as a contraception method were central to him being violent toward her. According to Carmina, ending the relationship was the result of not being willing to endure his physical violence anymore,

> *He used to hit me, the man used to hit me… whenever I came back from my mother's house, he suspected that I had been with another man… I hadn't made any mistakes… thus because of all the mistreatment I decided, I told him: 'if it is so, if I'm not worth anything to you… I'm leaving, find a woman that will want you (querer), that will love you (amar)… and I'll get out of here'. Then I left and went to my mother's house.*

Carmina then exercised her agency both through resistance and connection. In doing this she was both caring for herself and her children, and allowing her kin group to care for her.

Kinship support was paramount in the process of decision-making. Matilda's situation was one that required this form of support in order to protect her respectability as a mother. This value is more important in El Bajo than her respectability as a woman. For the most part Matilda was a mystery to me; she was generally shy and quiet around people she didn't know very well, but at the same time she was a very secure woman. This ambivalence about her was probably enhanced by the way she carried herself, a mixture of might and dignity. One day, after coming back from school, Matilda and I ran into each other and began a conversation. I knew she had kids but had never known the reasons why they were not living with her. That day I decided to ask. She then told me her very convoluted story.

She had been together with her first partner for several years since she was very young. She had two children with him and had lived in several communities of the southern region of Costa Rica due to his job. Ever since their relationship started she had been the victim of physical violence. She said he was a very jealous man and wouldn't allow her to visit her mother or even her sister who lived very close by. He used to imagine that she went out with other men while he was at work. This made him angry and as a result he hit her. Attached to his jealousy, was his insistence that she attend to the house chores. It is my interpretation that keeping her busy at home was his way of controlling how much time she had available to be with another man. Thus, to him, an unclean house might be a sign of infidelity.

Eventually, she decided to leave him and went back to her mother's house. Family members advised her to give up her kids to make sure he wouldn't follow her. Here we find one cruel example of the paradox of connections as enhancing and limiting agency. On the one hand, Matilda was able to leave her partner due to her kinship support. On the other, the only possible way for her to truly leave her husband was for her to renounce to care for her kids. Soon after Matilda ended the relationship and gave up her children, he found another partner and his insistence on getting her back diminished. The violence that he inflicted on her was manifold. He used physical violence when he had her close; now that they have been separated he keeps her away from her children inflicting on her emotional violence. Furthermore, he insists on contacting her causing her anxiety[45].

The instances of physical abuse presented here, illustrate the one edge of the spectrum of violence motivated by jealousy. These events of physical violence were not as common as the accounts of emotional violence among the participants in this study. Nonetheless, they were fairly prevalent among women's narratives. Thus, I suggest that in El Bajo tolerance in regards to physical abuse is relatively low, particularly when it is sustained through long periods of time. Thus, a woman who decides to end a relationship based on claims of physical abuse will find support amongst members of her community.

Of Gaining Control and Building a Second Household

Lucina is a very hardworking and skilful woman in her senior years. She has lived in the parents' land for most of her life, where she has fended for herself and her kinship ―parents, siblings, children and grandchildren. She had four main relationships throughout her life and most of her narratives about them point the way in which she was abused through the misappropriation of her labour. Her longest relationship was with her second partner. He was a man around her age, and she had gotten involved with him after her mother insisted she did. She worked beside him to generate resources for the household. As a result of both their labour, Lucina's partner bought land. This meant that other needs around the house were not meet,

45 During my stay in El Bajo, Matilda had two other partners, both of whom her mother was not fond of. The most recent partner had forbade her to continue at school. This seemed to be a similar situation than the one she had escaped from. Cora, her mother, was aware of this and in more than one occasion she expressed her worry.

such as the purchase of clothing. Lucina also complained about the way he used to treat her; she referred to his jealousy, and his infidelity as the main forms of emotional abuse she experienced.

Once they had established themselves, through the acquisition of a considerable portion of land and after having two daughters, he came up to her and told her "*I'm going to get another woman that is over there [in Panama], and is in love with me"*. She said it was fine, but thought "*if he brings her, then I am going to get out of the house"*. Her mother had already offered her support by telling her "*that [if he] did not need her anymore, then she should just go back home"*. Lucina was then able to end this union as a result of her mother's care and support. However, she also felt she was giving up the land that was rightly hers. This meant that she had been able to resist a union she didn't agree with, but only by surrendering the land that she had contributed to obtain. She ended the relationship but to this day she regrets leaving her land and depriving their daughters of that right.

In a similar way, Cora also resorted to a complex reasoning to talk about the end of her second relationship. Cora's first partnership had a fatal ending, this resulted in her moving to another sector of the community with her seven children. While living there, her older son worked in a neighbouring county as a coffee picker to provide for the family. Additionally, Cora got involved with another man who contributed with money to her household. She was together with him for about two years without getting pregnant, until one day he came to visit when she was on her eight day after her period, and she became pregnant with her ninth and last child.

She said their relationship changed after she told him she was pregnant. He was glad she will have his child, Cora mentioned: *"he told me –That is great – he said – now you will live with me […] that is what I'm looking for"*. Cora refused to live with him, because this meant he was starting a polygynous relationship. He had an established partner and on top of that he was already involved with a younger woman. He suggested she leave her family to go and live with him. In his opinion, Cora's older son and daughter could care for the rest of the children, freeing her of that commitment. Cora interpreted his desire to formalise the relationship as a way to control her. He couldn't do this before she got pregnant, but a child between them strengthened the relationship. Cora then resisted the continuation of the relationship and the

formalisation of the partnership on two grounds: the ill-intended suggestion for her to abandon her children, and his interest in establishing a polygynous relationship. In addition to this, she mentioned the ownership of land as an element in her favour. At the time, she also had the economic stability that her son's labour and a recently acquired access to welfare provided. Thus, Cora was able to exercise her agency through connection and belonging.

Lucina and Cora were both mature women when they ended their relationships with these men. For both women these men were their second partners and making the decision to leave them was informed by past experiences and their understanding of their place in the community. Valeria was also leaving her second partner because, among other reasons, he had another relationship. However, at the time she was only a few years past her mid-teens. In terms of personality, Valeria is a young woman inclined to fall in love, always daydreaming and listening to romantic songs on her cell phone. She avidly watches telenovelas in her free time and is always aware of the plot, helping others to keep up with the stories of love, betrayal, and jealousy. She also belongs to a generation that is characterised for being keen users of technological devices and as a result of social media.

Valeria's first relationship ended soon after it started. She was received back in her mother's house and soon after she got involved with a boy from the community. This was also a short relationship. She said that she disliked many things about him, such as his disorganised habits, which were expressed in the poorly equipped house he had and his lack of a steady income. He was also jealous of the fact she had already been in a sexual relationship with another man, and was constantly acting out his jealousy —through negative comments about her non-virgin status and controlling her everyday actions. Additionally, he had another partner with whom he had already had a child. She lived in another community in a neighbouring county, but he had the intention of bringing her over to live with them. The day he decided to bring his other partner to the community, Valeria packed up her things and burned the few possessions he had bought for her. She went back to her mother's place and never re-established the relationship. In the time they were together Valeria never got pregnant, which facilitated the end of the relationship. Valeria's mother pointed out to me that she was always willing to accept her daughter back into her house, even if she felt she had made a

mistake by getting involved with the second partner. Thus, Valeria was able to end undesired relationships as a result of the support of her kinship. Consequently, Valeria's mother was providing care in the form of social and emotional support that enhanced Valeria's well-being.

These women's actions were not peacefully accepted by their ex-partners. All three women had to endure their insistence to get them back. Lucina said after the man came back with his new partner, he went to talk to her at her mother's house. She then asked him to leave and never come back. Cora also said her ex-partner came back to try to convince her to move in with him. After she rejected him a couple of times, he accused her of being interested in another man and refused to support the child until he was sure about his paternity. Valeria had to endure her ex-partner's violence in more than one way. He harassed her at school, intervened on her subsequent courtship experiences, and posted a picture of her on Facebook with a warning portraying her as a player. Therefore, women ending relationships are, in many cases, forced to continue the resistance; in Valeria's case she had to endure his emotional abuse for months.

The stories included in this section have in common the men's seeming intention to establish a polygynous relationship. They were not only unfaithful, which is a common practice in El Bajo, an elsewhere, but were also interested in establishing a second partnership. Furthermore, the women whose narratives are included in this section considered the men's desire to establish a polygynous relationship in conjunction with other circumstances. For Lucina it was her feelings toward her partner and her family's support which prompted her decision. Cora based her decision on the fact that she had achieved the necessary economic stability to fend for herself and her children. Valeria based her decision on his carelessness and resorted to her family's support to end the relationship. Additionally, all three women had former partnership experiences that gave them more knowledge into the consequences of a break-up and available resources to move ahead with their actions.

Sexual Practices

In El Bajo, among the Ngöbe population, partnership formation and reproduction are closely intertwined. Nevertheless, this doesn't translate into sexual practices as only intended for reproduction. In

fact, many interviewed women were open to expressing their non-reproductive desire toward their partners. However, this was a delicate subject that was handled with a lot of shyness —and in consequence humour[46]. Even though women were shy when sharing their sexual experiences, they knew their respectability was mostly determined by their role as mothers. Thus, sexual practices were judged and gossiped about but they didn't necessarily impact their status. This was particularly true for adult women whose reputation had been established by their roles as caregivers and as established members of the community.

Conversations about sexual practices in the community took many different forms. Among them, gossip was probably the most prolific one and probably the least reliable[47]. However, in gossip, the information found a way out. Thus, here I include and make a distinction between the information obtained through serious conversations and gossip. The evidence, however, correlates making the overall data reliable. The sexual practices discussed here include a variety of experiences. I analyse sexual practices within partnership and those that take place outside this arrangement. I also talk about same sex practices taking place in the community that, I argue, are made possible based on the opportunity of the Ngöbe gender structure present in this community.

Within Partnerships

Half of the interviewed women were asked about their enjoyment of sexual practices within their partnerships. Before asking the question, considerations were made in relation to, the pertinence of the topic in relation to the information they had provided up until then, and the general environment in which the interview was conducted. In many cases, the question felt inappropriate because of the woman's experience and therefore it was omitted. The question about enjoying (*disfrutar*) sexual experiences was answered in

46 Throughout my year of fieldwork, I watched Ngöbe women laugh about subjects that seemed to me, very serious. As time went by, I was able to understand that in El Bajo, laughter was used as a form of dealing with the world. Dealing with conversations about sex was high on the list of topics that became easier to handle if laughter was involved.

47 Anthropologists have considered gossip, also analysed under the synonym rumour or the word scandal, an important source of information. Through gossip it is possible to identify a series of phenomena that people consider of great relevance (Gluckman, 1963; Stewart & Strathern, 2004; Wilson, 1974).

mostly positive terms. However, in most cases it was also complemented with the moments in which this activity was not pleasing.

Some women talked about sexual desire as something that was not always realised and therefore turned sexual encounters into uncomfortable experiences. About this Rosa stated,

> *When we are going to have sexual relationships is because we are truly feeling it, the days when we don't do it is because, maybe due of exhaustion or due to the tasks we did all day, then we are tired, or I'm tired, then he doesn't force me. Then when he sees the next day that I'm fine, then it is normal again, […] I do desire it and he is eager, then all is good. But sometimes, when I do not want and he wants that is when we have problems, because he starts to tell me that I don't desire him anymore, that I do not feel the same way I used to feel about him […] one then feels bad […]*

Rosa's complaint was common among most of the interviewed women. The obligation to perform sexual practices with a partner was something that some presented in the way Rosa did, as an inconvenience. Most women talked about these instances as the moments in which they had sex because they had to please their partners. Rosa went on to explain how some men were prone to have an orgasm even though women had not achieved one. She said that for her and her partner it was important that they both enjoyed the sexual experience. However, on occasions when she agrees to a sexual encounter to please him and she doesn't feel pleasure he starts questioning her again, about her feelings for him.

Cora, who was involved with a man 10 to 15 years her junior, and who had several partnership experiences, talked about enjoyment in sexual relationships in a more active voice. She said, "*[…] as I have always told him, I'm with him not because we have intercourse every time, all the time … when I want [fine] and when I don't want nothing"*. She said their relationship didn't use to work this way before, but that was because "*… he still did not know the regulations that I have, that I am implementing now, he still did not know"*. For Cora, sexual desire had not left her, but it had diminished and she made this known to her partner.

The women that were not questioned about pleasure in sexual practices had mainly talked about this experience in a way that resembled sexual violence. These women had been forced to engage in intercourse. Even though Rosa's account —and other women speaking in similar ways— was not considered violent, she felt she had to subordinate to her partner's desires at times. Thus, the power relationships within partnerships are still impacting on women's ability to choose. Even though Rosa's description highlights her practice as one of connection with her partner, she still felt the sexual act as a responsibility a woman had to her partner. This is not uncommon in other contexts where sexual practices are negotiated within relationships based on gender inequality.

Outside of Partnerships

Sporadic or one time sexual practices outside of a partnership mostly depended on opportunity. During sporting events it was common to hear how couples participated in the drinking and dancing environment to later engage in sexual intercourse in the surrounding areas of the football field. In one occasion, when walking back to the house with Amelia, we ran into a young couple coming out of the bush holding hands. When talking about the incidents taking place in these events women pointed out that when desire flourished any semi-secluded area was good enough. Social occasions, like sporting events, presented an adequate atmosphere for women to express this desire. There was no evidence pointing to sexual encounters motivated by feelings of obligation. However, women did mention circumstances in which drunken men harassed them during these events.

Similarly, men having sex with men was a sexual practice that also depended on opportunity. As mentioned before, there were no known same sex couples in El Bajo. There were also no known male partnerships in El Bajo or other neighbouring Ngöbe communities. However, people commented on men having sex with men. The first time I heard about this practice taking place among men in El Bajo was through an outsider like me. She had heard from other people that it was a common practice in the community and in a neighbouring Ngöbe community. Her source was also an outsider to the communities. Nonetheless, one of these sources was an openly homosexual man that received offers from two Ngöbe

men to engage in sexual practices, one married, and one single —with a reputation of being homosexual. I was able to later confirm the existence of male only sexual intercourse in El Bajo, with two study participants, one male and one female.

The homosocial environment that allowed men in El Bajo to spend considerable amounts of time together in unobserved and isolated areas of the community provided the necessary environment to undertake these activities. The interviewees who confirmed this information pointed out that in most cases these practices took place under the effects of alcohol. They were also adamant in their disapproval of these practices. About same sex intercourse in relation to the Ngöbe lifestyle Augusto pointed out "*within the system of the indigenous people this is wrong, this cannot happen, this is a disease that people have learned from white people"*. The frequency of this behaviour in the community was not confirmed. Amelia, the female interviewee providing information about this sexual practice pointed out two cases, one that she could confirm, and another one she heard through gossip. Augusto, the other informant didn't mention any names or refer to any particular cases.

In reference to women having sex with women, Amelia pointed out that this was also a common event but in other Ngöbe communities. In one occasion, while in town, Amelia pointed out two Ngöbe women from a neighbouring community who were involved. Based on the commentary about same sex relationships among women, it seemed as though there were several cases in which these women created partnerships, even if the community didn't accept their behaviour.

Men's and women's same sex practices were frowned upon. However, inferring from the already discussed data, same sex female relationships might be easier to accept when women already comply with the social mandate of reproduction and are constantly working on caring for their children. Women gain their place in Ngöbe society through their adequate performance as mothers. Even though their sexual practices could negatively impact their reputation, they would still be respected as women if they comply with their reproductive labour. Men have to constantly engage in sexual practices with women to protect their reputation. Even though their role as providers in the family is respected, men gain their place in Ngöbe society by constantly proving their masculinity.

Recalling Amelia's commentary about the 7 pm news edition on the 19th of November, reporting on the first same sex marriage in Costa Rica; it becomes clear the extent to which Ngöbe values are intertwined with religious values, to coincide with Costa Rica's conservative view on same sex marriage and LGBTQI rights in general. The case of Laura and Jazmín, a lesbian couple who got married in July of 2015 as a result of an error in the national registry[48] prompted a particular reaction in Amelia. She first used the word *cochinada* to refer to the situation. This Spanish word stands to mean uncleanliness, and can be used to describe a wide range of circumstances, from a diverse variety of sexual practices to the uncleanliness of objects or places. The word is closely attached to a feeling of disgust. Amelia's first reaction was followed by laughter which, as mentioned before, was a common way to deal with uncomfortable topics or situations among Ngöbe women. On another occasion, the subject was brought up by the news again, this time she went back to the word *cochinada*, but she added that these types of practices were against God. Amelia was an enthusiastic church attendee[49]. Her religious practices, however, were intertwined with Ngöbe cosmological belief and the beliefs of the Mamachi cult. For her, God was one and the affiliation didn't really matter as long as one was faithful to him.

Amelia's religious expressions might not have been the norm in El Bajo, in fact, even though many people aligned with a mix of Christian, Ngöbe cosmological beliefs and belief of the Mamachi cult, most people in the community were not part of any particular church. Nonetheless, negative reactions about homosexuality were strong around the community[50]. Amelia's reactions illustrate not only how this is an expected response, but also points back to the *compulsory heterosexuality* that is desired in the community.

48 According to news reports, Jazmín was registered as male when she was born due to an error in the registrar's office (Valverde, 2015). Their marriage was reported as the first same sex marriage in the country.
49 She practiced at the local Pentecostal church that held services in a shed that had been built with resources gathered by the community and the main branch of the church.
50 Costa Rica being a conventional and conservative country, this type of reaction could be heard all across the country and across different social groups.

Conclusion

Going back to Young's 1971 accounts of Ngöbe unions, I agree with the centrality he gives to kin relationships in the process of establishing these unions. However, that centrality is given by the protective element that kinship is supposed to provide and not necessarily by its structural forms or interactions. Carmina's example is particularly illustrative in that she follows the norms to ensure the care of her kin; particularly the care of the two most important figures in her childhood, her mother and her grandmother. Likewise, the experience of Rosa is charged with her mother's concern for her well-being and her reluctance to see her daughter in a situation similar to the one she had to bear. Care, thus, is a central category in the creation of and compliance with kinship.

This reality is in contrast with non-indigenous women's experiences in El Bajo. Even though the interviewed women represent a smaller group in comparison with the indigenous women who participated in this study (only five), the examples were clarifying. Two of the five women admitted having had recurrent experiences of sexual abuse with their partners. However, they continued with these relationships, in the case of one of them for over 30 years. Two other women also commented on the sexual abuse perpetrated by their fathers at an early age. These instances of abuse had never been reported to the authorities. One of the women shared the impact this experience has had on her sexual life with her partner, which prevented her from having pleasurable intercourse. The other woman who was interviewed refused to talk about sex and sexual experiences. Four of the five women interviewed had had only one formal partner in their lives. This is in clear contrast with indigenous women's experiences.

The Ngöbe women in this study had very diverse partnerships experiences. Nevertheless, there was a certain continuity that allowed for a systematic analysis. These similarities can be identified across generations, revealing the permanence of a gender structure that oppresses women in their relationship to men, even if some of the discourses around partnerships in El Bajo emphasise on the aspect of duality and complementarity (Favela, 2014; Loría Bolaños, 2000; Marcos, 2014; Segato, 2012). For women, these relationships were important on several grounds that involved emotions, social compliance and economic

subsistence. Out of the 16 interviewed women, half of them had been in more than one partnership arrangement. These women's ages range from young girls in their early 20s to senior women in their late 50s. Even though the remaining eight women had only had one partner, two of them had extramarital affairs and one was single at the time of the study. Of the remaining five, one was in her late teens and one in her mid-20s, which doesn't rule out the possibility of forming future partnerships. Thus, only three women in their mid-30s, early-40s —about one fifth of the participants— had had only one partner.

In terms of emotion, even though women referred to the Spanish verb *amar* —to love— when talking about their relationships, they most commonly used the word *querer* —which can be variously translate as to love, to want or to like. Some other women only referred to their devotion to their partners using metaphors to explain their feelings. Thus, expressions of emotion were regularly used. Nevertheless, I move away from the concept of love because I find it problematic. The notion of love has a particular importance in the way romantic relationships are perceived today. Esteban, argues that the notion of love in the context of modernity is ideological and that at its core there are gender, race, class and sexual inequalities (2011). Thus love has become a culturally charged notion that carries multiple analytical limitations. One of those limitations is the risk of talking about love from an ethnocentric perspective. Therefore, I respect women's choice of word, while at the same time I highlight the story lines around those emotions. In this way I seek to avoid ethnocentric assumptions of what it means to love a man from an indigenous Ngöbe woman perspective.

Study participants' narratives revealed the aspect of social compliance as an important factor influencing the beginning, maintenance and end of their partnerships. The kinship relationships were among the most important elements motivating women to act. Furthermore, physical and emotional violence was considered as an important cause for ending a partnership. The attitudes related to jealousy and infidelity were a widely discussed aspect of emotional violence. When confronted with these situations women in El Bajo pondered their options, most of which were associated with the support obtained from their kinship, and particularly from their mothers.

In terms of economic subsistence women were constantly commenting on their desire to find a hardworking and responsible partner. These attributes were valued as more important than physical appearance or even the feelings that women had toward their partners. Thus, economic stability was an element that women contemplated when forming a partnership. Similarly, the end of a relationship was measured in terms of the possibilities a woman had to fend for herself. Women's agency through connection to kinship was particularly important when faced with the end of a partnership. Thus, the regularity of matrilocal residencial arrangements may be attributed to the strong bonds between Ngöbe women and their daughters in El Bajo that impacted on the choices of residence of the Ngöbe couples.

Access to welfare is also motivating women to engage in less formal arrangements. This situation is merged with efforts made by the government's redistributive programs to favour women (Piedra Guillén, 2015). This has resulted in women's access to housing and other forms of welfare programs, such as monthly stipends and educational programs. Furthermore, the Indigenous Development Association has suggested that women receiving welfare in the form of housing should also get land in their kinship's sector to avoid future problems about land rights between members of the community. This has been the tendency even though access to land is limited since there is no unclaimed land in the territories and the areas in which the indigenous people are located are insufficient for the growing population. Thus, the independence that women have gained as a result of their access to welfare, associated with strong kinship bonds ―particularly through the support of their mothers― have allowed many women to stay closer to their social network, where they have better access to care for themselves and their children.

Many anthropological studies have pointed out the importance women from different contexts place on values such as fidelity, zero violence, and economic support within partnerships all around the world (Gregg, 2003; Hirsch et al., 2009; Rebhun, 2002). The way in which these values are prioritised, however, take different shapes in different places. Although in El Bajo there are cases of women searching for a *companionate marriage* (Hirsch, 2003; Hirsch & Wardlow, 2006), both Rosa and Celia might be examples of this, this is not the only or the most common form of relationship. As Amelia pointed out when talking about her first partner:

> *... I did love (querer) him, I don't know why; he was neither handsome nor was he… as I always say to [my daughter] Valeria, 'you can't eat beauty [lo bonito no se come], pretty doesn't give you money' but, I say that even if the man is ugly or black or whatever he may be, but he is hardworking, I love (querer) him very much, and I did love (querer) him…*

I argue, therefore, that in El Bajo there is a sense of relationality at play that carries, at the centre, a responsibility to care for others. This sense is stronger than that of individuality which will encourage personal improvement and self-care. The relational logic impacts not only the way women feel about their kinship relationships but also the way they expect men to feel about them too. Furthermore, I will suggest that the logic of individuality has become relevant in El Bajo too, but this logic is still strongly intertwined with ideas of kinship responsibility at the level of discourse, and in everyday practices.

Women's narratives presented here show a diversity of experiences that are made Ngöbe by the identity of the women sharing the stories. Emphasising this diversity has the risk of further stereotyping a population that is already discriminated against based on their gender, class and ethnicity. This risk is associated with a tendency to hyper-sexualise men or victimise women belonging to these groups. Following Baxi (2014), I understand these forms of representation are part of a long history of colonialism. Therefore, I have shared Bourgois (2003) concern of reproducing, through the incorporation of narratives of sexual violence and suffering, "popular racist stereotypes" (p. 15). These stereotypes were constantly being discussed by the health care professionals assisting Ngöbe indigenous women. That being said, I also share the author's commitment to offer a full account of the subjectivities that constitute the Ngöbe experiences. Thus, these narratives aimed to show a comprehensive view of women's experiences, in which sexuality is analysed considering both the oppression that women experience and the experiences of enjoyment and fulfilment that they described.

Part II: Health Care and Sexual and Reproductive Rights in Costa Rica

Here we enter a different realm in terms of care. Not because this realm is not imbued with the relational logic, but because it is dominated by relations of power organised around biomedical knowledge, and knowledge production. Indigenous Ngöbe women's knowledge and social manifestations of care are generally dismissed in favour of biomedical knowledge that is deemed more effective and scientifically accurate. This hierarchy is the product of global historical processes. In this Part II, I look at its effects within the Costa Rican context. I zoom into the process of medicalisation in Costa Rica. It suggests that even if the influences of international agencies initiated this process, it is clear that its continuation has been a joint effort with the active participation of national actors at high political levels and on the ground, *in situ* in the region. A central national actor in this process is the *Caja Costarricense del Seguro Social* (the national social security fund, CCSS Spanish acronym), the public institution in charge of delivering health care in Costa Rica. It is my intention to dive and dwell into the reality of medicalisation in Costa Rica to later emphasise on the medicalisation of sexual and reproductive health, and its impact in the country's health care system. Additionally, I explore employees' interactions at the HCF assisting Ngöbe women. The two chapters in part II aim at providing a national and global context for the care practices that will be explored in Part III. In this way, we connect indigenous Ngöbe women from El Bajo with larger processes taking place nationally and globally.

Through a general overview of the Caja's history, the history of sexual and reproductive discourses and transformations, and the structure and performance of the HCF in the county of Corredores, Part II of the thesis shows the ubiquity of the state-run health care system in Costa Rican society. I show the impact of biomedicine in Costa Rica's history and in everyday life. This process of medicalisation of health and everyday life in Costa Rica complies with the two features of the process presented by Briggs and Martini-Briggs, namely, *"[...] the equation of clinical institutional sites with the labour of care and the identification of biomedicine as the locus of knowledge production in health"* (2016, p. 5). Both historical

analysis and participant observation in a HCF provide evidence of the bearing that medicalisation has had on health in Costa Rica. One particularly important point of impact has been the medicalisation of sexual and reproductive health.

As a result of this process of medicalisation, the labour of care performed by women in the community has become invisible. Menéndez (2015) has highlighted the importance of the care work performed by kinship and community in terms of prevention, diagnosis, and treatment. Along the same lines, Briggs and Mantini-Briggs (2016) have argued that in the process of medicalisation, care is reduced to *"[…] interventions provided by health professionals […] overlooking forms afforded by family members, friends, and neighbours"* (p. 263). This overview of the Costa Rican state-run health care system and the influence of the bilateral and multilateral organisations, provides evidence of the centrality of biomedicine at the institutional level. In this context standards of health and well-being are measured through the aggregation of quantitative variables that, even though relevant in the context of health care, only offer a partial view of the aspects involved in achieving well-being. A more holistic view accounts for the care performed by all the actors involved and the power structures enforcing the inequalities experienced by the population.

The provision of health care in Costa Rica, particularly the one that women from El Bajo access, is dependent on the state and as such it is essential to understand how the state operates. In order to do so, I follow Fassin (2015) by paying attention to the policies and the work of individuals on the ground. About this he elaborates,

> *"[This] approach […] could […] be regarded as a dialectical one, […][the state's] agents are confronted with explicit and implicit expectations formulated in discourses, laws and rules while keeping sizeable space to manoeuvre in the concrete management of situations and individuals. So it is in the actions of the agents within public institutions that the politics of the state can be grasped" (Fassin, 2015, p. 4).*

Both the policies and discourses, and the actions of individuals working for the state are relevant in this process of understanding the institutions. In both chapters of Part II I pay attention to the standardized

actions that these individuals are expected to perform while at the same time looking at the values and ideas associated with health, sexuality and reproduction, and ethnicity among other factors.

The central aim of this Part is to understand the rationalities informing the current situation of sexual and reproductive health discourses as well as the policies and practices in Costa Rica. This reality runs parallel to the development of the state-run health care system and at many points they intertwine. Thus, I examine the history of sexual and reproductive health in Costa Rica paying particular attention to the medicalization of birth, the popularisation of birth control and the incorporation of screening tests, such as Pap smear, HIV test and mammograms, within the health care system's services. I follow Roberts' and Morgan's (2012) concept of *reproductive governance* to analyse these aspects of sexual and reproductive health. The authors consider this concept as *"[…] an analytic tool for tracing the shifting political rationalities directed towards reproduction"* (p. 241). They argue that the political rationalities related to reproduction have shifted in the past century from a concern on population growth to one on migration tendencies, from a focus on population control to one on human rights. This shift, from a Malthusian discourse to a rights based discourse can be traced back to the Cairo Conference (Hartmann, 2016; Roberts & Morgan, 2012). Furthermore, global events of the past few decades uphold Roberts and Morgan's argument, that there are contesting discourses that complicate this view of population growth, for example, the fear of migrant populations and their reproductive practices (Goldade, 2011), the proliferation of the use of fertility technologies, and the contesting discourses around these practices (Roberts & Morgan, 2012).

There are also important shifts in political rationalities around sexuality that are closely linked to the shift in reproductive governance. I also use this concept in a more expansive way to cover aspects of sexuality, like sexual education and marriage equality. The existence of sexual governance is exemplified in the increment in political activism and new legislation supporting sexual diversity. In response, the activism against the expansion of sexual rights has become more visible. This is true in the global and local context, as I will show in Chapter Six. Overall, discussions related to sexuality are flourishing. In relation to the proliferation of voices Alcoff (2018), in her book about rape and sexual violence, suggests that the

pressure to conceal issues around this topic has opened a window for these experiences to be shared and discussed. These new outlets for debating sexual practices and experiences inform and impact the way we look at both sexuality and reproduction. This reality meets with increasing concern for the effects of sexual diversity in the moral configuration of the nation, which contributes to the fear of minorities, be they ethnic or sexually diverse communities. Thus, political rationalities move away from and toward essentialist perceptions of sexuality and reproduction. In many ways, women from El Bajo are impacted by these shifting rationalities when their sexual and reproductive practices are judge based on them.

Roberts and Morgan (2012) argue that reproductive governance in Latin America is complex and in many cases counter intuitive. According to the authors the opening or closing of access to sexual and reproductive practices, are the result of several factors. Among these factors are the political alliances among parties with different ideologies, the affinities/aversions between parties and other entities, such as pro-life and pro-choice activist groups, and the alliances with religious organisations. These political alliances have taken many forms in Latin America in the past few decades, expanding or constraining sexual and reproductive rights for women. In addition to the political alliances and moral discourses impacting the changes around sexuality and reproduction in Latin America, Roberts and Morgan (2012) argue that women's rights in the region *"[…] are framed as a movement to eliminate ethnic discrimination and to humanise medical care for all women, rather than on the right to bodily autonomy"* (p. 247). Furthermore, pro-life movements and religious groups have adopted the discourse in human rights to advance their causes. In Costa Rica, activists advocating for sexual and reproductive rights have, at times, made compromises to secure an expansion of rights, even if this expansion is only limited. For example, feminist activists have refrained from advocating for the decriminalisation of non-therapeutic abortion, in order to avoid the risk of creating a negative effect toward a more severe law (Carranza, 2007).

Chapter Five of Part II concentrates on the historical development of the health care system in Costa Rica, considering the participation of various institutions as well as of political figures. I take note of the transformations that impacted rural communities in a more direct way. Then, I describe the HCF called EBAIS for its acronym in Spanish (Basic Establishment for Comprehensive Health Care) as the central unit

for the access of health care services for El Bajo's population. This description emphasises not only the characteristics of these places in relation to el Bajo, but also refers to the social dynamics and social actors that inhabit these places. Chapter Six highlights relevant sexual and reproductive discourses in Costa Rica and their impact on the labour of care that women in rural areas can access. Then, in the last section of Chapter Six, I explore the views and values around sexuality and reproduction shared mostly by female health care professionals through gossip and storytelling. The history and current state of health care and sexual and reproductive care explored in this part sets the background for the reality that will be explored in Part III.

Chapter Five: The State-Run Health Care in Costa Rica

Health care in El Bajo is mostly determined and provided by the *Caja Costarricense del Seguro Social* (the national social security fund, from now on *Caja*, as is called by most Costa Ricans) created in 1941. This institution has been part of Costa Rica's health sector since that time, but it was only through a series of reforms in the 1970s and the 1990s that it became one of Costa Rica's most ubiquitous institutions —only surpassed by the ministry of education and its multiple outposts. After the reform of the 1990s the *Caja Costarricense del Seguro Social*, assumed all PHC responsibilities. To carry out this labour of care, the Caja created teams of health care professionals that included, a doctor, a nurse, a pharmacy technician and, in rural areas, a Technical Assistant of Primary Care (from now on ATAP, Spanish acronym). Even though the reform impacted the organisational form of both the Caja and the Ministerio de Salud (Ministry of Health, from now on *Ministerio*), many of the employees from the Ministerio, continued to do the same work but now in the Caja. New employees were incorporated, including doctors and the newly created ATAPs. In El Bajo, Arturo was the assigned ATAP, in charge of visiting the community regularly to establish a link between the health care system and the population. Throughout the more than 20 years in his post, Arturo's activities changed to some extent, but he continues to be central to the impact the EBAIS has on El Bajo.

The creation of the Caja propelled the process of medicalisation that had already started in Costa Rica. This process has been largely influenced by the role of international organisations. In reference to this Morgan (1993) states:

> *"Perhaps their most influential impact, […] has been the least tangible: international agencies have paved the way for Western biomedicine and public health models […] to penetrate Costa Rican medicine and public health, thus limiting Costa Rican's ability to forge their own responses to public health problems. Consequently, Costa Rica is extremely dependent on the United States and Western Europe for its health models as well as medical material" (p. 11).*

Jaramillo-Antillón (2013) and Low (1985) agree with Morgan on the process of medicalisation that has impacted health care in Costa Rica. Nevertheless, I argue for the central role of the Costa Rican state in this process. In fact, Jaramillo-Antillón (2013) suggests that the incorporation of medical doctors in the EBAIS was carried out against the advice of the World Bank that considered this action too economically demanding. In a way, the Costa Rican state has resisted the neoliberal trend that has influenced the privatisation of Latin American health care systems. However, this has come at a high cost and paradoxically has only been possible with the economic support of these bilateral and multilateral organisations. In this context, the high value placed on biomedicine and its pervasiveness in Costa Rica's everyday life is undeniable.

Development of Costa Rica's Health System

In organisational terms the health care system belongs to the Health, Nutrition and Sports Sector, created in 2014 (executive order 38536-MP-PLAN); previously the Health Sector from 1983 to 2014 (executive order 14313-SPPS-PLAN). This sector's governing body is the Ministerio which was appointed wit regulatory duties since 2008 (executive order 34582-MP-PLAN). Currently, besides de Ministerio, the Health, Nutrition and Sports Sector in Costa Rica is composed of the Caja and other institutions in charge of water and sewage systems, work, accidents, nutrition, sports, alcohol and drug dependency, and rehabilitation (executive order 38536-MP-PLAN). In a way, curative and epidemiological duties are assigned to the Caja. Prevention, surveillance and regulation practices are distributed among the different entities, while the entire sector is organised and supervised by the Ministerio. The current structure of the Health, Nutrition and Sports Sector, is the result of more than half a century of interactions between the Costa Rican state, a series of bilateral and multilateral organisations, and the civil society. These transformations have created a series of institutions that in their daily interactions with the population create and recreate the Caja. Here I look at the historical development of the institution of the Caja with particular attention to the national and international actors and its current organisation.

Costa Rica´s Health System in Historical Perspective

Health-related activities run by the Costa Rican's state started in the middle of the 1800s[51]. The first model of health was composed of a board that was in charge of the creation and administration of a hospital. This first board and its corresponding hospital –the San Juan de Dios Hospital– were created in 1852 and were followed by other binomial entities of the kind in the country. Later, in 1922 the Secretariat of Hygiene and Public Health was created, becoming the first centralised entity in charge of regulating and managing the health-related activities in the country. Shortly after, in 1927, the Secretariat was commissioned with the administration of all HCF including hospitals and maternity houses (Jaramillo-Antillón, 2004; Low, 1985). In addition to these events, there were several international actors emerging that would deeply influence health care in Costa Rica. At the beginning of the twentieth century the two main actors were the United Fruit Company and the Rockefeller Foundation. These organisations mostly worked in rural areas, developing many of the initiatives on health in sectors closely linked to the main economic activities in the country at the time, the export of bananas and coffee (Morgan, 1990).

During the 1920's and 1930's the government faced major labour strikes, with the participation of banana plantation workers and unions from other sectors (Cordero Ulate, 2004; Jaramillo-Antillón, 2004; Low, 1985; Molina Jiménez & Palmer, 1998). The workers' demands had a strong impact on the subsequent reforms implemented in the 1940s. In the 1920s several urban protests demanded the implementation of the eight hour shift and the increment of wages (Mora Carvajal, 1995). The 1934 protest was protagonised by banana plantation workers, employed by the United Fruit Company. The protest was the result of several decades of labour exploitation in which the population was being exposed to reduced salaries and long delays in payment, long shifts, unhealthy working and living conditions, lack of resources to assist workers in the risks they faced during their labour, such as snake bites, among other situations (Hernández, 2000). Furthermore, the international climate at the time was also tense, characterised by the economic crisis of

[51] Costa Rica's independence from Spain took place on the 15th of September of 1821 (Palmer, 2004, p. 91).

the 1930s that impacted the world economy and destabilised the political elites in Latin American countries (Cueto & Palmer, 2015).

In the 1940s as a consequence of the major events of the previous decades, the Costa Rican government, with the support of the Communist Party and the Catholic Church, and in response to workers' demands, incorporated a series of reforms to improve the wellbeing of workers around the country. The reforms included the incorporation of workers' rights –among them the eight-hour shift and a minimum wage– the enactment of the labour code and the creation of the *Caja Costarricense del Seguro Social* (Jaramillo-Antillón, 2004; Low, 1985). The Caja was organised in the form of a compulsory social insurance, following the Chilean model (Mesa-Lago, 1985) that conversely was designed following some of the ideas of the European social medicine approach that was popular at the time in Latin America (Cueto & Palmer, 2015). During the first few decades of its existence, the Caja insured a limited percentage of the population. At the time, the institution targeted workers and later some of the dependant families (Mesa-Lago, 1985).

Since its inception and until the 1970s, the activities of the Caja were important, but still limited. The Ministerio, successor of the Secretariat of Hygiene and Public Health in 1949 ("Reseña Histórica de las Instituciones del Sector Salud," 1997), was still the entity in charge of managing the hospitals and the main health actor in rural areas. During the 1940s and the first decades after World War II, the Costa Rican government received major support from the Office of the Coordinator of Inter-American Affairs (OCIAA)[52]. The OCIAA was linked to the Rockefeller Foundation through Nelson A. Rockefeller, who established the institute in the 1940s. The OCIAA continued the work that the Rockefeller foundation had started in many Latin American countries. In Costa Rica, the OCIAA provided assistance in the development of infrastructure, water and sewage systems and health care posts, and training. In Costa Rica, the different programs developed in rural areas were also based on paternalistic and dependence relationships, directed at guaranteeing political support for the political party in power at the time (Morgan,

52 Later known as the Office of Inter-American Affairs (OIAA).

1990). The support from the OCIAA came at the time of social and political unrest, offering the government the means to alleviate social discontent (Cueto & Palmer, 2015; Morgan, 1990). The assistance provided was also of great value to the government of the United States of America (USA) that expanded its influence during World War II and the Cold War, and *"strengthen trade and cultural ties between the United States and Latin America"* (Cueto & Palmer, 2015, p. 131).

Thus, Costa Rica's political actions toward the development of a health care system were deeply influenced by an international climate urging the allocation of political, social and economic resources to the development of a medicalised structure. The intended result was to impact on the economic and social standards of the population in countries characterised at the time as belonging to the Third World. Ultimately the goal was to ensure that populations all over the world achieved not only similar health conditions but also similar lifestyles with effects on the economic production (Cueto & Palmer, 2015). As I will show later, current programs and services are still embedded in this tendency toward productivity and economic development based on the goals and values of bilateral and multilateral agencies.

In the decade of the 1960s, the Costa Rican government passed a major legal reform toward the universalisation of health care coverage. However, it wasn't until the 1970s that the Caja was consolidated as a nationwide system through the integration of most health care services under its administration and the concrete extension of health care coverage[53] (Mesa-Lago, 1985). Although true universalisation of coverage has never been achieved, it has reached high levels in the past few decades[54].

During the 1970s and the 1980s, the Caja controlled most curative activities in the country, while the Ministerio was responsible for,

> *"primary health care for low-income groups in rural areas and urban-marginal areas, as well as for the control of some communicable diseases (e.g. malaria, TB, VD), keeping track of immunizations, environmental protection, drug control and child nutrition" (Mesa-Lago, 1985, p. 14)*

53 From 30.6% in 1965 to 85.1% in 1980 (Mesa-Lago, 1985).
54 All throughout the 1990s more than 80% of the population was covered by the Seguro de Enfermedad y Maternidad ―Disease and Maternity Insurance― (Rosero-Bixby, 2004) and in recent years it has raised to 90% of the population (MIDEPLAN, 2017a).

These decades were characterised by great advances in health care coverage and access to PHC in rural areas, but it was also imbued with great dependency on international agencies. This dependency was intensified by the world recession and the implementation of Structural Adjustment Programs in Costa Rica and other Latin American countries.

During the 1970s, the support of international agencies was essential to the Ministerio. This support came in the form of loans, training and donations from several bilateral and multilateral organisations – among them the United States Agency for International Development (USAID), United Nations Children's Fund (UNICEF) and the Pan American Health Organisation (PAHO). In the 1980s, when the effects of the recession became evident in Costa Rica, the health care system suffered (Morgan, 1987). These effects were intensified by, among other factors, the increment in health care costs and the demands of the Caja's employees for better salaries, both of which were influenced by the increased rate of inflation in the 1970s and beginnings of the 1980s (Mesa-Lago, 1985; Morgan, 1987). Furthermore, the foreign debt became overwhelming and forced many Latin American countries to sign structural adjustment programs with the World Bank, the International Monetary Bank and other financial organisations, that further limited their spending in social programs, among them health. According to Armada, Muntaner & Navarro (2001), these programs were designed to promote economic growth to enable Latin American countries to pay their debts. Simultaneously, they were directed at reducing government spending and at the same time reducing the welfare state, giving leeway for the neoliberal market to develop in the region.

In the 1980s, as a result of the influence that bilateral and multilateral organisations had secured in the country and as a response to the foreign aid provided by them, Costa Rica implemented several actions directed at mitigating the effects of the economic crisis. These actions impacted on the health care sector in tangible ways[55] (Morgan, 1987). In the next decade, international financial organizations, like the World Bank, the Inter-American Development Bank and the International Monetary Fund, funded health care reforms all across Latin America. The provided support came in the form of loans and technical advice

55 For example, reductions in the public sector's budget that had severe effects in the health sector, cuts in the number of drugs imported by the Caja and stagnation of the growth of the health sector, impacting rural areas and medical specialties like paediatrics and gynaecologic services, were some of the effects of the actions taken to mitigate the crisis (Morgan, 1987).

(Armada et al., 2001). These reforms sought to *"[…] boost the financial sustainability, equity, efficiency, and quality of health services, as well as to extend coverage to the poor"* (Armada et al., 2001, p. 733), in the face of the deterioration of the services in the 1980s. However, in reality the reforms have been inclined toward the funding of private provision of health care instead of financing public services. According to Rosero-Bixby, *"[i]n practice […], it seems that the dominant objectives in the process were of economic nature: improvement of efficiency and introduction of economic rationale in resource allocation decisions"* (2004, p. 1272).

The health care reform in Costa Rica, funded and influenced by international financial organization, was developed during the second half of the 1990s and the first half of the 2000s. Through this reform the Caja became the country's only public health care provider, in charge of services that went from PHC to hospital care and more complex health-related procedures[56]. This reform relieved the Ministerio of its previous duties related to PHC for low-income populations in rural and urban areas, and assigned the entity the *"supervising and stewardship functions"* (Rosero-Bixby, 2004, p. 1272)[57]. This reform had an important impact on the public sector as many of the employees of the Ministerio and its infrastructure were transferred to the Caja (Rosero-Bixby, 2004).

In terms of the effects of the reform on the general population, both very positive and more moderate evaluations exist. On the one hand, Mesa-Lago classifies Costa Rica's health care system as a *unified with very high coverage* model, alongside Cuba's health care model. According to the author this is a *"[…] totally integrated [model][…][with] a small private sector"* (2008, p. 160). This classification positions Costa Rica's health care system among the best in Latin America. On the other hand, Rosero-Bixby, in a study conducted at the beginning of the century to evaluate the impact of the health care reform in terms of accessibility and equity, concluded that even though there were improvements in the service —in terms of access and equity— 12 to 14% of the population were still underserved (2004).

56 The INS also provides medical services to the insured population in case of injuries caused by accidents, work related and otherwise.
57 That have been strengthened through the 2008 and 2014 executive orders.

Caja's Organisation

The Caja is one of Costa Rica's most complex and bureaucratic institutions, one that has a territorial and social impact throughout the Costa Rican territory. The institution is composed of different branches in all the counties. The importance of the institution can be perceived through news reports and in everyday conversations, where both negative and positive appreciations of the institution are shared. In part, the structural complexity of the institution results from the incorporation of both health care and a pension scheme. Additionally, this complexity is acknowledged by the fact that even though there are other public pension schemes within the state apparatus, for example the teachers' pension scheme, the Caja is the only public health care provider in the country. Public, private and independent workers who opt for a pension scheme outside the Caja, can still access the Caja's health care services, since by law all workers in Costa Rica have to have health care insurance (Jaramillo-Antillón, 2004). The Caja is in charge of all public health care posts and hospitals. Thus, the Caja constitutes one of the most relevant institutions in Costa Rica, along with the education system, not only in terms of health care, but also in terms of its interactions with the population. For example, in terms of public expenditure, between 2011 and 2015 6.5% of the budget was allocated to health care services, with 5.9% of this amount spent by the Caja (MIDEPLAN, 2017b). If we consider that in Costa Rica most of the energy and telecommunications activities, an important part of the tourism industry, through national parks administration, along with education and social services are in the hands of the State, a 6% of the budget is not a small part of the government's total spending.

By law, the Caja is an autonomous institution run by a board of directors composed of nine members; three members representing the executive power, three members representing the employers, and the final three members representing the workers (CCSS, 2017; Jaramillo-Antillón, 2004). The chair of the board or executive president is one of the members representing the executive power, and is the highest authority within the institution. The executive president is in charge of ensuring the board's decisions are executed and of the coordination of activities between the Caja and other governmental institutions (Costa Rica, 1943).

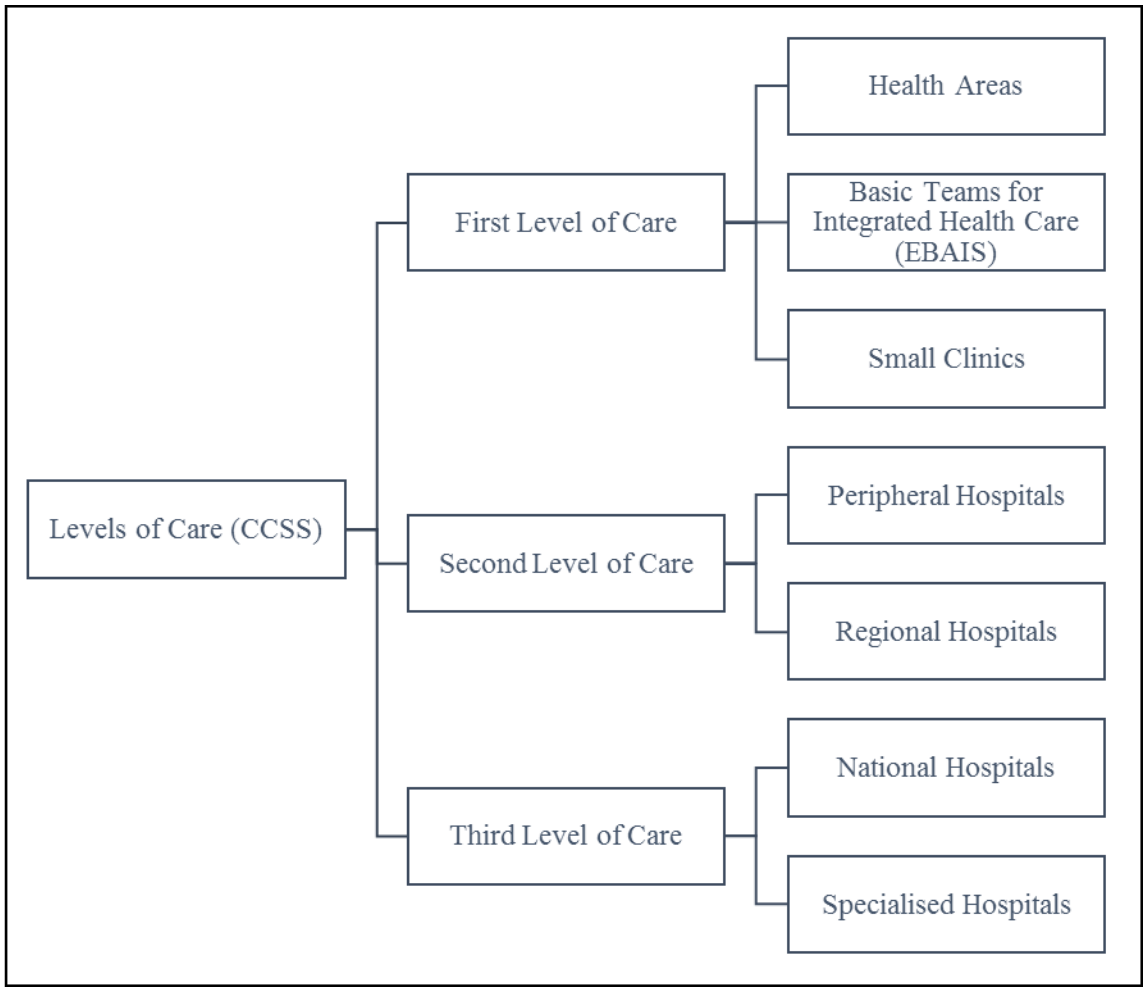
The Caja is financed through a tripartite contribution from employers, workers and the state, based on the workers' salaries. The financial contribution covers two insurance schemes: disease and maternity insurance (SEM Spanish acronym)[58], and disability, old age and death (IVM Spanish acronym)[59]. These schemes benefit a population composed of workers actively contributing to the system and their dependants, the retired population under the Caja IVM scheme and other state-run pension schemes, and the population insured by the state. This last group correspond to *"persons and their relatives that do not contribute to the system on account of their condition of poverty or disability"* (Sáenz et al., 2010, p. 8). In El Bajo, at least 50% of the non-indigenous population benefit from this insurance coverage. All the indigenous inhabitants are also covered in order to comply with the 169 International Labour Organisation agreement (ILO, 1991).

The executive president is in charge of six management directors: pensions, infrastructure and technologies, logistics, administration, financing, and medical (CCSS, 2011). Recently the board of directors created the general management office responsible for assembling the different actions undertaken by the management offices of the institution (Solís Ramírez, 2017). The coordination of health care services is under the medical management. In organisational terms, the health care network is divided in seven regional directions of health care services (CCSS, 2011). There are also three levels of care that further organise the services. The health care levels are designed to offer services from basic care to more complex assistance. The first level includes all the Basic Establishment for Comprehensive Health Care (EBAIS) and small clinics; this level takes care of PHC, immunisations, and basic consultations with general practitioners. The second level includes major clinics and basic hospital care that offer emergency services, consultations with specialised professionals and minor surgeries. The third level includes three national hospitals and six specialised hospitals ―see Figure Two― (CCSS, 2011; Sáenz et al., 2010).

58 The total contribution is 15% of the salary distributed in the following way: 9.25% provided by the worker, 5.50% provided by the employer, and 0.25% provided by the State (Sáenz et al., 2010).

59 The total contribution is 10.16% distributed in the following way: 3.84% provided by the worker, 5.08% provided by the employer, and 1.24% provided by the State (Ó. Rodríguez & Chinchilla, 2017). In June 2017 the board of directors of the Caja voted in favour of raising the worker's contribution by 1%, making it effective in January 2018. This decision created a controversy within the executive power that ended with the resignation of the executive director of Caja at the time María del Rocío Sáenz Madrigal (Ávalos, 2017a). The president appointed the Ministry of Health, Fernando Llorca Castro, as Dr. Sáenz Madrigal's replacement (Costa Rica, 2017). According to the constitutive law of the Caja, the board of directors is entitled to decide on the increments for both schemes, based on actuarial calculations (Costa Rica, 1943).

Figure Two: Levels of Care, the Caja



Source: Own elaboration based on (Sáenz, Bermúdez, & Acosta, 2010).

The Brunca Region is in direct relationship to the context of El Bajo. This region includes six counties, every one of which has a Health Area that organises the 71 Basic Establishments for Comprehensive Health Care (from now on EBAIS) and the major clinics in the region[60]. These Health Areas also coordinate with the basic hospitals in the region, five in total. The region has 650 employees distributed throughout the different posts (MIDEPLAN, 2017b; Sáenz et al., 2010). According to a health-related analysis developed by the Ministry of Planning, and based on standards established by the World

60 There is no official data about the amount of major clinics in the region. However, based on the conducted fieldwork there is evidence of at least one of those clinics, in the county of Corredores, in the district of La Cuesta, that offers urgency services during the day.

Health Organization (WHO), the region has a 30% deficit in terms of the first level of care infrastructure and a 21% deficit in terms of necessary health care personnel (MIDEPLAN, 2017b). Thus, the Brunca Region is one of the underserved areas within Rosero-Bixby's study previously mentioned (Rosero-Bixby, 2004). The county where el Bajo is located, belongs to the Brunca Region and therefore falls under the category of underserved area.

In the county where the study took place there are eight EBAIS, one major clinic and one basic hospital. The existing EBAIS are distributed along the territory in order to offer better access to the population. However, six out of the eight EBAIS are located in towns or small cities of the county. This situation has been assessed by the local office of the Ministry of Health. According to institutional representatives, this distribution of services presents important inequalities. The study conducted by this entity identified that the time a patient invested in health care[61] varies considerably between someone living in the town or small city —who invests around three hours— and someone living in a distant community —who invests 12 to 14 hours. The disparities in economic investment are also important, since most people living in towns or small cities can walk to the EBAIS, while those living in isolated communities have to endure long walks to the nearest road and then pay for transportation. El Bajo is one of the latter and an example of the burden residents' face in terms of time and economic resources in order to access health care services.

This county's health network has a clinic that offers emergency services. It is located in a densely populated area of the county. This facility houses the Health Area in charge of administrating the EBAIS within the county's health network. The Health Area, the clinic and the EBAIS of the county all belong to the first level of care. The local hospital is in the same small city as the EBAIS that corresponds to El Bajo, but this facility has an administrative division of its own. This hospital corresponds to the second level of care. As well, within this level of care are other hospitals in neighbouring counties, which in emergency cases, when interventions by a specialist are necessary, might work together based on the available

61 This includes both the time traveling and the time spent at the health care facility.

personnel. The third level of care is represented by a national hospital, which is located in the capital, San Jose, more than 300 kilometres away.

As a result of the 1990s reform, Health Boards were established with the intention of fostering *"citizen participation"* (Sáenz, Acosta, Muiser, & Bermúdez, 2011, p. 164). The boards have volunteer representatives from the employer sector, the insured population, and the hospital and clinic associations. They have no authority, but their input is requested by the director of the Health Area in matters related to budget allocation and management commitments, among other issues (Costa Rica, 1998; Sáenz et al., 2011). While conducting fieldwork in El Bajo, I encountered the county's Health Board once. At the time the board was paying visits to some communities to consult with community leaders about health needs. This experience provided some evidence of the complexities of having only one board to channel the sentiment of a large and diverse population in terms of ethnicity and socio-economic status. The Health Boards included in the reform seem to be a clear example of what Morgan calls utilitarian models, an *"[…] effort on the part of donors or governments to use community resources […] to offset the costs of providing services"* (Morgan, 2001, p. 221). In this case, the volunteer board members are overworked, failing to foster real participation from the different communities in the county.

Current State of the Caja and Challenges

In spite of the great influence that international agencies have secured in Costa Rica and the enforcement of neoliberal reforms all around Latin America, the country has managed to sustain universal health care coverage among the benefits that all citizens can enjoy (Armada et al., 2001). Nevertheless, the survival of universal health care coverage has faced many challenges. Paradoxically, these challenges have been partially overcome by inflow of loans from international financial organisations (Rosero-Bixby, 2004). Recently, the Costa Rican government signed a new loan with the World Bank for the amount of US$420 million to pay the government's debt to the Caja and strengthen the Social Security in the country (Costa Rica, 2016). This new loan comes in the modality of *Program-for-results* in which every disbursement depends on a specific result (Bank, 2012). According to a government press release, the loan

will *"[…] strengthen the Universal Health Coverage in Costa Rica and impact the institutional efficiency and the financial sustainability"* (Costa Rica, 2016). Some of the concrete actions include a screening program for colon cancer, design and integration of a health network[62] and the expansion of the unique digital medical file. Even though the new loan seems to have explicit actions directed at improving the health of Costa Ricans, it might still be more concerned with impacting on the economic difficulties that the institution faces and not the ones related to the attributes of the institution, like service quality and equality. The objectives here, thus, might again be of an *economic nature*, as they were on the reform of the 1990s (Rosero-Bixby, 2004, p. 1272).

The challenges faced by the Caja are mostly explained in terms of the economic difficulties that the institution has borne for almost five decades. According to Jaramillo-Antillón (2013), these problems are related to a series of miscalculations related to the demographic change and decision-making during the 1990s that have put pressure in the system. The author explains that Costa Rica's demographic characteristics have changed in two important ways: the life expectancy has increased[63] and the fertility rate has decreased[64]. These changes inflict pressure in a system that is designed to be sustained by the economically active population. First, the larger senior population lays pressure in the system due to increase in chronic illness. Thus, both schemes, the IVM, pension scheme, and the SEM, health scheme, are affected by these changes, but the IVM scheme is the one facing the most risk. Second, the Caja is affected by a historical and increasing debt of the government and other private employers[65].

In addition to the financial problems that the Caja faces, there have been several cases of corruption attached to the institution. Many of these cases involve high level officials from Caja and other sectors of the government. One of the best known corruption cases consisted of the purchase of unnecessary medical equipment in exchange for high commissions. Many of these corruption cases, involving the Caja and other State institutions in Costa Rica took place in the late 1990s and early 2000s and their trials were carried out

62 It isn't clear what is meant by this aim, but is precisely this type of ambiguous phrasing that might be directed at a reform that ultimately eliminates not only universal health care coverage, but the right to equal treatment within the system.
63 In 2015 the life expectancy in Costa Rica was 78,8 years (Estado de la Nación, 2016).
64 In 2015 the fertility rate in Costa Rica was 1,8 children per woman (INEC, 2015a).
65 The debt has been the result of non-paid or miscalculated quotas (Jaramillo-Antillón, 2013).

in the past decade. Furthermore, low level corruption is also common within the institution, a well-known example is the practice of *biombos* that consist of payments received by medical doctors to perform surgeries ahead of schedule (Jaramillo-Antillón, 2013).

The interactions between health care institutions and the communities in Costa Rica have been traversed by a multiplicity of discourses that have moved from top-down approaches to the interest in motivating community participation (Morgan, 1990, 1993, 2001). In El Bajo, this has been a complex relationship that bears the added burden of a national identity based on an idea of homogeneity and the erasure of not only the indigenous background of the population, but also the existing indigenous populations mostly inhabiting rural areas of the country (Campo-Engelstein & Meagher, 2011; Palmer & Molina Jiménez, 2004; Townsend-Bell, 2014).

The participation of the community is both desired and criticised. Community participation is desired as a tool to achieve objectives, taking advantage of community leaders' knowledge of their context, its population and their surrounding natural environment. However, as previously discussed, in terms of the Health Boards, the forms of community participation observed in El Bajo during fieldwork, moved along the lines of what Morgan has described as *"perfunctory and utilitarian […] designed to benefit the state by shifting some of the costs […] to the rural citizenry"* (1989, p. 235). There was no real desire to involve the community in a more active role or to consider their demands. Additionally, community leaders were criticised on the grounds of lack of involvement and failure of their actions. Nevertheless, most of the actions that are considered unsuccessful are determined by the state institutions that then blame the failure on the indigenous population that they considered incapable of organising themselves to take action. This perception is the result of the stereotype of the indigenous man as disinclined to hard work, and the indigenous woman as submissive and shy. This ambivalent and conflictive relationship will be further explored in the next section.

Health Care in Place

The medicalisation of health care in Costa Rica, as previously illustrated, has been a long process lasting half a century or more, with the active participation of international organisations and national political figures. This process created a system that extends largely across the Costa Rican territory. The centralisation of many of the decisions within a group of directors has created a standardised institution. However, the functioning of every EBAIS has its particularities, mainly due to the characters involved in providing and receiving health care. Mol (2008) has called attention to the importance of health care providers' subjectivity when delivering health care. Fassin (2015) has highlighted this aspect as central to the workings of the state and its institutions. In the following section I provide a general view of the workings of the state-run health care in the county where El Bajo is located. I see the EBAIS as the place where health care practices occur. I highlight the role of the ATAP as the first point of contact for rural communities. I also outline the mode of operation of the EBAIS by describing the infrastructure and the different services the facility provides. By looking at the interactions between the EBAIS' employees and the members of the community seeking health care services, I personalise a facility that would otherwise be identical to all the other EBAIS in the country.

First Point of Contact: The ATAP

By definition, the work of the ATAP is one of (dis)placement, as in a process of continued lingering and traveling. The ATAP lingers in the home of every member of the community and then travels between each home. Thus, the work of the ATAP is one that requires movement and that takes place outside of the EBAIS —the place of medicalised practice. However, this displacement from the EBAIS does not imply a separation from the medicalisation of the labour of care, on the contrary, the ATAP transports this ideology and he/she reproduces it in every place he lingers and even as he travels. Arturo, the ATAP assigned to El Bajo for more than two decades talked about the process of movement with high regard. He liked the traveling, even if he wasn't very fond of his means of transportation. In his view, the places he visited required a safer vehicle than the motorcycle he was using. He also felt a high commitment to the aim of his

job *"get to the last house, as is our mission"*. Additionally, he had a lot of respect for the institution and felt that since he was representing the Caja, he needed to look his best and so should his equipment.

In his own words, Arturo's duties are:

> *[...] we have to visit, check the blood pressure, give the antiparasitic medication, ask some questions [...] it's a long questionnaire. [We have to] check the vaccinations [...]. Check the pap smear, if it is [or isn't] up to date […], provide education; check for family planning, whether they are using contraception, what type, […] provide education, refer to the EBAIS if they are not using contraception. In case of pregnant women check if they are under prenatal care, what symptoms they are presenting… a comprehensive attention, everything is considered. In the case of children [confirm] if they are under the regular check-ups [and] if they are not, refer them [...]*

The questionnaire he mentioned is very detailed and it includes information about the condition of the house, the health status of all the members of the household, including vaccination, screening test, and substance dependence. The questionnaire also gathered information about employment and education, access to general services, and possible sources of pollution in the proximity. His job also had a great emphasis on education, which was mostly directed at the prevention of disease. Furthermore, he was the direct link between the communities and the EBAIS and a vital agent to facilitate the participation of the community in the health programs. This becomes evident in Arturo's quote, where he reiterates his role of referring the population to the EBAIS. Arturo was also in charge of keeping children's vaccinations up to date and for that he used to carry a small cooler in case he had to vaccinate a child.

A little more than a decade ago, Arturo worked in a Health Post very close to El Bajo. However, most of these posts were eliminated and he was transferred into the nearest city in 2005. The work in the Health Post was filled with many more responsibilities, since he managed the post and only referred the population to the EBAIS or the hospital when further assistance was needed, such as the case of disease and/or pregnancy. Even though the health care post doesn't exist anymore, Arturo still works with the same population. He is well known in the community not only for his service of more than 20 years, but also

because he was born and grew up in El Bajo. He is part of the non-indigenous population of the community, and he attended primary school with many of the indigenous people still living there. This makes the relationship more intimate and also more complex, since he acts as a health authority in a context that sees him as both an insider and an outsider. Furthermore, people sometimes undermined his advice based on knowledge, ideas or rumours about his background, past actions and lifestyle.

An example of an interaction between Arturo and a woman from the community was narrated to me when talking about contraception with a group of women. Leonor, a woman in her mid-thirties with only two children, commented on her dislike of Arturo's constant policing of her contraceptive practices. She mentioned that in response to his inquiries about her use of contraception, she had lied to him by saying she was not using any contraception. This prompted him to reply that she will soon be pregnant if she didn't use contraception. She then argued back by pointing out that his own family situation was not that different —Arturo himself had three children and his daughter had just giving birth to her third child. This type of interaction was possible because the close relationships Arturo established with the community and his consistent and lengthy visits. His insistence on care practices like contraceptive use, hygiene measures and screening tests, even though not always well received, had an effect in the community due to the relational character of his interactions.

Consequently, Arturo was a central figure for many in the community. His advice was constantly mentioned in interviews or everyday conversations. His help was sought in many occasions, either for tasks included in his regular duties or for others outside his job description – such as mediating with the doctor at the EBAIS, getting references to request the health insurance by the state, or giving advice about the right governmental entities to consult in particular circumstances. Arturo was heavily criticised in the community for some of his comments and personal experiences and he was the subject of gossip in both the community and the EBAIS.

Arturo was raised in a context where the logic of relationality was of great relevance. In the way he talked about his job and about the communities he regularly visited he showed great concern about his performance and about providing the population with a good service that would allow them to achieve well-

being. His efforts were also motivated by a desire to stand out in his job. Thus, he talked on more than one occasion about his desire to get recognition from community members and co-workers. However, this desire for recognition was also relational in nature. Even though Arturo's relationship with the community was a complex one, charged with mixed feelings about his responsibility and a sense of favours owed, his use of the relational logic made him a successful mediator. His role as intermediary and communicator, his extensive knowledge of the community and its population, and his understanding of the Caja made him a relevant figure in the community and the EBAIS. Thus, it was through conversations with him that many of the community discontents were communicated to the higher levels of Caja. Nevertheless, he had his own opinion of the community and the population and, therefore, his passing on information was never without bias or innocent[66], and his position within the Caja's structure meant he had limited power.

The EBAIS

The EBAIS is located on the outskirts of a small city in the southern region[67] of Costa Rica. The facilities are located in a small lot on the property of a Pentecostal Church. This property houses three mobile EBAISs built on containers. These three EBAISs correspond to the population of the north-eastern area of the county, including the population of the city and the surrounding areas bordering with two other counties. Every EBAIS has a medical doctor, a nurse, a medical records technician, who is in charge of scheduling appointments and filing, a pharmacy technician, and two ATAPS. The three EBAISs share the pharmacy where the drugs are dispensed, and the pharmacist that runs it[68]. The establishments also share one dentist and its corresponding office with basic equipment. The cleaning services and security services are outsourced to private companies that allocate two cleaners and one security guard for the three facilities.

66 For the sake of clarity, I would like to volunteer that my situation as a researcher close to the community and the EBAIS was, at times, very similar to Arturo's situation. I also found myself in the role of mediator and communicator, I also found myself helping out community members in their quest for better access to health care.

67 Just a few kilometres away from the border with Panama.

68 By law only pharmacists can dispense prescriptions. In the past, the pharmacy technicians, trained by a division of the Caja under the medical management direction, the same division in charge of training the ATAPs, were in charge of dispensing the prescriptions at the EBAISs. This change in 2009 when the Costa Rican Pharmacists Association pressured the Caja to comply with the law.

The clustering of these three EBAISs represents an administrative strategy to save resources by sharing some of the personnel.

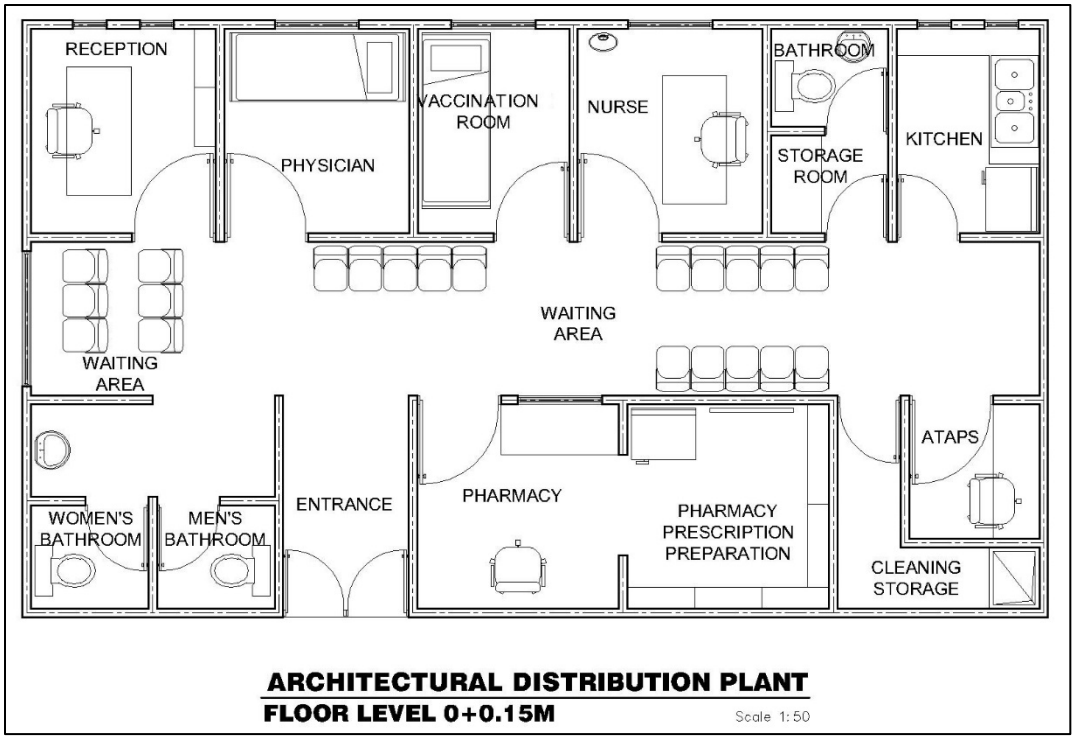
The EBAIS infrastructure is very basic. As mentioned before, it consists of adapted containers, built with the intention of eventually relocating them to a property owned by Caja. The offices are small and most of them lack air conditioning —of great importance considering the warm and humid weather of the county. The walls are also thin, which allows middle to high volume noise to travel quite freely. The establishments were put in place in 2009 and even though the main infrastructure is in good condition, some of the equipment is outdated. Each EBAIS is organised in a way that each of the services has been allocated one office in their corresponding container, with the exception of the pharmacy, which is contained in two facilities where it has two rooms in the EBAIS corresponding to El Bajo, and one store room in another EBAIS. The facilities have a vaccination room which is small with a refrigerator to preserve the vaccines. There is one set of gender differentiated restrooms allocated for users and one mixed gender restroom assigned to the personnel. There is a general storage area and a good size kitchen for the employees.

The operation of the EBAIS is reasonably consistent. The facility functions from Monday through Thursday from 7am to 4pm, and on Fridays from 7am to 3pm. The appointments are provided first in the morning, which forces users to line up since early morning to be able to get an appointment. However, recently the Caja implemented the online and phone service to book appointments. This service only provides a limited number of appointments per day and the rest are offered in the first come, first served basis. Hence, even though the booking of appointments has improved, many people still need to arrive early at the EBAIS to acquire an appointment. Despite the improved system, isolated populations, like the inhabitants of El Bajo, are at a disadvantage since distance and limited access to cell phone reception and internet connection[69], hinder the efforts of the population to book appointments according to established institutional procedures. This drives the population to seek appointments through back channels, including

69 As mentioned in Chapter Two, El Bajo has limited access to internet at the school through a satellite service offered by the government's telecommunications company. The phone land lines in the community are connected to the satellite service and, therefore, are subjected to the satellite connectivity which is not always good. Finally, despite a growing number of inhabitants of El Bajo that own cell phones, they don't always have good reception to either make a call or book an appointment online.

deal making with the medical records technician or network manager, either directly or with the assistance of the ATAP, or directly requesting an appointment to the physician —see Figure Three.

Figure Three: EBAIS Distribution



Source: Elaborated by Rebeca Ramos based on my own description.

Medical appointments represent a long and tedious process in which patients get to see the doctor for 15 minutes[70]. A full appointment might last three to four hours from the moment the patient first arrives to the EBAIS. An appointment as described from the patients' perspective consists of:

- A first contact with the network manager to check-in. The network manager locates the patient's medical file and passes it on to the nurse. The network manager also initiates the electronic appointment in the system[71].

70 This means that the physician should assist thirty-two patients per day.
71 The electronic medical file is a new system implemented in the Caja. It centralises all the patient's information in an online system that allows personnel at all levels of care to access the information. This system was being tested when I was conducting fieldwork and it was related to the new online and phone appointment booking. Because the system had only recently been implemented, the physical medical files were still in use, but the intention was to eliminate them.

- The nurse calls the patient and starts an interview in which he/she finds out about the patients reason for consultation. The nurse also checks the blood pressure and takes measurements for height and weight. He/she then transfers the patient to the medical doctor through the electronic system and by providing him/her with the physical file.
- The doctor's appointment involves, for the most part, a 15-minute conversation. On some occasions the patient is examined for physical evidence of the patient's cause of discomfort. At the end of a consultation the patient is likely to obtain a prescription for drugs or lab tests, or both.
- The patient then proceeds to the network manager with the physical file and the prescriptions to return the file and get the required stamps in the prescriptions.
- Finally, the patient is sent to the pharmacy, right there at the EBAIS, or the laboratory, at the Hospital approximately three kilometres away, or both.
    - At the pharmacy the patient submits the prescription and gets a number in return. After about an hour the prescription is ready.
    - At the hospital, the patient books an appointment to start the testing process.

The appointments might consist of follow-ups or a one-time consultation. The follow-up appointments are regularly in direct relationship with programs established by the Caja based on the needs of the population. The programs are mostly designed for the surveillance of chronic disease patients, hypertension, diabetes and dyslipidaemias. Programs are also directed at monitoring vulnerable populations such as pregnant women, children and adolescents. Other Caja priorities include the screening for cervical cancer and other STDs, for example, regular testing for syphilis and HIV among pregnant women. Finally, contraceptive use also requires follow-up appointments, generally every three months. According to a Caja representative from this county, the program evaluation is both quantitative ―the percentage of the population covered by the program― and qualitative ―the patients' individually achieved results, for example, achieving an optimal blood pressure measurement. The one-time consultations are related to the appearance of particular symptoms and their treatment.

The EBAIS with dispersed populations schedule weekly fieldtrips to visit isolated communities. The EBAIS assigned to El Bajo visited the community once every four or six weeks. These fieldtrips were designed to regularly provide EBAIS services to the communities and with the intention of decreasing the transportation load placed on their members. However, these fieldtrips had important limitations because the team had to operate without the necessary infrastructure. Furthermore, the communities had the responsibility of providing the team with the infrastructure to carry out the consultation.

These fieldtrips were regarded as unproductive by both parties. The community complained about the team's unpreparedness; they had no medical files and therefore no lab results, prescriptions needed the signature of a pharmacist and thus were delivered the next day. The health care team complained about the communities' inability to organise themselves in advance, generating a list of patients for the networks manager to bring the medical files, and about the communities' lack of participation during the fieldtrips. This meant that during fieldtrips the teams had little or no work, because most community people preferred to make the city trip to see the doctor. Ultimately, the problems arising on fieldtrips were the result of lack of coordination and of different understandings about the responsibility of each of the parties in the process of health care. The Health Area, in charge of administration considered the fieldtrips as essential to the performance of the Caja in the county.

The operation of an EBAIS is thus directed at developing both curative and preventive measures, or better said surveillance measures. All actions developed by the EBAIS are within the realm of biomedicine. The physician relies on the results of tests and measurements to dictate the necessary actions to either cure or prevent illness. Both the patients' evaluation and the process of educating them in relation to the correct way to care for their bodies are limited to 15 minutes and sometimes even less. Many of the physicians I talked to were frustrated by the limited impact they had on the population. Their frustration was related to both the procedures imposed by the Caja and the population's lack of commitment to their own health. Notwithstanding, these physicians were still concerned for the well-being of their patients and were also frustrated by what they could see were inequalities preventing the population from making real changes to impact their health. Despite their frustrations and their understanding of the obstacles faced by

the population, they were also trained and hired to perform a particular job in a standardised manner, which gave them little room to improvise.

Social Dynamics

The EBAIS presents a particular social dynamic enriched by health care providers and health care seekers. These dynamics are the result of structural conditions, emerging from global and national historical events that have important consequences in the local setting. Thus, aspects such as ethnic differentiation, that repeatedly takes the shape of discrimination, is visibly informing these dynamics. In many ways the process of ethnic differentiation and discrimination is a result of the colonial structure that is still ingrained in the everyday lives of people in Costa Rica. Another relevant aspect informing these dynamics is the hierarchical structure of knowledge production within a biomedical setting. This structure places the knowledge produced by the physician —the diagnosis— at the top of the hierarchy. In the context of the EBAIS, hierarchies are not openly discussed but they are performed on a daily basis. In this structure the health seeker is at the bottom of the hierarchy. Thus, physicians expect health care seekers to respond to their advice and consequently get healthier.

The Internal Dynamics

The EBAIS are, for the most part, lively establishments. The establishment where I conducted fieldwork was particularly congested due to the fact that it housed the pharmacy. Mostly, waiting areas were busy from early morning until mid-afternoon, when most patients had been assisted by the doctor. The EBAIS was also a place visited by other Caja employees that performed roles like stocking the supply of prescriptions, evaluating the performance of employees, or running errands, such as moving paper work from the EBAIS to the Health Area in charge or vice versa. For patients, this was a transitory establishment, but for employees, the EBAIS was the place where they spent a considerable amount of time during week days.

As in any other workplace, the EBAIS' employees built strong relationships that extended beyond that of co-workers. The dynamics were as complex and illuminating as the relationships in El Bajo. Conflicts were tied to emotions and illustrated power struggles over non-explicit hierarchical orders, such as that between physicians and nurses or pharmacists and pharmacy technicians. Furthermore, this non-explicit hierarchical order also (re)produced class, gender and race inequalities present in the county. For example, among the three EBAIS, the only male physician was in charge of the EBAIS where the only male nurse was appointed; this gender distribution of personnel among the three EBAIS begs the question of mere coincidence or intended action. But conflict was not the only type of relationship among health care workers. Many of them had strong relationships of friendship and knew intimate details about each other's personal lives. Furthermore, some of them spent leisure time together and participated in important events like weddings, birthdays or the death of a family member.

Even though the EBAIS was a fairly crowded place, it provided patients and employees with some privacy; from a doctor's consultation room where the relationship between patients and medical professionals took place, to the gossip among co-workers and the odd birthday celebrations. From one room to the next experiences changed through the opening and closing of doors. Closeness was another experience that some patients and employees achieved. This experience was given not necessarily by the amount of people participating in an activity, but by the matters being discussed, the procedures being undertaken, or the proximity of the people involved. Not all private interactions achieved closeness, but privacy was an element that was constantly being sought. In this context, one had to consider that on the one hand, privacy was a scarce resource affected by time and infrastructure. On the other, both patients and employees were constantly caught up on the ruptures of privacy, which resulted in designing mechanisms to restore it. In this context, the employees had not only the knowledge, but also the authority to navigate privacy. Most patients were caught up in the already established dynamics. However, among the patients, there were characters bold enough to either disrupt employees' strategies for privacy or to implement strategies to obtain such conditions when being assisted.

The Relationships: The providers and the beneficiaries

The population that visited the EBAIS was caught up on an already established dynamic within a very complex bureaucratic structure. Therefore, navigating the system was a complicated procedure that was further affected by the particularities of the people participating in both delivering and seeking services. Even though the activities and interactions developed within this facility were mostly standardised in a way that each experience is similar in any EBAIS in the country, gender constructions, race perceptions, economic status and even the weather impact on the way they are played out.

In the county of Corredores, the experiences were determined by many factors, one of them was the diversity of the population. Composed of a rural and urban population, it had a great ethnic diversity and an important percentage of migrants from other parts of the country, from other countries, and from different socio-economic backgrounds. The health care employees in the county and even within the EBAIS were also diverse. This composition made for a complex interaction between provider and beneficiary, impacting the population's capacity to navigate the system. Given that the focus of this thesis is in the indigenous population, I will refer to the main conditions impacting their relationships.

One common characterization used by health care professionals to refer to indigenous Ngöbe people was their shyness. This characteristic was both seen as positive and as negative. Those that considered this a positive trait, saw their quietness as a sign that they were unlikely to complain about the service, in accordance with the administrative aim to provide good service and avoid complaints. Furthermore, they perceived that if they were ever to complain, they wouldn't be bad-mannered. However, for other health care professionals this was a negative characteristic that interfered with their work, since it was hard to obtain enough information about their health condition, creating difficulties for the service delivery. Conversely, Arguedas-Ramírez (2014) in her study about obstetric violence has pointed out that health care professionals are generally not comfortable with patients that are too communicative. Communication in itself doesn't seem to be the issue. The concern seems to be related to the type of information that is provided and particularly the forms in which patients provide such information. Thus, quietness or shyness, which can also be translated into submissiveness, is valued when the patient is capable

of providing the right type of information. Furthermore, promptness in the provision of information is important in a place where time is limited.

Women's shyness can be representative of both the exercise of agency as resistance or the inhabiting of norms. Since Ngöbe women were known to be quiet in places where they do not fully understand the dynamics at play, it is important not to see their quietness as only the inhabiting of norms. For example, Alba would listen to the doctor talk about contraception and even accept the oral birth control he prescribed, but once at home she would not take it. The reasons for not using birth control were different for different women, in the case of Alba, it made her feel sick. Alba, however, would not comment about the side effects with the doctor, since she felt uneasy about interacting in this way with someone she barely knew.

The relationship between provider and beneficiary, therefore, is transitory and transactional. The patient is seeking to solve a health-related situation. The physician and the rest of the health care providers are seeking to comply with their job by assisting the population and recording data that will later be evaluated in terms of the quantity of assisted population and the success reaching desired health ratings. The transactional relationship is also one of power dynamics in which it is assumed that one of the parties has the knowledge to alleviate the discomfort that the other party manifests. Even though the communication is expected to flow from both ends, only the doctor is expected to produce knowledge. The patient's description is regarded as input to the production of knowledge. The existence of power dynamics might not turn interactions into unpleasant experiences, but it does limit people's participation in the labour of care and undermines their contributions. On the one hand, the indigenous Ngöbe lifestyle was perceived by health professionals as an obstacle in the process of achieving better health ratings. On the other, indigenous people were aware of the negative perceptions that health professionals had about their beliefs and practices, which limited the amount of information that they were willing to share.

Chapter Six: Medicalisation of Sexual and Reproductive Health

Since the mid-1900s until the present, Costa Ricans have been experiencing different processes that have opened up alternatives in relation to sexual and reproductive rights. These processes are connected to the medicalisation of sexual and reproductive health that has been taking place within the health care system. These process are also intertwined with social movements that seek to either expand or constrain the state's intervention. In this chapter I analyse the sexual and reproductive governance influencing the transformations of birth practices, the expansion of access to services related to sexual and reproductive health, such as contraception and screening tests, and the new services being incorporated into the health care system such as adolescent specific services. I highlight the historical aspects that are most relevant to women in the community of El Bajo. In addition, I mention some of the aspects that had lesser relevance to Ngöbe women in El Bajo at the time of data collection but that might be in a near future, such as pro-life, pro-abortion and LGBTQI movements.

At the heart of many of the transformations overviewed in this chapter is the right to health as a powerful mobilising discourse for the expansion of sexual and reproductive services. Carranza (2007) has highlighted this characteristic of Costa Rica's sexual and reproductive governance. Roberts and Morgan (2012) have also mentioned the importance of the discourse of the right to health in Latin America's reproductive governance. Furthermore, Wynn and Trussell (2006) have mentioned the occasional use of the public health argument in the process of advancing sexual and reproductive rights in the USA[72]. I argue that the right to health as a mobilising discourse is particularly important in a country that, as explained in Chapter Five, has made efforts to sustain a health care system that is not only economically onerous but that offers a striking contrast to the neoliberal system that advances the privatization of health care services. Nevertheless, the discourses are multiple and are associated with complex global and local dynamics. In the context of El Bajo some of these discourses pose challenges to indigenous women, who value

72 Wynn and Trussell (2006) concentrate on the use of the public health argument in the process of debating for the non-prescription access to Emergency Contraception Pills (ECP) in the US. They explained how activist promoting the non-prescription access to ECP deliberately used the health argument instead of framing "[…] the issue in terms of 'choice' or women's rights […]" (p. 300).

reproduction and experience fluid sexual lives. At the same time, they provide them with tools to exercise their agency inside and outside their community. Part III of this thesis delves into indigenous Ngöbe women's use of some of the health care services whose incorporation in the health care system is highlighted here.

This chapter explores the views and values about sexuality and reproduction manifested by the employees of the EBAIS assisting women from this community. These views and values emerge in informal conversations such as gossip and storytelling. The employees' understandings of their own sexuality and reproduction and of the services provided at the EBAIS impact on their perception of the men and women they assist and ultimately, on their work as health care providers. Through these conversations it is possible to identify some of the discourses on sexuality and reproduction, as well as aspects of the gender structure informing such views.

Sexual and Reproductive Health in Costa Rica

Knowledge about the work performed by midwives, the development of contraception, and the ways in which women attended to their bodily needs in Costa Rica at the end of the 1800s and early 1900s is limited. Nevertheless, there are important studies that shed light on this topic. An oversight that is impossible to ignore in the context of this research is the absence of studies about Costa Rica's indigenous women's sexual and reproductive practices and demands in the past. Even though Bozzoli (1979) wrote an extensive ethnography about birth among the Bribri of Costa Rica, her study concentrates on the cosmological aspects of this experience. Furthermore, more recent information about indigenous women's sexuality and reproduction is also limited. Gutiérrez Obregón (2011) thesis about indigenous Bribri women is one of the few studies of its kind. Due to this gap in the literature, I provide a general overview of the most important transformations around sexual and reproductive services in Costa Rica, which will serve as the context to understand the use of services by Ngöbe indigenous women from El Bajo.

The Medicalisation of Sexual and Reproductive Health in Historical Perspective

The incorporation of sexual and reproductive health practices into the health care system has had an important impact in everyday life in Costa Rica. This process was only incorporated into the community of El Bajo a few decades ago but its historical process goes back to the late 1800s. The period between 1960 and 1980 saw the rise in official sexual and reproductive health practices in Costa Rica, from contraception to screening tests and the continuation of the medicalisation of birth through training programs for midwives. It was during this period that most of the core activities relating to sexual and reproductive health were incorporated into the Costa Rican health care system. The medicalisation of birth is the best established practice within the health care system, followed by birth control. These two practices are also well incorporated into the lives of Ngöbe women in El Bajo.

Midwifery and the Medicalisation of Birth

The transformation of birth assistance started between the late 1800s and the beginning of the 1900s. This process shifted from the provision of home assistance during childbirth to its medicalisation, through the work of trained midwives working in the capital and its periphery, and in some small towns in the rural provinces of the country (Palmer, 2003). According to Palmer, this process of medicalisation of childbirth was common to most of Latin America. In the late 1800s only wealthy women could afford a trained practitioner to assist during childbirth. Prior to this shift *parteras* or popular midwives in Latin America were women living in the different communities and neighbourhoods offering their services. These women had empirical knowledge about the woman's body and the process of childbirth, and relied on some basic knowledge about the importance of asepsis. Even though by 1870 the medical profession was on the rise, birth was still overseen by midwives. Women's modesty and the characteristics of childbirth, as time consuming and poorly compensated, prevented the involvement of male practitioners. Nonetheless, the concern for infant mortality and the desire of politicians and community leaders to promote the well-being and reproduction of the Costa Rican population, resulted in the creation of a school of midwifery at the end of the 1800s.

By the end of the 1920s the School of Obstetrics had graduated 86 midwives that according to Palmer *"would have attended to roughly 25 percent of births nationally"* (2003, p. 152). Both local and national institutions fostered the process. The concern for reducing the occurrence of infant and maternal mortality motivated municipalities to request a qualified midwife to assist local women during childbirth. The success of medical intervention in the birthing process since the 1920s, and particularly during the 1930s and early 1940s, as a result of the increase of available physicians and other medical professionals in the country and the efforts of the Minister of Health at the time, facilitated the creation of the maternity insurance (Palmer, 2003). This insurance was extended to the worker's family, spouse and children under the age of 12, in 1956 (Jenkins, 2003). Meanwhile, in rural areas, where access to health care services was limited, midwives continued to offer their services to women in need all throughout the 1900s (Jenkins, 2003). Although there is no information about indigenous Ngöbe women's birthing experiences at the time, it is safe to assume that women were supported by kin members with specialised knowledge in the process of childbirth.

In the mid-1960s midwifery experienced an interesting turn when the Ministry of Health created a program to certify midwives to assist women in secluded areas. Called The Midwife Certification Program it was influenced by WHO's and UNICEF's stance toward midwives' training as a measure to provide assistance to women in areas where hospitalisation was not possible. The program began in 1966 and it ran until the 1980s. These midwives were trained and legally recognised as birth assistants in cases signed off by physicians prior to the birth, or in emergency cases (Jenkins, 2003). They were trained to follow certain *"rules and regulations set out by the program"* (Jenkins, 2003, p. 1900), including bureaucratic tasks related to keeping records to collaborate with the national registry.

The midwives under the Certification Program were not paid workers of the health care system, their labour was not recognised as legitimate by the system and so midwives only received compensation from the women being assisted. However, these midwives played an important role as bridges between rural communities and the state. Jenkins highlights that one important change motivated by the institutionalisation of midwives was that *"[…] rural women increasingly perceive hospital birth as the best*

way to ensure both maternal and child health" (2003, p. 1902). As recently as the 1990s midwives were still sought to perform prenatal massages and to assist births when access to a hospital was not possible due to distance and/or economic reasons. Some women also continued to use midwives' prenatal services while simultaneously attending to prenatal care appointments at the EBAIS (Jenkins, 2001). Although none of the narratives collected in El Bajo suggest the use of midwives in the way Jenkins describes it, women in their 50s who had their first children in the 1980s and 1990s, did mention homebirths in which they received the help of a relative. Currently, there are still forms of prenatal care present in the community, but all women seek hospital care for the delivery process.

The Institutionalisation of Birth Control

Several authors place the concerns around population growth and the subsequent introduction of family planning programs sometime around the 1960s (Carranza, 2010; Cueto & Palmer, 2015; Hartmann, 2016). This process coincided with the popularization of the pill and Intra-Uterine Devices (IUDs) (Hartmann, 2016; Takeshita, 2012). The concerns around population growth, though demographic in nature, were attached to preoccupations about the degradation of the environment. Nevertheless, family planning was not a new phenomenon. Throughout history, men and women have made efforts to prevent pregnancies and space childbirths (Hartmann, 2016). Moreover, the development and use of the condom and other barrier methods for pregnancy prevention have a longer history than that of hormonal contraceptives or IUDs (Amy & Thiery, 2015). The reliance on hormonal contraceptives, IUDs and sterilisations and their use across countries is a fairly recent occurrence dating a little over half a century. These methods were systematically promoted and popularised by bilateral, multilateral and national organisations (Hartmann, 2016).

According to Carranza (2010), in Costa Rica, family planning also began in early 1960 and followed two distinct trajectories. The first was among upper class women, who had the economic means to access medical services from a private hospital in the country's capital. The second trajectory, involved working class women that were somehow linked, directly or indirectly, to the Instituto Interamericano de

Ciencias Agrícolas (Interamerican Institute of Agricultural Sciences, IICA for its Spanish acronym)[73], located in Turrialba. The promotion of contraception by IICA scientists was motivated by what they perceived were the effects of population growth on ecological systems (Carranza, 2010). These concerns were popular in North America, where most IICA scientists received training. The deforestation activity was at the centre of these preoccupations that according to environmentalists was largely the result of demographic pressure. This perspective was in line with the Malthusian analysis of population growth that was feeding the discussions around the issue (Hartmann, 2016). The efforts to promote family planning among IICA scientists integrated with global tendencies gradually, through their association with Planned Parenthood Federation of America[74] (PPFA) (Hartmann, 2016), as it paved the way for the development of the Asociación Demográfica Costarricense (Costa Rican Demographic Association, ACD for its Spanish acronym). Later family planning activities were incorporated into the health care system.

The distribution of contraceptives by the health care system became official in 1968 when a program on family planning started (Rosero-Bixby & Casterline, 1994). Ever since, the availability of birth control pills in Costa Rica, in the early 1960s, the country underwent a change in fertility rates; these fell from 7.3 in 1960 to 3.7 in 1976. This demographic transformation also involved a process of institutionalisation that associated birth control with physicians' authority. Furthermore, this process ensured the continuation of the medicalisation of women's sexual and reproductive lives. The fertility transition can only be seen as multi-causal since elements like the improvements in schooling, economic growth and diffusion dynamics among women of all socio-economic status also contributed to the process (Carranza, 2010; Rosero-Bixby & Casterline, 1994).

The decline of fertility rate remained stagnant throughout most of the 1980s until 1990 when it changed to 3.2 (Rosero-Bixby & Casterline, 1994). In the year 2000 the fertility rate was 2.4 children per woman, and later in 2016 it decreased to 1.7 children per woman (INEC, 2016). According to Chen Mok

73 IICA was a Panamerican Union (today the Organisation of American States) initiative created in the 1940s that trained scientists from all around the Americas.

74 This organisation provided the first IUDs. This was an informal program developed by academicians and researchers in an agricultural science institution, in coordination with the state-run health care system, and with the active participation of the community, in a country where the distribution of contraceptives was, at the time, illegal.

et al. (2001) acceptance of contraceptive practices in Costa Rica has been on the rise since 1976 when the first poll on sexual and reproductive health was developed. The percentage of women using contraception in the 1992 poll was 75% and by the 1999 poll the percentage was 80%. In 2010 the prevalence increased slightly to an 82.2% (Gomez & Zamora, 2011). These polls also showed a decline in the use of natural methods like withdrawal and rhythm, and in the use of sterilisation as a contraceptive method.

The preference for sterilisation, for example, is an interesting case. Carranza (2004) argues that sterilisation in Costa Rica gained popularity among women from diverse economic statuses since its introduction in the 1940s. Women were able to request access to the procedure through the strong and consolidated state-run health care system. Nevertheless, until 1999 the law only permitted the practice of therapeutic sterilisations, a legislation that wielded physicians with full authority over who underwent the procedure. According to Carranza women and physicians made use of health rhetoric to access the procedure. However, access to sterilisation as a contraceptive method depended on the views of the physician providing health care, which resulted in inequalities in the distribution of the service[75] (2004). After sterilisation was decriminalised, this method became acceptable and available upon request to every woman above legal age (18 years old). Today, women and men can request sterilisation at the EBAIS as a form of contraception. The procedure is performed after a mandatory information session at the corresponding hospital after which the person undergoing the procedure signs an informed consent form and obtains an appointment. The legality of this practice, however, does not prevent health care practitioners from expressing their moral beliefs to women and men requesting the procedure as Goldade (2011) showed on her research with Nicaraguan women migrants in Costa Rica. In El Bajo, indigenous women showed resistance to this practice while health care practitioners showed concern about women's reproductive practices and their resistance to sterilisation.

75 In certain cases women were subjected to abuses of power when physicians required illegal payments and/or partners written consent in order to carry out the procedure (Carranza, 2004).

Screening Test as Standard Procedure

Cervical cancer prevention is an important element of Costa Rica's sexual and reproductive health programs. The health care system invests a great amount of effort into increasing the cytology-based screening around the country. The standard screening method for cervical cancer used in Costa Rica is the Pap smear. This method was developed by the Pathologist Dr. George Papanicolaou in the 1940s (Lowy, 2011), but became available in Costa Rica only during the 1970s in an opportunistic manner. The method's use in Costa Rica was incorporated into the health care system in 1995, along with the initial screenings for breast cancer and (Murillo et al., 2008) for other types of cancer, such as prostate cancer. After the year 2000 the incidence of cervical cancer has decreased and the mortality rate has *"[…] declined on average by 8.3% per year […]"* (Murillo, Herrero, Sierra, & Forman, 2016, p. S123).

The historical and qualitative information about the development and acceptance of these practices is very limited, which points to a possible line of future inquiry. For example, involvement of PAHO in the program's development through the elaboration of a recommendations report is known, but the details of such involvement are not clear (Salud, 2012). In El Bajo, health care professionals and other state employees highlight the importance of these procedures. Nonetheless, women still show resistance to these biomedical practices –this will be discussed in Chapter 8.

Sexual and Reproductive Health Currently

The historical trajectory described offers an idea of the medicalisation of the sexual and reproductive health care. Practices like hospitalised birth assistance, prenatal care, contraception and screening tests are now well incorporated into the practices of the Caja and are regularly promoted in all the EBAIS. The quantitative data presented here and my personal observations at the EBAIS show a well-established system of data collection in which progress is meant to be demonstrated. Furthermore, the state-run health care system is currently going through the medicalisation of other aspects of sexual and reproductive health, such a sexual education for teenagers. Thus, the state continues to expand the offer of

services with the support of international organisations, while at the same time enhancing the coverage of other services that are considered necessary to ensure a good quality of life.

In 2016 93.41% of births were assisted by the Caja. Additionally, 94.18% of all the births assisted by the institution had at least one prenatal care[76] visit during the gestation period[77] (CCSS, 2016). No information was found about the type of birth assistance the remaining 6.59% received or the prenatal practices of the 5.82% that were not assisted by the Caja. However, available birth data for 2015[78] show that 4.12% of births were assisted in private hospitals, and 1% was assisted by a qualified health professional, although it is not clear what the qualification of these professionals were or where these births took place. Furthermore, it is possible to assume that a portion of the remaining 1.1% of births took place at home with the assistance of a qualified midwife or unqualified carer, or with no assistance at all. Thus, we can conclude that the medicalisation of birth has been achieved for the most part, since an overwhelming majority of births were assisted by medical professionals in hospital settings and prenatal care has been extended to a wide range of the population. This tendency was confirmed in El Bajo through the shift in the past three decades from homebirths to hospital births.

In terms of contraceptive use, the prevalence dropped almost 5% points in 2015 (77.8%) compared to the prevalence in 2010 (Salud, Costarricense, Poblacion, & Fund, 2016). The 2015 poll also showed that methods being used are mostly controlled by women, 62% of all methods. For example, the distribution of the preferred methods shows that 25.5% of women chose sterilisation, a percentage much higher than men's sterilisation (5.1%), and only slightly lower than the use of hormonal methods (31.9%) (Salud et al., 2016). Even though not everyone accessed these services through the state-run health care system, access to sterilisation and a few options of hormonal contraception, as well as condoms are available to every insured person. Women from El Bajo make an active use of the hormonal methods offered by the Caja.

Besides contraception, the health care system plays an important role in the provision of other sexual and reproductive health services. According to the sexual and reproductive health poll of 2015,

76 Only one prenatal care visit does not qualify as adequate prenatal care (Alfaro Vargas & Campos Vargas, 2014).
77 The 2015 data show that only 79.7% of the women had adequate prenatal care (INEC, 2015c).
78 The percentage of births assisted by Caja in 2015 was similar to the 2016 percentage (93.48%) (CCSS, 2016).

69.4% of surveyed women have had a Pap smear on a regular basis (either every year or every two years). This percentage resembles national coverage in 2010 of the state-run health services of 66% (Salud, 2012)[79].

An example of the continued process of medicalisation of sexual and reproductive health is the implementation of the Mesoamerica Initiative. Framed within the Millennium Development Goals included in the Millennium Declaration, the Mesoamerica Initiative seeks to address goals one, four and five (IDB, 2012), related to eradication of extreme hunger and poverty, reduction of child mortality and improvement of maternal health, respectively. The initiative includes interventions in several Mesoamerican countries among them all the countries in Central America and Mexico (Mokdad et al., 2015). The actors involved in this initiative include local and global actors, among them,

> *the Inter-American Development Bank (IDB), […] the Bill & Melinda Gates Foundation, the Carlos Slim Health Institute, Spain's Cooperation Agency for International Development, and the ministries of health in these Mesoamerican countries (Mokdad et al., 2015, p. 2).*

In Costa Rica, the initiative has targeted adolescents and the intervention has concentrated on sexual and reproductive health. These activities were *"[…] implemented in the 11 health areas that encompass the poorest districts in the country"* (Mokdad et al., 2015, p. 6). The district where El Bajo is located was included in this initiative and although the perceived impact for the community was very limited, it still informed my research in several ways, since the program was discussed among health care employees who had different ideas of the correct way to implement it.

This intervention is of interest because it shows the Catholic Church's influence in the country —and the government's struggle to challenge it[80]—, largely the product of Costa Rica being a confessional state —which means that the Catholic religion is the religion of the state according to Costa Rica's constitution. The Catholic Church's political power has impacted on the country's sexual and reproductive

79 In reference to the screening method, other technologies have been developed in recent years offering greater precision and validity to the identification of cancerous cells. This method has been used in several Latin American countries as one of the methods of screening in combination with Pap smears and colposcopies. Methods, such as the HPV test, offer greater advantages like the frequency in screening, every five years, and self-collection (Almonte et al., 2010). In Costa Rica neither this method of screening nor the use of the HPV vaccination has been included in the state-run health care services in a systematic way (Mairena Mora, 2015; Murillo et al., 2016).

80 As I show later, this has changed in the past few years with the government recently launching a sexual education program in high schools.

public policy, leaving human rights activists little room to manoeuvre. In this context, the notion of health or as Carranza has framed it, *medical necessity* continues to be a potent tool to advance actions on sexuality and reproduction (2007). Thus, the Mesoamerica initiative contributes to the historical process of framing sexual and reproductive experiences in a biomedical context by prioritizing the role of the physician as an authority in the distribution of knowledge and resources, like surgical procedures, contraception, and other technologies, associated with sexuality and reproduction.

Additionally, the participation of international institutions continues the already mentioned trend of collaborating with the global demands imposed by bilateral and multilateral organisations. This reality places Costa Rica in a global context where discourses about sexual and reproductive rights are being contested. One of the most recent discussions converges at the so called 'Global Gag Rule'[81] and its impact on family planning actions around the world (Ford, 2017a; Sutton et al., 2017). This discussion provides evidence of key actors in the global sphere and their views on sexual and reproductive rights in general, and contraception in particular. The Bill & Melinda Gates Foundation has been actively involved on the reporting of the negative effects of the rule. According to The Guardian the Foundation is the major donor in the world for family planning.

The views expressed by international actors advocating for family planning can be characterised as part of the *secular western feminism* (Weir, 2017). For example, a United Kingdom official stated *"If you can give girls and women the chance to own their bodies they can own their futures"* (Ford, 2017b). This small example highlights the emphasis on notions of property, individual rights and freedom, disregarding the importance of the relational logic for some of the ethnic groups included in these programs. These discourses emphasise the idea of productivity and economic well-being. The assumption is that by providing girls with the means to limit their reproduction, they will be able to access education and eventually participate in the labour market (Lamble, Ford, & Stewart, 2017). This is promoted in the context of neoliberalism, where inclusion and equality creates a paradox. Thus, girls whether their fertility is

81 According to the Guardian reporters, the 'Global Gag Rule' is a rule "[…] otherwise known as the Mexico City policy, requires NGOs to certify that they will not perform or promote abortions anywhere in the world as a condition for receiving US family planning funds" (Ford, 2017a; Sutton, Daniels, & Maclean, 2017).

contained or not, become either part of the system, surrendering their labour force to sustain a neoliberal system, or become excluded.

This is not to say that access to contraception has no positive effect on women's' livelihoods. On the contrary, as this thesis shows, it allows them to envisage a wide diversity of sexual and reproductive experiences as well as social growth, by providing ample possibilities. However, to emphasise the importance of these changes at an economic level, fails to recognise the importance of the social and political change that might be achieved by allowing women to shape their sexual and reproductive lives. Furthermore, these transformations have important effects not only at the individual level, but also at the community and kinship level. The impact of these transformations is not necessarily considered.

Sexual and Reproductive Rights: Achievements and Challenges

Women's movements in Costa Rica have had an important role in the process of effecting change for women in many areas. These movements have continually made demands to expand women's access to education, the labour force, and to sexual and reproductive health among other aspects. In El Bajo, women made use of many of the services available to them as a result of the women's movement advocacy. However, it is important to point out that the achievements and challenges presented here do not incorporate indigenous women's expressed needs or claims, since indigenous women have been excluded from this process.

The women's movement in Costa Rica emerged by the late 1800s and beginning of the 1900s as a result of the professionalization of women in roles such as midwives and school teachers. These movements were the product of the increase participation of women in the public sphere and the increased political activism through diverse institutions (Cordero Cordero, 2013; Piedra Guillén, 2013). The first formal female organisation was the Feminist League (Liga Feminista) created in 1923. This organisation participated in the political struggle resulting in the 1949 right to vote decree (Hidalgo, 2004).

The period between the 1960s and 1980s was characterised by a resurgence of the political participation of women, that had subsided during the 1950s (Piedra Guillén, 2015). During this period

women's movements achieved important goals that have also resulted in small changes for women's sexual and reproductive lives. In the 1980s and 1990s feminist movements in Latin America were successful in fostering transformations in the political and economic structure (Piedra Guillén, 2015). Some of these achievements are the criminalisation of gender violence, the endorsement of quotas of political participation, and the increasing participation of women in the labour force, especially in science and education, with important benefits for women's economic well-being (Sagot, 2014). Furthermore, LGBTQI movements began to have a presence in the public sphere as a result of the HIV/AIDS epidemic of the 1980s (Gamboa Barboza, 2009). In the past decades both feminists and LGBTQI movements have shifted their attention more clearly into sexual and reproductive health, while still addressing issues in the economic and political spheres.

Two of the most important accomplishments in sexual and reproductive rights of the past decade are the lifting of the ban on In Vitro Fertilization (IVF) in 2000 (República, 2016), and the implementation of sexual education programs in schools. Activists in favour of allowing IVF procedures in Costa Rica presented a lawsuit to the Inter-American Court of Human Rights. The court ruled in favour of the plaintiffs in 2012 (Human Rights, 2016a), but it wasn't until the end of 2016 that a final ruling of the court established the 11th of September of 2017 as the deadline to guarantee access to IVF within the health care system (Human Rights, 2016b). Currently the Caja has started the process of implementing an IVF program to provide users with access to this technology (Ávalos, 2017b).

The debates around school sexual education programs over the past two decades, illustrate the confrontation between the state, the Catholic Church and movements in favour or against these programs (Faerrón, 2002; Gamboa Barboza, 2009). The Catholic Church's argument against sex education programs in schools points to gender theory as *"contribut[ing] to the destruction of the family"* (Gamboa Barboza, 2009, p. 56). Despite this opposition, the Ministry of Education launched a sex education program in 2012 (Solano Salas, 2017).

In spite of the ability of these social movements, in particular women's movements, to impact the political sphere for important changes to take place, there are still many challenges related to sexual and

reproductive health. These challenges include a constitutional reform for a secular state, the decriminalisation of abortion, and marriage equality (Piedra Guillén, 2015). Feminists consider the secularisation of the state one of the most important challenges since it is one of the major limitations toward the achievement of sexual and reproductive rights for all (Arguedas Ramírez, 2010; Sagot & Carcedo, 2002).

In reference to the challenge posed by the current abortion law, Carranza (2007) suggests that in Costa Rica *"[…] there is a real danger that discussion could bring further legal restrictions"* (p. 63). According to the author, bringing attention to the ambiguity of the legislation might move the process in the direction of criminalisation in all cases[82]. Moral and religious beliefs around the idea of the beginning of life are central to the limited use of therapeutic abortion. This, however, doesn't mean that therapeutic abortions or other forms of abortion are not performed in Costa Rica. On the contrary, clandestine abortions in Costa Rica are common (Carranza, 2007), but they are low risk because they are generally induced using misoprostol[83] (Gómez, 2007).

Activist groups, such as the Colectiva por el Derecho a Decidir (Collective for the Right to Decide) and the ADC, have instead focused on widening the access to other sexual and reproductive rights (Decidir, 2017; Piedra Guillén, 2015). For example, despite the fact that Emergency Contraception is not illegal, in Costa Rica there is no registered dedicated Emergency Contraception product, making it difficult for women to access this contraceptive option (Morán Faúndes, 2010). Thus, these NGOs provide information about how to access Emergency Contraception through specific doses of available products on their website, pamphlets and word of mouth (Costarricense, 2012; Decidir, 2017). In their edited volume, Foster and Wynn (2012) mention similar forms of activism around Emergency Contraception in other parts of the world.

In this context, where sexual and reproductive rights are oscillating between expanding and contracting, the services that had been incorporated into the system as far back as a century ago are also

82 This was the case in El Salvador in the late 1990s (Sagot & Carcedo, 2002) and Nicaragua more recently (Kampwirth, 2008).
83 Misoprostol is a pharmaceutical used to treat stomach ulcers, which is contraindicated for pregnant women due to its abortive properties. Its use in gynaecological procedures is common and safe (FLASOG, 2007).

experiencing important challenges. A major challenge is the *obstetric violence*[84] that birthing women experience in the state-run health care system, as a result of the use of power based on biomedical knowledge (Arguedas Ramírez, 2014). This situation has been reported as recently as 2015, by the Office of the Ombudsman (Ávalos, 2015; República, 2016). The report disclosed abuses that included mockery, scolding and blaming as well as shortage of trained professionals and refusal to perform caesarean sections when necessary.

The screening coverage offered by the Caja also faces important challenges. The incidence and mortality rate in relation to cervical cancer is still considered negative in relation to international standards. Thus, the coverage and consistency of the program could be enhanced through the introduction of new technologies. This has been acknowledged by the institution and as of 2015 a pilot plan started making use of Human Papilloma Virus (from now on HPV) test (Mairena Mora, 2015). Furthermore, according to a report developed by a group of physicians specialising in cancer in Costa Rica, the country has the highest incidence, prevalence and mortality rate for breast cancer in Central America (Cancer, 2016). In 2012, breast cancer was the second most common cancer among the female population after skin cancer (Salud, 2015). Furthermore, in 2014 breast cancer had the highest mortality rate for malignant tumours among women, rate of 14.01 deaths per 100,000 women (Salud, 2014). As a result of this situation, the state-run health care system has been improving the actions toward early detection. In the southern region of Costa Rica, where the mortality rate for breast cancer is twice the rate for the country (I. Rodríguez, 2011), the Caja created Breast Clinics with specialised personnel to improve early diagnosis (Cancer, 2016).

At the time fieldwork was conducted, many of these challenges had little to no relevance for women in El Bajo. In fact, topics like abortion, marriage equality or the secularisation of the state were never discussed. However, these are sexual and reproductive rights that might become important in the next few years. Furthermore, pro-life advocacy groups have become stronger, overtly opposing transformations

84 The term refers to violence inflicted on pregnant or birthing women by health care professionals. This form of violence was first identified in Venezuela, Argentina and Mexico and was later recognized in other countries of the region. The term seeks to highlight the "… mechanism of control and oppression…" (Arguedas Ramírez, 2014, p. 147) that has been derived from a specific form of power termed *obstetric power*. The notion of *obstetric power* follows a Foucauldian framework and emphasizes on the forms of power that pregnant or birthing women are subjected to. Arguedas Ramírez's elaboration of this term takes notice of the biomedical use of this power.

related to sexual and reproductive health in favour of foetal rights (Roberts & Morgan, 2012). These movements have been advocating for the non-intervention of the state in matters of sexual and reproductive rights. This opposition has created stagnation in several topics, and might even cause setbacks that will impact indigenous Ngöbe women in negative ways.

Sexuality and Reproduction and the EBAIS

Health care professionals' subjectivities impact the provision of sexual and reproductive health care. These professionals were all non-indigenous and most of them were in their early to late 30s. Although there were both males and females, not all of them belonged to the EBAIS assisting indigenous women from El Bajo. Yet, the relationships between the workers in all three EBAIS were close. The most visible challenge these professionals experienced is the one of working as a team in an environment where hierarchies are implicit. This challenge intensifies or lessens as a result of everyday interactions, which include the performance of the corresponding tasks, conversations, and quarrels, among others. Conversations in the form of gossiping and storytelling were particularly interesting. Information sharing was scattered throughout a day's work, offering layers of data about people's understandings of sexuality and gender, ethnicity and class differences. The expression of sexuality, for example, was part of everyday conversations and involved talking about themselves, gossiping about co-workers, or talking about patients. The sharing of stories also made it clear that health care professionals' personal experiences had the power to create a sense of affinity with the population. Thus, the particularities of the characters but also the interpersonal environment and the agency of each member of the team in relation to their co-workers and the institution, determined to a large extent the services that women had access to.

Challenges at Work

The members of the EBAIS corresponding to El Bajo, are an interesting mix of characters. They are all male, except for the pharmacist who assisted all three EBAIS. They all grew up in the area but they came from different socioeconomic backgrounds and different generations. The interactions, therefore,

were complex. The fact that there were other EBAIS in the proximity added complexities to the relationships of the members of the team, expressed in the form of loyalties, gossip and judgements. The other EBAIS, were composed of mostly women. This was an interesting fact if we consider that the male exclusive team was in charge of all the indigenous communities in the district. The members of the team were fully aware that indigenous women preferred to interact with women when getting sexual and reproductive health care. It seems then that the team's configuration was purposely done. Furthermore, the EBAIS in charge of El Bajo, was also in charge of the most isolated communities, and according to the physician assigned to this facility this population was characterised by having a large group of peasants and working class people. The logic behind this arrangement seemed to have a relationship with males' abilities and the requirements of these settings, such as the difficult access and the vulnerable conditions of the population. However, no one at the clinic, where administrative decisions for all EBAIS in the county were made, was particularly aware of the reasons behind this composition. The other two EBAISs were mostly situated in urban areas with larger populations, but also with more diverse populations in terms of socioeconomic distribution.

The health care professionals I interacted with in the EBAIS were all from the area. They all grew up in the county, although in different districts. The differences between them could be seen when talking about their rural/urban affiliations and also the difficulties they faced to access education. Most of the people working there had been trained by Caja, with the exception of the pharmacist and the physician who had university decrees and had applied for a job with the Caja following their graduation. They had both studied in San Jose and had made sacrifices to obtain their education. Nonetheless, they were from middle class backgrounds. Thus, their professional background and status placed them at the top of the EBAIS structure; their income was also considerably higher than the rest of the people working in the EBAIS.

On paper, the EBAIS was a non-hierarchical entity. According to the physician, he was only in charge of coordinating with the team, but had no authority to dictate actions. Although this seemed to be true in practice, it was clear that the physician and the pharmacists had more agency. They not only made important decisions on their own, but were also consulted by members of the team in regards to the right

procedure to follow when the directives from above were not clear. Their flexibility or lack thereof also impacted on the flexibility of the team. This unspoken hierarchy was also a cause for resistance and struggles among team members.

For most people working in the EBAIS their team mates were daily companions. They saw each other for more than forty hours a week and they also regularly spent time with each other outside of work either on weekend activities or the odd drink after a day's work. Some of them knew each other from before and in many cases, they knew each other's family and run into each other when shopping or eating out. They also shared important moments in their lives like the formalisation of a partnership, the birth of a child or the death of a relative. This made their relationships close but also complicated. Due to the close knit structure of the Caja, they were all subjects and active participants of gossip.

Gossiping about Sex

The EBAIS is a very lively place. There is always a lot of chatter between employees, and between them and the individuals visiting the facility. A television set in the waiting room is always on, tuned to a national channel that offers the news early in the morning followed by a morning show, a cooking show and then one or two telenovelas. The second television set, positioned in a room where health care professionals often hang out, is of greater importance for this study. Even though this set is tuned to the same channels selected for the waiting area, it is the additional commentary of health care professionals that makes it interesting. From homophobic comments about the gay identity of the television presenter, to a sign after the telenovela protagonists finally express their love for each other, this is all informative of the health care professionals' views about gender and sexuality. Thus, the different shows stirred up the conversation by providing examples about different types of relationships.

In this context gossip flourishes. Gossiping is an important aspect of relations taking place in institutions (Waddington, 2016). It includes the latest on changes in the Caja procedures, at work

interactions (particularly between bosses and subordinates[85]) and relationships. Conversations about extramarital liaisons, new couple formations, formalisation of old couple formations, conception, births, break-ups, fights, and much more were very common. While gossiping, people in the EBAIS demonstrated their own understandings of gender differences, sexual desire, and socially accepted interactions. Some of the offices in the EBAIS were places where a certain level of comfort was achieved, allowing for information to be shared freely. This was so, even if the walls of these containers were thin and sound travelled quite easily.

This gossip included both the interactions between an employee and an outsider or between two employees. The Caja facilities were filled with areas where intimate interactions could take place, from kissing in offices and consultation rooms, to sex in the vaccination and storage facilities. Gossip about employees and outsiders engaging in these activities and within the boundaries of the institution was in everyday conversations. All of this was, nevertheless, only gossip; but in the process of talking about it, people supported or judged the actors according to their gender, their social standing, their marital status, or simply based on the interactions they had had in the past. Thus, a man in a marital relationship involved with a married woman might be at fault or not, depending on his wife's dedication to their marriage and their children. The same was true for a woman. Moreover, their relationship was also judged based on the person they were holding the liaison with ―was he/she a 'good' person― and the characteristics of this affair ―did they 'love' each other, were they 'faithful' to each other. Another contrasting view offered a more definitive judgement. For example, once during a conversation, one of the female health care professionals working at the pharmacy stated that a *"man that is unfaithful to his wife is also unfaithful to his family […]"* (direct quote from fieldnotes). She continued by saying that "*spending time with another woman takes time away from the family and this means that the man is not a good father or a good husband"* (direct quote from fieldnotes).

85 The Caja is an institution with a strong hierarchical distribution and clear-cut levels of authority.

This type of gossip, whether or not it was true, seemed to suggest these practices did happen, even if they were not so frequent. It also showed a degree of acceptance that is at odds with the Catholic or conventional values that many people in Costa Rica claim to adhere to. Furthermore, the people implicated in this gossip either dismissed or ignored the comments. This created ambiguity when people around them strongly maintained that the relationship was taking place, but they seemed to be unaware of the comments and dismissive of its veracity. I was unable to confirm most of these rumours, but through them I could identify gender views that were consistent with a patriarchal society —where men's status benefits from sexual conquests and women are only justified if their husbands are violent or negligent— and some contrasting views in which both men and women were judge based on their infidelity.

Personal Stories

Besides gossip, the chatter in Caja facilities revolved around life histories. The female employees belonging to other EBAIS, and on an odd occasion the male employees assisting women from El Bajo, would share with me their childhood, adolescence, marriage, motherhood/fatherhood, and work experiences. This type of storytelling, was part of the common chatter of the EBAIS since employees also found enough moments in the day to share their experiences. Many of the experiences shared by female employees were similar to those of women from El Bajo in the sense that they too complained about the services and they had also gone through difficult situations when caring for their sexual and reproductive health. With the EBAIS being a diverse setting in terms of class, some stories were closer to the ones I heard in El Bajo, and others were far apart. However, for many employees their choices were associated with their social class, which allowed them more agency when choosing when and what type of health care they were going to receive.

An important similarity between the female health care professionals I talked to in the EBAIS and the indigenous women in the community is that a large majority of them were mothers. However, female health care workers in the EBAIS managed their reproduction in a different way. They had one or two children and expressed their desire to keep it that way. Their decision-making was based on their desire to

offer their children a good life, but also on their enjoyment of their work and personal accomplishments. Thus, they had all gone back to work after their maternity leave and in at least two cases, the daily task of caring for their children was shared. Three of them have had only one formal partner in their lives and they took pride in their relationship with their husbands.

In terms of childbirth, they had all had their children in a hospital. Most of them had used the services provided by the Caja, but at least two of them had gone through a paid elective Cesarean Section at a public hospital in Panama[86]. One of them was a pharmacist with an income considerably larger than the rest of the workers in the EBAIS and had expressed her fear of giving birth as the main reason to opt for a c-section. The other one had an assistant role and a basic income. She had had a stillbirth several years back, an experience that was recalled with sadness and anger toward the service in the public hospital in the south of Costa Rica, hence her decision to resort to the paid services in Panama. Birth was another aspect that showed similarities and differences, impacting on the possibility of relating to Ngöbe women's personal experiences.

The conversations about sexual practices among female health care professionals in the EBAIS were overt and unguarded, which was in great contrast with Ngöbe women's approach to the topic, at least around me. In these conversations the female workers talked about their own experiences or what they knew about the experiences of others. They took pleasure in going over details about sexual encounters and retold other people's stories they found amusing. These women were very open about their sexual desire and their right to experience sexual pleasure. In the process of sharing this information, some, but not all, would use explicit language to describe their experiences. Stories were shared with both male and female workers around. In contrast, male workers were more reserved and careful about the information they provided. This was especially true when they were in larger groups with other male health care workers. In

86 This was a fairly common practice among middle class population in the counties of the southern region of Costa Rica. They generally talked about the service in Panamanian hospitals, specifically in the city of David, to be better than the hospitals in the south of Costa Rica. These services were also less expensive than the private services in San Jose. Furthermore, the proximity with these hospitals made it more convenient for people in the south to resort to these services.

the presence of smaller groups of women, men would share more about their experiences, although in general, their attitude was mostly cautious.

Sexual health care was mostly sought somewhere other than the EBAIS. Female health care employees talked about their use of private health services in Panama or around the area for their Pap smear test, for example, or when experiencing any discomfort or concerns related to their sexual lives. The main reason to seek assistance elsewhere was their working relationships with the health care physicians in the EBAIS; they knew each other well; they preferred not to interact as patients with any of these health care professionals. Nevertheless, they also complained about the service that people experience in the Caja, and this may have been another reason why they avoided the service. Some of their complaints included: difficulty in getting appointments for specific ailments, the unprofessional attitudes of some of the health care practitioners, among them drinking while working and sexual harassment were mentioned, and the lack of commitment of some of the physicians. Not all of the stories where negative, some of the women talked about specific instances where the health care system had done a good job of ensuring their's or their family's well-being, identifying and treating cervical cancer on time, providing prompt treatment for the safe delivery of children, and providing the necessary medication for particular ailments. Thus, the service was both elevated and contested depending on the experiences of the health care provider narrating the story. A similar comment can be made of the stories of Ngöbe women using the service.

Conclusion

The network of EBAIS in Costa Rica, as places and as groups of professionals caring for others, is consistent in the sense that each EBAIS provides a set of services following standardised procedures. As a result they have gathered a set of quantifiable information that will give evidence of the outcomes of their labour and will allow other members of the institution to evaluate their performance. This set of procedures, regulations and expected outcomes are ruled by parameters determined by national and international criteria. At the same time, the network of EBAIS is inconsistent between each other in the sense that they are composed of individuals with particular characteristics that result in singular everyday experiences. These experiences are informative of and informed by the Caja structure, the policy and discourses about sexual and reproductive health, structural factors like gender, ethnic and class relationships in the area, and relevant moral and religious values. Furthermore, all of these factors shape the different subjectivities of people working in the EBAIS (Biehl et al., 2007), contributing to the dialectical relationships between individuals and the structures they inhabit. Therefore, it is in the everyday labour of the agents in the EBAIS that we are able to grasp what Fassin (2015) calls the *politics of the state*.

The state-run health care in Costa Rica has been in a process of transformation for more than seven decades. In this process, it has expanded its influence in the national territory becoming one of the most relevant institution in the country. Health care providers, and Costa Ricans in general, express mix feelings about the institution and its benefits. From complaints about the service, to deep respect for the possibilities it allows those who have serious illness, to criticism in relation to the administrative decisions and corruption scandals. The Caja is, therefore, a controversial institution and at the same time an indispensable resource for many in the country. Its benefits, however, do not conceal the impact it has had on the population in terms of the medicalisation of health. Throughout this process, biomedical knowledge production and practices have been raised to a position of power that dismisses other forms of knowledge production that are also beneficial. In the context of El Bajo, this process of medicalisation has impacted women's lives in contrasting ways, enhancing their agency and at the same time becoming the very aspect

that constrains it. This is particularly true in terms of sexual and reproductive health, particularly if we consider that most of Ngöbe women's consultations are related to these aspects.

The histories of health care and sexuality and reproduction are at times parallel and at times intertwined. This relationship is common in other countries in Latin America and is interrelated with a global history of concerns about health and well-being in relation to population control and rights (Cueto & Palmer, 2015). Furthermore, in this process of medicalisation of sexual and reproductive health and the debates around sexual and reproductive rights, several institutions have intervened looking to either enhance the possibilities that Costa Ricans have access to through the state, or constrain the participation of the state in matters related to these aspects. In this context, the argument presented by Wynn and Trussell (2006) in their study of the USA Food and Drug Administration (FDA) hearing about non-prescription access to Emergency Contraception Pills, pointing out that "*[…] medicine is always a political process*" (p. 314), is of great relevance. The history presented here shows the ways in which medicine and health have been used to advance causes on sexual and reproductive rights.

The changes in sexual and reproductive health, have had a strong impact in the lives of Ngöbe women in El Bajo, as I show in Part III. Women constantly make use of the services provided by the Caja, with consultations on sexuality and reproduction being the most important among them. In El Bajo, hospital birth and contraception are the services women make more use of, which highlights the importance of reproduction in the community. Other services like prenatal control and screening tests have been more reluctantly incorporated. Nevertheless, women continue to incorporate more of these practices as they start to make sense of them in their everyday lives.

Currently, sexual and reproductive rights debates in Costa Rica have been polarised due to the rise of the Renovación Nacional political party, a neo-Pentecostal religious party that won the first round in the presidential elections of February 2018. This event is a cause of concern that threatens the stagnation of the ongoing transformations of sexual and reproductive rights. This has been a process that has been taking place for several decades in Costa Rica and that has seen a strengthening of pro-life movements. These movements, with support from the Catholic Church and other religious institutions (Roberts & Morgan,

2012; Sagot, 2014; Sagot & Carcedo, 2002) have organised demonstrations in San Jose to voice their disagreement with the demands of feminists and LGBTQI communities (Chinchilla, 2017). Thus, sexual and reproductive rights will continue to be a contested subject that impacts the social relations in the public and private spheres. These struggles are developing in a context where gender discrimination and gender violence are still relevant issues in both public and private settings.

Part III: Caring for Reproductive and Sexual Well-being

Indigenous Ngöbe women have acquired an ability to navigate diverse settings that conform to different norms and expectations. The knowledge they acquire in this process of interaction with different setting gives them the *epistemic advantage* that Narayan (2004) theorises about, allowing them to navigate both the context of their community and that of the state-run institutions. Furthermore, due to their constant interactions with different groups in the county of Corredores and sometimes in other areas of the country, these women are socially competent to negotiate successfully with people from the Ngöbe community, non-indigenous people from the community of El Bajo, people from the nearest town, and people working at different institutional levels. This competency has allowed them to take advantage of resources ,in terms of welfare or services, offered at the institutional level and to recognize dynamics within their community structure that allow them to care for themselves and their children, such as the possibility of ending abusive relationships and going back to their kinship's households. The socio-economic transformations that Ngöbe women have faced in the past two decades have impacted their ability to adapt to different contexts and to incorporate knowledge from different sources. The degree to which Ngöbe women adapt varies according to their exposure to the different contexts, their age, and their fluency as Spanish speakers. Exposure to education is one of the elements that prepare them for this interaction.

Pregnancy, childbirth and mothering are regarded as paramount in El Bajo as they are in many other places in the world. They impact women's status, moving them into better or worse positions of power within their community and in relation to the state (Browner & Sargent, 2011; Ginsburg & Rapp, 1991; Jolly & Ram, 1998; Lukere & Jolly, 2002; McPherson & Walks, 2011; Ram & Jolly, 2001). This has the effect of expanding their agency in one sense and constraining it in others. The process of becoming a mother is an element that plays an important role in everyday life. Motherhood is a significant and sometimes desired experience. Thus, in the past few decades, women from El Bajo have started to make active use of the state-run health care system's services to ensure a healthy delivery. Hospital birth was

incorporated as a practice that has completely replaced homebirths. On the other hand, prenatal control is an activity that, even though used by women, is not considered as necessary.

In El Bajo women have started to articulate contraceptive practices to manage their reproductive lives. Although reproduction still has a central importance, presently women are more successful in their effort to space their children and to control the number of children they have. Additionally, women have started to articulate other sexual practices promoted by the state-run health care. One such practice are the screening tests women are encouraged to undertake. However, these practices have only been partially articulated into women's everyday lives. Here I argue that this partial articulation is the result of the lack of existing dispositions encouraging women to get tested. That is to say, that in Ngöbe indigenous women's habitus there are no principles motivating them to actively seek the practice of screenings for sexually transmitted diseases.

In the next two chapters, I analyse two reproductive care practices and three sexual care practices that have been articulated in different degrees through the logics of relationality and individuality. It is in existing dispositions that we find the points of connection between these logics. Pregnancy and childbirth are the main reasons for women of reproductive age to seek health care in the EBAIS. The process of becoming a mother has a great relevance for women of El Bajo, which explains women's desire to seek the most successful and risk free childbirth practices. I argue that the process of pregnancy and childbirth is intrinsically relational. Women going through this process and seeking health care are already resorting to the relational logic when making decisions for themselves and their new-borns. The individual logic in this case is less prominent and despite going through biomedical childbirth, health care professionals are constantly considering the relationship between mother and child when offering assistance.

The gender structure has produced the dispositions motivating women to engage in reproductive practices once they are deemed ready to become mothers. This disposition is challenged by the increasing insistence of governments and bilateral and multilateral organisations to reduce the number of children per woman. This insistence has made the use of contraception practices ever more present around the world (Gutmann, 2011; Hartmann, 2016; Lamble et al., 2017). Women are advised to control their reproduction

using an individualistic logic common to development discourses that associate less children with more opportunities and a responsible life (Pigg, 2012). As such, the practice of contraception is echoed in both the logics of relationality and individuality.

Both indigenous women from El Bajo and health care professionals from state-run health care agencies colloquially referred to the practice of family planning as *cuidarse*. This is a Spanish word that literally means to take care of oneself. The verb *cuidar* (to care) is joined with the pronoun *se*, to indicate an individual's action. Thus, the use of the word *cuidarse* in this context refers to the act of looking after and protecting one's body, through natural or artificial methods, to prevent a pregnancy. In El Bajo, the word *cuidarse* was regularly used in Spanish conversations. However, I have no evidence pointing to its use in conversations held in Ngöbe. This word was most likely introduced by the health care system in the attempt to promote contraception. Nevertheless, it has been articulated into indigenous women's narratives of sexuality and reproduction. The word *cuidarse* emphasises the '*I'* through the use of the pronoun *se*. Following Cordova, *"[…] the 'I' is conceived as containing the capacity to be 'self-determining'"*(Cordova, 2004, p. 173). Therefore, through the use of the word *cuidarse* the logic of individuality is constantly highlighted, entrusting women with the task of caring for themselves.

I also show that the logics of relationality and individuality play an important role in articulating other sexual care practices like screening tests. Nevertheless, the screening test as a care practices is not articulated to the same degree that contraception or birthing practices are. The sexual violence prevention or assistance is another element that is still handled in the community through social care practices offered by kin groups, instead of resorting to services offered at the state level.

The articulation of these care practices, echoes various degrees of adherence to existing dispositions. The interconnection of existing dispositions with the incorporated care practices is a process that is only accomplished through time because it involves the modification of the habitus, which explains the different levels of articulation in the practices analysed here. For both Mol(2008) and Menendez(2005), care is axiological. In order to understand it we need to constantly examine the actions performed by the care seeker and the care provider. The logics inform the habitus that determines people's agency. The

structural elements influence the manner in which practices are incorporated. But it is in the habitus where we find those points of articulation.

The possible practices women perform, that is their exercise of agency, are multiple considering that the emphasis they place on one logic or the other may produce various outcomes (Bourdieu, 1977; Csordas, 2011; Samuelsen & Steffen, 2004). I mainly analyse this exercise of agency in terms of subordination, resistance, connection and belonging. Part III presents a general landscape of this diversity by exposing contrasting views and experiences present in each practice found in the context of El Bajo, as well as in the context of the state-run health care system. Largely, these diverse views are influenced by the actors' different positionalities in terms of gender, ethnicity, class, geographic location, and access to biomedical knowledge.

Overall, the reality in El Bajo contrasts with the broader Costa Rican society where the fertility rate has been declining in the past decade to 1.8 children per women (INEC, 2015a, p. 1). Nevertheless, the community is going through a process of transformation in which the actions of women, in terms of sexual and reproductive health, are starting to resemble the practices of women in other areas of Costa Rica. Yet, the state-run health care system, along with other state-run institutions still show concern for women in general, but mostly for the high rate of teenage pregnancy in Ngöbe communities. Teenage pregnancy is a state category that has only become relevant in El Bajo as a result of the state's intervention. However, indigenous Ngöbe women's concern surrounding teenage pregnancy is not related to the girls' pregnancies in themselves, but with the consequences of the state intervention, such as placing the girls under state custody. To avoid this experience, mothers of teenage girls that fall pregnant promote matrilocal residency. This form of residency has become common in the community. Thus, even though the discourses of the state-run health care system have an effect on women's exercise of agency, its result is not always the one the state desires.

In Chapter Seven I analyse care practices concentrating on reproduction, pregnancy and birth including Ngöbe women's unhappy tales of reproduction. In Chapter Eight I concentrate on sexuality, exploring the practices of contraception, screening tests, sexual violence, and Ngöbe women's use of

services provided by the state and the logic behind their use. Ultimately, both chapters seek to understand women's use of health care services in relation to their views and values. The emphasis is on the degree of articulation between past and current Ngöbe practices and the practices promoted by the state.

Chapter 7: Caring for Reproductive Well-being

The logic of relationality, which is so central to indigenous residents from El Bajo, is of vital importance to the care related to being pregnant and giving birth. The concrete experience of reproduction, the process of creating a life, is one that produces the greatest concern among all members of the community. My analysis of reproductive care practices in the context of El Bajo begins by exploring the concerns surrounding the nature of the reproductive experience, the incorporation of biomedical assistance and the risks associated with it. I present relevant care practices that emphasise either social care, associated with care provided by kinship and other community members, Ngöbe medicine, and/ or biomedicine. One can identify a strong articulation of the practices promoted by the community and those promoted by the state because they both expect the same outcome. Women from El Bajo practice two very different forms of prenatal care in the community and the EBAIS. Both concern the well-being of mother and child, but they use very different methods to achieve it. Thus, although articulated through the desired outcome, they run parallel in the ways sought to achieve them. Furthermore, in the case of birthing, hospital births have all but replaced homebirths. These two practices provide similar results, but involve a completely different process of care.

The process of becoming a mother, of being a woman, is valued as one of the most important activities guiding women into adult life. Motherhood both constrains and enhances women's agency. Mothers' agency through connection and belonging is broad, especially in their senior years, since senior women are respected and their community involvement is well received. Motherhood involves a lot of responsibilities while simultaneously situating girls in a higher status that they continually develop through their participation in community activities and around the household. In El Bajo, both indigenous and non-indigenous people consider having children as beneficial for the future, when parents will need companionship, economic support and other types of care, such as emotional care, or care due to a disability. Currently, the experience of pregnancy and birth exposes women to their first individual encounter with biomedical care. The girls, even when very young, have their children in the hospital without the company

of their mothers or any other adult person from the community. This is the first time they find themselves in a context where biomedicine is dominant and where the logic of relationality is subtle; thus, the contrast with their community everyday experience is high.

The practices analysed here show the ways in which women make use of care practices associated with Ngöbe beliefs and lifestyle and biomedical care practices as parallel experiences and not as articulated activities. This separation between Ngöbe and biomedical care practices is evident in the practices that are still part of the habitus of a group of community members. In the particular case of experiences of pregnancy care, the separation is visible. Other care practices have been displaced by biomedical care practices that are considered either safer, more practical or both. For example, hospital birth has almost totally displaced homebirth practices.

Caring for Pregnancy

The experience of pregnancy in its great diversity has been extensively researched in anthropological studies (Ginsburg & Rapp, 1991). Caring for pregnancy is a priority in many cultures. The ways in which humans handle this very critical experience takes many different forms. I identify some of the ways pregnancy is experienced and perceived in both the community of El Bajo and the EBAIS where these women access biomedical care. The community regard both of these care practices as important elements of successful pregnancies. In the process of looking at care practices, I aim to provide a comprehensive view of the nature of pregnancy care that is available to women of El Bajo.

Within the community there were supporters of both practices, as well as those using a mixture of both. The two sets of care practices involve different logics and different forms of knowledge (Briggs & Mantini-Briggs, 2016; Weir, 2017). The care practices taking place in the community are a constant endeavour that weaves into everyday life. Relations between people and between people and the environment seemed to be of great value. The biomedical care practices are a scheduled concern that measures and calculates. The knowledge provided by the implementation of standardised procedures that

were systematically applied to every woman, except when particular circumstances required a more detailed examination, enhanced the development of stronger relationships between all actors.

The analysis of pregnancy care concentrates on care practices without paying attention to the specific aspects of healing rituals. I pay particular attention to the actions that need to be performed and those who are part of the ritual. The emphasis on actions is intentional, since too much inquiring about the specific herbs being used and the preparation methods was considered suspicious. Indigenous Ngöbe living in El Bajo distrusted outsiders' interest in their use of herbs because they suspected the knowledge would be appropriated with the intention of profiting from it. Thus, the indigenous Ngöbe people that had some knowledge about the healing properties of certain plants were very careful not to share this information. Furthermore, I was also careful not to inquire much about this subject as to avoid mistrust that could negatively impact my ability to engage in conversation about other topics.

Pregnant Care in El Bajo

In general, pregnancy wasn't a condition that caused any uneasiness, as long as the process continued in an uneventful way. Women continued with their regular activities throughout their pregnancies, making small changes in their mobility and in the speed at which they attended to housework as their pregnancies progressed. Frequently, pregnancies went unnoticed until the second or third trimester, a concern expressed by practitioners from the health care system. For the most part, the arrival of a child was a common transition in most households, especially those that already had children, having little to no impact in their everyday lives. However, not all pregnancies were uneventful and in some cases interventions were necessary. Many of these interventions required the active participation of several community members and depending on the difficulties experienced by the woman, biomedical care was also sought.

As a result of the regularity of pregnancy in the community, conversations about this experience were common. Nevertheless, conversations about the foetuses were not as frequent. For example, children were not given names prior to their birth. This resonates with the ways in which foetuses are seen in other

parts of the world and contradicts the tendency among certain groups, particularly those with access to reproductive technologies, of turning foetuses into subjects (Ginsburg & Rapp, 1991; Layne, 2014; Morgan, 1997). In El Bajo, the conversations were more likely to be directed at the *bule*, swollen abdomen of the woman, and at her discomforts and desires.

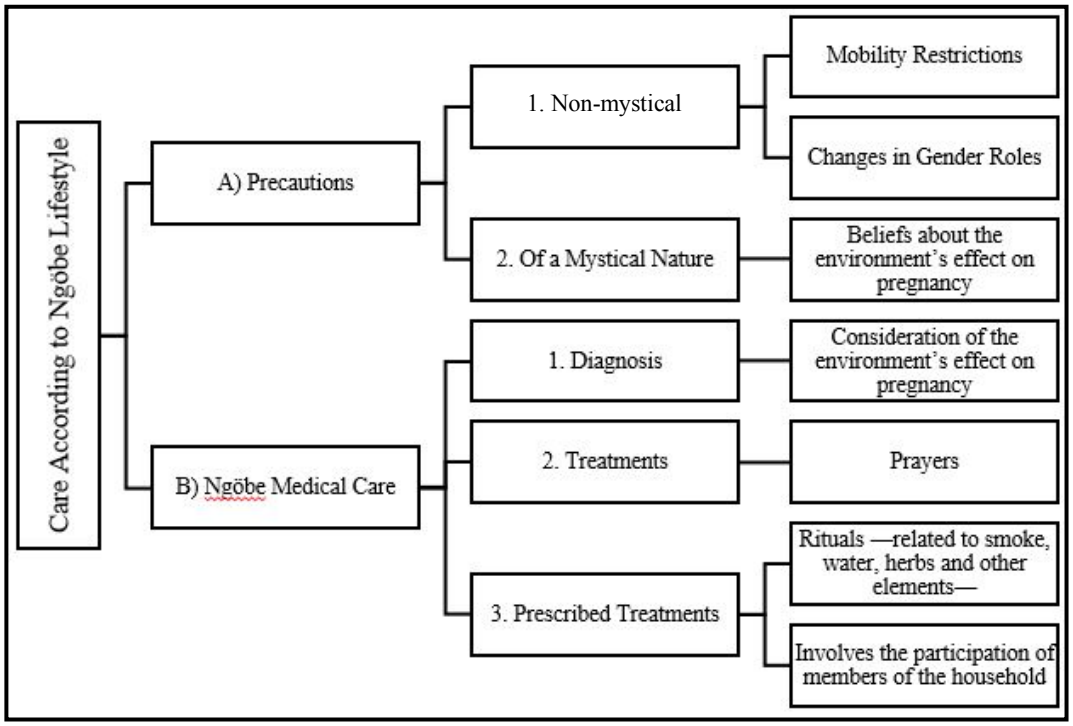
Table Three: Women's Approximate Age at First Pregnancy

Interviewee	Approximate Age	Number of Children		Approximate Age at First Pregnancy
		Alive	Dead	
Lucina	58	3	5	13
Cora	53	8	1	16
Adela	51	9	4	16
Amelia	50	8	1	18
Carmina	47	6	1	13
Penelope	41	6	1	13
Celia	41	6	4	14
Paola	40	5	1	16
Emelina	38	5	0	15
Rosa	35	2	0	19
Rebeca	26	1	0	22
Rosibel	25	1	0	18
Sara	20	1	1	13
Noelia	19	1	1	16
Nadia	16	1	0	14
Evangelina	15	1	0	12

For most women pregnancy occurred for the first time early in life. As a result, there was no woman over 20, indigenous or non-indigenous, that hadn't had a child in El Bajo. According to the state categories and as shown in Table Three, most women in this study were teenage mothers. Although people in the community showed little concern for women's young age during their first pregnancy, this reality was

changing as a result of the frequency and the intensity of the community's interaction with governmental institutions.

Figure Four: Pregnancy Care as Experienced by Ngöbe Indigenous Women in the Community



Pregnancy is cared for in the community through the performance of everyday practices and exceptional practices. These practices are the result of existing dispositions that sometimes echo the concerns of the health care professionals at the EBAIS. Nevertheless, most of these practices were not articulated with the EBAIS practices and were mostly practiced as parallel activities —see Figure Four. In the community, close kin play the most important role in the delivery of care. In particular, partners perform a great deal of the care needed by pregnant women. The exceptional practices require the intervention of Ngöbe medical professionals that provide diagnoses, perform healing rituals or prescribe rituals or activities that have to be followed at home. These activities might involve special diets, the use of infusions to either wash the afflicted pregnant woman, usually suffering from common discomfort such as morning sickness

or early contractions, or to have her and her relative drink[87], the burning of objects, and the inhalation of smoke, among other practices.

Everyday Care Practices

Among Ngöbes, everyday precautions associated with pregnant women are for the most part relational in nature. Precautions are not only performed by pregnant women, but also are carried out by those around them. In my view, the value of these practices is found in the weight placed on pregnancy as an experience rooted in a particular body, at a specific time and place. This experience requires particular care practices involving both mobility restrictions and practices of a mystical nature. Furthermore, this care is recognised as necessarily collective in nature since pregnancy is viewed as a highly relational experience. The involvement of members of the women's households in insuring the women's and their children's well-being forms a connection that places pregnant women, and later their new-born children, in a network with people within a given environment. The knowledge behind these care practices intertwines with basic understandings about child development and about difficulties associated with childbirth.

Many precautions are strongly associated with mobility restrictions. Due to the particularities of the terrain and access routes, the everyday life of a pregnant woman is affected by movement limitations, especially toward the end of the pregnancy. For example, going to the river to wash clothes might not be something she can do for a few weeks before or after the baby is born, moving around while pregnant might also be difficult since they face the risk of falling and hurting themselves or the child. Thus, during this time and particularly after the birth of her child, the interaction with the environment might become more challenging. This reality impacts on the whole family, forcing people to assist the woman. During this process, gender roles experience momentary transformations. The situation experienced by Laura and her partner Oscar, is a good example. Laura was having regular contractions towards the end of her pregnancy. This prevented her from taking care of her housework duties. Oscar was forced to carry out tasks that are

87 As already mentioned, I gathered no information about the specific herbs being used in such beverages to avoid mistrust from informants.

considered to be primarily feminine activities, such as washing clothes, caring for small children and on rare occasions, when other women couldn't contribute, cooking. Oscar was particularly conservative in his view of gender roles, but he knew that social dynamics in the community expected him to support his partner by taking over her household responsibilities

The limitations that the context of El Bajo places on pregnant women are not common to all pregnant women in Costa Rica. In urban settings, mobility during pregnancy might not be an issue in the way that it is in El Bajo. Additionally, access to devices like laundry machines and cooking stoves make the housework tasks less onerous. The restrictions experienced by Laura while pregnant had a disruptive impact on established gender roles. This is particularly interesting in a context were gender interactions are highly segregated. An alternative arrangement could have involved another woman within the household taking over the tasks that the pregnant woman is unable to perform, which in the case of Laura and Oscar was possible considering they lived with Oscar's family. However, the way in which men are expected to get involved shows the relevance of pregnancies and the ways in which it impacts everyday life.

The mystical precautions impact the interactions between the pregnant woman and the environment, and between her and other people. These precautions are different from the ones previously described. An example is the prohibition of crossing a fence by going over it. I came to know about this belief on an afternoon Alba and I were walking to the football field along with other members of her family. At the time, Alba was pregnant with her second child. The walk to the football field involved a lot of walking through the neighbour's land. Generally, these paths are clearly demarcated and they have some opening in the fence that would allow a person to walk through. But the last section of the walk had a broken fence and no section for people to walk through. The best way to cross was by going over the broken fence. However, Alba was cautious and after the rest of the group crossed, she lifted the loose barbed wire and walked underneath it.

Alba explained that according to Ngöbe beliefs going over the fence could cause the umbilical cord to get tangled around the child. Alba further explained that she shouldn't eat food that was passed over the fence ―only under― unless the person offering the food was crossing over the fence with it. Alba was one

of the few younger girls that I met that was interested in knowing about these practices and that was conscious about following them. She told me on that day that people don't always respect the Ngöbe teachings but that her grandmother had always encouraged her to obey them, and she always tried. Alba's respect for Ngöbe beliefs didn't prevent her from attending prenatal care regularly. Thus, the precautions she was following run parallel to her use of biomedical care.

This fence crossing account exemplifies the ways in which a pregnant woman's interaction with the environment is a cause for concern. In this example, the environment is seen as having specific effects on a woman and the foetus that might bring complications during the delivery process. The precautions associated with fence crossing, by pregnant women, food or people carrying food, provide evidence of the importance of the experience of being pregnant. Furthermore, the consideration of a fence and its relationship with the umbilical cord might be of a mystical nature, but it proves the extent of the understanding of child bearing and the risks involved not only at the time of delivery, but also during the pregnancy.

The practices described here illustrate the ways in which people surrounding a pregnant woman become involved in caring for her well-being. This places the responsibility of the pregnancy outcome in everyone around her. All these preventative measures are based on knowledge about the everyday risks associated with falling, demanding physical efforts, or facing certain complications during the delivery. These risks are not always avoidable. Thus, to assist pregnant women face the different risks associated with their condition, the community care practices also offer healing practices.

Ngöbe Medical Care in El Bajo

Two Ngöbe doctors, most commonly called healers or simply by their names, living in opposite areas of the community provide medical care in El Bajo. These doctors have been apprentices of the Mama Chi spiritual practice. One of these doctors is a senior man who is known in other Ngöbe communities for his knowledge and provides assistance to people searching for healing or knowledge. Members of the community seek these doctors' help to cure different discomforts on a regular basis. They treat and prescribe

treatments for the ill, and on some occasions refer the patient to the state-run health care if a treatment is unsuccessful or if they determine that the problem requires biomedical care. The treatments they provide or prescribe are relational in nature. In the case of pregnant women, the active participation of household members in the prescribed treatments is considered central to the outcomes.

According to Ngöbe knowledge and the prescribed/prohibited practices, a person must be mindful of the interactions with certain animals. The snake, for example, is a relevant animal in more than one way, since it is associated with sexual partnerships, economic subsistence, as well as pregnancy. The snake is a common reptilian species of El Bajo. There are several snake species in the southern region of Costa Rica and at least two of them, the coral (*Micrurus alleni* or *Micrurus clarki*) and the terciopelo (*Bothrops asper*), are venomous and therefore feared by people in the community. There are also many harmless species of snakes and the wide presence of the *Boa constrictor* that, although is mostly harmless to humans, is widely disliked for their tendency to kill household animals like chickens or ducks (Savage, 2002). Ngöbe men consider the act of killing a snake a trophy and take pictures of their kill to show people while they narrate the killing process. Women also talk about the snakes they have killed. However, while conducting fieldwork I never came across a woman who would show the picture of the snake she killed with the same pride men did. In general, women are afraid of snakes but they will kill them if they consider it important for their safety.

The act of killing a snake is believed to have negative effects on the child if a man kills it while his partner is pregnant. Therefore, when a snake is found around the house, the killing will be the responsibility of a single man or one whose partner is not pregnant. Nevertheless, a man might kill a snake without realizing they are harming their child, since the pregnancy might not be known or suspected at the time of the killing. This was the case of Laura and Oscar as it was explained to me during an afternoon conversation. I heard the story from Oscar's sister when we were talking about her faith in her grandfather's ability to heal. Offering an example, she told me about the restrictions to kill a snake and the procedure to heal a harmed child. She said that Oscar and Laura's first born had an infection in her belly button a few weeks after she was born. The grandfather interpreted the infection as a result of Oscar having killed a snake while

Laura was in her first trimester. He described a ritual in which Oscar had to find a snake, kill the snake and hit it with a stick. Then he had to bring the stick home to be boiled. The treatment ended once the child was washed with the concoction.

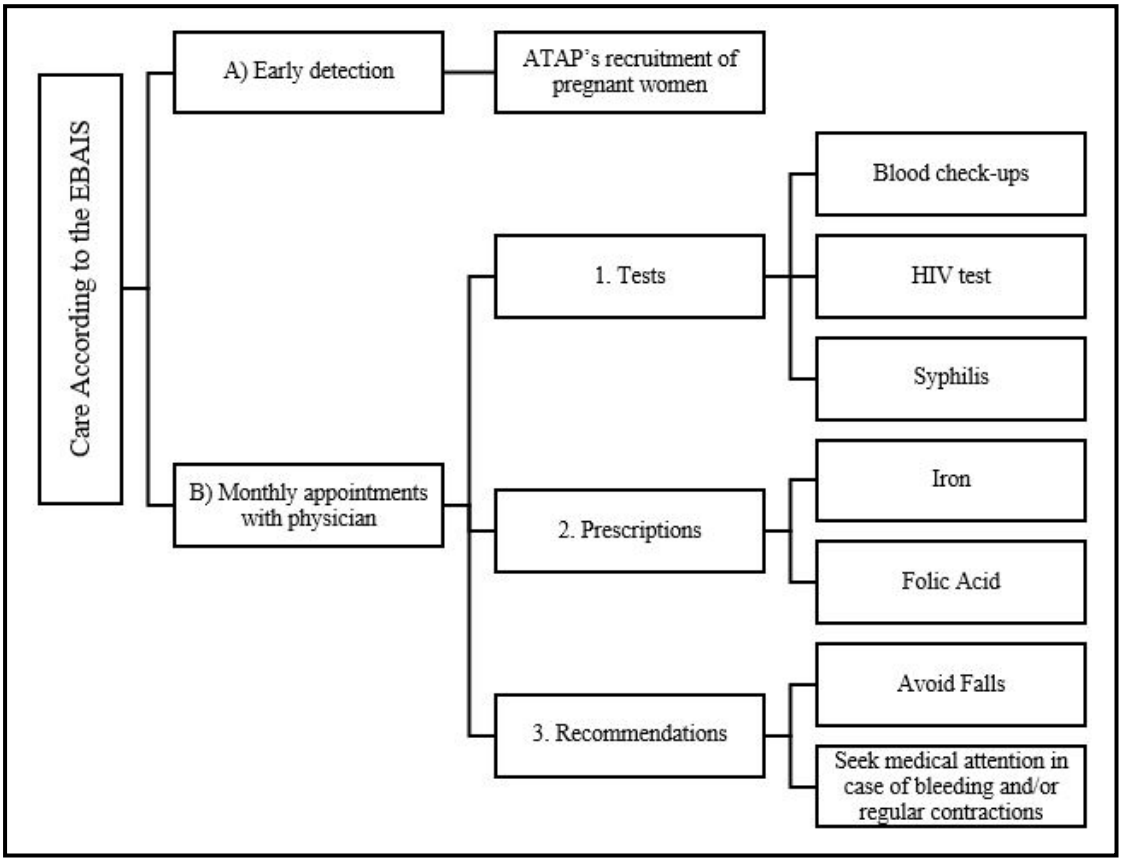
The process of seeking treatments, such as the one described above depends on many factors, including the severity of the affliction or the family's economic means in terms of disposable resources. Other resources, such as time and available transportation are also considered. Furthermore, family members would also consider previous attempts at healing the affliction using both Ngöbe and biomedical knowledge and the willingness of the patient and her family to accept the recommendations provided by either Ngöbe or biomedical healing practices. In many cases, the first choice is to resort to Ngöbe healing. This decision might be related to the close relationship the pregnant woman has to the healer, the easiness to communicate in their own language, and the convenience of their location. However, in many instances, it is the Ngöbe healer that recommends the biomedical consultation as the best practice.

The use of Ngöbe healing, as opposed to biomedical healing, requires the active participation of important family members. For example, if the process of healing is directed at a child, both parents should be present as well as the head of the family, who might be the grandmother or grandfather of the child. The healer insists on the participation of the kin members that are central to the patient during the consultation. Later, these people are motivated to be involved in the healing ritual, either by procuring the necessary elements for the treatment or by attending the healing ritual with the rest of the family members involved. Biomedical healing is driven by practices centred in the individual; thus, a kinship involvement is not required. Biomedical healing also relies on ideas about confidentiality and privacy that further exclude family members.

State-Run Pregnant Care

The essence of biomedical care for pregnant women is the prenatal care visit. This visit is structured to take place once a month since the date the woman is aware of her pregnancy. The prenatal care visit involves the recollection of data that will inform the actions taken by physicians and other health care professionals in case of an emergency or when the woman starts labour. The prenatal care visit serves three main purposes: a) to provide the pregnant woman with information about the precautions she needs to take and the warning signs she should be aware of, b) to schedule regular tests to monitor her health status and c) to provide the pregnant woman with the necessary supplements to ensure the favourable development of the child, mainly iron and folic acid supplements, or other pharmaceutical products such as pain killers.

Figure Five: Pregnancy Care as Experienced by Ngöbe Indigenous Women in the EBAIS



In the following section I explore the work of two health care professionals who are directly involved in the provision of prenatal care —see Figure Five. The first, the ATAP, performs his/her job in

the community and is mainly in charge of gathering general information and recruiting patients. The second, the physician, is placed in the context of the EBAIS and seeks specific information through an individual and private interview, a process of examination, and the ordering of specific tests. The physician is also in charge of providing women with supplements that will support the mother and the foetus during the pregnancy. The information these health care professionals gather is recorded in individual files. The physician is also in charge of gathering statistical information that is later presented as the institution's service outcomes. This statistical information is of great value to the institution because it is regarded as an important indicator of institutional performance in the labour of care. The information collected is used by national and international organisations for the assessment of the country's performance.

Pregnant Care in El Bajo: The ATAP's labour

Based on the life stories of interviewed women, biomedical care has only been a part of everyday life for women younger than 50 years of age in El Bajo. Most women in their 50s reported receiving home care for their early pregnancies that was based on the knowledge of their parents or grandparents. They only started to attend the health care centre in later pregnancies, when they were in their 30s or 40s, and in some cases after having negative experiences while giving birth. Even though some women sought hospitalised birth care before the Caja's reform in the 1990s, prenatal care was uncommon. The changes in infrastructure certainly played an important role in allowing people from the community greater mobility. However, the constant interactions with a representative of the state-run health care, who was also part of the community, probably had a deeper impact on women's acceptance and active search for biomedical care.

As previously mentioned, the role of the ATAP is of great importance to the delivery of state-run care in rural communities. In the community of El Bajo, Arturo was in charge of gathering data and distributing information about all sorts of concerns. He had also played an important role in the process of introducing biomedical health care in the community. Thus, he functioned as a link between the EBAIS and the community. His role involved data gathering and the recruiting of the population, in particular those

that fell under an established category within the delivery of care in the EBAIS, such as pregnant women and young children, among others. Thus, the ATAP's role is central to the production of knowledge about the communities seeking health care assistance at the EBAIS. In relation to pregnancy, and particularly to first pregnancies, the ATAP's responsibility as a recruiter is highly important. One of Arturo's stories is illustrative of this point.

On a May afternoon, while chatting with Arturo at his relative's house, he used the following example to explain the responsibilities of the job. He said one time a young girl whom he had known since she was born, called him over to ask for an appointment at the EBAIS. She complained of stomach-ache. He inquired further, asking her about feelings of nausea and the date of her last period. She confessed she had not had her period for the last three months. He then told her it might be a pregnancy and confirmed he would schedule the appointment for her at the HCF. Prenatal care was valued as a care practice that allows the state-run health care system to gain knowledge about the health status of pregnant women in order to enable safe deliveries. The prenatal care practice was designed to provide the woman with the necessary supplements to keep her and the child healthy. Arturo's recruiting job was of great significance and his ability to motivate women to start prenatal control early in their pregnancies was valuable. Arturo, however, did more than just motivate women to access prenatal care. He scheduled an appointment for the girl, which was not only outside his job description, but also not in compliance with the institution's procedures. Moreover, he inquired about the boy she had been seeing, because he made it his duty to talk to the boy and make sure he would assume his responsibility.

Statistical information about recruitment, results of screening tests, monitoring of foetal heartbeats, adequate supplement intake, among other quantifiable institutional concerns, do not provide evidence of Arturo's labour of care. His concerns are as much biomedical as they are relational. Through a life time of personal interactions with the community and more than two decades of professional interactions he has developed a type of care that is not only engulfs a concern for biological outcomes but also for the social elements that, in his view, impact a person's well-being. His labour of care can be described as a point of articulation of the logics of individuality and relationality Thus, he concentrates on gathering individual

information and providing individual assistance, while at the same time considering the wider context in which these people interact. The ATAP's labour is a stepping-stone in a process of care that extends from the house to the EBAIS and even beyond to the hospital.

As a link, Arturo provided a secure step for both the health seeker and the state-run health care system to stand on. His understanding of the importance of his role as a PHC professional, along with his deep sense of responsibility and appreciation for the institution seem to motivate him to be proactive. Furthermore, he was a good representative of the discourses on sexual and reproductive health that had been shaping the provision of care in Costa Rica, since he had a set of well-established moral values that coincided with these discourses. During an interview conducted with Arturo almost at the end of the fieldwork he expressed that his training called for actions along the lines of psychologists, priests and doctors. In this way he joined together emotions, moral and spiritual values and biomedicine.

Pregnant Care in the EBAIS: The physician´s labour

An adequate prenatal care practice at the EBAIS is a routine process that involves a series of activities. The visit is designed to gather information about the mother and the foetus. The gathered information has been standardised on a cardboard sheet that is filled up by the nurse and the physician every month. The card has information about the date of the last menstruation, the possible date of birth, the gestational age, the monthly weight, monthly blood test result, and the routine test results for HIV and syphilis. During this visit the physician usually inquiries about any discomfort the mother has been feeling and then performs a physical check-up that seeks to identify foetal movement and heartbeat. The practice of prenatal care consists of obtaining measurements that are associated with an adequate/inadequate pregnancy development. Although technologies like monthly ultrasounds are common in private practice in Costa Rica, this is not a standard procedure in the context of the Caja in the south of the country. However, it is common to schedule an ultrasound close to the time of delivery to identify possible complications during childbirth, like cord or placenta issues, but most women give birth before they receive

their appointment at the hospital. Other technologies, like amniocentesis are not common practice, in either private or state-run practice, to a large extent due to the illegality of abortion.

During the three months of participant observation in this HCF, I was able to see Dr. Brenes —the assigned physician to El Bajo— interact with his patients, and on more than one occasion we shared a conversation about his concerns. On a Friday afternoon, as he was coming to the end of his shift, Dr. Brenes assisted an indigenous pregnant woman from a community neighbouring with El Bajo. She was seeking health care because she was in a lot of pain and wanted to request sick leave from her work as a cleaner in the public school. She had had some tests done since her problem might be related to a urinary tract infection, but no results had yet been received from the hospital. Dr. Brenes went through the regular prenatal consultation listening to the baby's heartbeats and then filling up the information in the system. He ordered tests again. Throughout the whole consultation, Dr. Brenes made an effort to make eye contact, but the woman kept on avoiding him. He had told me before that one of the reasons why he didn't like the new computer system was because he couldn't make eye contact with the patients, since he lacked typing skills that forced him to keep his focus on the computer to enter the information correctly. This time, even when he made an effort to move away from the system to establish an eye connection with her, he was unable to.

I made a note of this in my fieldnotes and inquired about it on another occasion. During the conversation, Dr. Brenes said he couldn't talk to someone about something related to their health if they wouldn't look him in the eyes. He also added that he felt that indigenous women were reluctant to take his advice seriously and in many instances, didn't believe him. He resorted to the words trust and faith, along with credibility, to talk about his relationships with patients. He associated women's lack of eye contact and basic verbal reinforcement as distrust. He seemed frustrated about the possibility his recommendations may not be followed. Considering women's shyness, I suspected the subject of reproductive health might be particularly difficult to engage with, for these women. However, Dr. Brenes stated that: *"Any subject is difficult; [...] because one feels that they are not really believing what one is telling them [...]"*.

Some women in the community seemed to value Dr. Brenes efforts to establish a closer relationship, but this didn't prevent them from complaining about the service. From the women's

perspective, a successful consultation was one in which the physician would actively seek physical evidence to provide a diagnosis. Furthermore, women felt the consultation was only worth their time when pharmaceutical remedies where provided. Put in perspective, it is possible to make sense of these complaints while at the same time identify contradictions within their arguments. On the one hand, women were used to long unhurried interactions in the context of everyday life. Thus, when women found themselves at the doctor's office with only a few minutes to express their concerns and with the expectation to express those concerns in a direct way, they might have find it too challenging to interact and thus were left with a sense of dissatisfaction. On the other hand, many women were uncomfortable with physical examinations, especially when their intimate body parts were involved. Thus, examinations were desired, but some forms of interactions were considered inappropriate, even if a health care provider performed them. Women were less resistant to these types of practices when another woman was performing the examinations. Thus, state-run sexual and reproductive health care practices were better received from female health care practitioners.

The physician's office was the place where more in-depth interactions occurred. Dr. Brenes resorted to elements associated with a relational logic seeking for cues of mutual understanding. Intuitively, the physician valued eye contact as a significant aspect of his labour, but institutional constraints, such as lack of time or training or as already mentioned the use of technology, hindered the possibility of achieving a closer connection. Dr. Brenes was well aware that in many ways the difficult interactions he was experiencing were the result of gender differences. He interpreted women's shyness as a lack of trust, when in fact lack of time was probably a more determining factor. Nevertheless, Dr. Brenes' frustration seemed to be the result of women appearing to challenge the legitimacy of his biomedical knowledge. His frustration also seemed to be associated with his inability to satisfy his genuine intention to establish a relationship with these women. Nonetheless, the state-run health care's reliance on a claim of legitimate knowledge hinders the possibility of a dynamic communication. This prevented Dr. Brenes from achieving his goal. Furthermore, he feared that his own lack of knowledge, about the women's experiences and their

cultural background, also represented a barrier that prevented the possibility of establishing a more fluid relationship with them.

Caring for Birth

Experiences of homebirth in El Bajo have not been as common in the past decade as they once were. However, the practice has not completely disappeared. For some women, homebirths were desired and valued in contrast to hospitalised birth. Nonetheless, an increasing use of biomedical services was visible and women in their 40s and 50s talked about their preference for hospitalised birth after negative homebirth experiences. Additionally, governmental pressure to opt for hospitalised care grew increasingly during the 1900s and by 1992 97% of women were assisted by the state-run health care system (Chen Mok et al., 2001). In 2015, when fieldwork for this study was conducted all women were birthing their children at the hospital. Even though many senior women had their children at home a few decades back, none of them felt prepared to help other women in the birthing process.

This increasing trend of hospital birth is visible in El Bajo through women's stories. For example, three women whose reproductive lives were similar in terms of the number of children they beared, had their first few births at home, either with the help of their mother or by themselves. Later in life, these women decided to have their last births in the hospital; this was the result of either a negative experience during childbirth or of the social pressure to use the health care system for birth assistance. The reasons for opting for hospitalised births are similar for most women in the community. Yet, there are important exceptions. Carmina, who was in her 40s insisted on having her children at home, and when interviewed, expressed pride on not having had hospital births. Lucina, who was in her 60s, stated that at the time of her children's births women in the community had only homebirths. Four of the five women that had experienced homebirths appreciated these experiences. Two of the women considered their homebirths as more pleasant experiences in comparison with hospital births; some of the advantages they identified were the possibility of resting at home for a few days after childbirth, direct access to their children as soon as they were born, and the use of less invasive procedures on their bodies —see Table Four.

Table Four: Homebirths and Hospital Births

Interviewee	Approximate Age	Number of Children		Type of Birthing Experience(s)
		Alive	Dead	
Lucina	58	3	5	Homebirth
Cora	53	8	1	Homebirth / Hospital Birth
Adela	51	9	4	Homebirth / Hospital Birth
Amelia	50	8	1	Homebirth / Hospital Birth
Carmina	47	6	1	Homebirth
Penelope	41	6	1	Hospital Birth
Celia	41	6	4	Hospital Birth
Paola	40	5	1	Hospital Birth
Emelina	38	5	0	Hospital Birth
Rosa	35	2	0	Hospital Birth
Rebeca	26	1	0	Hospital Birth
Rosibel	25	1	0	Hospital Birth
Sara	20	1	1	Hospital Birth
Noelia	19	1	1	Hospital Birth
Nadia	16	1	0	Hospital Birth
Evangelina	15	1	0	Hospital Birth

The experiences of homebirth and hospital births elicit a diversity of emotions in women. Through narratives highlighting both positive and negative aspects I explore the processes and the elements that were important for both the women and the health care professionals. I look at these aspects from women's perspectives. When talking about homebirths I look at the experience in two different contexts: when assisted by a family member and when home birthing alone. In the case of hospital births, I start by giving attention to the decision-making process and to some of the difficulties women have mentioned in accessing the service.

Homebirth

Women experiencing homebirths for the first time went through this process with the support of their kin members. The homebirth with kin assistance was an experience in which responsibility was shared and the eventualities of birth supported by family members. Women talked about the experiential activities and about their role and the roles of others around them. The at home alone birthing experience was mentioned by two of the five women. These narratives were filled with pride of having accomplished a difficult task without any help. The women unfolding these narratives had had several children, were knowledgeable of their bodies and the birthing experience as a whole. They highlighted the ways in which they prepared for the births and how they resorted to their acquired knowledge from the women that had assisted them previously.

Birth Care through Kinship

Cora provided most of the knowledge and understanding of the context in which homebirths took place. As an indigenous community leader, Cora has become an important link between El Bajo, particularly indigenous women from El Bajo, and governmental institutions. Through formal and informal conversations Cora talked about the way in which life in El Bajo has changed and her own perception of these changes. She started her community work once she had had all her children. She was also a single parent at the time and still in charge of four of her eight children. She birthed nine children, one of which died as an infant, and birthed six of her nine children at home. Her last three children were born at the hospital and, thus, she had an opinion about the advantages and disadvantages of both experiences. In her homebirth narratives she emphasised the labour of care performed by her kin members, especially her mother.

Up to this point in Cora's accounts the suggestion had been that these were homogenous experiences in which a series of activities occurred. However, as the conversation continued, it became clear there was great diversity in her birthing experiences. The first child she gave birth to she had at home with her mother's help. She said her mother took really good care of her. She would heat up water and make

her rest. The use of warm water was important because, according to her mother, she had warm blood due to her condition. Being exposed to cold water was harmful and was something she was advised to avoid for a few days after giving birth. Her mother would also prepare special food for her with a low content of salt and sugar. These products were only recently introduced into their diet[88], and according to Cora's mother they were not recommended for a woman in a new post birth situation. She ate a simply prepared meal of white rice and a house chicken (grown, killed and cooked at home). Cora spoke very fondly about the resting time after having the child. She said both the child and the mother got special treatment having warm water in which to bathe.

Cora's narrative of her first childbirth portrayed a desired experience in which her mother provided skilled care and nurture in an environment Cora trusted and in which she felt comfortable. The care that was provided in this particular narrative also spoke of a particular knowledge about the body and the specific intention of interacting with it in a way that would help re-establish balance ―warm water to warm blood and simple food to assist the body. The intention, as Cora said, was to prevent a "blood crash" that might cause a problem. These Ngöbe birthing practices that were intended as ways to bring women's bodies back to a balance dealt with environmental factors impacting on the body like food consumption and changes in temperature. Other women reported on the use of medicinal plants before and after labour to assist women's bodies through the process of birthing and restoration. The knowledge was based in a relational logic in which different elements interacted in ways that impact on the bodies of women and their new-borns.

However, both Cora's own as well as the narratives of other women, regarding homebirthing complicate this notion of desirability and safety. Even though Cora described her experience with much appreciation, the narratives of other women in the community confirmed that there was variation in terms of birthing practices and experiences. Amelia, for example, talked about her second birthing experience as traumatic. Amelia experienced labour as a long and painful process in which the child was born feet first.

88 During regular conversations, Cora had mentioned how her father used to go to town to exchange some of the products he grew for salt, sugar, coffee, cooking oil, and soap. Currently, these are very esteemed products, but not long ago they were replaced with products that were available to them in the community, like the use of bananas to sweeten corn based drinks.

During this particular birth, her mother didn't know how to assist her, triggering her partner's decision to resort to biomedical care for future births.

Amelia's negative experience was complicated enough to impact on her notions of safety and explains her advocacy for biomedical care. Furthermore, this experience impacted on Amelia's mother's confidence as a midwife and on her partner's trust in homebirth as a practice. At the same time, this is not to say that among Ngöbe communities there is no available knowledge about how to assist a complicated childbirth. For example, Carmina who had her first child in a Ngöbe community in Panama, explained that her child was also breech. She was under the care of her mother who resorted to her partner's knowledge once she realised the child was not in the most desirable position for birth. Carmina's partner performed a special manoeuvre in which she was turned in different directions several times turning the child into the proper position for its delivery.

The narratives of these three women ―Cora, Amelia and Carmina― provide examples of diverse homebirth experiences. These narratives portrayed women as agents in connection with different elements, such as water, food and fire, as well as with others. In this process, their agency is performed through either receptive or active practices. Women, in the process of being assisted by others, performed their agency by complying with their carers' advice. These women were highly dependent on the person assisting them. At the same time, they were at the centre of the birthing process, performing the difficult task of birthing the child. This process portrays women as being in control or out of it, frightened, relieved, able to move, or forced to rest. Meanwhile, others around them also performed important tasks such as the provision of physical and emotional support. Partners, for example, were instructed to hold the women while giving birth. The birthing assistant was not only supervising the birth but also instructing the women on the correct way to act and rest, easing their birthing process concerns. In the narratives offered by Ngöbe women of El Bajo it is possible to identify the impressions women gathered of their own labouring bodies, and what they regarded as other people's perceptions of them. These experiences ultimately impact on women's understanding of motherhood and the difficulties associated with this experience.

Birthing Alone

Women who had had several births would talk about the most memorable of their births or would summarise the most common experiences. Yet some women's experiences seemed to cause a deeper impression that prompted detailed narratives about the events of the day and their reactions toward them. This was the case for Carmina's experience of birthing alone. This wasn't Carmina's first child, she had been through childbirth several times when she found herself giving birth on her own. Carmina referred to this narrative as special in terms of the pride the experience elicited in her given the favourable outcome. She provided information about the experiences of self-care and the care for the infant.

Carmina's narrative started with an account of the activities of the day. It was the time of Camina's fourth childbirth, which happened while her mother was away visiting her sister for the end of year festivities. It was New Year's Eve and Carmina gave birth with no relatives to care for her. She tells me that she first made sure her two oldest children gathered water and wood for the fireplace. Later she prepared dinner for them and allowed them to play for a while until it was time for them to clean themselves by the river. Meanwhile, she bathed her youngest daughter and when they were all clean she sent them to bed.

By the time Carmina's children were ready for bed, she already had some mild cramps. Then she said:

> *[...] around ten o'clock at night some sort of pain came to me, then it went down, fading away, then I said: —This is not fine anymore, this ... And I was alone in the house, I said: —Now what do I do, who could help me. [...] Well only God knows. I grabbed a rope and I tied it up [on a beam on the roof], then I cut a pole and tied it in the middle, where I could hold on tight to make the force [...]. And then, I started a fire near [...] where I tied the rope. [...] I put medicine to cook, [...] I grabbed scissors, I put it nearby, I grabbed a rope, I left it nearby, and I grabbed a cloth, I left it nearby, and I got the [sanitary pads] (Kotex) I left it ... everything, I left it ready, ready nearby. Then I was there, at 11, at 12 ... At 11:30 I no longer, no longer could stand it. And grabbed another medicine, I took it, and I was grabbing ... And all those children (toda esa*

chiquillera) were asleep, they were all asleep ... And I grabbed [the pole hanging from the rope attached to the beam] with all that strength, and Noel was born.

She later explained how she gave birth in a squatting position. She also put some soft fabric on the floor to support the baby's fall in the same way her mother had done during her previous births.

Carmina's experience of childbirth with the assistance of a knowledgeable women several times before provided her with the necessary information to care for herself on her own. This knowledge, however, wouldn't have been enough in the event of a complication, something she was well aware of. The practice of birthing alone was not irregular at this time. Cora also birthed her fourth child alone. Furthermore, Cora explained that in the past women used to give birth by the river on their own. However, the practice of birthing alone, either by river or at home, had not been common for a while.

Carmina's narrative has at its basis a strong emphasis on the responsibility of self-care while simultaneously not neglecting the care of others or the care of the household. Both Cora's and Carmina's previous childbirth experiences equipped them with the knowledge to identify when the time for childbirth was near. This knowledge was helpful in making birthing preparations. They knew about the importance of preparing an area of the house for the birthing moment and they knew about the necessary tools to assist during the birth, for example, the use of boiled water and the soft cloth to receive the child. Soon after giving birth women continued with their regular duties of caring for the house, their children, their partners, and their new-borns. Regardless of the circumstances, the process of childbirth is highly relational since its success depends on the relationship the mother establishes with her new-born and the care she simultaneous provides for the two of them. For women birthing alone, not only the practice of self-care but also of caring for others in the process is involved in this relational logic. Central to women's practice is the need to ensure the well-being of all family members.

Hospital Birth

In El Bajo, a hospital birth involved deciding the appropriate time to start the trip to the hospital and what means of transportation to use. In this process, some women were unable to arrive at the hospital

before giving birth. In these cases, women were assisted by kin and in most cases transported to the hospital for examination. Women who experienced successful hospital trips were incorporated into a process of care regulated by the state and biomedicine. This context required women to actively participate within the limits of the structure. The care delivered at the hospital represented a routinely and standardized process for the health care professionals. Women were either instructed to perform certain tasks or had their bodies manipulated in ways that would make the process of delivery and, therefore, the labour of the health care professionals easier. For Ngöbe indigenous women this was one of the few individual interactions they had with the state-run health care. Furthermore, Ngöbe women, particularly young girls, were shy and quiet outside their close kin and social network, which made it even more difficult for easy communication between health care professionals and the women.

Seeking Biomedical Care

During the period of fieldwork, all pregnant women attended the EBAIS for prenatal control and the hospital for childbirth. This transition from home childbirth and care to hospital childbirth and care has been gradual and some significant failures have impacted the community's understanding of the state-run health care system. This perception is intertwined with other forms of inequality that this community has faced, like lack of water and sanitation systems, and other infrastructure deficiencies. Ngöbe women's narratives about successful and unsuccessful experiences while seeking biomedical care in the past decade are illustrative of this point.

The day Sara gave birth to her second child, she woke up in pain. It was early in the morning and quickly the pain got worse. Her sister, with whom she used to live, called the emergency service from her cell phone, which barely had signal. The emergency service told them they didn't have an appropriate vehicle to reach the community. Sara's sister then called several informal taxi drivers that have been doing trips to the community regularly for the past decade, until one of them agreed to take them to the hospital. Meanwhile, Sara had to walk from her house to the road. The trail from Sara's house to the road is only about one kilometre in distance, but the terrain is difficult to navigate since it involves steep slopes and a

walk through the nearby river. By the time Sara had to start this journey, her aunt Amelia had arrived and asked her if she was able to walk. Because of the regularity of the contractions, Sara had to be carried to the road by her brother and cousins on an improvised pallet.

They managed to get to the road, but the hired car was nowhere to be seen. Sara then tells me,

> *[…] then […] I told [my sister]: - I cannot take it anymore! […] and I still had a dress and my underpants also on […] Then [my sister] told me: - Lie down there! - […] When I was about to get off my underpants […] [the baby] was already out and, well, I really thank God that it was not hard at all […] Then [my sister] told me […], because we have that habit of fixing [the child's] nose and all that […] so that it doesn't remind crushed, […]: —Pull his nose to fix his nose! -She just told me that. And I still had the baby's umbilical cord […] And his bag still had it too, and I had him only in my hands and he did not even have a cloth […] just with the dress […] I rolled it over and he was crying […] Then, I thought, if I stayed here on the road, people would come along the road and see me, I thought. I got up like that, with all that and I moved [out of the road], inside [the nearest property] and I was there waiting […]*

Once the child was born Sara's sister ran back to the house to get clothes for the new-born baby and to ask for her aunt's help with cutting the umbilical cord. Amelia went to find Sara by the side of the road and helped her clean up, clean up the child, cut the cord and handle the placenta. Eventually Sara and her new-born baby got a ride to the hospital on a car that came by a property near the road. Unfortunately, Sara's child died a few days after being born due to a congenital heart malformation. However, Sara continues to wonder if his death was associated with the conditions in which he was delivered. She also mentioned the fact that she was unable to breastfeed him right after birth due to the lack of privacy and the constraint of her dress as a possible cause of his death.

Sara's experience of childbirth on the side of the road wasn't the only one of its kind. Paola found herself giving birth by the side of the road twice. The first time she was giving birth to her first child. She was with her partner and neither of them knew how to assist childbirth. Their limited knowledge almost cost them their child since they cut the umbilical cord but didn't tie it. Paola's partner remembered just in

time, from seeing her mother do this, that they had to prevent the blood flow from the cord by tying the cord with a string. Paola's second and third children were born in the hospital, but with the fourth one she was again caught up in the middle of the road and ready to deliver. This time she was traveling with her mother, who had had homebirths and knew how to assist during labour. Her mother took her to a secluded area where Paola could get some privacy to deliver. This time, Paola and her mother brought the child with the placenta still attached to the hospital since they had no tools to cut the umbilical cord.

Although Sara's and Paola's experiences are not the norm in El Bajo, they have had an impact on women's concerns when approaching childbirth. However, during my fieldwork time, residents of El Bajo confirmed that the availability and response of the emergency service in the area had improved. I was able to confirm this when at least three women were transferred to the hospital in time to deliver their children. Notwithstanding, the efficient and successful journey to the hospital still involved a successful phone call, which means someone from the household has to travel to a high altitude area to get an acceptable signal; as well as the availability of an adequate ambulance vehicle at the nearby emergency service to travel to the community. Thus, even though the service has improved, seeking biomedical care is still an uncertain task. In the absence of acceptable emergency transportation, people from El Bajo resort to the local taxi drivers that they know well and that might do the trip with the promise of getting paid sometime in the future.

Giving Birth in a Hospital

Women who experienced successful trips to the hospital were incorporated into a process of care that was regulated by the state and biomedicine. For the health care professionals, hospital care was an everyday activity. For women giving birth for the first time, the process was described as frightening. Women who had previous experiences giving birth at the hospital were acquainted with the process and therefore, were more concerned about getting through it as quickly as possible. Whether women were experienced or first time mothers, they all found it difficult to communicate with health care professionals. The excruciating process of giving birth exacerbated their ability to communicate. Communication

difficulties emerged, most likely, from the contrasting forms of relationality that exist in the community and the hospital. Furthermore, the hospital emphasized individual care, especially after the child is born.

The childbirth experience at the hospital was specially confronting for a young girl, who was not only away from her social network, but who was dealing with health care professionals on her own for the first time. The issues around communication, more visible when dealing with younger girls even though it cut across women of all ages was, to a certain extent, something that the older and more experienced women talked about in the community. Many of them would mention how they had trouble speaking their minds when they were young. They also mentioned the frustration they felt when they saw their daughters repeat the same pattern. They felt that women should learn to communicate their needs, especially when they are in an institutional setting where their requests might result in different outcomes depending on how they are expressed. However, quietness was also valuable, since confrontation was usually not welcome[89], particularly coming from women. One of the interviewed physicians explained that the ideal patient was the one that came to the emergency service already in labour and presented their pregnancy card[90]. Thus, the ideal patient is the one that comes with the right type of information.

Rebeca, who was a young and educated woman, complained about some of her interactions with the hospital's medical personnel. This was her first experience in a hospital setting. Even though she suffered from regular and uncomfortable menstrual pain when she was younger, she was never willing to seek biomedical attention. However, by the end of 2014, when the time came to give birth to her first child, her mother took her to the hospital. She arrived with some discharge and no pain. Frustrated about her experience, she explains,

> *[…] we went to the hospital, there they checked me and everything, they told me that they had to leave me, because of my condition because I lived so far […] And there are women who really do need to stay and they do not admit them*

89 Indigenous Ngöbe seemed to be at ease when using humour to overcome uncomfortable situations.
90 As previously explained the pregnancy card is a cardboard sheet that includes information gathered throughout the prenatal care appointments.

After she was admitted she experienced no pain for three days. She was mystified, how could she give birth to her daughter with no pain. During those three days she was examined several times during the day and night, this bothered her but she assumed it was part of the process, still she suspected it was unnecessary. On the third day the doctor in charge broke her water and she started labour. However, the delivery was difficult and long. While in the delivery room and already tired from hours of labour, Rebeca was encouraged to push to save her child's life. As a final intervention, the childbirth assistants performed an episiotomy. Overall, Rebeca recalls her childbirth experience as a difficult one.

Even if women are quiet during their visit to the EBAIS or at the hospital, they still comment, and in many cases complain, about their experiences. According to Cora, her hospital birth experience was acceptable in all aspects except for the disease with which she was discharged on the next day after she delivered her child. Cora didn't complain about interactions with nurses and doctors, or about being examined too many times before giving birth, a common objection to hospital births among women in El Bajo. For her, the fact that the health care system wasn't concerned about her having to endure a long walk home under the sun or in the rain, carrying a new-born in her arms highlighted the main flaw of this system. Cora's appreciation of this shortcoming was based on having experienced her mother's care, which was focused on bringing the woman's body back to balance through resting and careful management of body temperature. Whereas, Cora had profound knowledge of the risks and difficulties she faced returning home, having to walk a long distance in a difficult terrain and with limited possibilities of opting for a more comfortable means of transportation.

Nonetheless, not all women considered giving birth at the hospital a negative experience. Celia had positive memories about one particular child-birthing experience. She went through ten pregnancies and had six surviving children. When comparing her ten births, she recalls the fifth one, a birth of a surviving child, as the most beautiful one. She says this was a birth without pain and without much effort. Celia recalls:

... I arrived, at six in the morning I was hospitalized. I was with little pain, nothing, nothing and around two they put me on the serum[91] that was used to hurry us up… around three o'clock another doctor arrives and says ―and there were a lot of ladies that were going to have a baby, there were about ten― … and he says: 'I will make all of these ladies give birth in a minute!' … And we were all already in pain but the waters were not breaking… He went and broke them all forcibly, and one by one they were all indeed giving birth right away, and I was the last one… And he came to me and broke my waters, it hurts a lot but it hurries you up. By the time most of the women had giving birth, I had no pain… And I said: I no longer feel pain!, … and the doctor comes, he checks me to see how I was and I felt no pain, and I feel that he grabs the baby and pulls him … and I said: - At what point did I had him?... It did not hurt at all, but with the others I was there pushing to deliver them, but not with him.

Although both Rebeca and Celia were subjected to the same practice to induce/accelerate childbirth, only Celia found comfort and relief in the experience. These two women had very different circumstances and experiences. Their personal circumstances, one experiencing birth for the first time, the other going through her fifth childbirth, impacted on the perception of the experience and on the easiness or difficulty experienced during labour. While Celia was already in pain when her membrane was ruptured, Rebeca's was not. For Rebeca, this was her first childbirth experience, while Celia was birthing her fifth son.

The relationship between birthing women and health care professionals is hierarchical. The power relation is built on the legitimacy of biomedical knowledge. Briggs and Mantini-Briggs (2016) have pointed out that the power relationships are not only present in biomedical practices but that they can also be part of other medical knowledge. Nevertheless, in El Bajo, kin members of Ngöbe indigenous women usually assisted them in childbirth. This meant the power relationships were slightly different, placing women in a closer relationship with everyone around. In the hospital, the power relationships between healthcare

91 She means intravenous serum. It isn't clear if this serum had in fact oxytocin. However, it is pretty common in Costa Rica to use oxytocin to accelerate labour.

workers and the women were visible and women found themselves exercising their agency through the inhabiting of norms. That is to say that they complied with the health care professionals' procedures, such as the regular examinations and requests, and the command to push or not push. This was also somewhat true for homebirths. Nevertheless, the experience of homebirth gave more room for women to exercise their agency through connection and belonging, expressing themselves in their own language, among their own kin network. In the context of homebirths, women's ability to exercise their agency was enhanced by their presence in an environment that they knew and understood, among people whose care was embedded in their connection to others.

Unhappy Tales of Reproduction

In El Bajo, maternal mortality was not an issue as there was no evidence of maternal death in the community in the past five decades. However, 10 of the 14 women interviewed experienced late miscarriages, stillbirths or infant mortality of one or more children. These deaths resulted from an array of circumstances, which if categorised in biomedical terms, belong to at least two of those categories. According to Layne (2014), the term perinatal death has been most broadly defined by the National Centre for Health Statistics in the United States to include miscarriages after twenty weeks of gestation, stillbirths and neonatal death within the first twenty-eight days after birth[92]. Table Five shows the classification of infant mortality for El Bajo according to two sets of categorisations:

92 The Costa Rican terminology, used by the National Institute of Statistics and Census, describes perinatal death as starting at the twenty-second week of gestation and ending seven days after birth (2017). This terminology is close to what Layne (2014) describes as a narrow terminology. For the purposes of this study I will use the broad definition, particularly considering that the statistical information in Costa Rica for the death of the foetus before being born (what will fall under either miscarriage or stillbirth) is scarce and for the most part is condensed under the term abortion.

Table Five: Death of Infants According to Two Classificatory Systems

Interviewed Women	Perinatal Death			Infant Mortality	Total Loss	Alive Children
	Miscarriage	Stillbirth	Neonatal Death			
Noelia (late teens)	--	--	1	--	1	1
Sara (late teens)	--	--	1	--	1	1
Paola (thirties)	--	1	--	--	1	5
Penelope (thirties)	--	1	--	--	1	6
Celia (thirties)	3	--	1	--	4	6
Carmina (late forties)	2	--	--	--	2	6
Adela (late forties)	2	1	1	--	4	9
Amelia (early fifties)	--	--	--	1	1	8
Cora (early fifties)	--	--	--	1	1	8
Lucina (early sixties)	--	3	--	--	3	4

During the interviews, some information was gathered about some of the causes of death. These causes were associated with physical and emotional factors. Among the physical causes, Celia and Carmina mentioned falling and hurting themselves. In Celia's case the miscarriage took place months later. Celia also mentioned another physical cause for one of her miscarriages, placenta praevia[93] which was diagnosed by the doctor at the HCF. Penelope mentioned physical and emotional causes. She blamed exhaustion from the walk to the hospital and also the distress caused by the disregard of her partner. She never received a biomedical explanation for her infant's death and was unable to ask the doctor, possibly because she was 14 years old at the time. In contrast, Noelia received biomedical information about her child's death. The cause was physical, the child died due to meconium aspiration syndrome[94] during childbirth. In the cases of Sara, Cora and Amelia, the causes were also physical. Sara's and Cora's children died due to congenital

93 A condition in which the placenta is located in the lower arc of the uterus and partially or totally obstructs the birth canal (Kollmann, Gaulhofer, Lang, & Klaritsch, 2016).

94 This condition is the result of an infant inhaling meconium during or after labour. Meconium is "[…] the dark greenish-brown material excreted in utero, usually from a full-term foetus" (Lim & Arulkumaran, 2008, p. 106). The excretion of the meconium is caused by foetal distress during the process of childbirth. The result of this condition varies according to the moment in which it is detected. The condition can be fatal for the child (Lim & Arulkumaran, 2008).

malformations. Amelia's child died of bronchopneumonia. Cora's and Amelia's, children's conditions required constant traveling to the health care centre to access biomedical care. The explanations offered by women during interviews were diverse and involved biomedical knowledge, everyday events and relational aspects.

The three other women didn't explain their losses. Instead they talked about the events surrounding the time of their deaths. For example, Paola didn't have an explanation for her loss, but she said she started to have vivid dreams about the child, sometimes a girl, sometimes a boy, around the time when she realised the foetus was no longer moving. Adela, when talking about her new-born baby girl's death recalled that everything was normal, until one day the baby started to cry and they were unable to calm her down prompting them to take her to the hospital. In the case of Amelia's child, she couldn't understand what had gone wrong. She tried to feed him properly but he wouldn't eat. She remembers that period of her life with a lot of sadness and points out that besides the worries that her child's condition used to cause her, she was subjected to a lot of questioning on the part of the nurses at the hospital who queried if she was properly feeding the child at home. Amelia expressed with bitterness that at the time she had already raised seven children and there was no reason for her not to know how to feed her child adequately.

Their memories about dreams, children crying, and questioning from authorities became central aspects of these women's traumatic experiences of loss. These elements seem to hide a certain doubt about their responsibility in their child's death. For example, Paola mentioned that she felt guilty for not resorting to biomedical care as soon as she realised the foetus was no longer moving. Adela's narrative prompted a search for extraordinary factors that could have caused her baby's death. She mentioned that the girl used to breastfeed regularly and that she always cared for her by giving her regular baths. The child was not sick and never took a fall. Adela even mentioned that she never allowed the younger kids to care for her to prevent her from getting hurt. Amelia, in her recollection of the queries from health care professionals regarding her mothering skills, seemed to express guilt for being unable to prevent her child's death. Besides caring for a sick child, she had to care for her other children and in her narrative a feeling of guilt arises for being unable to provide certain forms of care due to the constraints she faced at the time.

Experiences of loss also provide evidence of the difficulties associated with care during pregnancy, childbirth and at the beginning of a child's life. Most of these narratives are closely associated with biomedical care, which shows the importance of accessing this form of care in extreme situations. In the case of Carmina, no biomedical care was sought for her first miscarriage due to the inevitability of her condition. By the time Carmina was miscarrying she didn't see the point of going to the hospital. Lucina experienced the loss of her first three children in the 1970s, when home childbirth was still the norm in El Bajo.

Chapter 8: Caring for Sexual Well-being

In this chapter I analyse three sexual health care practices in order to further explore the articulation between the community and the EBAIS' practices. Even though all three-care practices are part of the concerns of both indigenous women and the health care professionals, their treatment is different within each context, impacting on the way they articulate. These three care practices are centred in the avoidance of unwanted outcomes: pregnancy, sexual disease, and sexual violence. They are centred on women as individuals and in most cases, are not publicly discussed. These practices are relevant to this research because the first one exemplifies a well-articulated practice, the second one is a part of the EBAIS' protocol that women of El Bajo are only starting to articulate, and the third one is a well-established community practice which finds limited points of articulation with the EBAIS and other state institutions.

I first look at the practice of birth control[95] that is clearly integrated into the habitus of both the indigenous women and the health care professionals. Contraception, although sometimes challenged by members of the community, is a widely-used resource among women and an important part of the care labour within the EBAIS. The introduction of contraceptive methods enabled a transformation that was made possible by women's exercise of agency. Women's agency was both expressed through resisting the gender structure in Ngöbe society and inhabiting the norms of the EBAIS. Furthermore, women using contraceptive methods are constantly negotiating the relational and individual logics, by using arguments related to both the needs of their children and their communities, and their own personal needs.

Secondly, I examine the practice of screening for STDs as a well-established concern within the state-run health care system. I consider the health care professionals' provision of Pap smear testing paying close attention to their actions and the institution's insistence in achieving a required quota. This practice has gained relevance among women in the community considering that their welfare is contingent on getting this test, and that women are starting to show concern for the effect that their partner´s infidelity can have on their health. Furthermore, the ideas related with HIV in general and other STDs stigmatise mainly

95 In this chapter I use the terms birth control, contraception and family planning interchangeably.

women by labelling certain practices as risky —like sexual activity with Sulias— while ignoring other sexual behaviours—like same sex intercourse. Finally, I analyse long-term experiences of rape manifesting in partnerships and among kinship in order to identify care practices to prevent or stop the abuse. The prevention of sexual violence involves a series of relational practices within the community that include women, their kin and the community at large. At the state-run health care level, the protocols are bureaucratic, involving extensive paperwork and the actions of several governmental institutions with their own procedures, and designed to assist the individual.

Avoiding Reproduction

In El Bajo, biomedical contraceptive[96] practices have gained popularity in the past couple of decades, especially amongst women who have already giving birth. A close analysis of the wide use of contraception illustrates women's existing dispositions toward the management of reproduction. Accordingly, women in their 40s and 50s talked about the desire to space children or prevent an undesired pregnancy and their difficulties in achieving this end. Currently, younger women talk openly about the practice of *cuidarse* (take care of oneself) to avoid pregnancies with the support of biomedical technologies. The use of contraception is here understood as a care practice that seeks to enhance women's sexual well-being by allowing them to ensure a gap between their children, and at the same time eliminating some of the risks of engaging in, or avoiding, sexual practices. This practice, however, is not directed at limiting childbearing to a pre-set number of children or to avoiding reproduction altogether. Women still expressed their desire of having children. In this way, women are able to conform to the gender structure while at the same time abide by the state-run health care system's insistence on contraception.

According to the medical records, 10 out of the 16 interviewed Ngöbe women have used biomedical contraception. In Table Six I summarised women's contraceptive practices. These data show the extent of the impact of the state-run health care system in the use of contraceptives. The Table also shows the lack

96 Also referred to here as hormonal or medical contraceptive practices.

of popularity of the sterilisation method, even when the physician reported on the promotion of this method among indigenous women with several children. These data contrast with Carranza's (2004) study of women's preference for sterilisation in other regions of Costa Rica. Furthermore, the limited use of sterilisation as a contraceptive method demonstrates the importance of the relational logic in indigenous women's decision-making process.

Table Six: Reproduction and Contraception Use

Contraceptive Method	Number of Women Using the Method
None	3
None / Calendar Method[97]	1
Calendar Method	2
None / Depo-Provera[98]	1
Depo-Provera	6
Depo-Provera / Norgylen[99]	1
None/ Depo-Provera / Sterilisation	1
Norgylen / Depo-Provera / Other[100]	1

As shown in Table Six nine of the interviewed women were making active use of medical contraception. Of the seven women not using hormonal birth control, two had never used any form of birth control—they were teenagers without a partner. However, their status does not rule out the possibility that they would use contraception in the future. The remaining five women were post-menopausal. Three of them had only used non-medical contraception. One of them had used non-medical contraception at the

97 This method relies on a monitoring of past menstrual cycles —at least 6— to identify women's fertile days either to enhance the chances, or prevent the occurrence of pregnancy (Planned Parenthood, 2017). According to the book by The Boston Women's Book Collective (BWHBC, 2011), the calendar method or rhythm is obsolete.

98 The Depo-Provera injection is composed of progestin hormone similar to the progesterone hormone that forms part of women's menstrual cycle (BWHBC, 2011; Planned Parenthood, 2017).

99 The oral contraceptive Norgyle is composed of Levonorgestrel 0.150 mg and Etinilestradiol 30 mg(CCSS, 2014). This is one of the two oral contraceptives offered by the Caja

100 Rebeca reported using contraception purchased at the pharmacy at the time of the interview. She was the only woman not using the state-run health care system's free of charge hormonal contraception. She explained she wanted to use an oral contraceptive that was compatible with breastfeeding. The Caja only carries the Depo-Provera injection for breastfeeding women.

beginning of her reproductive life and had relied on medical birth control for a few years before menopause. One had never used any birth control, medical or non-medical.

Non-Medical Contraceptive Practices

Through the narratives of women in their late 40s and 50s it is possible to determine the depth of the transformation that has taken place in relation to their generation's experience with birth control practices. In conversations, these women talked openly about their inability to make decisions about their reproductive activity mainly because of social beliefs reproduced by their partners about contraceptive use. These beliefs were closely tied to the idea of sexual freedom and were also strongly related to male understandings of women's place in society. Browner (2000) and other scholars in different parts of the world have reported a similar experience. In spite of the negative beliefs surrounding contraceptives, three indigenous Ngöbe women from El Bajo reported avoiding sexual intercourse with their partners during certain days of their menstrual cycle as an attempt at preventing or spacing their pregnancies. These practices show that the idea of having fewer children or of having a gap in between them was not new to the community when the state-run health care system started promoting biomedical contraceptive practices. Furthermore, women in this study were highly aware of the importance of their reproductive labour to enhance or constrain their agency according to their particular circumstances. However, the consistency of these non-medical practices and their effectiveness were limited and highly depended on their partners' willingness to accept postponing intercourse. Additionally, their narratives illustrate women's (and men's) misguided understanding of the menstrual cycle and women's fertility. Thus, women's limited knowledge about the best ways to *cuidarse* through the use of non-medical methods hinders their ability to manage reproduction to their advantage.

Carmina, an important participant in informing our understanding of partnership formation in Chapter Four, attempted to use the calendar method throughout her first partnership. She used this contraceptive method to widen the gap between her children. Carmina explained that she wanted each new-born to grow and develop before another sibling came. In this way, she resorted to a relational logic in

which her actions were mostly driven by her desire to ensure the well-being of her children. About her experience of contraception she said:

> *[...] [I]'ve never had [birth] control, never taken pills, nothing, nothing, nothing. I alone took care of myself. When the man arrived I was like this, handling menstruation, I took off, I did not sleep with him, I told him this and this. That's why he beat me, [he would say] that I did not want his children, because he was bad [...] that's why I did not want, [but] it was not that, I wanted my children to grow a little bigger. That's what I said to him.*

Carmina's proud tone when explaining her attitude might denote an individualistic view if her response is not analysed in light of her interest in caring for her children. A desire for self-autonomy underlay her approach. However, her autonomy was supported mainly by a relational logic in which individual actions carry the awareness of the consequences for the agent undertaking the action and those around her(Weir, 2017). Carmina avoided her partner in spite of knowing the violent consequences her actions might bring. She rationalised her action in relation to the well-being of her children. If we bring the element of breastfeeding into this analysis, the relational logic is even clearer. For Carmina, devoting time to each of her children was important, and this included breastfeeding them for two or more years. Unintentionally, it was the practice of breastfeeding for long periods of time that allowed Carmina to successfully space the births of her children[101].

Cora also shared with Carmina a similar view of the calendar method. Cora had been unable to manage her reproduction during her first partnership. After her partner's death, as already mentioned in Chapter Four, Cora found herself in a difficult situation having to care for seven children on her own. She managed to provide for her children with the help of her oldest son's labour and some government welfare. Then she got involved with an indigenous man who traded cocoa beans for a living and paid her visits when out on his fieldtrips. In every visit, once or twice a month, he provided Cora with some resources that helped

101 Carmina breastfed all of her children for two years, the exact gap in between them. The fourth child she breastfed for four years, until she gave up breastfeeding due to social pressure. She had another child after this one and the gap between them was five years. Thus, the spacing of children in Carmina's case seemed to be the result of the lactational amenorrhea method, which she was unintentionally using. For examples on the use of lactational amenorrhea in other context see Jolly (2002) and Salomon (2002).

her in looking after her household. She stated that at the time she was using the calendar method to prevent a pregnancy. She had used this method for some time successfully. During our conversation, she told me about her understanding of the calendar method when talking about the time when the method failed,

> *[...] at the time I was taking care of myself, I never went to the hospital, I took care of myself like this ... I was two years [...] walking like this, nothing else. And one day the [...] period arrived; eight days later I was well [...] [and] he came ... and I already thought that I was alright [...]. Well, seven days or so, something around that; it happened today, my period was gone, tomorrow, the day after tomorrow, at five, six, seven days, he arrives, and for me I was already fine [...] [for sexual] relationships [...][but] from there [...] I was [...] like ... with doubt. And I felt at once that in that period [...] I got pregnant.*

According to Cora's description, the use of the calendar method for her was circumstantial. She didn't keep track of her past cycles, and she didn't talk about the strategies she used to avoid her partner if he came on her fertile days. Based on the way she described the method, which as already illustrated in Carmina's example, was a common belief, she associated menstruation and the days right after with fertility. This belief didn't account for a woman's period of ovulation that starts approximately ten days after the first day of menstruation. In this way, Cora was putting herself at high risk of getting pregnant.

Even though Cora's use of the calendar method was unsuccessful, it is interesting to analyse the rationality behind her practice. Three elements stand out. The first one is a sense of pride, similar to Carmina's when speaking about her ability to manage contraception. In a way, Cora was proud of not having to depend on the resources provided by the state-run health care system to take care of her. Not all members of the community were open to the use of medical contraception. The rejection of medical contraception was perceived as a way of strengthening the association with the Ngöbe identity. The second distinctive idea in Cora's narrative is her awareness of the relevance of the cacao trading man in her ability to care for her kin. This relationship enhanced Cora's ability to provide for her children. At the same time, due to the man's job responsibilities and his sporadic visits, Cora was able to enjoy a greater degree of agency than the one she experienced in her previous partnership. The third element, which somehow stands

in contradiction to the second one, is Cora's awareness of the cementing quality that childbearing would bring to her relationship with this man. By avoiding a pregnancy, Cora was showing a good understanding of the relational logic that influences partnership formations among Ngöbes and actively avoiding this bond. In this way, Cora was resisting the formalisation of the union, while at the same time she was able to strengthen her connection to her children and to the land that she owned. Thus, in a way Cora was at the same time reinforcing a relational logic and rejecting it, by choosing the elements of this logic that were relevant to her situation and her life history. This negotiation is a constant struggle for indigenous Ngöbe women today, as I will show later in this section.

The experiences of Carmina and Cora show similar dispositions toward managing reproduction but with two different outcomes in mind. Cora's intention was to prevent reproduction by avoiding intercourse during the fertile moments of her cycle. Carmina's intention was similar, but driven by the desire to space the children to allow them to grow and develop before the next one came. Even if slightly different, these examples demonstrate some women's interest in managing their reproduction. The interest of managing reproduction through care practices related with the menstrual cycle also shows a relational logic strongly attached to the importance of their role as mothers and the labour of care it implied. Two examples from younger women, Rosa and Rebeca, that will be analysed later in this section, showed an inclination toward an individual logic to justify their contraceptive practices. These two examples were in contrast with Carmina's and Cora's examples. Although both Carmina's and Cora's understanding of the calendar method was misguided, they both used it with the intention to favour their kin and enhance their ability to care for them. Furthermore, these examples also allow us to see this care practice as a process in which actions informed by the habitus —that is to say, informed by women's pasts— are undertaken in order to achieve an outcome. Carmina's care practice, for example, was concentrated on avoiding her partner during the bleeding part of her menstrual cycle. She acted in this way even if this put her at risk of violence. Cora's concern about pregnancy was only present when the man's arrival was on or around her days of menstruation. In her narrative, there was no mentioning of violence from this particular partner. Both of

these women's actions were motivated by the success of their practices in the past and their experiences of birthing and raising children.

Medical Contraceptive: *Cuidarse* as a Care Practice

The Ngöbe indigenous women's use of medical contraception in El Bajo can be explained through a process of articulation. Women's care practices around medical contraceptives are at the intersection of El Bajo's indigenous people understandings of Ngöbe identity and the forces of modernity that influence the Costa Rican state-run health care system. Women resort to both the logics of relationality and individuality to make sense of their care practices. At the same time, health care professional's actions evoke the two logics, although informed by different structures as a result of their different positionalities in terms of gender, ethnicity, class and religion. Since women of El Bajo still have very positive views about fertility, their use of contraception is determined by how many children they have had and the age of their last child. Thus, for example, Penelope was open about her reliance on medical contraception to cease reproduction. Younger women with fewer children use medical contraception to ensure there is a gap between their children but interrupt this practice when they deem themselves ready for another child.

The community's atmosphere toward medical contraception is characterised by conflicting views on this practice, informed by community member's understandings of true Ngöbe lifestyles and the influence of Sulia ways of being. The interactions between health care professionals and indigenous Ngöbe women reveal the different positionalities of both actors and the different privileges / oppressions they are subjected to. Ethnicity, gender, class, and geographic location are some of the most important elements influencing the dynamic of this relationship. The health care professional's views on contraception and the logics present in the women's narratives are ultimately linked to reproductive care in the sense that they seek to limit the number of children per woman. However, the logics displayed by women through their story telling also reveal a more expansive rationality related to a women's ability to negotiate their choices. This process of negotiation is based on past experiences and on their understandings of sexual well-being through the practice of *cuidarse* (caring for themselves).

Conflicting Views on Contraception

At the community level discussions about the use of medical contraception are common and intertwined with other aspects of people's sexuality, like partnership formation. At the centre of these discussions is a preoccupation with what it means to be Ngöbe and how can this lifestyle survive in a world infused with an individual logic favoured by modernity. At the community level, discussions about the use of medical contraceptive techniques are many times motivated by Augusto, a community leader. Although not all members of El Bajo always share his views, he raises important concerns. Augusto's concerns are relevant here because they are representative of the struggle between what is perceived as the experience of being Ngöbe and that of being modern.

Augusto was in favour of promoting non-medical contraceptive methods in the community since he believed that *[...] now a lot of women are getting sick from injections and pills [...]*. Augusto was also suspicious of the state-run health care system's insistence on the use of contraception by indigenous people. In his view, this insistence was motivated by the government's interest in decimating the indigenous population. Hence, Augusto advocated in many occasions for resisting state-run interventions that he perceived as non-beneficial for the indigenous communities. Nevertheless, his argument was representative of his positionality as an indigenous man with influence both in the community and among some state institutions. Thus, many indigenous women in El Bajo openly rejected Augusto's views based on their identities as indigenous women with limited resources, which confronted them with different forms of oppression from the ones experienced by Augusto. These women were well aware of the unequal burden that reproduction places on women's bodies and livelihoods, and were outspoken about it. Consequently, Ngöbe indigenous women leaders in the community generally perceived medical contraceptives as beneficial. Notwithstanding, women leaders were also aware of the negative side effects of the medical contraceptives and because of that were sometimes sympathetic with Augusto's views. Similar conflicts have been reported in other indigenous communities in Latin America (Espinosa Damián, 2014), which speaks of the still conflicting nature of contraceptive use for many women today.

Close attention to indigenous women leaders' views on contraceptive use reveals the incorporation of elements from the relational and individualistic logics. Cora, for example, shared many informal comments about the importance of promoting contraception among young girls. She was also outspoken about it in community meetings. For women sharing Cora's view, this care practice allowed them to consider other life options, like accessing education and entering the work force. This take on medical contraception reproduced the individualistic logic. Alongside this argument, these women also talked about being better suited to care for their children when able to manage their reproduction. A similar case presented by Hirsch (2008), analysed Mexican Catholic women's negotiation of medical contraception as a means to ensure their children's well-being. Mexican Catholic women emphasised the importance of being able to *afford* the children they procreated, while indigenous Ngöbe women from El Bajo focus on the care they provided in everyday life.

In this context of struggle around contraception, it is possible to identify the paradox informing women's views. On the one hand, the logic of individualism impacts on the understanding of childbearing as an experience that subordinates them by inhibiting their ability to access education and the work force. On the other hand, the logic of relationality places a high value on motherhood allowing women who have children to enjoy a more respected status that enhances their agency through connection and belonging. Thus, women in El Bajo negotiated these two views by becoming mothers at a young age and then engaging in contraceptive care practices. They were able to consider and explore options outside the role of motherhood because of the support and care provided by their own mothers. Consequently, indigenous Ngöbe women with teenage daughters were compelled to motivate them to use contraception to avoid recurrent pregnancies. They did so using the logic of relationality through indirect comments. Furthermore, they rationalised their discourse by highlighting their own experiences of having many children and having to care for them, and by the burden their daughters' children brought on themselves.

Contraception as Promoted by the EBAIS

To this context of conflicting views about contraception we add the labour of care performed by the state-run health care professionals. As already mentioned in Chapter Five, women from El Bajo engaged in conversations about sexuality and reproduction mainly with two health care professionals: the ATAP, Arturo and the physician, Dr. Brenes. These professionals were keen on providing women with information to prevent pregnancies. For the ATAP, the promotion of family planning is one of the most important activities. This labour is performed in the context of the community. The physician is restrained to his office and an occasional field trip to the community, but his role is of great importance to women because of the confidential character of these exchanges.

The relationships that women establish with the physician and the ATAP reflected their perception of their roles and their interaction with them. On the one hand, even though the physician was born and raised in the same county, he was a more distant figure for women. The physician, Dr. Brenes spoke about his insistence on getting women to access better contraceptive methods. Women' attitudes prompted in him a sense of frustration due to their negative responses, or disregard for his advice on practices like sterilisation. This sense of frustration, that has been reported as a common experience within health care professionals working with rural indigenous people in different parts of the world (Briggs & Mantini-Briggs, 2016; C. L. Hunter, 1996), suggests a concern for women's well-being based on routine and close interactions with them. Dr. Brenes also established this relationship from a position of authority that thwarts the possibility of establishing a dialogue with the women that result in *health/communicative inequalities* (Briggs & Mantini-Briggs, 2016). On the other, the ATAP, Arturo had been a member of the community until very recently, even though he is not an indigenous man. Thus, women in El Bajo knew him and his family well, which strengthened this relationship. Furthermore, Arturo seemed to be more hopeful about the possibility of change that was taking place among the women, albeit slowly, the same way it had happened with birth control in general in past decades.

These different views women held about Arturo and Dr. Brenes seem to be the result of their experience, their position within the social structure and their adherence to biomedical principles. The

physician had only been working at the EBAIS for a few years, while the ATAP had been there for almost two decades. Thus, Arturo's attitude was the result of having seen changes evolve in a slow fashion over this period of time. The close relationship Arturo had with the community of El Bajo allowed women to reach out to him either in the community or at the EBAIS. However, it was in the community where women could express their views and concerns more openly. Thus, even though Arturo promoted contraception by relying on arguments associated with the logic of individuality, like the importance of personal development through education, he interacted with the community through the logic of relationality. Thus, his promotion of family planning also included advice on family values inspired by religious beliefs and interdependence. He also positioned himself as an authority figure, based on his ethnic background, educational level, moral values and gender. Dr. Brenes limited his interactions to the 15- minute consultation, mostly referring to biomedical information like side effects of contraception or the availability of other methods.

Based on the medical files of women from El Bajo the use of contraceptives is the most common reason for accessing health care at the EBAIS, followed by prenatal control. However, the contraceptive methods used by women in the community were still restricted, with most women resorting to birth control injections and a few of them using the oral contraception. About women's contraceptive preference, Arturo stated:

> *In terms of family planning […] [they] prefer […] injectable, the pill is not easily accepted, sterilisation is hard to promote, vasectomy not [accepted], only that one [man] I told you about, and very little condom use.*

He further explained that in the late 90s, when he used to run the health post near the community, the distribution of contraceptives was easier. Currently, people in the community have to travel to the town to get a prescription for the contraceptive and this makes it harder for him to promote family planning. Arturo's close interaction with the community and the relational character of his labour, allowed him to be sympathetic with the economic difficulties and the challenges of transportation that members of El Bajo face.

Thus, even though both Arturo and Dr. Brenes were in close interaction with women from El Bajo, they were unaware of the role that reproduction plays in shaping the experiences of indigenous Ngöbe women. Furthermore, their positionality as non-indigenous men and carriers of biomedical knowledge prevented them from considering the relational logic driving women's reproductive practices. Nevertheless, Arturo's attitudes or even Dr. Brenes' frustration had no negative effect on women who had already decided to access contraception. Even if they did not appreciate the tone of their comments or their insistence, the women did not seem to be discouraged by them. As I will show in segment 1.2.3, women from El Bajo continued to request contraceptives if they deemed it necessary and rejected it whenever they wanted to become pregnant again or if they considered it harmful or unnecessary. This is not to say that the state-run health care system had no effect on women's decision-making. Nonetheless, Arturo's and Dr. Brenes' actions were not the only elements informing women's decisions.

Of major importance in women's decision-making process were the oppressions they faced in relation to their ethnicity, gender, class and geographic location. As already mentioned, Arturo was highly aware of the oppressions women face in relation to their class and the geographic location. Furthermore, Arturo was constantly advocating for women, which made the employees at the EBAIS aware of their situation. In spite of this, the oppression that indigenous women were subjected to was constantly being downplayed or misinterpreted by most employees. Thus, when accessing health care services, indigenous women from El Bajo were often subjected to request special favours due to the rigid established procedures. Women complained about the fact that they were forced to beg for the service, and this situation prevented many of them from seeking the necessary care.

A far more significant concern that dissuaded women from accessing contraceptive care is the experiences of harassment many of them have been exposed to. These experiences were the result of the multiple oppressions impacting indigenous women's daily lives. For example, Emelina was suspicious about the way in which a particular employee touched her when being injected with the Depo-Provera vaccine. She commented about her aversion to this particular employee's attitude when her daughter started to get contraception. Alba shared Emelina's dislike and talked about a more worrying incident, in which

this particular employee touched her breasts. She commented that this experience impacted her to the point of preventing her from accessing contraceptive care. Furthermore, she talked about other women having narrated the same experience to her. Women perceived this experience as a risk associated with accessing contraception that highly impacted their decision-making process. These events were known at the institutional level. However, there did not seem to be any procedures put in place to allow users or other employees to deal with them.

Therefore, there is a paradox found in the access to contraceptive care at the state-run health care institution. On the one hand, women are constantly persuaded to use contraception and encouraged to adopt permanent methods. On the other hand, women were dissuaded from accessing contraceptive care due to the unyielding way in which procedures are applied. Furthermore, the lack of adequate ways to deal with sexual harassment at the institutional level is preventing women from experiencing sexual well-being and from enhancing their well-being when engaging in sexual practices. These two obstacles to accessing contraceptive care are the result of the multiple oppressions indigenous women experience, which are perpetuated by the attitudes and abusive behaviour of health care professionals.

Women's Contraceptive Care Practices: Between individuality and relationality

Indigenous Ngöbe women from El Bajo influenced and were influenced by the community's and the state-run health care system's actions and discourses in relation to contraception. Thus, their logics were sometimes characterised by relationality and sometimes more representative of individuality. They used both of these logics to make sense of their decisions when negotiating their reproductive abilities and their options for contraceptive use. As a result, women considered both the economic difficulties as well as the afflictive characteristics associated with their reproductive activities when making decisions about contraceptive care practices. In addition, women also considered the risks associated with using contraception and dealt with them according to their circumstances.

The commentary about the difficulties of being a woman was never paired with the intention of allowing women to enjoy sexual activity. However, the fact that the use of contraception was promoted

among young girls seemed to suggest that sexual activity in itself was not a particular problem. Moreover, during fieldwork one mother commented on her daughter's sexual desire in positive ways. For example, Cora once used the verb to crave (*estar antojada*) when mentioning her daughter's travel to another community to meet her boyfriend. Thus, sexual desire and sexual activity in itself was, for the most part, not considered problematic, it was the consequences of such activity that most concerned mothers. Hence, the practice of motivating daughters to use contraception could be seen as a way of caring for sexual well-being.

Seeking and using contraception also represented a risk for women in El Bajo. As already described, women who sought to control reproduction could be at risk of intra-familiar violence. A major reason informing male response to women's desire to manage their reproduction was a fear of infidelity. Sara commented on her mother's experience saying that her father *[…] did not like her to use birth control, […] if she was going to use contraception it was because she was going to be with another man […].*This belief is still part of couples' discussions about using contraception. Rosa, for example, talked about the process of negotiating sterilisation with her partner. They both considered going through the surgery102, but she insisted she wanted to have it done on her. He then implied that she was interested in the surgery because she wanted to be with other men and avoid getting pregnant at the same time. Therefore, the association between contraception and infidelity is still present in everyday experiences of couples in El Bajo. However, these experiences don't have the same impact as they did in the past.

Women of El Bajo constantly made references to their reproductive activity as afflictive. Cora, for example, advised Sara to use contraception to avoid the suffering she had been exposed to. By the age of 19, Sara had already experienced the death of her new-born and one miscarriage. In Cora's view, the only way to end her suffering was to prevent her from getting pregnant again. Furthermore, Amelia constantly commented on the sacrifices women had to make throughout their motherhood experiences. Women, thus,

102 According to Arturo, he knew of only one man from an indigenous community who had had a vasectomy. Furthermore, Arturo, Dr. Brenes and indigenous women from El Bajo talked about men's resistance to condom use. Thus, based on these data, men were not in charge of managing reproduction. Nevertheless, it is possible that they were in the past, through the use of methods like withdrawal or the calendar method. What is a fact is that men, now and in the past, might use force to achieve a pregnancy, which would cement a relationship with their partner, or with a woman they would like to have as a partner.

were seen as being at a disadvantage based on their reproductive capacity. Sara used this argument to *negotiate contraception use in the following way: […] if he [asked] me [why] I'm using birth control, I'll tell him, 'because it's not the men who suffer, it's the women' […]*.

Another risk women have to face when using contraception is the side effects of the different methods. This risk echoes Augusto's concern for women using biomedical contraception in the community. In fact, some of the side effects narrated by the interviewed women seem to suggest that Augusto's perception of birth control pills and injections as poisonous is not far fetch. Penelope, for example, suffered severe nausea while being on birth control pills. Later she tried the injection but because of the risk associated with breast cancer and the appearance of a small lump on her breast, she was advised to stop using this method. This left her unprotected and thus she had several unwanted pregnancies. Other women in the community also talked about these side effects. Side effects like persistent amenorrhoea or the regulating effect the birth control pill had in some women's menstrual cycle were perceived as positive. Nevertheless, in at least one occasion this amenorrhoea hid a pregnancy.

An interesting exception to the injectable and oral contraceptive methods used by women in the community was Rosa's choice for sterilisation. At first, Rosa and her partner used the calendar method avoiding having sex during her period and the days after. Three years after they got together they started to actively try to conceive, but it took two more years until eventually she got pregnant and had a son. After her son was born she says she never used any contraception but she did not get pregnant until five or six years later. This unexpected pregnancy motivated her to make up her mind to get the surgery. Her decision-making process included several elements. About getting pregnant one more time she states,

> *I did not want to because the situation is very difficult, and the other thing is that I … it's not like I like children, […] And I say to people, many children, imagine, one gets dragged into something and the other gets dragged into something else and there are two already, and with two you can fight, I tell you, now five or six, […] it is more difficult […] then I decided [to have the surgery]*.

In this passage, Rosa resorted to the same logic of avoiding suffering used by Cora several times during the fieldwork. A great deal of the reproductive burden is solely in the hands of women, who are the primary caretakers for other pregnant or birthing women and for children.

The last consideration that impacted Rosa's decision-making was her plans for the future. She pointed out that her expectation had always been to work and study. Rebeca had a similar experience, and even though she had recently entered motherhood, she was *taking care of herself* with oral birth control to avoid getting pregnant again too soon. Rosa and Rebeca were the only two interviewed women who wittingly prevented a pregnancy for the first few years of their partnership and were making efforts to obtain an education and a stable job. They were more prone to use the individual logic to justify their actions, pointing to their personal development as an important element and to their desire to have fewer children. This logic might seem a generational trend that can easily be found in younger girls. However, based on the evidence found in medical files and through observation, most teenage women only started using contraception after having a first child, and many of them were unable to continue their education due to the responsibilities attached to motherhood.

Many women in the community rejected sterilisation based on the possibility of eventually wanting another child. From the point of view of the relational logic, women might be interested in having another child with their partner to further strengthen their relationship. Furthermore, some women might be cautious about sterilisation based on the possibility of having another relationship in the future that might be cemented by the birth of a child. Rosa talked about not wanting another child neither form her partner or from another man. Notwithstanding, she insisted her partner should not get a vasectomy in the event that he would have another partner in the future. Arturo and Dr. Brenes ignored this logic. They both were frustrated by women's insistence on maybe wanting another child in the future. About this frustration Arturo stated

> *[M]ost [women] [...] say no, [because] they might later want to have another baby and […] they will not be able to. I tell them: - No, but it's enough, you already have four, or you have five, or you have six, eight, why would you want more than eight? […]*

In order to explain the logic behind this resistance, the physician would point to the women's partners as the cause. However, his explanation didn't account for women's persistent use of contraception.

The relationship between past dispositions and the introduction of new practices have created a dynamic that complicates the structure in which women interact, allowing them to enhance their options. This effect has the same result as the interaction between other new and old practices like women's participation in diverse political and social activities and access to welfare programs.

Monitoring Sexually Transmitted Disease

The screening for sexually transmitted diseases (from now on STDs) was mainly a concern of the state-run health care system. At the community level, commentary about STDs included mentioning of HIV/AIDS, gonorrhoea, and syphilis. The state's insistence on screening for HPV had also made people aware of the risk of developing cervical cancer and its association with sexual activity. Nevertheless, the attitudes about STDs were mostly dismissive of the importance of monitoring and preventing these diseases. This reality presents a clear contrast with the incorporation of contraceptive practices in the community of El Bajo. For example, even though Amelia was constantly stressing to her son and daughters the importance of using contraception, she never insisted her daughters should get a Pap smears, or pressured her son to use condoms to prevent STDs.

As such the practice of monitoring or preventing STDs was not well articulated into women's everyday lives, at least not to the degree that contraceptive use as a care practice had been articulated. This practice requires a deeper engagement with the logic of individuality stressed in biomedical practices. Screening for STDs is used by the state-run health care system as a way to monitor the population. This care practice is promoted as an individual responsibility. As stated by Gregg (2003) in relation to the notion of risk, *"individuals become ultimately responsible for their own disease states"* (p. 972). Along the same lines, Mol (2008) notes the praising of the idea of choice within healthcare, assuming every individual would autonomously choose what is best for their health according to biomedical standards. Both authors highlight the missing aspects of this logic, namely that not all individuals think of themselves as detached

from people around them, and that not everyone has access to the same options to choose what is best for them. I make use of the logic of relationality and intersectional theory to highlight these elements in the state-run health care system's quest for STD screening.

Before engaging with the data gathered at the intersection between the community and the state-run health care system, it is important to point out that the state's desire to monitor disease, was not paired with an insistence to prevent it. Thus, promoting condom use was not a priority for health care professionals. Furthermore, even though the EBAIS had very stable procedures put in place to ensure adult women were tested these procedures seemed rigid and fixed in the structure of health care provision. The unbending character of the procedures gave women the impression of limited choices, even if health care professionals occasionally made concessions.

In Table Seven I summarise the information related to the interviewed women's past screening tests for HPV[103] and HIV. The table shows that most women have had at least one Pap smear in their lifetime, with the exception of three of the younger informants who reported never having had a Pap smear. Furthermore, on the medical files there was evidence that all women under 41, with the exception of one, had a routine HIV test when pregnant. This summary also shows that even though there is resistance in the population and an apparent lack of flexibility in the state-run HCF, the screening processes are still taking place, although not with the regularity that the state-run health care system would prefer.

Table Seven: Routine Screening Tests and Outcomes

Randomly assigned number	Age group	Pap Smear Tests		HIV Tests on File	Comments
		On File	Interview		
#01	42+	0	2	0	No available info
#02	42+	1	1	0	Negative
#03	-25	0	0	1	Both negative
#04	26 - 41	1	1	1	Both negative

[103]Currently the state-run health care system in Costa Rica only uses Pap smear for HPV testing. The introduction of other techniques are in a trial stage and might be implemented nationwide in the next couple of years.

#05	42+	--	1	--	No available file
#06	-25	0	0	2	Both negative
#07	26 - 41	8	Regularly	2	Both negative
#08	42+	0	1	0	No available info
#09	-25	--	1	--	No available file
#10	26 - 41	5	Every 2 years	2	Pap smear +, HIV –
#11	-25	1	1	1	Both negative
#12	26 - 41	7	Every 2 years	2	Both negative
#13	26 - 41	5	Regularly	1	Both negative
#14	-25	0	0	1	Negative
#15	26 - 41	1	--	1	Both negative
#16	42+	5	7 years ago	0	Negative

The reason for emphasizing the analysis on Pap smear and HIV screenings represents the community's interest in them. Several people in the community mentioned both the screening test and the disease in spontaneous conversations. It was clear, however, that the interest people showed in the experience of being tested and their HIV status were prompted by the current discourses on sexual health. These discourses were present in multiple contexts: media, the education system, the health care practitioner's everyday interactions, and in informal conversations in town and in the community.

Sexual Disease and Stigma

HIV is a condition that still carries a great deal of stigma in Costa Rica and particularly in rural areas. The community of El Bajo is not an exception to this reality. However, HIV stigma in El Bajo takes a different form. Here I consider the ideas associated with HIV in general and other STDs among members of El Bajo. I explain how the stigma affects mainly women and how selective sexual practices are labelled as risky, while other sexual behaviours are left unproblematised. This selective view of sexual practices is also at the intersection of the struggle between the Ngöbe identity and the perceived dangers of modernity. Thus, risk is measured in relation to experiences that are seen as outside of Ngöbe lifestyle.

A recurrent idea, and probably the most relevant one, surrounding the contagion of STDs in general and HIV in particular was that it was a white people's disease[104]. Thus, the general logic was that as long as Ngöbes limited their sexual encounters to other indigenous Ngöbe, there was no risk for contagion. Augusto went further to talk about having sex with *clean* women. It was not clear what he meant about this, but he said that he had manage to stay healthy because,

> *[I] have never met a sick woman; what I have come across in women, [is] healthy women, I have never caught illness and I do not know the woman's disease; But I have certainly heard that there are women who have AIDS, that there are women who have gonorrhoea [...] but I have never [...] received a woman's disease, I have only run into healthy women [...]*

Augusto was sure his sexual experiences had always been risk free. He seemed to believe he could tell from a first impression if a woman was sick or healthy. At the end of the interview he pointed out he had never accessed paid sex or had never been with a white woman for fear of contagion.

Augusto's views suggest, as well, that women were the main carriers of the disease. The women's condition concerned him, and not the men these women had been intimate with. This belief was expressed in Amelia's fear of being labelled as having a STD. Her concern came up during a formal interview. Amelia told me, after I asked her about her sexual health, about a recurrent urinary tract infection and some affliction in her genitals. She said she had consulted biomedical care since she was concerned it was a STD. The biomedical doctor discarded the possibility of it being a STD and even though she had been able to solve her discomfort momentarily, the symptoms seemed to have come back. After I asked her about the possibility of using Ngöbe medicine to attend to this problem, she stated,

> *Maybe some of the men that have knowledge, a botanist, might know, but I've never asked [...] [Because] if one says something about it, [people are going to comment], 'surely that lady has AIDS', and I don't know what else [...] I better not say anything [...] [They are going to say] 'Surely that lady has AIDS'. Since they say, more than one of them says, that because I live with*

104 A similar experience is reported by Senior, Helmer, Chenhall, and Burbank (2014) in which STI risk is related to the lack of familiarity with the partner's community.

that man, that white people are more contaminated with those diseases, they said, that he was the one that contaminated me.

In this context, biomedical care is an important alternative to the difficulty of accessing care for this condition in the community. In direct contrast to the concerns expressed in regards to Pap smear screenings, in this case the biomedical care provided the necessary privacy to protect oneself from stigmatisation at the community level. In a way, the relational care that women enjoy through their kin, can be constraining when the stigma around a disease is as persuasive as HIV stigma is in El Bajo. The biomedical care offered women a safe space for consultation avoiding being labelled. Nonetheless, the speed of the consultation experience and the non-relational character prevented women from getting the necessary information to understand their condition and preventing it in the future.

Screening Test: Pap smear

Screening for cervical cancer is a well-established procedure at the EBAIS. Testing for this condition is a mandatory practice for health care professionals and it has been enforced through imposed quotas to every primary care facility. Women who access the health care system—most commonly seeking contraceptives— are urged to get tested for HPV, which according to the protocols on Pap smears should be every two years. The Pap smear test is perhaps the only procedure consistently performed by the state-run health care that assists women in caring for their sexual well-being. This form of testing is directly associated with preventing a disease that can affect women's lives in many ways and that is, for the most part, contracted sexually. Most other practices related to caring for women's sexual and reproductive health were mainly associated with reproduction. However, the delivery of this form of care was characterised by many struggles. Here I analyse the health care professionals' provision of Pap smear testing with emphasis on the employee's actions and the institution's desire to achieving the required quota. Women's perception of this test is also considered in relation to the main reasons for seeking the test and the relational character of the motivation.

The practice of recovering samples for HPV testing had a particular place within the EBAIS' structure. The physicians do the testing, but the nurses do the preparation of the required equipment. On arrival, the nurse would ask women about the reason for their visits. Once a woman stated she wanted to be tested, the nurse would prepare the speculum for the physician to take the sample. Pap smear testing, as some other specific tasks in the EBAIS, was schedule for Tuesday mornings. This rule was meant to organise and speed up the service. At the same time the rigid structure of the internal procedure gave room to health care professionals' inflexibility, turning away women requesting Pap smears on the basis that they were only performed on Tuesdays. Furthermore, women from El Bajo complained about having to subject themselves to being tested by a male practitioner. This complaint was based on the modesty that characterised Ngöbe women who presented strong concerns for nudity. Based on these two situations, Pap smear testing became a conflicting experience.

Nevertheless, most of the interviewed women had had a Pap smear at least once in their lives. This can be explained in two ways. First, even though the procedures appeared rigid at the time the fieldwork was conducted, it was clear that rules in the Caja were in constant modification. A good example is the introduction of the computer system in 2016, which modified several protocols within the institution and forced employees to adapt to the use of technology. Second, the rules were bent all the time. Close to the end of fieldwork, Dr. Brenes mentioned that his superiors had expressed their desire to get better quotas of Pap smear samples by encouraging health care professionals to take samples any day of the week. Furthermore, on more than one instance, the occasional fieldtrip to the community included a female health care professional with the necessary skills to take Pap smear samples. In this case, rules were bent based on the knowledge that indigenous Ngöbe women's modesty often prevented them from getting a Pap smear with a male health care professional.

Even though health care professionals at the EBAIS commented on possible actions to honour women's requests, these actions were perceived as special favours. Thus, in the health care professional's views, the indigenous women were the ones seen as inflexible. Furthermore, the service being provided was perceived as a state action put in place to favour women's health, which implied that women's

negativity to have the sample taken was an unappreciative act. This logic is in line with Mol's analysis of the element of choice. Thus, the male, non-indigenous, middle class, urban dwellers, health care practitioners assisting women from El Bajo regarded this action of getting a Pap smear as a common-sense choice. Nevertheless, in this case, even if health care practitioners didn't understand or agreed with women's requests, the need to comply with the necessary quota was an incentive to give in to their demands.

Despite the bending of rules, women from El Bajo still resisted the practice of being tested. Adela, for example, explained that she had only been tested once a long time ago. She mentioned she has not had a Pap smear since because she did not like the experience. Furthermore, she said,

> *Andrés explained everything to me, why one has to do the Pap smear. [He said] because of any disease, if one gets cancer, and I don't know what else; He has explained everything to me, but I do not feel sick, that's why I haven't done it, I told him that […]*

Even though Adela showed some basic knowledge about the importance of the test, there is no clarity as to what she understands she might be gaining by being tested. Furthermore, she sees no logic in being tested for disease when she feels healthy. This is a common experience for many people around the world, for example Gregg (2003) mentioned a similar rationality among the participants in her study. This type of misunderstanding, in relation to the struggles experienced when trying to access services, is a menace to women's sexual well-being.

Women who voluntarily requested the procedure or accepted the advice to get tested were encouraged by two main reasons: the welfare stipend being contingent on women getting tested and their partners' known infidelities. Women made sense of these reasons through a relational logic. In the case of the state's welfare, women knew their household survival was partly dependent on them getting the stipend. Therefore, they were willing to subject themselves to this procedure. This strategy also made evident the state's institutions' ability to coordinate actions to achieve an end that was perceived as necessary, even if the methods used were coercive. The state's insistence was at the same time contradictory, considering the strict procedures put in place at the EBAIS. For example, during an informal conversation, Emelina expressed her concern about not being able to get tested a few weeks back when a female health care

professional visited the community with the intention of performing Pap smears. She commented on how the health care worker had assisted many requesting women, but had not been able to assist everyone in need of the test. Emelina referred to the Pap smear explicitly as a requirement imposed by the state-run welfare institution. Thus, accessing a Pap smear became part of the process of caring for others and not of the process of caring for themselves. Since welfare[105] is not something women have a constant access to, the Pap smears also become irregular and as I have shown here, a struggle.

Women also made sense of their need to obtain a Pap smear based on their partners' sexual affairs. Thus, they understood the risks attached to the fluidity of sexual experiences in El Bajo. However, women ignored the fact that cervical cancer is a condition that might develop even when they haven't been sexually active for a long time. Thus, the reasons for undergoing a Pap smear screening need to be framed not only in relation to sexual encounters but also in connection to bodily processes. Emilia, a woman in her 40s who was not formally interviewed for this research, understood the risk that her partners' liaisons represented to her health. She commented on her way to the EBAIS that she needed to get a Pap smear test because she knew her partner was being unfaithful to her. This comment suggested she would not get the test if she was single or if her partner was faithful. Furthermore, this evidence suggests that in El Bajo understandings of the importance of Pap smears may have similar effects to the understandings reported by Gregg (2003) in her ethnography of cervical cancer in a Brazilian favela, where

> *The biomedical message equated sexual activity with risk, suggesting that all sexually active women should receive Pap smear in order to decrease that risk. Women in the favela interpreted lack of the Pap smear as their primary risk, and sexual behaviours —both their own and their partners— as a given, and not as a risk for which anyone should actually assume responsibility (p. 1974)*

105 Welfare is dependent on the state resources which are limited and have to be divided among many. Thus, women are constantly navigating the state's bureaucracy and constantly being rejected on the basis of having recently enjoyed the benefit. The procedure followed by the state's welfare institution are beyond the scope of this research, but they certainly require more attention since they represent an important aspect of women's ability to care for themselves and others.

Thus, Emilia's comment about the Pap smear screening seemed to suggest that the test was perceived as designed to detect STDs in general and not only HPV in particular. Although there is no evidence to this, other women might have perceived this test in a similar way. Furthermore, women accessing the Pap smear test because of fear of getting sick due to their partner's infidelities, didn't talk about taking any other measures to protect themselves, putting themselves at risk of getting sick.

Thus, even though most women interviewed for this study, and many others in the community, had been tested for HPV, the articulation between the state-run health care system logic and the indigenous Ngöbe women logic was only partial. On the one hand, the state-run health care system insistence to get women tested demonstrated a desire to care for women's sexual well-being. On the other hand, the health care professionals struggled to accommodate women's testing demands due to the lack of flexibility of the structure. Nevertheless, the need of the system to monitor the population, which without a doubt was also motivated by the need to optimise resources through early detection of disease, occasionally transformed the procedure to ensure women were screened. The same preoccupation with screening quotas developed coercive measures that forced women to subject themselves to procedures that were considered invasive, unnecessary and demeaning. Furthermore, the message women received as a result of the state-run health care system's insistence was misleading, putting women's sexual well-being at risk.

Testing for HIV

The regular testing of pregnant women for the HIV virus was the only standardised practice identified in the EBAIS' procedures for the monitoring of HIV. No other population was regularly tested. Therefore, HIV cases were mostly detected as a result of the onset of symptoms. Once a case of HIV was detected, the case was transferred to two case managers at the county's hospital: a physician and a social worker. A small commission composed of these two hospital workers and a few other members from other state institutions was functioning on an off in the county to supervise the behaviour of the disease and its impact in the community. In conversations with the social worker, it was clear that the information about HIV patients was highly sensitive and because of that it was handled in a confidential manner. In fact, the

social worker explained that once a patient is recruited, the medical file is sent to a third level hospital in the capital, San Jose, for the patient to receive special care. Once the patient is incorporated into the third level of care, they lose contact and might never hear from this patient again. This means that HIV patients in rural areas are constantly moving around to obtain the care they need due to the lack of specialised practitioners and treatments at the local level.

The secrecy surrounding HIV infection in the county is not surprising considering that people with this disease are stigmatised. While conducting fieldwork I came across two stories of HIV positive Ngöbe patients. However, neither patient was from El Bajo. The first case was a well-known woman in her late 40s, early 50s, who had contracted HIV/AIDS and died in a non-Ngöbe indigenous community a few months back. The second case was a homosexual young man who contracted HIV/AIDS while having multiple male partners and was referred for treatment in San Jose. This young man had family members living in El Bajo. In both cases, the patients had multiple partners, mostly from outside the community, including Sulias, further reinforcing the local ideas about STDs and HIV being a white people's disease.

The ideas surrounding STDs in general and HIV in particular are not associated with any particular form of community care. In fact, these are conditions that don't seem to trigger any response and for the most part are kept quiet to avoid stigmatisation. In this context, biomedical care seems to be the only option, considering that they have the necessary technology and remedies to overcome the conditions. Additionally, the private and un-relational character of the biomedical experience seem to offer an adequate environment to care for intimate discomforts that can create conflict at the community level. Nevertheless, the care provided at the state-run health care system is still limited in terms of long-term solutions. Furthermore, the hierarchical character of the consultation hinders the possibility of sharing knowledge to provide a more consistent sexual well-being.

Managing Sexual Violence

The pervasiveness of sexual violence in the community of El Bajo is one of the experiences that most harms women's sexual well-being. Women recounted many of their most difficult experiences of

sexual abuse and the impact they still had on their well-being. Even though the care practices analysed here did not resolve the structural problems of gender inequality and misogyny, they provided women with safer environment and forms of support that sometimes prevented, and in most cases managed, the situation. Furthermore, the relational nature of these forms of care created stronger bonds between women in the community. These bonds of solidarity were many times supported by existing kinship relationships and sometimes based on common experiences or on women's awareness of the difficulties experienced by many. At the state-run health care level, the care practices available to women were limited and created bureaucratic pathways that involved many institutions, from the child protection agency (PANI for its acronym in Spanish) to the education system and the legal system. Even though some of the mechanisms offered by the state-run institutions to manage sexual violence were sought by women from the community, the outcomes were, many times, counterproductive. The prevalence of the logic of individuality in state institutions had the effect of isolating women from their kin and community networks. In addition, the assistance was also individualised and centred on the affected person without considering their social, economic and cultural backgrounds.

Experiences of rape were also identified among the interviewed women. Several women commented on their long-term experiences of rape. One time occurrence of rape was only reported by one of the interviewed women. Here I will concentrate in the long-term experiences of rape. These manifested in mainly two contexts: within partnerships and within kin members. The existing care practices offered to women suffering from sexual, and physical, abuse within partnerships were mainly relational. They were based on support offered by kinship and was part of Ngöbe dispositions around the accepted actions to end a partnership reported by Young (1971). One of the sixteen women reported having experienced sexual abuse within kinship. During fieldwork, I heard o at least two other cases. In relation to rape within kinship, no community care practices were identified. Here the relational logic made it difficult for women to provide support when the abuser was part of the household. At the state level, several cases of statutory rape were reported by the education system as a result of girls' pregnancies. One of the recently reported cases corresponded to a participant in this study. Her case showed some of the difficulties girls face when

identified by state institutions as victims of sexual abuse. Hence, state support was somehow insufficient and in many cases subjected women and girls to other forms of abuse, like racial or emotional violence.

Sexual Violence and Community Care

Sexual violence was a commonplace experience for many women in El Bajo. This form of violence was mostly characterised by two different experiences: inappropriate touching that was generally part of women's early experiences, and forced intercourse that, for most women, occurred within partnership arrangements and that in some cases also involved physical violence. This is not different from other communities in Costa Rica, where sexual harassment and intra-familiar sexual violence is also common (Gomez & Zamora, 2011; Salud et al., 2016). Proof of this are the experiences of sexual harassment at the state-run health care system narrated by women of El Bajo in segment 1.2.2. Therefore, in Costa Rica and in El Bajo there is a generalised environment where women are subjected to sexual experiences they do not desire. Several scholars have also emphasised the pervasiveness of sexual violence in other parts of the world, making the issue of sexual violence a ubiquitous and all-encompassing problem (Alcoff, 2017; Rebhun, 2002; Wardlow, 2006).

Senior women talked bitterly about early experiences of sexual abuse in the form of inappropriate touching. These experiences took place not far from home and were generally carried out by men that were known to them, in many instances a relative. Amelia, for example, mentioned that when she was young, as she was walking on her own to school, she often ran into an acquaintance of her father who would take advantage of her. This experience of being sexually assaulted by a known man, is also very common in other contexts around the world (Alcoff, 2017). Based on this experience, Amelia made the decision to never let her young daughter walk to school on her own. This was the way in which she cared for her daughter, by minimising men's opportunities to approach the girl in isolated places. Other women in the community, who were fully aware of the dangers young girls face, cared for their daughters and granddaughters in a similar way. Furthermore, Amelia was very critical of other women in the community who didn't care for their daughters in the same way. This policing of other mother's practices was also a

care practice in a way, common to many women in the community. Nevertheless, this practice had the unintended effect of creating antagonisms among community members and kin.

Hyperawareness with kin members was a care practice among women in El Bajo. Thus, during my time there, I saw women being careful of allowing younger girls to be alone with male relatives. Even tasks like caring for girls' hygiene was exclusively managed by female relatives to avoid inappropriate touch. This type of concern, however, was not equally expressed for boys, neither were any cases of male sexual abuse ever mentioned to me. The lack of information about these types of experiences is not sufficient evidence of its presence or absence within the community. Thus, further research about this topic is necessary to develop a better comprehension of sexuality and its impact based on the gender structure within this community and in Ngöbe communities in general.

Six out of the sixteen interviewed women mentioned having been victims of sexual abuse within their partnerships. These forms of sexual abuse seem to manifest in two ways: a particularly violent one in which a man will use the necessary force to subdue a woman, and a more subtle one, in which a man will force himself on a woman but without using excessive physical force. The use of physical violence to force a woman to have sex was only mentioned explicitly in one interview. Carmina stated that when she first had sexual intercourse with her first partner, she didn't agree to it. About it she said *I did not want him to do that to me, but at the end, he hit […] and I had to let him, but that I did not tell because I was embarrassed to let my grandmother and my mom know*. Following on Carmina's narrative, talk about being controlled or subordinated by a man who seeks sexual release is not only painful but also shameful. This might prevent other women from talking about their experiences, particularly among women from their own communities. Forms of sexual abuse considered subtle, were more common among interviewees. These narratives were present in everyday conversation. However, women didn't explicitly characterise this experiences as rape, although they did perceive them as violent.

Care practices developed to offer support to women experiencing sexual abuse were well established and accepted by community members. Many women, like Carmina, had returned to their mother's household in seek of support. However, this care practice was only performed once women made

up their minds to leave their partners. There were no recurrent community or kinship strategies of intervention[106]. Furthermore, none of the women who reported having been subjected to sexual violence within their partnership reported the abuse to state-run institutions equipped to deal with this type of experience, like the HCF, the police, and the school, among others.

Case Study: State Care

To illustrate the experience of sexual abuse within kin, I will resort to Evangelina's case. She is a teenage girl who had been abused since the age of two by her stepfather. When she was thirteen she fell pregnant, which prompted the schoolteacher to report the abuse to the corresponding state institutions, health care system, the child protection agency and the court. Her case presents a particularly dire experience. Due to the proximity with her abuser, Evangelina was put into the state's custody, removing her from the community. She was placed in a family setting called *Familias Solidarias* (Solidarity Families) that has been created by the child protection agency with the intention to prevent the institutionalisation of children facing abuse. Evangelina was not only left without her kinship network, but also placed in a culturally different setting among strangers. In this new context Evangelina suffered other forms of abuse, like emotional abuse from the person assigned by the state to care for her. In this way, the state institutions successfully put a stop to the sexual abuse, but exposed Evangelina to other forms of abuse. Even though no studies identifying consistent emotional or physical abuse among children and adolescents in the custody of the state were found, the Ombudsman's office has reported on the need to examine the figure of *Familias Solidarias* (República, 2017). About her experience while in the state's custody Evangelina stated,

> *I spent two months [at this house] [...] that lady, in front of me she would mistreat the other girls [...] she would throw water at them [...] one day she hid [my] baby from me, she did not want to give her back [...] I got mad [...][after I went back to my mother's house] later, about a week after, the woman from the [child protection] agency arrived and asked me if I knew*

106Although there is an example of kinship intervention in a case of physical abuse that has been described in Chapter Three.

something about what was going on in the house, I did not want to be hiding things [...] I told her yes, that this lady was mistreating and beating the girls

Thus, her experience of sexual abuse was also compounded by emotional violence while in the custody of the state, which highlighted her condition as an underage indigenous girl.

Throughout this process, Evangelina's mother was also affected by the separation from her daughter further contributing to the stigmatisation of indigenous women as unfit caretakers (Briggs & Mantini-Briggs, 2000). Similar to Evangelina's there were several known cases of young girls being raped by their relatives and later in their early teens bearing their children. This, however, is not an indigenous issue but an issue perpetuated by an oppressive gender structure (Alcoff, 2017). Nevertheless, indigenous Ngöbe women are also subjected to oppressions based on their ethnicity, class, education, geographic location, age, among others. Senior women in the community, among them Cora, were strong advocates of appealing to legal support to assist in such cases, but with the involvement of indigenous women leaders to offer support to young girls.

Sexual abuse is directly related to women's younger age. As women mature and have children, their agency through connection and belonging allows them to resist violent relationships, to set some of the terms of this relationships, and offer support to younger women in the community. Senior women and mothers, are also aware of the inequalities that younger women face and have been acting as advocates for younger girls in the community. Indigenous women leaders in El Bajo are also advocating for the transformation of practices within the state to include a relational logic that involves the community in the process of ceasing the abuse. Here, I have not concentrated heavily on the coordinated bureaucratic actions developed by the state, since that topic is beyond the scope of this research. Nevertheless, as this section shows, further research on this topic is of great importance to understand not only the experiences of women who are recruited by the system, but also the institutional procedures, and the employees and collaborators' subjectivities impacting on these experiences.

Conclusion

A careful consideration of the narratives presented in chapters Seven and Eight, denotes diversity of experiences of one of the most intense human events: reproduction. Women's narratives related to accessing care from kinship and biomedicine while pregnant or giving birth illustrates the elements that are considered helpful and necessary throughout this experience. As discussed by Layne (2003) in her analysis of pregnancy loss, both biomedical approaches and the women's health movement critique of this approach emphasize the notion of control; the former approach sees birth as an experience that has to be controlled and the latter is set to return the autonomy and control to women, with the unintended effect of attributing blame to women when the event has negative results.

The narratives of pregnancy and birth provide another approach, based on relational experiences that account for the physical body and kinship networks and their centrality to processes of pregnancy and birthing. According to Briggs & Martini-Briggs (2016), *"... narratives are crucial means of X-raying the way that forms of care, bodies, and human dignity circulate and how they get incarcerated by ethnoracial and other inequalities"* (p. 161). Thus, by incorporating the negative and positive views about these experiences narrated by indigenous Ngöbe women it is possible to identify the particular forms of inequality that they experience. From disparities in the value attached to different forms of knowledge production, to the availability of resources, economic or otherwise, the women of El Bajo have had to rely on their own contextual understanding and other state-run contexts to arrange better services for themselves. Their narratives identify the elements that are important for them during pregnancy and birth. Safety, attention to their bodies and their children, and the use of techniques that would allow them to undergo these events with dignity are some of the claims that deserve attention. Within a careful attention to Ngöbe women's world view we can identify and reclaim the epistemological perspectives (Narayan, 2004) grounded in these women's experiences.

The care practices analysed in this Part III have an important impact on women's life experiences. The care that women experience through these practices is the result of a process of constant articulation and tension between the views of the community and those of the state-run health care system. In this

process, women constantly negotiate the practices that are more beneficial to them and to their kin. As exemplified, women use mostly the logic of relationality in their negotiation process. The logic of individuality is present although contested by their own experiences and the views of others around them. In the case of the care practice of contraception, the constant use of the word *cuidarse* provides evidence of how the logic of individuality is becoming more visible, with a stronger emphasis on women's individual actions and the benefits to themselves.

These practices also have a great impact on men's agency. Women's use of contraception, for example, has limited men's ability to influence women's reproduction (Gutmann, 2011). As exemplified in the case of Cora, in the past men used reproduction as a means to cement a partnership. Based on a relational logic that emphasises kinship relationships, the bond of a child strongly influences women's decisions when forming a partnership. The use of contraceptive methods that are highly effective, within women's reach and control, expands women's ability to make decisions during the process of kinship formation. This in a way explains the resistance from some members of the community to medical contraception, since it was perceived as a threat to Ngöbe identity and lifestyle. Additionally, the practices of monitoring STDs and management of sexual violence have provided women with better knowledge about the risks associated with sexual practices, and the community and institutional means to manage these risks. Women's access to this knowledge has a constraining effect on men's actions.

Ultimately, El Bajo women consistently resort to care practices offered by the state to care for their pregnancies and birthing experiences, prevent pregnancies, monitor STDs, and manage sexual violence. However, the reliance on each practice is dependent on the existing dispositions in women's habitus and their compatibility. Thus, in their performance of these care practices, El Bajo women struggle with conflicting views that arise in relation to what it means to be a Ngöbe women and how to reconcile this with their desire to access education and enter the work force. In the process of caring for themselves and others, these women test their abilities to negotiate with men, kin and community. Furthermore, in the process of accessing and providing care they also develop skills through mobilising themselves in and outside their community and navigating the state-run health care institution. Thus, although some practices

can enhance women's ability to act, their use also requires them to exercise their agency through subordination, resistance, connection and belonging, not only in the context of their partnerships, but also in the context of the community, and at the state level.

Chapter Nine: Conclusion

In this thesis I have explored Ngöbe women's engagement with community and institutional sexual and reproductive health care practices using their experiences to provide a comprehensive understanding of women's realities. The processes of beginning, maintaining and ending partnerships, as well as the views and ideas encompassed in the gender structure of this community have been explored. I have also made reference to the historical development of the state-run health care system in Costa Rica and the main events in relation to sexual and reproductive health care and rights. This historical overview has provided a context to the current state of sexual and reproductive health care in Costa Rica and the particularities of its practice in the EBAIS assisting Ngöbe women from El Bajo. Finally, this thesis included an analysis of the main sexual and reproductive health care services accessed by indigenous Ngöbe women and the ways these practices interact or articulate with women's pursuit of sexual and reproductive well-being.

The analysis of the dynamics described above has been enriched with a comprehensive understanding of women's exercise of agency through resistance, the inhabiting of norms, and connection and belonging (Weir, 2013). The exercise of agency has been made intelligible by highlighting the importance of the logics of relationality and individuality. I have proposed that these logics are principles located in the habitus (Bourdieu, 1977) informing the practices of health care professionals and Ngöbe indigenous women. My purpose has been to show how both sets of participants display different combinations of these logics; that is, these two logics are not meant to be understood as a binary but as two ends of a spectrum. The combination of the logics of relationality and individuality are multiple and in the process of exercising their agency people navigate this spectrum according to their possibilities, based on their positionality within the structures around them. Some of the factors determining people's positionality are gender, ethnicity, class, geographic location, age, and access to knowledge related to Ngöbe or biomedical practices.

Through the narratives of various Ngöbe indigenous women residing in El Bajo, I have revealed the importance of their identity in their sexual and reproductive lives. These women made constant references to what it meant to be an indigenous Ngöbe and the importance of maintaining their identities through sexual and reproductive practices that were considered beneficial for themselves, their kin and their community. In the process of assigning themselves an identity, these women were expressing sexual and reproductive care practices that enhanced their possibilities of engaging in experiences that afforded them well-being. Furthermore, women's claim to their Ngöbe identity was illuminating in the sense that it displayed ways in which they exercise their agency through connection and belonging. Thus, it was through women's understandings of their identities, with its limitations and possibilities, that their practices through connection and belonging became evident.

For example, the importance of child bearing within the Ngöbe lifestyle was illustrated by young girls' use of contraception. The majority of the research participants used contraception after having had their first child. Having a first child shortly after forming a partnership was a way of exercising their agency through the inhabiting of norms to strengthen their partnerships, enter adult status and enhance their social standing in the community. Thus, the process of child bearing had the effect of expanding their agency in many ways, while at the same time, grounding them to their role as mothers. The expansion of women's agency was the product of their own connection and belonging, experienced through their relationships to their children. Young girls' agency was further enhanced by the support of their mothers that were not only in favour of, but motivated them to use contraception to avoid further pregnancies and work toward personal achievements. In this way, young girls could advance toward social, economic and political aspirations supported by their kinship connections. This process was the result of existing dispositions encouraging mothers to care for their daughters as well as of transformations in the communities' socio-economic structures that had impacted on women's experiences and possibilities and consequently, on the gender structure.

However, the link between identity and the exercise of agency through connection and belonging is not free of the tensions present in power relationships. By acknowledging their identity, women are also

recognising the structural oppressions that they are subjected to within their kinship relationships, in their communities and in the institutions to which they resort. In a world where oppressions are ever present, more so for indigenous peasant women from rural backgrounds, the distinction between agency through the inhabiting of norms and agency through connection and belonging is not easy to unravel. Nevertheless, I believe that it is important to continue to pursue a search for agency through connection and belonging as a way to understand identities. Equally important is to explore the ways in which kinship and community relationships enhance people's ability to interact with the world, even if these attachments ground them to specific realities.

This call for a better understanding of agency as connection and belonging is a call for identifying the potentiality of human relationships as central to the achievement of well-being. In this thesis, I have also pointed out the importance of understanding the exercise of agency as resistance and as the inhabiting of norms too (Weir, 2013). It is through this complex understanding of the exercise of agency that we can grasp women's interactions with their communities, with their kinship and with themselves. Through these interactions it is also possible to identify both the structure that impacts on women's experiences, and the changes that women's actions trigger in these structures. For example, senior women's views and experiences of polygyny are influencing young girls' perception of this practice and their willingness to engage in these forms of partnership. Furthermore, perceptions of male infidelity, new understandings of its consequences, and the availability of screening test for STDs at the EBAIS along with the assurance of privacy are motivating women to screen for STDs. Ultimately, it is by looking at women's actions and their diverse experiences that we can better understand their reality.

The five sexual and reproductive care practices analysed here provide a detailed picture of the ways in which the logics of relationality and individuality are considered by Ngöbe indigenous women in the community of El Bajo. The interplay of these logics show women making sense of their actions through their relationships with others and their understanding of themselves as individuals. In this process women draw on care practices present at the community and from the biomedical level. Overall, the study shows the increasing role of individuality in women's experiences, and a constantly renovated understanding of

relationality through women's persistent consideration of what it means to be a Ngöbe woman in El Bajo. An essential aspect of women's experience of relationality is that of the mother-daughter bond. This bond is built on the shared experience of being indigenous women.

A great deal of this thesis has concentrated on the interplay between these two logics. I believe that this interplay can further explain the ways in which human beings understand their experience in the world as informed by the body and the self, by others, and by the material and spiritual environments. It is in relationships that humans make sense of their individuality. However, the increasing biomedical emphasis on the individual as the unit of analysis/intervention, leaves out the social, economic and political aspects that impact on people's well-being and on the real possibilities they have to act on their health (Briggs & Mantini-Briggs, 2016; Menéndez, 2005, 2015). Furthermore, individuals ―indigenous or non-indigenous, trained as biomedical professionals or as Ngöbe healers― incorporate these two logics in their everyday professional or/and personal lives. While in the field and later in the analysis of the collected data, I was unable to identify any person that would only consider her/his relationships when making decisions or when engaging in the process of acting, or a socially isolated person for whom interpersonal connections were irrelevant or non-existent. Thus, a conscious understanding of how these two logics benefit people as they face multiple and diverse circumstances in their lives might enhance the possibilities of engaging them in communication and in care practices that guarantee their well-being.

The logics of relationality and individuality have been incorporated into this thesis not with the intention of highlighting a dichotomy but with the interest of identifying the different degrees to which they are incorporated into people's lives. All the research participants, from health care professionals and other state employees, to indigenous Ngöbe and non-indigenous inhabitants from El Bajo, were always fluctuating between these two logics, incorporating their various relationships in different ways as part of their decision-making processes. Ngöbe women's fluctuation was characterised by a strong influence of relationality with the incorporation of new elements associated with individuality. Health care professionals were influenced by individuality discourses, promoted by bilateral and multilateral organisations, NGOs and other entities, and at the same time displayed strong aspects of relationality associated with their

upbringing and the nature of their relationships to their families. Accordingly, the combinations of these logics impacted on their performance as health care providers, mothers, daughters, and community leaders, among other roles.

For indigenous Ngöbe women of El Bajo sexuality and reproduction are two aspects of their everyday lives that are firmly linked to each other. Most women start their sexual lives at a young age and their reproductive lives shortly after. It is in the process of caring for reproduction that women first encounter sexual and reproductive health care at the state-run facility. Thereupon women continue to make use of the social and Ngöbe medical care practices in the community as well as the biomedical practices at the EBAIS as part of their search for their and their children's well-being. Many of the biomedical practices have been articulated with existing dispositions, others have been included into women's practices either as parallel experiences or as a way of displacing practices that, as a consequence, have slowly disappeared.

Among the social care practices that women enjoy, the support of their kin to end violent relationships is central. This mechanism responds to existing dispositions of uxorilocality where women are allowed to return to their mothers' households. In contemporary El Bajo, Ngöbe women choose their maternal residence as the household where they can seek protection and stability when needed. This practice has been recognised as necessary by senior women in the community and by the political organisations like the Indigenous Development Association and the Women's Association.

El Bajo Ngöbe women have the support of Ngöbe doctors that offer a series of healing rituals for different conditions during pregnancy. These practices run parallel to prenatal care practices offered at the EBAIS. Women in the community make active use of both of these services. In the case of birth practices, homebirths have been completely replaced by hospital births. In the community, there are only a few women that have knowledge about homebirth assistance. However, none of these women expressed interest in offering their services unless further training and state support were provided. Currently women in El Bajo are constantly choosing to give birth at the hospital.

Sexual health care practices have been articulated, to different degrees, into Ngöbe women's everyday lives. The use of contraception has been articulated with existing dispositions toward insuring

women's ability to have less children. Contraception has become one of the most widely-used sexual health care practices in El Bajo. Through the notion of *cuidarse* women have been engaging with the logic of individuality in which contraception is seen as a tool to enhance their social and economic opportunities. At the same time, this notion of *cuidarse* has placed the responsibility of avoiding pregnancies solely on women, lessening men's participation in reproduction. Similarly, the practice of screening for STDs has been extensively promoted by the EBAIS. Tests such as HIV and syphilis are routinely added to pregnant women's blood tests. Other tests such as the Pap smear is encouraged and women have started to request it as a tool to protect themselves from the consequences of infidelity. However, ideas associated with the transmission of STDs as a Sulia specific problem, continue to foster apathy among Ngöbe women involved with Ngöbe men, toward getting the test.

A central care practice performed by Ngöbe women is the everyday surveillance of young girls to protect them against sexual violence and harassment from male members of the community. As a precaution, many senior women accompany their daughters and granddaughters on their walk to and from school to guarantee an environment free from sexual violence. In the same way, women were careful not to allow male relatives to spend time alone with young girls and were constantly alert to the girls' whereabouts. This care practice was the result of Ngöbe adult women's past experiences of sexual abuse that included harassment, unwelcome and inappropriate touching, and rape. The state offered a parallel practice of managing sexual violence cases, but women only resorted to this service in extreme cases, since some of the procedures were considered damaging for the girls and contrary to the logic of relationality that guided this care practice in the community.

Overall, Ngöbe indigenous women from El Bajo sought to obtain sexual and reproductive well-being that made sense in the light of their existing dispositions. In many ways, these dispositions were relational in nature. In this context, individuality was also an aspect that was gaining traction among younger women with career aspirations. Nevertheless, women's individual endeavours were still strongly associated with their kinship relationships, their partnerships, their responsibility toward their community and their role within the Ngöbe context as educated young mothers. In the context of the EBAIS, however,

Ngöbe indigenous women were still perceived as lacking control of their reproduction and resisting biomedical advice based on non-progressive values and beliefs. The dissonance between Ngöbe women's personal experiences in the community and the health care professionals' perceptions of them, complicated their interactions and further impacted on the health/communicative inequities (Briggs & Mantini-Briggs, 2016).

The Costa Rican health care system through its work in the various institutions, but particularly through the work of the Caja, has an important impact in women's sexual and reproductive well-being. The contributions that the institution makes are indispensable to ensure women monitor and preserve their health. However, the Caja's operation which is strongly impacted by medicalisation, has a standardised delivery of health that lacks the sensibility that community and kinship relationships can sometimes offer, as is the case in many other places around the world (Espinosa Damián, 2014). This characteristic generates a tension between health care seekers and health care providers that is even more evident in the case of indigenous Ngöbe women. Nevertheless, Ngöbe women increasingly seek the health care provided by the state-run health care system because they find some of its services beneficial as resources to achieve sexual and reproductive well-being. In Latin America, the advances on sexual and reproductive health services have been the product of resorting to the right to health (Roberts & Morgan, 2012) or *medical necessity* (Carranza, 2007) as central arguments for advocacy.

The thesis describes the Caja's institutional structure and operations as complex. Some of the challenges faced by the institution are: a) the difficulties of its management, b) the complexities attached to delivering quality health care, most relevant to this research, c) the diverse composition of the population in certain facilities like the EBAIS assisting indigenous Ngöbe women from El Bajo, d) the persistent inequalities associated with ethnic differences among the population, e) the disparities in the geographic distribution of the health care facilities, and f) the availability of professional and technological resources throughout the country. Additionally, the Caja faces economic difficulties that complicate the resolution of these challenges.

I have also pointed out some of the challenges associated with the sexual and reproductive rights that haven't yet been addressed in Costa Rica, such as the decriminalisation of abortion, the availability of the Emergency Contraception, and marriage equality. Attending to these challenges is a complicated endeavour that requires negotiation with religious institutions, particularly the Catholic Church. Thus, a major and more important challenge might be the secularisation of the state, because Costa Rica is still a confessional state. However, some progress has been made and recently the country incorporated the IVF technique as part of the services offered by the Caja (República, 2016). Furthermore, now adolescents can obtain information about their sexuality and reproduction through the sexual education programs recently included into the school curriculum (Solano Salas, 2017).

A general view of the health care services delivered by health care professionals on the ground and their interactions in the work environment is illuminating of the significance of state employees in the performance of the institution. Although this thesis lacks a comprehensive approach to state employees' everyday working experiences, this attempt provides a glimpse at: a) the complexities of the working conditions, b) the multiple relationships established between co-workers, c) the diversity of patients that health care professionals serve, and d) the diversity of the possible interactions that can take place on a daily basis.

The findings of this research have opened up new lines of inquiry. The research streams mentioned here were identified and overviewed but not analysed in detail, or represent topics that were only tangentially related to the main theme of this thesis. In terms of theory, these lines of inquiry could provide more insights into the care practices performed at the community level and the exercise of agency through connection and belonging. Furthermore, the study topics encompassed here have the potential to enhance our understanding of Ngöbe indigenous people's experiences, the workings of the Costa Rican state, and the impact that multilateral and bilateral organisations have on the views and values of Costa Rican communities.

For all the information about women's experiences this thesis provides, it also lacks depth in the experience of motherhood and child rearing. Even if the role of mothers in the process of caring for sexuality

and reproduction is highlighted, the details of the experience after birth is not studied. A detailed inquiry of this aspect of the Ngöbe experience will provide greater insight into the logic of relationality and the exercise of agency through connection and belonging in its operation and the dispositions guiding it. Furthermore, the role of emotion in the experience of motherhood and child rearing is another research vein that extends from this research.

The process of forming, maintaining and ending partnerships, along with the sexual practices performed within and outside these partnerships can also benefit from a closer look at the role of emotion. Even though several anthropologists have pointed out the importance of developing further research on emotion (Beatty, 2014; Wynn, 2015), I have purposefully moved away from the notion of love in this research. Nevertheless, I have acknowledged the fact that women have made reference to emotions through the verbs *amar* and *querer*. The relationship between these two words, the experiential meaning and the relationship with words that might have a similar meaning in the Ngöbe language are topics worth researching. Furthermore, there are a series of other emotions that need careful consideration in the study of partnership processes and sexual practices.

This thesis has, as well, neglected to include men as actors in the process of sexual and reproductive health care. This neglect has been the result of a methodological decision to concentrate on women who are the main users of the sexual and reproductive health care services offered by the state. Furthermore, this thesis' omission is also the product of the state-run health care system's limited services related to men's sexual and reproductive health. The lack of services directed at allowing men to achieve sexual and reproductive well-being is a research topic in itself. Nevertheless, this thesis' oversight of men's experiences of partnership formation, reproduction and sexuality impacts on our understanding of women's reality. Therefore, future studies gathering and analysing Ngöbe indigenous men's narratives will greatly enhance our understanding of the reality of Ngöbes in general and of Ngöbe women in particular.

The Costa Rican state-run health care system as described and analysed here has proven to be a system of great complexity. The Caja, as the central institution within this system, is elaborate in its organisation and intricate in its everyday operations. The many health care facilities and their diversity in

terms of services and biomedical expertise make of the institution a place of abundant possibilities for research. Additionally, the evidence provided by this research of the impact of the state-run health care system in Ngöbe women's contemporary experiences has shown the importance of state-run institutions in rural communities. During fieldwork, the presence and influence of other state-run institutions constantly surfaced; of great importance were the Child Protection Agency (PANI), the National Institute of Women (INAMU), and the Mixed Social Assistance Institute (IMAS for its acronym in Spanish). Furthermore, several researchers have already enlightened the field with comprehensive analyses of the impact of global tendencies in sexual and reproductive health in Costa Rica. However, there are still many more aspects to explore, among them the impact of multilateral and bilateral organisations on teenage pregnancy interventions, such as the Mesoamerica intervention.

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Appendix A

Participants' Pseudonyms	Approximate Age	Partnerships	Alive Children	Dead Children	Approximate Age at First Pregnancy	Homebirths	Hospital Births
Lucina	58	4	3	5	13	8	
Cora	53	3	8	1	16	6	3
Adela	51	2	9	4	16	10	3
Amelia	50	5	8	1	18	2	7
Carmina	47	2	6	1	13	7	-
Penelope	41	3	6	1	13	0	7
Celia	41	1	6	4	14	0	10
Paola	40	1	5	1	16	2	4
Emelina	38	1	5	0	15	0	5
Rosa	35	1	2	0	19	0	2
Rebeca	26	1	1	0	22	0	1
Rosibel	25	1	1	0	18	0	1
Sara	20	2	1	1	13	1	1
Noelia	19	1	1	1	16	0	2
Nadia	16	1	1	0	14	0	1
Evangelina	15	-	1	0	12	0	1

Appendix B

Semi-structured Interviews

- Childhood: place of birth, siblings, parents, where did they live? Did they move a lot? What did she do as a child? What did her siblings do? Important events.
- Adulthood: has she moved away? When did she move away? Where did she go? With whom? How was her life different? How many pregnancies did she have? How many children does she have? Has she lost any children? How? What are her daily activities?
- Partner: how is her relationship with her partner? Is he the only partner she has had? How many other partners has she had? How long ago? How was her relationship with them? Why did the relationship end? How is her current relationship different from her parent's relationship? What are his responsibilities? What are her responsibilities? How could their relationship be better? How could their relationship be worse? How is their relationship similar or different from their neighbours or other family member's relationship? How is her current relationship similar or different from her past relationship?
- Sexual activity: is she sexually active at the moment? Does she find her sexual activity pleasurable? Why is she involved in sexual activity? How often? How does her sexual activity affects her illness or vice versa? What does she think is her partner's perception of sex? What does she think is her partner's perception of their sexual interactions? What does she think is her partner's perception of her illness and the way it affects their sexual lives and vice versa? Is her partner faithful? Is she faithful? How is their sexual activity similar or different to that of their parents and/or other couples in the community?
- Disease: what illness does she have? How does this illness make her feel? What does she think caused her illness? Where has she sought treatment? How does this illness interfere with her daily activities? What does she do to feel better? Does she have the support from her family? How is her family supporting her through her illness? Does her partner support her in any way? How?
- Health care system: how often does she use the health care system? How does she get there? How long does it take? How does she come back? How long does it take? What assistance does she get at the health care facility? What have they told her about her situation? How often does she go? Does she go to San Jose to get treatment? How often? What kind of treatment does she get? Where does she stay? How much does it cost? Who goes with her? Who takes care of her responsibilities while she is gone?
- Alternative medicine: has she sought treatment outside of the Costa Rican Social Security Fund? Where? With whom? What kind of treatment? Has this other treatment helped? How?
- Community: what do the people around her say about her illness? Do they know what disease she has? How do these comments make her feel? Do the people in the community help her in any way?

- Grief: how has she coped with this situation? Have they performed a ritual in the community? How is this situation a part of her life? Does she have any support system? Who does she talk to when she feels sad/anxious?
- Experience working in the community: how long ago did she start working in the community? How has her opinion about the community changed? What are the greatest problems that women in the community have to face? What is her perception of institutional impact on the community? What has been her experience with the health care system? What stories about people in the community have impacted her most? Who are the political figures in the community?
- Changing stereotypes: what has been her experience as a working mother? Do people comment on her life choices? What do people say? How does it affect her and her decisions? What does her family say about her choices? Does she have support from her family/partner?
- Traditional values: which traditional Ngöbe values are important to maintain? Why? Which ones do you practice in your daily life? Which ones do you think the community should make an effort to recover? How?
- Pap smear and breast exam.