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The GRHPP project aims at generating innovative knowledge about women's and men's needs regarding reproductive health services. Its data and conclusions provide evidence to help improve these services and to influence the development of reproductive technologies in such a way that they protect women's health and uphold women's rights to a free and well-informed choice from among a range of contraceptive methods. The direct participation of the target group - users of fertility-regulating technologies and reproductive health services - in action-research projects is a key aspect of defining more need-oriented development interventions in the field of reproductive health.



Contraceptive practices in Chiapas, Mexico, and the value of children are the topics examined in this third issue of *Current Reproductive Health Concerns*. The authors' study shows how an apparently contradictory high fertility rate and high contraceptive prevalence can occur simultaneously. The study explains this situation as a result of women receiving tubal ligations only after having many children. Preference for this method is based on many reasons: fewer side effects compared to other methods; its natural mechanism (it does not "drug" the body); it is convenient and cheap; and its definitive nature allows for tranquillity and heightened sexual pleasure. Moreover, it is a one-time procedure, quickly and easily performed, often just after childbirth. And not to forget, it is a one-time expenditure as well, a strong motive in such a poor region. Users' voices form the basis of this issue. The researchers notice the lack of information available about contraceptives. In the discussion, a critical voice on public health concerns is included.

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CONFLICT AND CONTRACEPTION IN CHIAPAS, MEXICO

David Halperin, Austreberta Nazar and Namino Melissa Glantz

Gender, Reproductive Health and Population Policies Project

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**Conflict and Contraception
in Chiapas, Mexico**

David Halperin, Austreberta Nazar
and Namino Melissa Glantz

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Het Spinhuis

1999

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HIGHLIGHTS

- The quantitative data indicate a high fertility rate of 3.6; a high contraceptive prevalence of more than fifty percent; a predominance of tubal ligations and slight urban/rural differences.
- Women are aware of the existence of a range of methods, both temporary and permanent, and that dissemination of basic contraceptive information occurs.
- Study participants had information about advantages and disadvantages of a variety of methods. Close to half of the comments regarding advantages and disadvantages were based on personal experience using the method discussed, either the informants' own experience or those of people around them. Medical personnel offer little of the information (five percent).
- Despite the fact that children play a crucial role as the basis of a proper individual, marriage, family and home, it may not be assumed that more children is always considered as better. Our informants view having too many children as just as much of a problem as having too few. One critical factor mentioned repeatedly is the cost of maintaining children: feeding, clothing and sending them to school.
- The quantitative data indicate that whether or not to use contraceptive methods is mostly a joint decision between husband and wife (more than ninety percent). In the qualitative study, the women stated clearly that, while joint decisions regarding this decision as well as which method(s) to use would be ideal. In reality, economic and social pressures and the wishes of the husband most often combined to make the decision.
- The consequences of not satisfying the husband's desire for children can be drastic. A man may begin to drink a lot, see other women, or leave his wife altogether.

- In terms of when to use methods, all but one of the informants preferred not to use contraceptive methods at all until they have had at least one child, and usually not until after they have had all the children they desired. In the qualitative study, twelve of the forty women had had their tubes tied, after having an average of five children.
- The informants offered many reasons for choosing tubal ligations: it causes fewer side effects than other methods; it does not drug the body; it is convenient and cheap; and its definitive nature allows for tranquillity and heightened sexual pleasure. It is a one-time procedure, quickly and easily performed, often just after childbirth. It relieves the need to repeat treatments – use a condom for every sexual act, take pills daily, get shots monthly, change the IUD. This also means that it is a one-time expenditure – a strong motive in such a poor region.
- With the other popular methods – pills, the IUD, injections, and the rhythm method – they fear possible pregnancy and that a pregnancy carried to term while using some of these methods may even result in birth defects.
- It appears that in this part of Chiapas women are having the number of children they have chosen to have, within the social, economic, and spousal constraints mentioned. Unmet demand does not seem to be an important factor in determining non-contraceptive usage. However, the option of a wide choice of contraceptive methods is fundamental to integrating fertility control into programmes that promote health and well-being, for women, for men and for children. And that choice is lacking.

CONFLICT AND CONTRACEPTION IN CHIAPAS

The politics of birth control in the developing world are immensely complicated and controversial. There are two, fundamental purposes that underlie these policies. One is to effect a decrease in population growth in poor countries and the other is to provide poor people, particularly women, with a means to control their reproductive processes. It is no secret that for many years population control is what has driven the family planning programmes funded by the developed world and by Third World countries whose leaders share the point of view of what one might call the international family planning establishment. That is, population control is necessary for development. There are, in fact, few data that unequivocally support this statement, and much data to contradict it, although there is an enormous academic and 'para-academic' (for-profit, funded 'think tanks') industry which attempts to provide this position with support. According to Betsy Hartmann (1998), in the *International Journal of Health Services*, US\$5 billion are spent each year promoting or providing birth control services in developing countries.

Since the growth of the women's movement and in particular the United Nations International Conference on Population and Development held in Cairo in 1994, the second purpose of a birth control programme, to enable women to control their bodies, has received new emphasis. This has occurred to such an extent that the discourse of those entities most interested in promoting demographic change through birth control must now include at least a passing reference to the promotion of women's health and well-being as well as the empowerment of women to be derived from the option to practice birth control.

In spite of all the effort expended in the study of contraceptive practices carried out by those who seek to expand those practices, we believe that contraception continues to be a crucial item on the reproductive health agenda. We are challenged to understand those elements that underlie the decision to limit fertility precisely in the context of women's perceptions of their own health and well-being. Hence, this is the reason for our research into fertility and contraception in Chiapas.

This paper presents work from the Program for Research and Action in Reproductive Health in Southeastern Mexico, carried out jointly at the

College of the Southern Border (El Colegio de la Frontera Sur [ECOSUR]) and the Comitan Center for Health Research in the State of Chiapas, Mexico.

Chiapas: The research area

Chiapas, long known mainly to tourists and anthropologists for its Mayan culture and its colonial architecture, is also one of the poorest parts of Mexico whose misery has been historically ignored by local, regional and national governments. The appearance of an armed, indigenous revolt in the Highlands and Lacandon Forest of Chiapas was an international sensation in January, 1994. The Mexican government's response to the Zapatista rebels has seesawed between confrontation and conciliation since the cease-fire which occurred barely twelve days after the initiation of hostilities. Nevertheless, the effect of the uprising, not only in the conflict zone, but also in the rest of Chiapas, has been striking. Clearly emboldened by the uprising, peasants sprang into action throughout the State, demanding land, credit, and local democracy. Large land holdings were invaded, highways blocked, and the town offices in many municipal centres taken over. At the same time, many communities were divided and local reaction mobilised. So-called white guards, or private armies, supported the local oligarchy, a long tradition in Chiapas, and were strengthened, provoking much violence in the State. The consciousness of the terrible conditions which exist in Chiapas, in particular the conditions in which the indigenous population lives, also moved public sentiment in the whole country, and the Mexican government is clearly sensitive to such sentiment. There presently appears to be a government policy of a tight, military encirclement and a 'truce of attrition', that is, no war but no peace, in hopes that the Zapatistas will just fade away. With the election victory of the left in the Federal District July 1998, the government hopes the issues raised by the Zapatistas will lose their relevance to the great majority of the Mexican public. That remains to be seen.

Various social, economic, and political characteristics distinguish Chiapas from the population residing in other Mexican States. Chiapas is home to approximately 3.2 million people, about 4% of the national population. Almost one-third of its inhabitants belongs to one of a number of indigenous, Mayan groups. A third of these people speak no Spanish and are illiterate. This circumstance is much more frequently found among women than men.

Chiapas suffers from the worst levels of health and well-being in the nation, attested to by statistics that show it to have the lowest life expectancy at birth, and the highest infant, child, and maternal mortality. The principal causes of death and illness are the diseases of poverty: tuberculosis, malnutrition, diarrhoea, and acute respiratory disease. Chiapas also has the poorest statistics in terms of its health system, with the fewest hospital beds, physicians, and nurses per person of any State in Mexico. Official statistics admit that the capacity of the health system ideally can only cover two-thirds of the population. Official figures also show that only 18% of the population seeks care at government hospitals, clinics, and health centres in the State.

This study was carried out in Health Jurisdiction III, the border region of Chiapas, which is contiguous with Guatemala. The region has a total, largely rural population of about 300,000, with one major city, Comitan (population 90,000) and two towns in the 10,000-20,000 range. The climate of the region ranges from hot and arid in the lowlands close to the border, and a lush, tropical area along the banks of the great Grijalva River, to tropical rainforest (a portion of the Lacandon Forest falls within the region), and temperate highlands including cloud forest.

Methodology

Our study population was all Spanish speakers who identify themselves as *mestizos* rather than as indigenous. We excluded indigenous people (approximately 13% of this population) from this phase of the study, because in the piloting of this work within the region's indigenous communities both the qualitative and quantitative instruments were found to be inadequate. Not only were there problems of translating from Spanish into Tojolabal and Tzeltal, the principal Indian languages spoken (and as previously mentioned, a high percentage of the indigenous women are monolingual, non-Spanish-speaking), but we encountered more complicated, conceptual problems, starting from basic notions of health and disease. A separate and specially designed study of reproductive health within an indigenous community began in July, 1995.

Although the principal impulse for this work was the development of qualitative research in reproductive health, we were faced with the lack of a quantitative database concerning women's health in the region without which we felt the qualitative data would be 'floating in the air'. Basic, reliable statistics were

not available concerning infant mortality, the prevalence of reproductive health problems, the places in which children are born, and the use of contraceptive methods. Therefore, we had to develop such an information base ourselves.

A team of epidemiologists and biostatisticians at the College of the Southern Border (ECOSUR) designed a questionnaire that was applied to a representative sample from among approximately 64,000 women in nine municipalities of Health Jurisdiction III. In all, 1,560 women – excluding indigenous women – were surveyed. Informants ranged in age from 15-49. The sample size provided a confidence level of 90%.

The section on contraception was designed to obtain information concerning the use of different methods, advice received concerning contraception, morbidity caused by each of the methods identified, and current usage (in the last month). These questions were applied to those women who have had partners and who have been or are pregnant or have children.

The qualitative component was designed with the help of Linda Hunt, a medical anthropologist now at the University of Texas School of Nursing in San Antonio. A field team made up of four women (two nurses, one physician, and one woman with a bachelor's degree in psychology) conducted forty interviews, each ranging from one to four hours in length, during the course of five months. The interviews were preceded by the development of a guide of open-ended questions concerning a broad range of reproductive-health issues. The forty women were chosen from the same localities from which the subjects of the quantitative study were selected. They were also selected to include older and younger women, poorer and better-off women, urban and rural women. All of the women interviewed were in or have been in a couple relationship, and all have had at least one child. The majority of the interviews took place in the subjects' homes.

Living conditions

The study participants live in houses which range from two-room huts of wooden plank walls, corrugated aluminum roofs, and dirt floors, to larger, more formal, cement block and brick structures. Almost all had radios which broadcast music and local news; half had television sets on which they follow soap operas (*novelas*) and national news. Although all of our informants had piped water and electricity, those who reside in rural settings live without sewage and cook with wood rather than gas stoves. Modern labour-saving devices such as washing machines, dryers, dishwashers, gas, electric and microwave ovens are unheard-of in this population.

These living conditions weigh especially heavily on women, since they are responsible for household chores, child-care, procuring food, and preparing meals. While our informants structure their daily activities primarily around these tasks, half have income-earning tasks as well. Nine of the forty prepared food for sale outside the home. The rest worked at home, growing vegetables, washing clothes, raising poultry, sewing, or selling basic household items (soap, sugar, matches, etc.) out of home-based shops. Four of our informants held professional positions (nurse, psychologist, radio announcer, and kindergarten assistant).

Nearly all of our informants suffered from fatigue and stress as well as physical and reproductive-health-related problems. While they find little relief for the former, most seek 'modern' health services for the latter, although these women also employ home remedies and visit traditional healers (*curanderos* and *hueseros*) and midwives.

With few exceptions, the women we interviewed are beholden to the decisions and actions first of their fathers and subsequently of their husbands, as the taken-for-granted authority figures of the household. Most of our informants' social lives centre around the extended family. Nearly all the women interviewed lived with their in-laws at the start of their couple relationship and many continued to live with members of their extended family. Those who did not share the same dwelling tended to live in close proximity to family members. The majority of our informants married in their late teens and pregnancy followed shortly. Children are critical to the legitimisation of the couple relationship and one's sexual identity. The majority of our informants had more than four children. Aside from the family, other social networks are limited to religious groups (only slightly more than half are practising Catholics and a quarter are members of one or another fundamentalist Protestant group) and, in a few cases, professional acquaintances and Alcoholics Anonymous groups.

Fertility and contraceptive prevalence

The sample of 1,560 women interviewed in the quantitative component were divided fairly evenly between those who live in villages of less than 2,500 inhabitants, communities of 2,500-10,000 and in towns of more than 10,000 people. Their ages ranged from 15-49. Women in this region, even excluding the indigenous population (approximately 13% of the region's population which we know lives in much poorer circumstances than the non-indigenous population), are very poorly educated and live in difficult circumstances. For example,

54% began but did not complete primary school – statistics far worse than the Mexican national average (30.4%). Of the study participants, 60% were married and 18% were in a common-law relationship (that figure is double the most recent national figure in Mexico). The majority (74%) of this sample of women were in their first relationship before age twenty (about 40% nationally).

Women in this part of Chiapas are having considerably more children than the average Mexican woman. The estimated total fertility rate is 3.67 in this area of Chiapas, with an average number of live births per woman of 3.48. The Mexican, national, fertility rate was reported as 2.8 in 1995. This is information we had expected. (In fact, we have data from other studies carried out by our team in the Soconusco region of Chiapas of a fertility rate of six, also among a non-indigenous population, and we have preliminary data from an indigenous region of a total fertility rate of more than eight). The data on contraceptive use, however, were surprising in that more women used or have used birth control methods than we expected. Of the women interviewed, 51% had used one or another form of 'modern' birth control in the previous month and 58% had used birth control at least once in her life. Even more surprising to us was the finding that there are no differences in the total fertility rate, nor in the average live births between women who had never used contraceptives and those who had used them.

With regard to methods used, slightly more than 43% of contraceptive users have had tubal ligations. Following this are IUDs, 16%; pills, 15.5%; injections, 13%; and other methods (specifically withdrawal, rhythm and condoms), 12%. We found only a slight difference in contraception prevalence and methods used between the rural and urban populations of the region. This finding is in contrast to the urban/rural differences in the 1987 national Mexican survey in which 32.5% of the rural women were current users as opposed to 60% of urban women. In Chiapas in 1994, we found that 48.4% of rural women were current users and 53.0% of women in urban centres (localities with populations above 10,000) were current users of contraceptives. We found only a slightly higher fertility rate in rural areas.

In summary, the quantitative data indicate a high fertility rate of 3.67, a high contraceptive prevalence of more than 50%, a predominance of tubal ligations and slight urban/rural differences. Our qualitative findings led us to a deeper, more complete understanding of these data.

Women's views on contraception

The forty open-ended interviews confirmed a general knowledge of contraceptive methods. When asked to name contraceptive methods with which they were familiar, more than 90% mentioned five or more different methods. More than 80% mentioned oral contraceptives, the tubal ligation and long-acting injections. The IUD was mentioned by more than 70%. Very few informants mentioned other methods such as breastfeeding, contraceptive sponges and foams, Norplant, abortion, and herbal teas. With the important exception of condoms (mentioned by 60% of the informants), the methods most often mentioned were those that assign responsibility to the woman. Listed less frequently were methods requiring active, male participation, such as rhythm (abstinence during a woman's fertile period) or abstinence (57%), vasectomy (35%) and coitus interruptus (withdrawal) (5%). Searching for indicators of a deeper understanding of contraceptive methods, we noted numerous spontaneous explanations regarding how methods function. More than 70% of our informants offered a detailed explanation regarding how one or more methods functions.

We're using the method where you don't let the sperm in the vagina, in its slot, but instead let it go outside, and that way the woman cannot get pregnant.

These data suggest these women are aware of the existence of a range of methods, both temporary and permanent and that the dissemination of basic contraceptive information has occurred.

When we asked about communication and advice regarding contraceptive methods in general, our informants mentioned four types of sources: (1) health professionals (doctors, nurses, and pharmacists); (2) husbands and family members; (3) friends and acquaintances; and (4) mass media (newspapers, radio and television). The majority (82%) of these women has talked with medical personnel; half (50%) has discussed the matter with their spouse and/or another relative, including daughter-in-law, child, mother, sister-in-law, sister, or aunt; and many (41%) have talked with non-family members (*comadre*, another woman, friend, or neighbour). Few (9%) receive information from the mass media. This broad range of sources for information and advice helps explain the knowledge base women have regarding contraceptive methods.

Here the one who talks is the doctor in the clinic. She highly recommends it. ... They have meetings, girls come to them, she mostly warns them. ... She says that if they want to have sex and don't want to have children, that they should take care. She tells them about the methods that exist so that they don't get pregnant.

(age 22, three children, experience with the rhythm method)

Another strong indicator of knowledge regarding contraceptives is the frequent discussion of different methods' advantages, disadvantages, and side effects. This type of information was offered by 95% of the women interviewed. The women discussed side effects related to an average of four different methods. 87% of the informants mentioned the pill's side effects and between sixty and 70% discussed the advantages and disadvantages of tubal ligations, injections, and the IUD. Just more than half of the women commented on aspects of the condom. Close to half of the comments regarding advantages and disadvantages were based on personal experience using the method discussed, either the informants' own experience or those of people around them. In this case, medical personnel offer little of the information (5%). In summary, our study participants had information about advantages and disadvantages of a variety of methods.

The value of children

We were told that having children is a requirement to obtain and maintain identity as a woman and that the role of wife requires children. The definition of a proper family and a proper home is based on the presence of children.

Children are first ... because it is the joy of men that their women have children. If they have children, they are happy. ... If not, they are not happy.

(age 42, seven children, never used a method)

Wives who do not want children don't really love their husbands, and don't want the fruit of that love. If real love exists in the family, the first thing they will want are children.

(age 21, two children, experience with pills and the IUD)

Bearing a child is not only essential to society's value of that woman, but often seen as the most meaningful and valuable experience a woman could have. A woman who has none or too few children is often criticised. She is viewed as selfish and lazy, accused of wanting to pamper her body or of having sexual interests beyond her husband. She is especially characterised as a failure, not a real woman. *Marimacha* was a term frequently used for women who willingly do not have children. Perhaps 'masculinised' is the closest interpretation of the word, which by one person was paired with *mampo*, 'effeminate', for a man who does not want children.

[Regarding women who want children but cannot have them.]

They criticise them with tyrannical words ... She's a *marimacha*, she's incapable of having a child ... it must be God's punishment. ... *Marimacha* means that she's a woman because she has a man, she has given herself to a man, but at the same time she's macho because she doesn't create a family. ... There are couples in which the man mistreats the woman because he thinks that she is to blame; he doesn't know that he's probably the sterile one.

(age 47, five children, experience with pills, the IUD, and tubal ligation)

They think she's a lazy bum ... that she does not want to have more children because she wants to go around and do crazy things. ... My sister-in-law was going to get a tubal ligation but her husband didn't want her to; "She's going to have a lover, or I don't know what."

(age 26, two children, experience with pills, condoms, and tubal ligation)

The majority of our informants claimed to be traditional Catholics, yet we found no relationship between being Catholic and contraceptive usage. 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 of its use.

When God wants children, there's no other option but to have them.

(age 30, five children, no method use data)

God has decided for us to have our children, but if one has many and the man is a peasant, how is he going to be able to care for so many children?

(age 61, nine children, never used a method)

It is not to be assumed that because of children's crucial role as the basis of a proper individual, marriage, family and home that more children is always better. Our informants view having too many children as just as much of a problem as having too few. One critical factor mentioned repeatedly is the cost of maintaining children: feeding, clothing and sending them to school. Although children traditionally were productive in a rural family setting, more and more often in contemporary Mexico, including Chiapas, children are in school, even through secondary school. This makes them unavailable as additional labour and results in a considerable net financial output. Men and women must reconcile their ideals with resource factors as well as social pressures in their decisions regarding having children and using contraceptives. Many people feel they are simply too poor to have more children.

It's awful not to have family. When you're sick and alone, there is not even anyone to offer you a glass of water. But if you have children, they'll help.

(age 39, seven children, experience with injections and pills)

If a woman has many children, they are poorly cared for, poorly nourished, and poorly dressed.

(age 25, two children, experience with condoms and the IUD)

For these informants, the ideal family size is between three and four children; less than three is considered too few and more than four too many.

We shouldn't have had so many, but I don't regret having had them all.

(age 49, seven children, experience with the rhythm method, the IUD, and tubal ligation)

However, this notion of the ideal family size is not an inflexible one. This plasticity is reflected in the fact that some of the mothers of these informants had 15 children and it was socially acceptable. Now, having more than five or six is

looked on negatively. (In fact, a review of our forty informants showed the average number of siblings of the group was 7.3 as opposed to their average number of children of 4.6.) Additionally, most informants hoped their children would have even smaller families than they had.

Back then, pills and injections were unheard-of. Poor people had no choice but to have their children. Perhaps in cities contraceptives were known and available, but not here.

(age 61, nine children, never used a method)

She, my mother, would scold us, "Don't follow in my footsteps. I had all of my children because there wasn't any way to prevent pregnancy." ... One suffered a lot before. ... My mother had 15. ... There was even a time when she had three children hanging onto her and she was carrying one that couldn't crawl yet.

(age 27, five children, experience with tubal ligation)

In the old days, people ended up having 18, up to twenty children, but now they say that that time is over, because for many it is difficult to maintain so many children, now there's not enough for food, for shoes, for everything. Because of this, many people here, almost the majority of men and women look for a way of ... using a method for family planning.

(age 31, three children, experience with the rhythm method, injections, breastfeeding, and tubal ligation)

Decision-making

Who makes the decisions regarding birth control and the method to be used? The quantitative data indicate that it is mostly a joint decision between husband and wife (more than 90%). In the qualitative study, the women stated clearly that, while joint decisions regarding whether or not to use contraceptive methods as well as which method(s) to use would be ideal, in reality, economic and social pressures and the wishes of the husband most often combined to make the decision. Informants described the many manifestations of social pressures – the feeling that people were always watching, preaching, gossiping, criticising, and mocking. Some offered explanations, revolving around tradition, the importance of family, and *machismo*.

They give them dirty looks, they think it's strange that they don't have children.

(age 28, three children, never used a method)

If they do not have children, the people talk; if they have too many children, the people talk.

(age 42, seven children, never used a method)

All Mexicans are macho. They want to see the woman with children, pregnant, and bearing children continually. The people [society] focus on this. They want to see family.

(age 47, five children, experience with pills, the IUD, and tubal ligation)

Husbands' wishes weighed most heavily on contraceptive decisions. We asked our forty informants to talk about who makes decisions regarding whether and how to avoid pregnancy. Sixteen stated that it was always the man. Another 16 indicated that decisions were made by the couple, but of this group, seven mentioned that disagreements are a cause for the man to leave the woman or for the woman to assume the common practice of using methods secretly against the wishes of her husband. Five of those who said the couple made a joint decision and five of those who said the man decides said the woman may use methods secretly. Just five of the informants stated that the woman was the decision-maker. The consequences of not satisfying the husband's desire for children can be drastic. A man may begin to drink a lot, see other women, or leave his wife altogether.

The man makes the decision. ... Well you have to have your children, even if you don't want to. Well, what can the woman do? She has to have them.

(age 29, five children, experience with pills and the IUD)

The woman makes the decision, because if the man knew, he would not accept it.

(age 38, nine children, experience with the rhythm method and tubal ligation)

A woman can use methods secretly ... but it means not satisfying the wishes of her husband.

(age 25, two children, experience with condoms and the IUD)

Women who do not or cannot succumb to such pressure suffer in a number of ways ranging from physical and psychological violence to the loss of the men on whom they are economically dependent.

If they cannot have children the man can blame the woman and look for another woman.

(age 29, five children, experience with pills and the IUD)

Those who cannot have children separate ... even if it's his fault, she is the one who is blamed. ... They are machistas.

(age 21, one child, experience with pills and condoms)

This mixture of social and spousal pressure is the clearest effect of gender issues as they affect contraception. One's identity as a woman, shaped in particular by what one's peers and spouse require of a woman for her to be 'womanly' is a very powerful determinant of a woman's wish for a particular number of children. Predicated by the wish for a particular number of children, couples adopt a strategy that includes when to use contraceptive methods and which ones to use.

Contraception: Not before the first child

In terms of when to use methods, all but one of the informants preferred not to use contraceptive methods at all until they have had at least one child, and usually not until after they have had all the children they desired. Only one of the forty women had used contraceptive methods before having her first child; eight had used something after the second or third child; and ten after having all the children they wanted (which was four or more). Others used contraceptive methods only after bearing the optimal number of girls and boys. This often leads to 'filling-up' with either sons or daughters while the parents wait for a girl or a boy. We see also that most women with fewer than three children have not used contraceptive methods because they are still striving to have additional children.

People use family planning after they have had two or three [children].

(age 36, three children, experience with injections and pills)

Sometimes there are women who ... have just girls, just girls, and so the man wants to have his ... that she must have more even if it's just one boy. Or other times, pure boys and they want a girl. There they are ... until they have one, until the end. There is a girl who didn't have even one boy, just little girls, and because they waited for a boy, they filled-up with children.

(age 35, four children, experience with injections and the rhythm method)

My husband suggested that I get a tubal ligation. I agreed, but only if my fourth child was a son. It was, and I will soon be operated on.

(age 31, four children, experience with injections, pills, the rhythm method, condoms, and tubal ligation)

I have not used methods because I haven't gotten to the point at which I need to use them.

(age 28, three children, never used a method)

Although many informants themselves made the distinction between using contraceptives to space their children versus using them to prevent any further pregnancy, few informants used contraceptives to space children. The majority simply has children as they come along until they decide not to have anymore.

Tubal ligation: The preferred method

Having once achieved the desired number of children (or the ideal mix of boys and girls), there is almost unanimous praise for tubal ligation as the method of choice. The quantitative data indicate that, of the women who reported using contraceptives in the previous month, 43.1% had a tubal ligation (compared to the IUD, 15.9%; pills, 15.5%; injections, 13.3%; and other methods, 2.2%). In the qualitative study, twelve of the forty women had had their tubes tied, after having an average of five children.

Here, the majority prefer this method [tubal ligation], but after having two, three children.

(age 31, three children, experience with the rhythm method, injections, breastfeeding, and tubal ligation)

The tubal ligation has been the most accepted. ... It's what I've most liked and I ended up very happy.

(age 47, five children, experience with pills, the IUD, and tubal ligation)

I'd say that they're bad, to begin with they are drugging themselves with so much medicine, and then later when they want to have a baby, they won't be able to.

(age 28, three children, experience with condoms, and tubal ligation)

I tell my daughters, "Have all the children you want without taking contraceptives and then get your tubes tied." That's my only recommendation.

(age 49, seven children, experience with the rhythm method, the IUD, and tubal ligation)

The informants offered many reasons for choosing tubal ligations: that it causes fewer side effects than other methods; it does not drug the body; it is convenient and cheap; and that its definitive nature allows for tranquillity and heightened sexual pleasure. The advantage most often reported was that the tubal ligation provokes comparatively few side effects. The convenience of the tubal ligation was also highly acclaimed. It is a one-time procedure, quickly and easily performed, often just after childbirth. It relieves the need to repeat treatments – use a condom for every sexual act, take pills daily, get shots monthly, change the IUD. This also means that it is a one-time expenditure – a strong motive in such a poor region.

The *salpingo* is the best because that way one stops martyring herself with injections and pills, and pills, yes, if you forget just one, you can end up pregnant ... Sometimes women say, "I'm taking care with pills but they give me headaches", or, "They give me this or that." And if not, some say that the body goes on storing up the pills until they finally get the operation done.

(age 35, four children, experience with injections and the rhythm method)

Tubal ligation is the best. ... It is a one-time expense ... and we avoid bad side effects.

(age 31, four children, experience with injections, pills, the rhythm method, condoms, and tubal ligation)

Well, because of the poverty that one is stuck in ... people decide to get the tubal ligation.

(age 27, five children, experience with tubal ligation)

Many women cited the fact that the tubal ligation permanently eliminates any possibility of pregnancy as a great advantage. With the other popular methods – pills, the IUD, injections, and the rhythm method – they fear possible pregnancy and that a pregnancy carried to term while using some of these methods may even result in birth defects.

If you're afraid that you may get pregnant, you can't ... satisfy that necessity of a sexual relation with your partner.

(age 24, one child, experience with condoms)

In conclusion

Several issues emerge from these data. First, it appears that in this part of Chiapas women are having the number of children they have chosen to have, within the social, economic, and spousal constraints mentioned. Unmet demand does not seem to be an important factor in determining non-contraceptive usage. However, the option of a wide choice of contraceptive methods is fundamental to integrating fertility control into programmes that promote health and well-being, for women, for men and for children. And that choice is lacking. Moreover, the poverty in which these people live often leads them to make very painful decisions to limit their family and we need to appreciate that for what it is – yet more suffering superimposed on the other manifestations of poverty with which they live.

Second, the high prevalence of tubal ligations in this population appears to be growing rapidly and might suggest a public health triumph. In fact, it is not even a demographic triumph, as we see tubal ligations are performed *after* having many children. The public health consequences are also less than

optimal. Temporary forms of birth control enable couples to space their children at desired intervals. This gives women a chance to recover physically from the stresses of pregnancy, delivery and newborn care before undertaking another round. It also grants a woman the option of pursuing further education or work during these intervals. A child, too, benefits from longer inter-gestational periods. She or he is the result of a healthier mother, the object of greater attention for a longer time and is likely to breastfeed longer. All of these factors lead to improved overall child development.

Third, the complaints women often voiced concerning pills, injections and IUDs may reflect the inappropriate use of these methods and a lack of understanding about their side effects. If women understand why they have chosen this or another method they might be more willing to tolerate some of its side effects. There are also changes that can be made in dosage and formulation, which can lessen undesirable side effects. It is clear that, for the health system, tubal ligation is a relatively simple and practical option. It is a one-time intervention that does not require any involvement with the client's health, there is no need for client education, no uncertainty considering side effects and no follow-up. In fact, it is an instance in which a birth control method is completely separated from overall concerns for health. It is also an instance in which what should be reproductive rights are being violated.

Our data reveal only a 3% prevalence usage of condoms in this population. This is the only birth control method that also can affect the spread of sexually transmitted diseases (STDs) including AIDS. This is reason enough for health authorities to promote condom usage and highlight its positive role as a method of birth control. Condom use is also important because it is a male method and the only temporary method besides withdrawal in which birth control responsibility rests with the man. This is an example of our fourth concern – gender issues surrounding the responsibility of fertility regulation and the decision-making process to do so. Women find themselves with diminished authority in deciding about fertility control and confront pressures from their neighbors and friends and particularly from their husbands and mothers-in-law. In some cases, service providers enforce this decision-making process by requiring the husband's permission before prescribing contraceptives.

Vasectomy is also a rarely chosen method in Mexico, particularly in this region. There is a strong prejudice on the part of men in general, including male health authorities, against the procedure. For example, after a recent ten-day campaign carried out by the Health Ministry to promote surgical sterilisation for men and women in the region, 811 sterilisations were performed, of which 98% were for women and 2% for men.

My husband has decided that I get operated on. I even told him, "You get the operation." He says, "I would never get operated on," and I say, "Why don't you men get operated on?" He says, "Well, it's very different for a woman than for a man." He will not consider an operation.

(age 31, three children, experience with rhythm, injections, breastfeeding, and tubal ligation)

Our findings are not completely discouraging for those who would wish to reduce fertility in the region. It is happening, although behind the national rate of change and at a slower rate than official policy would wish. Women are having fewer children in Chiapas than before and they wish their children to have still fewer. The complex, cultural, economic and psychological factors that determine fertility rates are moving these rates toward smaller families. Much benefit could be offered to people in Chiapas with a more balanced birth control programme that stressed multiple options and particularly one that integrated family planning into an overall programme to promote reproductive health.

Those issues that the current conflict in Chiapas has placed in the spotlight are the same issues that are critical to improving the reproductive health of women in the region. These include the need for economic security, education (especially for women), job opportunities, political participation by women at all levels, integrated, effective primary health care with attendant lower infant and maternal mortality, and, finally, democracy, which can provide for greater local and personal autonomy and power.

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