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Ethnographic study of intergenerational relationships involved in domestic health care during pregnancy and puerperium (Molinos, Salta, Argentina)[1]

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Abstract. In this paper we analyze intergenerational relationships in the care of women and children during pregnancy, childbirth, and puerperium in Molinos (Salta). Our study is ethnographic and qualitative, focusing on the stories of women from different generations who primarily assume responsibilities and tasks related to domestic care. We compare their domestic and extra-domestic relationships and experiences in order to assess whether they correspond to the age integration model. We find that generational differences in the extent to which older women participate in care arise from the changing composition and location of households, conjugal relationships, livelihood, and access to health institutions. But despite these generational differences, older women still provide care and social support during these life stages and become references for decision-making.

Keywords: Intergenerational relationships; interpersonal relationships; maternal and child health; prenatal care; medical care; pregnant women; Argentina.

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Acronyms and Abbreviations

ANSES	National Social Security Agency (Agencia Nacional de Seguridad Social)
AUH	Universal allocation per child (Asignación universal por hijo)
CONICET	National Council for Scientific and Technical Research (Consejo Nacional de Investigaciones Científicas y Técnicas)
DU	Domestic unit
LINEA	Applied Ethnography Research Laboratory (Laboratorio de Investigaciones en Etnografía Aplicada)
PHC	Primary health care
UNLP	Universidad Nacional de La Plata

Introduction

In recent years, the social sciences have shown increased interest in the role of intergenerational relationships and age integration in human development processes (Riley & Riley, 2000). The forms and effects of these interactions, especially as regards the possibilities of cooperation in livelihood and healthcare activities, manifest themselves in different ways depending on the sociocultural context. The domestic organization of caregiving, above all during childhood and old age, constitutes a form of social reproduction while promoting the maintenance of life and health. Throughout the historical development of societies, many social reproduction activities have become normalized in this domestic environment, and are almost entirely linked to the role of women. However, in recent decades two processes have converged to alter this configuration: the problem of population ageing, and the emergence of feminist perspectives.

Increased longevity as an emerging global phenomenon leads to couples coexisting, and often cohabiting, with their children, parents, and grandparents (Chackiel, 2000). In many Latin American and Caribbean societies – where high rates of poverty and inequality translate into low coverage and quality in social protection systems – population ageing creates greater responsibilities between the different generations, without this necessarily resulting in the emergence of more numerous or better supportive relationships between them. These responsibilities fall especially upon women, who are expected to look after children as well as the elderly. In this regard, Faur (2012) refers to an "ideal of the woman-mother with primary responsibility for care"[2] that encompasses all adult females working inside or outside the home, irrespective of the different social classes to which they belong. However, the author points out that differences in ethnic-cultural origin and status within the family generally shape distinctive profiles. As C. Krekula (2007) notes, the homogeneous view of a collective female identity has been criticized from a gender perspective, whereby it is stressed that women share experiences linked to their condition but also to their ascriptions of age, ethnicity, class and other diacritics.

Notwithstanding the multiple forms of domestic organization that have been documented ethnographically, it tends to be women who make the decisions about the organization of daily life, beyond the varying role of the state, the market, and families. The assignment of this role, as a general and a normative pattern, is revised from a gender perspective because it reduces,

2 All translations of quotes originally published in Spanish are by *Apuntes*.

among other opportunities, equal access to the labor market (Esquivel, 2012; Batthyány, 2011; Faur, 2012, Gherardi, Pautassi, & Zibecchi, 2012). The distribution of activities that provide wellbeing and protection requires, according to this position, appropriate distribution of these responsibilities between the different members of society. In this respect, C. Krekula (2007) observes that the absence of intersections between gender and age leads to an acceptance that most domestic caregiving responsibilities are assumed by young women of reproductive age and mothers of young children who are or could potentially be included in the labor market. Moreover, these acceptances are based on a model of domestic unity that is equated with the nuclear family. Such associations do not take into account the caregiving roles played by other women from the domestic group, such as childless women, women who do not work, and ageing women who are both mothers of adult children and grandmothers. In the same article, Krekula argues that, in gender perspectives, older women in particular have been made invisible as key agents of care to others (children and/or adults).

Based on the ethnographic study of domestic units in rural communities in the Calchaquí Valleys of Salta, we aim to answer a series of questions that arise from the observation and description of intergenerational interaction contexts related to healthcare. To this end, we ask: in what way are everyday caregiving routines linked to different compositions and organizations of domestic units? In what way are parental and non-parental relationships involved in the domestic organization of care? Who are the caregivers in these domestic units? What effect does the involvement of individuals from different generations in caregiving activities have on the health and wellbeing of members of the domestic unit?

In this regard, and since it is the women in these rural communities who assume the responsibilities associated with caring for the domestic group, we are interested, on the one hand, in characterizing the instances in which the representatives of different generations share, negotiate, and refresh know-how and practices related to healthcare during pregnancy, birth, and early childhood development; and on the other, we seek to explore the circumstances in which these interactions transcend the domestic unit, extending to relationships with friends and neighbors as well as interactions with state agents. Finally, we assess whether these relationships and interactions respond to an age integration model, and whether this has positive consequences for the development and wellbeing of children, adults, and older persons.

These questions emerge from ongoing ethnographic research in the department of Molinos focusing on livelihood activities on a domestic scale, especially childrearing and healthcare practices, in terms of the participation

of individuals of different genders and generations (Remorini, Morgante, & Palermo, 2010; Remorini & Palermo, 2012, 2015, 2016; Remorini, 2013). Although this line of research has only been consolidated over the last decade, it forms part of larger-scale projects carried out in the region by the team of researchers to which we have belonged for more than four decades.

Brief characterization of the population of the department of Molinos

The department of Molinos (Salta, Argentina) is located in the southern part of the Calchaquí Valleys. It has a population of 5,652 people: 2,785 males and 2,867 females, of whom 1,293 are of reproductive age. An estimated 3,500 people live in rural areas, and the sex ratio is less than 95%. The high birth rate explains the high dependency ratio in the population age structure (Instituto Nacional de Estadística y Censos, INDEC, 2010; Dirección General de Estadísticas, 2014). The departmental capital, also Molinos, is referred to as the *pueblo* ("the village") while the rural areas – Churkal, Aguadita, Tacuil, Amaicha, Colomé and Gualfín – are called *fincas*.[3] Meanwhile, the immediate peripheries of the pueblo are known as *orillas* (outlying districts). The *pueblo*, whose foundation dates back to the 17th century, currently has 1,166 inhabitants (Planilla de Atención Primaria de Salud, APS, Hospital Fernández de Molinos, 2015).

Part of the population lives in the pueblo, where there is a limited number of fields that are arable or suitable for animal husbandry. There, traditional subsistence activities are supplemented with income from formal and informal employment and from social programs. Another part of the population resides on the *fincas*, where they engage in crop and animal production. Census data shows that the number of people living on *fincas* has fallen in recent years, primarily due to migration by younger individuals.[4] However, these two forms of settlement are not mutually exclusive, since some Molinos residents own properties in both the *pueblo* and the *fincas*, allowing them to alternate between both enclaves and temporarily host friends and relatives who follow a similar pattern of movement. Therefore, entire domestic groups or individuals transfer periodically between different

3 The term "*finca*" refers to private properties engaged in agricultural, livestock, and artisanal production, where traditional labor-based systems (leasing, metayage, and grazing) are combined with production for subsistence. Recently, numerous *fincas* with artisanal wineries have been acquired by local and foreign firms, reflecting an increase in wine-production and tourism.

4 The progression of this temporary migration entails a notable decline in the population on the *fincas* and a change in livelihood practices within the domestic units, as well as relocation of the population in the *pueblo* or other parts of northwestern Argentina (Crivos, Martínez, Remorini, Teves, & Morgante, 2017).

locations, a dynamic which also results in many of them staying temporarily in the city of Salta, the provincial capital.

Traditionally, Molinos was characterized by its significant numbers of matrifocal domestic units involving alternating generations[5] (Remorini *et al*., 2010; Remorini & Morgante, 2016). Considering the temporary or permanent absence of young persons and adults, this is a recurrent form of organization in which the oldest take partial or complete charge of raising the grandchildren (Morgante & Martínez, 2013). The proliferation of such domestic units render them a form of organization that has been sustained over time, albeit one that has been subject to recent processes of change. This results in variable identification between individuals and domestic units and in the unstable composition of these units, which directly affects the ways in which individuals establish intergenerational cooperation networks (see Table 1).

Table 1
Characteristics of domestic units, by location

Location	Families	Average number of children	Composition	Ownership of house	Residence
Pueblo	Nuclear or vertically extended	Four	Temporary and variable composition	Grandparents and/or children	Matrilocal or patrilocal
Fincas and *orillas*	Vertically and horizontally extended families	Seven to eight	Cohabitation of four generations	Grandparents and great-grandparents	Matrilocal

Source: Compiled by authors based on surveys and genealogies.

Theoretical-methodological strategies

We approach caregiving routines, connections, and practices, and their impact on generational relationships within the framework of the domestic unit, considered as "a complex unit that includes a social component (a group of persons that share a residence); and a spatial component (the physical

5 The matrifocal monoparental composition can be attributed to multiple factors: migration in search of work or education; spousal abandonment; not knowing about a child's existence; or a conscious decision not to form a stable relationship. In those cases where the male constitutes a steady presence in the relationship, free unions predominate over those formalized civilly and/or religiously (Remorini & Morgante, 2016).

space they inhabit), articulated by a set of activities relevant to the group's livelihood, which are carried out partially or entirely in that environment" (Crivos & Martínez, 1996).

This notion demarcates the social and symbolic space in which the individuals comprising that space interact. Thus, we must distinguish between the notions of "home," which refers to the residence, and "family," which denotes blood and partnership relations. As well as focusing on domestic units individually, we recognize that the spatial proximity of one unit to another produces ties that transcend and strengthen certain conditions for cooperation. This occurs especially on the *fincas* given the absence of other institutions or services, which are more accessible from the *pueblo* (school, hospital, stores, etc.)

The information presented is from a qualitative study that makes complementary use of various observation techniques (participant, systematic, and heuristic) as well as interviews (open, semi-structured, and structured). The forms of information registration include audio and video recordings, photographs, observation sheets, and field diaries.

In this study, we center on the information obtained from 28 semi-structured interviews with women aged between 21 and 70 who act as caregivers for children below the age of six (see Table 2),[6] of whom eight are from domestic units in the *pueblo*, four are from the *orillas* (Santa Rosa and Entre Ríos), and 16 are from the *fincas*. Selection was based on the following criteria:[7] a) presence of children below the age of three in the domestic unit; b) diversity in gender-unit composition in terms of gender and age; c) diversity in terms of spatial location within the department; and d) diversity in terms of the livelihood activities in which members of the domestic unit are engaged. Although the sample is not representative in statistical terms, it groups together a set of cases that illustrate the varying forms of domestic organization, and how these create differences in the caregivers' trajectories and their childrearing and healthcare practices. Some informants

6 As Table 2 shows, with the exception of nine interviewees (six in Molinos and three on the *fincas*), women with young children did not work outside the home and were beneficiaries of social programs. In 2009, Argentina implemented the Universal Allocation per Child (Asignación Universal por Hijo, AUH), through the National Social Security Agency (Agencia Nacional de Seguridad Social, ANSES). In 2016, this program was extended to pregnant women starting from the third month, under the name Allocation per Pregnancy for Social Protection (Asignación Por Embarazo Para La Protección Social). The plan fosters compulsory health check-ups and vaccination programs for children up to four years of age. For minors between the ages of five and 18, proof must be given of attendance of state education establishments. Meanwhile, pregnant women must undergo the prenatal check-ups established in the so-called Plan Nacer/Sumar.

7 These criteria were established in research about childrearing and early-childhood healthcare, from where the results presented here are taken.

were interviewed on different occasions between 2009 and 2016, allowing for the observation of any variation in their residence and activities. The absence of adult males from the domestic units for part of the day and, hence, their limited involvement in everyday caregiving activities prompted us to select only women as informants.

Table 2
Interviewee characteristics

Informant	Age	Level of education	Civil status	Occupation	Number of children	Year of first birth
"Generation" A, 20 to 39 years of age						
TV	21	Complete primary	Single	Housewife	3	2012
IL	25	Incomplete tertiary	Single	Housewife	3	2012
YC	26	Complete secondary	Single	Retail employee	1	2011
ELo	28	Complete secondary	Single	Housewife	2	2012
PC	30	Complete primary	Single	Housewife	4	2002
CC	31	Incomplete secondary	Cohabiting	Housewife	2	2007
IC	32	Incomplete secondary	Cohabiting	Health worker	2	2007
MaC	32	Complete secondary	Cohabiting	Housewife, agricultural laborer	3	2005
NR	33	Complete primary	Single	Housewife	4	2004
NG	34	Complete primary	Cohabiting	Teacher's aide	3	2004
NM	35	Incomplete university	Single	Retailer	1	2009
MV	36	Complete primary	Single	Housewife, Agricultural laborer	6	1996
GR	38	Complete secondary	Married	Housewife	5	2000
NY	39	Complete secondary	Cohabiting	Tutor	6	1998
"Generation" B, 40 to 59 years of age						
AM	40	Complete primary	Married	Housewife	5	2001
RCh	41	Complete primary	Cohabiting	Housewife	8	1994
EG	41	Incomplete secondary	Cohabiting	Housewife, Agricultural laborer	9	1991
PR	42	No data	Married	Housewife	7	1997

SG	42	Complete primary	Cohabiting	Retailer	8	1992
SR	44	Complete primary	Married	Retail employee	4	1994
CG	44	Complete primary	Single	Housewife	7	1994
EL	45	Incomplete secondary	Married	Housewife	7	1989
MT	46	Complete secondary	Married	Housewife	2	1987
MC	52	Complete primary	Married	Housewife	11	1993
DF	53	Complete primary	Married	Retail employee	11	1983
ACh	56	Complete primary	Married	*Finca* employee	17	1983
"Generation" C, 60 years of age and over						
SC	63	No data	Married	Housewife	10	1971
FD	70	None	Married	Housewife, agricultural laborer	11	1962

Source: Compiled by authors based on interviews with 28 women

Interviewees provided their free and informed consent, pursuant to Law 25,326, and their personal information is protected through the use of their initials.

For the purposes of this study, we classified the interviewees into three categories, which we call "generations," based upon present age: Generation A, between 20 and 39 years of age; Generation B, between 40 and 59; and Generation C, 60 and over. Women in the latter two categories tend to be mothers and grandmothers, respectively. In order to perform the comparative exercise, we consider each of the categories as representative of one of three successive generations, even if there are no parent/child connections between them. Since this is a small-scale population, this categorization allows us to reconstruct common aspects based on the scenario whereby the women started out as mothers at different times, notwithstanding the singularities of each life course (Remorini *et al.,* 2010; Jacob, Palermo, & Remorini, 2011; Remorini & Palermo, 2012).

We conducted the qualitative analysis using the NVivo 10 (QRS International©) program, which is suitable for semantically organizing, codifying, and linking the discursive information. Our focus is centered on the perspectives, experiences, and expectations of female caregivers, taking into account the differences that stem from their age status. Consideration of these differences allowed us, on the one hand, to define scenarios and opportunities for intergenerational interactions and the contextual con-

ditions that favor them; and, on the other hand, to identify changes and continuity in healthcare practices, in light of the transformations that have occurred in recent decades.

We propose to show that the variables of gender and generation must be considered together in order to understand the particular forms of intergenerational linkage that occur in healthcare and childrearing practices at the domestic-unit level. This is not to ignore the fact that these variables are influenced by other factors that transcend the domestic units and increasingly incorporate the references of significant others, such as different formal and informal institutions (Moncó, 2011; Flores Cisneros & Rodríguez Salauz, 2012). These references, alongside families, kinship networks, and various other types of relationships, articulate and shape discourses and practices about how to live age (Cerri & Sánchez Criado, 2014).

Intergenerational care, relationships, and solidarities in the communities of Molinos

In this article, we understand that care, as a complex and multidimensional activity, involves instrumental aspects, as well as personal and emotional variables among those who participate in it. The notion of care refers to all actions and relationships oriented to meeting the physical, emotional, and social requirements of human beings. It also includes the normative, economic, and social framework within which such activities are carried out by different actors. It tends to be assumed that everyone needs to and must be a subject of care, although some individuals require greater or special attention given their status as "dependents" (Daly & Lewis, 2000; Gherardi *et al.*, 2012). As such, care implies the development of social and affective capacities that are intrinsic to the human condition and necessary for collective life, which are favored in those sociocultural contexts in which intra- and intergenerational solidarity occurs. Studies conducted from different disciplines argue that age-integration mechanisms[8] at the domestic-group level have a positive impact on the health, well-being, and living conditions of children, young persons, and older persons (Bowers & Myers, 1999; Howes & Spieker, 2008; Seara & Mace, 2008; Meehan & Hawks, 2014). In this way, they influence the development and prolongation

8 The concept of "age integration" refers to the absence of structural age barriers and to interactions between persons of different ages (Riley & Riley, 2000; Uhlenberg, 2000). An "age-integrated" structure is one where chronological age is not used as a criteria for entry, exit, or participation. However, this absence of structural barriers must be considered alongside interaction between persons of different ages.

of functional skills, autonomy, and independence, impacting the quality of life of the different age groups (Santos de Santos, 2009).

The dynamics of composition and stability in the domestic units of Molinos result in the concentration of caregiving actions among adult and older women, assisted in some cases by other younger females. These interactions usually transcend the family environment, to involve ties of putative parenting, friendship, and/or neighborliness. Looking at healthcare practices during the stages of pregnancy, birth, and puerperium, we recognize that intergenerational interactions manifest themselves as intergenerational solidarities, which replace the gaps left by the limited or nonexistence of government and non-governmental institutions as providers of protection and cohesion in caregiving.

Healthcare during life stages involving the well-being of subjects considered as "vulnerable" – pregnant and postpartum women and young children – involves a set of interactions that favor learning, exchange, and negotiation around preventative and therapeutic know-how and practices. This learning does not occur unidirectionally: older women tend to possess knowledge that stems from their age status and, consequentially, from their experiences throughout their life course, while younger women can offer alternative visions to such knowledge, which implies negotiation in order to make decisions. Thus, in these relationships, the resolutions of the youngest are affected by the experiences and know-how projected by the eldest.

In view of the above, healthcare is a sphere of interest for the ethnographic analysis of the role of intergenerational relationships: especially the ways in which *mamis* (elder women, or *viejas*) interact with other women and children during pregnancy, childbirth, and puerperium. From our research, we have observed that *mamis* constitute a social resource for women from younger generations (mothers), performing specific tasks that, at times, cannot be transferred to others. The experience of these women constitutes a source of ideas for decision-making about health treatment options in the current context of greater availability of resources, know-how, and actors with different levels of legitimacy.

The analysis of the narrative requires the introduction of certain semantic distinctions. In the Argentine Spanish vernacular, the term *mami* or *mamita* designates a woman from two generations above, but it can also refer to the *mamita de antes*, (the "mommy from the past," i.e., from a few generations ago), in reference to a different way of life to that of her descendant. These *mamitas* may be persons who assume the role of caregivers in the absence of the biological mother (Morgante & Martínez, 2011). Moreover, in the context of everyday conversations, it can allude generically to grand-

mothers, regardless of whether or not they have been solely responsible for the upbringing of the person using the term. The designation *abuelita* ("grandma") for its part, constitutes a broad category that refers to individuals who precede the previous-but-one generation. This, depending upon the discursive context, can become a generic category; that is, it can allude to persons with whom one does not have family connections. The term *abuelo* ("grandparent") may also refer to a person who belongs to two generations above ego and who is or has been incorporated into the domestic unit (Morgante & Martínez, 2011).

At present, the practice of "traditional medicine," primarily by *mediquitas* or *médicas campesinas* ("little doctors" and "country doctors," respectively) and *mamis*, coexists with improved state healthcare and social security services and programs[9] – especially in the pueblo, given it has a hospital, whose influence extends to the "high part" of the locality through health posts and weekly visits by its professionals. Far from constituting opposing strategies for the pursuit of health, on many occasions these practices, services, and programs complement one another and fit together in a single problem-solving logic.

Mothers and mamis: their caregiving roles during pregnancy, childbirth, and puerperium

In this section we present and analyze a set of references from the accounts of the interviewees, which reveal their experiences based on the grouping into three generational categories. Our analysis of the discursive references of women from the three "generations" focuses on the role of *mamis* over time in caring for mother and baby in the pre- and postnatal stages, with emphasis on changes in expectations and experiences regarding healthcare and availability of and effective access to biomedical services.

For the most part, the interviewees had experiences of maternity and "grandparenthood" at a young age, since in this region, despite the efforts of local health and education institutions to arrest the trend, the average woman has her first child between the ages of 16 and 20. This, added to high fertility and the composition of the domestic units, results in large proportions of children of different ages, which is conducive to girls assuming the role of caregiver for other children (siblings, cousins, etc.). These activities may

9 Molinos corresponds to Operative Area 26, which is served by Abraham Fernández Hospital in the *pueblo* and six health posts in the *fincas*. The hospital is staffed by three doctors, two dentists, one biochemist, and paramedics. It can handle diseases with low levels of complexity and childbirths, receives patients from the *fincas*, and refers the most severe cases to more specialized centers. In turn, the health posts are each assigned a nurse and/or a health worker.

be combined with the care of older subjects, in cases where the domestic units include such individuals. Depending upon age, residence, roles, and domestic and extradomestic activities, the extent to which women participate in caregiving can vary. That is, some only give care in certain circumstances, while others assume caregiving responsibilities on a more sustained basis.

In their accounts, the older women (generations B and C; see below) played down or denied male participation in caregiving during these stages. In many cases, they went through some of their pregnancies without the presence of their partners, something they attributed to the "youth" or "inexperience" of the men concerned, not knowing who the father was, or other circumstances. In this context, women stress the support and assistance provided by their peers. Moreover, they emphasize the burden of female responsibility in caring for members of the domestic unit (Remorini *et al.*, 2010). The male incompetence alluded to in relation to childcare responsibilities was also cited in references to circumstances in which the mother, or any other women who might have been able to assume the role, was absent. This may be due, for example, to the death of the mother during childbirth or puerperium, which has direct consequences on the newborn's prospects of care and survival. Any women who dies while giving birth leaves the baby in a vulnerable position, insofar as men are not seen to possess the necessary caregiving skills.

> [My sister] when she had the baby she got worse, she got worse, she got sick after having the baby. The baby also died, it was small [premature] (FD, age 70, Gualfin).

In Molinos, just like the rest of the country, pregnant and postnatal mothers have increasingly become a focal point of public health professionals and institutions that seek to monitor and normalize their health trajectories through various strategies. As we have observed elsewhere (Remorini & Palermo, 2015), the scope of primary healthcare programs has prompted changes in everyday caregiving expectations and experiences, which articulate with professional and institutional discourses but also confront them.

Although women currently have systematic access to healthcare during pregnancy and puerperium, this was often not the case for women who are now more than 40 years old. Not only did they lack such support, but they had to give birth at home with the aid of more experienced women, whether relatives, neighbors, or *mediquitas* (Remorini *et al.,* 2010). Thus, the expression "before they didn't know about having a doctor" speaks of the previous lack of consistently available biomedical resources during the perinatal period (Remorini & Palermo, 2012).

Among the testimonies, some women reported occurrences along the lines of the following:

> That's what mom says, she tells me at that time it was difficult [to get to a hospital], at times too, the woman giving birth died […]. There are girls of my age who were left like that, without a mom, because they say they bled to death […] during the birth itself or at times them took them from the *finca* but in a tractor, those sluggish tractors, have you seen them? (SR, age 44, Molinos).

In their testimonies, the 60-year-olds alluded to a time when biomedical healthcare was uncommon and doctors shared responsibility with *médicas campesinas* and *mamis* for care during pregnancy, childbirth, and puerperium, as well as for the protection of women and *guaguas* ("babies") − both perceived as vulnerable. The consideration of these "hazards" surrounding birth and puerperium, especially for mothers, plays a central part in the accounts of the women over the age of 40, who argue that such hazards should be counteracted through actions carried out by older women considered *baqueanas*[10] and *corajudas* ("courageous"). Most of these women grew up in a context in which diseases and death among adults and children were common occurrences in everyday life (Remorini *et al.*, 2010).

In contrast to "the time of the *mamis*," primary care strategies now form the basis of intervention, the main aim of which is to expand coverage through weekly visits to domestic units and health posts. These visits include actions associated with health promotion and disease prevention, nutritional checkups for pregnant women and children, early detection of pathologies, and timely care for pregnant women. According to data from the Molinos hospital, in 2015 all pregnant women received at least four prenatal checkups. As to care during childbirth, at present most babies are born at hospital, and the few home births that still occur are usually on the *fincas* far from the *pueblo*. A common experience is the admission to hospital of women living on *fincas* from the 36th week of pregnancy so as to prevent home births and/or emergency admissions, in line with the provincial public-policy objective for women to give birth in a safe environment. Moreover, women stress the peace of mind that comes with giving birth at urban hospitals, despite the difficulties that some face in meeting the costs of staying in the city in the absence of help from other family members through care, money, and/or

10 Translator'note: A term used to denote those with expertise in local customs, traditions and practices.

accommodation (Remorini, 2013). Despite improvements in biomedical services, a lack of specialized staff at the local hospital means that challenges remain when dealing with childbirth complications and cesarean sections, both of which require referral to larger health centers.

Current perinatal care trajectories stress the biomedical logic of risk reduction. While decades ago caregiving was a space monopolized by older women (whether traditional curanderos or not) and the family in general, today it is a planned sequence of events aimed at avoiding the risks inherent to pregnancy and home birth without professional intervention (Drovetta, 2009, 2014). These interventions, as well as favoring the "medicalization" of the reproductive trajectory, have contributed to a reduction in critical rates of maternal and infant morbidity/mortality in the rural populations of northwest Argentina (Longhi, 2010; Drovetta, 2014; Hirsch, 2015).

For the treatment of illnesses affecting mothers and children, most of the women interviewed turned to the hospital in the first instance. However, some of them continued to receive care in the home environment. Resorting to the knowledge of mothers, *abuelas*, and *mediquitas* (or their male counterparts, *mediquitos*) is justified above all when children present ailments that are not recognized or treated by biomedicine, such as *susto* ("fright"), *recaída* (relapse), *falseado* (*dislocation*), *desarreglo* ("upset"), and *empacho* ("indigestion") (Remorini, 2013; Remorini & Palermo, 2016).

In sum, the accounts provide evidence of aspects of modern ways of life in the Calchaquí Valleys that represent continuities, as well as other aspects that constitute "novelties" and involve new experiences for women from each generation, while giving members of the domestic unit and public health workers different expectations about care. An overview of some of these changes and continuities is provided in Table 3.

Table 3
Comparison of prenatal and postnatal experiences of women of different ages

Experience	Generation		
	A (20-39)	B (40-59)	C (60+)
Pregnancy		Pregnancy-illness association	Pregnancy-illness association
	Limited involvement of *mamis* in comparison with new healthcare-system actors.	Involvement of *mamis*: restrictions in diet and activities due to the vulnerability of the woman.	Continuation of everyday tasks until just before birth.
	Greater access to biomedical technology for diagnosis, prognostication, and control of child development.	Greater influence of biomedical advice and practices.	Absence of biomedical technology for diagnosis and prognostication of child development.
	Importance of pregnancy stage to the child's subsequent health.	Evidence of tensions between biomedical advice and practices and those of the *mamis*.	Little value placed on pregnancy stage in relation to the child's subsequent health.
	Continuation of traditional practices in response to specific problems or those unresolved by biomedicine.	Use of traditional childbirth risk-prevention practices (*manteadas*).[1]	Use of traditional childbirth risk-prevention practices (*manteadas*).
	Greater value placed on one's own experience.		Efficacy of advice and practices founded on the experiences of older women.

Childbirth	Compulsory care in an institutional environment.	Frequent care in an institutional environment.	No or restricted access to health services for delivery care.
	Avoidance of home births. Greater access to technology or transportation that facilitates access to institutions.	Progressive increase in access to technology or transportation that facilitates access to institutions.	No access to technology or transportation that facilitates access to institutions.
	Mamis: No direct involvement in delivery care, except during emergencies. Accompaniment of the mother during admission and/or referral. Care of other children in the domestic unit.	*Mamis:* Frequent delivery care given irregular access to health services. Preparation of medicinal resources for treatment of pain and complications in women's health. Care of other children in the domestic unit.	*Mamis:* Frequent delivery care given no or restricted access to health services. Preparation of medicinal resources for treatment of pain and complications in women's health. Care of other children in the domestic unit.
Puerperium	Does not require specific care: rapid recovery, incorporation into everyday tasks.	Specific care entrusted to *mamis* in preventing *recaida* and *matriz*.[11] Referral	Specific care entrusted to *mamis* in preventing *recaida* and *matriz*. Referral
	The advice of *mamis* during this period is not as respected as it once was.	Active collaboration of *mamis* in everyday tasks.	Active collaboration of *mamis* in everyday tasks.
	Mandatory and planned health checkups: home visits, emphasis on monitoring newborns.	No health checkups carried out at biomedical institutions on a planned basis.	No health checkups carried out at biomedical institutions on a planned basis.

Note: (1) During a *manteada*, a women is laid flat on a blanket or poncho placed on the ground, then two people grab hold of her extremities and raise her alternately to create swaying movements end-to-end, in order to "settle" the fetus in the birth canal and thus prevent complications. (Massaccesi & Massaccesi, 2008). Translator's note: The name of the practice comes from the Spanish word for blanket, *manta*.
Source: Compiled by authors based on 28 interviews.

11 Literally, "the womb" (see later explanation).

Pregnancy

The change in the consideration of pregnancy as an illness (generations B and C) is associated with its more-recent characterization as a healthy gestational process governed by checkups for the mother and child (Generation A). This reflects the greater degree of biomedical involvement during this stage. At the same time, the change results in the gradual displacement of the know-how and practices of the elders − in relation to the care of mother and child as well as risk prevention − with that imparted by health workers and/or prior experience (in the case of mothers who have undergone earlier pregnancies). For the youngest, pregnancy is a process accompanied by events that are mostly foreseeable, while for generations B and C it is characterized as a stage with a less certain beginning and end, interspersed with occurrences associated with illness. For these generations, the emphasis is on continued performance of habitual activities until a late stage of pregnancy, except where doing so would cause harm to the mother or the child, as in the case of *mala fuerza*.[12] The greater influence of biomedical advice is due to the increase in PHC strategies as well as the increasing settlement of young women in the *pueblo*, which favors access to the hospital and, sometimes, voluntary admission or referral to other, more specialized centers such as those in the city of Salta.

> My mom is always recommending […] that we shouldn't go putting up heavy roofs, because that's when you make a *mala esfuerza* and you can have a hemorrhage […]. Then [her mother would tell her] you can't go out much under the sun, that, like people did in the past, you see? […] At times I paid attention to her and at times I didn't, we need to leave behind those ideas of people from the past (IC, age 32, Churkal).

> The *mami* says that people looked after themselves before, but they worked, I don't know. They tell me I have to look after myself, that the baby might have problems (NR, age 33, Entre Ríos).

> You see, when you're little, your mom has to be there, because you go wild, going out, playing around, whatever! And it's my mom who's helped me (MT, age 46, Molinos).

12 Women can *sufrir de la matriz* ("suffer in the womb") when they carry out tasks that require excessive strain, or "*mala fuerza*." The "*matriz"* manifests itself through symptoms such as aches, palpitations, stabbing pain, swelling in the abdominal region, vomiting, and loss of appetite (Martínez & Pochettino, 2004).

> If the baby was badly placed, they gave us the *manteada*, and it has to be a *baqueano*, as they call it [...], with experience, with an idea of how to deal with the little one. There they settled us, a month before. Just by seeing us walk [they knew] because there were no x-rays [ultrasound] or anything (DF, 53 years old, Santa Rosa).

> With P, the *mami* advised you, she helped you, but then with J, it was different, I already had experience with the little one, with A, I'd brought up P, I knew just about everything, yes. If I had doubts here and there, I'd go to the doctor; I asked him, I was scared, because the difference was huge (MT, age 46, Molinos).

Childbirth

The *mamis*, in the case of Generation A, do not involve themselves directly in labor and delivery in the way that they used to, according to the accounts of women from generations B and C. In these cases, the presence of *baqueanas* and *mediquitas* at the domestic unit was central to childbirth, where they received the child, administered first care, and, in some cases, cured birth ailments using preparations of *remedios de yuyos* ("herbal remedies"). For the most-recent generation, the participation of the *mamis* is limited to caring for the other children in the case of non-first-time mothers. This caregiving role is central, especially in cases where younger women are taken to the Molinos hospital, or elsewhere before their due date.

> Mine [were all born] at hospital, because now it's not like it used to be, the doctors check you and they send you to hospital when you're about to have [the child] (MaC, age 32, Gualfin).

> There was no doctor. Everyone had their babies at home. [I had mine] with my mother-in-law and my sister-in-law […]. That's just how they used to have them. My other daughter was born at school, my [female] cousin helped me […], they sent for an ambulance, but by the time it came she was already born, then they took her to Molinos (FD, age 70, Gualfín).

> We had to call the ambulance [but] here by the time they go and talk [to arrange it], we had to go on horseback, we went to Amaicha, to the health post. Since we didn't have a health worker, we went to Molinos. The first child I had [was born] in Molinos. And for the second child we went to Amaicha (ACh, age 56, Colomé).

Puerperium

According to the accounts of the women from generations B and C, risks of disease associated with pregnancy have to be overcome to reach the puerperium stage. Thus, women must observe a series of restrictions that require the collaboration of older female relatives and neighbors. The care given by the *mamis* assured the restoration of a woman's health, which, given her domestic role and responsibilities, had to be "protected" against ailments that jeopardized the family's well-being and even survival; these ailments included *recaída* ("relapse"), a set of symptoms and maladies that can occur in the days after birth due to the new mother's exposure to situations that involve a cold/hot imbalance, such as contact with water or exposure to fire or to the wind (Remorini, 2013). To prevent *recaida*, women had to comply with a set of restrictions on their everyday activities and spaces: remaining in an enclosed part of the house without exposure to temperature changes, rest, following a "light" diet, and so forth. This meant that new mothers were exempt from certain responsibilities, which fell instead to other women.

If men have any involvement at all during birth, although this is not normal practice for these three generations, their work responsibilities prevent them from prolonging such involvement through to puerperium. This can also apply to women from the same generation as the new mother, who are kept busy with responsibilities in their own domestic units. Hence, older women are relied upon for caregiving in the longer term.

For Generation A, the resumption of everyday tasks occurs more quickly over time. In turn, the advice of the *mamis* becomes less important as a reference point, and is replaced by that dispensed by doctors during periodical checkups. Moreover, for the representatives of this generation, the exchange of experiences between peers and with individuals from outside the domestic unit has become a useful source of information. Changes in the composition of domestic units and in the everyday activities performed by women in this latest generation translate into a decrease in the importance placed upon care during puerperium as a means of recovering health. Moreover, the primacy of biomedical discourse over that of the *mamis* has led to greater emphasis upon healthcare for the newborn than for the new mother.

> The *mami* didn't want us to go out, we had to stay indoors for 15 days, they kept us away from cold water, they didn't give us any heavy desserts. These days, the very next day they give you sauces, they give you everything. Before you couldn't bathe for a month and then you moved closer to the fire [because] they said it caused relapses, your chest hurt, your head, and that

> relapse was always cured by a *médico campesino*, doctors didn't know how to cure it (DF, age 53, Santa Rosa).
>
> Before they looked after you a lot, after the birth, now you have to get up in the afternoon or the next day at the latest. Back then I remember that my mom kept me in bed so I didn't suffer a *recaída*, that kind of thing (PR, age 42, Tomuco).
>
> Now, look. You give birth and they throw you in the shower that same afternoon. I think it must be because of the injections they give you now […]. That must be why nothing happens to you, I don't know […]. You are better looked after now than before (PC, age 30, Churkal).
>
> After having them [her children] I was left with a bit of belly pain and she [a *mediquita*] always gave me an oregano tea, she said it was for, let's say, cleaning all the, the blood that's left […] Afterwards, I stayed [at home]. Yes, back then we were kept from bathing for around 15 days (SC, age 63, Tomuco).
>
> Many times they come out of maternity and right into the water or by the fire […] and they're stubborn. They have the little one and then they're back out in the fields, sooner or later that illness gets you and at hospital they don't cure you, they don't know […]. You need to be cured by the *médicos campesinos* (FD, age 70, Gualfin).

Final considerations: generational experiences and intergenerational relationships in Molinos over time

Our analysis of the testimonies about the pre- and post-natal care experiences of three generations of women and children shows that the "ideal of the woman-mother with primary responsibility for care" (Faur, 2012), which may be representative of other contexts, does not correspond to the forms of social organization in Molinos. Rather, our data allows us to delineate differential profiles of domestic caregiving arrangements, based on variables such as the location, composition, and organization of the domestic units.

Whereas mothers or *mamis* from previous generations often stayed on the *fincas* full- or part-time, their younger counterparts increasingly choose to live in the *pueblo*, thereby altering previous caregiving models. Displacing the primacy of mutual assistance between alternate generations, mothers who have the option of remaining in the domestic unit usually prefer to cohabit with their children in the *pueblo*. Many older women, whether accompanied by older men or not, choose to continue living on the *fincas* for part or all of the year.

Now just as before, the ties that are significant in giving care and support come largely from the domestic context − primarily from mothers, and to a lesser extent from other older women in the family. This occurs as part of an organizational framework in which men are temporarily or permanently absent. Even if they are present, the older women believe that they lack the skills required to replace them in the provision of healthcare, especially where young children are concerned. However, having analyzed the composition and routines in the domestic units of women from Generation A, we note cases of incipient male participation that stretch beyond the pregnancy stage through to birth and puerperium. Moreover, women from this generation allude in their accounts to greater involvement by their male peers in childrearing; this merits more systematic analysis in a future study, with males incorporated as informants and the discursive data complemented with the observation results.

However, the role of the *mamis* during these stages remains important in comparison with the still-limited male participation. This situation is not necessarily recognized by institutions in which the ideal of the two-parent family continues to prevail. In this region, the predominance of single-parenthood and free unions[13] is complemented by a form of domestic organization that favors female solidarity at the intra- and intergenerational levels. Thus, these relational patterns do not constitute "risk factors," despite claims to the contrary by some documents linked to public health policies.[14] In this regard, intergenerational solidarities translate into effective support networks in the framework of extended families of three or more generations, in which family care is associated with cooperation between the mother, daughter, and granddaughter (Bazo Royo & Maiztegui Oñate, 2006; Remorini, 2012). Moreover, the limited availability of the fathers creates the need for other adults to commit to childrearing. Grandmothers and grandfathers also

13 These forms of organization based on extended families, and not always including the stable male-female dyad, are very common in rural Argentina. It is common to find "female multi-families that, by definition, are headed by women, since they involve the co-residency of several incomplete cores of women with their children" (Cacopardo & Moreno, 1997, p. 19).

14 Health workers and professionals reported negative assessments of marriage ties during interviews and workshops that addressed different problematics related to access and use of biomedical services, in the framework of primary healthcare strategies (Remorini & Palermo, 2015). Moreover, the inclusion of "single" and "multiparous" mothers on the list of "risk factors" for child health and development in PHC protocols leads to a set of assumptions regarding forms of family organization and types of relationships considered "healthy" and "normal," which do not necessarily correspond to forms of family organization such as those referred to here; a decontextualized and *a priori* selection of risk factors is in evidence in this criteria (Kaufert & O'Neill, 1993; Bonnet, 1996; Remorini & Palermo, 2015), disregarding the way in which each member of the family unit contributes to child development and sustenance.

constitute a valuable resource and have a decisive impact on the wellbeing of children and their parents (Remorini & Morgante, 2016).

Given the centrality of relationships within the domestic units in the case of older generations, it is worth noting the limited frequency with which women turned to individuals outside the family for help or advice, except for doctors or nurses or, sometimes, a *médico campesino*. The pursuit of social support and advice in relation to healthcare and childrearing appears to have been circumscribed by blood or affinity relations (Jacob *et al.*, 2011). However, neighbors constitute a possible resource for the youngest, above all given the possible breakup of domestic units characterized by matrilocal residence or the cohabitation of three or more generations. To these considerations, we must add that alternating residence between rural and semi-urban enclaves serves to multiply and diversify the spectrum of actors upon whom caregiving activities may occasionally fall.

In sum, men and women participate in caregiving in different ways depending upon whether there are marital relations, the composition of the domestic unit, livelihood activities, and form of residence. However, it is women from different age groups who most frequently assume these activities.

In this study, we have focused on the involvement of *mamis* in key instances of the health trajectories of women and children, in circumstances in which their knowledge and experience prevail over that of other members of the domestic unit. Despite the displacement of their roles by the expansion of state primary healthcare strategies and the prevalence of the biomedical discourse in prenatal risk prevention, older women remain key figures in giving care and support to mothers and newborns.

As such, our results contribute a set of ethnographic and sociological evidence concerning the role of older women − specifically, *abuelas* − in providing healthcare to women and children in the domestic unit during the pre- and postnatal stages. Studies conducted in rural and/or indigenous communities point to the positive effects that the active participation of grandmothers (*mamis*, in our case) has on child health and nutrition (Seara & Mace, 2008; Meehan & Hawks, 2014). These studies acknowledge grandmothers as sources of support at the breastfeeding stage; care for mother and child during puerperium − especially in situations such as those described, where there is a period of hospitalization; and access to pre- and postnatal care services (Bender & McCann, 2000; Gerard, Landry-Meyer, & Guzzel Row, 2006). In the specific case of Andean communities, grandmothers and other "old" women have been described not just as providers of social support, but also as healers, given their knowledge of how to use

local resources to treat numerous conditions (Finerman, 1995). This is particularly relevant in those communities where physical access to health services may be restricted, as is the case of the women who live or lived on the *fincas* of Molinos.

The situations described here also highlight how older women are a valuable resource in terms of intergenerational sociability. We also show that interactions between grandmothers and mothers in relation to care-giving and support-seeking are not exempt from negotiation, and involve agreements and disagreements in which the younger women do not always subscribe to what their older counterparts say. In turn, the older women often criticize the decisions of the youngest, as has been recorded in other contexts (Catell, 1994). All of this requires the overcoming of stereotypical views of old age and maternity, which, as we pointed out at the start of this article, is often regarded as synonymous with being a mother of small children (Krekula, 2007).

As to the influence of intergenerational integration on health and well-being, our research contributes to current debates about the intersections between gender and generation (Traphagan, 2003; Krekula, 2007; Moncó, 2011) and the place of older persons in the area of care (Golbert, Roca, & Lanari, 2012). Following Uhlenberg (2000), and how, without overlooking the level of vulnerability to which older persons can be subject, they can constitute an important resource when responding to the care needs of children and adults. Their roles and possibilities are much more extensive when their status as "dependents" is relativized. Consideration of their participation as givers of care and support to younger generations allows us to reconsider the frequent and necessary relationship between the notions of old, dependent, and vulnerable. Indeed, focusing only on their care needs[15] obscures their contribution to a context of intergenerational solidarity associated with situations such as those described here. The unfolding of these solidarities requires, and at the same time promotes, the development of social and affective capacities. We observe a transition in the age integration model in relation to the care of women during pregnancy, childbirth, and puerperium, in which intergenerational relations are complemented by intragenerational ones. In this regard, *mamis* and mothers care for daughters and granddaughters with whom they negotiate an exchange of know-how, comparing and articulating theirs with that generated by the

15 Some experts in policies targeted at older persons argue that there is a need to recognize and promote the role they play, as well as the huge contribution they can make to general and community well-being (Golbert *et al.*, 2012).

younger generations in the context of peer relationships. As well as acting as reference points for decision-making and promoting the continuity of certain traditions associated with care, *mamis* provide economic support and assistance in certain livelihood activities that complement women's tasks during pregnancy and puerperium. Moreover, it is they who accompany their daughters and granddaughters on their visits to health institutions. In this way, our results complement the findings of Traphagan (2003), who proposes that in indigenous and rural societies, unlike industrial ones, older women are often considered as givers more than receivers of care, contributing in different ways to the collective well-being. In Molinos, the consideration of healthcare in articulation with intergenerational relations alerts us to the expectation of the "availability of the other" as part of the normative context in which relations of mutual help occur (Ramos, 1981, p.17, quoted in Faur, 2012).

Based on these considerations, our understanding is that ethnographic research can yield important case studies for consideration of how caregiving activities are organized on a micro-scale, and identification of their articulations on the meso- and macroscales. Ethnographic studies have extensively documented the diversity of subjects who routinely participate in children's care and upbringing, and this can allow us to explore the extent to which ethnographic cases converge with or diverge from the models based on family roles and relationships that we studied here. Thus, the variety of subjects who routinely participate in caregiving and childrearing is evidenced, taking into account the sociocultural and historical construction of different ages and generations and the relationships between them.

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