

GENDER, REPRODUCTIVE HEALTH AND POPULATION POLICIES

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# IMPROVING REPRODUCTIVE HEALTH IN CHIAPAS, MEXICO: NEW FINDINGS ON CONTRACEPTION FROM QUANTITATIVE AND QUALITATIVE STUDIES

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## ***Introduction***

This paper offers the first results from the Program for Research and Action in Reproductive Health in the Southeast of Mexico, carried out at El Colegio de la Frontera Sur (ECOSUR) and the Comitán Center for Health Research in the state of Chiapas, Mexico with resources from ECOSUR and the Ford Foundation. Chiapas, long a forgotten backwater of misery in a supposedly rapidly modernizing Mexico has been on the front pages of the worlds newspapers for more than a year because of a indigenous uprising in the Highlands and the Lacandon Forest. This event plus the current collapse of the Mexican economy has seriously questioned the viability of the entire model on which Mexican national development has been based during the past twelve years.

Reproductive Health is a term only recently in vogue because the long established international programs in family planning and maternal-child health confronted such fundamental criticisms that another model was needed to promote womens health and sexual health of both men and women. In synthesis, the criticism of family planning programs is that they are not vehicles for improving health and well being but means for reaching demographic goals which may or may not be desirable in a particular setting. Maternal-child health, the name for many international health projects over many years, most often have little to do with mothers but are in fact child

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survival programs. In so far as they do address the needs of women it is only in their role as bearers and caretakers of children. The feminist movement, now world-wide and not limited to the developed world, no longer accepts that womens health be a concern only so far as it address population 'problems' or childrens problems.

In much of the developing world women now equal or exceed men in their risk for AIDS. The concern for AIDS has led to a new interest in sexually transmitted diseases and other reproductive tract infections worldwide in which women are the principal victims.

Our initial work in womens reproductive health in Chiapas also began with research into reproductive tract infections in which we found an alarmingly high prevalence of more than 50% of one or another reproductive tract infection in women, principally periurban and rural poor women. Most notable was a prevalence of between 12 and 18% of chlamydial infections.

For our current research program, reproductive health includes the very wide range of problems which women confront not only because of their biology but principally because of the social construction of their gender which places them at a disadvantage in so many aspects of their lives which affect their health. We choose to examine therefore not only the pathologies related to sexual activity, pregnancy and childbirth but the much broader area of access to family resources and health services, divisions by gender of work and authority within the family and community, issues of self-esteem and body concepts and womens perceptions of health and illness.

The area in which this study was carried out is the Health Jurisdiction III, the so-called Border Region of Chiapas which is indeed contiguous with Guatemala but does not include that portion of the border in which there are important migratory movements. It has a total population of about 300,000, largely rural with one major city, Comitán (pop. 80,000) and two towns in the 10 to 20,000 range. It was conducted with a Spanish-speaking population that does not identify itself as indigenous. This is because in the piloting of this work in indigenous communities in the region both the qualitative and quantitative instruments were found inadequate. A separate study of reproductive health within a indigenous community will begin in July of this year.

There are two major components to this research, one quantitative in nature, the other qualitative. The quantitative aspect is a pre-coded survey, with over 400 variables, of an representative sample of 1700 women, excluding indigenous women, in Health Jurisdiction III. It addresses a large number of medical

problems such as the complications of pregnancy and delivery, menstrual problems, uterine prolapse, vesico-vaginal fistula, cervical cancer and STDs. It also asks questions about health service preferences, contraception and maternal and infant mortality. A team of epidemiologists and biostatisticians of ECOSUR led by Dr. Austreberta Nazar created the design and are now developing the analysis of this component.

The qualitative component, an ethnographic study, was designed with the help of a medical anthropologist who has a long experience in medical anthropology research in southern Mexico and has used as interviewers people not previously trained in anthropology. This was very important for us because our team had had practically no experience in qualitative research until this project. We developed an interview guide covering the general topics of interest to us.

We fashioned open interviews in which our subjects were given the opportunity to talk at length and long interviews ranging from 1.5 to 3 hours were held with forty women and ten men chosen from the same localities from which the subjects of the quantitative study were chosen. The men were questioned concerning the same topics as the women so as to appreciate the mens perspective even though many of the issues we were asking about are usually thought of as primarily 'womens' issues.

The first topic we chose to examine from our data from both the quantitative and qualitative components deals with contraception. I want to report on the prevalence of usage, preference for certain methods, evidence we have of trends and prospects for the future. And I want to suggest explanations for these findings and relate these explanations to general notions about family planning programs, gender and womens health.

### ***Quantitative Results***

First some information about the women in the region. Fifteen point 3 per cent of them have no schooling at all and 39% have not completed primary school, characteristics far below the Mexican national averages. Please remember that this excludes the indigenous population (app. 13% of the population in this region of Chiapas) which we know lives in much poorer circumstances than the non-indigenous population. Thirty-eight per cent are married, and 18% are in a common-law relationship (that figure is more than double the most recent national figures in Mexico). Over 70% of this sample of women were in their first relationship before age 20 and over 50% before age 18. These percentages show much earlier age of first union than the most recently

obtained national statistics in 1987 which show 42% and 28% respectively for under 20 and under 18. The fertility rate is 6.38 in our population with an average number of live births per women of 4.2 last year. The Mexican national fertility rate was reported as 2.8 in 1993 and the most recently reported average number of live births as 2.5 per mother. These data confirm what we had thought, that women in this part of Chiapas are having almost three times as many children than the Mexican national average. The data on contraceptive use was however surprising. Fifty point three per cent of the women interviewed had used one or another form of birth control in the previous month and over 90% had used birth control at least once in her life. This puts this population in Chiapas very close to the national statistics from 1987 of 52.7% current users of birth control.

We have data on methods used and this information is also striking. Just over 40% of contraceptive users have had tubal ligations. Following this are pills (20%), IUDs (13%), injections (12%) and other methods (specifically coitus interruptus, rhythm and condoms) 13%.

I would like to show one overhead which must be taken with some caution because it is comparing different populations but, nevertheless, I think it is interesting to note the changes occurring in the choice of methods since the national fertility study of 1976 through the national studies in 1979, 1982 and 1987 and the Chiapas study of 1994. There has been a striking decrease in the use of pills from 36 to 20%, spectacular increase in tubal ligations, 9 to 40% and doubling in the use of injections, 5.6 to 12%. Finally another surprising result of our study was the lack of any significant difference in contraception prevalence or methods used between the rural and urban population of the region. This is in striking contrast to the urban/rural differences in the national survey of 1987 in which 32.5% of the rural women were current users as opposed to 60% of urban women. In 1994 we found in Chiapas 47.4% current users among rural women and 52.7% in the urban population. We also found no significant difference between urban and rural women in Chiapas in their choice of methods.

In summary, our quantitative data show us high fertility and high contraceptive prevalence. What can account for this apparent inconsistency? Our qualitative data say much about this.

### ***Qualitative Results***

The interviews confirm a broad knowledge of contraception and almost universal acceptance of some method at one time or another. When asked about ideal family size most of our informants said women should have 3, 4

at a maximum, although these same women often had more than four children themselves. One mother of seven said, *we shouldn't have had so many, but I don't regret having had them all.*

Factors that appear to form peoples opinion about desired family size turn around economic issues and social pressures. Both of these factors contain contradictory messages. On the one hand several women spoke of the necessity for children in old age to help their parents and that without many children where would we be when were sick and old. Yet informants also say that it is much more expensive now to have children than before especially with costs of school and clothes. Economics provide both an incentive and a disincentive to have many children. Several informants talked of the increased cost in having children nowadays. I would suggest that it is the changed perceptions of what childrearing should consist of and that it costs more money to meet those new standards. Informants usually mention costs of schooling, which imply not only clothes and books but also the indirect costs of lost labor for the family. In the old days they could afford more children because children worked and contributed income to the family. Social pressures for children to go to school in this population are strong.

In one rural community where some of our research is underway, parents are fined by the community authorities if their children, boys *or* girls, leave secondary school.

Social pressures, however, are not always clear. A woman who has none or too few children is criticized for being selfish, for wanting to pamper her body, perhaps for having sexual interests beyond her husband and especially she is criticized for not being a real woman. 'Marimacha' was a term frequently used for women who willingly didnt have children. Perhaps masculinized is the closest interpretation of the word, which in one person was paired with 'manpo', effeminate, for a man who didnt want children.

Besides the need to satisfy their perception of identity as women the role of wife also requires children. The first thing that should occur in a marriage is having children. Having children implies love for the husband. *A marriage without children is not a true marriage.* However, having too many children is looked down on, thought to be ugly and having too many children is just as bad as not having enough children.

The role of the Catholic church does not appear to be very important in influencing contraceptive practices. The Protestant evangelical churches, now gaining great strength in the region, are not of one voice. Some of them preach

that birth control is a sin, others approve. In fact one women said to us *having too many children is a sin*.

For these informants the ideal size for a family is between four and six children, less than three is considered too few and more than six too many. This ideal matches well with the results of the quantitative study data on actual number of children. The notion of ideal family size is not an inflexible one. This plasticity is reflected in the fact that the mothers of these informants had 15 children and it was seen to be OK. Now, having more than five or six is looked on negatively. (In fact a review of our fifty informants showed that the average number of siblings of the group is 7.5 as opposed to their average number of children of 4.4) And our informants for the most part would wish their children to have fewer than what they have.

Who makes the decision regarding birth control and the method to be used? The quantitative data says that it is mostly a joint decision between husband and wife. In the qualitative sample the women and men state clearly that social pressures and the wishes of the husband combine to make the decision. Some women admit to using methods secretly when their husband does not want to use contraception. But overall, the husbands wishes weigh most. This mixture of social and spouse pressure is the clearest effect of gender issues as they affect contraception. Ones identity as a women, in particular the external pressure, that is, what ones peers and spouse require of a women, to be womanly, is a very powerful determinant of a womans wish for a particular number of children.

There is almost unanimous praise for tubal ligation as the method of choice and in this group in which 19 of 40 had had their tubes tied, they expressed no regrets. However, since we know that tubal ligation has been promoted by health authorities and that we, as outsiders and from a higher social class, might easily be seen as allies of those authorities we should be cautious in interpreting the replies.

Certainly women said again and again that with a tubal ligation *its one expense and youre done*, that with a tubal ligation youre not *drugged* and that tubal ligation caused many fewer side effects. It is used after women have achieved their ideal family size (or the ideal mix of boys and girls). As reported in a qualitative study of 13 women in rural central Mexico by Figueroa and colleagues in December 1994, women commented that a tubal ligation was like menopause, that after they were no longer child bearing they lost sexual desire. In this group there was no suggestion of that. In fact one women



commented that the tubal ligation increased sexual pleasure because it eliminated the fear of having a baby. Some women use birth control to space children after their first (no one uses birth control until they have had their first child), others simply have children as they come along until they decide to not have anymore. From a public health point of view, that approach does not give proper time for physical recovery between children, nor optimum circumstances for child development. Neither does it allow for continued education or work that would interfere with child rearing.

In summary I should repeat that in our work we find high fertility and high contraceptive usage. People seem to be having the number of children they wish to have. This is less than what their parents had and probably more than what their children will have. Tubal ligation seems popular with little evidence of regret. Women are not as free as it appears to choose the number of children they have because community and spousal pressures are very great.

## Discussion

### *Tubal ligation – desired family size*

- The researchers involved in soliciting information on the tubal ligation (TL) method were people from the local community itself, who were not perceived as outsiders by the informants.
- Usually women aged approximately 25 to 27 years old can opt for sterilizations if they had already about 5-6 children. This indicates the early mean marriage age in Mexico and also shows how popular TL is. The 'desire' to have 5-6 children before having a TL is related to the enormous social pressure of the community. The women have to follow norms of the community, otherwise they risk being stigmatized. Therefore contraception in the area studied is only accepted after the ideal family sizes has been attained and not usually before. This is also due to social influences. Women do not speak about child-spacing in order to be able to continue their education or work.
- The question has been raised: to what extent do women consider tubal ligation a real choice? In Mexico, the official policy is to sterilize women. However, there is also a lot of social pressure. Women with too few children are criticized. From this study nothing is known about sex preferences.

In general having boys is very important in the culture. Later in the discussion, it is proposed to examine this social pressure from the perspective of the social construction of gender. Indeed, women criticize each other enormously if one feels the other does not have the right number of children.

- Women themselves have very strong ideas about womanhood. There are terms used to distinguish between different kinds of women, i.e. the masculine woman who does not want to have children as opposed to the socially defined one who wants to have children to please her spouse.
- Demographically, TL is not considered very effective, because it offers no benefits to anyone to have TL only after having six or more children.
- It has been remarked that even if the present generation says that if they want their children to have fewer children, this does not necessarily mean that there will be a population decline in the future. The significance of children, and the value attached to them, changes for each generation.
- Some say that the way people perceive contraception is related to the way it is provided. The information people get on, for example, side effects, is part of the context, as well as the wider political and economic context in which the decisions are taken.

Women's health advocates might also have a negative impact on contraceptive use.

The women in the Chiapas study seemed to be quite satisfied with tubal ligation. This was derived from remarks such as: 'It is done once and forever okay.' 'You don't have any problems with pills and IUDs.' 'Once you have the number of children you wanted, you stop.' Women don't want to 'mess around' with their bodies. Educational differences are not yet analyzed. Women's opinions on tubal ligation in Mexico seem comparable to experiences expressed by Indian women.