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**The Social Context of Family Planning Policy in Highland
Chiapas, Mexico.**

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Department of Anthropology
University of Durham**

**Submitted in partial fulfillment for the
requirements of the degree of PhD**

January 1999

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ABSTRACT

The Social Context of Family Planning Policy in Highland Chiapas, Mexico

Mary S. Thompson
PhD 1999

This thesis focuses on the concept of informed choice in family planning and how numerical and systematic targeting aimed at raising the numbers of contraceptive acceptors fundamentally undermines this concept in highland Chiapas. The Government of Mexico's policy aims within its Reproductive Health Programme (1995-2000) are to reduce the total fertility rate whilst promoting reproductive health services and family planning choices. Though Mexico has seen a decline in its total fertility rate attributed to increased contraceptive use in urban areas, in rural parts the rate remains high. Consequently, the rural poor, and in Chiapas overwhelmingly indigenous populations, have become a major target of the Reproductive Health Programme. Monthly targets are set for clinics and family planning services are offered systematically every time a woman attends a clinic for whatever reason.

Amongst the factors which must be accounted for in assessing family planning provision in highland Chiapas are cultural differences between mestizo providers and the indigenous target groups as well as local economic and political conditions. Presently, the state of Chiapas is highly militarised and under the cloud of a low intensity war precipitated by the Zapatista uprising in 1994. The provision of any kind of health services is difficult under these situations, but more so when one considers the distrust sown between some indigenous communities and the government who provide the health services.

This thesis examines the practicalities of implementing a global policy at a local level and the constraints faced by both providers and intended recipients in the social context of Los Altos. Mindful of the care required in identification most people in this thesis (with the exception of a few well-known academics) appear under pseudonyms.

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INTRODUCTION

In considering the concept of *informed choice* within a framework of reproductive health rights as they relate to family planning, I am particularly interested in the relationship between policy formulation and the implementation of policy edicts at the level of local cultures. As Justice argues in her work on health development in Nepal there are difficulties inherent in large scale planning by policy makers often far removed from and uninformed about the people for whom they plan [1989:1]. Like her I could find no definitive answer to this problem except that the involvement of local people and the use of local knowledge might result in more successful policies. How to do this, however, is another matter. So too is the intention of policy mandates. Policy rhetoric is often framed in a neutral, apolitical language, which is put forward as something for the *good* of the recipients and therefore incontestable. At best, it is often paternalistic. At worst, in not recognising differences within local cultures and the power relationships which exist between them, policy rhetoric makes assumptions about the intended recipients which might prove inappropriate and cause the policy to fail.

In situating my research in highland Chiapas, known as Los Altos, in south-eastern Mexico, and with a majority Mayan indigenous population, my intention was to look into the apparent lack of success of family planning policy in the area. This research site was chosen after discussion with David Halperin and Héctor Ochoa of El Colegio de la Frontera Sur (ECOSUR) in San Cristóbal, who briefed me on the problems in the area and suggested it as a suitable location. I spent 18 months between 1996 and 1997 researching the implementation of policy and local views on service provision before concluding that the major problems lay in a policy framework far removed from the local culture, harshly imposed upon service providers, who in turn imposed these policies on the local populations, the vast majority of whom are culturally distinct from these providers. Problems of policy formulation notwithstanding, the cultural opposition between mestizo providers and a mainly indigenous population are core factors which policy makers need to address if they are to succeed in making health services more accessible to the indigenous

population in this area. The current conflict in Chiapas which has been ongoing since the indigenous Zapatista uprising against the State in 1994 (see, for example, Holloway and Paláez, 1998) has exacerbated the existing situation and increased distrust in the area so that government health services have become suspect to many people.

Reproductive health policy in Chiapas not only fails to take account of the local culture¹ but also fails to address the problems of the conflict which health service providers themselves must deal with. Thus, I contend that policy formulation, at least in relation to reproductive health, is framed within a “neutral” rhetoric which fails to take account of extenuating political and cultural circumstances. Whilst I firmly believe that a good reproductive health policy would seek to ensure that information about such services and the services themselves should be widely accessible, the problems lie in the implementation of policies designed by remote planners vis-à-vis methods of local provision and in the implementation of contesting policies (for example population control mandates for economic concerns), both of which can undermine the basic inherent tenets espoused almost universally in reproductive health agendas: the right to information about, and access to, services and the right to make an informed choice to contracept or not and which method to choose.

Methodology

I collected data for this research in Los Altos over a period of 18 months employing various techniques in an effort to understand the cultural, socio-economic and political dynamics of the area and how these might impinge upon the provision of family planning services. Using methods of multiple data collection the idea was not to present a static time frame picture of provision of services but an interpretation of both macro and micro variables as they impinge upon health practices and how these compare with policy intentions.

This is a departure from traditional anthropology in a number of ways. Firstly, in focusing on a region rather than a smaller demographic area such as a town or a village, the research is outside the mould which finds anthropologists living in small, bounded communities. Secondly, in attempting to bring the macro and micro aspects together [cf. Ortner, 1984], the research becomes infused with a political-economy approach which I believe is necessary for any anthropological research on policy and practice. Thirdly, although the use of anthropologists in policy planning by government agencies and NGOs has become popular in recent years, there is little evidence of such work on policy and practice as such in the public academic domain of anthropology, with Justice [1986] and the recent works of Shore and Wright [1997] being major exceptions. Fourthly, whilst anthropologists have looked at new reproductive technologies, (notably Marilyn Strathearn, 1991), there is scant evidence of anthropologists tackling contraceptive issues although a few PhD and Masters theses have addressed the topic.

Whilst recognising the contributions that anthropology has made to development theory and practice, and noting the consequent strategic moves between top-down policy, through integrative approaches, to participatory approaches and the “people first” agenda [see, for example, Chambers, 1983; Cernea, 1991; Gardner and Lewis, 1996] with a current focus on empowerment, there seems to be little work on institutional effects on the wider intentions of these approaches. Despite people-oriented approaches in development anthropology it seems to be depressingly the case, at least concerning family planning policy, that planners continue to formulate policy in a top-down manner rather than taking on any of the social development methodology which would point to social/cultural assessments of the target areas prior to policy formulation or implementation [cf. Rew, 1996].

Another departure from traditional anthropology is the structure of this thesis. Because it deals with policy issues and the political economy the traditional ethnography has been eschewed in favour of an approach which attempts to incorporate and explain the ethnographic features within the context of policy and

political economy issues. The case-study which is my research in Los Altos is the basis upon which to question and interpret macro and micro variables.

Macro to micro interpretations

Unlike Justice [1986] I did not have recourse to the kind of funding which would have allowed me to gain direct access to the personnel of international organisations involved in the formulation of family planning policy, such as the WHO and UNFPA. Likewise, being situated in remote Chiapas left few possibilities of access to national level members of the health bureaucracies, though I communicated by fax with personnel in Mexico City in order to gain permission to carry out research amongst government health organisations. Such high level contact would undoubtedly have benefited my research by providing me with some insightful interview and anecdotal material on the experiences and attitudes of national and international planners. Because of the aforementioned constraints I made use of the primary source materials available at national Mexican and international level on the theme of reproductive health and family planning. This included a review of Mexican policy papers laying out plans on a national and regional level, focusing on those papers directly related to policy for Chiapas. This primary material was supplemented by secondary source material on the family planning/reproductive health/population control debate and included a consideration of material on informed choice and consent.

From these materials I laid out the macro research agenda (Part I) from which perspective I want to consider the application of policy in practice at a local (micro) level in Chiapas (Part III). It is important to understand something of the population/family planning debate in a historical sense leading up to the present international consensus (at least as far as the Beijing and Cairo conferences are able to attest) on a theory of reproductive health which seeks to incorporate the population control argument through addressing issues of sustained development. However, for the purposes of this research one of the most important issues to consider is the ubiquitous policy emphasis on the individual: in this case the tenet of

individual informed choice with regard to family planning and reproductive health services. Whilst few would quibble with the idea of informed choice as a worthy goal, or that people should have full access to information on family planning services and a wide range of methods available to them in order to make an informed choice, I wanted to understand how this policy tenet operated at a grass-roots level. To do this I considered these wider national and international policy prescriptions, and their application and meaning, in highland Chiapas.

In Part 1 I will look at how the concept of informed choice in family planning and the rationale for family planning programmes is formulated at international and national (Mexican) levels under a reproductive health agenda, and how this ties in with economic goals and the process of globalisation. In discussing the agendas of the population control and reproductive health rights lobbies respectively I will argue that despite the rapprochement between the two groups put forward under a new banner of sustainable development, notably at the International Conference on Population and Development, the relationship remains strained due to a fundamental incompatibility between their core concerns: controlling population growth and promoting freedom of choice and reproductive health rights.

In Part 2 I will discuss the research setting and methodology in order to provide a view of the area which will illustrate the relationship between the local culture and the state in Los Altos. This is important in order to show how local conditions are a crucial factor in creating appropriate policy and sensitive service provision; and also to illustrate the difficulties in providing health services (and carrying out research) in a conflict zone.

Part 3 will focus on the local ethnographic data which is the basis of my research. Here I am concerned with how providers implement policy and how they may be constrained by local conditions with which many are unfamiliar, being *pasantes*² or doctors from other areas of Mexico. I also discuss the intended recipients of family planning policy, who are in fact targeted in a way which illustrates the aggressive nature of policy in the area: the compliance of the targets (the local people, particularly women) with policy goals is instrumental to population

control policy but leaves a lot to be desired concerning the goals of reproductive health based on informed choice. What I hope to show in this section is that a policy which does not take local conditions into account is not only likely to fail but may undermine the purported intention: for example, to make family planning services more available and acceptable. Cynically, when discussed in relation to population goals, one wonders whether or not adopting the rhetoric of the reproductive health lobby is simply an expression of political acumen in using the semblance of a rights-based policy to promote a less popular population control policy.

I became interested in aspects of informed choice in reproductive health policies when considering the problems of choice and consent inherent in the use of long-acting hormonal contraceptives [Thompson, 1996]. Provider abuse of Depo-Provera and Norplant is well documented [see, for example, Mintzes, Hardon and Hanhard, 1993] and it was my interest in studying both provider and client experiences with Norplant that led me to Los Altos. As it turned out, Norplant was not introduced in Los Altos during the period I had expected, though it was on trial in Tuxtla Gutiérrez, the state capital. However, after discussions with Drs David Halperin and Héctor Ochoa, respectively heads of the Health and Population Division and Epidemiology at ECOSUR, who pointed out the scope for research on family planning policies and practices in the area, I decided to turn my attention to contraceptive use in general. Chiapas, and in particular Los Altos, is characterised by high population growth levels, and concomitant pressure on land resources [cf. Vogt, 1990:51 & 139; Gossen 1989:228 and 1974:3], which have attracted much interest from the international reproductive health forum in general regarding family planning and population issues. The concern of the Mexican government is evident in a policy which seeks to reduce these population growth levels and implement related policies in their quest for modernisation in this area.

My research agenda thus became a consideration of reproductive health policy and its tenet of informed choice within the context of an area where family planning services are prioritised by national and local planners, where despite heavy promotion of family planning services the uptake remains low, and where the local culture is marginalised in relation to the larger state of Mexico. As an anthropologist

interested in health and development issues and the role of the anthropologist within these spheres, I particularly wanted to look at underlying factors to which local resistance to contraceptive use might be attributed. Researching attitudes towards contraceptives and contraceptive use at the local level, and also at relations between service providers and intended recipients, became my research goal within the social, cultural, economic and political context of Los Altos. My intention was to try to understand the context of service provision and the existence or extent of informed choice and reproductive rights at the local level in relation to national policy edicts. Given current international policy makers' demands for anthropologists as intermediaries in the local, national, and global triad of policy and planning, it is my hope that this case study, as well as providing ethnographic detail on contraceptive provision use and non-use in Los Altos, will offer some insight into how the gap between policy makers and intended recipients may be bridged [cf. Grillo, 1997:25], and raise questions about the effects of the globalisation of social policy. In doing so it is necessary to consider Apthorpe's contention that such gaps are not voids but spaces full of "moral practices" and competing conceptions [1997:21].

¹ At least in any positive way, though the "problems" of an indigenous population are often referred to at the local level.

² Trainee doctors in their penultimate year of training

PART I

REPRODUCTIVE HEALTH, POPULATION POLICY AND INFORMED CHOICE: THE INTERNATIONAL RESEARCH AGENDA

Chapter 1

Family Planning and the Individual: Rights, Needs and Informed Choice

Informed choice in family planning policy making is central to the consensus formulated at Cairo [United Nations 1994a, 1994b; Harcourt, 1997:8] on reproductive health and population policy. It also remains a guiding principle of those who eschew this consensus and continue to work as women's health activists apart. The language of informed choice signifies that people (women in particular) should have the right to use or not use a contraceptive method, and to make that decision for themselves in the light of all available information about the various methods on offer and any risk factors involved. It assumes that no pressure or coercion should be used to make women become family planning acceptors. The concept of informed choice in family planning thus impinges directly upon the individual as does the enshrining of family planning as a human right within United Nations directives.

An underlying concept is that of *informed consent* spawned from the same concern about individual self-determination resting upon autonomy and responsibility [Faden and Beauchamp, 1986:7]. In fact, informed choice relies upon informed consent. Theoretically the latter must exist first though the exercise of it relates to two basic choices: to give consent or to withhold it. With regard to family planning, once the choice has been exercised to use a contraceptive method an individual must have information about several methods in order to make an informed choice [Rutenberg *et al.*, 1991:33]. The availability of information, the way in which it is presented and by whom are all factors which affect the ability to exercise an informed choice and are also pertinent to how it might be judged whether or not an individual may have truly made an informed decision. This is something I will take up in the cultural context of family planning provision in Chiapas but which I want to set out generally here.

In terms of the ways in which contraceptive methods might affect the body it is important to note that contraceptive acceptors are not making a choice about the treatment of an illness but a decision about their fertility. However, they generally do so in a medicalised space [cf. Kaufert & O'Neal, 1993:50]. In exercising a choice to use an invasive or systemic form of contraception¹ individuals, who are well [cf. Russell, 1984:80], are also exercising their choice within a context of perceived risks which might include risk of unwanted pregnancy; risk of ill-health due to pregnancy; health risk to the new-born or to other children as a result of the arrival of the new-born [cf. Backett *et al.*, 1984] and risk of medical side-effects from contraceptive methods [cf. Boyle, 1991]. These are all risks which are in the domain of development policy making.

Other kinds of risk which affect the likelihood of informed choice include whether or not the individual fully understands the contraceptive information given to her, which must account for being told not only that there are 'x' number of methods available, but also whether or not she can trust the provider to know of all the associated biomedical risks and whether such information has been imparted to her in a way she can understand it and act upon it. Failure on the part of the provider to disclose information undermines the whole decision-making process. Respect for autonomy is one of the critical tenets of informed consent leading to the right to make independent choices [Faden *et al.*, 1986:8]: failure to disclose information by an agent in a more powerful position, with the intention of promoting his or her own preferences, effectively undermines the autonomy of the individual and her ability to make a choice. For example, women in Chile who agreed to be sterilised with quinacrine were not informed that quinacrine sterilisation is classified as investigational, with unresolved safety questions, rather than procedural [Shallat, 1995:145], and cannot be said to have made an informed choice. (See also Berer, 1995.) In Chiapas a major problem is that within this mestizo-indigenous society health providers are monolingual Spanish speakers. A large proportion of intended health service recipients are monolingual Mayan speakers. I have observed the inability of providers and individuals in Los Altos to understand each other's language. This is a huge barrier to ensuring that individuals can make informed

decisions about contraceptive use within an often alien biomedical narrative in a foreign language imparted within a highly medicalised space.

There are other sets of risk factors which may affect the decision to contracept or not. I refer to cultural or social risk factors associated with using family planning services. Sobo points out conflicts arising in relationships (between couples and extended family) where contraceptive use has been associated with female promiscuity [1993 a&b; cf. Molyneux, 1988:118-9]. From my own fieldwork in Chiapas I was aware of situations where some women would chose to use fertility regulation² rather than modern methods of contraception for any number of reasons. These included the reluctance of some women to undergo gynaecological examinations necessary for some modern methods, and perceived risks of modern methods which lie outside of biomedical risk definitions such as female sterilisation weakening the body, or hormonal pills forming large balls of blood or other matter within the womb. It was also apparent for a variety of reasons that some men did not wish their partners to use contraceptives. To do so in defiance of a male partner also constituted a risk. Moreover some community groups did not want contraceptive services provided by the government due to perceptions of the political conflict in the area.

Informed consent and choice cannot simply result from an imparting of information from a provider to a user, especially where knowledge systems vary. We also have to understand how providers and users interact with their separate or overlapping knowledge systems, and the attitude that providers take in these situations where a balance of power often lies in their favour, to assess whether or not informed choice can be seen to work. As Faden *et al.* [1988] point out there are many problems concerning the extent to which informed consent occurs, such as how to assess the extent of any manipulation, persuasion and coercion; judgements of competence and ability to understand; and a consideration of the ideology of paternalism.

It is worth remembering that we are considering a concept, informed choice, which dominates the transnational reproductive health arena yet impinges upon

individuals far removed from the dizzy heights of this powerful lobby. Justice [1989] outlines not only the structural aspects of bureaucracies delivering top-down formulations but also the cultural aspects which vary widely between a bureaucratic culture seen by her as self-justifying and self-perpetuating in a manner that overlooks the socio-cultural conditions of the policy targets, thus widening the existing gulf between the planners and the people. I believe that language forms part of this bureaucratic culture, creating concepts and ideas in a rhetoric far removed from the understanding of the people at whom policies are aimed. As Rivera points out, informed choice and informed consent are still new concepts in some developing countries and their role and importance in research involving human subjects requires special attention [1993:58]. For me, the important thing is to consider the ideological trappings of this concept, how it is packaged as policy rhetoric, and how it is perceived at the local level where the policy ideals are supposed to penetrate. Informed choice and informed consent are integral components of family planning/reproductive health policies but how are these components understood at the local level, if at all? Family planning/reproductive health programmes are generally presented within the context of wider preventative health policies but there is no guarantee that people targeted by the policies will accept them unconditionally. In fact, as Justice points out, people may pick and choose depending on availability, convenience and local custom, observing that in Nepal people were happy to use curative medicines whereas they did not really understand the concept of preventative medicine [Justice, 1989:97]. People may then resist and challenge the practicalities of a policy mandate, i.e. the actual provision of a service, or they may incorporate and accept it.

Much will depend on people's understanding of what a particular service is intended for and to some extent how the practicalities fit in with local cultural expedients. In Los Altos the extensive practice of menstrual regulation, using traditional methods and even adapting modern contraceptive methods for this purpose in urban areas, indicates that post-coital contraception could be an avenue of investigation for policy makers to complement existing modern methods. I will discuss this further in Part III. Moreover, a policy may result in unintended consequences. For example, in countries where women have few rights and little

autonomy it is possible that transnational family planning directives may oppress women further by giving them additional burdens. This would be opposite to intended results which suggest hitherto unavailable freedoms (brought about by the ability to limit family size), as suggested within empowerment strategies which seek to challenge women to question their places within local and national contexts [cf. Calabrini & Vaccaro, 1997; Seidel and Vidal, 1997; Kabeer, 1995; Grillo and Stirrat, 1997; Gardner and Lewis, 1996].

How a service is provided and by whom is also an extremely important factor in the context of rural south-eastern Mexico. Relations between service providers and target groups is a fruitful area of research, in my experience, to understand the success/failure ratios of policy mandates, as are the constraints faced by service providers themselves in understanding and implementing these mandates. Whether or not policy makers view this as a serious issue is open to doubt, as will be discussed during the course of this thesis. Moreover, it is an area where policy formulation would be hard pressed to find a neat solution. For example, given a situation of wide socio-cultural differences and the inherent prejudices this implies, asking providers to implement policies with cultural sensitivity may be difficult on two levels: firstly, the policy mandate may not have accounted for the differences because the policy makers simply did not have enough knowledge about them, leaving the provider in a no-win situation if the policy itself is culturally insensitive; secondly, it is difficult to see how policy can overcome prejudice and distrust. The latter is something which needs more attention and can only begin to be tackled if policy makers have enough information about any given local situation to begin to perceive the problem, an area where anthropologists are well equipped to provide an input.

Inasmuch as factors such as top-down policies, local understanding of service provision and provider attitudes, prevail upon the concept of informed choice at a practical, local level, the ideology of the autonomous individual [Faden *et al.*, 1986; Turner, 1996] is another important factor. The ideology of the individual with individual power and autonomy is a wide reaching concept which hides the reality of life for many people. Choice is not only constrained by an individual's material circumstances (Hobson's choice being hardly a choice at all) but also by gender,

tradition and local custom, and power [cf. Seal, 1990:86]. At the Cairo conference poverty was marked out as a constraint of choice to be overcome by economic development, and education the desired means of overcoming any cultural obstacles by raising women to the empowered status of individuals [Nafis Sadik in United Nations, 1994b:32]. This is incredibly simplistic and fails to address problems of impoverished men (also largely left out of the family planning equation), or indeed impoverished communities. Poverty is also treated as a non-negotiable given though within development theory it is recognised to be open to socio-cultural interpretations dependent on space and time [Rahnema, 1992:159-161].

For many societies the individual is not the marker of reproduction for that society, whether social or literal, but rather a component in a larger process - the wheel in the cog concept. As Jongmans describes it in his study of family planning in Tunisia the "*individual is not entitled to decide independently to regulate the number of his children with modern contraceptives*" [1974:46-7; my emphasis]. In Tunisia women must discuss the pros and cons with each other, coming to decisions which will not ostracise them or mark them out in the community. Jongmans criticises family planning studies which focus on individuals, failing to take into account the wider social context [*ibid*:33].

In Chiapas, rural communities are likewise not based on individual priorities though neither do they operate according to some egalitarian ideal. There are complicated processes which mark out the local political situations in which people vote upon community issues. In some communities women are allowed to vote, in others they are not. Even where they are allowed to vote they are still likely to be influenced by the male members of their family. Increasingly, in the municipal centres, though age is still respected in terms of cargo holding positions, those who have power are families with resources: land, local transport facilities, money, the soft-drinks and/or beer contracts. These processes have been well documented by anthropologists [cf. (amongst the many) Arias, 1991; Bricker and Gossen, 1989; Collier, 1975; Esponda Jimeno, 1994; Korsbaek, 1992; Nash 1970; Pineda Sanchez, 1993; Pozas Arciniegas, 1962. Vogt, 1990]. I cannot discuss them here but I want to

contend that this is a society where community values are fostered through the socio-cultural set up in a way which tends to exclude individualistic utilitarian values. For example, in Chiapas it is recognised in rural areas that most women need their husband's consent to use family planning methods but that mothers and mothers-in-law are also often involved in such decisions. Local perceptions about family planning services are informed by a number of issues: ideas about why the government is interested in offering such services in their areas; the meaning of family and children; the roles of men and women in the community; and local beliefs regarding the causes and symptoms of illnesses and the perception of contraceptive secondary effects with regard to this.

Individualism is no less a vague concept in the poor urban areas of San Cristóbal. There has long been a sizeable indigenous presence in the town and more recently indigenous groups had invaded land to set up rural-urban communities on the outskirts of the city. They brought their rural community-oriented values and practices with them, though how these will be mediated over time remains to be seen. Where poor barrios exist which more properly belong to the established city, whether occupied by indigenous or mestizo people, they may appear to be less obviously a unit on the surface, but behavioural values also permeate this sector and control is facilitated to a large extent through the use of gossip. Here *individuals* needed moral authority for their actions through the acceptance, persuasion and coercion of the larger group. It is clear from listening to women talking about contraceptive use and fertility that peer pressure and practice is as important to contraceptive use as to general pronouncements on acceptable social behaviour.

There are many factors to consider in assessing whether and how women may make informed decisions to use contraception or not [cf. Sobo and Russell, 1997:126]. Even where the choice has been made, informed or not, to use contraceptive methods, then a second level of questions is raised relating to the ability of the individual to make a choice at the point where the provider and the user discuss which method the woman will choose. I have argued above that these might be culturally dependent for the woman concerned. In fact for some women in Chiapas it is the male partners who decide not only whether women should contracept but

also when they do, and which method to use. Rakusen, in discussing the politics of birth control, points out provider constraints for an individual attempting to make an informed choice about contraceptive methods. She argues that the range of choices open to women is very much governed by commercial and/or population control interests, and the prejudices of on-site providers [1981:96]. She further points out that the information received by contraceptive providers generally comes from these larger interest groups who tend to weigh the balance in favour of drugs thus positively influencing the promotion of the contraceptives concerned. She concludes by warning that promotion of informed choice as a goal by these agencies should be considered with this basic imbalance in mind. Policy edicts may also suggest a provider preference which potentially undermines individual choice. In Chiapas, amongst government health providers, there is a clear preference for the IUD because it is a long-term method requiring minimal compliance after insertion whereas the pill and monthly injectables are less favoured because they require frequent returns to the clinic.

If provider preference might constitute one constraint upon the ability of an individual to make an informed choice, the provider's knowledge may provide another. Professionals may disagree on the safety of a systemic contraceptive as witnessed by the long-running battle over links with breast cancer in young women and the use of Depo Provera. This concern is assumed refuted by the US Food and Drugs Agency's eventual licensing of Depo Provera, and yet a reproductive biologist involved in the debate insists that the danger is extant [Stone, 1992:1754]. Clearly the burden of proof and the balance of risk is still open to interpretation.

When reproductive biologists cannot agree over issues of safety and risk, what hope have ordinary doctors of fully understanding, or having the time to study, all of the factors involved? What social or cultural factors will lead doctors to side with one interpretation or another regarding safety and risk? What hope, or impetus, have the on-site providers then of trying to explain this to a man or woman who has little if any education, who may speak another language, who may rely on a translation through a medium similarly lacking in basic education and whose second language is that of the provider, and who may have a belief system which does not

account for what they are being told? This illustrates many reasons why providers may be economical with disclosure of information [cf. Faden *et al.*, 1986 and Porter, 1990]. It also illustrates Rakusen's point that even given the fullest possible information most of us, despite levels of education, would be totally ill-equipped to use it to make an informed decision [1981:97]. In Chiapas, these are very real constraints. In addition to the imbalance of medicalised knowledge between the potential contraceptive user and the provider, matters are further complicated by the extensive use of trainee doctors or *pasantes* in Los Altos who are not necessarily completely au fait with contraceptive side-effects and contraindications as well as often having to negotiate such issues with the potential user through a translator.

Ultimately, the concept of informed choice is very complicated. The moral impetus for, and the professional kudos accruing to it, makes its promotion a very worthy goal. One of my misgivings is that it has the potential to become a panacea for all ills, relieving the transnational reproductive health organisations of the social responsibility that is part of their chosen remit. I believe it passes such social responsibility into the realms of individual responsibility, which is a problem in areas where people have little social, economic or political power accruing to themselves as individuals, and where the reality of informed choices is unlikely to exist except in the corporate imagination of the family planning promoters. Further, raising the tenet of informed choice in contraceptive decision-making to some mythical altruistic level may imbue it with the potential to depoliticise the on-going debate about population control and family planning by apparently leaving the individual to shoulder the responsibility when in fact the individual is ill-equipped to do so, leaving reproduction far removed from its wider social context [cf. Morsy, 1993:106]. This is one of the reasons why some women's health activists doubt the apparent transnational consensus on family planning and population growth reached at the Cairo conference. It also ties in with Jongman's assertion that fertility behaviour should be studied within the total social and cultural context [1974:33-4].

In considering the social context of family planning the issue of rights is equally important. The concept of informed choice is, after all, based on the premise of an initial right to, and the provision of, family planning services. But where do

these rights come from? I do not want to dwell here on the long western philosophical tradition and history of rights and the individual, well documented elsewhere, but rather to contextualise the issue in the present. The 20th century drive for modernisation resulting in increasing market globalisation has created increasing internationalisation of economic and development policies, including social and welfare policies, and one result of this has been the globalisation of a rights agenda. This agenda assumes a universalisation of human rights, but how do we define these and who decides what they are? The UK government definition of human rights as a general point of illustration is typical of the international rights agenda:

“all those rights essential for human survival, physical security, liberty and development in dignity. They stem from the recognition of the inherent equality and dignity of all human beings. All States have committed themselves to respect, protect and realise human rights, both in a number of international treaties, and through a series of recent UN conferences.” [UK Government White Paper on International Development, 1997:17]

Within such a general guide to rights, reproductive health and family planning rights have been ensconced as inalienable. Taken by themselves, without the existence of other rights as detailed in the White Paper, family planning/reproductive health rights may be rendered meaningless, if not a coercive tool of the state which presents an oppressive policy as a charade of rights. To bring in the highly politicised social context of the state of Chiapas, where there is a low intensity war being fought over such indigenous rights as land tenure and free elections, family planning is not considered to be an immediate concern amongst the indigenous population.

Whereas the government strongly promotes reproductive health rights through specific policies, rights to those things which sustain life and allow indigenous communities to reproduce themselves are lacking and often eroded by socio-economic policy. For example, Mexico's recent membership of NAFTA has had some dire consequences for the rural poor in Mexico, particularly in Chiapas [Rich, 1997] where land privatisation has exacerbated the ever-present land problem. On the one hand economic policy deprives some Mexicans of rights deemed important at an international level to which Mexico subscribes. On the other, the State itself (or powerful members of it) can be the instrument of oppression which undermines such seemingly fundamental rights as the right to physical safety.

Clearly rights are open to interpretation. Though human rights are said to be universal, I believe that there can be no universal hierarchy of rights because the need and desire for some rights will be greater in some areas than others. This may seem obvious but given the blanket rhetoric which policy papers so often divulge, an alien studying earth from the perspective of such papers might be forgiven for thinking that we had organised our world in such a way as to benefit the greater good of the majority of the people whose rights were the pinnacle of our global society. On landing upon earth the alien might be bemused to discover that policy on rights is more of an effort to maintain political stability and eschew the worst consequences of the morally destitute global market which concurrent policies continue to fervently pursue. As an alien arriving in Chiapas I discovered in the course of time that reproductive rights was both a highly political issue that might be acclaimed or denigrated depending upon one's position in the region, and an issue negotiated through the culture and ethnicity of the region which was to prove much harder to understand and interpret. However, as Gardner and Lewis argue, "anthropology is a way of looking at social realities, of looking behind apparently simple situations" [1996:160] which can be valuable to policy makers and prospective recipients, and may help to unpick the contradictions and expose deficiencies in policy mandates. It is a contribution I hope to make in the context of Los Altos though one made whilst being mindful of arguments within anthropology relating to power and knowledge with regard to who is speaking for whom, who hears, and with what effect. In seeking to give a voice to the weak or oppressed anthropologists need to be mindful of the basis of their claim to authority in a local context and moreover not to denigrate local customs and values with over-riding assumptions that marginalised societies have nothing to redeem them and are characterised only by the misery of poverty, to paraphrase Escobar [1992:136-7].

Throughout the thesis the issue of rights and the tenet of informed choice will be significant, especially considering the government's stated commitment to reproductive rights in a local context, Los Altos, which is marked out by ethnic tension, cultural diversity (including the significance of child-bearing), gross inequities, and explicit indigenous fears that the government's family planning policy

is a genocidal instrument. The meaning of reproductive health rights will be considered through an interpretation of policy, behaviour and attitudes of the local players. These interpretations will, of course, be my own and apart from offering some insight into the Mexican government's reproductive health policy in the context of Chiapas I hope also to contribute something to the theory of development anthropology. For anthropologists working in policy and development the issue of rights dominates much of the rhetoric in policies formulated to extend rights yet within the public domain of anthropology there is little direct criticism of the subject. On the other hand, from the perspective of ethnicity as a politicisation of culture [cf. Wright, 1998] the issue of rights has been more profoundly addressed owing to the highly politicised sphere in which ethnicity is addressed, and where rights are generally demanded rather than extended. Nash [1996:20], for example, discusses such rights discourse in relation to the conflict in Chiapas. This brings me to another important point in relation to the discipline of anthropology: we should be asking questions about what rights are, who decides and for whom, what is the significance of rights politically and within the development agenda. Crucially we should be asking what rights are to different people in different social contexts and how the imposition of policies which claim to extend rights affects societies and processes of change, especially where the rights which might be demanded do not cohere with those extended by dominating policies. I cannot hope to give any definitive answers but through looking at a particular ethnographic example I may offer locally specific interpretations in answer to some of these key questions.

To put these questions into a global context, before considering the national and local aspects of policy in Mexico, I want to turn now to look at international policy and consider the rationale behind family planning/reproductive health programmes. These programmes are formulated on national and international levels as a part of wider social and economic development programmes, which consider social ills such as poverty and illness as a deterrent to economic development.

¹ An invasive contraception would be any method which involved insertion into the body such as an intra-uterine device (IUD); a systemic contraceptive is any hormonal based contraceptive which works upon the body's system such as the contraceptive pill, hormonal injections or implants. Some methods may be both i.e. implants and hormone-releasing IUDs.

²Fertility regulation in this context refers to the traditional use of herbs to bring on menstruation especially where it is known that the menstrual period is overdue.

Chapter 2

From Birth Control, Through Family Planning to Reproductive Health: Shifting Paradigms or Political Acumen?

The population of the developing countries was about 4,086 million in 1990 and will increase to about 5,000 million in the year 2,000 ... In order to keep population growth to no more than 900 million persons during the decade, however, there must be a modest increase in contraceptive prevalence from about 51% to 59% [Mauldin 1991:1373].

Fertility regulation is different from population policy. Women in the Philippines need fertility regulation. They do not need people who tell them that our country's poverty is due to their fertility. In our culture women do the real everyday work to keep the country going. We completely reject a population policy that would make women scapegoats for poverty brought about by the unequal distribution of wealth, a subservient economic policy and a gross disregard for the human rights of the people in our country [Estrada-Claudio in Mintzes, 1992:46].

Population growth is one of the most serious obstacles to world prosperity and sustainable development. We may soon be facing new famine, mass migration, destabilization and even armed struggle as peoples compete for ever more scarce land and water resources [Gro Harlem Brundtland, United Nations, 1994b:20].

These views on views on family planning policy illustrate the dominating discourses of the past 40 years in the international reproductive health arena. I want to consider how they affect national family planning programmes in developing countries. International agencies concerned with development in general and family planning in particular such as the World Bank, the IMF, UNFPA, WHO, governmental and non-governmental organisations (NGOs) all focus their attentions on women in developing countries. *Developed* countries rarely have such cogent family planning policies, a point which reflects the post second world war drive to modernise the developing world, and which relies heavily on economic development planning and intervention on the part of powerful international entities. As the rhetoric of family planning policies has changed since the 1950s from an emphasis on controlling population growth to a prioritisation of individual rights within family planning, so too has there been a shift in development policies which now emphasise social as well as economic development with the alleviation of poverty, at least in theory, an integral part of their rationale. The change in family planning rhetoric reflects this general development shift away from wholesale prescriptive directives to a participatory approach.

Modernisation: An Enduring Goal

Three main phases of policy change in development and family planning, and the early stages of a fourth, may be identified over the past fifty years. Firstly, after the Second World War the emphasis was on modernisation with economic growth seen as the primary goal. Any alleviation of poverty was to be left to the *trickle-down effect* which would allow the successes of large-scale urban infrastructure programmes to trickle down the social scale to help society's poorest or most marginalised peoples. During this time population growth and overpopulation was considered to be one of the ills of underdeveloped and primitive societies which would thwart the possibility of modernisation. Apart from sheer numbers affecting governmental gross national product (GNP) levels, large rural populations in developing countries directly confronted the modernist technological drive. As Boutrous-Ghali pointed out in 1994 this issue remains vital for those concerned with overpopulation: *"how can we adhere to the demand for social progress envisaged in the Charter [of the ICPD¹] when every day, 377,000 new human beings are born, mostly in the developing regions and, in many cases, in circumstances of intolerable hardship and poverty?"* [United Nations, 1994b:6]

Vociferously promoting population growth control is seen as one of the main tools for achieving economic targets. These policies came to be criticised because of the failure of economic growth models to achieve their predictions [Cernea, 1991:1], and for the failure of the trickle-down theory to alleviate poverty at the base [Tacconi & Tisdell, 1992:268]. A backlash against wide-reaching population targets emerged from developing country planners who accused organisations such as the UNFPA and the IMF of imperialism at the UN World Population Conference in Bucharest. These factors, together with the influence of women's health activists, led to a shift in family planning policy [Hofsten, 1980:214-217; Whelan, 1992:8-9; Information Project for Africa:1995, 66-7], which was also a reflection of changing development policies generally.

The apparent failure of economic growth models and the general neglect of rural development led, in the 1970s, to the ideal that poverty should be directly tackled with programmes which targeted specific groups. After Bucharest the rhetoric of population growth control gave way to the more egalitarian language of family planning as developing countries became dissatisfied with outside pressure to implement these population goals. The focus shifted to considering women as recipients who could benefit from the use of family planning in health and economic terms on an individual and community level whilst at the same time hoping that an ensuing reduction in fertility could have a positive effect in reducing population growth. Family planning became integrated with broader development initiatives, marking a second phase of development and population/family planning policies.

By the late 1970s/early 1980s a third shift became apparent in the move to implement family planning through primary health care policies. Justice outlines the rationale for this shift in terms of the limited success of top-down policy making which “overlooked the cultural context of childbearing [and the] indications ... that decreases in population growth are linked not only to family planning programmes but more significantly to social, economic and political changes, and higher literacy rates, improved status of women, improved access to health and education services, lower unemployment and income leveling.” [Justice, 1986:51; cf. Dyson, 1975:25.] This shift to primary health care strategies incorporated the idea that development initiatives depended on community participation [Justice, 1986:59]. This led to the discourse on empowerment embedded in development models which by the late 1980s envisioned “a form of developmental change brought about by local problem-solving efforts and techniques” [Gardner and Lewis, 1996:116]. The problem is that it is difficult, if not impossible, to see where such theories have been applied to family planning policy and practice. Simply bringing in local health promoters has not yet been shown to empower or offer a more participative process for women in Chiapas, and continuing government preoccupation with population goals further removes this possibility.

Now, in the latter half of the 1990s, development theory is still very concerned with the idea of grass-roots participation in project development with the

international policy forum very much fixed on eliminating or reducing poverty in poorer regions of the globe [cf. UK Department for International Development, 1997]. Today, social development within local cultural norms and consciousness about environmentally sustainable development are very much to the fore and perhaps we are entering a fourth phase of family planning/reproductive health policy as environmental issues become more dominant and population control issues gain a new respectability.

This changing emphasis from prescriptive to adaptive rhetoric in development and family planning since the Second World War did not come about simply as a result of perceived failures in the modernisation model. On the contrary, this model still holds on an economic level as a means of pursuing growth, though it is now under attack by a paradigm shift which argues for sustainable livelihoods to alleviate poverty. These do not depend upon economic growth *per se*.² The more subtle change, involving adapting to local patterns and encouraging participation as well as recognition of human rights, was wrought by the conflicting voices in development and family planning debates. Women's health activists have been and are involved in a concurrent struggle for women's rights and needs to be addressed within the development environment; indigenous and community struggles also bear witness to issues of consultation, participation, cultural identities and rights. Policy prescriptions affect different people in different ways and within competing political processes these are noted and pronounced upon depending on the vast array of views between economic determinants, social justice and environmental concerns.

Anthropologists are practically and theoretically concerned with these complicated processes of development [cf. Abram, 1998] though our concern with family planning *per se* has been less obvious. Issues within anthropology which heavily impinge upon development include discourses on ethnicity, culture, social adaptation, community participation and human rights. In discussing reproductive health rights as an integral component of development policy, I follow Petchesky [1995:153] who says that a paradigm shift has been effected from reproduction and sexual issues which focus on health to one which focuses on human rights.

Inasmuch as this popular rights discourse has made itself heard and had its influence noted, it might also be considered a victim of its own success. The ICPD in Cairo (1994) resulted in an apparent consensus between governments concerned with policy issues and popular movements concerned with rights. Consensus was a visible trend before this date [cf. Whelan, 1992] but was seen to crystallise during that moment perhaps because of the inclusion of NGOs as part of the process at the UN level for the first time. During the post conference analysis period there were conflicting views about the success of the conference with issues raised concerning the cooption of women's health activists and NGOs [Sadik Nafis, 1995]. Those unhappy at the outcome believed that the issue of population control or family planning had not been resolved but rather that the language of popular rights discourses had been hijacked for effect by the controlling interests of the conference.

This debate over rhetoric has been going on for some time. Whilst to some it may seem that population growth issues are returning to the forefront in the guise of environmental sustainability, there are those who would argue that it never really went away. Where population control emphasises fertility decline, family planning emphasises choice and the right to reproductive self-determination. Whelan believes that fertility decline targets continued to dominate the agenda throughout the post-war period though they may have remained hidden under the rhetoric of family planning [Whelan, 1992:9; cf. Mauldin, 1991:1373]. The issue is cloudy because of the synthesis of population concerns and policies promoting economic well-being and health and choice in family size which have been concurrent and enduring facets of policy at national and international levels since the 1970s. However, a review of UNFPA, UNDP and WHO reports [UNDP, 1993] quite clearly points to an ongoing concern with reducing fertility rates particularly in developing countries. The important factor about Cairo in 1994 is, as Betsy Hartmann points out, the legitimisation of population control as a policy tool [1995:131] and, I believe, the extensive use of a rights discourse aimed particularly at women coupled with an agenda for sustainable growth and development.

Despite this apparent consensus, or hegemonic use of rhetoric, one enduring factor of policy making remains: it is still largely a top-down procedure, at least with regard to family planning policy. In that respect, despite continuing institutional emphasis on community participation, little has changed since Justice, writing in the 1980s, referred to the “momentum of international health policy, which inundates local realities as it sweeps downward from policy making circles to planners as part of the bureaucratic culture of international donor agencies” [Justice, 1986:147].

One of the important inferences I want to draw from all of this is that despite apparent paradigm shifts in the way the international arena presents population and development policies the modernisation rationale has not gone away. This is an important consideration when, on a theoretical level, we have to deal with questions about whether or not we now live in a postmodern world. Firstly, it influences the way we can respond to policy making and practice because we have to understand the premises on which decisions are made; secondly, understanding these premises is not a sufficient condition for responding unless we also have some understanding of the power bases which underpin those responsible for decision-making and implementation of such policies.

Despite heavy criticism of modernisation goals relying largely on free market economic models [cf. Wolf, 1982] and a theoretical emphasis on sustainability, we continue to discuss growth within a capitalist political and economic framework as an enduring facet of development and progress. Growth models now take on the mantle of sustainability whether economic or environmental and this has been brought about by the globalisation of the capitalist imperative and concern with both natural and human resources but the real mediating factor in all of this is power, or the lack of it.

Those countries with meagre political power and economic clout on the global stage, i.e. developing countries, are generally the recipients of aid from those with power and resources, unless they fail to support the political and economic goals of the hegemonic, order in which case they may either be ignored, chastised or coerced³. This aid is not some altruistic gift but quite clearly shows an aid for trade exchange which also benefits the donors. Recent UK policy is now trying to place

more emphasis on alleviating poverty and is seen, at least rhetorically, to be forswearing morally suspect aid-trade deals such as the notorious arms, trade and aid fiasco over the building of the Pergau dam in Indonesia. However, an aid for trade play-off is to remain in place. Apart from relieving poverty aid is for encouraging the development of market economies. In one sense there is an inherent possible conflict of interest in this: countries which seek to modernise may be forestalled by agreements with donor countries through protectionist policies which will seek to control the recipient's exports if they have negative effects on the donor's own economic competitiveness and thus economic stability [cf. Schlesinger and Kinzer, 1982, on the US role in Guatemala].

However, the alleviation of poverty remains a central tenet of development policy in general and family planning policies have been seen as a means to this end. The rationale for this is that if women have fewer children they will have better health, less risk of maternal death, and their children will be better cared for and face less risk of death at birth and in infancy. With fewer children there will be more resources to go around to feed, cloth and educate the family in general [cf. Palma Cabrera and Rivera, 1996:154]. In a sense economic well-being becomes a woman's responsibility on two levels: on a macro scale the fewer the children brought into the world the more resources there will be to share. On a micro scale a woman can increase her family's consumption of goods per capita when there are fewer children, and thus alleviate ills of poverty such as malnutrition, and lack of access to education and health. Whilst the Cairo debate referred constantly to sharing scarce resources only one mention is made in this report of the disproportionate consumption of resources by developed countries in comparison to their *over-populated* developing counterparts. President Mubarak of Egypt commented that "*five and a half billion people live on our planet. This number increases by 90 million every year. Three quarters of those people live in the developing countries, whose share of world income is only 15 per cent*" [United Nations, 1994b:11]. Mubarak's point deserves consideration. Moreover, we are also left with the continuing saga of women being targeted with regard to population/family planning programmes in a way which makes them simultaneously responsible for population problems and subject to

blanket international policy which removes them from the social context of their local lives.

Without attempting to offer a critique of capitalist economic theory or development policies per se it is important to make the point that development theory with its integral population and family planning concerns has evolved in a world where economic and political imperatives dominate international and national policy making. If we can no longer refer to the grand narratives as a way of describing the world in which we live, we can at least refer to a world which is dominated by transnational economic and political processes; where the profit motive continues to drive production and investment; and where success may be measured by the influence a country has within the international economic and political arena. Ascendancy within this sphere denotes power to influence, coerce or dictate to those without it, and to threaten and coerce perceived enemies.

Those with power set global agendas: for population, the environment, sustainable economic development and political democracy, all concerns which dominated the Cairo conference in 1994. Chomsky has argued in his thesis on a New World Order that the US is a dominant player in a hegemony underpinned by the IMF, the World Bank and the GATT [1990]. He further argues that these organisations undermine the democratic processes in developing countries which they profess to support, in the interests of their own power base. Chomsky singles out the US as a major hegemonic power which attacks such democratic processes, particularly for its involvement in Central America [*ibid.*]. But the US is not alone. Chomsky perceived a three-fold hegemonic alliance which includes Europe and Japan. He claims to have found documentary evidence which affirms the function of the "Third World" as a source of resources and raw materials, as well as being a market for these three entities, which allows the support of repressive regimes to fulfil the economic functions and needs of the three [*ibid.*].

In essence this theory is not new but has been alluded to before by proponents of dependency theories [cf. Gardner & Lewis, 1996:16-20]. Another way of looking at this domination would be to consider Bourdieu's work on symbolic capital

inferring its equation with credit [1990:133]. Symbolic capital may be seen to hide exploitation and domination by Western hegemonic powers through the transfer of aid. The receiver becomes indebted to the donor, not simply through the incurring of a money debt if the transfer is in the form of a loan, but also through possible requirements of exchange. The much maligned structural adjustment programmes spring to mind whereby the donor institution (e.g. the IMF) has dictated economic and political conditions to the recipient, including the reduction of population growth and modernisation goals, as one of the terms of agreement for aid. Such agencies for aid are at the apex of family planning and population policies, a fact pressed home by President Mubarak of Egypt when he pointed out that major international organisations (mostly United Nations organisations) cooperated with Egypt regarding their population policy [1994b:13].

I find Chomsky's thesis persuasive. Since the fall of communism in Eastern Europe as a competing political and economic system this hegemony may be seen to have greater dominion, chaos now reigning in place of state control, and economic growth following a capitalist model high on the agenda. What we need to consider now is how that hegemony makes itself extant within the transnational processes which shape population and family planning policy. What also needs to be considered though is that the transnational agencies through which Western hegemonic influence may be seen to flow also carry their own internal momentum through their bureaucratic systems. In this I follow Justice [1986] who emphasises the effect of these policies as a top-down imposition through the vast planning mechanisms, and which may be so concerned with their own self-perpetuating bureaucratic concerns that this may forestall the possibility of addressing action in terms of local cultural significance.

We live in a world of asymmetrical global power relations, but one which must be accounted for through the analysis of transnational processes which are not static but fluid and able to change. We can look at population and family planning services as facets of these processes. Whilst international agencies such as the World Bank and the IMF continue to be committed to promoting economic growth as a principle strategy then population growth control will continue to be a major tool of

that strategy. On the other hand a rhetorical shift means that whilst population control remains a principle goal, the focus of achieving this is said to be through focusing on women's or people's rights and needs. Unfortunately, the gap between these institutions and local provision of family planning is so wide that if coercion or undue persuasion is used to implement policy then these institutions can remain aloof and detached from actions which directly assault the rights and needs of the people the policies are supposed to help. The World Bank has not been seen to change its policy of supporting countries where this has happened.⁴

Since the Cairo conference on population and family planning, reproductive health has become a dominant discourse which both supersedes and encompasses family planning imperatives. This is an important point in the context of the fieldwork I carried out in Chiapas. In other chapters I hope to be able to illustrate the gap between the rhetoric and the practice together with some of the problems faced by those responsible for implementing top-down policies but not being a part of the consultancy process. This rhetorical move reflects development concerns with empowerment and needs. On one level, women's health activists have sought to empower women for their own sakes, addressing women as marginalised individuals. For the population lobby the empowerment of women is sought in the context of women as the bearers of children, responsible not only for their children's moral development but also for family planning.

Is there a postmodern-modern dichotomy amongst the various narratives to be found surrounding family planning debates? Perhaps it is possible to see family planning as a *modern* concept with its emphasis on planning (though indeed equally *modern* neo-classical economic theory would eschew this) whilst reproductive health is concerned with a whole host of issues concerning women's health needs, reproduction and empowerment, and in that sense may be considered *postmodern*. A correlating shift could be the respective moves from family planning as a way of improving women's health and economic welfare to reproductive health as a way of considering health, welfare, social and cultural conditions, preferences and needs - a whole array of concerns under the one central theme.

What concerns me about offering a simplistic model within this postmodern-modern debate is the continuing emphasis on the individual, the roots of which are firmly grounded in modernist theory stemming from the meta narrative of Western liberal philosophy which hinges on the paradigm of individual autonomy and responsibility. Whilst there is a fluidity and multivocality between transnational economic and political processes (which includes women's health activists) there is also a definite locus for their attentions: the individual, or more usually the individual woman. What is being addressed is the individual's right to health, education, economic subsistence and fertility determination which is translated into the individual's right to live in a democratic society and to exercise a democratic choice.

My second concern is that after all the postmodernist deconstructing has been done and we have discussed competing realities, critiqued development strategies and assessed power differentials within national and international boundaries, we are left with the fact that many national governments in the world still look to the modernisation model as a goal to be aimed for within their national policy making strategies. Modernisation, situated within the paradigm of modernism and its emphasis on rational behaviour and linear progression, is thus still considered to be a model for attaining economic growth on a national level and becoming a competitor for greater riches on a global level. A case in point, which I will discuss more fully in the next chapter, is that of the Mexican national government. A policy document which seeks to outline the rationale behind their family planning programme states that:

Mexico is living through a process of modernisation on all levels, with the explicit aim of integrating into the global economy from a clear position of competition between equals in the quantity and quality of products and services it puts at the disposal of Mexicans and the international community.
[Dirección General de Planificación Familiar, 1995:7 *trans.*]

The modernisation model also remains explicit in the 1994 Cairo conference amongst all nation-state participants though there were those who expressed concern for the respect of national sovereignty within this forum. So, whilst on an academic

level it might be passé to talk about *developing* countries juxtaposed against the *developed*, and whilst the validity of development as an area of study and practice might be called into question on an ethical level [see Gardiner and Lewis, 1996] we still have to deal on a practical level with the consequences of the practical implementation and dominance of modernisation theories which harbour development per se whether as economic progress or social policy. We cannot completely escape the grand narrative of capitalism because at the very least we have to consider it as one of the theories upon which policy decisions in some cases are taken. However we can analyse the various processes which affect policies and those which are affected by them. We can look at social interaction and interpretations as part of the economic, social or political processes in any given situation [cf. Nash, 1992:290]. This might include considering ethnic identity as a political tool against some perceived threat from a dominant power structure [cf. Hawkins, 1984:99-100; Nash, 1979:121]. It might warrant considering forms of cultural hegemony whereby, for example, on the one hand Taussig would see the result of this as commodity fetishism which annihilates indigenous culture and alienates people from each other [1980:181] whilst Hannerz suggests a more positive outcome that might lead people to new ideas and ways of dealing with their own culture through access to new technological and symbolic resources [Hannerz, 1987:555]. According to Widyantoro women in Indonesia easily adopted Norplant as a contraceptive implant in their arms because it fitted in with the traditional practice of *susuk* in a part of the country where objects are inserted under the skin to enhance beauty [1994:20]. Yet to report this without also noting that Indonesia is known to have a strong pro-family planning programme and that abuses of power amongst family planning providers have been documented⁵ would be to allow only one interpretation of the situation.

As an anecdotal example of “commodity fetishism”, in the context of Chiapas, one commodity which interested me was Coca Cola. Chiapas is probably no different from other remote rural areas in the world where Coca Cola seems able to penetrate to the innermost reaches of the hinterlands despite transport difficulties. In highland areas which lacked basic infrastructure, including roads, electricity and piped water supplies, I saw that these drinks for sale where few other industrially processed goods were available, saving perhaps a few tins of tuna fish and some

packets of plain biscuits or taco chips. I became aware of a number of ways in which attitudes to this soft drink might be interpreted. Firstly, whoever held the Coca Cola contract in a village had access to money and therefore power, and was often the village president himself. Secondly, indigenous people incorporated these soft drinks into ritual. I visited many churches in Los Altos, fascinated by the syncretic religious processes which could be observed, to find that many men and women incorporated soft drinks into their ritual as offerings and as curatives to drive the evil spirits out of their bodies. In a third case the independent hospital run by a religious order (widely believed to be Zapatista sympathisers) exhorted the local population to give up bottled drinks for various reasons in a sign hung over the main entrance:

Nos desnutren	(They give us malnutrition
Nos envician	They give us vices
Nos empobrecen	They impoverish us
Las botellas contaminan	The bottles contaminate.)

In yet another situation the mayor of a rural village sought to ban the sale of alcohol, not for health reasons, but to eliminate competition for his Coca Cola sales. This clearly illustrates how an imported product can become a commodity embedded with various and conflicting symbolic significance. Given that reproductive health and immunisation banners hung along urban streets and in rural ceremonial centres of highland Chiapas frequently carry the logo of Pepsi or Coca Cola one wonders about the possibility of sending out confusing health messages, especially amongst the illiterate population who may recognise the logo of the company and the health service but cannot read the written health promotion.

In another adaptation of a modern commodity it came to my attention that women in San Cristóbal were using the contraceptive injection Depo Provera, bought from pharmacies, to practice menstrual regulation. I will leave a discussion of this until chapter 11, except to say that in this situation, it seems that women are adapting a new commodity to use in the context of a long standing customary practice: menstrual regulation.

Following Chomsky's analysis of a New World Order I would argue that hovering over independent states' powers to act we must also consider the power and rationale of the various transnational entities at work. Equally within the confines of the state there are myriad bureaucratic forces with internal imperatives and goals which exist through interlinking power structures with other sectors of society. We are left then, to unravel the myriad bundle of relationships to increase our understanding of interconnected processes in the world [Wolf, 1982:3] If, as Foucault argues, power is not a linear process but rather that it circulates through a net-like organisation [1986:234] then we can argue that within each dominant power structure at whatever level, there will be contesting positions and that the locus of power may be open to interpretation and change. In an analysis of family planning such organisations would include government health services and NGOs. What ultimately has to be considered is how, given the emphasis on individual rights, this conglomeration of interests affects the individual at the point of delivering family planning services. To do this I have chosen to analyse a central tenet of family planning policy whatever rhetoric it may be couched in: namely *informed choice*.

In the first two chapters I have sought to set out a macro framework in which to consider the tenet of informed choice in family planning through references to power in and of the global political economy. I would like to continue by adding Mexico, as an independent state (though with an ethnically diverse population), to this framework before going on to discuss fieldwork in Chiapas and offering some insight into the provision of family planning services in the Highland region. I hope to demonstrate within this study that both macro and micro approaches in anthropology must be combined to make sense of a global system dominated by transnational processes which has diverse effects at a local level. We need to understand these processes to understand the relationship and interchange between them [cf. Nash, 1992:291]. Historical as well as current processes should be taken into account. Wolf argues that we should reject the model of linear progress mapped out by a history of modernisation in favour of multiple interpretations [1982:12-13, 385] to try to understand how different groups interpret their own past. Moreover we should ask how these interpretations affect representations of their present

[Davis, 1992:19; cf. Rappaport, 1998 and Paerregaard, 1997]. In Chiapas cognition of such historical processes is crucial to understanding mestizo-indigenous relationships, wrought over more than 500 years, which must colour all interpretations of local Chiapaneco life whether of the political economy or the bureaucratic functioning of the nation state within the smaller state of Chiapas, and the claims currently being voiced for self-determination and autonomy amongst the indigenous Maya. Anthropology lends itself well to understandings of world views at a local level which can be analysed in relation to macro processes rather than simply as a smaller dominated part of a greater dominating whole.

¹ International Conference on Population and Development (Cairo, 1994).

² It remains to be seen how far this notion will be reflected in future planning decisions of countries which crave growth to fulfil the requirement of their international debts.

³ Latin American examples of this would be overt US involvement in Cuba (1950s to the present) and Nicaragua, and covert involvement in El Salvador, Guatemala and Chile particularly during the 1970s and 1980s.

⁴ See note 3. Also, the one-child policy in China, which results in the practice of female infanticide, forced sterilisation and late abortion received over \$200 million from the World Bank. [Information Project for Africa:1995:123; cf. Hartmann:1995.]

⁵ The World Bank supports the Indonesian family planning programme which plans around target numbers of users. On-site providers use *safaris* [rounding up large numbers of women] as a means of attaining these target numbers, coercing or bribing village leaders to comply, incorporating police or military personnel where villagers might be reluctant. In 1990 it was alleged that women were forced to have IUDs inserted at gun point after refusing to comply in order to reach local targets. [Hafidz *et al.*, 1995:122-3]

Chapter 3

Mexico, Modernisation and Family Planning Policy

Global ties and national sovereignty

From the revolution in 1910 up to the 1970s Mexico followed a pro-natalist stance [Alba and Potter, 1986:16-17]. However, since the 1970s as Mexico has become increasingly embroiled in the process of economic globalisation, moving from inward investment strategies to promote economic growth to export-led growth, [See Llera, 1991; Barkin *et al.*, 1997; Gereffi and Hempel, 1996], population has become an increasingly important issue. At the UN International Conference on Population held in Mexico City in August 1984 “delegates from 149 countries affirmed that population dynamics are an intrinsic part of the development process and that all people, including adolescents, have a right to family planning information and services” [Wulf and Willson, 1984:228]. Economic globalisation brings with it social policy concerns either to underpin economic imperatives or related to pressing political issues. As such, population and reproductive health policies are international issues though many of the practices seem to rest upon first world nations formulating and financially supporting programmes for underdeveloped countries. At the Mexico City conference the US delegate underlined the US commitment to providing increased funding for population policies [*ibid.*]. Funding is available, of course, for other aspects of development policy but population is prioritised not only within donor country aid packages but also by the World Bank, who pledged in 1984 to double its loans for population and health projects in the following years [*ibid.*:229].

It is not only the World Bank which prioritises population issues. The UNDP has prioritised population control as a means of combating poverty in Latin America [Mexico City Times, 30th March, 1996], whilst the UNFPA was set up specifically to deal with this issue.

Within this equation of promoting population control as a priority variable vis-à-vis economic growth the Mexican government moved to a pro-family planning stance out of the desire to address economic problems [Singh, 1994:217-8;

Merrick, 1985:1-3; United Nations, 1989]. President Echeverría did a u-turn from his position that “to govern is to populate” in 1970, to his programme of “responsible parenthood” in 1973, which allowed for family planning. This was largely a response to the new economic problems the Mexican government faced at the time, seen to be exacerbated by an increasing population [Riding, 1985:233]. The introduction of family planning services overturned the General Population Law of 1947 under which promoting or advertising contraceptives was banned [Singh, 1994:216] and population growth rate positively encouraged through various means amongst which was a national contest giving prizes for the most fecund mothers [*ibid*:217].

By 1977 a National Plan for Family Planning had been established which began to set targets for the population growth rate seeking to reduce it from the 1976 rate of 3.2% to 1.4% by 1994 and to 1% by the year 2000 [Singh, 1994:220; Parra, 1989:48; cf. Potter, Octavio Mojarro and Leopoldo Nuñez, 1987:144-5]. In fact by 1990 the population growth rate was 3.8% but had dropped by 43% from 6.7% in 1960 [International Programs of the Population Reference Bureau, 1992:6]. This decrease in population growth corresponds with an increase in the use of contraceptive methods [cf. Potter *et al.*, 1987:2]: in 1973 around 12% of the population of women in union used a modern contraceptive method; in 1976 this figure was 30% and it continued to rise steadily to 52.7% by 1987 [Palma Cabrera and Morales, 1991:1846-7] and 63.1% by 1992 [INEGI, 1992:26].

Alba and Potter point to Mexico as a “fascinating and polemical study of the relations between population and development” between the 1940s and 1980s [1986: 8-9 *trans.*]. They attribute the accommodation of a rapid population growth (30 million in 30 years, 1940-1970) to agrarian reform between 1920 and 1930 which they say changed the nature of landholding from the *hacienda* system, whereby campesinos worked under oppressive conditions for large landowners, to the formulation of *ejidos* which promoted small scale community exploitation of land. [*ibid*:11]. They also argue that modernisation of the agricultural sector and government support for the industrial sector allowed for this increase in population [*ibid*:13]. However, these major developments did not affect the southern parts of Mexico greatly, particularly Chiapas which has remained poor and marginalised.

With regard to the contemporaneous development of family planning and economic development policies it is interesting to consider Mexico's position and strategies within the global economy. Mexico's economic miracle may have been seen to be failing by the 1970s but the debt crisis of the 1980s further devastated the national economy and Mexico became a country increasingly dependent on international loans, particularly from the US, and was correspondingly keen to be seen as a model country in terms of attracting loans and scheduling their repayment [Browne, 1994:13]. Since the 1980s Mexico has become embroiled in successive agreements with both the IMF and the World Bank which tie it to strict stabilisation agreements including reductions in public expenditure and trade liberalisation [Hansen-Kuhn, 1997:24]. Whilst the latter is inherently destabilising for Mexico's home industries in theory it can provide for economic growth in the medium term through foreign investment. This was substantial after deregulation of the financial sector. However, the current economic instability does not bode well for the immediate future. Meanwhile, Mexico continues to use 70% of the revenue from its petroleum industry to service the external debt [MacEoin, 1996:39].

Economic growth and poverty - a neoliberal dilemma

Whilst neoliberal policies can increase economic growth they may also create an underclass: these are the casualties of decreases in welfare spending affecting such elements as health, education and housing; of land privatisation, reducing this already scarce resource for local sustainability; of business streamlining involving drastic reductions of the work force; and of geographical relocation. Poverty may thus increase for some sectors of society despite economic growth. However, as Vilas points out poverty is a potential source of political instability and must be dealt with accordingly:

Neoliberalism considers the growth of poverty to be a pathology, not a consequence of the economic system. Hence it isolates poverty from the process of capital accumulation and economic development, and reduces the solution to designing specific social policies. [Moreover, social policy] legitimises the overall political order by offering social services that help create consensus

among the population that benefits from them.
[Vilas, 1996: 16-17]

Poverty thus becomes a global focus of international relations as a malevolent force to be dealt with, to be alleviated, but the rationalistic forces of neoliberal policy divest themselves of responsibility, with poverty becoming the problem of the individual.

However, the dialectical contradiction between implementing neoliberal policies and treating poverty is quite clear and in itself gives rise to conflict, often emerging in political opposition. Briefly, to consider Chiapas as an example, opening the way for privatisation of indigenous lands further reduces this resource thereby increasing the population pressure on a given area leading to further hardship for the local population and increased poverty. To counteract this the transnational aid organisations, which have demanded the economic structural adjustments in the first place, then pour money into the area for welfare needs which the national government either cannot afford or is under structural adjustment constraints to reign in. Aid is then sought from transnational organisations. Meanwhile, political opposition arises from groups opposed to the adoption of neoliberal policies which have had a detrimental affect upon their lives or pose a future threat. A mixture of coercion and aid are the anodyne solution of the national government. A simplistic overview perhaps, but the powerful mixture of coercion and aid on a local level, with a government view to contain and reduce opposition, have undoubtedly caused much internal conflict within the state of Chiapas.

The result of neoliberal forces is a transferral of power from national sovereign governments to transnational agencies. As Barkin *et al.* contend in relation to Mexico “real economic - and therefore political - power in the country has accrued to transnational corporations, U.S. portfolio investors, international financial institutions and the U.S. government” [1997:14]. Meanwhile the fight against poverty and the direction of this fight is led by the transnational aid organisations who become powerful entities in directing national governments’ social policy agendas. Family planning and population issues are prioritised and politicised within a global context as one of the areas from which to direct the fight against poverty.

Inevitably, many national governments adopt strategies accordingly. Whilst family planning is deemed an individual area of control vast sums of money are ploughed into the promotion and provision of family planning programmes which emphasise social welfare gains from smaller families.

Poverty and overpopulation have been linked since Malthus, but within a neoliberal context both have moved into the realm of individual responsibility. Yet, paradoxically, they remain very real concerns for the state and its stability. On the one hand poverty is demonised as something which accrues to the individual through his or her lack of ability to combat their economic situation, whilst population issues are thrust into the realm of the individual through family planning policies which emphasise individual responsibility to regulate fertility. Meanwhile the state must continue to concern itself with the problem of poverty and perceived overpopulation to retain political control and economic stability. Such a scenario takes no account of the social context of what families mean to different people and how family planning is viewed, culturally, in different societies. The problem for governments then is what to do with citizens it doesn't need; what to do with rural indigenous populations who subsist outwith the national economy and are deemed to contribute nothing to national economic growth. In Carter-Wilson's novel, *Crazy February*, based upon anthropological fieldwork in highland Chiapas, this notion of the unproductive Indian is highlighted in comments made by the Ladino school-teacher to a local Chamula, and highlights a *raison d'être* for government intervention in indigenous life:

"The Indians work for themselves, not for all of Mexico. They don't want to learn to make more, to produce more. They say they are happy enough when their children are fed. But look at it this way, Juan. In San Martín [San Cristóbal] there are almost as many people as there are in Chomtik [Chamula]. But the people in San Martín work in town, they don't have the land to grow corn to make their tortillas. So some Mexican has to grow enough corn to feed his own family and the family of a man in town. You understand? But the Indian doesn't think of this. The Institute [INI] wants to teach him to grow more corn - but will he learn? No. He says he has enough for himself. Maybe he does, but he sees no farther than his own hamlet. He doesn't see the great goals of all Mexico" [Wilson, 1974:69-70].

In this scenario the unproductive Indian is definitively outside of the national economy. While it remains true in Los Altos that subsistence farming for the individual family or for group consumption (*autoconsumo*) is the norm, indigenous people undoubtedly participate to some extent in the national economy. As Espinosa Cortés points out, in Highland Chiapas the work of *campesinos* is “characterised by various subsistence strategies: day workers, coffee cutters, artisans” with many relying on temporary migration to the large agricultural centres [1995:17, *trans.*]. These activities constitute participation in the national economy, with the *municipio* of Zinacantán illustrating major participation through large-scale horticulture.

Since overpopulation came to be perceived as a problem in Mexico during the late 1970s there has been a constant preoccupation with statistics. Justice refers to international health agencies’ preference for “hard” data such as economic measurements of financial soundness requiring monitoring of expenditure and investments. This gives “hard” data a predominance over “soft”, examples of the latter being social and cultural information [1989:133]. A classic example of this is to be found in the combined UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, which spans a time period from 1972 to the present. The country reports of this programme form a litany of statistics on demography, financial aid, institutional collaboration. High level national and international cooperative research is clearly carried out with all manner of statistical goals and evaluations intended to have a qualitative outcome on child-maternal health and yet the view at the base in these reports is completely obscured, with no indication of quantitative achievements achieving their qualitative goals.

In Mexico, policy goals in family planning and other health goals are measured by statistical targets and achievements. Hence there are target figures for increases in contraceptive prevalence, measured against actual rates over time; targets for fertility decreases juxtaposed with constant monitoring of the fertility rate; and goals and available statistics for a whole host of demographic and health data upon which planners calculate ever more policy goals, strategies and objectives.

Yet at the heart of reproductive health policy espoused by the Mexican government is an almost mystical qualitative goal: informed choice in contraceptive use and contraceptive methods. How is this formulated and measured? In the context of my fieldwork it seemed that most practicalities of family planning provision mediated against the possibility of informed choice in the clinic setting. Statistical goals to increase contraceptive prevalence and reduce the fertility rate are major factors which undermine the concept of informed choice.

Current policy formulation in Mexico

Mexico's current modernisation goals are premised upon the adoption of neo-liberal economic policies, largely at the behest of the United States, in order for Mexico to become part of NAFTA. In addition to these Mexico is borrowing heavily from organisations such as the World Bank, the International Development Bank and the IMF and following the structural adjustment policies these imply, as well as developing anti-poverty strategies through, for example, health and education programmes. Decreasing fertility levels amongst the Mexican population is an overt goal of Mexico's economic development policy and one in which it has contained the population control element within the sphere of reproductive health rhetoric which seeks to address a wide range of issues. This has been effected through the adoption of a programme which seeks to shift the emphasis from family planning per se to reproductive health in general, yet which can still address the development of the country as a national entity within these terms. The International Conference on Population and Development (Cairo, 1994) led the way in reincorporating population control as a link in economic development issues which governments should prioritise but within the remit of reproductive health concerns about respect for individual rights [cf. United Nations, 1995:5]

After the Cairo and Beijing conferences ¹, and drawing on the "international consensus adopted at these conferences" [Poder Ejecutivo Federal, 1996:iii; *trans.*], Mexico unveiled its National Development Plan 1995-2000 in which it stated that "reproductive health and family planning are strategic axes in the development of the

country” [Poder Ejecutivo Federal,1996:i; *trans.*]. In this one sentence the policy rhetoric links the economy with population growth. The policy result was to reconstitute the pre-existing Family Planning and Maternal-Child Health Programmes into a single Programme for Reproductive Health and Family Planning. To further the objectives of this programme the Interinstitutional Group for Reproductive Health² (Grupo Interinstitucional de Salud Reproductiva), which includes the major government health services³, was set up at federal level to formulate policy for the Programme for Reproductive Health and Family Planning. At state level the group has prioritised rural and indigenous areas which have not followed the prevailing trends of increasing contraceptive use and decreasing fertility rates shown in urban areas of the country in the central and northern regions [Poder Ejecutivo Federal,1996:2].

Reduction of the total fertility rate per woman is a defined goal. The National Plan for Development has set a target of a total fertility rate of 2.4 children per woman by the year 2000 [Poder Ejecutivo Federal,1996:20]. By 1990 the total fertility rate amongst non-indigenous women was 2.8 but amongst indigenous women the average was 5.7 [El Mercado de Valores,1995:14]. There is clearly a substantial difference which explains the emphasis on rural and indigenous areas. However, within this larger goal to decrease the national fertility rate and prioritise target areas the Mexican government specifies the need to address individual rights to decide upon the number of children an individual or couple wish to have: the National Development Plan emphasises that the promotion of reproductive health and family planning services “should be carried out with absolute respect for the dignity and freedom to decide of individuals and couples” [Poder Ejecutivo Federal,1996:iii, *trans.*]. Accordingly, Mexican policy on reproductive health is defined as follows:

Reproductive health is the ability of individuals and couples to enjoy a satisfactory sexual and reproductive life, which is healthy and free from risk, with absolute liberty to decide, in a responsible and well informed manner, on the number and spacing of their children. This holistic vision bears in mind that the whole population must have access to wide-ranging information and a complete range of available and acceptable reproductive health services [Poder Ejecutivo Federal, 1996:ii, *trans.*].

This policy goal is reflective of, and rooted in, international policy edicts on human rights which foster a perspective of individual liberty, responsibility and freedom to decide, which few would question. However, it assumes a number of conditions which cannot be taken for granted: the cultural perspective from which the idea of individual responsibility contributing to making an informed choice about controlling fertility, the spacing of children and deciding how many children to have runs contrary to many non-Western based or influenced cultures, a point I will resume below in discussing Chiapas. Moreover, the promotion of family planning is underlined by a general acceptance that population control can be directly linked with health and welfare [cf. Palma and Rivera, 1996:155]. However, concepts such as child spacing may not be understood or accepted by some cultures and can certainly not be taken for granted in the formulation of blanket policies. Likewise health risks may not be perceived to be directly linked with reproduction. That is not to say that such policy goals are inherently wrong, rather that the formulation of such policy leaves no space to address cultural sensitivities which do not fit with mainstream views of reproduction. The notion of "acceptability" is an integral key concept here but even this is subject to the pressure of what is deemed to be right: if a particular population or group, for example, consider contraceptive use or child spacing as unacceptable to their way of life, then this group or population should be educated to show them the error of their ways. The policy is presented as infallibly correct with doctors attitudes in Los Altos reflecting this in their beliefs that they have to convince (*convencer*) the local population about what is good for them. This raises serious questions about what constitutes *acceptability* and what it means to *convince* people about benefits they could reap by following clinic advice on family planning.

Family planning promotion: targeting rural and indigenous areas

According to the United Nations [1989], population programmes need to move in the direction of specifically targeted groups in an effort to identify barriers to fertility decline amongst specific social groups or particular regions. To achieve these goals the target population is required to be in accordance with them and to understand the health benefits that may accrue from few births spaced over a number

of years and the improved standards of living that families may attain from having fewer children. In short, they must believe that the policies are there for their own gain set in place by a government who has prioritised these issues for the good of the target population.

Whilst this might be perceived as a necessary condition for aggressively promoting family planning, by itself it is insufficient. The targeted areas in Mexico are known as economically and politically marginalised and, in the south of the country at least, ethnically diverse. To promote family planning and other health services on a practical level requires the infrastructure necessary to reach inaccessible populations and the resources to maintain them. For a government committed to structural adjustment policies in order to attract and service foreign loans the material conditions required to practically ensure that the target populations are well served would severely strain the national purse. Until recently these marginalised areas were largely ignored regarding the concerns of the national economy. Now, with trade liberalisation and the reform of the *ejido* system to allow privatisation, they have become nationally important economic resources within an international economic framework. It remains to be seen what effect this will have on the marginal status of these areas but for the moment it remains high.

Equally important, to aggressively promote family planning in such areas whilst maintaining the moral and ethical principles which underline the stated reproductive health policy, there must be full recognition of the socio-economic problems in rural and ethnically diverse areas and an overt understanding displayed of both the cultural, and sometimes political, disincentives to using family planning services. These problems should not only be understood by the government who formulates the policy but, crucially, by those responsible for implementing the policy and providing the services at a local level. To be fair, the National Development Plan does specify that coverage of family planning services should be extended in indigenous areas “in accordance with their perceptions and preferences” [Poder Ejecutivo Federal, 1996:14, *trans.*]. However, the Plan does not give any clues as to how this might be achieved by mestizo providers, only that services should be

amplified to reduce the fertility rate largely through educating and informing women of the benefits, within procedures for informed consent which remain unelaborated.

Particularly in areas where the dominating culture of the government runs contrary to the local culture targeted to *benefit* from particular social policies, if some basic level of mutual respect and understanding does not exist between the disparate groups then family planning programmes may be resisted and cause greater resentment and distrust within the communities. To judge their likely effect, such programmes should be considered within the context of the local culture's views of the wider society. The family planning programme does not take account of this. Instead, policy is presented as a neutral entity which has been formulated to benefit the target population.

In international terms the Mexican experience with family planning since the 1970s has been heralded as a success for its record in curbing rapid population growth [UN, 1989:42; cf. Potter *et al*:44-5] through a highly centralised approach. This top-down strategy has been successful in urban areas but in rural areas, of predominantly indigenous people in particular, policy objectives have made minimal inroads, and contraceptive prevalence remains low and fertility high. This is why indigenous populations are now the targets of family planning policy. Although the targeting is now directed the strategy remains unchanged with policy continuing to be formulated and funded at international and national levels and directed down to the providers at a local level. I hope to make clear the various reasons why this serves neither the policy makers, the providers, nor the local population when I discuss policy and practice in Part III, but I would emphasise here that part of the problem remains the quantitative, statistical nature of policy formulation. Increases in contraceptive prevalence, decreases in the fertility rate and decreases in maternal mortality are all countable, but where is the evidence which might discuss quality of services and optimum conditions for informed choice? They are hidden in the maelstrom of bureaucracy or in the assumed link between statistical achievements and social and material well-being, which are in fact equated only haphazardly. This is not to deny that birth-spacing and reduced child-bearing may improve a woman's health and well-being. What the statistics fail to show are the qualitative aspects

which can be uncovered in observing policy mandates in practice. Notional goals, such as informed choice, and practical goals where we believe these should benefit the recipient with some improvement in the quality of their lives, also have to be accounted for and be a means of offering some flesh to a statistical analysis. It is important to know how women themselves perceive the benefits of limiting fertility and child spacing; how they perceive health providers; under what conditions they use or refuse clinical care and services; and why they might prefer traditional healers. It is equally important to understand under what conditions clinical care is provided, who the providers are, and what are their own agendas.

Answers to such questions will be socially and culturally bounded and are not to be found in the burgeoning statistics the medical government is able to provide about numbers and types of units covering 'x' parts of the populations in the various states, and with corresponding figures for types of carer. Whilst these figures are useful to show the extent of national health coverage available and areas where cover is lacking they tell us nothing of the variable levels of quality of care offered in these places or the acceptability of government health services. This is not a problem peculiar to Mexico to but one which all policy makers need to address in general.

To illustrate some of the problems of policy provision in marginalised, rural, indigenous areas Chiapas will serve as a good example. Whilst the majority of the population in the research area are Mayan, and we cannot extrapolate cultural aspects on a universal level, I would nevertheless argue that some of the problems in provision are to be found globally: dichotomies of national/indigenous language, allopathic/traditional medicine and national/indigenous social and cultural divisions, are stumbling blocks in provision faced by planners international. The knowledge base for effective medical services in these circumstances are not the interminable statistical machinations at national and international levels, but qualitative local level studies which are able to filter up to influence the higher levels of policy making. But how do we interject qualitative local knowledge into a vast bureaucratic machine which makes policy at national not local level? One solution might be more autonomy for local planners and providers once they have been informed of the general national plan. Chiapas does indeed have a local state-level paper on

reproductive health for the region but it is practically a carbon copy of the federal policy objectives with detailed regional level statistical targets, and so the problems remain. Before considering this I want to outline the methodological component of my research.

¹ ICPD, 1994; The 4th International Conference on Women, Beijing, 1995.

² The new name for the Grupo Interinstitucional de Planificación Familiar, set up in 1989 to support the National Programme for Family Planning 1990-1994 [Consejo Nacional de Población, (undated): 14]

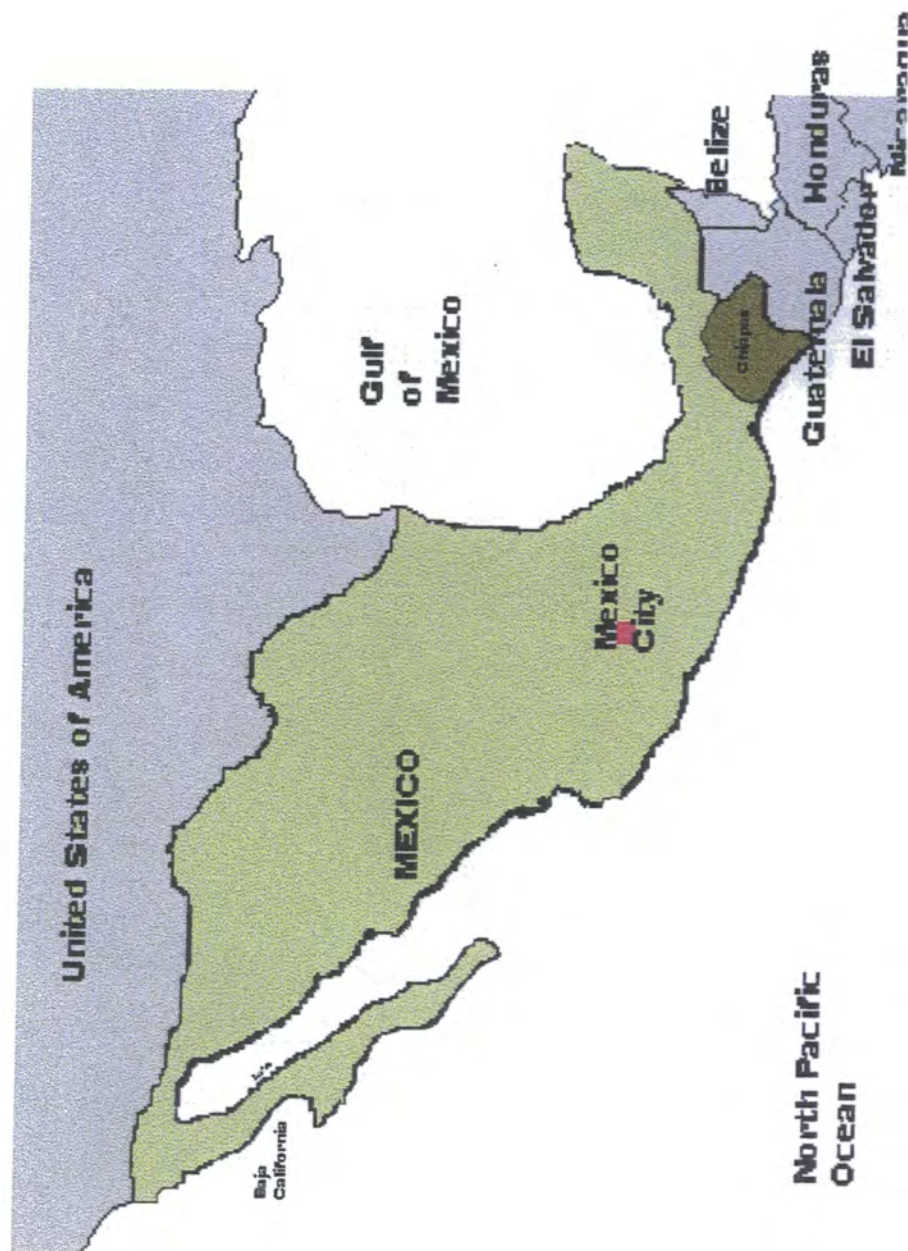
³ Twelve government bodies, including the SSA, IMSS, IMSS-Solidaridad, ISSSTE, DIF, INI, as well as five NGOs.

PART II

RESEARCH IN HIGHLAND CHIAPAS (LOS ALTOS)

Map 4.1

Mexico showing the state of Chiapas



Map 4.2

Chiapas and the 17 municipios of Los Altos (the research area)

THE STATE OF CHIAPAS, MEXICO - POLITICAL DIVISION

The 17 Municipios of Los Altos

Key:

4. Altamirano
7. Amatenango del Valle
22. Chalchihuitán
23. Chamula
24. Chenal
26. Chenalhó
38. Huixtán
49. Iarráinzar
56. Mitontic
64. Oxchuc
66. Pantelhó
75. Las Rosas
78. San Cristóbal de las Casas
112. San Juan Cancuc
93. Tenejapa
94. Teopisca
111. Zinacantan

Symbols:

+ + + International Border

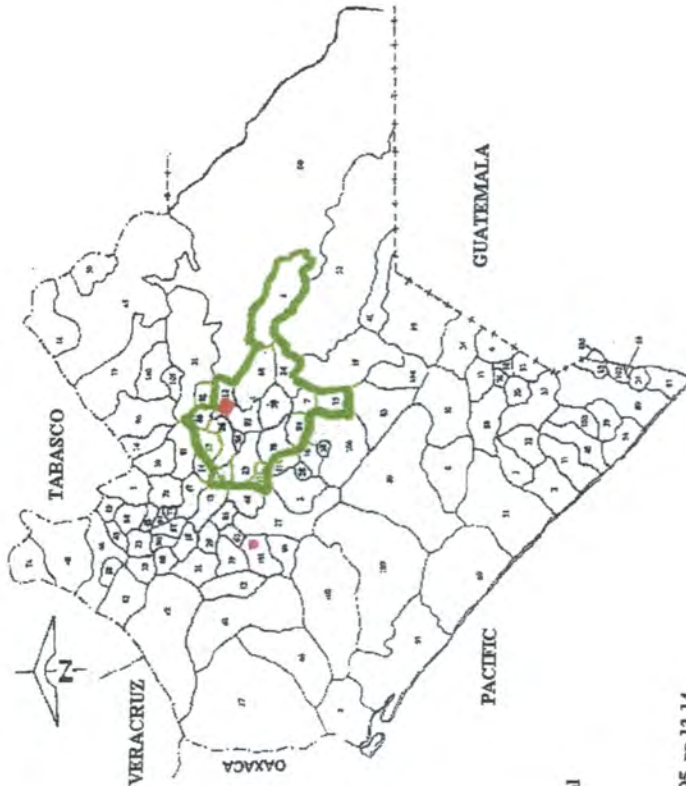
- - - State Border

--- Municipal Border

State Capital - Tuxtla Gutiérrez

Departmental Capital of Los Altos - San Cristóbal

Border of Los Altos Region



Source: Marco A. Orozco Zazaro, Síntesis de Chiapas, 1995, pp.13-14

Chapter 4

Los Altos: The Setting and Methodological Factors

In explaining their views on Chiapas to me a number of *coletos* jokingly referred to Chiapas as the Fourth World, a concept which became popular in anthropological terms some years ago [cf. Paine, 1985; Stills & Morris, 1993]. They referred to Mexico as "Third World" but Chiapas as "Fourth World", and in so doing singled out the fact of a large indigenous population. Joking apart, the term "Fourth World" implies indigenous peoples who seek autonomy or self-determination based upon historical claims of autochthony¹ [Stills & Morris, 1993:10], and as such may indeed be applied to many indigenous groups of the Americas. These populations remain distant from the State, often defining themselves in political, cultural and sometimes economic opposition to it. In Los Altos the indigenous communities maintain a certain autonomy in their community organisation but are not free from government direction, especially in the *cabeceras* where mestizo influences are found in the schools and clinics. Aguirre Beltrán has described such areas as *regions of refuge*: areas out of synchronisation with the majority of the country, which is considered to have advanced culturally and economically since throwing off its colonial mantle to become an independent nation:

In these regions ... it is easy to see a structure of domination with a surprising number of archaic elements that are totally extinct in culturally and economically more advanced regions. Ladinos^[2] and subordinate Indians live together, the former as a dominant elite, the latter gathered into satellite communities around the Ladino centre. Together they live as a dual population segregated from each other: neighbours divided by a mutual barrier of prejudice and racial preconceptions. [An area where] racial and social segregation endures. [1979:35]

Los Altos region in particular fits well with this description considering that the departmental capital of the San Cristóbal, a centre of commercial attraction and exchange, is dominated politically and economically by mestizos. This city of approximately 90,000 people is said to have an indigenous population of around 35% (see Table 1) and is an area of migratory attraction, both permanent and temporal. In recent years there have been large increases in indigenous people invading land to set

up permanent homes, much to the consternation of some *coletos*. A *coleta* friend expressed her views about the land which belonged jointly to her *colonia* being invaded and annexed to the local indigenous market:

Well, its dirty and noisy now. The streets are full of rubbish from the market and it smells. The land belongs to all of us, to the *colonia*, but well, what can we do about it now? I wouldn't say anything to them [to the Indians]. I would like to move one day to a better area.

There is a lot of conflict in the city over land and the indigenous groups are very well organised, though not united. The local political situation is complex and dissatisfaction usually made known through the frequent roadblocks that go up around the city, blocking movement within and without the city for a day or so. What is interesting is that the city does appear to be a very indigenous area in many parts with, as Vogt points out, Indians living as Indians rather than immediately beginning the process of "Ladinoization" [Vogt, 1990:145]. This view contrasts with that of Arias who says that indigenous people coming to the city are in transition and deny their background, tradition and language. He argues that there seems to be an idea, conscious or subconscious, that to be Ladino is good, prestigious, powerful in contrast to being Indian which is bad, degrading and weak [Arias, 1991: 73-4]. My own views on this are that with a growing politicisation of what it means to be "Indian" and a continuing degrading by both mestizos and migrant indigenous people of "Indian" culture, both aspects exist side-by-side in the city. The complexities of politics and identity continually threw up apparent contradictions for me like the Tzeltal man who had set up home on invaded land with a confidence that he was morally correct to do so because this land belonged to the indigenous people before the Spaniards came. His views contrast with the woman I knew who denied she could speak Chol because she wished to appear mestizo and deny her indigenous background, and the Tzeltal woman whose children could not speak a word of Tzeltal because she wanted them to be acceptable in a modern, mestizo world.

Politicisation of indigenous identity did not begin in Chiapas with the Zapatista uprising in 1994³ but the ongoing conflict keeps this notion to the fore in local politics. In the 1970s Collier [1975:137] was writing about ethnicity as the expression of a boundary distinguishing "Indians" and "Ladinos" in Chiapas, which

he further classified as “subordinate and dominant castes”. The current conflict challenges this historical subordination of indigenous people. San Cristóbal was often the colourful scene of mass demonstrations during my stay in the area where indigenous rights would be loudly proclaimed from the central *zócalo*: rights to land, health, education, respect for identity and language. Thousands of rural indigenous people would march to the city from their villages to take part in such demonstrations, the streets a riot of colour reflecting local indigenous dress, especially of the women. Often the demonstrators would wear bandanas over their mouths or ski-masks in the style of Sub-Comandante Marcos, the man credited as the intellectual author of the modern Zapatista movement⁴.

Political infrastructure

Los Altos is made up of 17 *municipios*⁵ each of which has its own municipal seat (*cabecera*), which bears the same name as the *municipio* (see map 2). In discussing these entities where I refer only to the name, for example Chamula, I refer to the *municipio* otherwise I state that I am referring only to the *cabecera*. With the exception of the three urban centres of San Cristóbal, Las Rosas and Teopisca the *cabeceras* are small rural villages symbolically dominated by a central square or *zócalo*, a few municipal buildings and a church. Municipal organisation centres around the *cabeceras* which are the ceremonial centres of religious and political power [Pineda Sánchez, 1993:39]. However, the *municipios* are further divided into *parajes* (hamlets) which also fulfil such functions at the local level and whilst the official seat of municipal power is the *cabecera* there is much fragmentation and contestation of politics and religion at the level of *paraje*.

The predominant religion in Mexico is Catholicism and remains so in Chiapas (67.6% in 1990 [Orozco Zuñiga, 1995:72]) despite significant conversions to Evangelical Protestantism. This has been a cause of conflict in Los Altos which in 1990 showed that 14.2% of the inhabitants were Protestant whilst 13.6% professed to having no religion and 68.4% were Catholic [calculated from INEGI, 1990]. However many Catholics are so in name whilst practising a syncretic form of religion based upon long-standing Mayan customs and traditions [cf. Barrios Ruiz and Pons Bonals, 1995 *passim*; Lenkersdorf, 1996:173-4; Arias, 1991:*passim*]. In fact, a

number of *municipios* such as Chamula have no resident priest or pastor, having expelled them in previous years⁶. One priest explained to me that often he would arrive at his church to find the celebration of an event already underway and noted that his attendance was often perfunctory.

The political conflict is often further complicated by religious affiliations. According to one church worker when the Zapatistas were routed from Chanal in 1994 the local PRI supporting *caciques* (Evangelicals) had all Catholics rounded up and banished as Zapatista supporters, including the priest. Though many local people went back and maintained a low profile in religious and civic life the priest was not allowed to return. When I visited the locality of Siberia, which belongs to Chanal, I found that the majority here were Catholic but had cut off all contact with their *cabecera* (Chanal) owing to this problem, and made lengthy journeys to San Cristóbal in preference when they needed supplies.

Whilst the Zapatista movement is overwhelmingly indigenous it is not representative of all indigenous people in Chiapas. There are also many detractors. This is not surprising given the nature of indigenous groupings. In Los Altos there are two main indigenous language groups, Tzotzil and Tzeltal, but throughout Chiapas such groups number around 15 and political affiliation is not dependent on these groupings. Perhaps a more illuminating way to consider the nature of local politics is in terms not of language groupings but of geographic units. Drucker-Brown [1982:40] discusses the geographical isolation of “socially and culturally discrete local communities” which Aguirre Beltrán considers to be closed despite ethnic ties with other groups:

Many of these [ethnic groups] may share, and in fact do share, a common culture and a language with slight dialectal variations; but despite this, each community, mystically linked to its territory, to the communal land, constitutes a unit, a small nucleus, a closed society which often finds itself involved in conflict and ancestral feuding with the neighbouring communities, from whom they always consider themselves different. [1991:16, *trans.*]

Haviland's work in Zinacantán supports this thesis of fragmentary groups showing that it is often the hamlets, rather than the *municipios*, which may represent a geographic and political unit, and may even result in *super hamlets* where ritual

kinship ties between certain hamlets across municipal borders are more important than those within [1977:19-20]. So, whilst the government may group localities within *municipios* and *municipios* within regions, identifiable units exist below and beyond the municipal level.

Whilst for some *municipios* the surface appearance reflects a cohesive group or unit operating at municipal level, further investigation supports the work of Aguirre Beltrán and others, uncovering the cracks which show discrete small units working in their own prospective interests. For example, Chamula has maintained this surface cohesion by expelling Protestant dissidents in large numbers; Chenalhó reflects the disparate groupings through the current strife which has engendered political factions, based on geographical locations with the *municipio*, either supportive of, or against, the Zapatista movement; San Andrés Larráinzar is in open conflict along pronounced national party political lines (PRD vs PRI), which also reflects, in this case, Zapatista vs State affiliations; Cancuc fought and won its independence from Ocosingo in the early 1990s showing a concerted level of unity to justify its claim. These are but a few examples, superficially given, which illustrate the complexities of life within the region.

Working in a conflict zone

The politics of the region and the conflict deserve a thesis in themselves and I can do no real justice to them here. Suffice to say that it is important to bear in mind that working in this region I was continually aware of civil unrest. This fact is as important to methodology as it is to any other questions raised in this work. Problems of political geography are important to the ability to carry out research and to the results obtained. There are also questions of personal ethics and interpretations of events. Should anthropologists involve themselves politically as they work? Should they attempt to remain neutral? Is it not the case that neutrality is a myth which only upholds the current balance of power? Is it possible to operate as an apolitical body in highly charged and often violent political situations? As research students in anthropology we are given various bits of advice on such matters before

going into the field but until you are actually there it is difficult to appreciate the implications of these questions.

In October 1996 a series of events brought questions of neutrality very much to the fore for me. The café of an indigenous coffee growing cooperative at the end of my street was firebombed. It was a new, up-market venue which attracted mestizos and foreigners alike. Days later another café was attacked for the same reasons: to get at the indigenous cooperatives involved. The damage was superficial, though not the threat, and both attacks were considered to be the work of a local *priista* right-wing paramilitary group. A short time later a local NGO involved in the peace dialogue between the government and the EZLN was firebombed. This time the attack was much worse. Sofia, an educational worker and member of the FZLN, came to my house to tell me what had happened:

Well, the offices are usually guarded by a watchman but, well, [trails off, shaking her head]. The attackers burned all the blankets and food they could find. You know with the Verification Talks⁷ we're expecting many people from the communities. We need to provide shelter and food for them. They burned papers and spray-painted the walls and stairs with horrible messages threatening people and their families - their children. The workers have been receiving anonymous phone calls. They say "we know who you are and where you live; your children [x] and [y] attend [z] school. We know everything about you. We can take your children. We can kill you." Now they have kidnapped Raul and his wife and children. It's terrible. We don't know what will happen

The kidnapped adults were badly beaten. The family was released a few weeks later. The city was very tense in the following weeks. Death threats to named individuals continued and a request went out for foreigners to volunteer for *acompañamiento* i.e. to escort Mexican individuals and groups, in their homes and offices, who had been threatened by name on these lists. Eventually, I was called upon.

This raised questions for me about my role as an anthropologist in town and the possibility of compromising my position with people I knew outside of the NGO sector, and with regard to my visa status⁸. Though I did not actively involve myself in local politics, I could not be neutral, and accepted the request. Working in a

society in the upheaval of transition and subjected to the vagaries of paramilitary action it was difficult not to have an opinion.

Christmas 1997. Jesús ha nacido muerto. (Jesus is born dead)

By the following December the crisis in Chiapas had deepened further⁹. According to eye-witness accounts nearby government officials did not raise a hand to stop the Acteal massacre by paramilitaries in December 1997, in which 47 people were killed, 21 women, 14 children and nine men. Only the involvement of the international press ensured that suspects were arrested when the same officials were going to let them go free. The dead were removed by soldiers from the site of the massacre to Tuxtla and only returned two days later in coffins marked with numbers, not names. Bishop Samuel Ruíz, preaching in Acteal on Christmas Day, proclaimed that this year Jesus was born dead. He had few words of comfort as the victims were sent upon their last journey watched over by a large number of Mexican and foreign observers, horrified by the events and overshadowed by the presence of the police. Before this could happen the gruesome task of identification had to be undertaken. People did not know which coffin their relatives were in or even if they were there at all. They had brought clean clothes to dress their dead, and a blanket and a drinking bowl to place inside the coffin for the journey to the other world. Even this mark of respect and care for their dead was almost impossible:

The families had to open the coffins and look inside to see which of their loved ones (*queridos*) were there. The bodies were riddled with worms (*agusanados*). They were mutilated and it was difficult to recognise them. The mothers and the grandparents asked the police if they could dress their dead, their children, but they could not remove the bodies from the boxes so they put the clothes on top and then closed the lids. They opened one of the white boxes, of a little girl. A high calibre bullet had blown her head apart. [Durán de Huerta Patiño and Boldrini, 1998 *trans.*]

Twenty of the dead remained without positive identification. Most of these people had been shot in the back as they were running away and then, after they were dead or injured, they were hacked with machetes. Hundreds more took to the cold,

wet, inhospitable mountains as refugees leaving their possessions and their fields behind.

In the face of such horror neutrality is not an option and to ignore the turmoil of areas such as Chiapas with a view to focusing on a narrow strand of policy, like reproductive health, would undermine the meaning of the research. In fact, it would have been difficult to undertake such a task when everywhere I was surrounded by reminders that the area was in conflict. To disregard such a situation from a methodological perspective at the very least would undermine any discussion of policies, politics and power which must be rendered even more important in conflict situations.

Collecting data in Los Altos

Chiapas has a varied terrain ranging from the hot coastal plain to lowland jungles and the cooler highland mountains [cf. Halperin and De León Montenegro, 1996:3]. Of the nine regions within Chiapas Los Altos and La Selva, bordering Los Altos to the north west, are the most remote, inaccessible and underdeveloped in the state [cf. Menegoni, 1996:381]. Between them these regions are home to 80% of the indigenous population of Chiapas [Viqueira, 1995:281]. In Los Altos the lack of infrastructure and lack of access to services in many areas are problems compounded by a widely dispersed population [Freyermuth, 1993:20]. Illiteracy in the region is high with only 23% of the population of Chiapas attaining any post-primary education [Sánchez Pérez *et al.*, 1995: 64]. In the rural highlands electricity supply and potable water is scarce, housing is usually of wooden planks or adobe with dirt floors and roofing tends to be of sheet metal or straw [Gobierno del Estado de Chiapas, 1996:23]. Poor nutrition, hygiene and sanitation are major health problems [Menegoni: *op. cit.*].

The physical geography of Los Altos, a mountainous, forested district with few major roads, meant that it was quite difficult to travel to many of the more inaccessible areas and for this reason I centred the clinic interviews around the *cabeceras* of each *municipio*. Even then some of the research sites remained difficult

to reach. The main road to Tenejapa had suffered from subsidence closing the road for over six months. An alternative route through a mountain forest was used during this time which was hazardous or impossible to cross after heavy rains. The main highways in Los Altos were dilapidated with cracks, crevices and gaping holes, some of them crumbling away on the mountain edges of the road. The routes to San Juan Cancuc, Mesbiljá and Chanal were particularly rough and mainly dirt tracks. Like Tenejapa they were often rendered inaccessible during the rains. Away from the *cabeceras* there are many localities which can only be reached on foot or horse-back.

The political geography also presented difficulties. The areas around Chanal, Altamirano, Pantelhó and Larráinzar were more heavily militarised at that time than any others in Los Altos. Problems in travelling around were lightened by the use of local buses, when possible, which the military rarely stopped in those parts, and by the possession of a visa and letters from the health authorities giving me permission to carry out clinic interviews. These were essential items when travelling by jeep, whether for work or pleasure, as they officially legitimised by presence. My credentials were checked out a few times by military field telephone in rural areas. Local buses were rarely subject to harassment on the main highways outside of San Cristóbal but private transport was targeted for political petitioning and raising funds, a frequent occurrence for example on the road from Oxchuc to Altamirano. The toll was low on these occasions but it would have been unwise to withhold it for any reason. Besides, the accompanying leaflets were worth collecting to read about the various grievances which were being expounded.

In comparison to the rural areas, collecting data in San Cristóbal was a relatively easy affair. Apart from the government clinics, a number of local NGOs and diocesan health groups had their bases in the town and frequent contact became possible with various members of these organisations, in addition to carrying out major taped sessions with each of them. When it came to interviewing local women about their lives and reproductive health histories living in the centre of the city proved to be a boon. These women journeyed back and forth between the centre and their *barrios* most days and most of them eventually took to dropping in on me in a casual manner. From my home it was equally easy to walk or take local buses out to

the *barrios* and in this way traditional anthropological techniques based around in-depth immersion in a community setting became the norm for my life amongst this group of women and their families. In the last months of my fieldwork I employed and guided two of these women in carrying out a contraceptive survey of 98 households in their *barrios*, addressing a questionnaire to the *ama de casa* (housewife) of the house.

In the 18 months I spent living and working in San Cristóbal much information was provided by way of the casual encounter: the indigenous street sellers eager both to sell and ask questions, and generally not unwilling to respond to similar questions about home life and children; and through an extensive social network built up over this period. Whilst this included the women who formed the core group of my interest in terms of reproductive histories, it also included many others: academics, doctors, health promoters, diocesan workers (including priests), political activists, parents met through the local school attended by my children and such like. Many of these willingly volunteered their own perceptions on Mexico, the Mexican government and the local political situation; their experiences of health services; and their hopes and fears for the future of Los Altos, providing me with a rich source of material. Moreover, they shared their family lives with mine which enabled me to observe such factors as gender roles attributed between men and women and how these gave rise to expectations with regard to areas such as work, dress and behaviour; familial relations and expectations; perceptions of ethnicity and relationships between the dominant mestizo group and the indigenous or mestizo inhabitants of the poorer *barrios*, bearing in mind that I had a foothold amongst different groups who did not mix easily on a social level.

Interviewing health providers in Los Altos

Staff from 34 government clinics situated in the 17 *cabeceras* of Los Altos were interviewed using a semi-structured interview schedule which allowed for the possibility of open-ended discussion on various topics. Nine NGOs situated in San Cristóbal and known to be working on health projects were also interviewed but

using a very loosely structured format. (See Table 4.1 below.) In this way my sample covered 100% of the Ministry of Health's (SSA) medical units above the size of a Rural Health Centre with a Dispersed Population (CSRD). Anything below that size could not be expected to have a doctor or *pasante* (trainee doctor) in attendance and would be staffed by local promoters. Units smaller than a CSRD were generally in more inaccessible locations outside of the *cabeceras*. With regard to the Department of Social Security-*Solidaridad* (IMSS-S) I interviewed only those with medical units, mainly Rural Medical Units (UMRs), in the *cabeceras* which also included the hospitals in Altamirano and San Cristóbal. This was not equivalent to the SSA sample coverage as each *municipio* was likely to have more than one UMR, but not necessarily any at all in the *cabecera*. Therefore, whilst coverage of SSA units was 100%, only 15.5% of IMSS units in Los Altos were sampled. The SSA has only 16 medical units scattered throughout Los Altos which should have a doctor or *pasante* in attendance. IMSS has 71 such units, 68 of which are UMRs. Seven interviews were also carried out with staff of other government organisations.

The Interview Schedule

The interview schedule was designed to elicit attitudes from providers on family planning in the context of highland Chiapas, including what difficulties they perceived in their work and what differences they had perceived between the old programmes of Child-Maternal Health and Family Planning and the new Programme of Reproductive Health, implemented in 1995, a year before my study began. Most of the questions were designed to elicit qualitative responses but there were some quantitative questions amongst them referring to such factors as numbers of family planning users and contraceptive targets. I particularly wanted to collect statistics on

Table 4.1

INTERVIEWS WITH HEALTH PROVIDERS BY NAME AND TYPE OF ORGANISATION

Municipio - Localidad	CLINICS
1. Amatenango del Valle	1. IMSS UMR
2. Altamirano	2. Hospital San Carlos 3. IMSS Hospital
3. Chalchihuitán	4. IMSS UMR
4. Chamula	5. IMSS UMR 6. SSA Mixto 7. SSA Mixto/Traditional Clinic
5. Chanal	8. SSA CSR(C)
6. Chenalhó	9. SSA CSR (D)
Yabteclum	10. SSA CSR (D)
7. Huixtán	11. IMSS UMR
8. Larráinzar	12. SSA CSR (D)
9. Mitontic	13. SSA CSR (D)
10. Oxchuc	14. SSA CSU 15. IMSS UMR
Mesbiljá	16. SSA CSR (D)
El Niz	17. IMSS
11. Pantelhó	18. SSA CSR (C) 19. IMSS
12. San Cristóbal de las Casas	20. SSA Hospital General, (Coordinators) 21. SSA Hospital General Family Planning Clinic 22. SSA CSU 23. IMSS, UMF 24. IMSS, Clínica-Hospital 25. ISSSTE 26. ISSTECH 27. DIF 28. NGO, Chiltak 29. NGO, Hogar Comunitario - Yach'il Antsitik 30. OMIECH, NGO 31. INI 32. Hospital de Caridad, Diocesan Franciscan Order 33. Diocesan Health Workers (for Huixtán and Chanal) 34. Nueva Primavera Diocesan Order 35. PRODUSSEP, NGO 36. Grupo de Mujeres, NGO
13. San Juan Cancuc	37. IMSS, UMR
14. Tenejapa	38. SSA, CSR (C) 39. IMSS, UMR
15. Teopisca	40. SSA, CSU
16. Villa Las Rosas	41. SSA, CSU
17. Zinacantán	42. IMSS, UMR
Navenchauc	43. SSA, CSR (D)

contraceptive use in Los Altos but it proved to be very difficult to gather comparative data from the different health organisations. The SSA never failed to provide this kind of information when asked for it but with IMSS-S and DIF it was more difficult. DIF provided statistics on contraceptive targets but failed to provide actual user data though I returned on numerous occasions to ask for it. IMSS-S promised for months to provide the data I wanted but failed to do so. I discovered from another source that in fact the IMSS had lost a lot of statistical data and that this was the reason why I did not receive it rather than being deliberately blocked in my endeavours. Despite this the data I did manage to collect reinforced what most people told me: that modern contraceptive use is low in Los Altos.

Qualitative questions also related to perceptions about client attitudes to family planning and any preferences observed for particular methods. All but three of the interviews were recorded and later transcribed which allowed a consideration of the kind of language providers used in discussing their job to extend family planning use in their respective areas. For example, references to problems “because of the culture” were frequent, as were comments on the need to “convince” the population of the benefits of family planning. Attitudes to clients were evident in many cases from the contents of these interviews and there was a particular section on the policy-led incorporation of traditional healers and *parteras* (traditional birth attendants) into government clinics, which also elicited provider attitudes to the local indigenous population. These aspects of the research will be covered in Part III.

Considering that I had set myself the task of trying to understand how informed choice in family planning services might be mediated by local circumstances, I did not directly ask clinic informants about “informed choice” as such. Rather I concentrated on attitudes towards family planning and to clients, and practices attested to in the clinic setting with regard to provision of information. Discussions were held on the linguistic make-up of the local population and how the clinic provided information in those rural areas (the majority) where hardly any women spoke Spanish, the language of the mestizo providers, though men’s abilities varied with many having some understanding of the dominant language. I also observed the origins of the “local” promoters and whether they were indeed from the

local area and spoke the local language, or whether they had come from other areas of Los Altos and spoke a different indigenous language to that which prevailed in their work area. In the post fieldwork stage of work, I remain of the opinion that this was the best strategy to elicit impressions and an understanding of the informed choice tenet as it works, or not, in a local setting. It is not simply the providing of methods (the range of which can be quantitatively assessed), or the provision of information (to be qualitatively assessed), which are the prerequisites to allowing informed choice in family planning.

Traditional observation of provider-client surgeries was not undertaken, except informally when accompanying women to clinics, nor did I interview clients in a clinic setting. There were a number of reasons for this. As I was interviewing clinic personnel across Los Altos I did not become attached to one particular place. It would have been possible to carry out systematic clinical observation in city clinics but I ruled this out due to the possibility that clients would associate me with other clinic staff. Such work would have been difficult in rural clinics because they were often empty, and therefore the exercise would have provided little information for a large amount of input in getting to rural clinics and spending a lot of time there. However, I did carry out observation of provider-client relations in two very ad hoc ways. During clinic interviews I spent long amounts of time in clinic waiting rooms, waiting for doctors or *pasantes* to turn up and begin consultations. Where there were clients it was possible to observe many interactions between providers and clients in this space as on a surprisingly large number of occasions clients were interviewed by the doctor before going off to the consulting room. In other cases an interview (which always took place in the consulting rooms) would be interrupted by the arrival of a patient and I would be invited to remain during the consultation.

Such ad hoc opportunities to observe provider-client relations were a good source of material but perhaps the most interesting, and fruitful, were those observations I conducted while accompanying women to clinics within the city. Interestingly, one of the roles these women developed for me was to accompany them to places where they felt they lacked power. Of course, this was not directly stated but put in terms which indicated that they were afraid to go alone and would

be grateful if I could go with them. This applied mostly to health clinics but I also found myself accompanying women of low socio-economic status to lawyers and municipal authorities to press various claims, which they hoped my presence would help. Such observations rarely included family planning consultations but nevertheless allowed assessments of service provider/client relations in a medical arena.

One final research strategy was observation of government training of indigenous paramedical personnel in remote rural regions. This I could not have completed without the help of a leading epidemiologist, and erstwhile head of the family planning division of the SSA in San Cristóbal. She gave me the opportunity to travel with her and to stay in remote rural areas during training sessions for local paramedical health workers which meant I was able to observe and think about the advantages and disadvantages of using local paramedical workers, and to see training procedures in operation. These observations allowed me to consider the informed choice theme of my research given the quality of training that the *parteras* received, who were already practising in a traditional context, and the expectation that they would then use this training to increase family planning prevalence in their local communities. It was also another window onto relations between mestizos and indigenous people: the trainers being mestizo doctors with formal educational qualifications whilst the trainees were bilingual men and mainly monolingual women, Mayan traditional healers or trainee promoters with no formal qualifications. Moreover, these training sessions took place in small indigenous localities which provided opportunities for observing general interaction between the two groups outside of the clinic setting.

This formal gathering of information was supplemented by informal contacts which were established and maintained over the course of my stay in San Cristóbal, and beyond. For example, whilst I met many of those doctors and *pasantes* I interviewed only once, others I got to know very well and the information they provided in the formal interviews was well supplemented by continued contact. In addition there were the ex-government health doctors I got to know and with some of whom I established warm friendships. I never formally interviewed these people

but we chatted frequently about our work and mutual interests, and they provided a lot of qualitative information for my research.

Within the government health services most of my interviews were with fully qualified doctors or *pasantes*. Sometimes I managed to interview local paramedical staff either alone or with the clinic doctor but it was difficult. Doctors were often dismissive of the answers of their auxiliaries except when it came to *cultural* questions. If the auxiliaries were not present during an interview they were often called in when I asked questions about local birth practices such as what happens to post partum placenta and why. However, though these auxiliaries were indigenous they were rarely allowed to answer questions pertaining to local attitudes such as those designed to find out which members of a family are most influential in decisions on whether or not to use contraceptive methods. Many doctors were very opinionated on such subjects and would often cut in on auxiliaries answers or override them altogether. They kept the responses within the sphere of their control which could be frustrating. The doctors maintained control of the situation as interviewees only allowing auxiliaries to contribute under their direction and auxiliaries did not generally contradict or talk over the doctors.

The interviews undertaken with NGO staff were loosely structured. This was because I had no prior knowledge of their policies with regard to reproductive health/family planning whereas I did in the government context, and also because I wanted to ask them about their own work and their experiences of any work they had undertaken in the government sector as well as their attitudes towards government reproductive health policy. As all the NGOs concerned in the study were Mexican, any doctors within the NGOs had gone through the government system before moving out to work elsewhere and so had experience of working in both sectors. I had extended contact with some of the NGO personnel because of the social circles in which I mixed which provided further ad hoc material for my research.

Interviews with local women around San Cristóbal

Because of the nature of government policy, which is designed to increase family planning prevalence and decrease the fertility rate in regions such as Los Altos, it was important to get to know the kind of people who would be potential targets. I had already ruled out work in a rural community because of language difficulties with women who did not speak Spanish and decided instead to somehow find and befriend women of low socio-economic status who lived on the outskirts of San Cristóbal, and who were indigenous bilingual speakers.

I did not want to carry out these interviews in a clinic setting because I did not want to be associated too closely by interviewees with clinic staff, and it was unlikely that I would gain extensive contact in this way, so I relied on informal networking in the town. I focused mainly on women. I met many men too and was also interested in their views but whilst family planning was not too difficult a topic of conversation amongst male doctors whom I knew socially and some middle class mestizo men, it was really a non-starter with indigenous and mestizo men of low socio-economic status. I resigned myself to the fact that as a woman it was difficult to open conversations with many men on the private subject of family planning.

Whilst it was easy to meet middle class mestizo women, as a white foreigner and with our children at a private school, my problem was how to meet women living in the poorer *barrios* and on the relatively new, mostly indigenous, sites that had sprung up on the fields around the outskirts of town. One of these areas in particular became an important fieldwork site. It was known locally as the invasion site (*tierra de invasión*) though it was officially called *Primero de Enero* according to Pedro, a Tzeltal resident, who said that it was named in honour of the Zapatista uprising on the first of January 1994. In this place the traditional conception of a rural/urban divide stretches the imagination. Whilst officially belonging to the city, this land is a large field upon which 400-500 dwellings have been constructed and where living conditions are similar in many ways to those left behind in the rural areas by the majority of migrants who now live there, though there are some non-migrant

residents too. Most houses are made of wooden planks with corrugated iron sheeting for the roofs, with dirt floors and no drainage systems. Few have even the benefit of a pit latrine, some have electricity (imaginatively filched from the local power grid) but there is no piped water except a couple of taps on the extremities of the site from which water has to be collected in plastic buckets. In the rainy season the area is a swamp with mud and water knee deep, and pouring into dwellings, in the lower areas. When it rains people cover their shacks with large sheets of clear plastic in an almost futile effort to keep the inside dry and warm. But even here there are contradictions and variety. Towards the end of my stay a number of breeze-block buildings with cement floors were being erected, and signs of material wealth such as cars and televisions began to appear but the people who lived in such houses were in the minority.

Dahl Jorgensen [1992:201-2] reported particular problems in interviewing women about family planning, regarding family size, in another part of Mexico. Many of her informants agreed to be interviewed once but did not want closer contact with her, not even in the form of a second interview. I did not want simply to interview someone once and then leave never to see them again. I was not going to be asking only about use or non-use of contraceptive methods but, more importantly, I wanted to know more intimate details of how they lived their lives so that I could gain a wider knowledge of those people who were specifically targeted by government family planning services: rural and urban poor, mestizo and indigenous women in whatever combination.

Meeting these women was easier than I anticipated. The different social circles in which I came to mix rarely fraternised across their cultural boundaries. The women from the poorer *barrios* and the invasion site were a mixture of mestizo and indigenous rural migrants who worked, with few exceptions, as domestic servants for mestizo families. These women were of various ethnic origins: Tzeltal, Tzotzil, Chol and mestizo. Some of those of indigenous origin varied their dress and behaviour depending on whether they wished to appear indigenous or mestizo. All spoke Spanish, though for those who had migrated from rural areas it was usually their second language. Education levels varied from none to a few years in secondary

school but most had only a basic primary level. All were materially poor, some more so than others and none of them had the perfect happy relationship with male partners which family planning promotional material presented to the public: the perfect caring relationship, with time and effort spent taking care of each others needs and thinking about how many children to have in relation to personal aspirations, and then carefully planning when to have the first and subsequent children to fit in with the couple's life plans. I firmly believe that for most people in the world this image is a mere fantasy but for those women from San Cristóbal's shanty areas it is a cruel joke. Alcoholism, domestic violence, infidelity, abandonment of partners and children, infanticide - these are amongst the many factors of human fallibility which played a part in the lives of these women and men. This is not to insist that all is doom and gloom with no moments of caring, sharing and happiness, but their lives were a struggle to varying degrees and whilst family planning was not always shunned outright, their experiences, as we shall see, were not necessarily satisfactory.

All it took was to meet one woman, the domestic servant of a friend, to achieve a snowball effect of eager informants. A few women quite clearly did not want to continue meeting after our first encounter and I did not press the matter. One woman in particular, a young, newly married Chol woman living on the invasion site, was very embarrassed about discussing family planning methods and we met casually and infrequently after the first interview when her squirming discomfort prompted me to change the subject. However, in a sense many of the women chose me for their own strategic reasons [cf. Rapp, 1993:58]; and a few I met by chance. The strategic reasons seemed to vary. I came to know the women and their families over a lengthy time period. I explained my intentions to each woman when we met for the first time, or when the subject of what I talked about with these "other" women came up with those women I had known for some time but not yet discussed my work. I explained that we would be talking about intimate areas of life: the family, partners, family planning, sex and that I would prefer to record the sessions to make sure I had not missed anything, or misunderstood something, owing to my less than perfect Spanish and my inability to take notes at speed in this language. I paid 10 pesos¹⁰ every time I recorded an interview with a woman for half-an-hour. These interviews were not to be one off sessions with each woman but were to be frequent

occurrences and so they were also a way in which those women who agreed to be interviewed could earn extra money.

Another function I seemed to serve for these women was that over time I became an unofficial adviser to many of them regarding whatever problems they had, and was frequently requested to accompany them, sometimes with their children, to both government and non-governmental health clinics. I did not attempt to solve anyone's problems but in the way that friendships bring about confidences so I was consulted about different aspects of their lives and things that happened to them. If I was of any practical use to them perhaps it was as a facilitator in dealing on their behalf with people from a different social strata. There were times when my frustration at this almost got the better of me. Not because I minded helping out, and indeed was flattered to be asked, but because some of the women would painstakingly tell me what to say on their behalf in one of these unequal client/provider situations, and what it was they would like, but then would sit at my side with their heads bowed, remaining silent, while I gave the monologue in my broken Spanish. The biggest battle then is to get these women to speak for themselves, not between themselves where there are few problems in airing disputes, but between them and those who represent power and authority. They are not unable to articulate wants, needs and preferences but gaining their confidence in situations which allow them to speak freely does not happen in one-off encounters especially where there is a disparity in the relationship between them and a person who is embodied with the power of being a doctor, a mestizo, a rich person, an official, and so on.

Although I purposely shied away from trying to befriend the domestic workers of my mestizo friends with a view to getting to know them and interview them because I felt sure that this would have caused too much ill-feeling and discomfort between all of us, I made one exception in becoming friends with Carolina, a young mestiza¹¹ woman, of Chol descent. As these disparate groups in which I moved did not mix socially there arose occasions when I was acutely aware of the disapproval of some mestizo friends who could not understand my relationships with these women. Inviting Sebastiana, who worked for me as a

domestic servant, to my house for social gatherings as a guest with her children rather than in her role as *sirvienta* or *muchacha* caused comment. Some felt that she was trying to take advantage of me. Similarly, some mestizo friends could understand my interviewing these women as “subjects” for my study but were mystified by my social visits with my family to their homes.

Initiating the snowball effect

Carolina was painfully shy when we first met yet with a desire to talk about her life and ask me about mine. She was twenty years old with two children and separated from her partner at that time. She had secondary level education but had never worked as anything other than a domestic servant or helping out on her grandfather's clothes stall on the local market. Why did she want to talk to me? There were various reasons as I saw it at the time. There was a possibility of some employment with me that would pay better and be more interesting than domestic work. She knew from her Dutch employer that I might want someone to help me conduct a small scale survey interviewing local women. I did in fact employ her for this some considerable time after we first met. Also, I was an oddity: a *gringa* interested in the lives of women like her who, as she saw it, had hard and uninteresting lives. I was someone to talk to who could offer tea and sympathy at the very least; someone who could agree with her that her partner had treated her badly; someone to complain to about her life in a shack on the invasion site; someone to talk to about her children and her worries about them. Ultimately, I was someone who might be there to help should her situation turn into a crisis.

The question of whether or not to pay informants for interviews was a major dilemma for me at the beginning of fieldwork. Of course you don't pay professional doctors for interviews, nor middle class mestizos, but what about these women from the poor *barrios* whom I wanted to question about their lives? I solved this problem with Carolina before interviewing other women in this way. On the one hand I was afraid that paying for interviews might compromise any meaningful relations I might form with these women and even distort what they might tell me; on the other hand

observing their sometimes fragile lives I knew that paying for interviews would be a way of helping them out financially. In the end, I came to a compromise which worked well for me and, I think, for them. Like Vogt [1990:8] and others working on the Harvard project I paid for interviews, which took the form of informal discussions, but only when they were tape recorded. All other communication with these women I treated as normal, informal, relations. As time progressed I could drop in on them in their homes without them expecting me to produce my little black box and start wittering on about experiences with the health services or contraceptives. They would similarly drop in on me at any time of the day or evening sometimes for a chat about nothing in particular or to rest and have a drink on the way home, or sometimes to ask if I would come to visit them with my *máquina*.¹²

Through Carolina I got to know other women within and outside of her family, some of whom came to me to ask about my work and to be interviewed. Some other people I met opportunistically whilst wondering around the *barrios*, especially when I had my own children with me. Having two fair-haired foreign children with me attracted a lot of attention and I was frequently stopped by people in the street who would ruffle the children's hair and ask them questions before turning their attentions to me. In this way I met Juanita, a Tzotzil woman from Chamula, an *expulsada*,¹³ now living in the *colonia* La Hormiga close to the invasion site. We met for the first time in the Zócalo. Juanita was not a domestic worker. Continuing to wear her blue blouse, black skirt and woollen *rebozo* (shawl) indicative of Chamula women she made some money selling *cinturones*, *pulseras* (woven belts and bracelets) and hair slides which she made from cotton threads or wool. Juanita stopped me and began trying to sell me some of her wares:

"Buy a hair slide for your little girl - 5 pesos, buy one. Buy one - something for my tortilla."

Sadie chose a hair slide and Juanita put it into her hair. Playing with the strands and commenting on the colour she asked me:

"How many children do you have?"
- "Two"

"Ah, only two! Ahhhh."

- "And you, how many have you got?"

"Five. Three girls and two boys."

She had two of the girls with her: a young baby slung across her back, the other a five year old who looked to me closer to three, she was so small and frail. Juanita asked me:

"Do you want any more?"

- "Hmm, I don't really know [laughing]. What about you?"

"No! Oh no! I am very poor. I don't have money for tortillas, for food. No, I don't want more - it's very expensive."

We met many times after that and I acquired a growing stack of *pulseras*.

My methodology, like most anthropology, relied on formal and informal contacts and building up an extensive network of friends and acquaintances. Having children in the field was a very positive experience in terms of gathering informal information. Although I was a foreigner to the women I got to know and therefore of some interest to them because of my different origins and life, I was also a mother and therefore shared at least one aspect of life with them making it easier to start conversations about family planning.

Deciding to carry out a small survey

Having been influenced in the early days of my arrival in San Cristóbal by ECOSUR's emphasis on statistical significance I decided upon a small survey of about a hundred women towards the end of my fieldwork. In hindsight I could have done without it but it provided a few useful lessons on the use and validity of using quantitative and qualitative information gathering techniques. On the one hand quantitative surveys are very useful for gathering demographic household data and for comparison with qualitative information, either positively reinforcing some aspect of the research or to point out possible contradictions. On the other, sensitive information may be lost where the respondent is embarrassed or reluctant to answer.

Census surveys of the kind ECOSUR create or manipulate from government statistical sources are excellent for providing a general overview of the population of an area especially in relation to education levels, types of housing and infrastructure, linguistic boundaries marking ethnically diverse areas, religion, etc. However, there is a possibility of giving research based on large-scale statistical techniques unwarranted authority because of the numbers involved which researchers may imbue with unrealistic result statements. For example, in contraceptive studies there has been a tendency to rely heavily on quantitative research [cf. Helitzer-Allen *et. al.* 1994] especially in relation to researching user preference or levels of acceptance based on numbers of people utilising particular methods. Most of the public health service doctors I interviewed equated user preference with statistical evidence on method use. In fact use may relate more to provider preferences or availability amongst other variables, something which purely quantitative research cannot show. Supporting qualitative research can reveal much more about the statistics and what they indicate. At ECOSUR, a very good paper [Montero *et al.*, 1996] written on sterilisation in Health Jurisdiction III of Chiapas was considered weak because it lacked statistical validity, having only around 40 respondents. This provoked debates on internal and external validity, which is to say the difference between a survey from which conclusions can be drawn about the group (internal validity) but not extrapolated to a wider group (external validity). In fact, the work contained an enormous amount of qualitative information on sterilisation as a contraceptive method and the women who had undergone the operation, and said a lot about the way policy is implemented in the area. Even if the results of this work can only be validated for use in a particular health area of Chiapas it still tells us that there are some quality of care issues which need to be looked at in that area and should be considered seriously by planners if they really do have an interest in improving people's lives and promoting family planning which incorporates good quality of care standards.

The tendency of planners to use large sets of statistical data covering wide areas makes it more likely that top-down planning strategies will be utilised thereby subsuming local variations and problems. People-centred strategies of development

can only be hampered where the large scale survey takes precedence in planning strategies which ignore local conditions at the outset, something which is evidently the case in terms of reproductive health in Chiapas. There were no studies of local “wants” or stated “needs” by government providers amongst the population of Los Altos before heavily targeting the area for increased family planning service provision. Given that the population is largely indigenous, neither were there any studies undertaken on how to promote family planning and other services in a culturally sensitive way.

The survey

I employed Carolina and María Elena (two of my main *informants*) to carry out interviews for me in their *barrios*. I drew up a questionnaire which required short responses to questions about contraceptive use and some demographic details, and instructed them both how to go about it. They were to interview on an opportunistic basis. This worried me at the outset because of questions which might arise over the validity of the sample but I was comforted to discover that Terry had also used “*opportunistic*” sampling in her work on reproductive decision making in Tlaxcala, Mexico “*due to the personal nature of the information being sought*” [1994:22]. Both María Elena and Carolina reported that some women simply refused to be interviewed on the subject and some days Carolina would return despondent at her lack of success in contrast to her buoyant behaviour on the good days when she came through the door laughing, with her clutch of papers.

I had envisaged accompanying Carolina and María Elena in turn to carry out the interviews with them. However, both women made it abundantly clear after the first few interviews that my presence was hampering their work. In fact what they were telling me was clear to me when I accompanied them. Women I did not know were acutely embarrassed about being asked questions on such a private and personal matter in front of me. Carolina said that women’s general embarrassed was increased by my presence as a foreigner. I agreed with them and after every five interviews they would bring the questionnaires back to me and we would go over them together

before I put them onto the Excel database. The downside of this arrangement was that for the first time the direct control of my work was out of my hands and I had to trust these two women to carry it out for me. María Elena, who had worked as a health promoter for both public health organisations and an NGO, coped well from the start though she had much less formal education than Carolina. Carolina was initially very nervous, and in fact embarrassed at asking such personal questions, but her confidence grew as we discussed each batch of five interviews she completed and by the end of the survey one of the most positive aspects for me, outside of the work, was seeing how her self-confidence and self-worth had been improved by the experience.

Having described the main methodological features employed in my research I will turn next to a description of health providers in Los Altos. Health staff and the organisations they represent are the crucial interface between government policy mandates and the people at whom they are directed. It is therefore important to situate them in the context of the population with whom they work.

¹ Autochthony - "native to a very specific place", predating the advent of the nation state [Stills & Morris, 1993:10].

² Ladino is used in most academic literature pertaining to Chiapas to describe non-Indians of Spanish decent. Originally, it had the connotation of being *pure* Hispanic though now it is used in the same way as mestizo to mean someone of Spanish/Indian mixed decent. Other than in quotes I use the term mestizo which was the more common amongst Indigenous and non-Indigenous alike to describe non-Indians; though the former had other terms such as *Jkaxlan*.

³ In January 1994 the EZLN (Zapatista Army of National Liberation) occupied San Cristóbal and other towns in Chiapas during an armed uprising which lasted a number of days before they were beaten back to their jungle hideout. Since then the conflict has been played out on the world stage.

⁴ The Zapatistas take their name from Emiliano Zapata, a national hero of the Mexican revolution, ironically killed by the State.

⁵ These boundaries are subject to change. Freyermuth's study (1993) carried out during the 1980s there were 16 municipios, Cancuc at that time belonging to Ocosingo. The boundaries changed again during the course of my research but I hold to the original 17 I found upon arrival.

⁶ Not only was the priest expelled during a political altercation in the 1970s but all Protestant converts were also expelled and the property expropriated by the leading *caciques*.

⁷ In November 1996 Verification Talks relating to peace negotiations were held in town.

⁸ Mexican law forbids foreign involvement in national politics with threat of expulsion.

⁹ My sources prefer to remain unidentified and so their accounts have been mixed with those from Durán de Huerta Patiño and Boldrini (1998) to protect them.

¹⁰ During our stay the exchange rate was between 10 and 12 pesos to the pound sterling

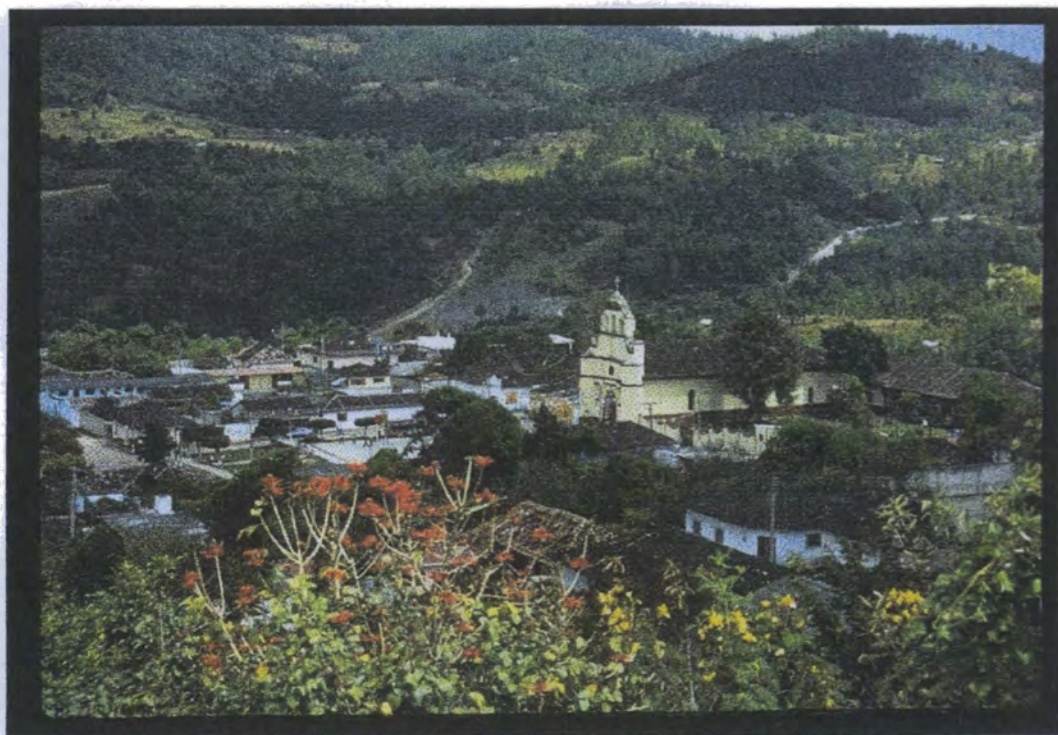
¹¹ Carolina's own interpretation of her identity

¹² Machine (tape-recorder).

¹³ An expelled Protestant.

Plate 4.1 Los Altos

Looking down upon the cabecera of Huixtán, 1997



Fiesta of St Peter and St Paul, Chenalhó, 1996

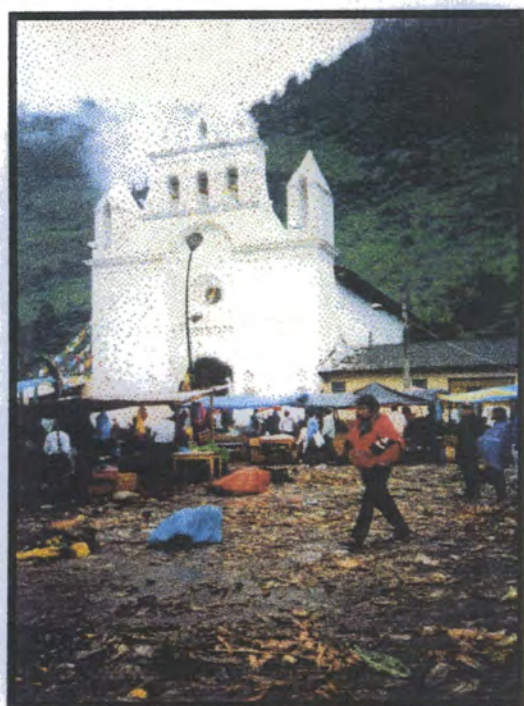


Plate 4.2 San Cristóbal's Markets

The Main Market Place



The Artisan Market, Santo Domingo



Plate 4.3 Demonstrations in San Cristóbal, 1996

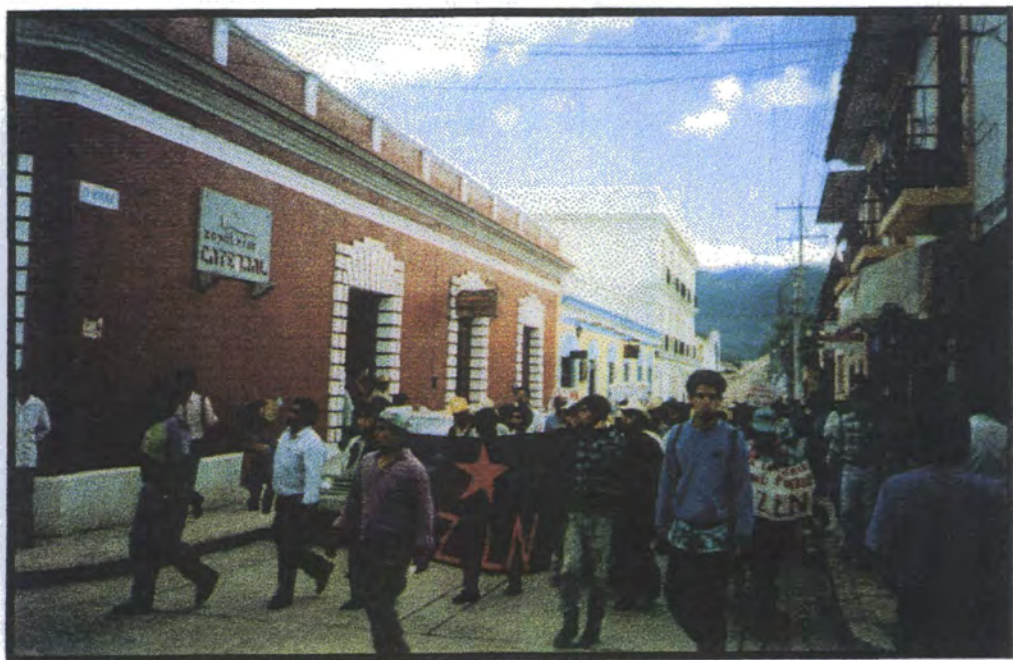
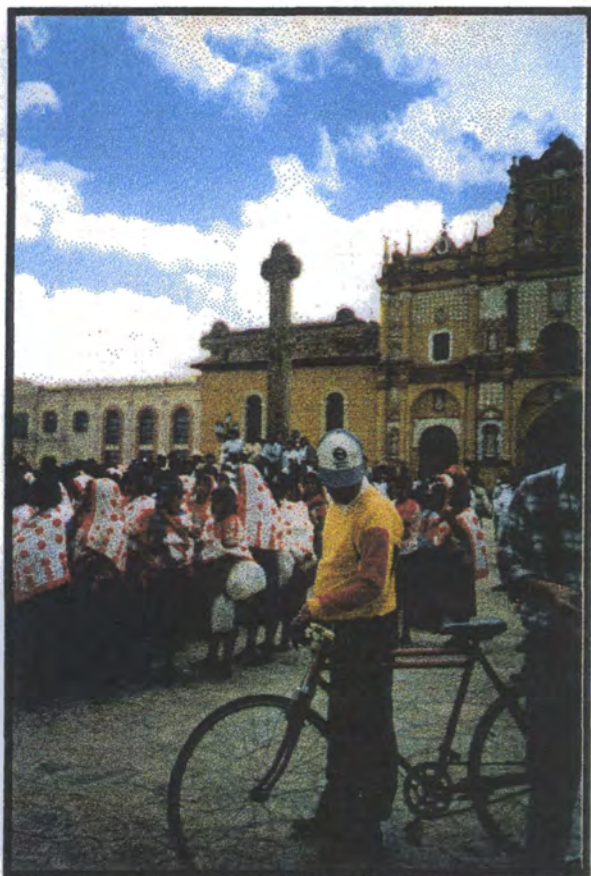


Plate 4.4 Chamula (Tzotzil) Expulsados in Candelaria, 1997

Fig. 1 Chamula Girls



Fig. 3 Grinding Corn



Fig. 2 Chamula Boy



Fig. 4 Making Tortillas 1



Chapter 5

Health Providers in Los Altos

The ethnic opposition between mestizos and indigenous groups in Los Altos, resulting in the dominant-subordinate relationships referred to by Aguirre Beltrán [1979:35], affects all areas of indigenous life but is highly visible where institutional agents and indigenous populations meet: for example, in health and educational spheres. The dynamics of these relationships go beyond the nominally dominant/subordinate positions of teacher/pupil and doctor/patient scenarios to encompass a long history of unequal relationships. Negotiation at the interface of these mestizo/indigenous spheres is highly contested and in the following chapters I hope to shed some light on the various strategies employed by both mestizo and indigenous players in the area of health.

Government organisations

The majority of allopathic health providers in Los Altos are employees of government institutions providing family planning services under integrated programmes of primary preventative health care. Government health providers are directly informed by government papers which set out national and local reproductive health/family planning objectives. Local government providers in Los Altos are answerable to their departmental masters in San Cristóbal, who are in turn answerable to regional superiors, and so on following up the chain of command to Mexico City. The policy edicts flow down and the accountability, statistically measured, flows upwards.

The majority of the inhabitants of Los Altos constitute what is known as a *población abierta* with regard to health service provision. That is to say they are not covered by any form of medical insurance. This population is estimated at 81.4% of the population of Chiapas [Gobierno del Estado de Chiapas, 1996:69]. The medically insured section of the population (*población derechohabiente*) are covered by ISSSTE, ISSSTECH, IMSS, SEDENA and the Secretaría de Marina, amongst

others, financed largely through employee contributions. Although these institutions are all members of the Interinstitutional Group for Reproductive Health only ISSSTE and IMSS provide any significant level of reproductive health service coverage in Los Altos, and this cover is provided almost exclusively within San Cristóbal. There are also private allopathic practitioners, again mainly situated within the more urban *cabeceras* such as San Cristóbal, Teopisca and Las Rosas.

In Los Altos the *población abierta* is mainly served by two government organisations: The SSA serves the poorer sections of the population not covered by other institutions, and, since 1989, the programme of IMSS-Solidaridad, which is mandated to serve the uninsured population and is funded by various sources including the main IMSS budget, as well as some government and international funding. In SSA terms Los Altos comes under Health Jurisdiction II of Chiapas which coordinates a series of primary health care units, while the IMSS units remain within the political administrative regions of the state [Halperin & de León, 1996:20].

These primary care units are scattered throughout the region. IMSS relies mainly on UMRs which are small buildings featuring a consulting room, a small waiting room, lavatory facilities, a room with two beds for patients, and a small bedroom where the doctor in charge is supposed to live. The SSA has far fewer units but a wider range, from the Auxiliary Health Unit (UAS) which is staffed by a promoter, to the two types of Rural Health Centres for concentrated and dispersed populations (CSRCs and CSRDs), and finally the Urban Health Centre (CSU), all of which should have at least one doctor or trainee doctor in charge. Both of these organisations provide secondary level care through the General Hospital (SSA) and Hospital Clinic (IMSS) in San Cristóbal with IMSS also having a large new hospital in Altamirano, in the conflict zone. The SSA further relies on outreach workers in the rural areas such as the Mobile Medical Units (UMMs) and local technical assistants in primary health (TAPs).

Other institutional contributors to health projects are DIF and the National Indigenist Institute (INI), who generally concentrate on educational programmes, often in conjunction with the two main health service providers. My research work

mainly concerned the SSA and IMSS-Solidaridad as these are the main providers of family planning services though DIF also carry out a lot of promotional work. INI is not involved with reproductive health projects.

People's perceptions of these institutions varied both regarding the practicalities of what they could offer, and on a political level about the rationale for the work of each organisation.

DIF - The national system for the development of the family

DIF came in for most criticism as it is so closely linked with political power in the government which is seen to undermine its credibility. Though NGO staff were most critical of DIF, even some government health staff scoffed at the organisation and its *raison d'être*, to help the poor. A leading epidemiologist from San Cristóbal's general hospital told me:

DIF is very much tied in with the government. The president of DIF at national level is Zedillo's¹ wife, at state level it's the governor's wife and at *municipio* level it's the president of the *municipio*'s wife. So, you see, DIF is always PRI controlled at national level and at most other levels - here in Region II, for example.

As Sofia, a mestiza NGO worker commented wryly:

DIF does not have a very good reputation as it started out as a paternalistic organisation to give the wife of the president or mayor something to do. It is something for all of these rich women to do with their time.

The DIF coordinator in San Cristóbal offers a different view. Sra. Gamboa says that DIF is non-political and non-cooptational - simply an organisation which seeks to do good amongst poor communities. It is difficult not to feel sceptical about this given that she has her job because of her husband's position:

DIF is the pretty face (*la cara bonita*) of the government - the only one it has. It's not political.

She says that DIF does not concern itself with whether people are from PRI, PRD, PAN or Zapatista communities. However, few *cabeceras* of Los Altos are not overtly PRI despite vast difference in the localidades of many *municipios*. The *municipio* of Altamirano is in the conflict zone though the *cabecera* is situated on the edges of Zapatista territory and is heavily militarised with migration check-points and soldiers all over the *municipio*. There is no DIF office in this *municipio* at all. Similarly, Larráinzar is a divided community which is still hanging on to its PRD rule. DIF do not work here because of the situation. According to Sra. Gamboa:

You can't work in this community because it's a conflict zone but we'll carry on trying in order to meet the proposed aims.

Having described DIF as totally independent from other health services Sra. Gamboa later retracted this and insisted that DIF had a purely promotional/referral role. Initially she insisted that DIF was better than the other government services because she said that government clinics often did not have a doctor attached to them due to inability to attract staff whilst DIF did. However, DIF medical staff are not resident in the villages and have no clinic base. Rather, they work as part of a mobile health unit. It transpired that doctors associated with DIF health teams were in fact from the other government health services.

There were various contradictions regarding what I was told about the operation of DIF by DIF staff. On the one hand it is non-political and yet it is the "pretty face of the government", which means of PRI. It was said to have independent status and yet had an obvious supportive role vis-à-vis the two other state organisations. This was brought to the fore when I pressed for statistical material regarding contraceptive method use, prescribed through DIF, in the various communities of Region II. Scant information was offered along with the explanation that "DIF is only a support for the other services" and the contention that after promotional events "acceptors are directed to the SSA or IMSS-S in the communities for contraceptive supplies". Despite this, the figures regarding those individual contraceptive acceptors captured by DIF are maintained separately from figures of other contraceptive acceptors within IMSS-S and the SSA. I will come

back to this in a discussion on targeting in Chapter 8, but in the meantime I am left wondering about the possibility of double counting with regard to contraceptive figures between DIF and the other government organisations. Statistical collection seemed piecemeal in any case and trying to get hold of comparable figures extremely difficult.

IMSS-Solidaridad - Department of Social Security non-contributory wing

In 1989 The IMSS Solidaridad programme replaced the preceding programme IMSS-COPLAMAR², which was suspended in 1983, its remit being to carry on where IMSS-COPLAMAR left off in providing services to the *población abierta* [Coordinación General del Programa IMSS-Solidaridad, 1995:1-2].

This programme has also been criticised by political opponents of PRI as a vehicle for political machinations and also, as with DIF, a measure for coopting indigenous communities. Whilst there is a political rationale for criticising these organisations at federal and state level, those who work for the organisations as health staff are also subject to the vagaries of the policies and face their own particular problems in being the local on-site providers. In this kind of analysis there is a tendency to conflate the organisation with the workers which is likely to raise some confusion. Those who work for government health services have their own reason and purpose which does not necessarily coincide with the those of the organisation, and may even be opposed to it. Many of those medical doctors now working for NGOs or in research who criticise the government organisations have been trained within them and came to reject them. These people understand well the difficulties and frustrations for those working within the organisations and those who remain within the system are not necessarily uncritical of government health policy.

The whole “Solidaridad” programme has been referred to as a “pork barrel” [Castañeda, 1993:370], a tool of clientilism and patronage for fattening the PRI faithful and coopting or reinforcing PRI bases throughout Mexico. This view of the political nature of the organisation was reinforced by NGO workers in San Cristóbal

who complained about what they saw as the disproportionate amount of resources afforded them and for misguided policies. Sofia, a mestiza NGO worker saw IMSS-Solidaridad as the most potent vehicle for government cooptation of indigenous communities but pointed out that there was mistrust of government services in general:

There is a lot of government money in Chiapas. Some communities have a lot of services, sometimes because they demand them, sometimes because they have been coopted. Chamula has two health clinics [in the *cabecera*] and a lot of money goes into that community. Everyone knows it's a payoff for their support of the PRI. It's what the Zapatistas are afraid of. They want clinics and medicines but they are afraid that their support bases might be coopted. Some will work with and accept government services, others continue to refuse them.

Sister María, a trained medic and nun working for an order in San Cristóbal, believes that there is a mutual distrust between government and civil society. Whilst Sofia, above, cites the Zapatista distrust of government services Sister Maria contends that it is the government who does not trust either the Diocese or the NGOs in the area:

The government doesn't accept either the Diocese or the NGOs - what we do. They see us as subversive, as though we are working against the government, as though our work will incite the people against them. But look, we have too much work, too much to do and precious little time for these other things. We are more interested that information should reach everybody, that they should know all the risks that they're running with this type of contraceptive or that type of medication that's becoming available. Not so much so that they're looked after by the government but rather that they look after their own health, and if the government has given up on that, well, it's not our fault.

Another nun working for the Diocese was particularly critical of the limited medicines she believed were available from IMSS-Solidaridad medical units. Sister Carla complained bitterly about the "mountains of contraceptives" available though she was not against family planning and said women should be educated to understand and avail themselves of contraceptive methods. What bothered her was the lack of medicines in contrast to the availability of contraceptives. Her colleague Normita, a mestiza teacher who works for the diocese criticised the lack of appropriate medicines within IMSS:

For example, there is a huge amount of medicines for the heart. A lot of medicines brought to the rural communities by Solidaridad are almost all for the heart or for arthritis but these are not serious problems here. The local people tell them 'but these are illnesses which are illnesses of the people from the city not from the communities. This is not a problem here'.

As with DIF, IMSS' detractors generally focus upon the perceived political nature of the organisation as a party political tool of PRI.

The SSA - The Mexican Ministry of Health

In Los Altos the SSA faces less criticism of a political nature (though Sofia's comments above on distrust by the Zapatistas extends to the SSA as well as IMSS-Solidaridad) and most comments testified to its lack of resources as a major drawback rather than any overtly political condemnation. The irony is that at a federal level the SSA is considered to be the head (*cabeza*) of all the health services yet it is consistently underfunded in relation to IMSS-Solidaridad. Whilst most NGO personnel I spoke with were forthright in pointing out the difference the irony was not lost on staff within both the SSA and IMSS-Solidaridad. Dr Gómez who worked at the IMSS-Solidaridad rural medical unit in Tenejapa commented:

IMSS have greater coverage and a better service than the *Secretaría*. This is partly to do with the way the two organisations are financed. The *Secretaría* is funded at federal level but IMSS-Solidaridad gets funding from two main sources - federal funding and also from IMSS-Ordinario so it gets much more money.

This belief that IMSS-Solidaridad is better resourced was supported by Rosi, one of the heads of the SSA family planning programme who told me that "Solidaridad [IMSS] manages more people than the SSA". It is certainly true that if fixed-base medical units are accounted for in Region II then IMSS-Solidaridad numbers 71, mostly rural medical units but with two hospitals, whilst the SSA numbers only 21 of which 10 are rural based clinics; 5 are auxiliary health units (UAS), which are small basic medical posts, and the remaining 6 are in the urban city area. [SSA Hospital, San Cristóbal, July 1996.]

It is easy to account for how this divide came about given that IMSS is resourced largely by contributions whilst the SSA is financed from the public purse. However, what is not so obvious is why IMSS should be seen as a vehicle for PRI party politics. Jorge, a doctor working for the SSA in San Cristóbal summed up his views on the matter:

Money equals power. IMSS raises its own money through contributions and the SSA relies on whatever the government give. This means two things. Firstly, although the SSA is officially in charge of all health policy IMSS can ignore it because money is power and therefore IMSS can also implement their own new programmes, such as Solidaridad. Secondly, the poorer the state the more power IMSS has. This is the situation in Oaxaca and Chiapas where IMSS are able to maintain more autonomy. So in Chiapas IMSS has more power and the government use this institutional power to buoy up their authority in the face of strong opposition from PAN at state level and PRD in the communities. IMSS does this through constructing lots of UMRs in the communities which in turn give it more institutional and political power. Meanwhile, the genuine needs of the people are not taken into consideration.

In a one party State, facing increasing opposition, it is perfectly understandable that government institutions may become vehicles for upholding the power of the government. However, at the local level Jorge contends that people trust neither the SSA nor IMSS because what they do, the things they seek to provide, do not correspond to the needs of the people but rather those of the government.

Jorge works extensively in rural communities in both his official capacity as an SSA doctor and also unofficially, as a volunteer. He has considerable support from various sections because of his dedication: NGOs seek out his help and advice; and in the communities he has managed to build some confidence and is even allowed into some of the Zapatista communities. He considers NGO work in the area a critical factor in attempting to provide some health coverage due to rural distrust of government institutions. He says that when the government organisations persist in wanting to build a medical unit in the more remote localities the locals say "Well, build it then. But then go away and leave us alone." Jorge, as a doctor attached to a government institution, is not alone in his political stance regarding health provision

in Los Altos nor in his practical attempts to work amongst rural communities, but he is one of the few who were so candid about his work and views.

Despite apparent differences in the resourcing and political use of these two main government health organisations many people criticised both for lack of medical supplies. A general lack of basic medicines caused much criticism in the context of Los Altos. At a higher level, in Mexico City a leading doctor was sacked for complaining about lack of supplies in IMSS hospitals. Dr Ignacio Madrazo Navarro lost his job after claiming that supplies of medicines in IMSS hospitals met only one third of the need. [Mexico City Times, 5/12/96:3]

The SSA's apparent lack of resources is reflected not only in its lesser coverage of Region II but also in its problems in paying staff. Whilst in the rural areas a large number of health promoters are elected from and by the local community, and then work on a voluntary basis with the government health services, both the SSA and IMSS-Solidaridad take on salaried health promoters for particular projects such as vaccination or family planning campaigns. Eva, a bilingual Tzeltal woman from Oxchuc described her experience working as a promoter in a Tojolobal community in Comitán for the SSA:

I was trained for 15 days in how to promote and give vaccinations. Then they gave me a job in Comitán. There was nothing available here [San Cristóbal]. So I go there and work from Monday to Friday and return here at the weekends. It is hard work. We have to walk all day in the communities to give the vaccinations. They pay me 900 pesos a month. They pay two months in arrears but I have not been paid for 4 months now. They keep telling me next month it will be okay but how can I live when I'm not paid? I've had to borrow money to live and to travel to Comitán. If they don't pay me soon I will have to leave.

- Do you have a contract?

Yes, for a year, but it doesn't help me. When I complain and ask for my money they [the SSA] say if I don't like it I can go somewhere else to work. But they always pay the doctors - they don't have to wait for their money. For us [promoters] it's different - we have to wait, we are afraid to leave in case they do not pay us at all.

Similar stories were repeated by many who worked in government services: health workers, teachers, municipal administrative workers. Rosa, a Tzeltal woman from Cancun who had lived in San Cristóbal since her early childhood, left a government administration job because she hadn't been paid for months. She should have been paid by the *quincena* (15 days) but she got so desperate that she took domestic work and effectively lost all the pay owed to her. Normita, the mestiza health education worker, had a similar story to tell when we were discussing health promoters having problems with the payment of wages:

With the people who work in education for the government it's the same. You begin to work months before they pay you. How is it possible? But you have no option. If you have no option but to work in a government school then you have to accept this situation. Sometimes your pay arrives three months late, sometimes six.

I ask about trades unions.

Well, they exist but in Mexico most of them are corrupt. I worked for three months in a government school, three months but never again in my life will I do this. I will never return to work for the government.

When the head health service organisation, the SSA, is so resource constrained compared with its major counterpart, IMSS-Solidaridad, it is not surprising to find criticisms of the latter that it exists for *razones políticas* (political reasons) with an agenda which fits with the country's historical political reliance on clientelism to maintain in effect a one-party political state.

Health coverage of the *población abierta*

One question which constantly nagged at me was why it was necessary to have two health organisations, the SSA and IMSS-Solidaridad, to cover the uninsured population. Jorge's opinion that IMSS had more money and therefore political clout and resources to extend its sphere of influence was the closest anyone came to giving me an answer. Most people simply said that the reasons were "political" but without seeming able to say more. Perhaps it was a case of what appeared odd to an outsider was simply a normal situation which there was no need

to question for most Mexicans. Interestingly, just as I was leaving Chiapas in July 1997, it was decided at federal level that the SSA should absorb IMSS-Solidaridad in all states with the exception of Chiapas and Oaxaca. Perhaps this illustrates how complicated the political situation has become and illustrates something of the power which IMSS has on a state level given that Oaxaca and Chiapas were exempted from the general rule. This anomaly drew the ubiquitous answer that this exception was for “political” reasons. So whilst the other 30 states of Mexico undergo institutional changes in the health sphere Chiapas and Oaxaca, two of the most marginalised states and both with significant indigenous populations are to remain under the administration of two mutually autonomous organisations. Elsewhere the SSA will take over IMSS and authority for health care will be decentralised and vested in each state. Dr Figueroa of the IMSS-Solidaridad Clínica del Campo in San Cristóbal would not be drawn on the question of why these two states were excluded. He shrugged and told me that this was government policy and could not be opposed but he failed to offer any comment on why these two states had been singled out.

The respected Mexican newspaper, *La Jornada* [12 September, 1996], reported the speech of the Secretary of Health, Juan Ramón de la Fuente, announcing that these changes would include increases in monetary resources and that decentralisation of the SSA would mean more local accountability. In that case, to leave out Chiapas and Oaxaca possibly indicates that the political situation is so volatile that local accountability could not be guaranteed and that the government wish to remain, at least on paper, in total control. It would at least explain the constant answer “for political purposes” in relation to questions about why these two states have been exempted from the general rule. I left Chiapas before decentralisation of the Ministry of Health and its subsumation of IMSS-Solidaridad got underway, and as yet the process is in its infancy. It will need some time to assess what, if any, changes will occur in the quality of medical services provided in Mexico.

Non-governmental organisations in Los Altos

There were a small number NGOs based in San Cristóbal who worked in various parts of Los Altos. Of these, a few provided family planning services though most concentrated on educational work, rather than on service provision, designed to make people aware of development opportunities, including those relating to reproductive health. It came as some surprise to me that most women working in the Catholic diocese on health projects viewed reproductive health (including the provision of information about family planning) as an integral part of their work. They did not provide family planning services but like the NGOs made the issue part of their remit within an educational framework.

The activities of many NGOs in the area were directed outside of Los Altos in the La Selva region areas with only a minority addressing needs in the highlands. These focused mainly on formal and health education. Government educational facilities are basic, if they exist at all, in the remote areas and post-primary school is only provided in towns like San Cristóbal. Some NGOs worked directly with Zapatista communities providing, for example, expertise in building drainage systems, though many stated that they worked anywhere that there was a need for their services. Within Los Altos there were a number of important NGOs providing health care. Amongst these were the Grupo de Mujeres (the Women's Group) who had set up a clinic in the marginalised barrio of Tlaxcala where they also provided other services, such as legal advice, at a very low cost. Women came from all over to use this clinic, often accompanied by men, and of course their children. The group also had a number of health projects in rural areas. I had intermittent contact with the group because I often accompanied local women to the clinic. OMIECH is also a significant group, primarily because it is an indigenous NGO dealing with health. Its main work is to carry out research on indigenous medicines and to work with indigenous healers. As such it is not currently concerned with modern methods of family planning provision though they have carried out some studies into the use of traditional methods of fertility regulation. Other Mexican NGOs providing health education include Chiltak and Produssep.

Choice of health providers available to the *población abierta*

Amongst the *población abierta*, whether rural or based in the towns, there is a significant reliance on traditional healers and midwives and also, according to a senior doctor in ISSSTE, substantial amounts of self-care (*auto-cuidado*). Amongst poor women I interviewed in the city I found that there was also a willingness to go to private allopathic practitioners where other solutions to health problems had failed or where there was a belief that the service provided would be of a higher quality than alternative possibilities. Despite the fact that these women had low and insecure incomes there was willingness to pay for private consultations in certain circumstances; recourse to traditional healers is not free though usually less expensive than private allopathic treatment. A notionally free government services is not necessarily preferred by the uninsured section of the population to private or traditional services charging fees. Moreover, not all services within the government organisations are free. In the SSA's General Hospital secondary level services must be paid for, as well as some technically primary level care such as cervical smear testing. In the IMSS Clínica del Campo all care is supposed to be free but with shortages of resources this is not always the case. All family planning services in government organisations are free but demand, especially outside of the city, is very low.

The clinic in the rural highlands: a mestizo space in an indigenous world

Given a consideration of the clinic as a supralocal institution, following Nash, I want to briefly describe the setting of two clinics in Pantelhó as typical health units. This is one of the few *cabeceras* which counted both an IMSS and an SSA unit within the boundaries of the *cabecera* itself (the other two being Chamula and Tenejapa).

The SSA Rural Health Centre for a Concentrated Population (CDSR(C)

The SSA clinic was newly built and firmly situated, like most SSA clinics, within the main part of the *cabecera*. The old clinic, now dilapidated and abandoned, was even more centrally positioned off the main square. It was a definite feature that within the boundaries of *cabeceras* SSA clinics were built in a central location whilst the IMSS UMRs were situated away from the centre on the edges of the main area, sometimes quite a walk away.

The *encargado* (person in charge) of the SSA clinic was a young male *pasante* who had been in the position by the time of the interview in November 1996 for 10 months. There were no qualified doctors attached to the clinic but he was assisted in his work by three qualified nurses (two male, one of whom attended the interview, and one female) along with two local technical assistants in primary health care. The *pasante* was quick to emphasise that his work was mainly in preventative health care measures which meant a lot of promotion, especially out in the rural communities of the *municipio*. Despite the outreach nature of his work, and the fact that he had been in the post for some 10 months, he was of the opinion that the ethnic make up of the *municipio* was around 50% Tzotzil: 50% mestizo. In fact the *municipio* of Pantelhó has an indigenous population of around 93% of whom around half are Tzeltal and the other half Tzotzil³ [INEGI, 1990]. The remaining 7% of the mestizo population live mainly in the *cabecera* and this may have given the doctor the impression that there is a larger mestizo population than there actually is but his misperceptions should have been corrected by his work in the rural communities. Another factor in his misrepresentation of the size of the indigenous/mestizo populations is the fact that so few indigenous people use the clinics (the waiting room was virtually empty on the few occasions I found myself in Pantelhó) and so he probably dealt with more mestizos in the clinic relative to the size of their actual population.

As is to be expected from a new clinic, it was bright and clean with white, freshly painted walls. The small, neat consulting room housed a desk and chair for the doctor, a chair opposite for the patient, and an examining couch. The walls were

decorated with posters promoting family planning and child vaccination, as well as advice on how to avoid cholera and diarrhoea. All of this information was given in Spanish and intended for a literate population. One family planning mural had contraceptive methods pinned on to it: a packet of pills, a vial and syringe for injectable contraceptives, an IUD strategically placed on a line drawing of the female reproductive organs (disembodied), and other line drawings (again disembodied) of the male and female reproductive organs showing where incisions and cuts would be made for vasectomy and female sterilisation.

The clinic building itself is not physically too out of place amongst the other brick buildings of the *cabecera* but the integral space represents the authority of a mestizo doctor who is from another part of Mexico and knows little of the culture of Chiapas, mestizo or indigenous. He was, however, more than aware that he was working in a conflict zone and illustrated how the situation affected the results of his work:

They say that [vaccination] was to stop them from having children and so they refused it. We still promote vaccination and still none of the *localidades* accept it. It's worse now with the conflict. They think the government has sent the vaccinations for this reason.

Unlike other mestizo doctors in the majority of *cabeceras* of Los Altos who are faced with being ethnically isolated, this *pasante* lived in a *cabecera* with a significant mestizo population but still he was an outsider with an agenda based on proving his worth by providing his bosses with statistical verification of his success in preventative health strategies.

The IMSS Rural Medical Unit (UMR)

When I went to visit the IMSS clinic in the hope of interviewing the doctor I had to wait two hours until he arrived. He was over an hour and a half late in opening the clinic for the afternoon surgery. He was in no rush and perhaps did not see the need as there had been no patients in the clinic all the time I waited except a drunk man looking for some pills for his hangover. In the doctor's absence the local

auxiliary opened the clinic and awaited his arrival, so I used the time to chat with him. The auxiliary was from Zinacantán and spoke various dialects of Tzotzil (his native language) and Tzeltal which he practised at length to explain the difference to me. His job was mainly to act as interpreter for any indigenous patients who might come to the clinic but they were few and far between because, he said, “they don’t have any confidence in the clinic”. He says that some indigenous people come once for a consultation then do not appear for their next appointment. He also said that they pay for medicines which are free in the clinic but that they have a different trade mark in the chemists and so the indigenous buy them believing them to be both different and better, because they have to be paid for in a chemist’s. On the other hand, he said that mestizos were quite happy to use the clinic and always kept their appointments.

When the doctor finally arrived he agreed, at first grudgingly, to the interview but later seemed to enjoy talking. Dr Hernández, like his counterpart in the SSA clinic, was the *encargado* of the rural medical unit and a *pasante*. He had been in the position for six months and seemed to have a greater awareness of the ethnic make-up of the *municipio* than his colleague at the SSA clinic. He said that he believed the *municipio* to be mainly indigenous with a large core of mestizos living in the centre of the *cabecera*. Dr Hernández was from the *municipio* of Tlaxcala and thus an outsider in Chiapaneco terms but he was very opinionated on the lack of clinic use by the local indigenous population:

Well, they don’t accept us because they don’t understand - they have their myths, which comes from their culture. But once they are brought up to date (*actualizados*), well then some of them accept us.

His use of the term *actualizados* is indicative of his general attitudes towards the local indigenous population: that they are ignorant and need to be brought up to date, and made to understand what is good for them. Throughout the interview he refers to problems in providing health care for the indigenous population as a result of their culture. The word “culture” is used as a throw-away filler to express his views of their backwardness and traditional attitudes which must be overcome though he seems to know nothing, in reality, of what indigenous culture entails on

any level other than his perceptions about the existence of myths which stop them from taking advantage of health services.

The position of the clinic in relation to the centre of the *cabecera* was a strange choice on behalf of the planners. Situated on a steep, high hill on the far edge of the *cabecera* with no road or footpath leading up to it and all the closest inhabitants at the bottom, it entailed a lengthy climb to the top. On the bright sunny day on which I arrived this was a pleasant walk but for someone who was sick it would have been difficult and tiring, and perhaps for some impossible. On leaving, after a sudden deluge, the hillside had turned to rust coloured sludge and the descent was treacherous. With no actual path the mud became knee deep on the well-worn sections of the track and the boulders which held firm in the dry earth slithered away from underfoot in the rain displacing hopes of a foot hold on the steeper more frightening sections. A run away, angry pig and a few antisocial geese added to this farcical descent. Perhaps this was another reason why the clinic attracted so few people. A hasty ascent or descent in or after rain for some emergency would be impossible. When I finally reached the bottom I was only too happy to accept the offer of a local man to stand in a bucket-full of clean water, in full view of amused onlookers, to wash my feet and legs.

The clinic itself is typical of all UMRs as described above. The walls were decorated with the same posters found in the SSA clinic, which is not surprising as many of them are published by international organisations such as Pathfinder International, Planned Parenthood Federation and the UNFPA. The majority of posters were to promote family planning with one on good health in pregnancy and one on how to avoid cholera. In addition there was a large booklet entitled “Salud Reproductiva” (Reproductive Health) with the logo: “Nosotros te informamos, tú decides” (We inform you; you decide). The booklet gave information in Spanish on care during pregnancy with a number of pages devoted to contraceptive methods. As with the SSA clinic the information was given in a form meant for literate Spanish speakers not illiterate mono- or bilingual Mayans. The one exception to this rule was a box of condoms situated in the waiting room with a hand-written sign in both Spanish and Tzotzil saying “take one”.

These clinics are typical of those found in the *cabeceras* throughout Los Altos: supralocal mestizo institutions in largely indigenous areas. Exceptions are Teopisca, and Las Rosas which have large mestizo populations and of course San Cristóbal though for indigenous people using these clinics the spaces remain alien inasmuch as they face the same problems and attitudes as their rural counterparts. Even within mestizo rural areas people may choose between allopathic health care from clinics or remedies from local mestizo curers. Every day on a corner of General Utrilla, a main street of San Cristóbal, an indigenous man promoted his cures, often distilled from the flesh, blood or skin of animals. My favourite spectacle was his salamander routine. He would bring a jar of water containing two salamanders and talk about their amazing features: that they could live on land or in water. Then he would talk about how useful these creatures were to human beings as a good source of food and medicine. His major claims for the properties of salamanders were a cure for womb cancer and restoration of sight, and he always had a “healed” patient with him.

Domination through supralocal institutions

Returning to the domination/subordination paradigm outlined in the previous chapter and reintroduced at the beginning of this chapter I would like to take up Nash’s assertion that supralocal institutions shape the role of the *Indian* in the regional and national economy [1970:71-2] by suggesting the clinic as such an instrument of cultural and political domination. Such institutions do not only have a role in relation to economic variables but also to social and cultural factors. In a sense this echoes the debate on assimilation or integration of the indigenous population [see Pineda Sánchez, 1993; Favre, 1973] as a political strategy of nation-state building; though in the wake of the Zapatista uprising there is at least an academic focus on indigenous participation in the state through limited autonomy [see Stephen, 1997]. The indigenous struggle for such autonomy apart, it might be argued that the spread of government services ever further into indigenous areas may be viewed as cooptational for such political ends. Certainly the schools, clinics, and other supralocal institutions give a government presence within otherwise semi-

autonomous areas⁴ and at the very least can maintain a watch over what is happening in these areas; a Mexican mestizo eye on an indigenous *region of refuge*.

Conversely, we could argue that government health policy is a benign instrument of health care to which all should be entitled rather than a cooptational or even repressive presence in a Foucaultian sense. A rationalistic, benign, apolitical view of government health services vies for position with the dominating, acculturative or integrative view which marks out government health services in Mexico as highly political tools in the hands of a one-party state system, which is being employed to help deal with a historical indigenous *problem*. Of course, these competing paradigms blur at the edges where the clinic and the community meet and much depends on providers attitudes and local preferences at this interface. Whatever the viewpoint, it may be found in a social, cultural and political-economic matrix of domination and subordination. The clinic remains an alien mestizo institution in the local indigenous context.

With regard to the assimilation/integration debate, the health institutions providing primary level care in rural communities rely on local people to work as promoters and technical assistants in primary health care. These people are meant to reinforce the allopathic health view displacing indigenous practices to assimilate the population into a mestizo-based health care system. The attempt to incorporate indigenous *parteras* is part of this programme, there being no apparent desire on the part of the health services to share a level of understanding between the allopathic and the traditional, but to use the *parteras* for clinic purposes: gathering demographic information and promoting family planning. There are more recent attempts to incorporate or integrate indigenous traditional medics as well. The government decision in 1997 to build 20 new rural clinics and incorporate traditional medics within them will have the effect of extending the influence of the dominant mestizo culture into areas where such supralocal institutions do not yet exist. The question remains as to what purposes this will serve. Whilst one way of extending primary health care is through the use of locals, who already have the confidence of the people, as intermediaries who can promote allopathic and preventative health measures, what about the skills and knowledge of traditional healers within a clinic setting? There is little evidence as yet that traditional methods are given respect or



prominence within the mestizo clinic setting, even within the traditional consulting room of the SSA clinic in Chamula (see chapters 10-11). Yet, this is supposed to be the intention of such a policy - to integrate aspects of both traditional and allopathic in a complementary system of care which is the opposite of long-standing programmes which have sought to displace local reliance on traditional healers. What undermines the scope of this apparently integrative measure is that it seems to be the case, in Los Altos at least, that the traditional medic and the *partera* give up their independence to a dominating authority once they take this path. Few *parteras* have been truly incorporated so far and in Los Altos the only medic to be incorporated at all is Don Mariano from the Chamula clinic. It remains to be seen, if and when the new clinics are built, whether IMSS will have any success in attracting traditional healers and, if so, how things will work out. The experience of the traditional consulting room in Chamula does not provide us with an optimistic example.

Nash illustrates how institutional buildings in a *cabecera* are peripheral to local life but are areas in which to view outside influences:

“The house has retained its importance as a ceremonial locus not only for life crisis rituals but also for initiating new officials into the civil and religious hierarchies. The institutional buildings grouped round the plaza - the church, the *cabildo*, the school house, the clinic, the mill, and the cooperative store - are the meeting ground for outside representatives of national or supra-local agents and townspeople. These provide the settings in which behavioural adjustments to internal changes and to external standards can be viewed.” [Nash, 1970:292]

If the clinic can be considered as such an area where outsiders and townspeople meet, then the view of outside influences with which we are provided is one which shows the clinic as marginalised in importance to local people. Throughout the rural areas clinic use is low, forcefully illustrating that as a *supralocal* structure its influence remains low and for many people unwanted. Nash's reference to the school being regarded [in Altamirano] as an alien structure [1970:302] applies equally to the clinic. Doctors live in these rural clinics but, despite the desires of their paymasters, remain unintegrated within local life. Some doctors make more of an effort than others to involve themselves in local life but for all of them it is difficult. Distance

from the departmental capital of San Cristóbal may have some influence on the likelihood of doctors making inroads in the respective areas given that the more remote the locality, the less contact the people within it will have with mestizos on a regular basis. However, other factors such as local politics and the severity of the conflict may also mitigate against doctors becoming fully integrated in the rural setting. It is to such constraints I will now turn in the next chapter which begins the final section on aspects of policy, provision and use of family planning services.

¹ The Mexican president

² IMSS and the *Coordinación General del Plan nacional de Zonas Deprimidas Y Grupos Marginados* (General Coordination of National Plan for Deprived Zones and Marginalised Groups)

³ Pantelhó has a total population of 13131 of whom 12204 are indigenous. Of these 6173 are Tzeltal and 5781 are Tzotzil, and 250 accounted for as "other" indigenous [Inegi:1990]

⁴ Though without participation or influence in wider Mexican state affairs.

Plate 5.1 Health Units in Los Altos, 1997.

Fig. 1 SSA Centro de Salud Rural (D), Mesbiljá



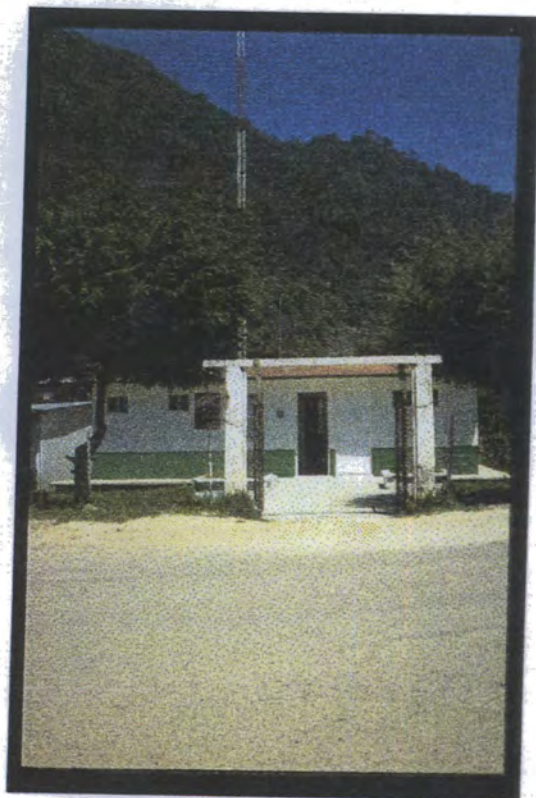
Fig. 3 Unidad Médica Movil, Las cañadas de la selva



Fig. 2 IMSS Hospital, Altamirano
(The poster says it is forbidden to enter with a baby bottle)



Fig. 4 IMSS UMR, Tenejapa



PART III

PROVIDING FAMILY PLANNING SERVICES IN LOS ALTOS: ASPECTS OF POLICY, PROVISION AND USE.

Chapter 6

Government Health Service Providers in Los Altos: Constraints and Quality of Care Issues

Access to health services is not only related to geographical and economic aspects but also to culture, education and perceptions of quality of care. The question is what kind of doctor is required to attend indigenous and peasant communities who live in rural areas with high levels of marginalisation. In this context there is not only a gap in the required academic profile of the doctor, but also with regard to his mentality, disposition and expectations of offering adequate attention and quality to poor people in remote rural marginalised areas. [Sánchez Pérez *et al.*, 1995:73; *trans.*]

The realisation of the ideal of informed choice in family planning hinges on the relationship between the provider and the client or potential client. High quality of care levels are demanded, according to national and international reproductive health protocols, in order to ensure that clients may make an informed choice for themselves. Quality of care standards relate to general medical service provision and access, and not only to reproductive health services, though there is a wealth of literature relating to quality of care and informed choice specifically concerning the latter [see Katz, Hardee and Villinski, 1993; Potter, Octavio Mojarro and Nuñez, 1987]. However, where reproductive health services are provided in conjunction with other health services at a primary level in rural clinics or at secondary and tertiary levels in urban areas it is possible to gain some idea of standards of quality of care by assessing general attitudes of providers towards their clients. Moreover, it is hardly likely that the same practitioner will offer variable standards of care depending on what service he or she is offering a particular client. Some literature on quality of care in family planning addresses the subject as though it were the only service being offered [World Bank, 1993]. In practice, at least in Los Altos, this is not the case. In rural areas it forms part of a primary health care package. In San Cristóbal most of the larger urban clinics/hospitals have a consultancy area devoted to family planning (IMSS, SSA and ISSSTE).

Another issue which must be addressed is that of government (or NGO) provided resources in highly marginalised rural areas. Whilst informed choice between various contraceptive methods allows us to examine one set of conditions

under family planning services, what of the choice between the use of family planning and another desired service? Might not an individual, couple or community wish to choose, for example, access to potable water or the construction of a drainage system, electricity, or access to antibiotics rather than contraceptives? These are also possible choices which under conditions of constraint may be a preferred choice sought by the intended recipients of family planning services living in rural and marginalised localities.

This is an important point considering the living conditions of many rural people in Los Altos, not to mention those living a highly marginalised existence on the outskirts of San Cristóbal itself. Given the marginality of the region, should people be given the right to choose between the different services they want rather than have the choice foisted upon them by a government (or other agency) ostensibly seeking to improve conditions in the area but whose hands are tied, at the very least, by lack of resources? A deciding factor in this might be that funds donated from abroad for family planning services cannot be used for anything else. This also then denies the Mexican government itself of its sovereign prerogative of deciding upon what priorities it should focus its attentions. This is an important point. If participatory development solutions have any chance of success should they not also rest on the priorities voiced by the targets of such development programmes rather than on those of the facilitators?

In the light of such questions I would like to examine health service and family planning service provision in Los Altos a little more closely. Sánchez Pérez *et al.* [1995:73-4] raise points concerning the socio-economic and cultural gulf between doctors and patients in rural Mexico. They refer in particular to the practice of final year student doctors, known as *pasantes*, mostly from middle class urban areas, being compelled to carry out a year of social service, often in rural indigenous areas, in order to qualify as medical doctors. Given that informed choice rests upon meeting certain aspects of quality of care, how is such a cultural gulf likely to affect the provision of services in such areas? These *pasantes* bring with them their experiences of class and culture; they also bring with them their expectations, whether these are a concern for indigenous people, a simple desire to pass the year and then get on with

the rest of their lives, or the wish to do a good job in constrained circumstances. They operate within many constraining boundaries: they find themselves in remote rural villages unable to speak the languages; they usually have no knowledge of the local culture and are unable to understand the apparent ambivalence of their client population towards the services offered; they are cut off from their families and friends and thus have no immediate support network. In short, they are alone in an utterly alien environment. They then face problems concerning the lack of resources which they can do nothing to rectify and the imposition of policies which they must attempt to carry out fully or face castigation from their superiors, even where they come to consider these policies inappropriate for the local population.

In one sense these *pasantes* are in a position of power vis-à-vis their clients. They are of, and represent, the ruling mestizo class. They are in a position to diagnose illness and prescribe cures. They are in a position to aggressively promote government campaigns for family planning, vaccination, sanitation strategies and other components of primary health care packages. They are educated and literate. They are appointed from outside of indigenous communities by invisible bureaucratic government sources. In bringing their backgrounds to these indigenous villages many maintain the view that they are working amongst traditional peoples who need to be brought into the 20th century. Some qualify and leave for urban areas hoping never to return. Others decide to stay and work for the government or NGOs. Despite the seeming opposition between government and NGOs many doctors of both types of organisation cooperate with each other. There are many doctors within the government system critical of the way things work but who are driven by a determination to improve health conditions in Chiapas. There are also some who work covertly with, and have been accepted by, Zapatista communities. A few government clinics also operate officially in some Zapatista locations. Views amongst political savants in the area vary on this matter as to whether the government is providing a much needed service or using the services as a way of coopting local populations and trying to cause divisions within the ranks of Zapatista communities.

I want to turn specifically now to the issue of health service delivery and a consideration of provider-client contact. The final point of contact between provider and client is absolutely crucial in any assessment of informed choice. It might be that a clinic has the widest possible variety of contraceptive methods from which to choose in a clean and comfortable setting but without a basic level of understanding and of respect between the provider and client the result is dubious. Where the material conditions are poor and the provider and client have difficulty in understanding each other, culturally as well as linguistically, the final outcome of the consultation is unlikely to meet basic standards for an informed choice outcome on behalf of the client. Local community translators are a main feature of health service provision in indigenous communities of Los Altos but this does not guarantee that the provider-client discourse will be mutually understood. Even the desire to offer health services which both respect and are respected by the client is likely to be coloured by provider perceptions of their clients, dependent on cultural and social differences [cf. Perea, 1994:15]. Constraints faced by providers within the clinic setting, as discussed above, only compound the situation.

When interviewing doctors, nurses and local paramedical staff in Los Altos my questions were designed to elicit how the providers felt about their clients and what their attitudes were to providing services in a particular area to a particular section of the community. Apart from conducting interviews I was continually observing at each event and location. My experience was that you can observe many styles of behaviour and attitude between providers and clients simply by waiting in the clinic, watching and listening closely.

Respect is a keystone in the provision of quality of care in family planning services and thus informed choice [cf. World Bank, 1993:29]. Respect for a person might be perceived through standards of courtesy and consideration. Respect for beliefs and culture can be more difficult to interpret but not impossible and can be gauged in the way that a person views another's culture and beliefs, as well as in the way a person treats one who is different. Chiapas is a society which displays the open wounds of its cultural and social rift clearly. Where I found racism it was not always intentional, in fact, sometimes it was precipitated upon fear of the *other*;

where I found respect and/or sympathy, it was often accompanied by a desire to change the ways of these “backward” people.

Behaviour and discontent amongst doctors and *pasantes*

Dr Pérez (*Pasante*), Amatenango del Valle, IMSS UMR

Pérez works at the IMSS rural medical unit (UMR) in Amatenango, 40 minutes by bus from San Cristóbal. It is economically reflective of Los Altos in general in that it is a rural *municipio of campesinos*. However, it has a much lower indigenous population (36.4%) than many other *municipios* in Los Altos though Dr Pérez is of the opinion that the area is 70% indigenous. The clinic lies a 10 minute walk over fields from the centre of the *cabecera* though it is immediately accessible from the main highway which runs past it to Comitán. The clinic is a converted *bodega* (grain store) and fairly standard of IMSS UMRs.

In the waiting room I sat amongst the six patients who were also waiting to see Pérez. The Tzeltal woman sitting at the back of the small area was nursing a very young baby. Pérez arrived three-quarters of an hour after the surgeries should have begun. After going through the formalities with me about who I was and what I wanted (I was after all an oddity being the only gringa in the room and was thus addressed first) Pérez walked up to the Tzeltal woman and conducted the consultation there in front of me and the other clients standing over her as he questioned her. He did not even greet the couple [cf. Maternowska, in press] but perfunctorily began questioning them:

Pérez: Who is the sick one?

Woman: My baby has diarrhoea

Pérez: How many days has the baby had diarrhoea?

Woman: Three

Pérez: What colour is it?

Woman: Yellow

Pérez walked off to his consulting room and returned carrying a few oral hydration sachets. He gave them to the woman instructing her once to mix them with water and give them to her baby so many times a day. The woman took them and left.

The consultation was not recorded; no names given or exchanged. Neither had the baby been examined - no temperature taken; no physical probing. In fact, the baby was barely looked at and all that was visible underneath the shawl was a partial view of its face. The woman spoke so few words I was unable to ascertain how good her Spanish was. She was not asked if she clearly understood the instructions nor was she likely to ask him as the next dialogue will illustrate.

Pérez went on to a Tzeltal couple who sat at the front of the waiting room. The woman had a very prominent rash all over the visible parts of her body: arms, lower legs, face. He did not greet them in any way but addressed the man as follows:

Pérez: Who is the sick one? (*¿Quién es la enferma?*)

Man: My wife.

Pérez: What is the problem? (*¿Qué es el problema?*)

Man: My wife has this rash over her whole body (pointing to her arms).

Pérez, turning to the woman: Have you eaten anything that you don't normally eat in the last few days?

Woman: No

The woman never looked at Pérez' face¹. Even whilst voicing her perfunctory "no" she sat with her head bowed as though studying her bare feet. Again no record was checked or recorded; no names exchanged; no questions about possible previous occurrences of the rash. The man and the doctor spoke about the woman. The woman was barely included. Neither she nor her husband actually asked any questions of the doctor who quickly decided it must be an allergy to something she had eaten. At this point I was invited into the consultation room. I indicated strongly that the doctor should see to his remaining patients before we began the interview and that I expected the interview to be interrupted by the appearance of newly arriving clients. His response was to close the door on the waiting area and we sat ensconced like this for the next two hours. When I finally

emerged the waiting room was half full including the patients who had been present but not seen to when I arrived.

A number of issues arise from this. Whilst my own ideas of holding a consultation are of course coloured by my European background, my normal experience of private, NGO and other government clinic consultations in Mexico run along similar lines: that is to say that consultations are held in private areas; personal details such as name, address and medical history are entered as a formally written record of the consultation, with new details about the current consultation entered at the time. In Mexico, the health authorities expect patient records to be kept yet Pérez did not record a thing. A question I asked of all providers was whether or not their indigenous clients objected to written records being kept of their consultations. Without exception the question was treated with surprise and where most doctors were unanimous in their assertions that women did not like to be gynaecologically examined they were convinced that record-keeping did not pose a problem.

On the day I interviewed Dr Pérez, he was 45 minutes late in arriving for the afternoon surgery. He was late on the two previous occasions when I had visited the clinic. I have no idea of knowing how frequently this happened but persistent lateness by *pasantes* was a problem related to me by a local health auxiliary in Pantelhó where, on the day I visited, the *pasante* turned up one and a half hours late to begin his surgery. Pedro, a Tzotzil health auxiliary was there on time to open the clinic. He had worked at the clinic for a number of years and had experienced a high turnover of doctors and *pasantes*:

The doctor isn't here. He will still be asleep. These *pasantes*, they never turn up on time but doctors [sic. qualified doctors] do; they keep time. He's leaving soon anyway, and then another will come.

Such lateness (or other reasons causing patients to wait for long periods), lack of privacy and lack of record-keeping fall far short of quality of care guidelines set out by Family Health International [Katz *et al.*, 1993:10-11]. This is one of the US-based organisations which issues guidelines and recommendations for family

planning programmes upon which the Mexican government bases its own family planning guides [Dirección General de Planificación Familiar, 1995:59]².

Another major issue arising out this scenario concerns gender relations. The Tzeltal woman who was accompanied by her husband and the woman with the sick baby hardly spoke and were barely addressed by Dr Pérez. Women are generally accompanied on visits to consult doctors not simply because they may lack the Spanish language skills to deal with the situation, but also because their husbands may make decisions for them, or because family and friendship links lend them support in the face of the perceived power of medical personnel. Moreover, the diagnosis of illness and decisions about what remedies to follow are family concerns. I discovered how important these factors were during my fieldwork as I was obliged on many occasions to accompany indigenous women living in San Cristóbal to the local clinics.

Dr Gómez (*Pasante*). Tenejapa IMSS UMR

The attitudes and actions of Dr Pérez can be contrasted with those of Dr Gómez who ran the UMR in Tenejapa. Gómez was happy to be interviewed but not if the surgery was busy. We went to elaborate lengths to organise a meeting time and day suitable to us both so that I would not arrive at his clinic during a busy time and so that neither I nor his patients would be greatly inconvenienced by having to wait. At that time the road to Tenejapa was closed and the journey involved a detour over a steep mountain track which proved to be almost impassable during the rainy season. Vehicles were left stranded in two feet of sludge in places. I seemed to have a knack of turning up, despite the best of intentions, when Gómez was either extremely busy or had been called away to San Cristóbal for a meeting but ultimately I was able to interview him on a number of occasions. Gómez was a fastidious record keeper who ushered his clients into the surgery (along with their families) and who, despite his tenuous position as a *pasante*, would speak out against measures he found lacking in government health service provision.

As *pasantes* both Pérez and Gómez had been put in their posts for a year. Pérez, a *coleta*, had his family quite close to him in San Cristóbal. Gómez, from Tlaxcala, a more urban part of Mexico, was remote from his family but lived with his girlfriend at the weekend in San Cristóbal. Neither *pasante* wanted to be in their respective jobs for a year and were looking forward to becoming fully qualified doctors and practising in other areas. They expressed their frustrations with the job in different ways.

For Gómez, IMSS' obsession with numerical targets and his own powerlessness in the face of the bureaucratic machinery in San Cristóbal were his overwhelming reasons for despondency. The monthly meetings in town where all doctors discuss their own clinic's targeting results, particularly upset him and though he argued against targeting he said that not only is he powerless to prevent it but that opposition can damage your end of year results and affect your future prospects. Gómez' frustrations about his powerlessness are explicitly illustrated by his experience during one of the frequent and extensive vaccination campaigns:

The fridge broke down in the middle of a vaccination campaign ruining my supplies. I told my assessor in San Cristóbal and he said he would bring me a new one soon. Months passed and still the new fridge did not come. During all of this time I could not vaccinate anyone and yet we had banners and leaflets everywhere as part of the campaign. Every time I mentioned it to my assessor he told me that I would get a new one soon. Finally, during a meeting of *pasantes*, assessors and more senior personnel in town, I mentioned it in private, though in the presence of my assessor, to his boss. The next week my new fridge was delivered. However, at the following meeting of *pasantes* and assessors my assessor shouted at me in front of everyone. He was very angry and said that my behaviour had been unacceptable and that for this I might lose two points in the end of term assessment. There is nothing I can do about this.

The assessor, in publicly castigating Gómez, was able thus not only to humiliate him and punish him with the threat of losing assessment points at the end of term but also to reinforce, for the benefit of the other *pasantes*, their subordinate positions.

On a separate occasion Gómez's partner confessed that she was worried about him and would be glad when his social service was over:

He gets too angry. Every month he argues about targeting. One day he will say too much and then he will be in serious trouble.

This is not an unsubstantiated fear. A number of qualified doctors now working outside of the system told of losing assessment marks as *pasantes* for their opposition to targeting contraceptive methods. Amongst non-governmental health providers it was an issue of condemnation and, for many, proof that the government did not have the best interests of the people at heart.

Gómez lived in Tenejapa during the week. He was in effect on 24-hour call during this time because, although the clinic officially had set hours, he was obliged to live there to provide almost constant cover in case of emergencies. This is the norm in rural clinics whether run by *pasantes* or qualified doctors. Like many of his colleagues he has a base in San Cristóbal which he goes to at the weekend. *Pasantes* officially work Monday through to Saturday with only Sunday off.

During his working week in Tenejapa, which is 98% Tzeltal, Gómez involved himself in local activities as far as he was able: he played football with the locals; he involved himself with the school; he ate in a small local restaurant. One of the major problems faced by *pasantes* in his situation is isolation. This can vary depending upon how far you are from San Cristóbal, a local town, or a main village which also appears to relate directly to how likely your immediate neighbours are to speak Spanish. For those *pasantes* who live and work in *cabeceras* there is usually a reasonable paved road linked with San Cristóbal. For those who live and work in more remote localities the situation is somewhat different: the clinics can be many hours off the road via dirt tracks and while all the clinics have electricity those in remote areas are more subject to power cuts. Moreover, outside of the central areas of *cabeceras* the local population is less likely to have electricity, drainage systems or potable water.

Dr Pérez, unlike other doctors in rural areas, neither lived in his clinic nor in the local area. He returned home to San Cristóbal every night. The travelling distance was negligible, half an hour each way, but it meant that the clinic was

without cover during his absence. The requirement to live in the clinics undoubtedly puts a strain on *pasantes* and doctors. For those who experience frequent calls outside official clinic hours there can be aggravation and frustration; on the other hand, for those who preside over clinics which see few patients boredom is a major factor which adds to their sense of isolation.

Freyermuth alludes to these problems pointing out that lack of infrastructure and cultural differences put a strain upon rurally based medical staff who suffer from lack of knowledge about local language and culture. From the ensuing difficulties experienced they conclude that the local population is difficult and does not want changes offered to them [Freyermuth, 1993:48; *trans.*].

Pérez was perhaps the least isolated of the medical staff I spoke with and yet his social service depressed him. He was close to Teopisca, a small town with services such as good restaurants, banks, bars and shops, and quite mestizo in character. He was close enough to San Cristóbal to travel to work daily, though how he squared this with his superiors he did not say. He had great difficulty with the cultural differences he perceived between his client group and his own background:

The population that we manage is very difficult, very difficult. It's very difficult to communicate with them.

When talking about problems in reaching targets for contraceptive methods he emphasised this point:

The problem is the people. You know that the [indigenous] people are not very cooperative: because of the type of people they are; because of the environment in which they develop.

He elaborates further when talking about the attempt to raise health standards:

We need to reduce the levels of promiscuity; of cramped conditions. All of the family live in only one room - these are cramped conditions. Yes, we need to reduce these cramped conditions because there are more illnesses; I have been told that they even have sexual relations sometimes when other members of the family are in the same room. We have to reduce all of this. Apart from this we

give advice to raise their health levels; for example they should make latrines and boil the water. We tell them this is important to avoid cholera. Here [in the clinic], as soon as I have left my patients I bath myself. I bath myself daily, daily, daily, [rubbing his hand hard in washing motion] to avoid scabies; all these kinds of skin diseases.

And yet despite his comments about promiscuity he tells me that the women have a great sense of shame (*pudor*). They do not like to be examined, they rarely come to the clinic without another member of their family (often their husbands), and as indicated above, they do not speak very much, "because of the culture". Pérez' apparent lack of willingness to physically touch his patients and his demeanour of disgust as he related how he washed himself daily indicate that he does not like his client population very much or at the very least that he has little sympathy with them or understanding of them.

Dr Hernández (*Pasante*), Pantelhó IMSS UMR

About 93% of the population of Pantelhó are indigenous (Tzotzil and Tzeltal). The rest are mestizos who live almost exclusively in the *cabecera*. Whilst Hernández stayed all week in the *cabecera*, leaving for San Cristóbal at the weekends, he was not happy to sleep in the clinic and had lodged for some time with a local mestizo family at the bottom of the steep and rocky hill on which the clinic was perched:

When you live in the clinic people expect you to open the door at any time of the day or night whether it's two in the morning or six in the morning. I've been woken up at all hours. Its not just the lack of sleep but it could be a drunk knocking on the door. They [the drunks] come here all the time asking for medicines.

Like Pérez, Hernández did not wish to, and chose not to, live in the clinic despite this being against the rules. Like both Pérez and Gómez he was not satisfied with his position and was relieved that his year's social service was nearly over. He too commented on targeting contraceptive methods and said that it was a problem for *pasantes* and doctors if targets were not met.

Local politics and physical Safety

Apart from problems of physical and cultural isolation, lack of basic facilities, and lack of autonomy in decision making evidenced by the imposition of targeting, amongst other policy edicts, another potential factor which can add to pressures of working in rural communities is the potential violence and threat to physical safety. These problems do not all relate to the Zapatista uprising in 1994 but they are nonetheless related to the clientelist authoritarian³ nature of Mexican politics which persists in Chiapas despite apparent change elsewhere in the country. I shall examine these in the context of the following three examples from Larráinzar, Chenalhó and Cancuc.

Dr Moreno (*Pasante*), San Andrés Larráinzar SSA CSR

In San Andrés Larráinzar, where the unfulfilled peace accords between the government and the Zapatistas were signed, the local *cabildo* authorities are made up of opposition party PRD members. These men were elected by traditional local votes in contrast to the PRI *official* incumbents who were apparently the winners of the official government ballot but have been unable to wrest power from the PRD. It is known as a “community in opposition”. On entering the main square of the *cabecera* the first thing to catch the eye is the large banner on the town hall which proclaims: “This is a community in rebellion. Anyone caught with drink or drugs will be expelled.”

In San Andrés those who maintain the balance of power are Perredistas but the Priístas who won the official election have government support. Ironically, Chamula, one of the most famous of the *municipios*, has government sanction to vote by traditional means and for over 40 years has returned a majority Priísta vote. Opposition parties are not tolerated in Chamula and those who have fallen foul of this rule have been expelled in great numbers. One of the Zapatista demands is for respect of indigenous practices. The government is quite clearly partisan in this matter as

Chamula has been seen to be a favoured PRI stronghold for years in exchange for a certain amount of autonomy⁴.

In San Andrés armed disputes break out periodically between the two political groups. There had been trouble the day before I arrived to interview Dr Moreno. Two (supposedly PRI) men got into a local taxi and gave the driver directions. The taxi driver set off towards his destination and was stopped at a road block where the two passengers allegedly robbed the taxi driver of his money and cassettes. The men were caught and subjected to trial *por costumbre*, that is to say that the matter was addressed at a community assembly and people given a chance to suggest what should be done with them. The meeting turned into a fracas with no immediate agreement and the two men were jailed until a further meeting could be arranged to sort out the matter.

Dr Moreno told me that when problems break out the clinic is closed and the staff go back to (or stay in) San Cristóbal:

When there are problems between them we don't come to the clinic because we don't want to be caught in the middle. They [the *alcaldes*] advise us. They say "don't come now because there are problems". So we close everything and go to San Cristóbal. Yes, it's because we are neutral. We are independent of their problems.

Some might see this statement of neutrality as somewhat optimistic or politically naive for a representative of the government health system. The clinic is well aware that just 10 minutes by road from here is another clinic at Oventik run by Zapatista supporters. It is shown as a clinic on the SSA area map for the *municipio*. When I asked Dr Moreno about this other clinic he replied simply that it was a *private* clinic. When pressed for more information he said that it was run by the Zapatistas. At Oventik, guarded by young men and women in balaclavas at the gatepost, no-one is neutral. After showing some identification and explaining my business I was body searched, albeit by a young woman very embarrassed at doing this, before being finally allowed to enter the clinic grounds situated below the level

of the road in a small valley and overlooked from the other side by the international peace camp on the hill.

San Pedro de Chenalhó

In Chenalhó the new clinic was built on disputed land embroiling the clinic directly in the dispute. The SSA rural health centre opened in June 1996 two months before I carried out my first interview there. When I first went to investigate the clinic, some months before, I found it closed. On asking a young Tzotzil woman, sitting at the gate, she said that it should be open but that there were no doctors to work in it yet. The same day a church worker told me a story with a more political slant:

Most of the land on which the clinic stands belonged to INI. A small proportion of it was owned by a friend of mine. A few months after the Zapatista uprising, around Holy Week (March/April) the Frente Cardenista⁵ took the land by force. The title to the land has been in dispute ever since. Recently the clinic was built on this land and now the Cardenistas are refusing to allow the clinic to open.

This story, like many, is unequivocally bound up with local land and politics. During my time there the situation in Chenalhó deteriorated. There were a number of killings, officially unresolved, though many people had their own beliefs about what happened as well as about reasons for the lack of action by the authorities.

The story about the piece of land allegedly taken by the Cardenistas offers a microcosm of the factors involved: land, local politics, distrust and racism. The church worker's story continues:

On the day the Cardenistas took the land I had to go to San Cristóbal on business. They [the Cardenistas] had set up a road block and no public transport was allowed to pass. I asked one of the local *rancheros* to take me in his lorry but he was reluctant. I said to him, "But they know me," to which he replied, "In these days nobody knows anybody." Eventually I gave him enough money to persuade him to take me. We reached the roadblock and were stopped by men in balaclavas men with rifles. I got down to speak with them and they said I could go through on foot but not in the lorry. After some haggling with them I paid them 50,000 [old] pesos [i.e. 50 new pesos] and they let the lorry through. Almost immediately they stopped us again and one of them asked me, "How do we know that you haven't got any arms in that lorry?" "What me? Armed?" I

replied. "Look at you!" They began to shout "Viva Marcos" [mocking their belligerent voices] and I told them that what they had done was against the spirit of Marcos and Zapata. I told them that Zapata would not have taken land from communal holdings [like INI] or smallholdings [like his friend]. One man put a gun to my throat and of course I did not say anything else. They searched the lorry and allowed us through.

Afterwards the local mestizo population [the main landowners in the area] accused me of being a Cardenista; of being the intellectual author of the land takings, simply because the Cardenistas allowed me to pass through their roadblock when they weren't letting anyone else through. I asked them, "Then what was I doing with a gun at my throat?" The *ranchero* also told them about the guns and that I had paid them money to get through because I had urgent business in town.

A mestiza acquaintance of this church worker, living in San Cristóbal, confirmed his story and went on to tell me that because of the racism, political conflicts and land disputes there were two masses everyday in the *cabecera*: one for mestizos (about 1.5% of the population) and one for Tzotzils.

Although the clinic in Chenalhó was newly built the SSA had an old clinic in the *cabecera* dating back 20 years and so had a long-running presence in the area. Neither Dra Gutiérrez, the newly incumbent doctor, nor the nurse thought that the land dispute had anything to do with the delay in the opening of the new clinic, (though of course they were not in Chenalhó previous to the clinic opening). Instead, they cited the lack of doctors as the crucial factor. Dra Gutiérrez told me that the old clinic had been run exclusively by *pasantes* and that when there was no *pasante* attached to this post there was no medical cover. Her post was newly created to try to ensure that there was always a qualified doctor in the area.

There are two representations working here as to why the clinic had been closed for so long after being built. One rests upon the lack of staff to allocate to the clinic (a neutral stance) and the other on factors relating to the disputed land (a political stance) which carried with it violent overtones. As the church worker's experience shows, individual behaviour can be open to interpretation. He was seen as partisan by local mestizos because he had been able to pass a road block set up by indigenous politicians albeit not without threat to his and the *ranchero*'s safety.

However, at the present time in Chiapas most church workers are considered to be partisan: either as supporters of liberation theology, and therefore supporters of change in favour of the indigenous and peasant social, economic and political rights; or as upholders of the status quo. Being a doctor in Los Altos does not carry with it the same connotations of being politically active which go with being a church worker.

However, the state health machinery understands the potential for doctors to become politically embroiled or to be seen as partisan and for that reason auxiliaries are appointed on a community basis and thus reflect local political contours, though they are elected by their own communities. In Navenchauc (Zinacantán), for example, the SSA has to provide separate auxiliaries for the localities of Apaz and Conlum. According to Dr Morales, Conlum and Apaz had been one integrated locality but due to socio-political problems Conlum separated from Apaz to become the local political base for the PRD. In this sense the clinic space and outside mestizo staff can be claimed as neutral whilst paramedical local staff, crucial to the government's health plans of decentralisation and integration with local communities, must serve their own political entities by whom they are elected in order to find acceptance with the local political power brokers.

As I have pointed out, many of those who arrive to work in Chiapas from other states simply have little knowledge of the local political and cultural machinations within Chiapas. Dra Gutiérrez was new to Chiapas as well as to her post and had no first hand experience of the Cardenista land grab in Chenalhó. The frequent outbreaks of violence give cause for concern regarding the safety of clinic staff which declarations of neutrality cannot avert. Evacuating clinic staff back to San Cristóbal from San Andrés suggests that the danger to safety is real. One might expect that in such an area the clinic would remain on standby to deal with emergencies resulting from violent outbreaks and that, as "neutral" bystanders, personnel would not be subject to attack. This position was undermined by the violent attack on a group of SSA staff whilst carrying out a vaccination campaign in the *municipio* in 1995. The three female nurses in the group were also raped. They were attacked by an unidentifiable band of 25 armed men [Rojas, 1995:100-101]. On

the one hand it seems that the potential danger to staff is so great that they cannot be expected to remain in the area during violent outbreaks; on the other hand, the power of the community in rebellion might be such that they allow the clinic to operate on their own terms, as and when they decide, and do not necessarily see them as a neutral entity.

In Pantelhó where the PRI hold the Presidencia but where there are significant PRI/PRD divisions, Pedro, the Tzotzil auxiliary of the IMSS unit, said that sometimes things got a bit dangerous:

In the last three months three people have been killed in separate shooting incidents. It gets a bit dangerous at times if you live in the clinic. It's not wise to get involved. The army [who have a very large base in Pantelhó] took the ones who had been shot to the hospital in San Cristóbal so in these cases we did not need to become involved.

Dra Méndez (doctor), San Juan Cancuc, IMSS UMR

The intimation of danger to health workers' safety does not necessarily come only from situations of ongoing or sporadic violence. It may also be intimated from the maintenance of cultural boundaries through local narrative. Dra Méndez arrived in San Juan Cancuc from Veracruz to find herself living in a remote *cabecera* from which the indigenous Tzeltal population had expelled all mestizos in the 1930s. This spectacular area, lying next to the jungle⁶, is around two and a quarter hours from San Cristóbal by jeep. From Oxchuc or Tenejapa the way into Cancuc is by dirt track with phenomenal potholes and is practically impassable in the rainy season. The narrative history of Cancuc emphasises the indigenous rebellion of 1712 when the Tzeltal population, headed by Cancuqueros, famously rose against the colonialist Spaniards [Esponda Jimeno, 1994:79; cf. Pitarch Ramón, 1994]. The story I was told concerns the reasons why Cancuc has no mestizo population today; a story of a bloody confrontation which celebrates Cancuc's rebellious past.

According to INEGI Cancuc has an indigenous population of 99.71% [INEGI: 1991]. According to locals there are no mestizos there at all except for the

incumbent doctor. The perception is that the *municipio* is 100% indigenous for the very reason that that indigenous population expelled the mestizos. Esponda Jimeno refers to this story in passing in his book about the social organisation of Tzeltals but not in the colourful tones in which it was related to me by word of mouth. He dates the incident as happening in the 1930s. It was variably related to me as occurring in the 1940s, 1950s and 1960s. It is a story that has been narrated mainly through the oral tradition and the dates are less important than the essence of the story itself. As Esponda Jimeno puts it:

In the 1930s, Cancuc was the scene of a several uprisings generated by the abuses committed by the Ladino tradesmen who lived there. After the conflict with the Ladinos and their consequent expulsion from the area, no Ladino has been allowed to live there on a permanent basis. Finally, at the end of the 1970s a group of Cancuqueros began to tackle issues so that the township became classed as a free *municipio* and became independent from Ocosingo because this *cabecera* kept it in a forgotten and marginalised state. [Esponda Jimeno, 1994:80-81 *trans.*]

The version of the story which was related to me has more depth and conveys more horror. Felipe, a Tzeltal *catequista*, first told me the story of how mestizos living in the area were renowned for abusing the indigenous population, citing one family in particular. Under the *ejido* system the indigenous population was obliged to work so many days per year instead of paying monetary taxes. Theoretically, this work was supposed to be for the communal good but in practice much of the labour was on privately held mestizo lands thereby constituting a form of slave labour. A conflict arose over this and the Tzeltal *campesinos* decided to confront the landowner. Felipe said that men wielding machetes surrounded the landowner's house who appeared with his gun and started shooting, killing a number of the *campesinos*. The remainder stormed the house, killing both the landowner and his wife. Felipe said that the story, which has been repeated ever since, is that the *campesinos* then roasted the bodies over a spit after which they ate them as a warning to any mestizos who might have an eye on their territory. He said that since this incident no mestizo has dared to live in the area.

Regardless of the veracity of the details of this incident, and differences in narration, the story in itself is an indicator of the divide between the two groups of Chiapaneco society. The version I was told is particularly gruesome and is maintained to uphold the notional boundary which exists between the two groups. Mestizo medical personnel do work in Cancuc and Dra Méndez's contract stipulates that she must live in the clinic in case of emergencies. Of course, transitory medical personnel do not pose a great threat to the local political power structure and landholding issues. Moreover, government clinics, regardless of physical location are not integral to local life and are a space apart. Dra Méndez has been given an initial contract of six months which is renewable depending on whether she likes her position or not. She pointed out that although young girls at school speak some Spanish most of the women speak only Tzeltal. Most of the men speak Spanish. During the week she thus lives in a fairly remote rural community with whom she can have little communication, culturally or linguistically, apart from that which relates to the clinic. Although she did not express fears for her safety she did say that she was lonely. However, another female doctor with whom I travelled extensively expressed fear at working, as a female doctor alone in a remote and culturally distinct area. She admitted to being afraid of indigenous men, shaking her head in disbelief at my apparent ignorance when I asked her why.

Lack of resources

Apart from problems of isolation and discontent, one of the material constraints with which doctors and *pasantes* have to cope is the lack of resources. Lack of basic medicines as an obstacle to raising health standards is recognised within the local health services [SSA, 1996:10]. This was a complaint made far and wide by those working, or who had worked, in the government services who suggested that it was one of the reasons for the underuse of government health services. Lack of medical supplies and extensive delays in replacing medical stock were cited as reasons why people simply could not be bothered to seek out government medical services. Despite this, some people felt that there was a large amount of government money swilling around Chiapas but that the health service was not a major outlet for

it. Moreover, many health workers outside of the government services expressed anger and frustration that in some remote areas one might find contraceptives but not basic antibiotics.

Government health services offer mainly primary level care in rural areas. Most of this is directed towards prevention rather than cure. However, the clinics still have to deal with emergency situations for which they are ill-equipped. The difficulty in getting a patient to the nearest hospital depends on how far the clinic is located from a major hospital or town; whether or not a paved road links the clinic to such a location; and what kind of transport is available. Add to this the dispersed nature of many rural communities which are accessible only by foot and may be many hours walk from the *cabecera* on a paved road.

This situation, a common scenario for rural communities in the developing world and a source of pressure for health workers, is exacerbated by the nature of the relationships which exist between the local *presidencias* and the government health clinics, which in itself epitomises the mestizo/indigenous divide. It is the *presidencia*, and not the medical unit of the *cabecera*, which controls the ambulances. A doctor or *pasante* wishing to requisition the ambulance for clinic use must ask the *presidencia* if he or she can borrow it. From what I heard from disgruntled health staff it seems that permission is rarely given. It is certainly not given for ferrying sterilisation patients to and from hospital to be operated upon. Means of transport for this vary. Sometimes, though rarely, patients will be taken and return with a mobile medical unit from San Cristóbal. More often they will have to travel there and back by public transport for which they themselves pay.

Dr Gómez told me about how Tenejapa came to have two ambulances, both of them owned by the Presidencia, and usually to be seen parked next to the main offices. There are two government rural medical units in the *cabecera* of Tenejapa one belonging to IMSS the other to the SSA. Gómez was of the opinion that IMSS should control one of these ambulances and the SSA the other. Suggesting this to the *presidencia* caused a ruckus between them which Gómez lost:

The ambulances were gifted to the community by the national lottery. Because they were given to the community and not to us it means that the *presidencia* owns and controls them on behalf of the community. It would have made more sense for us to have them. They refuse even to loan an ambulance to take people to hospital to be sterilised. They say that this is not their intended use. But I see them using the ambulances to transport the local football team around and for other personal uses. It makes me very angry but there is nothing I can do about it.

Dr Pérez in Amatenango also complained about this situation with ambulances blaming it on the semi-autonomous power held by local *municipios* which he appeared to resent:

Here the power is theirs, theirs and nothing else but theirs. Its because of the power. They manipulate it.

In Yabteclum, a locality of Chenalhó, Dra Fábregas bemoaned the lack of an ambulance for transporting sterilisation patients to San Cristóbal:

They have to go by bus and they have to pay about 10 pesos. We don't have an ambulance. It would be fantastic if we did. Sometimes we have asked for help from DIF in Chenalhó but on these occasions they said to us "it's broken down" or "there is no petrol", these kinds of excuses. They have never helped me. I don't promise the patients anything because before I thought that I'd get at least five patients together for sterilisation [female] and ask DIF for help to take them there and bring them back, but no.

DIF are supposed to support the other government health services but these examples illustrate the complicated nature of politics in the area. Despite assertions that as the "pretty face" of government DIF is not a political organisation there are aspects of its organisational profile which belie this. Whoever has control of the *presidencia* also has control over DIF resources. Local DIF offices, as described in Chapter 5, are inextricably linked to party politics. Though they may return a PRI vote during elections it does not mean that they are in the hands of government (see note 4). In indigenous areas neither does it mean that they are more likely to accept government health services and lack of commitment on the part of many rural DIF

offices to help the SSA and IMSS clinics may again be reflective of the mestizo/indigenous opposition.

Infrastructure

Apart from poor or non-existent roads there is virtually no public telecommunications infrastructure and that which does exist is also likely to be tightly controlled by a leading member of the community. Few SSA rural clinics have telephones and so do not have instant means of communication with San Cristóbal. IMSS at least has a radio system facilitated by the building of huge radio transmitters outside each clinic. Some *cabeceras* have public telephones but it is rare to find one further afield. An epidemiologist from San Cristóbal told me how the Zapatistas had stolen many of IMSS' radio transmitters in remote areas for their own purposes. He was petitioning the government to replace them and take a chance that they would not be stolen again as he believes that it was grossly unfair to the doctors working and living in these areas, especially those relying on a monthly plane for communication with the outside world.

In Huixtán the only telephone in the *cabecera* is in the possession of a local shopkeeper which means that its use is severely restricted and messages left for locals are rarely passed on. [Interview: church worker.]

For me one of the greatest ironies in the communications system is that whilst the health system is in desperate need of resources the skies of Chiapas are awash with army helicopters. This is compounded by the excuses used by the army for entering indigenous villages. Sometimes they say they are looking for illegal drugs. On other occasions they have said that they were trying to deliver health services, for example, on the occasion of the armed confrontation with locals in Ocosingo in January 1998. It is hard to justify such action when government health services, although poorly resourced, have personnel trained in rural service delivery. As most rural health strategies are preventative the army can offer little to complement the health services except for help with transport in emergency situations. This is not

something I ever heard of. Moreover, any action by the military on behalf of the health services would seriously damage attempts to portray government health services as neutral entities.

With regard to medical supplies many doctors complained about the lack of continual availability and, as we mainly discussed contraceptive methods, pointed in particular to the lack of continuity in supplying injectables both in quantity and in type. I will discuss this in detail elsewhere but suffice to say that they experienced problems of acceptance from women contraceptors used to one type of injectable contraceptive and then asked to change to another because of lack of supplies.

Provider constraints and quality of care: Effects of this on informed choice

It is evident that the situation faced by doctors and *pasantes* working in Los Altos is far from ideal. They are constrained by a lack of resources, by a wide socio-cultural divide, by isolation and local political conditions. To provide a high quality of care in such circumstances is virtually impossible yet they are supposed to provide, amongst other things, family planning services in circumstances which afford the individual, or the couple, a free and informed choice of methods. In the face of apathy from the client population they must meet targets in contraceptive use whilst simultaneously facing shortages of seemingly popular methods.

Moreover, although they are available from the SSA and in chemists, IMSS does not currently offer injectable contraceptives, despite the fact that they are said by many doctors to be one of the most popular methods amongst women in Los Altos. Only two IMSS units in Los Altos included injectables amongst their range of contraceptives: Pantelhó which had none whilst I was there because supplies had not been delivered, and Huixtán, where the doctor had a good working relation with SSA mobile units in the *municipio* and unofficially got her supplies from them.

Method availability is an important corollary to the provider constraints outlined here with regard to providing good family planning services allowing for an informed choice and I will now turn to discuss contraceptive availability in Los Altos.

¹ It is of note that Mayan people do not make eye-contact with people whom they have tenuous or distant relationships, only with friends [cf. Freeman, 1989].

² Also included amongst others are the World Health Organisation, the Population Council, Pathfinder and the International Planned Parenthood Federation.

³ In reducing the role of the state and promoting free market economics, the neo-liberal policies of the 1980s have to some extent eroded the authoritarian unitary party nature of Mexican politics. This has historically relied on client patronage which undercut opposition to PRI authority by coopting workers and peasants. However, these changes have not appeared to penetrate rural Chiapas to any great extent where client patronage continues to engender both high levels of support for the ruling PRI and to exacerbate community division and violence.

⁴ Chamula-government relations are continually contested. Most recently the Chamulas refused to participate in state elections because the government refused to release five Chamulas jailed in Cerro Hueco for various crimes. Over 30,000 Chamulas blocked main roads (a common tactic throughout Los Altos) and refused to allow the installation of voting booths [La Jornada, 10th May, 1998].

⁵ The Frente Cardenista was named after General Lázaro Cárdenas, president 1934-1940, who of all PRI presidents carried out the most progressive agrarian reforms and nationalisation programmes. I was told that the mestizos in Chenalhó, sometimes deliberately, confuse the Cardenistas with the Zapatistas and also with the PRD which was founded and is headed by Cuauhtémoc Cárdenas, ex-Priísta and son of the former president. However, it is widely accepted that the Frente Cardenista is, in fact, a Priísta organisation, and avowedly anti-Zapatista.

⁶ Under current boundaries it belongs to Los Altos though earlier it was considered as part of La Selva.

Chapter 7

Contraceptive Provision in Highland Chiapas

A wide range of contraceptives and their consistent local availability is of course crucial to the ability to make an informed choice [cf. Kaufmann, 1993]. A couple of methods are not enough whilst choice within methods is also important. For example, providing progestogen-only pills and combined oestrogen-progestogen pills, and a range of injectables. Policy makers and providers in Chiapas rely mainly upon hormonal methods, the Copper-T IUD and female sterilisation as the main methods of provider preference from which clients can *choose*. What happens to other possible choices amongst natural and traditional fertility regulating methods, or client controlled barrier methods? As Russell points out [1984:85] choice implies more than just preference and must include a consideration of all possible methods and their evaluation by individual women. But in Chiapas, as elsewhere, non-invasive fertility regulating methods are frowned upon by providers who cite lack of efficacy, compounded by the ignorance of the local population. Local knowledge is not considered worthy when compared with the rational scientific knowledge which underpins modern contraceptive methods. Yet policy makers and providers may find it to their detriment to continue to ignore natural and traditional fertility regulating methods in Los Altos: at the very least they are blocking the possibility of an informed choice and discussion of all available means of fertility regulation and precluding options some women may choose in circumstances of wider availability and positive discussion.

Method choice in government clinics

The table below illustrates which contraceptives are available through the different institutions for the *población abierta*. ISSSTE, which covers a section of insured workers, has been included for comparison.

Table 7.1

**Contraceptive Methods Promoted Through Government Institutions in
Los Altos, 1996-1997**

CONTRACEPTIVES	IMMS-SOLIDARIDAD	SSA	DIF	ISSSTE (no targeting)
Pills	28C† Targeted	21C Targeted 28C Targeted	21C, 28C Targeted	21C, 28C, 21PO††
IUD	Copper T Targeted	Copper T Targeted	Copper T Targeted	Copper T
Injectables†††	N/A	Cyclofem Norethisterone Targeted	Cyclofem Targeted	N/A
Female Sterilisation	Targeted	Targeted	Promoted	Available
Vasectomy	Targeted	Targeted	Promoted	Available
Condoms	Not targeted	Not targeted	Targeted	Only as a support method

Source: Clinic interviews 1996-7

†C: Combined Pill (progestogen and oestrogen)

††PO: Progestogen-only pill.

†††: Depo Provera had been available and should be according to the Norma Oficial. Now only Cyclofem (monthly) and Norethisterone (2 monthly) are available but not necessarily both in any one clinic. Supplies of Norethisterone were in short supply and women were often arbitrarily asked to change from one to the other depending on supply.

The first thing to note is the limited availability of options, with no female barrier methods or natural methods, and the limited availability of options within those offered. At the time of interviewing, progestogen-only pills were not available through any of the clinics except ISSSTE. Only the SSA and DIF provide injectables and here supplies are variable between the two types which were rarely available together in any one clinic.

Injectables and IUDs

There was no satisfactory explanation amongst *pasantes* and rural doctors as to why IMSS did not supply injectables. The most common answers were simply “*es por la norma*” (because it’s policy) and “*no los ofrecemos*” (we don’t provide them). One doctor believed that they were simply not suitable because of side-effects and therefore IMSS did not supply them; others that it was due to the cost. The family

planning doctor at the IMSS Clínica del Campo in San Cristóbal astonishingly blamed the lack of injectables within IMSS upon their largely indigenous client population:

It's because of the culture, because of the bother, because people don't like injections - the injection itself, not the effect. Because poor people do not like paying for things and IMSS-Solidaridad don't provide them. [Interview 006, IMSS, Dra Peralta, 1996]

Despite her assertions, injectables are free from SSA units and moreover are said to be quite popular. Dra Peralta's boss, the Medical Coordinator of IMSS, San Cristóbal, said simply that they supplied what they were told to supply. When pressed further at a later date he elaborated:

Those epidemiological and family planning studies which have been carried out, show that injectables and oral methods are prone to discontinuity, and in this sense, the programme IMSS-Solidaridad is promoting a method of more continuity which is the IUD. Because of this, since 1996 injectables have not been included as a family planning method. In fact, you can find injectables in the basic package of social security, in this case the programme of IMSS-Solidaridad, and they will be supplied slowly but consistently to the UMRs. Since [1996] if a woman - if ten women are given an oral method or injectable then seven of them generally discontinue and this is the reverse with the IUD. Generally, of ten women, only three will discontinue. So you ensure that the woman has more information about the advantages so that she can have methods of longer continuity. However, the woman or the couple are the ones who are going to decide in the end which method they want.

Essentially, he is saying that they are promoting IUDs in preference to other methods and for a time have simply removed one of the options in order to promote IUDs more vigorously. Although he says a couple will choose, in reality they cannot choose what is not available. Not all doctors and *pasantes* are in agreement with this as a number of them were supplying injectables which they "borrowed" from friends and personnel in SSA and put them down as *orales hormonales* (the hormonal pill) in their figures. However, in the case of Dra Flores from the UMR in Huixtán, she was in agreement about the IUD being the best method from her point of view for her client population but was willing to obtain injectables for people who insisted upon them:

The institute [IMSS] does not give us injectables, in truth I think because of contraindications which have not yet been determined, but we have a relationship with *Salubridad* [the SSA] so they give us Cyclofem. Sometimes you can tell a person all the dangers inherent in a type of medicine [contraceptive] but they don't accept it. If the patient wants it even though we have said no, if she wants it, we give it to her. The thing is to avoid the risk of pregnancy. And if we didn't give it to her she would go to San Cristóbal and buy it there and so she will be a person that we don't have registered. [Huixtán, November 1996.]

There are number of points to be garnered from this passage. Dra Flores is unsure of the reasons why injectables are not provided but she is willing to acquire them from elsewhere even though she suspects that contraindications may be the reason that they are not provided. She is making the decision that pregnancy is riskier than any possible contraindications, so she will still prescribe injectables even though she may have initially refused. Is this the ultimate in informed choice that the patients wishes are met over the doctors misgivings? I don't think so. Questions must then be asked about what happens if she refuses a patient a method of preference because of contraindications - how hard and in what ways does she try to show the risks involved and given the Tzotzil ethnicity of the majority of her locality how does she ensure that she and the client understand each other? The male auxiliary (and/or her husband or other family member) translates for her in those cases where the woman does not speak Spanish, introducing at least a three-way interpretation of what is going on. Lack of education, lack of Spanish, lack of understanding of allopathic treatments make it difficult to ensure an informed choice for clients in these circumstances. Ultimately, if Dra Flores is prescribing against her better judgement then she is assuming the risk on behalf of her patient with the realisation that this person does not clearly understand what the risk of the contraindications are; and she is the person making the decision about the risk of pregnancy vis-à-vis the risk of the contraceptive method. The ethical questions this situation raises are compounded by the obvious concerns that the medical unit would lose a registered patient if a woman who wanted an injectable form of contraceptive was unable to obtain it there and, instead of choosing a different method, then went to San Cristóbal to buy it over the counter. A woman could thus be contracepting in the locality but not on the books in which case the medical unit is losing statistical information and a contribution towards targets. In a sense then they are losing

control of and contributions to their programmes and not just those of family planning but potentially from other programmes as well, such as the huge vaccination programme. The justification for prescribing a contraceptive asked for against the better judgement of the doctor, because the woman would only go and obtain it elsewhere, was something I heard quite a few times during interviews.

From the majority of interviews with government clinics it appeared that the IUD was the contraceptive of preference amongst medical staff for their clients. Comments included the lack of side-effects, especially menstrual disturbances and fewer instances of discontinuation and with better client compliance. These perceived advantages were often contrasted with pill use which was seen to incur the risk of users forgetting to take it or using it inappropriately. This provider preference is not necessarily reflected in use because of a continuing resistance to the IUD, especially in remoter areas, because women do not want to be gynaecologically examined. However, it is clear from attitudes within IMSS that it is a method which is heavily promoted.

Between government institutions there was no variation in types of IUDs available, all providing the Copper-T. Private clinics offer more modern alternatives where the price, excluding consultation and fitting fees, begins at around £18.00 (1996), almost double the weekly wage of the average domestic worker, and therefore only available to wealthy mestizos.

Subdermal implants

Knowledge of subdermal implants, such as Norplant, was low when I began my fieldwork in Los Altos. Many *pasantes* had only vaguely heard about them though most qualified doctors were well aware of their existence, as were academics and NGOs working in health fields. Few women I know had heard of them though many expressed interest in the idea. By the time I had completed my fieldwork some doctors had begun to receive training about them but there were still no indications that subdermal implants, such as Norplant, would be introduced in Los Altos though

they were available in hospitals in Tuxtla and privately in both Tuxtla and Comitán. Doctors' views on the suitability of subdermal implants as a method of contraception within Los Altos varied. Some thought that the cost would be prohibitive and therefore it would be unlikely that they would be introduced for the *población abierta*. Others believed that having put so much effort into promoting IUDs, and with little success, that it would be counter-productive to bring in another new form of contraceptive which would require huge inputs of time and effort to promote. The IMSS Coordinator in San Cristóbal thought that they would be provided relatively soon in urban areas but not in rural medical units.

Sterilisation

Female sterilisation is vigorously promoted with quite high results relative to other female methods of contraception, and in comparison to the low levels of vasectomy (see Appendix II). Whilst much effort goes in to campaigning for vasectomies *sin bisturí* (without a scalpel), acceptability remains lower than for any other contraceptive method. Despite highly visible campaigns announcing particular days when men can come to San Cristóbal to take advantage of this operation, it is obvious from available statistics that men, whether indigenous or mestizo, are not keen on vasectomy. Some doctors believe that the general reluctance amongst men is not helped by a similar reluctance amongst the majority of male doctors to promote this method aggressively within the consulting room. Commenting on the attitudes of male doctors in San Cristóbal, Dra Alvarez of the local health centre told me:

To hear the male doctors talking about vasectomy is just awful. When the promotions¹ were carried out by Silvia [a senior doctor in the SSA] there were more vasectomies. Now men are responsible and there are less. Before, there would be ten to 12 men, some days 15. Now the maximum is one or two. Why? Because the male medic doesn't accept vasectomy. [SSA, San Cristóbal, SSA, July 1997].

A culture of *machismo* is generally thought to influence men's decisions and I was often told that they preferred women to be operated on. It was interesting to watch health promotions on vasectomy amongst male rural health auxiliaries who

were supposed to pass the message on to their local communities: the operation was emphasised as simple and painless, but much emphasis was put on manliness and virility. The doctor quoted below is the one referred to above who had a much higher success rate than her male contemporaries in promoting vasectomy. Here, through an interpreter, she is giving information on vasectomy to Tzeltal health auxiliaries and *parteras* in a remote jungle region under the health jurisdiction of Altamirano:

The man continues to be a man. He's just the same. He's just the same when the wife does a little bit, the same carries on coming out that came out before, when his wife does a little bit, and in the same quantity, the same colour and the same consistency. It's the same, they don't have anything missing. They don't have anything cut - they have their little tube cut where the male semen comes out, that's all that they have cut. In the woman we make two little holes or stitches even. In the man, nothing in the skin of the testicles. That way they don't even have a scar left They arrive, they stay a while and then they go home. I've been to visit them and they're so calm And we ask all of them if they're sure, really sure, that they want to be operated on. And if they say "I don't want to," nothing happens. There isn't any force involved. So we've asked them why they want to be operated on and they've said that it's because they want to help their wives and sometimes that it's not fair that the woman has the children and so they want to be operated on. It's a very simple operation. [Dra Silvia Olivares, SSA Hospital General, San Cristóbal. Las cañadas de la selva, July 1996]

Silvia's main emphasis is that a man continues to be a man after the operation and it is interesting to contrast her assertions with those of Cecilia, a Tzeltal health promoter working for a local NGO, who believes that people believe that to be a man is to be able to give children (see interview below). In this instance it is not the consistency of sperm or the colour which is important but the ability to *give* a child which makes one a man and this is exactly what vasectomy takes away. From a local perspective a man is not a man if he cannot do this. Silvia is keen to promote the idea of vasectomy as a selfless act on behalf of wives who have already contributed their share of suffering on behalf of the family in bearing children though she does not go so far as to say that such an act makes a person more of a man.

Although the men in this training session were bilingual the women were not. I wondered how much either understood about the vasectomy procedure from the

passage above. Silvia drew the male and female reproductive organs (disembodied) on a blackboard, indicating the incisions and simply explaining the procedure for both operations and their effects. There was little feed back when she asked questions relating to her talk but this might have been due to the fact that women, in an earlier session on childbirth, were told to “shut-up” by the local male interpreter when they tried to ask questions before the doctor had finished her monologue. The men were effectively silenced when Silvia, explaining about sperm counts after vasectomy, asked them about masturbation. Though she tried to make a joke of it, explaining that masturbation was necessary to obtain a sample to check for sperm, the men were clearly mortified:

At three months you have to do a check: the man has to masturbate. Do you all know what that means?

- No [few low voices].

You have to stimulate yourself by hand and ejaculate into a little bottle.

A lot of uncomfortable murmuring follows in Tzeltal.

How do you say “to masturbate” in Tzeltal?

There was no answer. All heads were bowed and no-one would make eye contact.

Ay, this is not something that no-one knows! You know, when you do it with your hand.

Low murmuring ensued. Silvia picked out one of the men:

Jorge, say it in *dialecto*² for your friends.

He does not answer but is clearly embarrassed. She sighs, laughing, and continues to talk about the reasons for the sample, and asks if there are any questions before she goes onto other methods. There are none, only an uncomfortable silence.

These men were being asked by a woman, and an outsider, about masturbation, the most private and secret of practices for many people. Much to the embarrassment of the men she demonstrated how to put on a condom using her own hand. Although she joked and tried to make light of the subject it was clearly impossible to get a dialogue going due to the extreme sensitivity of the subject. This

situation was not helped by the public nature of the meeting. Local men and women were present, distant outsiders who included mestizo medical staff and indigenous health promoters from far away communities, and myself, a foreigner whose presence had not been properly explained by the medical staff.

Silvia made no comments about promiscuity, an acknowledged reason for the reticence men appear to feel towards their women contracepting, but kept her comments bounded within an appeal to "the family" - the man and woman looking after their children. In contrast to her emphasis on the parental responsibility of both parents a large mural on the wall of the SSA health centre in San Cristóbal appeals to this fear of female promiscuity with a promotion of vasectomy which suggests that with this operation a man would at least know any future children were *not* his (see Plate 7.1). In fact the mural gives conflicting messages: on the one hand the man is tearing his hair out because he is suffering from having too many children whilst his dog says "and they're not even yours"; on the other, the mural says "you can have sexual relations with your partner with the advantage of not making her pregnant" suggesting a more caring attitude towards the partner.

The image of the man and his dog are the most arresting aspects of this mural which, with only a few words from the dog, plays upon existing gender stereotyping whereby women are cast as promiscuous and inherently unfaithful. Contraceptive-using women in particular are subject to this stereotyping, especially it seems by men and mothers-in-law. Although there is a comic element to the mural, as an official SSA promotion it raises questions in relation to government goals of promoting policies which seek to empower women by raising their gender status and providing opportunities through education and work, some of which can be enhanced by access to family planning services. This mural, in suggesting that a man have a vasectomy so that he can then be sure of his promiscuous partner's future fidelity, does nothing to raise the status of women in relation to men. The mural plays on perceived existing gender relations to promote vasectomy and yet in government policy rhetoric family planning is connected with the empowerment of women, which implies a change in these gender relations.

Condoms

Appendix II, Chart 1, shows that for the SSA condom use is negligible except for peaks in Las Rosas, San Cristóbal and Teopisca, all largely mestizo and urbanised areas. Even so the numbers of users relative to the population is low. The picture is similar for IMSS, but Chart Four shows that for DIF, although condom use is low, the method forms a substantial part of DIF promotion in relation to other modern methods.

It was interesting that many staff considered condoms not to be a “method” of contraception per se but a “support method” (*método de apoyo*), to be used in lieu of methods considered to be more secure. A nurse from IMSS in San Cristóbal gave them reluctantly to women, but always to men:

Look, all the men who come here, if they come to ask for condoms, we give them condoms. If it's women we have to investigate further and ask “Why are you using condoms? The condom is very unsafe. And it will irritate you” All of these kinds of things, we say. We ask “Why don't you use a more secure method?” We try to make sure that she has a more secure method. It's not easy for a woman to get condoms, but if it's a man who wants condoms, “Here you are, here are your condoms,” we say. [IMSS Nurse, San Cristóbal, 1996]

Although considered largely as a support method of contraception for family planning purposes the government clinics did not heavily promote condoms in their rural clinics as a protective factor against AIDS and STDs. That is not to say that they were never given out for these reasons but that highly visibly promotional work, like that for family planning in general, did not focus greatly on these aspects of reproductive health. This attitude was summed up by many doctors in rural areas in relation to the isolation of the communities but the persistence of these beliefs could be detrimental to local communities:

Well, there aren't any [STDs] - we're not interested in contraceptives, not even the condom, as a method to prevent STDs. Because in fact there aren't any, because everything that there is, [i.e. illnesses] is within the community. [Interview 025, Dr Ramírez (*pasante*), Mesbiljá (Oxchuc), 1996]

Just how short-sighted this view is might be illustrated by considering the following points: the increase in militarisation throughout Chiapas, and Los Altos in particular, has brought with it an increase in prostitution. Moreover, in many communities, including Mesbiljá (Oxchuc), polygamy is practised quite extensively. In addition, the prevalence of STDs in rural areas is likely to be highly underestimated due to low clinic use and alternative options for treatment through *curanderos*. STDs are considered within the main Reproductive Health Programme as a feature requiring attention but there seems to be a dearth of available information vis-à-vis family planning methods in rural clinics. In urban areas there was generally a more optimistic view about condom use:

[A] method that is known to have increased is the condom, yes to avoid the transmission of sexual diseases. There is more information in the schools now, and this is for the young people. And the use of the condom as a family planning method has risen too. Well, in fact, as protection against STDs. [SSA, San Cristóbal, Dra in charge of family planning, 1997.]

In urban areas the rise in adolescent pregnancies has given the condom some respectability amongst providers, both as a contraceptive and as protection against STDs. However, it continues to be under-rated as a family planning method, particularly in rural areas, as providers tend to prefer methods such as the IUD which require little client control. Moreover, the condom is a method which can be obtained over the counter and so clinics miss opportunities for health promotion and the collection of statistical data when people go in preference to a chemist rather than a government medical unit. It is impossible to gauge the extent of condom use outside of government clinics but it is likely to be higher than government sources indicate, amongst the urban population at least. In rural areas there are few opportunities to buy condoms and where condom use is reported in clinics it is said to arise from demand by mestizo teachers or soldiers rather than indigenous locals:

Our users are teachers but the people from the community don't accept them. It's rare for them to ask for condoms; the majority of users are teachers, they are outsiders. Here, the condom is just not accepted A lot of people buy them - well most of them are soldiers from the base here. Sometimes they come here and ask for one, but they don't like to because it annoys them when we try to

give them a card [to enrol them in the programme], as a record, and they say "No, I only want one, not all of them." [Dra Fernández, SSA, CSR, Chanal, 1997]

It was reported that condom use is quite high in conflict zones and not just in the *cabeceras* but also in more inaccessible areas. I did not see any statistics showing how high this use was but anecdotal evidence suggests it is high for two reasons: firstly, and more obviously, there is a demand from the soldiers as illustrated above; secondly, it is said that there is demand from amongst Zapatista communities where there is a code of practice that those who are soldiers, especially the women, should not have children during the ongoing war. The family planning coordinators of the SSA in San Cristóbal noted that there was a significant demand for condoms in the conflict zones, where they are delivered on foot if there is no other way in. Technically the Zapatistas are shunning any form of government aid during the conflict period but there are some Zapatista communities allowing government doctors in.

A doctor from one of the local NGOs working in the health field also noted this increased condom use in Zapatista areas:

And with the war we are using more [condoms]. We have started to promote condoms through the promoters, because they [people in these areas] are using them. Suddenly they asked for condoms, oral contraceptives and injectables. [Dra Henriques, Chiltak, San Cristóbal, 1996.]

Ironically it seems that the conflict may herald the breakthrough in contraceptive use within indigenous areas that the government itself is trying to promote. I was told by an EZLN member that in Zapatista communities EZLN members were encouraged to avoid pregnancy. In such a way knowledge and use of contraceptives may be further spread throughout remote indigenous areas where programmes of political *concientización* (roughly, consciousness-raising but see below p. 140*?) are, in any case, taking place. Such programmes, organised by the Zapatistas and sympathetic organisations, aim to raise political awareness amongst

the local population of their marginalised condition in relation to the governing State of Mexico.

I was interested to see that government health workers have assimilated the term *concientización* in relation to raising consciousness about the use of contraception in Los Altos. Men, in particular, are said to be difficult to *concientizar* in contraceptive use but the term came up frequently when discussing the indigenous population as a whole and their resistance to family planning services. Referring to the fact that he only has one condom user on his books, Dr Ramírez, the *pasante* of the CSR in Mesbiljá lamented:

Men. They are difficult to *concientizar*. They don't know how to use the condom, much less so to want vasectomies. It's difficult. [SSA CSR, Mesbiljá (Oxchuc), 1996.]

In a similar vein, Cecilia, a Tzeltal *promotora* with the Grupo de Mujeres in San Cristóbal, but working in rural areas, mentioned the reasons why some men are reluctant to use condoms:

They don't use them because they think that they're real men and that it harms them. Now, with the workshops, there are plenty of promoters who are using condoms, even in the community ... What you need is to reflect a little that it isn't a bad thing, because they think it's a bad thing and they think it's wrong to use a condom because that way they won't *give* any children, because they are men, meant to give children, so that's got a lot to do with it.

In contrast to Cecilia's views, the mestizo nurse in charge of family planning at the SSA unit in Tenejapa put low condom use down to ignorance and embarrassment:

Men don't accept the condom. They get embarrassed, yes, or they don't know how to use it. They get embarrassed if we try to explain how to use condoms - they don't accept it and don't want it. [SSA CSR(C), 1996.]

Machismo or embarrassment and ignorance were the reasons given for low condom use by all providers. Lack of promotion was never suggested as an option though it was quite clear that all institutions except DIF placed low importance on

condom use as a method of family planning and failed to promote condom use with the vigour accorded female methods [cf. Sayavedra-Herrerías, 1995]. It was accepted amongst doctors and *pasantes*, almost as an unalterable fact, that men were keen on neither condoms nor vasectomies and so there was little progress going to be made in that direction. Promotional efforts and the thrust of contraceptive *concientización* thus remained geared towards modern female methods.

Natural and traditional fertility regulating methods

It is not only the condom that suffers from lack of promotion, though arguably this lack is great considering its dual feature as a family planning method and protection against STDs/AIDS. Also lacking in any viable way is a discussion on natural methods of family planning. Although included in the flipchart on reproductive health available in all government clinics, variations on the rhythm method are not promoted by any of the doctors interviewed. It is said that information would be given out if asked for, but this rarely happens and, given the renowned shyness of Mayan women, is not likely to. As with condoms, the rhythm method is viewed as an insecure method and one requiring a certain level of education in order for it to be effective. More importantly, perhaps, natural family planning methods remain intrinsically private and are not considered targetable.

The small survey that I carried out in the marginalised *barrios* of San Cristóbal amongst indigenous and mestiza women showed quite high ever-use of natural/traditional methods (see chapter 11), indicating that these are an important factor which could be addressed by government policy. One of the biggest problems in considering this area is the lack of information available about such methods. This kind of information would be extremely difficult to collect by way of census-style data collection but the possibility of doing so within the clinic setting could be explored. Most doctors did not have a clue about whether withdrawal, rhythm, LAM³ or traditional methods featured amongst local fertility regulation practices, or whether such practices existed at all. All had heard that some women used herbs but none knew of any who had or whether these methods might have any efficacy at all.

On the other hand a number of promoters vehemently attested their worth, especially the herbal preparation said to cause long term infertility. This is surely an opportunity lost. Even if data collection remains difficult, there is a source of local knowledge working within most clinics: the promoters and auxiliaries. A conversation between the doctor, the Tzeltal auxiliary (Luis) and myself about abortion at the SSA clinic in Chanal illustrates the gulf:

Dra Fernández: Look, the truth is, as far as I know, there are no provoked⁴ abortions (*abortos provocados*) here. I haven't seen any. But I imagine that they [the local Tzeltal population] know abortifacients.

Me: For example?

Luis: *I'najo*

No-one can come up with a Spanish translation of this Tzeltal classification and the conversation continues:

Dra Fernández: Look. It [abortion] doesn't exist here. Up to now, no. But there are herbs in Sonora [a state in the north of Mexico]; in the markets there. They sell *zopatle* and this has an effect like oxytocin. Here, the truth is I don't know what there is. Luis knows.

Luis cannot remember any more names and so I ask him about herbs for controlling fertility that do not include methods to bring on menstruation.

Luis: There are herbs used by the people here and the *parteras* to plan. My wife and I use them, pure herbs, no? But it's *definitivo* [irreversible]. It works well.

Dra Fernández: And how many years is it since your wife had children?

Luis: More than 7 years. She took this herb and stopped menstruating.

Me: And she took this herb only once?

Luis: No, four times; four glasses: one glass at six in the morning, another at six in the evening and the same the next day. That's it.

Me: And she's taken nothing since, in all these seven years?

Luis: No.

This should be fascinating to anyone interested in family planning. According to Luis his wife has not had a pregnancy for 7 years after taking a herbal preparation specifically with the intention of not having any more children. Dra Fernández knows the story but is not interested in investigating further, nor in collecting information like this to discuss at the departmental headquarters of the SSA. She has not looked into what herbs are involved, how they are prepared, nor collected a sample in order to have it classified. Neither she nor other doctors are encouraged to be interested in such information. Although there are plans to bring traditional medical doctors into the government clinic arena reproductive health remains firmly located in family planning targets. I doubt that Dra Fernández' information, or rather that of Luis, would arouse particular interest during the monthly meetings to discuss local family planning targets for modern contraceptive methods.

This is part of the culture of maintaining a hegemony of knowledge and power which continues to lie in mestizo hands. Local knowledge in this way stays where it is, ignored and unacknowledged apart from anecdotally as a cultural curiosity. Yet there is clearly a vast amount of such knowledge to be tapped in relation to traditional medicine. What could be done with it is manifold. To name but a few possibilities: investigation of the herbs; studies on efficacy; discussion of local traditional methods brought into the clinic as a way of approaching the subject of family planning if the planners are really interested in promoting smaller families for health and welfare reasons. The goal here would be to get family planning on the agenda as a topic for discussion with local people on their terms at first, as opposed to meeting targets which would have to be forsaken, at least in the short-run.

The realisation of this goal could be worked towards through gaining both an understanding of local traditional fertility regulation methods such as that described by Luis above or methods used to regulate menstruation as well as finding out about attitudes to natural fertility methods such as withdrawal, rhythm methods, periodic abstinence and LAM. When asked whether such methods were common in the areas in which they worked, many doctors replied incredulously: "These people, they don't

know anything" (*ellos no saben nada*). They were also sceptical as to whether the withdrawal method could be considered a method at all. Only two doctors in my survey said that it could be a viable option while the others dismissed it out of hand. Likewise, only two doctors in San Cristóbal believed that the practice of withdrawal was widespread whereas in the rural areas they simply did not know.

Differences in institutional provision of contraceptive methods

The differences in types of contraception available between institutions is slight but significant. In urban areas where there is a choice between institutions and access to private consultants and chemists anyone who can afford it can obtain most types of contraception with the exception of diaphragms. For the *población abierta* the choice is limited, especially in more rural areas. In theory, women in town could go to either the SSA hospital/clinic or the IMSS-Solidaridad clinic to obtain contraceptive methods free of charge. However, amongst such women as I knew, nearly all were under the impression that any service from the SSA would cost them money. This is because, in town, only family planning and vaccination services are free within the SSA. If these women go to IMSS then automatically the choice of injectables is removed and they are likely to be heavily pressured towards choosing IUDs.

Little was said about the contraceptive pill in interviews except to say that it was quite popular amongst those who wanted to use a contraceptive method but not a first choice amongst providers because of difficulties with user compliance and lack of understanding of the pill cycle. Women were reported to take it only when they had sexual relations or were said to forget it and then try to take too many a week later. There were no explanations as to why progestogen-only pills were unavailable in government clinics though there was a clear preference for the promotion of 28-day pills as opposed to 21 because it was thought that if women could be made to understand that they should take them continually, without a break, then compliance would be more likely. During a training session for health promoters Silvia Olivares of the SSA asked the Tzeltal men (there were no women trainee promoters) what

they thought would be the better type of pill - 21 days or 28. No-one answered even though she had been talking about the pill for over half an hour and these men were literate (they took notes) and could speak Spanish. Eventually, she answered for them saying that the 28 day pill was better because this minimised the chances that the woman would forget to begin her new packet [Training session, Belisario Domínguez, las cañadas de la selva, 1996]

The diaphragm as a barrier method of contraception was dismissed immediately. It was unanimously considered to be a culturally inappropriate method because women would not want to be gynaecologically examined in the first place for a fitting, and would then be reluctant to have to insert a diaphragm themselves as it meant touching a very taboo part of the body:

Indigenous women do not like to be seen below the waist. That's one of the reasons why they rely on *parteras* so much. They don't want doctors to see them or touch them. [Dra Suárez, ISSSTE, San Cristóbal, 1996]

This general reluctance for gynaecological examinations amongst indigenous women did not prevent avid promotion of the IUD. The real difference between the two methods however is that one is provider-dependent whilst the other requires client compliance. This method was not on offer as a method to anyone regardless of ethnicity or levels of education within government health clinics, neither for the *población abierta* nor for the insured population. As far as other female barriers were concerned no-one responded to questions about the female condom or spermicidal sponges except to say that they did not exist in Chiapas, and were contraceptives more appropriate for urban areas.

It may be that female barrier methods would be difficult to promote amongst indigenous women but there is also a substantial mestizo population in San Cristóbal, Las Rosas and Teopisca. Moreover, this avowed reluctance articulated by mestizo doctors on behalf of indigenous women that they simply would not want diaphragms is not based upon any concrete evidence. Of course, a reluctance concerning vaginal examinations indicates that it might not be a method of first choice but without information, education about and access to this method it remains a possibility

denied. Moreover, amongst both non-governmental organisations and indigenous promoters some interest was expressed in diaphragms. Dra Henríquez at Chiltak emphasised their promotion of condom use in rural areas and said that they were also planning to introduce diaphragms into their health promotion package when they could afford to obtain supplies and organise training and distribution. María Elena, a Tzotzil health promoter, expressed a strong interest in the diaphragm, the female condom and implants, none of which she had heard of before we discussed them together. She was very keen to get more information about all of these methods and thought that she could introduce them to rural women in both her home rural community and the urban community in which she now lived. She saw them as other options in which some women might be interested, and for herself as enhancing her reputation as a health promoter amongst the women.

Concientización

Women's choices are clearly limited in Los Altos by a marked provider preference for the IUD, openly expressed by many doctors, due to what is seen as its high efficacy level, with few *minor* side-effects, coupled with the lack of client-compliance required after the device has been fitted. Whilst the IUD takes precedence for most doctors, all emphasis is placed on modern contraceptive methods with little if any consideration given to other natural or traditional fertility regulating methods. The words *concientizar* and *convencer* (to convince) were frequently mentioned by doctors and *pasantes* who see this as a route to making modern contraceptives more acceptable. This has potentially more fundamental consequences than promoting use through education and information: staff feel that they must *convince* women and men that modern contraceptive use is *good*, lending heavier weight to the moral high ground claimed by health staff that they are only doing what is best for the patient. The dangers are apparent in that to educate a person about contraceptive methods indicates, in theory, there is some balance involved where a person becomes aware of the pros and cons of various methods and what family planning is for. They are thus deemed able to make an informed choice. On the other hand, to seek to convince a person indicates that the protagonist has

already made the decision for the subject, or has at least made the decision about what is good for the subject.

Concientización is an extremely important political concept in the history of Latin America. There is no single word in English which unequivocally translates the meaning and so we have adapted the term to "conscientisation". The meaning of this word is much more profoundly layered than the similar English phrase "consciousness raising" which denotes an awareness of the self. It is defined by Gustavo Gutiérrez as the difference between "naïve awareness" and "critical awareness" [1988:57]. He sums up this distinction by citing Paulo Freire, the major proponent of *concientización*, defining it as a journey where "the oppressed reject the oppressive consciousness which dwells in them, become aware of their situation, and find their own language. They become, by themselves, less dependent and freer, as they commit themselves to the transformation and building up of society."⁵ What grew out of educational concerns was taken on board by liberation theology and eventually became a tool of the political left in general. It is to be found in material of and about the Zapatista movement .

It is therefore very potent, symbolically, that health service staff (unwittingly or not) have commandeered this highly political concept which in Los Altos might be used by the political left to describe the health services (and certainly many other government services) as tools of oppression, and turned it into the expression of a process which would serve their own purposes, and consequently those of the State. In doing so the term has been adopted but the implications have been changed from an ideal of liberation from the conditions of oppression (which would include gender relations) to indicate liberation from poverty through the use of modern contraceptive methods as a panacea for all ills. Women and men are not being asked to become aware of their entire socio-political situation as campesinos, Tzeltals, Tzotzils, *coletos*, mestizos and so on, but rather their position as fathers and mothers, as well as caring partners. An ideology of the family is being promoted. There is no goal of liberation; this has been replaced by one of acquiescence of the client population with their governing masters; a promotion of the paternalism of the state for the good

of the people: small families, more resources, population control, sustained development.

But this ideal promotes a somewhat sterile picture of a loving couple with few children and therefore more resources and increased opportunities. It is an ideal of a bright future far removed from the socio-economic impoverishment of the region and related problems of migrant workers, land tenure, single female-headed households, alcoholism, domestic violence, low or no access to health and education services. For Paulo Freire *concientización* would necessarily encompass these aspects of the self in relation to the larger society in order for the self to become free. In seeking to *concientizar* people about contraceptive use, health policy seeks to promote a consciousness of the role of fatherhood, and motherhood, in relation to the family, rather than the self in society. In doing so the original meaning and impetus for *concientización* has become confused and depoliticised.

As a contrast to the government's vision of *concientización* we have Cecilia, the Tzeltal promoter. She was very open about her contraceptive practices, which interestingly, now that she herself was "*concientizada*", meant that she relied on natural rather than modern methods:

I never felt well when I took the pill or used [contraceptive] injections. I used to use injections but when I was much younger. Now I have a partner who understands me and we use coitus interruptus, we use condoms, we use two versions of the rhythm methods, but in agreement with each other. There is a lot of communication between us.

Working for the Grupo de Mujeres Cecilia has been exposed to the feminist ethos of many of the mestizo women there. These women are not against modern contraceptives, and these are available from the doctor there, who also facilitates sterilisation for those who want it through the Clínica del Campo. However, there is an ethos in feminist circles which recognises that many women are fed up with hormonal and invasive forms of contraception and have consciously decided to opt for more natural methods of fertility regulation which depend on a good relationship between a couple for these methods to be effective. Whilst Cecilia considers this to

be a responsible option adopted by a responsible couple, these practices go against the grain of the local health staff who equate responsibility with modern contraceptive methods because of their proven efficacy. What they are missing is that in doing so they deny other options to the intended recipients of their services because a discussion on the full range of fertility regulating methods, with their relative pros and cons, is not offered within Los Altos government clinics⁶.

Government health workers' use of *concientización* actually restricts a full discussion of fertility regulation and therefore limits choice. The practice of targeting of modern contraceptive methods goes some way towards explaining why natural fertility regulating methods are so resolutely ignored. This is a subject I shall take up in the next chapter.

¹ Apart from targeting within clinics, promotions are carried out through *jornadas* (intensive campaigns) which seek to bring men from various areas to San Cristóbal on particular "vasectomy days" so that a number of operations can be carried out at one time.

² It is interesting that Spanish speaking mestizos always referred to indigenous languages as dialects (*dialecto*) and not as languages (*idioma*), which they are.

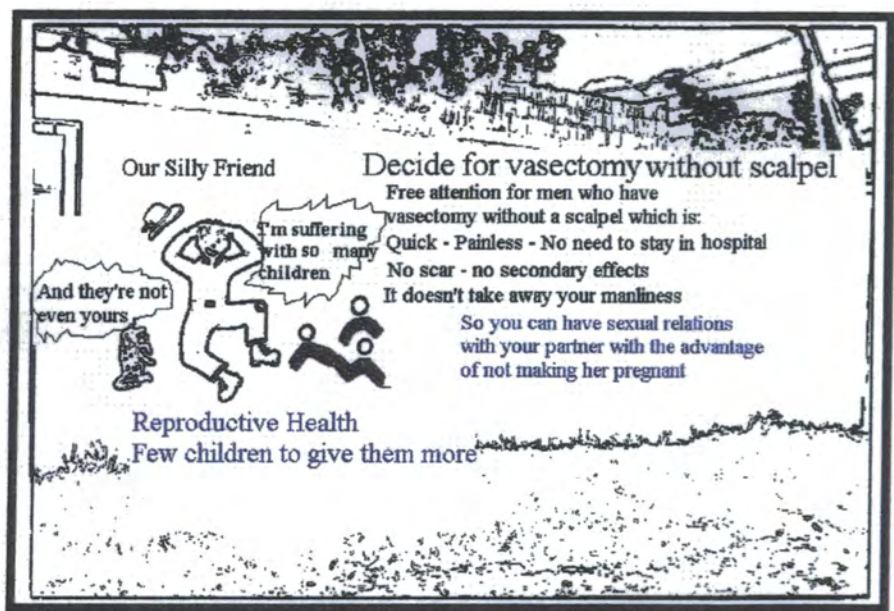
³ Lactational amenorrhea method

⁴ Provoked abortion - as opposed to spontaneous abortion.

⁵ Gutiérrez (1988) citing Paulo Freire, 1969, *La educación como práctica de la libertad*, Montevideo: Tierra Nueva

⁶ Even though all natural methods are included in the **Norma Oficial Mexicana de Los Servicios de Planificación Familiar**, [Dirección General de Planificación Familiar, 1995], which all doctors and *pasantes* should be aware of.

Plate 7.1 Wall Mural, SSA Clinic, San Cristóbal de las Casas, 1997



Chapter 8

Targeting of Family Planning Services in Highland Chiapas

Government policies are designed to target areas or groups, usually with a measurable policy result in mind. In Mexico, rural and indigenous populations are the most recent targets in a policy which seeks to impose lower levels of population growth as an overarching goal of reproductive health which also propounds health and welfare goals. Within these sections of the population women are singled out as the targets for the promotion of family planning. In theory contraceptive targets are also aimed at men; in practice men are hardly targeted at all. This is obvious from the major emphasis of the programme on female contraceptive methods: the IUD, the pill, injectables and female sterilisation, with male contraceptives, the condom and vasectomy, playing a minor part.

Targeting in Mexico has fixed numerical goals: a reduction in the total fertility rate and increases in contraceptive prevalence¹ designed to be brought about by the fixed targets assigned to local medical units of monthly and annual targeting of contraceptive methods. It is no great revelation that planners deal primarily with statistics but what effects does such planning have upon policy implementation at a grass roots level? Given the emphasis of the Reproductive Health Programme on informed choice and reproductive rights, how then does the practice of targeting equate with rights?

Theoretically, policy seeks to extend rights and empower those within the target area but much depends on the ultimate goals of the general policy and how this is put into practice at the local level. The general goals of the policy are to reduce the total fertility rate (TFR) of Mexico to 2.4 children by the year 2000 (see Chapter 3). Amongst mestizo women the TFR was already approaching that figure at 2.8 in 1990, though amongst indigenous women the figure was significantly higher at 5.7 and this explains why the government has prioritised rural and indigenous areas for aggressive targeting.

Misión Chiapas de Salud Reproductiva²

One aspect of the Reproductive Health Programme 1995-2000 was the inauguration of Mission Chiapas in 1995 to promote reproductive health goals and deal with the perceived population problem in Chiapas. It has been afforded priority status to investigate the problem of low contraceptive use and to establish actions and strategies accordingly [SSA, 1996:5-6]. Although it is billed as a “reproductive health” programme its main objective is to increase the practice of family planning, viz:

to orientate couples towards responsible parenthood and knowledge of family planning choices so that they can decide conscientiously and with free will their family plan. [Presidenta del DIF estatal, Expreso, Chiapas, 22/4/1997:11]

The idea of “responsible parenthood” highlights the cultural opposition between the ruling mestizos and the majority indigenous population. It implies limiting one’s family to a size which is deemed responsible on a societal level in terms of an increasing population, and is presented as responsible on a personal level in terms of having adequate resources to feed, cloth and educate one’s children. Conversely, to ask any indigenous woman what it means to have children invariably invokes the response that “children are a gift from God” and that you have “however many he sends you”.

This does not mean that indigenous women want vast numbers of children, nor that fertility regulation, abortion or infanticide do not exist in these communities as ways to limit fertility. However, there is a fundamental opposition between the idea that you “plan” to have a particular number of children according to a preferred “lifestyle” and living in indigenous communities where the post-modern concept of lifestyles is unknown and irrelevant, and where any notion of not having children would be seen as abnormal. Children provide security in old age amongst a population which has no age-related welfare cover. Children are considered to be an inevitable result of marriage and confer adult status upon new parents. Infertile

women risk desertion by their husbands and invoke pity amongst their community. As one Tzeltal promoter put it “if there aren’t any children, well the couple might divorce or separate. There’s nothing to tie them.” [El Niz, (Oxchuc), April 1997] Having children proves your worth as a woman; your *machismo* as a man [cf. Shedlin, 1982:102-3].

***Ellos no saben nada* - (they don’t know anything). Mestizo attitudes to the indigenous population**

Understanding these cultural differences are the key to providing family planning services which allow for the dignity³ and freedom, so important in policy mandates, of people to choose or reject such services, in an informed manner with a free will. This emphasis on dignity and freedom is important. If dignity is not afforded a client within a medical setting then it is likely that quality of service will be undermined to the extent that the freedom to choose in an informed manner will be significantly eroded. Whilst many other factors may affect informed choice, such as educational levels, language, and easy access to information, the relations between the client and provider are defining aspects. Providers, according to policy mandates, are supposed to afford their clients dignity; that is to say they should treat them as worthy of respect. In reality, this is difficult to monitor but in Los Altos it is apparent that whilst some doctors strive to meet these ideals, for others their contempt of “ignorant, dirty Indians who know nothing” (*ellos no saben nada*) is very apparent. Dr Pérez’s contempt for his clients was palpable within the waiting room and his discussion of indigenous people later reflected in words, his earlier countenance (see Chapter 7).

Such attitudes were not uncommon amongst government health workers, nor amongst the local *colecto* population. The most common answer to questions relating to the low use of contraceptive methods amongst the indigenous population was “*por la cultura*” (because of the culture). What this culture summed up in the majority of interview situations was not a simple expression of different beliefs, values and orientation but a term loaded with symbolic derogatory inferences some of which may be revealed by the tone of the following quote:

Contraceptive use is low because of the culture of the people and their customs. The population - nothing more than their indolence. [Dra Ocampo, SSA CSU, Teopisca, 1996]

Dra Ocampo thinks that contraceptive use is low amongst the indigenous people because they cannot be bothered to think about it; because they are lazy. Like many doctors she is unable to express how indigenous culture differs from mestizo culture in any way that shows an understanding of this other world but only in this ubiquitous phrase "*por la cultura*". For the most part, this phrase is negatively charged and is a stock phrase used by mestizos, and particularly by *coletos*, for dismissing the indigenous population as less educated and less cultured. In Chanal, a heavily militarised Tzeltal *municipio*, the doctor displayed similar contempt for her client population:

Well, first they come and ask for an injectable [contraceptive]. A little while later they come back and say: [here she put on a high pitched whining voice and screwed up her face in a pathetic attitude] "I don't want this one, I want pills (*tabletas*)". So we have to change their method [shaking her head in mock disbelief]. And we offer them the operation [sterilisation] but they are scared, not of the operation, but of what will happen afterwards. They think they won't be able to carry wood, carry their children, work in the fields, even though we tell them that they will have the same life, the same usefulness (*utilidad*) as before. [Dra Fernández, SSA CSR(D), Chanal]

The assumption seems always to be that the indigenous woman is to blame for various problems: not wanting a contraceptive, failing to put up with minor side-effects, fear of sterilisation. Amongst doctors who held such attitudes there was no self-analysis or criticism of the programme; no suggestions as to how family planning promotion could be offered in a more sensitive way; no question as to why people did not understand or not believe what they were told about contraceptive methods. Neither was there any suggestion that women may be demonstrating a form of resistance against mestizo power nor that their fears of side effects might have some substance. On the other hand, those doctors who were sympathetic to the plight of indigenous people were highly critical of the system even though they might not openly oppose it.

One such doctor who finally left the government services to work in academia told me that three years working as a government doctor in Tzotzil communities challenged her views and changed her outlook. Rosi became a close friend during my stay in Chiapas. Coming from Veracruz to work in Chiapas amongst indigenous groups was a completely alien experience for her and challenged her rationalistic, allopathic notions of medical care. She made an effort to learn some Tzotzil so that she could communicate with the women and strived to understand that those who consulted her also sought the help of *iloles* and *curanderos* for the same complaints. Her initial anger gave way to an understanding which she maintains helped her to work better amongst these people: for example, she came to accept that treating patients meant trudging miles to their homes because the *curanderos* had confined them there as part of their treatment, and as a part of this, that hospital care was a last resort even in the direst of situations. Rosi knew many *pasantes* during this period who could hardly wait to finish their contracts and move on because they could not get used to working in indigenous communities. One friend of hers gave up working in Chamula after a matter of months because “she thought that the Indians were dirty and she couldn’t bear touching them”.

In Los Altos, the mandate that patients should be treated with the dignity laid out in policy terms is not something which can be taken for granted. The cultural divide is wide between mestizo doctors and indigenous people; a divide exacerbated in some cases by racism at worse and lack of understanding at best.

Reluctance to use contraceptives amongst the indigenous Maya

Reasons for low use of family planning, beyond ignorance of, or a general reluctance to use, modern methods, need to be elicited and understood by providers, especially in relation to family planning as a right. It is not simply that “*ellos no saben nada*” (they don’t know anything) and therefore fail to understand either their given rights (given by others) or the advantages that these *others* propound on behalf of family planning services which could accrue to users if only they could be made to

realise it. In fact, there abound a number of reasons why people might not want to use family planning methods. There is much talk in Chiapas, for example, of family planning services being provided by the government in order to decrease the number of indigenous people and thereby solve the "indigenous problem". Some doctors are aware of this fear and at training sessions for indigenous paramedics overtly refer to it by stating that family planning is concerned with maternal-child health and family economics, that the government has no genocidal intentions, and by emphasising that everyone has a right to these services [Field notes: Training indigenous midwives to promote family planning, August 1996]. But it is a fear that is not easily assuaged, and one which is compounded by the many remote medical units which have few medicines and qualified personnel to attend to local communities in any case but which also have targets for contraceptive method use.

This perplexing issue of rights, the kind of category which Cohen [1987:16] considers "impossible to spell out with precision"⁴, will not necessarily be uniformly interpreted because of the various meanings it may be invested with, and perhaps more importantly in this specific case, because it is a concept authored by "the other" which is being forcefully promoted within an indigenous space. Where rights are propounded on behalf of others by a dominating force the concept is difficult to interpret and these rights may not be significant to the group on whose behalf they are being expounded or equate with perceived needs. On the other hand, rights which the group themselves author and ask for may not be extended because of a conflict with the interests of the State, for example, land rights. The subject of rights remains a difficult area not least because the power of granting rights remains with dominating authorities.

A fear that contraception is a genocidal tool of government hardly equates with the accepted notions of family planning and reproductive health rights. As a health education worker for the Diocese of San Cristóbal who worked in the *municipio* of Huixtán commented:

The people have realised that the government has the whole system of control in this question of reproductive health if they want to control birth and the increase

in indigenous people. They [the government] have taken very arbitrary measures and many people have decided not to go to the clinics. The clinics have very few personnel and when there are any they have virtually no work; people only go in emergencies; in extreme situations. [Field notes, Normita, Huixtán, May, 1997]

Normita is reporting an expression of this genocidal fear: that the government want to impose birth control to control the fertility of the indigenous population. NGO personnel had previously told me of leaflets found in indigenous villages expressing clearly and politically that these were government intentions, so it appears to be a concept that is being purposely fomented on a political level. But this resistance goes beyond politics and is to be found embedded in indigenous notions of what it is to be a man or a woman and the importance of having children, and as part of this, to confer adult status and worth upon new parents. In this sense the politicisation of these fears regarding government intentions is in fact quite rational for a group long used to mestizo domination. For the government to promote smaller families in such circumstances gives rise to suspicions over what their intentions could possibly be other than to diminish the size of the indigenous population to more easily rule and dominate them.

It is not only the government which meets opposition to family planning promotion. Normita emphasised that even NGO health providers meet with resistance in their attempts to forward family planning in these rural communities, though the reasons given are in this case not related to fears about government intentions but rather rooted in local practices and perceptions about men, women and children and the introduction of alien concepts, such as rights. Normita's extensive experience of health promotion amongst *catequistas* (all male) has meant she has directly confronted fears amongst indigenous people concerning women's rights and family planning and she states that:

They don't know much about birth control and they resist it. Amongst the themes we discuss are the rights of women, and one of these is that women have the right to decide how many children they are going to have; how many they want to have. But the *catequistas* say to us:

- *Why don't we leave this out? It's a problem for us.*

We can't, I tell them, because it's a right and we can't leave out rights, these rights exist.

- *Well, we're going to have problems, they say.*

I ask why and they say:

- *Because the people here are very angry with the health people. They always come here putting ideas around about women and this frightens us. The women are frightened and so are we [sic. the men] because it seems they want to give us contraceptives and they cause us to be sterile.*

Although Normita works for the Diocese which is well accepted amongst particular groups in Huixtán with whom she works, still she is introducing outside concepts that continue to be resisted. The work of the Diocese is varied and reproductive health issues form a small part of wider development initiatives which include health promotion alongside pastoral work. The promulgation of women's rights is something which she has problems with but she insists that it remains a topic of health education in her work though she acknowledges the difficulties:

We have to be careful. We do things slowly. First we must persuade the men that this is something both men and women need to think about. They need to think about what it will mean to them. This will take a long time.

Normita is acknowledging a frequently mentioned obstacle to family planning in the rural highlands: men. They are the ones who will decide if a woman will use contraceptives or not, and if she does, which method she will use. The government have also come to realise the importance of men in contraceptive use and so there is an increasing focus upon the couple (*la pareja*) rather than just the woman. Part of the reason for this was reported problems with men turning up at clinics in a rage having discovered that their wives had been given contraceptives without consulting the men or gaining their consent. The issue of women's rights and continued male control over certain aspects of family life are confronted head-on in the promotion of family planning services, with men now acknowledged by both NGOs and government workers to be important if promotion of contraceptive use is to succeed. Both groups assume that if the men would only agree then the women would use contraceptives. However, though men are obviously important as decision makers, it

is by no means clear that women in these communities would suddenly become avid contraceptors if the men failed to object.

Systematic offering and numerical targeting of contraceptive methods

Into the milieu of suspicion between mestizo and indigenous groups, and a rural indigenous culture which has to date shown little interest in modern contraceptive use [cf. Carlsen, 1997:136, on the Guatemalan Maya], the government have introduced Mission Chiapas for Reproductive Health with two main strategies for increasing the prevalence of contraceptive use within a stated framework of reproductive rights. These are systematic offering and numerical targeting of contraceptive methods [cf. Thompson, 1998]. Systematic offering (*oferta sistemática*) of contraceptive methods means that every time a woman goes to a health unit for whatever reason she will be asked about family planning and offered a method if not already using one. Clinic doctors and *pasantes* are compelled to do this whether or not they agree with it. In addition, they are given numerical targets every month to increase the various contraceptive methods offered by the clinics. Generally these are the pill, injectables, IUDs, female sterilisation and vasectomies. Condoms are given out but according to most clinic personnel are not counted in the figures.

At the end of every month clinic staff are called to a meeting in San Cristóbal under the auspices of Mission Chiapas where they must report their contraceptive rates and discuss new targets for the following month. Clinic staff are put under pressure to meet these targets. This compounds existing problems in terms of trying to implement health policies in rural areas generally regarding their own cultural and physical isolation and lack of resources. The frustration for medical staff can be summed up in the words of an ex-*pasante* of Chenalhó:

It embarrasses me that a woman comes to the clinic because her child is ill and I have to offer her family planning advice, and I can't give her medicines to give to her child. For me, this situation is totally inhuman and moreover we have mountains of boxes of contraceptives and not a single antibiotic. It's horrible. It

embarrasses me. And I'm not to blame. [Interview 045, San Cristóbal, December 1996]

It is not only the *mestizo* medical staff who have problems with this. Often, doctors and *pasantes* pass this pressure on to local health promoters who work with them in the rural communities. These promoters are usually bilingual locals elected by the communities, or volunteers who work as health promoters, sometimes for more than one health organisation at a time. The positions are usually unpaid to avoid internal community jealousies. They complain that they are told to offer family planning advice every time they visit someone's home so that the doctor or *pasante* may increase the chances of meeting his or her targets.

Pedro, a Tzeltal promoter from El Niz, a fairly isolated rural community in the *municipio* of Oxchuc, was scathing about this practice. He worked as a health promoter for IMSS and the INI and as an auxiliary for the SSA. He said that the main part of his work was visiting people in their homes in this community of 600 homesteads to give advice about preventative health measures. There were three couples of the 600 in the area using contraceptive methods in the past year and he was under pressure to increase this number. However, he no longer carries out the systematic offering of contraceptives and simply tells the doctors that he does but that no-one is interested:

They [the doctors] carry on insisting that we give more talks - more talks all the time. Well, it's a bit difficult because they [the locals] don't accept it. We give a talk once, then another, but by the third time they become bored or angry. Well, these people have their rights too and we can't make them use contraceptives. [El Niz, (Oxchuc), April 1997]

It is interesting that Pedro only ever referred to rights in terms of the right not to be pestered by countless family planning talks or by demanding that people use contraceptive methods. He was convinced that in general people of his community did not want family planning because it did not fit in with their way of life and their views on children. Despite his own training and his use of this new knowledge in his work amongst the local people for many years he said that the locals neither wanted to use contraceptives to limit their families nor to space births, no matter how many

times they were given advice on this. Pointing out that he too was a local, he said that it was difficult and embarrassing to keep on offering family planning advice when people did not want it.

Doctors also complained about the health promoters who worked for them, attributing their lack of success in promoting family planning methods to their inimical attitudes towards contraceptives, which attitudes they believed were a product of their indigenous backgrounds. Some doctors believed that these promoters, who were supposed to help them by communicating preventative health measures, actually hindered them in the case of family planning. One *pasante* commented on how she perceived her problems:

It's the fact of the ideology and the dialect (*dialecto*). It's very different. Although my auxiliary tells them about methods and explains how they work he omits things because he's of the same culture and he can't do it. More than anything, it's that. [Dra Parras, IMSS-S, Chamula, November 1996]

Many doctors complained directly about how targeting affected them and the people in their health care areas. The *pasantes* in particular had a hard time with targeting because if they objected too much they were threatened with "bad marks" (*nota mala*) against their future career prospects. On the other hand, systematic offering of family planning advice and methods further limited their prospects of gaining the confidence of the people in the local communities to which they were posted. In a sense they were in a classic Catch-22 situation which made working in indigenous rural communities more difficult for them than need be.

Dr Gómez of Tenejapa was one of the more outspoken doctors on the subject of government policy on family planning. He was adamant that every Mexican should have the right to family planning if they wanted it, and should be educated and informed about the options, but he recognised that amongst indigenous communities more sensitivity and concern was required. His frustration and anger caused him to be extremely frank at monthly meetings in San Cristóbal where targeting results were examined and formed for the following month. His supervisor threatened him by telling him that he was jeopardising his end of year examination marks. He

considered himself luckier than many *pasantes* who he knew lied about achieving their targets, throwing away contraceptives and returning figures to keep their superiors happy. Such is the pressure imposed upon *pasantes* in these circumstances.

Dr Gómez achieved his targets and put this down to his ability to win the respect of the community in which he worked and also because Tenejapa was a *lugar de paso*, a place where there was a lot of contact between local villagers and people from San Cristóbal and further afield. He believed this caused the local people to be more open to change and new ideas. Relating his experiences to me towards the end of his year as a *pasante* he said that in the beginning life was more difficult for him but that he relied heavily upon advice from his auxiliaries - Tzeltal men from local communities. Upon arrival one auxiliary advised him not to go into local communities to give talks on family planning because the people did not want it. He respected this advice and some months later the same auxiliary came and asked him to organise a family planning talk which he did without incurring problems and even gaining a few new acceptors. He maintained family planning promotions in a low-key way within the medical unit for his entire stay and only introduced them into local situations away from the medical unit upon the request of his auxiliaries and as a result the number of contraceptive users had risen slightly but consistently over the course of his internship. Although this approach meant that contraceptive uptake was low at the beginning of his internship, he later had few problems meeting his set targets and often exceeded them. He believed these results were largely attributable to his relations with his auxiliaries and through them with other members of the community.

Most doctors and *pasantes* were not prepared to discuss the existence of fixed targets for contraceptive use, simply saying that they existed but not disclosing details. Others claimed that fixed targets did not exist but this was clearly not true as, according to those responsible for family planning programmes in San Cristóbal's departmental headquarters, all medical units had monthly targets set and discussed during meetings in San Cristóbal. Moreover, in some medical units where staff claimed targets did not exist they were pasted on the walls. Clearly many doctors were unhappy with the situation and did not want to discuss it.

Government providers and fixed targets

All government health institutions operate the reproductive health programme on the basis of fixed targets for contraceptive methods for each of their localities, including DIF in their support role. Tables 1 and 2 (Appendix 1) illustrate the information on targeting and use I was able to gather from these organisations. The information is meant to illustrate only that figures are low and to give an idea of promotion and use between the various available contraceptive methods. Table 1 is particularly limited by the willingness of respondents to answer questions on figures for targeting and therefore is composed of only 12 of 31 SSA and IMSS-S government clinics interviewed. These units do not cover the whole population of the *municipios* but only those *cabeceras* or localities in which they are located. On the other hand DIF figures are given in relation to the whole *municipio* (see also Chart 4, Appendix II), and statistics were available at the departmental headquarters in San Cristóbal. However, they were unable to offer statistics relating to previous years which would allow for a comparison of targets with actual and new users.

The tables are further limited by the difficulty in obtaining figures for a particular time period. However, they serve to give an example of targeting and actual use in a number of localities. IMSS-S were unable to provide decentralised figures at a municipal level at the San Cristóbal offices, or figures for either Los Altos as a whole or their working area *Los Altos y Valles* which covered slightly more territory than the SSA's Health Jurisdiction II. The SSA provided centralised figures regarding actual use and targets over a number of years (see Charts 1 and 5) whilst IMSS-S was unable to offer me any centralised figures for the region at all (see Chart 3). It seems that a lot of statistical data had been mislaid and I was not the only person hampered by this problem. Doctors working within IMSS also complained that they could not get hold of these statistics for their own purposes.

Collecting reliable and comparable statistics at a municipal level in Los Altos region proved to be an impossible task. Clinic records were often not available for

more than the preceding month. In San Cristóbal the issue was confused by the working of two separate health systems and the added input of DIF. I was told that there was no double counting regarding users but the potential existed given the pressures for meeting targets, especially in areas with more than one medical unit where people used modern clinics opportunistically despite the clinics having their own set geographical boundaries.

Table 8.1

Active Users of Family Planning Methods by Method and Government Institution in the State of Chiapas, 1991.

Active Users	Total	Insured Population			Uninsured Population		
		IMSS	ISSSTE	ISSTECH	IMSS-S	SSA	DIF
	138,668	54,344	-	664	52,489	25,077	7,094
Injectables	32,612	-	-	92	27,714	4,806	-
Pills	29,872	4,076		394	7,663	11,698	6,041
IUD	33,372	13,206		175	16,947	3,044	-
Female Sterilisation	39,570	36,514	-	3	165	2,888	-
Vasectomy	571	548	-	-	-	23	-
Support Methods	3,671					2,618	1,053

Source: INEGI, Anuario Estadístico del Estado de Chiapas, 1992

To further emphasise the point that contraceptive use is low it is worth commenting on state and regional levels as indicated by some of the available national statistics. The above table on active users represents the 111 *municipios* of Chiapas. Around 81% of the population of Chiapas is uninsured [Gobierno del Estado de Chiapas, 1996:69]. In terms of contraceptive use represented in figures for the state of Chiapas, the area also takes in the cities of Tuxtla Gutiérrez and Tapachula. To attempt to put the figures in this table into some perspective, in 1990 there were 757,175 women of fertile age (15-49 years) in Chiapas [INEGI, 1991]. According to official statistics 42.79% of Chiapaneca women of fertile age were said to be using, or had ever used, a contraceptive method in 1991 [INEGI, 1992:294].

Ever-use of contraceptives is an interesting statistic in its own right but where the levels of actual use are much lower does not serve to reveal important details about current contraceptive prevalence and conceals rates of discontinuation if

separate figures are not available. Discontinuation rates for family planning services per se and for particular contraceptive methods are important to understand patterns of use and non-use and contraceptive method acceptability. There are no public statistics available on discontinuation. Concrete figures on actual use remain difficult to obtain in Chiapas, particularly in rural areas. The low actual use of contraceptives in Chiapas confirms what many doctors and health education workers told me: that many indigenous women will try a contraceptive method where these are heavily promoted but will soon discontinue. There were no clinic or institutional figures available to reflect rates of discontinuation by *municipio* in Los Altos.

These low figures are further reduced if we take only Los Altos with a population of women of fertile age of 93,026 in 1990 [calculated from INEGI, 1991] and contraceptive use for the same year as 1,519⁵ active users. For Los Altos region this gives a figure of 1.6%. By 1995 the figure for use in Los Altos had risen to 5,577 (5.9%) active users but is still very low.

These figures are hardly surprising if considered alongside the findings of Salvatierra *et al.* [cited in Sánchez Pérez *et al.* 1995:75] who state that in Chiapas only 15% of people who think they are ill actually use health services. If people don't use health services when they are ill then how much less likely are they to seek out, or be persuaded to use, modern contraceptive methods? This resistance to clinic use reflects in part a reliance on traditional curers and self-curing. Modern contraceptives are supplied by the government in rural areas through clinics which, it seems, are institutions which are largely rejected. However, it is these low levels of contraceptive use combined with a high fertility rate which has brought about the Mexican government's targeting of family planning methods in the area.

The consequences of targeting

Aggressive targeting of contraceptive methods has contrary implications both for the staff who are required to implement the policy and also for those targeted. On the one hand health staff are put under intolerable pressure to meet their targets

which can take on various forms of coercion and outright bullying. On the other hand the quality of care health staff are able to provide is undermined by this process because of the pressure they face to achieve a calculable output of their work. This in turn affects the target population whose prescribed right to make an informed decision about family planning services are thereby undermined.

How targeting can affect informed choice may be illustrated through a well publicised case of abuse in 1996. In Puebla, a mixed urban-rural region close to Mexico City, 70 women from the rural community of San Miguel Pocitos were said to have had IUDs fitted without their knowledge or consent whilst undergoing smear tests at their local IMSS clinic. The incident was uncovered when a large number of the women developed intra-uterine infections and three doctors were dismissed [Mexico City Times, 29 August 1996:1,3]. As one local politician pointed out at the time “if these women were reluctant to use contraception before, they are now terrified” [*ibid.*].

Such incidents serve the narrative of suspicion that the government only want to cut population growth rates rather than promote health and welfare, and that doctors are complicit in this as they seek to reach their targets. The incident in Puebla was turned into a political issue as one of the opposition parties (PAN) used it to discredit the ruling PRI. However, many incidents never come to national public attention but still affect local perceptions on family planning.

In Tenejapa a similar event occurred in 1996 though news of it never circulated out of the local area nor beyond the confines of the government health services and some of the local population. In the *cabecera* there is both an IMSS and SSA clinic. Whilst they are supposed to serve geographically distinct sections of the community, in reality they serve whoever attends them. There is little contact between the two clinics except that Gómez, the IMSS *pasante*, sends any of his patients who request injectable contraceptives over to the SSA as his own unit does not supply them. Because of his close relationship with some of the local people it came to his attention that nurses from the SSA were circulating the story that the IUDs he had fitted had not been done properly and that women should seek attention

as soon as possible at the SSA clinic where they could have the IUD changed and fitted properly, or they could choose a different type of contraceptive. When Gómez discovered this he was outraged. He put a stop to it by complaining to the head of the SSA clinic suggesting to them that if they wanted to boost their contraceptive figures then they had better think of another way. As far as he is concerned the matter ended there, though he could have taken it to a monthly meeting in San Cristóbal.

Whilst this incident may not constitute abuse on the scale of that perpetrated in Puebla it is nevertheless abuse: it is an abuse of the power of the mestizo clinic nurses, an abuse of the trust of the indigenous women involved, an abuse of the women's bodies that they should be subject, unnecessarily, to further gynaecological examination and IUD removal and insertion. The examples illustrate the pressures placed upon staff to meet targets, some of whom will abuse their positions in order to meet requirements. It also shows that there is some competition between clinics to make targets rather than cooperation within a given area where more than one medical unit exists. As this example shows, this increases the potential for misinformation and therefore undermines the likelihood of that an informed choice can be made by clients.

Female sterilisation was another major area where targeting became a serious issue regarding women's rights and the issue of informed choice. When questioned about how women from the community were advised of this service and what it entailed, various doctors and *pasantes* told how, after gaining a new sterilisation acceptor, they would seek to send her to the hospital in San Cristóbal as soon as possible so that she did not have time to change her mind. The following comments were related in a way which conveyed the feeling that the health worker was doing a good job in rushing acceptors through the process, rather than something which might be frowned upon:

If they decide, we take them straight away. If not, they change their minds.
[SSA, Tenejapa, November, 1996]

Normally a week because there are some people they get cold feet

beforehand. They get cold feet and then, no. Once a week, every Wednesday we take them. [SSA, Las Rosas, October, 1996]

Its quick. They do their papers and then they go. They don't wait any longer. [SSA, Yabteclum, (Chenalhó), November, 1996.]

Not all health providers feel that they have to get their sterilisation acceptors to hospital as quickly as possible. Some prefer to wait for a couple of weeks in case the woman wants to change her mind. These doctors and *pasantes* are more concerned with the quality of services they provide but still, the targeting pressures are great and most are conscious of a time lapse indicating a changed decision:

If you have treated them and they have accepted, well later they pull out, but that's to say they lie: "No, I'm ill." Last month I had two patients for sterilisation but when we went to get them to take them [to the hospital] one said "I've got a cough," the other "I'm ill." [El Niz, (Oxchuc), April 1997]

Sometimes they don't come back. They agree to be sterilised and then aren't seen again. Sometimes the woman wants the operation but the husband or the mother-in-law doesn't want her to. So she doesn't come back. [SSA, Oxchuc, October, 1996]

It seems on the one hand that for some women choice is undermined by health staff who want to rush women through the sterilisation process and on the other by husbands and family members who don't want a woman to be sterilised even if she has decided that she would prefer this. Targeting certainly increases the possibility of women going through a sterilisation without having made an informed choice. A study carried out in neighbouring Health District III found that many women had not realised that the operation would leave them permanently unable to have children and many women reported that they had not participated directly in the decision to be sterilised [Montero Mendoza *et al.* 1996:11].

In such a way is the climate of discomfort and distrust fostered, but it is easy to see how such situations arise out of the pressure placed upon providers. Monthly meetings are a time of reckoning and for *pasantes* their performance, or their demonstrated willingness to perform, is crucial to their end of year results. Some doctors reported problems if they had not managed to meet targets:

We have to explain why; yes it's a problem for us. [IMSS-S, Pantelhó, April, 1997]

Unfortunately, they have told us [contraceptive use] is low. We have to promote more. The thing is to convince the population. Yes, these low levels [of contraceptive use] cause us problems. [SSA, Chamula, October, 1996]

Every month we have a meeting and this includes an evaluation where they ask us to explain our figures. [IMSS-S, Chamula, November, 1996]

Of course, they demand that we try to promote [more contraceptive use]. [IMSS-S, Chalchihuitán, November, 1996]

Yes we had to try to reach our family planning targets otherwise they would threaten us with poor marks. [Rosi, ex- *pasante*; San Cristóbal, 1996]

Yes, we are rebuked. We have to promote more, to men as well because sometimes the man comes on his own, and we say to him that if his wife, hmm, if she's got a lot of children, we begin to introduce the subject to him. [SSA, Chanal, March, 1997]

Well, there are no problems, that is to say if someone has a problem it's because he does not want to work. But the problem is the people. You know, the people are not very cooperative. Well, every month they ask us why the numbers are like this [i.e. low]. [IMSS-S, Amatenango, December, 1996]

The last quote, from Dr Pérez (*pasante*), illustrates not only the existence of problems but reflects the view that the people themselves are partly to blame because they are not very cooperative. His views of the local population were generally unsympathetic and he assumes that their lack of complicity in the family planning programme is due to their own ignorance (*por la cultura*, as he says) rather than any problems with the programme itself or with local perceptions of him. Moreover, he is of the opinion that doctors who do not meet their targets simply are not working hard enough.

A contrary opinion was put forward by Dra Alvarez at the health centre in San Cristóbal. Although she worked in an urban clinic she still could not meet her targets and had a number of interesting points to make about this:

Yes, it's a problem. The problem is that we can't do it. These targets are for

the whole *municipio* [i.e. not just the city of San Cristóbal]. This is the problem. The targets are unrealistic. No-one here agrees with them. Promoting contraception requires education; and education requires time. The institutions ask for quantity not quality - this is the problem with systematically offering contraceptive methods. And the targets are not in accordance with the amount of people who come here - with the demand that exists. These targets are based on the whole *municipio* but only part of the population comes here. Therefore, these targets are for a population of over 73,000 people. It's just unrealistic. [Dra Alvarez, Head of Family Planning, SSA, CSU, San Cristóbal, 1997]

Dra Alvarez blames the system rather than either the people working in it or the people targeted by it, in opposition to Dr Perez' views. Her frustration was palpable during the interview as she discussed the problems that beset her work. She acknowledged problems in working with an indigenous population but not as something for which they should be blamed, rather as an aspect of her work which required sensitivity and care:

Working on this is to work with the culture, to work with feeling (*sentimiento*), it's difficult because it's very subjective. Sometimes they're not possible [i.e. the targets] more time [is needed] on the question of internal and external time-tabling of how to carry out reproductive health. For example, there's a lack of personnel training. For example, there are doctors with skills in fitting contraceptives [i.e. IUD] but they haven't been trained in sex education. It's something which is lacking, which has to be implemented. Because of the doctors' lack of sexual education, of all the doctors, nurses and paramedics. They all know the technical procedures.

The question of reproductive health is raised and she continues:

It's a different way of looking at it. Reproductive health has a different emphasis. Beginning from cultural knowledge, cultural respect and a knowledge of the body so as to be able to get involved. But the question is very practical here. It's practical "put in the IUD" [we say to a patient], but it's not your body [i.e. the doctor's] in the sense of your own body, and the patient says "no". And I believe that with advice - they choose don't they? What the couple say, not what one imposes on them. But sometimes the choice is very quick - because of the volume of patients that there are. The choice is very quick and doesn't allow them to decide themselves. Sometimes we see 24 or 25 patients in one day. Then, it's impossible to do things like that. For example, a procedure which you see is that IUDs are put in post partum. The post partum IUD comes along, and *pooom!* they're fitted; but then they start to produce bleeding in the first few months and the women come along wanting them to be removed. And why? Because there's no counselling before or during the birth about what's going to happen.

Dra Alvarez is a senior doctor with considerable experience unlike many of those who work in the rural medical units. She is well aware of the implications of a reproductive health policy as opposed to one which includes only family planning and she also acknowledges quite clearly the failings of the system: too many people dealt with too quickly, lack of training in reproductive health and counselling. As a senior doctor living in town, however, Dra Alvarez was in an enviable position vis-à-vis her more junior colleagues working in the rural communities who found the pressures harder to bear and were less well prepared to cope with them.

The effects of targeting on policy

Amongst health staff *pasantes* appeared to be under most pressure due to targeting of contraceptive methods because of their requirement to perform well regarding their qualifying exams. They were unable to object in any concrete way and might lie in order to conform. This situation serves no-one. It undermines national goals to decrease fertility levels because the pressure put upon intended recipients of family planning often serves to drive them away; it undermines any fertility goals at the local level and more crucially raises questions about providers and the quality of care they afford the local population. Neither does it serve the client population: it does not contribute to increasing access to family planning services or empowering women, and probably achieves the reverse through poor service and alienating the local communities [cf. Hartmann, 1995:38]. This is potentially more harmful to general health amongst the local community than non-use of modern contraceptives. Examples of abuses lead to further distrust of the health services and feed the narrative of suspicion that exists pertaining to both government intentions for the indigenous population and the secondary effects of contraception.

Many doctors and health workers in Los Altos recognise that targeting of contraceptive methods can result in abuses of women's rights which run contrary to the intended policy edicts on informed choice. Targeting undermines quality of care standards in clinic settings which may already be low due to the doctor-patient

relationship and the often reported racism of mestizo doctors against their indigenous clients.

Whilst it is becoming more fashionable to include men in discussions on reproductive health and family planning, women are still the main intended recipients, largely because there are few modern contraceptive methods available for men. As Sen & Grown point out women remain instrumental to population programmes [1988:47]. This is because they are seen primarily as responsible for family size [cf. Moser, 1994:60-1]. In Los Altos, condom use was rarely included in target figures and those for vasectomy were so low in comparison with female sterilisation as to be negligible. Many clinics did not have any monthly or annual targets with regard to vasectomy because it was believed that men, whether mestizo or indigenous, would not countenance it and preferred the women to be operated upon. Some people believed that male doctors exacerbated this tendency due to their own perceptions about vasectomy and their consequent reluctance to promote it.

Another important point is that targets are broken down by method, not given as global targets for general increases in contraceptive use. This raises other important questions regarding informed choice of particular methods and the importance of provider preferences. There appeared to be a marked preference for targeting the IUD and female sterilisation, confirmed by Dr Pérez, the IMSS *pasante* in Amatenango, when asked about targets for oral contraceptives:

We don't have targets for the pill. We focus mainly on the IUD and female sterilisation. I don't have the targets available here but for sterilisation it's about 15 a month. [IMSS-S, Amatenango, December, 1996]

Neither condoms nor vasectomy were promoted with the same vigour as any of the standard female methods, and the diaphragm was not an option for women in Los Altos, again *por la cultura*. Traditional and natural fertility regulation methods were countenanced by neither policy makers nor providers, though such practices are widespread. Targeting ignores those people (women and men) who use non-modern methods to regulate their fertility. The reporting of rhythm methods, withdrawal, LAM, and herbal methods was widespread, at least amongst indigenous women

living in the town (see Chapter 10). The question of effectiveness is used by health staff and providers to challenge such practices, thus placing the prevention of pregnancy as the paramount factor in a family planning context [cf. Barrios Ruiz and Pons Bonals, 1995:22], rather than the satisfaction of the client with regard to method choice based upon an informed decision which accounts for knowledge of safety and efficacy about the different methods.

Despite concerns about reproductive health rights and family planning, the mere existence of good policies on paper does not indicate the same in practice. Targeting is not compatible with reproductive health rights, undermines informed choice and leads to abuse. The Mexican case is an example of the persistence of top-down development policies which ignore local knowledge [cf. Gardner & Lewis, 1996:67-8] in the quest to introduce social change. In this case the desired changes relate to population control goals rather than local needs as expressed by local people. Although family planning technically falls within the remit of an integrated health service which should be less subject to top-down decision making and provided as one component within a primary health care package rather than as a single, unilaterally provided service, in reality the policy on reproductive health/family planning remains strictly a top-down affair traceable through the implementation of targets from the local to the national level. In Los Altos targeting has undermined any semblance of a reproductive health policy which on paper demands dignity for the people and informed choice in family planning services.

To put the effects of policy and provision into context I want to introduce some of the women I got to know during the course of fieldwork and consider how they deal with and think about contraception, and government health and family planning services, and also contextualise these issues in relation to the kinds of lives they lead.

¹ Contraceptive prevalence rates are subject to the following goals/targets: maintaining the level of contraceptive use in urban areas at 70% and above; raising the level of contraceptive use in rural areas to 57%. SSA, 1998.

² Mission Chiapas for Reproductive Health

³ "Reproductive health ... is a right of all Mexicans and a pillar of human dignity". [Poder Ejecutivo Federal, 1996:*I trans.*]

⁴ Cohen cites justice, goodness and duty.

⁵ Figures regarding active users in Los Altos were obtained from the SSA Hospital Regional, Coordinación de Planificación Familiar, San Cristóbal de las Casas, July 1997.

Chapter 9

Women's Lives in San Cristóbal's Marginalised Barrios

This chapter introduces some of the women I met, most of whom I befriended, in the 18 months I lived in Chiapas. It is here to broaden the perspective of reproductive health policy to include those people at whom it is targeted. In describing something of their lives and backgrounds through a series of vignettes I want to address some aspects of policy rhetoric and its relation to these women's lives. Though other women will be introduced in later chapters as necessary the following examples will serve to illustrate something of the ethnic and cultural flavour of life in Los Altos and to demonstrate the complexity of family planning in women's lives.

Sebastiana

Sebastiana was 37 when we met in 1996. She came to work for us, as a domestic, having heard of our arrival through a grapevine that loosely connects foreigners and domestic workers. San Cristóbal has a transient population of North Americans and Europeans most of whom come to study, work for NGOs or act as human rights observers. Working for foreigners is highly prized amongst women such as Sebastiana. Foreigners (*extranjeros*) are seen to pay more (and in fact are asked for more); they provide an exotic touch, being different from the local *coletos*, and are compared with each other as good or bad employers. They are both a source and a subject of gossip; they are often a resource when times are hard; and importantly they are outside of the mestizo/indigenous dichotomy which marks so many relationships.

Getting to know Sebastiana and her family was a first step for me in making contact with indigenous women who lived in and around San Cristóbal. With each other we muddled through all the idiosyncratic differences that marked our respective background and culture and what I learned from this was invaluable to my dealings with other women.

Sebastiana is a shy woman but far from subservient. Upon our first meeting she firmly laid out her conditions of working for us - she would not stay overnight as she had her own family to look after; she would not work late into the night nor at weekends; she wanted the same wages as her cousin who worked for our friends; she would like to bring her eight-year-old son Rodrigo with her when she came to work rather than allow him to go home alone. We had many conversations over the status of domestic workers in Los Altos as defined by their names: *sirvienta* or *muchacha* (girl) and the treatment they might expect from different kinds of people, graded on a scale from top to bottom running the gamut from foreigners, non-Chiapaneco Mexicans, non-*coletos* Chiapanecos to *coletos* at the bottom of the pile. This grading was based upon her own experiences but was echoed universally by the other women I knew who also worked as domestics, yet within these generalisations there were stories of the terrible foreigner and the good *coletos*. However, the majority of stories I was told of women's experience of domestic work reflected the gulf between being an indigenous person and being a mestizo and the long history of dominant-subservient relationships between the two groups: low pay, long hours, extra duties and hours with no recompense, physical punishment and verbal abuse. Sebastiana was in no doubt that she would never work for a *coletos* family given past experiences.

We foreigners who lived in San Cristóbal had our place in the scheme of things within the city as perceived by Sebastiana and others. We were considered to be rich, educated and potentially good employers. There was also some social prestige to be gained amongst peers if you worked for a foreigner. I heard local women boast of some fantastically high rates of pay by foreigners (including rumours about ourselves) which turned out to have been wildly exaggerated. Sebastiana delighted in telling her friends that she and Rodrigo ate with us each day and that her *jefe* actually cooked for her, an event that arose purely because she began work at lunch-time each day. It was mostly on these occasions that we swapped our life stories, slowly picking out the threads over the course of the year and a half that we shared our lives.

Sebastiana is Tzeltal. She was born in Chanal where her parents and much of her extended family continue to live. As a young girl she worked with her two sisters and her mother in the *milpa*. They also grew some fruit and vegetables and had a few sheep. Her mother, Señora (Sra) Díaz, continues to live in her small, dirt-floored, wooden shack, with no electricity or running water, tending the same parcel of land. She hauls large plastic buckets full of water from the bottom of a steep hill up to her house everyday. Sra Díaz appears to be a very old woman and it is hard for her to be self-sufficient. However, she refuses to go to the city to live with any of her daughters because of her attachment to her home, and because she does not speak a single word of Spanish. She can only communicate with her monolingual Spanish speaking grandchildren through their mothers. There is a deep pathos in watching her cuddle and kiss Sebastiana's children and yet being unable to talk to them. The gulf between their lives is immense and reflective of Sebastiana's long struggle to mestizoise her children in the hope of giving them better future prospects.

Sebastiana does not know when she was born and guesses that she was around 15 when she moved to San Cristóbal, and so bases her age on this calculation. The registration of births for people living in indigenous communities is increasing but still very low. Even in the city, Sebastiana was amongst the few indigenous women I knew who had bothered to register the births of her children and celebrated their birthdays. Birth certificates in themselves are important pieces of paper: without your *acta de nacimiento* (birth certificate) you cannot vote because you need this to obtain your national identity card; you cannot prove your parentage; and, importantly, it makes it difficult to claim maintenance from an absent father. The gap between the livelihoods of the urban and rural areas makes these things less relevant to the latter who, in indigenous communities, have their own ways of dealing with social problems. However, when women in particular move to the city, they discover that it is useful to have birth certificates for their children though their possession is no guarantee of success in disputes about maintenance.

Sebastiana's father left home for another woman after her younger sister, Angelina, was born. Thirty years later he is still with this woman who bore him many

sons and daughters. It is significant that Sebastiana's mother bore no sons. Sebastiana's mother received no maintenance after he left and when I first met Sebastiana she told me that her father was dead. It was some months later that I discovered he was alive and well, and living in Chanal. She refuses to see him now though he interceded on her behalf in disputes during the early days of her life with her husband. Sebastiana's mother lives alone:

No-one looks after her. She lives on what she grows - some beans and maize. She exchanges some of this for other things that she needs like salt and sugar. You know, the people there are not accustomed to dealing with money.
[Sebastiana]

When we took Sebastiana and Angelina to visit their mother they arrived at our house with huge plastic buckets filled with mangoes, melons, oranges, limes, salt, sugar and even a couple of freshly killed chickens. All the fruit was from *tierra caliente* (the hot lowlands) and not readily available in Chanal. They talked excitedly in Tzeltal on the gruelling three day journey by jeep over pot-holed dirt tracks. They were dressed in their usual *revestido* style: store-bought skirts, tee-shirts and cardigans, with the ubiquitous plastic sandals that poor women wear in town. We were met in Chanal by their mother who in contrast to her daughters was dressed in traditional indigenous clothing. She wore a bright yellow blouse with pale pink and blue stripes down the arms and around the waste: ribbons sewn on as decoration. Her traditional navy/black wool *nagua* was held in place by a deep pink woven belt and marked around the middle by a fine multicoloured woven band. Photographing them all standing together I was struck again by the implications of being *revestida*. I could only wonder how their mother felt about this outright rejection of their culture; of her continuing way of life and the fact that she could not communicate with the grand-children she so clearly adored.

Sebastiana said she would never go back to live in Chanal. In San Cristóbal she lived in a brick room with a cement floor. She had a plumbed-in toilet in the yard, even though she complained about it being shared with her sister's family downstairs. She also had a well which was always in reserve for those frequent disruptions in the piped water flow. She slept in a bed, not a mat on the dirt floor.

She earned money even though she kept chickens for their eggs and grew maize and some fruit and vegetables in the small patch of garden beside the yard. Angelina mocked her sister even for this attachment to the past: why grow maize and keep chickens like an *indio* when you live in the town and earn money? But Sebastiana was poorer than her sister and was careful with what money and resources she did have.

Sebastiana's personal history is inextricably linked with that of Angelina, even after marriage. It is a story of betrayals and jealousies which has left an uneasy peace between them, but it is a story which is not altogether unusual and illustrates something of their cultural background and of gender relations therein. When Sebastiana was fifteen (she thinks) she came as a young, illiterate, monolingual Tzeltal woman to San Cristóbal with her new husband Francisco. They were in *unión libre*, unmarried under civil or church law but by agreement of their respective parents, in the traditional way where he had to ask for her, and give gifts to her parents. She began working as a domestic servant, took in washing, and learned to speak Spanish out of necessity, a feat which, 20 years later, she described as very difficult. Her husband did odd jobs whilst studying in the evenings to become an *abogado* (lawyer).

Sebastiana gave birth to all of her children in Chanal. Both she and Francisco frequently returned to their home *pueblo*. During such a visit Francisco secretly began a relationship with the then adolescent Angelina. Eventually, Angelina followed them to San Cristóbal whereupon Francisco wanted to take her in. Sebastiana was furious and told Francisco "I am the first wife and I don't want to live with another woman." At first he agreed and set Angelina up in another rented room, spending his time between the two women. Money became tighter as Francisco was now contributing to two households. Eventually, his father came to Sebastiana to beg her to accept the situation because otherwise Francisco would have to abandon his studies as he could not afford to maintain two separate households. Reluctantly, Sebastiana agreed and Angelina moved into their small room with them.

By this time Sebastiana had two sons and Angelina a daughter. According to Sebastiana things deteriorated rapidly after this. The three of them fought constantly as the women jealously tried to guard their positions. If Sebastiana managed to buy herself new clothes then Angelina would tell Francisco that Sebastiana was *walking*^l (*caminando*) with another man.

The jealousies between these women dated back to their childhood. Sebastiana resented being kept at home to work whilst her two sisters were sent to school and the fact that they could read and she could not. She resented the older sister's success in becoming a school teacher for indigenous children. She resented Angelina because Francisco paid for her to have a *muchacha* so that she could continue with her schooling, though both these things stopped with the birth of Angelina's first child.

Sebastiana clearly felt displaced by Angelina and rejected by Francisco, believing him to favour her sister. For six or seven years she unhappily put up with this menage-à-trois. As the first wife she considered herself as the true wife (morally) and saw Angelina as the cause of all her problems. I pointed out that Francisco was also blameworthy and she agreed but reserved her greatest condemnation for Angelina.

Sebastiana's third child, a girl, was four years old Sebastiana finally decided that she had had enough. Leaving her two sons behind she took her daughter to Tuxtla to find work as a domestic servant. Close to tears she told me that if you have more than one child you cannot get work as a live-in servant. Sebastiana left telling no-one about her intentions. Her disappearance caused some consternation in Chanal causing her father to come to San Cristóbal to harangue Francisco, demanding to know what had happened to her: "Where is she? Is she dead? What have you done to her?" Apparently Francisco searched for her at length but without success.

Months later Sebastiana returned with her daughter to Chanal with the idea of settling there. Francisco, hearing of this, went to plead with her to return, saying that their sons were suffering without their mother. Having ascertained that she could

acquire a piece of land for a milpa, and that she had the support of her mother and cousins, Sebastiana gave Francisco an ultimatum: she would stay in Chanal unless he found her a separate home, away from her sister. By then he was working as an *abogado* on indigenous rights, and agreed to her demands. He bought the house in San Cristóbal where she now lives.

The house, in Barrio Tlaxcala, is built on two levels. The bottom half has five rooms. On the end of the roof, almost as an afterthought, there is a small brick building housing a tiny kitchen and another room. By the time Sebastiana returned from Chanal, Angelina was living in the bottom half of the building with her children, leaving Sebastiana to take the upper half for herself and her four children. Sebastiana was outraged, having thought that Angelina would be living some distance away, and even more so by her residence in the better half of the building. Despite many arguments Angelina refused to budge and Francisco did not intervene. Matters were made worse by Angelina's counter-claim to the superior position amongst the two women: as the second "wife" but with the most children (five surviving children out of seven by that time) she claimed, and still claims, to have the greater need.

Shortly after the move to Barrio Tlaxcala Francisco left both women for a third. However, he expected both Sebastiana and Angelina to welcome him back, and to continue sexual relations with him whenever he returned to visit either of them. Angelina still sees him and claims that her sixth child is his. Sebastiana now refuses to "receive"² him, and has little contact with him.

Though things have been bad both women are fortunate in that, despite a lack of maintenance payments from Francisco, neither of them have to pay rent to a third party. Life would be harder for them both if he had not set them up with this home, crowded though it is. The sisters now live an uneasy truce which is inflamed occasionally by continuing jealousies over questions about whether and to whom Francisco occasionally gives money.

By the time I met Sebastiana, Francisco had been gone for over eight years and her daughter had died. Sebastiana has continued to work as a domestic servant

and to take in washing. Angelina has a fast-food kitchen (*comida corrida*) in the market place from which she appears to make a reasonable living selling *tamales* and filled *tortillas*. Sebastiana claims that Francisco bought Angelina's kitchen stall in the market, another source of resentment.

Sebastiana says that she has never had another man since Francisco left. He appears to accept that Sebastiana will no longer accept him into her bed but he has told her that if she *walks* with another man then she will lose the house and any right to money for the children. He is legally married to the third woman, a mestizo lawyer, and now has three children with her.

This is Sebastiana's version of events. Of course there are two other sides, but I never met Francisco though we knew of each other. I was often briefly in the company of Angelina but on these occasions Sebastiana always spoke to her in Tzeltal and jealously guarded her relationship with me from her sister, as she did with other women we both knew. Despite this apparent one-sidedness the strengths of both women in fighting to maintain their positions in this menage-à-trois comes out. Sebastiana fought hard to defend her status as the first wife. One of the reasons she sought out and paid for her children's birth certificates was to ensure that they have a claim on the property in which they live. Angelina also held her ground and clearly managed to gain an advantage over the question of the house. Francisco remains in a position of power. He owns the house, he continues his relationship from afar with Angelina and he still seeks to dominate Sebastiana by threatening her with the loss of her home should she become involved with another man.

Such bigamous relationships are relatively common in parts of Los Altos amongst indigenous groups though not normally involving women from the same family. However, Sister Carla and Normita, health promoters for the Diocese, had noted other occurrences of this in Chanal. Sebastiana never referred to her relationship as bigamous though clinic doctors often described such situations by the use of this term. Civil marriage is rare amongst indigenous people, *unión libre* being the most common form of union, whether this has come about simply through a couple living together or whether they have gone through the formalities of a

traditional union. A church wedding normally requires a civil union as well. Two obstacles to civil marriage are the need to produce a birth certificate and the legal requirement to have a blood test to ensure compatibility of blood types with regard to future children. Both things cost money and all are fairly irrelevant to life in indigenous rural areas.

Amongst Sebastiana's peers in San Cristóbal her relationship with Francisco was a cause for continuing gossip and women tried to tell me about it long before Sebastiana herself confided in me. Many of the women I knew thought Sebastiana had been badly treated by both Francisco and Angelina though some were prepared to blame Sebastiana herself. Francisco's sister, known as "*La Maestra*" (the teacher), lives in the city but teaches in an indigenous rural school during the week. She uses gossip against Sebastiana and her children in an effort to protect her brother's reputation. Although she maintains an outwardly warm relationship with Angelina she does not speak to Sebastiana. *La Maestra* tells everyone that Sebastiana was a bad wife because she was lazy and did not look after him properly and therefore he took a second wife. She fears that Sebastiana will carry out a threat she has been making for a number of years: to force Francisco to pay regular maintenance to his children through the courts. Both Angelina and *La Maestra* are against her doing this and so promulgate rumours about how she was a bad wife to morally counteract this possibility.

La Maestra herself is in a three-way relationship. She is the "second wife" of a Tzeltal man whose first wife also lives in San Cristóbal, though they live in different barrios. I got to know her somewhat through a friendship with one of Sebastiana's enemies, though it was some time before I was to realise this. Claudia, who we shall meet below, was a friend of, and worked for, *La Maestra*. On those occasions we met *La Maestra* and I were cordial with each other but it would have been impossible for me to befriend this woman without devastating Sebastiana. In 1997 *La Maestra* had her first child with this man who spent three days a week with her and the rest of the week with his first wife and children. Through her gossip about Sebastiana she portrays this situation as normal and Sebastiana's objections to Francisco having a second wife as reprehensible. This complicity of women in the apparent ill-treatment

of women is apparent in other areas of life, such as the tenuous acceptance of domestic violence. Many women maintain that this is simply something one must accept and often do so to justify the same treatment in their own lives. This is a thread I will pick up with Carolina.

Carolina

Carolina was just 20 when I met her in 1996. Of all the women I got to know the sadness of her life touched me most, often invoking a private rage against the man I saw as responsible for many of her problems, and with whom I had to feign a friendliness which belied my true feelings when we met.

Carolina described herself as *mestizo*. I never met her paternal family though I got to know her maternal side well. Both of her parents were born in the *municipio* of Sabanilla and moved, when newly married, to Tuxtla. Her mother, Beatriz, now lives in San Cristóbal but still goes to Tuxtla to visit her husband who now has another wife. Carolina's grandparents, Doña Carla and Don Jaime divide themselves between Sabanilla and San Cristóbal, spending a few months in each place. Don Jaime defines himself as Chol and is bilingual. His wife maintains that she is *puro española* (pure Spanish), meaning *mestizo*, as does Beatriz. Many of those who spoke only *puro español* considered themselves *mestizo* despite any indigenous background they might have had.

Language is an important marker of ethnicity here both for those who wish to uphold their indigenous identity and those who are ashamed to be considered indigenous, as well as those mestizos who wish to denigrate what it is to be indigenous. I beheld an interesting conversation between Sebastiana and Beatriz one afternoon in my house, where they had met by chance. Each knew who the other was, in the sense of knowing something of each other's history through the local grapevine, without actually having spoken before. I introduced them and there followed a verbal tussle about who had what knowledge of the other and who was therefore in a position of power at that moment in my house:

Beatriz: Ah, yes, I know you.
 Sebastiana: No, no you don't.
 Beatriz: Yes, we have met before
 Sebastiana: No, we have never met before. You don't know me.
 Beatriz: Yes, yes I do. You are the *cuñada* (sister-in-law) of *La Maestra*.
 Sebastiana: Well, yes, but you don't know me.

In asserting that she knew Sebastiana's relationship with *La Maestra*, Beatriz was letting Sebastiana know that in fact she knew much of Sebastiana's life history with regard to her husband and sister. As I made coffee for all of us there followed a conversation about identity:

Beatriz: Where are you from?
 Sebastiana: Chanal.
 Beatriz: Oh, then you speak Tzeltal.
 Sebastiana: Yes, what do you speak?
 Beatriz: Nothing, only *puro español*. None of my family speak anything except Spanish.

This last assertion was a lie. Beatriz's father defines his identity as Chol and is bilingual. Beatriz told me, on a separate occasion, that she had a reasonable understanding of the Chol language. However, on this occasion, she wished to demonstrate her ethnic superiority to Sebastiana by denying any indigenous link at all. It turned out though that as Beatriz had known about Sebastiana's background so Sebastiana knew of Beatriz's Chol background. This kind of ethnic denial is common amongst those who are ashamed of, or want to hide their indigenous backgrounds. To speak *dialecto* is to be indigenous, with all the associations of ignorance and lack of sophistication that the term entails for many mestizos.

When I first met Carolina she was living with her two children in the home of her grandparents on the invasion site. The invasion site warrants some mention though it deserves an attention which goes beyond the scope of this thesis. It is a large, boggy piece of land on the outskirts of San Cristóbal which was invaded by indigenous organisations after the Zapatista uprising on 1st January 1994 and was named *Primero de Enero* in recognition of this. The groups organised politically and parcelled out the land to those who applied to build small homes. Many indigenous

people from rural localities came to take advantage of this, along with some already living in the city. Sebastiana had investigated the possibility but would not countenance returning to a rural-style home albeit one which would give her independence from Francisco.

The house of Carolina's grandparents was typical of those on the invasion site though considerably smaller than those owned by members of the indigenous organisation who oversaw the land. It was constructed from wooden planks, roughly put together, with a corrugated iron roof. The door, held closed with a padlock, was the only interior source of light when open, apart from the gaps in the walls. It was covered in parts by sheets of transparent plastic in an effort to keep out the wind and rain. Carolina complained that it was bitterly cold at night. A small table and two small wooden chairs had been set on the dirt floor with some rough planks of wood that served as shelves. Cooking was done on a small, light-weight metal, portable wood-burning stove. The tiny room was divided by an old curtain behind which there was a bed taking up the whole of the available space on that side. Outside, the small plot and house was fenced in by barbed wire. Carolina's grandfather had planted a few flowers but there was little space for cultivation. In a corner of the plot was a tiny wooden hut with a curtain hanging over the front. Behind the curtain was a hole in the ground which served as the latrine. To the side of the shack a large hole had been dug to the water table. This was the well from which Carolina took her water to boil and drink, and to wash. It was covered over by a couple of wooden planks and in the dry season it often dried up altogether necessitating a long walk to collect water from a public piped source about three-quarters of a mile from the shack.

When we met, Carolina had been living in this house on and off for nearly a year, the length of time it had been since she left Petul her husband (in *unión libre*). They had eloped together at 16 bringing down the condemnation of both sets of families for their behaviour. She describes a short but blissful period before she became pregnant, an unintended event but an inevitable one given that Petul had refused to allow her to use contraceptives. Her parents' fury was increased and her father beat her despite her pregnancy.

After Ulises was born the three of them moved to Petul's native Tzeltal locality where Petul found a job as a school teacher for indigenous children. Carolina describes this period as the beginning of her troubles: Petul started drinking and beating her. Carolina was isolated both by her lack of Tzeltal and because she was in Petul's home pueblo amongst his relatives who did not support her in disputes. Carolina left Petul 18 months later when pregnant with their second child. She had been relying on prolonged breast-feeding to avoid pregnancy but quite clearly relied on it for too long:

I left him because he beat me a lot. When I was pregnant he beat me too much. He bruised all of my body. I took my child and left him. I was injured because he had maltreated me too much, too many times. He would come home drunk and get angry about something, anything, that annoyed him. He drank a lot. He still drinks.

- Does he try to see the children?

He wants to take them from me to live with his mother. He took Ulises from me once and kept him at his mother's for a whole week. I cried a lot but he took him from me and escaped to his mother's house.

- How did you get Ulises back?

Well, I went to try to see my son. Petul wasn't there. Ulises cried and cried to come to me when he saw me. Well, Petul wasn't there, only my mother-in-law inside the house, so I took him and I ran.

Carolina described how he beat her so badly when she was seven months pregnant with their second son that she had to go to hospital:

My neighbour found me on the floor and took me to the hospital in San Cristóbal. I was seven months pregnant and he beat me and left me lying on the ground. I was bleeding from my vagina (*de mi parte* - lit. from my part) and I thought that the baby must be dead. Petul came to the hospital and the doctors shouted at him and told him that he was a bad man (*mal hombre*). Petul bowed his head and didn't say anything. From that day I have refused to go back to him. Never. I am on my own now.

- And what about your mother? What did she say? Did she help you?

No! She shouted at me. She shouted a lot. She still wants me to go

back to Petul. She won't have me in her house. She told me that all men beat their wives - you just have to put up with it - it's normal. No, she won't help me. That's why I'm living at my grandparents' now. But when they come back from Sabanilla I will have to move out. I don't know what I'll do then. Last time a friend allowed me to sleep on her floor but I can't keep doing that with two children.

When her grandparents returned Carolina was earning just enough money, working for her Dutch employer, to rent a room in a barrio close to the market. However, she remained extremely depressed about her circumstances. She wanted a proper home and someone to take care of her and the children. Despite her job she found it difficult to make ends meet and although she was given food and other resources by her employer she continued to be severely underweight and ill-looking.

During most of the time I lived in Mexico Petul had been on the sidelines of Carolina's life. He tried to woo her back to him with promises of a reformed character; a two-roomed apartment with electricity, running water and a toilet; food and clothes for her and the children. He told her that they could have a good life together but that he would give her nothing until she returned to him. She remained steadfast in her rejection of him for most of the 18 months I spent in Mexico and during which time he refused to give her any form of maintenance for their children. In the end he wore her down with his promises and her desire for a more secure and stable life than the one she led. A couple of months before I left Mexico she returned to him on the condition that if he ever lifted a finger against her he would lose her forever.

I remember Carolina's embarrassment the day she came to my house and told me she was moving in with Petul again. She had asked me many times for my opinion and though I always replied that only she could make this decision she was aware of my hostility towards Petul because of his previous behaviour and my belief that he would not change. Her embarrassment was partly due to this but partly due to her own feelings that she had finally given in to him. In the beginning Carolina was delighted with her new surroundings, with a real bed to sleep in which had sheets and a mattress, food and new clothes, hot running water and a shower. However, she confessed to me that when he touched her she was repelled and that she did not

love him anymore. Within a month she began to talk of their relationship as something she must endure until the children were older and less dependent on her so that she could be free to work and one day be able to leave Petul. I asked her if they would have more children and she shook her head vehemently. However, he was again refusing to allow her to use contraceptives and she talked of having an IUD fitted secretly. Before this could happen she had a number of scares that she might be pregnant and each time went to a chemist to buy Depo Provera. She injected herself with large doses of this to bring on her menstruation (*bajar la regla*). Petul never knew. She finally persuaded Petul to let her have an IUD and was relieved about this but she continued to be repelled by Petul's touch.

A short while before I left Mexico Petul beat Carolina for the first time since their reunion. A few days later I had to attend Adan's birthday celebrations which had been organised for friends and family in their new home. I had to embrace Petul and put on a friendly face despite my own revulsion for this man which increased ten-fold when I looked into Carolina's dead eyes. Despite her previous depressions and angst, despite her malnourished demeanour, I had never seen her eyes so devoid of emotion. By the time I returned from the Yucatan three weeks later Petul was drinking again and, supposedly, seeing another woman. This woman visited their home and Carolina was introduced to her as Petul's sister, rather than his wife. Carolina did not contradict him. He began to threaten her about her inappropriate behaviour which included having *gringa* friends and acting independently on household decisions. Carolina said that he told her he was the man and therefore he made all the decisions which she should not question. I left Mexico then and could only despair as to what the future might hold for her.

Since leaving Mexico I have received a couple of letters from Carolina³. These are frustratingly devoid of her thoughts and feelings. She makes no mention of having had her IUD removed but the last letter (September 1998) revealed that she was pregnant. However, a subsequent letter from a mutual friend described how Carolina had to have her IUD removed due to continual heavy bleeding, how Petul then refused to use condoms or a rhythm method, and how he became angry and blamed her for being pregnant. Carolina later lost the baby apparently due to her

continuing ill-health and malnourishment. She is still with Petul but once more she is living on the invasion site in circumstances that I know she finds detestable. I find myself wondering frequently about the conditions there since the devastating floods in Chiapas in 1998. In a normal rainy season the area is a boggy field with parts of it under a few feet of water. The only positive aspect is that her new home is near her grandparents with whom she has a warm relationship though they are often away in Sabanilla. However, her new home belongs to Gloria, her aunt, whom I knew well and liked a lot. I cannot imagine what has happened to Gloria and her five children. Carolina's only comment here was that she had moved out after a problem with her man. I am puzzled as Gloria technically "owned" this small, run-down shack and had nowhere else she could go to apart from her parents in Tila. She always swore she would not do this under any circumstances for reasons which will become clear below.

Gloria

Gloria was the cousin of Beatriz, Carolina's mother, though Carolina always referred to Gloria as her aunt and called her Doña Gloria which illustrated her respect on account of their age and generational differences. Gloria lived quite close to her paternal uncle and aunt (Carolina's grandparents) on the invasion site but had very little to do with them though she saw quite a bit of Beatriz. She was a cause of gossip in this family who generally disapproved of her behaviour and the way she lived.

Despite her deprived circumstances Gloria was a bright, engaging woman. We enjoyed some hilarious conversations, with her questioning me about my personal life as much as I did her. She had a very sexy demeanour and her banter reflected this but brought condemnation from other women, some of whom expressed surprise that I saw so much of her. She was considered a flirt and often wore an infamous red dress which hugged her voluptuous curves and was very low cut and revealing. It was not a particularly practical form of attire for the invasion site but she wore this

dress with aplomb, especially on those occasions when she knew I would be bringing my camera to her home.

Gloria's house was like that of Carolina's grandparents in nearly every respect: one room, with a bed tucked around the corner of a makeshift curtain, and a second bed next to the cooker. The cooker was a feature which surprised me. It was a modern, gas cooker and ran on replaceable gas cylinders though she also cooked on a charcoal burning stove to conserve the gas, which often ran out and was not replaced for weeks at a time. Like Beatriz, she denied any Chol connections to me, maintaining that her family were mestizo. I never met her parents as they lived in Tila, the *municipio* next to Sabanilla to the north of Chiapas in La Selva region, where they had some land which they cultivated on a subsistence basis. She visited them but rarely and usually only when she was in particular financial need. Of Gloria's five children, her two oldest boys aged 11 and 13 lived with their grandparents most of the time in Tila because she could not afford to maintain all of them. They worked for their grandfather in exchange for their keep. Gloria's two daughters, Normita and Lupita, aged nine and two, and her other son Beto, aged five, lived on the invasion site with Gloria and her partner in extremely cramped conditions. Normita and Beto were supposed to attend the school on the invasion site but Gloria only took the youngest when she felt like it and often kept Normita at home to help out.

Gloria was new to the kind of living conditions which prevailed on the invasion site. Less than two years earlier she had lived in Guadalupe, a central city barrio, where she had a house with all the comforts this implies. Her cooker is a remnant of this previous existence. She delighted in telling me about the material comforts of her life there which ended abruptly when her *mestizo* husband died prematurely in his late thirties. He was, she says, a *coletto* who made and painted furniture and so she had been used to a nice house with pretty furnishings.

Gloria had been thrown out of her old house by her mother-in law. She explained how she and her husband had not legalised their union so that upon his death her position in the house became tenuous. Her position was further

undermined by the fact that her mother-in-law had lived in the house with them for years and now wanted it for herself. In theory Gloria has a legal right to this house but the process for proving her case is long and complicated involving the need to obtain written depositions about her relationship with her partner in opposition to those which would be brought by her deceased partner's family. Gloria had all her five children with this man. As the oldest is now 14 and the youngest two she had obviously been in a long and established relationship which, like many people, they had not bothered to legalise.

Gloria's position was further complicated by the fact that she did not have birth certificates for any of her children and so any claim on the house, on their behalf, would necessitate a long drawn out battle which would first require Gloria to obtain these. She would need signed depositions from the *parteras* who helped her with the middle three children, and from the doctors at the hospital where she gave birth to the first and fifth child. These depositions would have to identify the father by name. Gloria was convinced that she could not easily obtain these even for the last child who was only two. She believed that the doctors would not bother to help her and criticised the Clínica del Campo where she gave birth because of her treatment by the staff. She maintained that she only had her last child there because she wanted to be sterilised straight afterwards. Her husband was in the last throes of his illness at this stage, and was himself in hospital at the Clínica del Campo. She related the following conversation at his bedside when he was preoccupied about his imminent death and what she would do afterwards:

When my husband was very ill he said to me "Ay Chaparra⁴, the day I die you will go and carry children for another." "No", I said, "I won't go and carry children for anyone. Look, I'm going to be sterilised." "No, no, don't do it," he told me. "Don't go and get sterilised." "Yes" I said. "I am going to do it." Afterwards he said to me, "Why did you do that?" and I told him, "Because I'm not going to have a single child more with anyone else." And that was that.

Gloria was sterilised partly to prove her feelings to her husband and to assuage his fears that she would go off with another and forget him. At the same time he realised that often a woman needs to have children with a new man to solidify their relationship and for that reason he asked her why she did it. However, Gloria

also said to me that after five children she most definitely did not want to have more anyway.

Another difficulty with obtaining birth certificates was the cost and Gloria did not have very much money, having no independent income of her own. Her new partner was a policeman on low pay, but he maintained her and the children. The *Grupo de Mujeres* began offering free birth certificates to women like Gloria who needed them to press for maintenance and other rights but still Gloria said that she simply could not fight her deceased husband's family.

Gloria was much maligned by the women in her own family and amongst her friends for her choice of partner and for being lazy. Carolina, although she was outwardly respectful to Gloria, said that her partner was horrible, that he beat the children, who were not even his, so he had no right to touch them. I remember that Normita was very afraid of him. He also beat Gloria occasionally, though she fought back and their fighting, when he came home drunk, was well known to all in the vicinity of her shack. Her laziness was attributed to her not having a paid job. She would not work as a domestic servant or take in washing and there was little else she could do since she had no education. At one stage she began to sell *tamales* around the market, making them at home and then carting them off in a basket to sell to the early morning stallholders around 5.00 a.m. However, this did not last long and she was seen as too complacent by Carolina in relying totally on her partner for maintenance, though this was before Carolina herself had moved back in with Petul.

The shack belonged to Gloria. She obtained it from Scopnur⁵ after her in-laws threw her and the children out of her old home. Gloria herself threw out this partner on many occasions for his behaviour though she always took him back. He drank a lot and would bring his friends back to drink more and play cards until the early hours of the morning, turning Gloria out of her bed so that his friends could sleep off their excesses of the night before. I considered myself fortunate that I only ever met him twice. He was never on the invasion site during the day and I rarely visited at night.

One rainy evening, however, I went up to see Gloria on some errand. The invasion site had become a quagmire and the cold had set in. In Gloria's house I huddled up at the small table next to the stove drinking coffee whilst she prepared *tamales*. It was very cramped. The few chickens she had were scuttling about on the earth floor and the children were all squashed up next to the cooker. There was barely breathing space for us all. On the bed lay Gloria's partner with blood-shot eyes. He was drunk and began asking me about what I did and how Gloria and I had met. Gloria was slightly tense and with a nervous laugh answered many of his questions for me before I could. I tried to leave because of Gloria's apparent discomfort and my growing uneasiness but I was pressed to stay longer. Meanwhile, Gloria's partner began telling me gruesome stories about the number of *gringas* who had allegedly been murdered in the area and what had been done to them. He was trying to frighten me with stories of rape, strangulation and bloody, macheted bodies. I finally managed to leave and though Gloria and I customarily embraced upon meeting and departing I made to squeeze out of the door with a quick "*adiós*" in his direction. He leapt to the end of the bed and grabbed my arm so I gave him my hand. Holding it firmly and for far too long he leeringly warned me to beware of men as I crossed the site on my way home. Gloria, laughing nervously, pushed me out of the door, telling me not to listen to him. It was quite an unpleasant encounter and I continued to avoid him when possible.

I asked Gloria why she did not move back to Tila where her parents, two sisters and brother lived. She said that she did not get on with them and talked of her oldest boys living there as a case of necessity rather than desire. She worried because her father was violent and often beat her children. The older boys did not want to live there. The eldest always cried when it was time for him to return to Tila prompting Gloria to comment on one occasion about her parents:

They know nothing of love. They don't know how to give affection to their grandchildren. Because of this the boys don't want to go back. I don't want to go back there. Today, the boys were supposed to return but I have not made them go yet.

Gloria is not really in a position to maintain the two older boys and her home is overcrowded enough with the three younger children, Gloria and her partner. When the boys come home it is more difficult and causes increased tension in her relationship.

During a trip I made to the Yucatán Gloria became ill and spent a few nights in the Clínica del Campo. When I returned she still looked pale and sickly. She had been rushed in with severe stomach pains and put on a drip for a couple of days. She did not know what had been wrong with her and said that the hospital doctors did not explain anything to her. When I left Mexico she still looked very fragile. Carolina told me how Gloria's partner had turned up at the hospital in a very drunken state and had had to be thrown out by clinic staff. The children were sent to friends because Normita became withdrawn and nervous upon her mother's illness and Beto turned up at hospital with bruises all around his neck after he had been grabbed by his step-father. Carolina related these incidents in a blind rage at Gloria's inability to leave this man.

Claudia

Claudia worked for *La Maestra*, looking after her room and baby whilst *La Maestra* was teaching in a rural community during the week. Claudia had been a friend of Carolina's until they fell out over some gossip relating to allegations that Carolina was seeing a man. She was 37 when we met and lived on the main road beside La Hormiga⁶ which ran past the top of the invasion site. Claudia was renowned as a gossip which I learned to my cost when she began to spread rumours about Sebastiana, claiming I was the source. She had often tried to engage me in discussions about Sebastiana's relationship with Francisco, claiming that Sebastiana had been a bad wife. However, I always stonewalled these attempts to gossip about Sebastiana as soon as they were raised not least because of Claudia's association with *La Maestra*.

Claudia is Tzeltal and was born in a small locality of Oxchuc. She has only lived in San Cristóbal for about eight years. Although she has had some schooling she does not read and her Spanish is quite stilted. Her father bought the small two-roomed house made of brick and concrete some years back. It has a latrine in the yard but no running water and Claudia has to fetch it in plastic buckets from a nearby public piped water source. This water has not been provided by the local government but has been illegally tapped by people from La Hormiga who have installed a tap above the mains so that anyone can have access to it. There is an ongoing dispute with local government officials about this and the fact that no-one pays for the water used.

Claudia lives alone though her father and brother are frequent visitors, bringing produce to San Cristóbal to sell in the market. Her father has some land in Oxchuc and grows maize and beans, vegetables and fruit. He is an important man in his village to which Claudia returns frequently. When she does she changes from her habitual jeans and tee-shirts into her beautiful indigenous clothing, comprising a dark wool *nagua* and white cotton *huipil*, brightly embroidered around the upper half in the style of her area. She never wears her indigenous *traje* in town, though she made an exception on the day she taught me how to make *tortillas* because she wanted to be photographed in it.

Claudia was single when we met though she had just come out of a five-year relationship with a Tzeltal man who had a wife. Claudia described herself as the second wife and therefore at a disadvantage because he did not live with her and support her as he did his first wife and children. She still wanted to be with this man but he had broken off the relationship and now refused to see her.

Though she had used modern contraceptives during the first year of this relationship she stopped after this because she insisted that if her "*marido*" (husband) really wanted her then he should care for her and any children.

I wanted him to live with me and so I said to him, "Now I am not going to look after myself (*cuidarme*⁷) - it costs a lot of money. And if you really love me,

then love me. If you don't then go." And from then I stopped planning. Four more years I was with him and I didn't get pregnant even though I wasn't planning.

Amongst the forms of planning Claudia had used she named modern contraceptives as well as herbs and natural methods. She also told me about an abortion she had undergone when much younger which had left her very ill. Since she had failed to become pregnant she now thought she must be sterile either because of this abortion or because of the cancer or cyst she said had developed in her womb in recent years.

Claudia had been trying to get pregnant and believed that her partner would not have left her if she had his child though she admitted that he did not express any great interest in her becoming pregnant. But neither did he mind that she was not using contraceptives. Claudia was anxious to have a baby because she was afraid she was becoming too old to conceive. She knew a pregnancy would bring down the wrath of her father and brothers if she was not married but was prepared to pay this price to have a child of her own. She also wanted a stable partner and in a quest to realise these aspirations she had casual, unprotected, sexual relationships with a number of men during the time of my fieldwork. Each time she hoped for pregnancy and the establishment of a long-term relationship, neither of which she had realised by the time I left. She was unconcerned about STDs or AIDS though we discussed the implications of unprotected sex on numerous occasions.

Claudia was aware that *gringos* were interested in indigenous people and told me that this was because we wanted to know about indigenous culture, because indigenous culture was special. She often opened sentences with "*muestras costumbres*" (our customs) or "*nosotros gente indigena*" (us indigenous people). Although she dressed as a *revestida* in the city she always emphasised her pride in her background, at least to me. But then as a foreigner interested in her culture I could substantiate her pride and not denigrate it as a mestizo might. Her attitude to her background was very different from Sebastiana's in this respect, who could see little positive in being Tzeltal and certainly thought that for her sons to get on in life they must appear to be mestizo.

Claudia spent a lot of time talking about ill health as she was often quite poorly. We also spent a lot of time together in clinic waiting rooms and she was a good source of information on health provision not to mention traditional curing.

These and other women came to form a core social group for me during my fieldwork. Through the relationships we established I was able to gain a lot of insight into their attitudes towards health and family planning not to mention insight into male-female relationships and family relationships. Unfortunately, I cannot give the same space to all of the women I got to know but will introduce others as necessary where appropriate. I cannot even relate the expansive tapestry of stories told by the women above. However, in introducing these four women I hope to have illustrated something of the lives of poor women living in marginalised districts of San Cristóbal. The women I got to know in the city were a rich source of information giving me far more insight into local attitudes towards family planning and contraceptive methods than the survey I carried out in the barrios in which they lived. However, the survey gave me some idea about the extent of contraceptive knowledge and use amongst this sample. I want to consider this in the next chapter.

¹ *Walking* with i.e. having an affair with.

² In other words, to have sexual relations with him.

³ She finished her penultimate year of secondary school.

⁴ Chaparro/a - short squat person - in this case a term of endearment.

⁵ The indigenous union and overseers of the land after the invasion.

⁶ La Hormiga (lit. The Ant) is a colony of mainly expelled Protestant Chamulas.

⁷ All of the women I knew used the expression "*cuidar*" - to take care - meaning to use contraceptives.

Plate 9.1 Gloria and Sebastiana, 1997.

Fig. 1 Gloria and Children on the invasion site



Fig. 2 Sebastiana and family, Chanal



Chapter 10

Women's Knowledge and Use of Contraceptive Methods in San Cristóbal's Marginalised Barrios

Although I did not get to know any women well who lived solely in a rural setting, my close links with migrant indigenous and mestizo women in town provided some insight into issues about contraceptive use in general. María Elena, one of two women I employed to carry out the survey, was an important woman both within her urban community and her home rural community. A migrant Tzeltal from Chimtík in Chenalhó living in the city she often housed and cared for sick people from her native *municipio*. Although she never called herself a healer in any traditional sense of the word she was obviously a resource with regard to ill-health and social problems for women and men who knew her. Two examples of her work will suffice to show this. The first relates to a man from her village who became ill after taking, on more than one occasion, a complete course of antibiotics at one time. When he eventually became even more ill his relatives took him all the way from Chenalhó to María Elena's small home on the outskirts of San Cristóbal. She made this diagnosis: that he had incorrectly taken all the antibiotics because no-one bothered to explain things properly to him; that because of this he was now very ill with stomach problems, probably an ulcer; and now she was left with the problem of making him better. She gave the man a mattress and blanket. He was put to bed on the floor of her house until she declared him fit enough to go home, caring for him in the meantime with food and herbal preparations.

The second example relates to her status as a woman with knowledge of the city and mestizo life. María Elena often had monolingual Tzotzil women visiting her home seeking advice about some illness or general predicament to do with city life. On one occasion the woman I met had recently arrived in the city with her five children, and was six months pregnant with the sixth. María Elena, as was customary, immediately launched into a discussion translating between the three of us about the woman's problem. Soon after arriving in the city the woman's husband threw her out of their home and was voluntarily paying her maintenance of 400 pesos

a month. Of this she had to pay half to rent one room for her and the five children. María Elena and her friend were discussing ways in which she might obtain more money or have the woman reinstated in the family home, and one possible solution put forward by María Elena was to seek legal advice from the *Grupo de Mujeres*. María Elena duly arranged to take the woman for a consultation.

María Elena's importance cannot be overstated. She has a foothold in rural and urban life; she knows how to use mestizo resources like the *Grupo de Mujeres*; she is a trained *promotora* under mestizo tuition and yet she knows and practises the herbal remedies of her home community. Whilst she is au fait with grievance procedures in indigenous municipalities following traditional custom in rural areas, she is also aware that women have the possibility of seeking redress through mestizo law in the town, though she is the first to admit it is neither a quick nor easy path to follow. In a sense she would be a perfect asset for any clinic because of her wide knowledge and because of the esteem in which she is held by other Tzotzil people. Though she has previously worked on government health programmes, she could not at that time obtain a job with any of the government clinics. Moreover, there is no guarantee that her particular talents would have been recognised and fully utilised by mestizo staff given the dominant position of the latter.

So when María Elena tells me that indigenous rural women largely know of the existence of contraceptive methods though few use them I feel she talks with the experience of her status, whatever one might call it: adviser/healer/health promoter. María Elena is party to information about which women use contraceptive methods. In her home village women mainly use sterilisation, once their family is complete, and some use the IUD and injectables; while in her urban *barrio* contraceptive use is more variable. To understand why rural women are such reluctant contraceptors requires an understanding of the cultural context of their lives, including those factors which mark indigenous-mestizo relationships. It is to this area that policy makers must look if they wish to make family planning methods not only more widely available, but more acceptable within indigenous communities.

The survey

With Carolina, introduced in the previous chapter, María Elena carried out a survey of 100 women (see Chapter 4). Of these only two were unusable giving a sample size of 98. María Elena's task, because of her status in her environment and extensive contacts, was the easiest of the two though she reported that women were uneasy about being asked personally about their own family planning practices. Carolina, younger and less experienced, had a harder time and reported that many doors were slammed in her face when she explained what she wanted. Nevertheless, she completed the task in the end.

It is impossible to generalise between women who live largely rural lives, regardless of contact with the urban centres, and those women who move to the city and are open to city influences and so the following analysis applies only to the latter. However, it is interesting to note in terms of migratory tendencies that of all 98 women, aged between 18 and 46, 70.3 percent of those who classified themselves as mestiza were born outside of San Cristóbal whilst 96.7 percent of those who classified themselves as Tzeltal, Tzotzil or Chol were born in rural localities. The sample turned out to contain 37 mestizas (though of those born outside of San Cristóbal 84.6 percent were from largely Chol areas¹) and 61 indigenous who defined themselves mainly as Tzotzil or Tzeltal, with two Chols. They all lived in similarly deprived economic areas though those on the invasion site were worst served in terms of basic material infrastructure.

All but eight of the women in the survey had some degree of formal education, though the majority did not get beyond primary level. Sixty percent of indigenous women and 63.2 percent of mestiza women who attended primary school completed Primary 6. Regarding secondary education, only 21.3 percent of indigenous women attended secondary school for any length of time compared with 45.9 percent of mestiza women. Of the sample only 4.9 percent of indigenous women completed their secondary education compared with 13.5 percent of mestiza women.

Of the 37 mestiza women 28 (75.7%) were currently contracepting, 17 (60.7%) of these with primary level education. Of the 61 indigenous women 42 (68.9%) were currently contracepting, 28 (66.7%) of them with primary education and six (14.3%) with no education. Only five women (three mestizas and two indigenous women) were not in a union at the time of the survey.

Table 10.1

Contraceptive use amongst Mestiza women according to educational attainment (n=28)

Educational Level	Pill	IUD	Sterilisation
No education	0	0	0
Primary	0	7 (25%)	10 (35.7%)
Secondary	0	7 (25%)	4 (14.3%)
TOTAL	0	14 (50%)	14 (50%)

Table 10.2

Contraceptive use amongst indigenous women according to educational attainment (n=42)

Educational Level	Pill	IUD	Sterilisation	Unspecified Method
No educational data	0	1 (2.4%)	1 (2.4%)	0
No education	1 (2.4%)	3 (7.15%)	2 (4.7%)	0
Primary	2 (4.7%)	10 (23.8)	15 (35.7%)	1 (2.4%)
Secondary	1 (2.4%)	3 (7.15%)	2 (4.7%)	0
TOTAL	4 (9.5%)	17 (40.5%)	20 (47.6%)	1 (2.4%)

Researchers have long been interested in correlating educational attainment with contraceptive use. I do not intend to undertake any advanced statistical analysis of the survey results as the purpose of this thesis has been to discuss attitudes rather than statistics. Education appears to be relevant to choice of method though I suspect it is promotion rather than educational factors which are responsible for the high uses of the IUD and sterilisation compared to a low registered use of the pill. Contraceptive use is high (73 percent of the mestizas in the sample and 69 percent of indigenous women). However, 47.6 percent of indigenous use and 51.2 percent of mestiza use is accounted for by female sterilisation with 50 and 55 percent respectively of these women never having used a modern method before sterilisation,

though some had used traditional and natural methods². This indicates that quite a number of women have decided to use a modern method (female sterilisation) having completed their families and not before, though I cannot tell if this is due to lack of previous knowledge of modern contraceptives or other reasons for non-use.

It is not simply the high rates of modern contraceptive use which are of note but also the apparent knowledge of modern as well as traditional and natural methods of fertility regulation. Moreover, an extremely interesting phenomenon which arose in both the survey results and conversations with women I knew was the use of a modern method, injectables, not in the prevention of ovulation but as method to *bajar la regla* (bring on menstruation), which I will discuss presently. First I want to give a brief indication of the women's knowledge and ever-use of all fertility regulating methods amongst the sample of women interviewed:

Table 10.3

Stated knowledge of modern and natural contraceptive methods (n=98)

	Mestizas (n=37)	Indigenous Women (n=61)
Pill	20 (54%)	28 (46%)
Injectable	24 (65%)	31 (51%)
IUD	24 (65%)	39 (64%)
Female Sterilisation	2 (5%)	27 (44%)
Condom	9 (24%)	39 (64%)
Vasectomy	0	9 (15%)
Rhythm	9 (24%)	13 (21%)
Coitus Interruptus	7 (19%)	22 (36%)
Menstrual Regulation	21 (57%)	50 (82%)

Women were asked at separate stages about knowledge of fertility regulating methods and ever-use of such methods. It is interesting that knowledge of some methods is understated in comparison to ever-use of methods (see Table 10.4 below). For example, amongst *mestizas* knowledge of female sterilisation appears to be low in comparison to the number of women who have had the operation but perhaps this

is because having the operation is such a final step. Also, those women (mestiza and indigenous) who have been sterilised did not consider themselves to be “using a method of family planning” as this implied to them temporal methods. Likewise, few stated a knowledge of vasectomy as a contraceptive method and yet all the women I spoke with knew of it and were vociferous in their views that men were not interested in this operation because of their *machismo*. The figures given for knowledge of vasectomy should therefore be considered as severely understated probably due to lack of consideration with regard to acceptability.

Responses to questions regarding methods for menstrual regulation (see Table 10.5 below) indicate a substantial knowledge of methods amongst mestizas and an even higher knowledge amongst indigenous women. I believe that this use could also be understated as modern and other fertility regulating methods were lumped together in the questionnaire regarding ever-use. In hindsight, they should have been separated. However, what should be of interest to policy makers in general is that if women, and in particular indigenous women, show such high levels of knowledge about menstrual regulation as well as some degree of knowledge of coitus interruptus and rhythm methods, then this may help providers to raise the question of modern family planning methods in areas where there is a reluctance to discuss such things.

Table 10.4
Reported ever-use of all methods - percentage breakdown (n=80)

	Indigenous Women (n=48)	Mestizas(n=32)
IUD	52.1	46.9
Pill	31.3	12.5
Injectable	33.3	28.2
Female Sterilisation	41.7	28.2
Condom	37.5	34.4
Rhythm	35.4	50.0
Coitus Interruptus	29.2	34.4
Traditional/Herbal	18.8	6.3
LAM	4.2	21.9

(Of these 80 women (81.6% of the sample) representing those women who reported ever having used a method, four women reported having used only traditional or natural fertility regulating methods and not a modern method.)

Apart from the substantial ever-use figures with regard to modern contraceptives, ever-use of coitus interruptus, rhythm and condoms is also significant: many providers believe condoms to be almost as unacceptable to users as vasectomy but from this sample of women this is clearly not the case, though of course there is no way of gauging from this information how long a method was relied upon or if it indicated casual use. The figures also show rhythm methods and coitus interruptus to be important, especially when compared with modern methods. According to this sample more mestizas have relied upon a rhythm method than have used any one of the pill, IUDs or injectables and for indigenous women the figure is higher than for all temporal methods except for the IUD, which is heavily promoted by health staff.

In the systematic offering of contraceptive methods rhythm methods are overwhelmingly ignored unless a person specifically asks for information, and then they will be told how it works but advised that it is better to use a modern method. There are no targeting figures to be achieved for this method. Coitus interruptus also appears to be relied on quite a lot but according to those doctors interviewed it is never discussed within the clinic setting, and the assumption was always that *machismo* would prevent especially indigenous men from performing coitus interruptus reliably. Health staff have never been instructed to find out about local fertility regulation practices whether natural or traditional, and few have taken it upon themselves to find out. Yet in adopting a more positive attitude towards these methods, regardless of concerns about targets and method efficacy in the short term, health staff may be able to open up a dialogue which would allow modern contraceptives to be included in a positive way as an option rather than a dictum, which could help in formulating a more acceptable form of dissemination of family planning service information.

Table 10.5 Stated knowledge of methods of menstrual regulation - percentage breakdown (n= 71)

	Indigenous Women (n=50)	Mestizas (n=21)
Herbs	76.0	85.7
Pills	6.0	71.4
Injectations	50.0	66.7

Though I had expected there to be a substantial number of women citing methods of menstrual regulation I was surprised that these included injections and pills, expecting to find only herbal preparations. I have no idea why pills were so infrequently referred to by indigenous women compared to injections. The questionnaire was not designed with this diversity in mind and so I cannot comment on what kind of pills were used or where they were obtained. They could have been contraceptive pills bought over the counter at a chemist's but they could also have been herbal pills widely sold in shops in San Cristóbal's market area which boast remedies for all ailments in many forms: pure herbs, powders, pills, creams, liquid medicines - and even salamanders. The suggestion that the pills cited could have been contraceptives is pure conjecture but springs from the fact that I knew of many women who had used injectable contraceptive preparations in this way. This is an area I would like to follow up in the future as I was surprised to find women using injectables in this way at all. With regard to the survey, it is again mere conjecture that the "injections" referred to were contraceptives, but I think it is highly likely, given the other women who talked to me about using injectables, particularly Depo Provera bought from chemists, to *bajar la regla*.

Implications for policy makers on the widespread knowledge of methods to *bajar la regla*

It is obvious that menstrual regulation is an acceptable and widespread way of attempting to control fertility³. Though I have no figures for rural areas I am told by the indigenous women I knew who lived in town that menstrual regulation is widely practised in this context as well. It must therefore be assumed that, although providers cite low use of family planning services and resistance by local rural populations, women are in fact interested in controlling their fertility. The questions remain as to what is socially and culturally acceptable and in whose hands the knowledge and power lies, as has been suggested in previous chapters. In both rural and urban areas *parteras* and healers are part of the fabric of social life. The use of traditional fertility regulating methods or methods bought over the counter fits in with the locally acknowledged widespread practice of self-healing. On the other hand the clinic is a place of authority: the authority of the *other* is doubly potent for

indigenous women with regard not only to provider-client status and knowledge, but mestizo-indigenous relationships.

It would seem from the survey material that, far from not knowing anything (*no saben nada*), indigenous women, at least those living in the town, have a substantial knowledge of both modern and natural and traditional fertility regulating methods equal to those mestizas with similar socio-economic status in the town. Few of these women were born in the town and both mestizas and indigenous women in the survey had a mean average of life there of 10.3 years, from women who had recently arrived to those who had been resident for over 20 years. Although living in town means that women who move there will be open to new experiences and forms of knowledge, many nevertheless continue to travel back and forth between the town and their home villages. This opens up possibilities for the transfer of information between urban and rural areas facilitated by women inside the fabric of local life, like María Elena, and not simply as something imposed by outsiders such as clinic staff.

Finally, with regard to knowledge, it is obvious that women are able to take new contraceptive technology and fashion its use in a way which fits with local custom. The use of injectable contraceptives as a method to bring on menstruation is precisely that. Whilst the phrase *bajar la regla* is distinctly concerned with menstrual regulation in a social context, it should immediately raise, from a medical or policy viewpoint, the question of post-coital contraceptives. These are not available in Los Altos and are not mentioned at all in the Mexican guide to family planning services, the *Norma Oficial*, 1995. Apart from wondering whether many women would benefit from the introduction of post-coital contraception in clinics, because of a widespread preference for menstrual regulation, I also wonder about the health problems in store for those women who frequently administer large amounts of drugs such as Depo Provera⁴.

If policy makers were to include post-coital contraception within their family planning services in Los Altos it might be most positively achieved through an approach which connects post-coital contraception with the notion of menstrual regulation. Discussing post-coital contraception within the framework of indigenous

knowledge and beliefs (notwithstanding provider-client problems as discussed throughout this thesis) might help in providing an acceptable, and I would argue urgently needed, form of contraception. Viewing, from the side-lines, the women who take Depo Provera to *bajar la regla* because they don't want to be pregnant, I am convinced that a post-coital option would be welcomed by many in the town. I doubt, at this stage, that much favour would be found amongst rural populations, not least because general clinic use is low and family planning use even lower. However, with harbingers of information like María Elena, news would spread eventually though use and acceptability would remain inextricably tied to local socio-cultural conditions. María Elena expressed a keen interest in the idea of post-coital contraception and also in diaphragms of which she had never heard. When I pointed out to her that doctors insisted indigenous women would not use diaphragms she countered that if it was possible to promote IUDs, then other options like the diaphragm were also a possibility. She, at least, was intrigued by the idea that a diaphragm is used as and when needed.

Getting the terminology right in the promotion of post-coital contraception would be important for another reason: for purists, menstrual regulation, post-coital contraception and abortion may all amount to the same thing, but for women in Los Altos there is most certainly a distinction, albeit a socio-cultural one, between abortion and menstrual regulation. Menstrual regulation is acceptable and discussed with some ease between women; abortion is discussed secretively in hushed tones. Those same women, for example, who use Depo Provera to bring on menstruation baulk at the notion of abortion. There is no public acceptance of abortion, despite its clandestine occurrence, compared to menstrual regulation. Firstly there is a moral and conceptual difference: regulating menstruation because of a late period *could* be due to problems other than pregnancy, such as a "cold womb"; getting rid of a baby which is most definitely there is another matter altogether. Secondly, there is a practical difference: menstrual regulation denotes taking a herbal concoction, pills or injections to solve the problem; abortion indicates physical interference usually through recourse to a *partera*, who apart from administering herbal preparations will insert an object into the uterus to cause the foetus to abort. The women I knew were also aware that abortion could be procured in private hospitals in Tuxtla for sums of

money which they themselves would never save in years of working as domestic servants or street sellers.

Despite my belief that the introduction of post-coital contraceptives would be welcomed by, and of benefit to, women in San Cristóbal, the over-riding factor against this possibility is government resources to pay for this method. The Coordinator of the SSA hospital in San Cristóbal explained how the Mexican government relied on donations of contraceptives from international health organisations and contraceptive producers. For example, he told me that the contraceptive injection Depo Provera was no longer available through the SSA or IMSS in Los Altos because they no longer received the donations. Instead, they were supplied with Norethisterone, and now more commonly Cyclofem, though both should have been available. Government reproductive health policy is clearly limited by the cost of methods and the ability to acquire them as aid.

Factors affecting women's decision-making processes in contraceptive use

Despite wide-spread knowledge about the existence of contraceptive methods in the city and some indication from the survey that women (indigenous and mestiza) do use contraceptives in quite high numbers in this area, there remain substantial numbers of women like Carolina who do not want to get pregnant and who do not use contraceptives with any consistency. Carolina's situation is not uncommon. Having left her husband, as discussed above, due to his drinking and violence she finally succumbed and went back to him a year or so after the event which saw her hospitalised from one of his attacks. Carolina returned to her husband under duress, beaten down by the combined efforts of Petul, his parents (rural-living Tzeltals) and her parents (separated urban-living mestizo/Chols) who all met every so often to discuss ways of persuading Carolina to return. The difficulties she faced in making ends meet were over-riding factors in her decision and Carolina made the proviso that she would leave if he became violent again and that both sets of parents had to support her in her condemnation of Petul's past behaviour. They agreed in principle

though Beatriz, Carolina's mother, frequently continued to tell her that it is a woman's lot in life to be so treated by her husband.

Against this background Carolina expressed fears about another pregnancy and announced to me that she was going to the IMSS clinic to have an IUD. Petul's violence had begun with her first pregnancy and she was keen to avoid this touchstone again, and keen also to limit the children she had to two in order both to better provide for them and to have some independence for herself. However, Petul objected. He had prohibited her wish to use the pill in the first phase of their relationship because, he said, it would be bad for her health and he did not want a sick, weak woman to care for. Upon her return to him he prohibited her use of the IUD, again because he said it would affect her health. We discussed the possibility of her attending the clinic secretly and simply not telling him but she feared this as a risky option should he discover that she had deceived him.

Slowly but surely Petul began to undermine the independence Carolina had gained during separation from him. Taking advantage of the volatile relationship she had with her mother, Petul often invoked Beatriz to side with him in disputes. In limiting her access to her friends he told her that he was the boss and that, as his wife, she must obey him. It was at this time that Carolina resorted to secretly buying Depo Provera to practise "menstrual regulation". Although we had many discussions on the fact that she could receive injectables free from the clinics and on the dangers to her health inherent in taking Depo Provera in such an *ad hoc* and frequent way Carolina continued to buy it as and when she thought she needed it, that is to say when her period was late. She was afraid to return to the clinic for two reasons: she hated the way clinic staff dealt with family planning issues and the way she had been treated in the past; and she was afraid she would have to admit to deceiving her husband to people with whom she had no wish to discuss the matter. Her lack of power in the home and her lack of power in the clinic setting were two fundamental factors which led her to resort to more dubious practices concerning her health. I left Mexico just as Carolina finally persuaded Petul to allow her to use an IUD. I have no idea if he discovered her clandestine use of Depo Provera or whether he later insisted upon removal of her IUD and another child to prove her fealty.

Whilst Carolina's lack of power led her into a third pregnancy which she had not wanted, other women, often in more tenuous relationships, feel empowered by the tie a child provides between them and a wayward partner, Claudia being an example of this. If she had been successful in her desire to get pregnant with a man who has another wife she would have brought the rage of her family upon her head but she would also have had a claim on this man who had been ambivalent about her and then stopped seeing her.

Women without partners, both in rural and urban areas, are unlikely to contracept because of the implications that they are having sex outside of a stable relationship. Women who get pregnant in this way are often disowned by their families and gossiped about by their neighbours. Despite any wishes to avoid pregnancy, most of these women will not use contraceptives unless they are in a stable relationship and then they may face opposition from partners. I met Ana (then aged 19), a Tzeltal woman from Tenejapa, through a project which had newly been set up in San Cristóbal, called *Hogar Comunitario*, to care for pregnant women (indigenous and mestiza) who had been disowned. She was pallid and exhausted when we first met having given birth to her dead baby four days earlier. Her mother died giving birth to her after which her father adopted her out to another woman. This woman also died prematurely and Ana was sent to live with her aunt.

Ana had her first ever sexual relationship with a man in Tenejapa who already had a wife. He refused to have anything else to do with her when she became pregnant and then her aunt threw her out for bringing shame on the family. Ana went to the city to look for work as she had no other support. She was found destitute and ill, almost at term, and taken to the Hogar Comunitario by passers-by in the street. Ana found it difficult to talk about family planning at all. With her head bowed and studiously avoiding my eyes she said she had never even considered the possibility of taking contraceptives. In Tenejapa, like many rural areas, the clinics are the only places where contraceptives can be obtained. Ana would never have gone there for fear of discovery. After all, local people work there as promoters and auxiliaries and secrecy in such matters is not a foregone conclusion. Ana left the

Hogar after a couple of weeks recuperation and found work as a live-in domestic. When I left Mexico she was working seven days a week from 10.00am until 8.00 at night for 350 pesos a calendar month.

I also met Malena, then aged 23, at the Hogar. Malena was from Teopisca and a mestiza, though like Ana she had no formal education. Malena was cared for by the Hogar staff who took her to the Clínica del Campo to have her baby and then took her back to the Hogar to recuperate.

Malena told me that there was an IMSS clinic in her home locality but expressed the same fears as Ana about using it. She was extremely embarrassed to be discussing contraceptives at all and said that her “ex-husband” had sometimes tried to be careful (i.e. to practise coitus interruptus). Malena was adamant that she had not wanted to get pregnant and that she did not want this baby. She seemed to know less about contraceptive methods than Ana having heard only of things (“*cosas*”) to guard against pregnancy but she could not name any and said she had not heard of any of those I suggested. However, her embarrassment was acute at this point and she clearly did not want to discuss the subject. Malena was very depressed about the fact that she was pregnant and alone with no job, no home and no money. Her father is dead and her mother did not know she was pregnant or where she was. Malena had taken it upon herself to leave for the city when she suspected she might be pregnant, rather than facing the wrath of her family. She had been living precariously for a number of months doing domestic work in San Cristóbal and was taken to the Hogar by a nurse from the Clínica del Campo. The father of Malena’s baby was 10 years her senior, already married and with three children. He did not want her after she became pregnant.

Malena gave birth to a little girl. She became a bit more animated after the birth of the child and although she had not wanted a baby, and things were sure to be difficult for her, within the safety and comforting space of the Hogar she seemed to be enthralled by the experience. After a further four weeks of being looked after and given instruction in how to look after her child the staff of the Hogar found her a live-in domestic position. There are limited options for women like Ana and Malena.

With no family support whatsoever and no resources live-in domestic work with a new baby may not be the most desired option but often it is the only one. Women with more than one child are rarely taken on as live-in domestics. Malena expressed a desire to work in a restaurant or shop because the pay and conditions were better, but with a new baby and no child care support there was little chance of this for her at that time.

Some women experience a sense of empowerment in becoming pregnant and having children, even if born outside of a recognised relationship. Carolina's mother treated her better after her first child was born. At least Beatriz stopped hitting Carolina because the pregnancy, child-birth and the baby conferred adult status upon her. Claudia believed she would have gained the power of recognition from her ex-partner, whom she referred to as her ex-husband, as is the norm even where State or indigenous rites have not been complied with, had she had his baby. Even though this man was unlikely to have supported her or the child in any way she would have been recognised as his woman or ex-woman in the local context which would have gratified her. In her 30s, she was a single woman without a child. She wanted both the status of motherhood and of a relationship even if that relationship was no longer extant. Motherhood is an important marker of adulthood [cf. Low & Newman, 1995:152] and, given the idealisation of the mother through, for example cults of the Virgin Mary such as the Virgin of Guadalupe⁵, it is a state which is important to most women: it is being a mother that defines them and the importance of their place amongst the equally important family. For rural and poor urban women there are few options in terms of gaining status other than motherhood and being a wife. To be otherwise renders a woman a child throughout the younger years and someone to be pitied in later years.

Sebastiana, though separated from her husband, continued to be recognised as the wife or ex-wife of Francisco. This defined her in relation to others in her local community. He was recognised as the father of her children and though he rarely gave her money she lived in his house. In fact, the gossip that defined these marginalised areas of San Cristóbal ran along relationship lines, who was related to whom and in what way. Changes or movements within relationships were a prime source of gossip. Hence, when Carolina left town to seek work elsewhere for a while

she was then considered to have truly left Petul and must have gone off with another man. The bit about the other man was not true but that is how her behaviour was rationalised and what people continued to say. Likewise, when Sebastiana began proceedings under mestizo law to claim regular maintenance from Francisco the gossip circulated that I had put her up to it, otherwise she never would have done this, and the rumour set off by Francisco's sister was that he would come and burn my house down. Again, it rationalised Sebastiana's aberrant behaviour.

None of these women lead the kind of ordered lives that would allow for planning as envisioned by policy makers. How many of us do? As poor women, indigenous and mestiza, they have so many factors impinging upon their lives. Women like Carolina cannot make an informed choice about the number and spacing of her children because her partner will not comply with her wishes and effectively will not allow her to go ahead with her preferred choice. Women like Malena and Ana can barely bring themselves to speak about contraceptive methods or sex. In their home villages their choices are constrained by social norms about relationships and children outside marriage; families who might disown them if they brought shame to the family; men who would not support them and who already had other commitments. Whilst policy makers would no doubt prefer that these women had access to contraceptive methods, and in theory Malena and Ana could have gone to the local clinics, in practice this is often unfeasible. Rural clinics are staffed by local auxiliary personnel and this would prohibit a single woman in a clandestine relationship from using them even if they could get over their acute embarrassment. Even married women and couples are constrained to a certain extent by this. Where contraceptive use is frowned upon or thought to be strange, then local auxiliary staff could be a source of gossip about this very private area of life.

Information and the influence of past events

Apart from the social conditions of daily life another factor which influences women's decision making about contraceptive use and indeed clinic use is the effect of past experiences on the present day. The influence of the "past in the present" as a

way of lending meaning to the present is well covered by Rappaport [1988] but where she takes a long-term political-historical perspective I believe that it is equally important to processing new information, for example, in the clinic setting in the long and short term. Good and bad experiences of treatment by clinic staff will form part of the equation upon which an individual makes decisions and formulates opinions of such services.

For example, when Carolina was admitted to the Clínica del Campo having been beaten by Petul, she said that doctors had treated her like a child because she was then pregnant with her second child a year after her first was born. She was still breastfeeding at the time and thought she would not get pregnant:

The doctors tell pregnant women off and afterwards they tell off the man but not so much. They told me off a lot (*me regañan mucho*) when I went that time. "Why didn't you take care?" (*¿por qué no te cuidaste?*) There are pills and other things." Uyy, *me regañan mucho*. "Your son is so young [the first one]. Now you will abandon him and he will suffer. There are pills, condoms ..." I didn't say anything. I was embarrassed. I bowed my head. (*Me da pena. Me agacho.*)

When she returned to the Clínica del Campo to give birth to her second son she was told off again about having another child so soon after the first. The oldest was 21 months old when the second was actually born; a gap which is not uncommon in western society. The doctors wanted to insert an IUD immediately after she had given birth:

The doctor says, "The baby's coming," and out he came. Meanwhile, the nurse was cleaning the baby and the doctor said, "They're going to put in an IUD. Do you want me to put the IUD in?"

"No," I shouted.

"Why?" he asked. "Well, next month, we'll do it. Do you want to keep on having children?"

"No," I said.

"Well, why don't I do it now?"

Carolina told the doctor she was now alone, that she had left her husband.

"Why? Where is he? Why are you alone with your children?" he asked me.

Carolina left the clinic without an IUD on that occasion but told me that whenever she visits the Clínica del Campo for any general health problems she is asked about family planning:

Well, when I go and say I'm not well they ask me if I'm planning (*¿Está usted planificando?*) I tell them "no" and they ask me why and the doctor begins to tell me off saying, "You're going to have lots of children (*se va hasta llenar de hijos*- to be full of children) - why aren't you planning?" I tell them that I don't have a husband and they say "Well when you get a husband come back to have an IUD fitted." There's a lot of pressure to plan.

The way Carolina describes her experiences it is as though the doctors make no allowance for the possibility that a woman may have made an informed decision not to use contraceptives (or which to use as they forcefully push the IUD), or that a woman might want many children, or may be happy with her state of pregnancy. Carolina did not plan to get pregnant either the first or second time but was not unhappy about the birth of these children. She was, however, unhappy about the way her husband treated her and to go to a clinic and be chastised for her pregnancies made her feel even more hopeless and undermined at a time when, many of us would argue, she needed support.

Carolina does not always use the Clínica del Campo when she or the children are sick. She goes because it is free but when she has money she also consults a local *curandera* whom she has known since she was a child and whom her mother also uses. Like most women I got to know she first said she was treated well at government clinics but later related stories of ill-treatment. Although Carolina was pregnant for a third time whilst being adamant about not wanting another child, her past experiences of clinic treatment and her current pressures from Petul both mitigated against the possibility that she might use a contraceptive: her reluctance to be pressurised by clinic staff into using contraceptive methods and the pressure Petul exerted against her using contraceptives meant Carolina was effectively oppressively pressurised by both sides.

The experiences of Carolina, Claudia and María Elena are interesting and informative in correlation to what it actually means to be "well informed". Carolina was 20 years old when her second child was born. She was educated until the end of

secondary school and knows about all available modern family planning methods. Her experiences with local providers informed her knowledge about government clinics, personnel and family planning services. María Elena, an educated Tzotzil woman with links in both rural and urban areas, promoted family planning services widely in her native community, delivering information in the local language, and yet apart from some success with sterilisation family planning use in her home village was rare, though she herself used modern contraceptive methods. Claudia an uneducated Tzeltal woman with poor Spanish, who had only moved from her rural home to the city in recent years, though no longer using contraceptives, had relied on the pill and injections for a period spanning five years. All three women had relied upon natural or traditional fertility regulating methods at some stage in their reproductive histories.

What are the implications of their histories? Policy makers and clinic staff alike must realise that something is wrong when a reasonably educated, articulate young woman like Carolina, who does not want to have any more children, feels unable to approach local services, which are freely available, to discuss her options. María Elena's experiences as a promoter led her to tell me that women in her native village know about modern contraceptives but have no interest in them. An uneducated Tzeltal woman like Claudia knows about modern methods and has used them for long periods. *Ellos no saben nada* and *por la cultura* are not then sufficient explanations of low family planning use in Los Altos though people in the remotest of areas not served by clinics may not have heard of modern contraceptive methods. What is important is that information is never introduced into a vacuum where it can remain suspended in a neutral glory waiting for the local population to realise the benefits if only they could bring themselves to think about it. Being well informed (*bien informada*) means that information introduced by policy makers will be mediated by local knowledge and experience. In rural areas the provision of policy or government service information is made more difficult by the language barriers which exist, something which the health services make an effort to address by providing leaflets in local languages and using local interpreters. Such efforts are constrained by the extent of illiteracy, the unlikelihood that mestizo doctors are very involved in community life, and the frequent use of indigenous interpreters from other

areas who do not enjoy the confidence of the local community and may even speak a different language⁶.

¹ This underpins the complexity of identity when we consider that Carolina is a self-defined mestiza with a Chol background. It is impossible for me to know how many of those women from Chol or other ethnically defined areas may have had indigenous backgrounds.

² When separated by educational attainment both mestizas and indigenous women with secondary level education show a 16.7% use of female sterilisation whilst at primary level the figures are wider showing that 38.5% of indigenous women have been sterilised in comparison to 17.2% of mestizas.

³ These findings compare with those of Nichter and Nichter's work in Sri Lanka [1987:23]

⁴ Like most medicines it is available without prescription in a totally unregulated fashion over the counter.

⁵ The Virgin of Guadalupe is Mexico's patron and an extremely important female symbol/icon.

⁶ For example, a *local* SSA auxiliary in Chamula was a Tzeltal in a Tzotzil speaking area, though the doctor himself was unaware of this, considering the auxiliary to be simply indigenous. Eva, a Tzeltal promoter was given work in a Tojolobal area. Whilst the Tzeltal understood some Tzotzil, Eva did not understand Tojolobal and used Spanish, her second language, which was interpreted by a Tojolobal who translated the Spanish, also his second language, into Tojolobal. Moreover, though both the SSA auxiliary and Eva were "indigenous" they were outsiders in the communities in which they worked.

Chapter 11

The Merging of Two World Views?

Policy makers and providers I spoke with recognise a number of local constraints with regard to promoting wider contraceptive uptake in Los Altos. Amongst these, they talk about men's resistance to contraceptive use and beliefs amongst friends, mothers and the ever-important mother-in-law, with regard to the desirability of family planning and the pros and cons of different methods. In order to combat these constraints, policy makers have recently come up with a new policy tool designed to make contraceptive methods and use more acceptable: to incorporate traditional healers within the sphere of the mestiza clinic. As with all governmental moves in Chiapas this act is open to several interpretations.

Introducing local knowledge: a policy rationale

In 1997 the Mexican government announced plans to build a total of 20 clinics and one hospital in the La Selva, Los Altos and La Sierra regions of Chiapas, each of which would incorporate traditional healers and *parteras* amongst the personnel. La Selva is the jungle region of Chiapas where Zapatista strongholds are known to exist while Los Altos is increasingly unstable due to the conflict.

Announcing these plans the then state president of DIF, Adriana Alvarez de Ruíz Ferro, said that all social and economic development projects in Chiapas "should without fail consider, in a detailed manner, a notable increase in the welfare levels and health of Chiapanecos and their communities" [Expreso - Chiapas, 22 April, 1997:11, *trans.*]. Furthermore she pointed out that traditional medics and *parteras* were the people who could best bring health services to remote regions and communities "because apart from respecting traditional uses and customs amongst the ethnic groups, they also communicate in the language of the potential beneficiaries" [*ibid.*]. These traditional healers will not be incorporated upon their own terms with their own autonomy; they will be trained, rather, in basic preventative

health care under the *Programa de ampliación de cobertura* (PAC), which is funded at state level in Chiapas, with UNICEF aid. According to the paper the aim is “to bring together shared features of occidental and traditional indigenous medicines, and incorporate the points of concordance to give good attention to the sick” [*ibid.*].

How many different ways may we interpret this? Taking these plans on face value it seems a laudable and possibly effective way of bringing services to marginalised areas and moreover one which not only respects indigenous customs but allows for the kind of rapprochement between the indigenous and mestizo worlds which might foment equality, at least in the provision of services for healing, curing and preventing sickness amongst the indigenous population. Undoubtedly, indigenous healers have a standing amongst their local community which mestizo health providers may envy and through these healers certain aspects of occidental medical care may be promoted. But how far do these strategies go in respecting a traditional health focus and what will relations be like between the traditional and allopathic healers working out of the same medical units? These are crucial questions if we are to gauge the government’s commitment to and respect for this other world. Sadly, under present arrangements the situation does not bode well. The fundamental dichotomy of dominant and dominated, within the context of the medical unit, remains well in place. There are a number of potent examples which illustrate this.

I interviewed Don Mariano at the SSA’s *Centro de Salud Mixto* (Mixed Health Centre¹) in Chamula in November 1996. He has a large bare room in the main clinic. There was a poster on the front wall of the clinic which described this *Centro de Salud Mixto*, the money invested in it and its aims: “to generate an alternative health unit for the indigenous population which will allow them to offer adequate and timely medical attention in the correct cultural context as both medicines (traditional and modern) coexist with the same end to improve the health levels of the inhabitants of this region.”

The idea of incorporating traditional healers into the government services is one which seeks to take advantage of the confidence local people have in their own

healers. However, it fails to, or perhaps simply cannot, incorporate indigenous concepts of health in a setting where the individual doctor seeks to cure or advise the individual patient as though in a cultural vacuum. Most doctors cannot cope with an indigenous belief system which attributes illness to a sickness of the soul or to witchcraft [Arias, 1991:60-1]. In interviews many doctors were quick to echo the opinion that low contraceptive use and low clinic use is *por la cultura*, thus excusing themselves of any perceived blame. Nevertheless, the mixed allopathic/traditional centres seek to at least bring people within the sphere of the allopathic clinic setting with the idea that the local population can consult either or both, and that the traditional healer will promote aspects of allopathic health care such as basic preventative health measures and family planning.

In Chamula this has not happened in any notable way. Local intellectuals and health workers refer to the centre as a white elephant. Graciela Freyermuth referred to it as a joke (*toma de pelo*) saying that it's always empty. Apart from traditional healers, she also believes that the use of indigenous auxiliaries is undermined because of a reliance on them as translators and not as health promoters and, like Manuel Palma below, that the cultural divide is too great to breach. She sums up her views on indigenous auxiliary health workers:

He knows both cultures, the traditional methods of the community and the clinical methods of the state. He knows that the second is necessary in the clinic. There are times when he cannot tell the doctor properly what the patient is saying, not because of an inability to translate the meaning but because he knows it won't be well accepted, so he produces a reinterpretation and a new meaning between what he says to the patient and what he says to the doctor.

Whilst the auxiliary health worker may feel under pressure to please both sides, government doctors are not so constrained. They are in positions of power with regard to their auxiliary workers and their clientele. Graciela believes that auxiliaries could be better employed as health promoters who could combine allopathic and traditional methods if given the authority to do so, but she also sees the system as an over-riding barrier against the practice of traditional medicine:

The fact is that the officials in the civil register can't appoint traditional nurses.

And the auxiliaries in the health sector, they can't tell the medics that indigenous people think in such and such a way. In this sense there's a double standard that the only thing you write down is what's within hegemonic allopathic medicine. That's where I think the problem lies.

Manuel Palma Barbosa, the General Coordinator of Na Bolom², who is involved in many traditional health projects in the Lacondona jungle thinks that the gulf in understanding between indigenous people and mestizos, and particularly the government, is too great to reap many benefits in terms of mixed allopathic/traditional health centres run by the government. He does not believe that more clinics are necessary: "There are clinics there already. The problem is finding one with a doctor in it, and medicines."

My interview with Don Mariano in Chamula provides an illustration of some of these points. As we sat huddled at one end of his consulting room a mestizo doctor from the clinic walked in. Other staff at the clinic knew about the interview as I had visited on numerous occasions, both to carry out an interview in the clinic and to speak with various people. I did not recognise the doctor who entered but he walked in without knocking and wandered down towards us at the end of the long bare room. He did not greet anyone, though we all turned to look, but ignored us and walked over to the high window, where he stood with his back to us looking out. The only time he spoke was once, to clarify a point of Spanish.

Of the many interviews I carried out in government clinic settings this was the only one in which there was a non-participative member present and the only one in which there was an intrusion which was not preceded by an expiatory commentary. The doctor had made it clear that he was listening to our interview through the single interjection made in reference to a Spanish word. It is difficult to ignore the silent presence of another human being standing in a corner listening when you are trying to carry out a lively interview. The cohesiveness of the little group is broken and somehow threatened by the aloofness of the other presence. Don Mariano was as aware of this as I was, and frequently glanced in the direction of the doctor during the interview.

Apart from the rudeness of this doctor in that he felt able to unceremoniously gatecrash the interview, the position of Don Mariano as a traditional medic in an allopathic clinic setting was made clear in other ways. He had little to do with family planning, fertility regulation or maternity issues but when asked about family size he completely towed the government line on behalf of the local Chamulas despite this area having one of the highest fertility rates in Chiapas. I asked him if grandparents wanted many grandchildren:

There are some that do, some - well, not many. A few want a lot. Look, it's better that they don't. Sometimes they want two, or three, but no more. That's not too many - three, two. Too many would be five or ten because there's not enough land to live on. They will use up the land. Two or three, that's all. Four is too many.

I ask about parents' preferences and received the same response:

They want three, or two. They come here to say so, here in the clinic, that they don't want more, only two or three.

It is difficult to tell how much the presence of the doctor influenced Don Mariano's replies but it is hard to imagine that he could believe that the preferred number of children in the area was two or three, especially as the clinic is so underused generally, not to mention the low levels of family planning users registered at the SSA clinic. According to their own clinic figures there were just 65 registered users of modern contraceptive methods in 1996³.

One problem for both clinic staff and traditional paramedics in this scenario is that indigenous people are accustomed to being treated within the home for illnesses supplemented by family supplications in places of worship. The expectation of providers that people should go to the clinic might be one of the keys to the apparent lack of success of the allopathic/traditional experiment in Chamula. Rosi, a medical doctor and researcher with Ecosur, described her early experiences as a *pasante* and explained how the importance of the home in curing by traditional means was something she had to come to terms with. Including her period as a *pasante* she

worked for three years in different Tzotzil communities in Los Altos which she told me challenged her and changed her views:

At first it was difficult. People go to the *curanderos*. Afterwards, some would come to me. When they got better they would say they had been cured half by me and half by the *curandero* but I don't really know what they believed. I remember a young child with severe bronchitis. I wanted to take the child to hospital but the mother would not allow it, telling me to do what I could there in her house. My problem was that the *curanderos* confine people to their home during treatment so they couldn't come to me at the clinic or go to the hospital. If things got bad they would call the nurse or me to the house. At first I used to get very angry about this but then I came to understand that this was how things were; that this was part of their culture. You have to begin to understand their beliefs to understand their world. For example, there is the belief in the *chu'lel*, the animal spirit which joins at birth with a human. If someone kills the animal in the forest then the person whose *chu'lel* it is also dies. So you see, it is very complicated.

Policy makers and service providers do not appear to have addressed this aspect of the healing location in the traditional/allopathic mix as they expect the traditional healer to be physically present within the clinic, though they allow Don Mariano to travel to people's homes, when he asks for permission, and to carry out rites in the church. However, the insistence of a physical attachment with the clinic, and Don Mariano treatment during our interview, makes me think that the issue of control is more important to the mestizo service providers than other aspects of service.

So whilst the clinic sets up a space in communities for the local people to seek medical help, the people themselves use the home and the church as a place of healing. That which is Mayan is embodied in the land, the home, the community and customs; in the villages that which is not Mayan is signified most clearly by the clinic headed by mestizos. Indigenous beliefs concerning illness, which are connected with the *mundo numinoso* (the invisible or spirit world)⁴, separates the world of the clinic and that of community by much more than the physical space lying between them. The attempt to bring the two worlds together is indeed a difficult task fraught with uncertainties.

As far as Graciela Freyermuth is concerned the project of using and training traditional healers is not so much to bridge the gap between the two worlds as a government strategy which involves continued domination of the indigenous world:

Even the official discourse which is “we are going to accept traditional medicine” is, in reality, “we are going to make them health promoters”. This is another thing. Who will be this new auxiliary? This auxiliary traditional medic will be a health promoter.

- Not with traditional methods?

Exactly. Why? Because the traditional medics have a different vision of the world. So, how they fit into this proposal is very complicated because generally they are old people, illiterate, and how do you integrate them into such a heterogeneous system? And this is the basic difference.

During the interview I carried out at the SSA clinic in Chenalhó I asked about what links the clinic might have with local *parteras*. The doctor said that they worked with four or five of them. In exchange for basic medical supplies such as cotton wool, soap, antiseptics and scissors these *parteras* bring information on the number of live births they have attended over a given period. Apparently they never report neonatal mortality as they fear being held responsible, at least this is how the clinic doctor views the situation. But what are statistics to a rural, illiterate population? What purpose could they possibly be seen to serve? Both local researchers and health providers complain that the collection of demographic statistics in rural communities is difficult and results in gross inaccuracies. Using local midwives is one strategy for obtaining data. The clinic had recently begun to train young midwives in basic hygiene and family planning promotion, including insertion of IUDs.

To pick up on Graciela's point about older people having a different, more intransigent world view, young women were preferred for training as *parteras* because they were more likely to speak Spanish than older women, and to have some basic schooling. These women were considered to be more malleable and easily persuaded to accept training in allopathic methods. The problem with this, however, is that particularly in the rural areas there is immense respect for age. Moreover, a

partera or traditional healer with many years of experience will not only be a respected figure but will have achieved recognition and respect for their work over the years. Young *parteras* cannot expect to win this kind of recognition, and young women who are not married with children are even less likely to be accepted in this role. This may be a transient, generational phase and time will tell what differences may be wrought by the current younger generation with at least a basic education and bilingual abilities which their elders do not. I would hazard a guess that those *cabeceras* which are close to San Cristóbal and have health service infrastructure and good communication access with the town might see an erosion in the reliance on older, traditional healers. However, for the distant *cabeceras* and all the smaller localities, I imagine few changes in the coming years because of their isolation, lack of penetration by mestizo health workers and teachers, and continued reliance on local economic activities for women. Although the men may periodically leave for work in the fincas elsewhere, the women will remain less likely to be educated and more likely to carry out traditional roles around the home base.

In the rural areas, training *parteras* and health promoters involves teams travelling from San Cristóbal to outlying communities to give talks. In San Cristóbal, training courses are given to those who live nearby or are prepared to travel. I met a number of indigenous women living in San Cristóbal and one mestiza who had undertaken courses in town with mixed experiences.

María Elena, Tzotzil Health Promoter

María Elena, who we have already met, says that she has to work because her husband is not always around and offers only sporadic financial support. As she put it: "*Bueno, mi marido, si está aquí, pero no muy está*", in other words "My husband, yes he is here, but not much here." She complained that all men just leave their women and children behind returning when they felt like it but with no responsibilities. For this reason, she says she has to work to support herself and her children but at least the small house is hers so she does not have to pay rent. In comparison with those who live on the nearby invasion site María Elena has a good

solid home made of breeze blocks, though without glass in the window spaces, with a concrete floor and plumbed toilet in the yard, running water and electricity.

She has worked as a health promoter for a local NGO and for the government but complains that the work is not constant. She also found occasional interpreting work (Spanish-Tzotzil) for the health services. María Elena's job for the NGO was to advise women in her home village in Chenalhó on health and family planning matters and to bring them into town if they needed medical treatment, smear tests or wanted to be sterilised. She was very proud of this work. However, she complained that the NGO paid less money than government clinics.

Some years back María Elena undertook a government training course for health promoters. The course was run over three months, five days a week, and the trainees received no money or grant (*beca*) during this time but at the end of it they obtained their diplomas. María Elena enjoyed her training course and work and told me that there was a new course on offer by the SSA which would make her better qualified and increase her job prospects. However, she could not afford to take it on because it meant training for six months full-time on a voluntary basis. She felt that the government should offer some money during the training period as it was so long and thought it unlikely that many women like her would be able to take advantage of it.

Eva, Tzeltal Health Promoter

In contrast to the many roles that María Elena filled as a health promoter working mainly with her own people, Eva, a Tzeltal woman from Oxchuc, had quite a different and less satisfying experience. In 1995 she completed a 15-day SSA course in San Cristóbal in giving vaccinations, mainly to children. This is her only role as a health promoter. Subsequently, the SSA gave her a job in Comitán in an indigenous Tojolabal community. Eva speaks Tzeltal and Spanish but not Tojolabal. I asked her if interpreters were provided for her work with people who do not understand Spanish. She said "no" and that if people did not understand, then a

member of the family had to help such as one of the men, or a child who had learned Spanish in school.

Eva is working in an area where she is in fact a stranger and cannot hope for the kind of confidence and respect shown to María Elena. Moreover, as she has to take lodgings in Comitán and travel back to San Cristóbal at the weekends she complains about the cost incurred and the low pay which is sometimes paid more than three months in arrears.

Doña Chely - mestiza *partera*

One of the best known mestiza *parteras* in San Cristóbal has also undergone government training. Doña Chely is much sought after by indigenous women as is obvious by her constantly full waiting room. She claims that 90 percent of her clients are indigenous the rest being mestiza with a few foreigners now and again. She charges 10 pesos per consultation and 500 pesos for her attendance during childbirth, but still those people from rural communities who know of her and can afford her come to consult her. She appears to have particular links with the communities of Zinacantán, Betania, some miles out of the city, and even Ocosingo, which is some distance away to the north of Los Altos.

Doña Chely was in her 50s and has been a practising *partera* for 25 years, following her mother before her into the same occupation. She was a wealthy woman in comparison to María Elena and Eva, enjoying a flourishing and independent business. Her experience of government training was one which she was extremely scathing about although she framed and displayed her *parteras* certificate on the walls of her waiting room. She said that she would never work with them again, though she accompanies women who want to go there to be sterilised.

We worked for IMSS as rural *parteras*, but they did not help us with anything. No, they didn't help at all.

- Not with materials such as scissors and cotton wool?

No. They are not supposed to give us materials⁵, but they should have treated us well, and supported us morally. If we took a patient, well, fine, we're going to attend to them, so that we don't fail as *parteras*; but no, not a thought did they give us. We had to retrain every two months, and I had 69 women planning with the pill, lots with the IUD, two or three a month going for the operation; but still they said to us, the head of the module in Tuxtla, here are your monthly [targets]. They gave us monthly targets, for this work, okay? To report what you have achieved. And they demanded we arrive in Tuxtla for meetings at inconvenient times. I said to her, "But look, it's better to lose five minutes than three or four hours." She replied "No! You are not worth anything, you are nothing. What are you? You do nothing for no-one. You have to come when I tell you. Goodbye." She was a very angry woman. She was a terrible woman, and treated us with the toe of her shoe....(*muy mala la señora, nos ha tratado con la punta del zapato*).

- You don't work with the government clinics anymore then?

No! They treated us very badly. They wanted purely indigenous people in the programme. But although there were many more indigenous people, there were mestizas too.

Doña Chely was picking up on the importance the government places on getting indigenous people into the family planning programme. She saw her work in terms of care of her patients and was unhappy that government targets existed, and that they focused on a particular section of the population when, as she saw it, both required her care. I asked her about the government's focus on family planning:

Well, there are so many people. There are people, look, there are couples who have ten, 12 children and still carry on having them. For me, I worry when people reach six and tell someone, "Look, you have to have your operation; do you want too many children? Now you have no money to give them, now you're half-naked." Well, if I convince them, they say, "Okay, but do me a favour, take me yourself and look after me, or you look after the small child, for a day," and I look after it. But they don't cooperate there [in the clinic]. They don't have any respect. For example, if you went now, if we went and said to them, "We've brought two women for the operation," they will reply, "Ah, we can't do it today, only on Friday, other days no." Look, these people come from Altamirano, *pueblos* like this, like Huixtán, Ocosingo, Oxchuc, wherever they're from. They should do the people from far away, the people who need it, whenever they come, but they don't. We have no support in this.

Doña Chely was exasperated at the treatment of indigenous people who travelled a long way at personal expense on local transport and people who were not willing to be away from home for long because they had to look after their children, their homes, their animals and their *milpas*. She believed that the government should

accept people as they turned up and not have a rigid timetable of one day a week when a person could be sterilised. Her own experiences as a *partera* with the government were unhappy ones and these days she neither needs or wants to work for them as her own business appears to be quite lucrative. She resented the way she was treated by government personnel and certainly would not put up with the notion that she was anything less than a *partera* who took a pride in attending her clients. This is not to say that she was universally applauded for her work. Amongst those I met who knew her there was a marked division between those who thought she was wonderful and those who thought she was terrible and had treated them badly. Doña Chely would not have put up with the treatment meted out to the Chamula *partera* working in the mixed clinic. This *partera* had not attended any births⁶ within the clinic as women prefer to give birth in their homes. Instead of working as a *partera*, the job she was employed to do, she did the clinic laundry. Many people in San Cristóbal were quick to point out to me that it is not unusual for women who work as *parteras* (with a few notable exceptions) to work taking in washing for other people to make extra money. However, in the context of the clinic setting where this *partera* was employed for a particular job, giving her the washing to do instead of sending her out on community visits, for example, undermined her value as a *partera* to the clinic and sent out the wrong messages to traditional healers who might have considered working for the government.

Knowledge and culture

The cacophony of competing voices and experiences illustrated in this thesis do not mask a basic division, when considered from the point of view of implementing family planning policies, between the disembodied knowledge of the policy makers and local knowledge of metizo providers, *coletos*, mestizos, indigenous groups, women from the barrios and traditional healers which are firmly embedded in local life and experience. Regardless of the many interpretations as to why the Mexican government want to expand family planning services and foment wider use, one aspect which stands out is that policy formulated at national level has made little or no use of local knowledge. Up to now government policy has been

concerned with gaining acceptance in indigenous areas rather than actually seeking to incorporate local knowledge within policy packages. Provider knowledge of their client populations has centred only on the negative images expressed through "*ellos no saben nada*" and "*por la cultura*" rather than in any positive way which might investigate, in this instance, the knowledge and use of local fertility regulating practices.

Whether or not the 20 allopathic/traditional clinics planned for remote areas will seek to redress the balance or whether, as the more cynical believe, or are simply a new counter-insurgency method generally expanding mestizo control in these areas, is still an open question as the clinics have not yet been built. Whatever happens it will be necessary to delve behind a disembodied and neutrally worded policy rhetoric to understand what drives the policy mandates. The relevance of such policy rhetoric to local people in Los Altos is the theme of the next chapter.

¹ Mixed in the sense that this clinic incorporates a traditional healer and *partera* amongst its staff

² Na Bolom is the anthropological museum in San Cristóbal bequeathed by Trudy Blom.

³ In 1990 there were 12,280 women of fertile age in the municipio. (Calculated from INEGI, 1991.)

⁴ Arias (1991:15) points out that terms commonly used to define *numinoso*, such as invisible, supernatural, or transcendental are inadequate and describes in depth all that he considers it to mean.

⁵ This had changed by 1996 when part of the deal between *parteras* and clinics was that the *parteras* should receive materials and training in exchange for information but no pay. The relationship is that of a mutually beneficial "link" between the two parties and not of employer/employee.

⁶ At least up to my departure in July 1997.

Plate 11.1 Health Promotion, Los Altos 1997

Fig. 1 Training *parteras* and promoters (SSA)
- las cañadas de la selva



Fig. 3 Mestiza doctor teaches Tzeltal
partera about birth practices



Fig. 2 "Few Children to Live Better" - SSA Mural,
San Cristóbal



Fig. 4 "Earth Mother" Mural at SSA
Hospital, San Cristóbal



Chapter 12

Understanding Rhetoric: From Policy Formulation to Implementation

Within the Programme of Health and Social Assistance reproductive health is identified as a component which can improve the general health and welfare of women and children. Following the emphasis of the old Programme of Maternal-Child Health, mother and child health are prioritised as integral to the promotion of reproductive health which itself is considered to “represent one of the most important tasks in the health system” [Gobierno del Estado de Chiapas, 1996:27 *trans.*]. The new Programme of Reproductive Health introduced in 1995 was meant to provide an integrated approach to the whole area of child-maternal health and family planning rather than having two separate strands of policy. How such policy change filters down to the grassroots level for on-site providers is a matter that needs some consideration. Apart from clarity of language and materials, and the provision of training to avoid misunderstandings amongst on-site providers, another issue which needs to be addressed is the existence of other policies which might run contrary to the one in hand, or the existence of contrary components within the new policy itself. In this respect, the continued policy requirement for population control hinders the spirit of a reproductive health policy which emphasises freedom to decide on number and spacing of children and choice of method. In what follows I want to consider policy rhetoric as a factor which legitimises government goals and brooks little opposition [cf. Shore and Wright, 1997:11-12]. Terminology becomes all and whilst reflecting imputed government goals may hide problems relating to the practicalities of achieving such goals. Without accounting for local conditions nationally and internationally formulated policies may bear the seeds of their own failure.

Despite the integration of the Mother and Child Health and Family Planning Programmes into the new Programme of Reproductive Health the major policy preoccupation with family planning promotion, as a primary goal, appears to remain unchanged. Many providers interviewed were sceptical about the changes and suggested that the only thing to change regarding the programme has been the name.

Moreover, it appears to have caused confusion amongst some government health staff who, during interviews, were unable to define the difference or implications of the changeover to an emphasis on reproductive health. These were in a minority though, significantly, some were responsible for the family planning programmes in the clinics where they worked. Most of these were confident that reproductive health was simply family planning with a different name. This is equally damning with regard to policy implications: either there has been a change of policy which has not been perceived by providers, or there has been a policy change which has not filtered down to the providers in any concrete way; or the policy change is truly just a change of name. The following responses were given to questions about what things have changed in particular medical units since the new programme of reproductive health came into effect in 1995. Whilst some answers were given hesitantly by respondents who were not sure of the answer, other people were sceptically convinced that there had been no real change made:

I think that up to now it's, well I don't know, the same but with another name. Well, we do the same things with nothing more than a different name. That which was family planning is now reproductive health.
[*Enfermera titulada* with responsibility for family planning. SSA, Las Rosas, October, 1996]

Well, it's the same, because we give the same talks.
[*Dra(pasante)*, IMSS, Zinacantán, October, 1996]

In practice, for us, it's the same - the same themes, the same programmes.
[*Enfermera titulada*, SSA, Chamula, October, 1996]

Really, I'm not absolutely sure.
[*Dr (pasante)*, SSA, San Andrés Larráinzar, October, 1996]

Well, I'm not well up on it.
[*Enfermera titulada* with responsibility for family planning. SSA, Tenejapa, November, 1996]

Absolutely nothing. Everything is the same as before.
[*Enfermera titulada* with responsibility for family planning, DIF, San Cristóbal, May, 1997]

Nothing. In essence nothing has changed much. The changes have been only in name because for as long as I can remember we have carried out the same programme. I am talking about fifteen years of family planning. It's the same

programme. [Head of the family planning clinic, SSA, San Cristóbal, July 1997]

Well, here [in the clinic] there have been no changes. There have been changes at the institutional level but not here.... here we do the same as before, we offer the same service, the same methods. [Dr (*pasante*), SSA, Mesbiljá (Oxchuc), November, 1996]

Nothing has changed at all. It's just the same.
[*Enfermera titulada*, Chanal, March, 1997]

Well, it's the same. That's to say there have not been any changes except for the name, but the service that's given - for those who receive these services - nothing has changed. It's the same. [*Promotor*, IMSS, El Niz (Oxchuc), April, 1997]

It is easy to understand why health providers may perceive reproductive health as more of the same thing, i.e. family planning, even those who know that reproductive health should cover more than this. As already discussed, the promotion of reproductive health hinges upon the systematic offering of contraceptive methods to the whole population in the fertile age group and the general objective of this systematic offering of methods, apart from increasing the extent of contraceptive use, is:

... to ensure that the population knows and understands the benefits and risks of contraceptives and can choose the one which is most suitable to allow them to live in a state of physical, mental and social well-being in accordance with their expectations. [Gobierno del Estado de Chiapas, 1996:66, *trans.*]

What can we understand from this statement? The first half denotes expansion of knowledge through education and promotion of family planning but there is an underlying assumption that people will choose a method, and moreover one which will meet with certain expectations. But what are these expectations likely to be amongst an indigenous and/or marginalised population? If large families fall within their expectations, how does policy address this? By advising that smaller families are more desirable than large families with ensuing implications for health and well-being, these expectations revolve primarily around the propounded expectations of the policy makers rather than local expectations. This issue is brought to the fore in the comments of health staff below who perceive the role of the patient within the programme either as an entity who does not really understand

what family planning is or as someone upon whom policy goals regarding increased use and participation in decision making are focused. The crucial issue which appears to be overlooked is how to effect education and promotion of family planning in a culturally sensitive manner considering the physical, mental and social well-being and expectations of indigenous and marginalised groups. The use of indigenous auxiliaries to overcome cultural and language barriers has limitations, as does the use of traditional healers, largely because of the continuation of power differentials between the two groups, mestizo and indigenous [cf. Kaufert and O'Neil's findings amongst Inuit and the Canadian government, 1993:50].

An important related issue is that whilst health staff expressed that increased participation of women and couples in the programme through increased decision-making was a new concept within the reproductive health programme none could say how this had been, or could be, achieved. To say that women or couples now participate more in the decision about contraceptive use suggests that they did not make the decision before, implying that decisions were made for them. This possibility is underlined by the inability of staff to say more about why and how people now make the decisions for themselves. Moreover, if the targeted population are deemed to be ignorant and superstitious, how are they to participate more in making an informed decision?

The combined practices of targeting and the systematic offering of family planning services, as outlined in Chapter 8, pressurise government health staff and would seem to suggest that the reproductive health programme could indeed appear to be simply more emphasis on family planning. For those clinic workers who did perceive a change in the programmes before and after 1995, the emphasis was placed upon changes in the way family planning was offered (i.e. *oferta sistemática*) in order to enhance the local population's understanding of what family planning is and the risks of too many pregnancies:

With this new system the only new thing is that they try to control (*controlar*) more.

- What do you mean by control?

It's because people instead of, hmm, it was a question of interpreting the idea of family planning and supporting yourself, having fewer children, that is, the risks they run having children, more children than they should have, the obstetric risks that they run. They are told about the risks they run but sometimes they take no notice. Efforts in reproductive health are very worthwhile, how they are being carried out on behalf of the users. [Dr Rojas, (*pasante*), IMSS, Oxchuc, October, 1996]

Dr Rojas begins to talk about control before fudging the issue into one of risks. It is difficult to know exactly what he meant by saying that now they "control" more. Perhaps he meant through the introduction of targeting that it is easier to assess the local situation in statistical terms and therefore have a basis for further targeting, or maybe he was referring to the relentless offering of family planning services. His strong opinions on what people should and should not do certainly contain no suggestion of participation in decision-making.

Systematic offering was certainly to the fore in Dra Flores' interpretation of changes between the old and new programme:

Look, things have changed mostly with regard to diffusion of the programmes. Yes, because before the diffusion of the family planning programme was in a superficial form. They didn't have to insist much that the patient make a decision. Now, they take more interest in the patient and taking a stance on how they make a specific decision. It's so that they understand the message that we give them and moreover that the auxiliaries will speak the *dialecto*, the language, so it's more understood. [Dra Flores, IMSS, Huixtán, November, 1996]

Dra Flores' thoughts are echoed by those of Dra Fábregas, leaving the impression that patient choice under the old system was not important whereas now it is:

The offering under Mission Chiapas began very strongly. For example, methods were more accepted. Because, in fact, beforehand the programme didn't grant them the least importance. People would come for a consultation and they would just come to ask for their method and there was no "offering". With Mission Chiapas they [the staff] offer the method. Now there has been a lot of acceptance, I've noticed it. I've worked when the programme wasn't in place and at the moment, yes, there's a greater number of patients coming into the programme. [SSA, Yabteclum (Chenalhó), November, 1996]

The warning bells begin to ring here with regard to Dra Fábregas noticing more acceptance. Under normal promotional circumstances the rate of contraceptive use may have increased but there is a problem with this notion of acceptance and also with choice when one begins to realise the efforts that go into promoting IUDs in particular, and other modern methods in order to reach set targets. Dra Alvarez is convinced that patient participation has increased but few could say exactly how this had been effected except this doctor who thinks there is a greater emphasis upon counselling, though this was not borne out by the experiences of the women I asked about clinic experiences:

Things have changed a lot. The way in which the method is offered, counselling for example, was something which changed a lot. The patient participates more of course. [Dra Alvarez, SSA, San Cristóbal, July 1997]

One of the very few doctors to describe the new programme of reproductive health as a wide-ranging integrated service was, surprisingly, a *pasante*:

I think everything it stands for has become more integrated. Apart from family planning, the other things it covers, antenatal care, reproductive risks, all that, the whole thing has been brought together. It's not just aimed at family planning per se. [Dra Parras (*pasante*), IMSS, Chamula, November, 1996]

On the other hand, Dra Méndez's comments were typical of the majority of male and female doctors, including both qualified staff and *pasantes*:

It's nothing more than a change of name because it's carried out in the same way. More than anything because the people thought that family planning meant not having children, but really the term doesn't mean this, rather it's spacing of children between each pregnancy and they think that to plan means not to have children, but they are wrong about the term, more than anything. [Dra Méndez, SSA, San Juan Cancuc, March, 1997]

There is some mention of spacing and the risks of pregnancies in these illustrations but few health staff mentioned other aspects of reproductive health such as cervical smear testing, breast cancer screening or STDs, though most were emphatic that much of their work concentrated upon other preventative health measures.

The specifics of the reproductive health component of the Programme for Health and Social Assistance are crucial to gauging the difficulties in both communicating these concepts to a population of low or no educational instruction, and in gauging how these concepts are understood. If there is trouble in getting health staff to fully understand this component then there is little chance of succeeding with the intended policy recipients who are all of low socio-economic status. Where this is a problem, any ideal of understanding local expectations and working out how programmes can be communicated in a culturally sensitive manner will be severely undermined. Bearing in mind the problems policy makers appear to have in communicating their intentions to providers, I want to discuss some components of the Programme of Health and Social Assistance which providers are supposed to consider in implementing the policies handed down to them.

A selection of essential components specified by the Programme of Health and Social Assistance in the provision of reproductive health services

Inform the population of the new concept of reproductive health (through a programme of dissemination, promotion and information), with the support of those involved in health promotion. [Gobierno del Estado de Chiapas, 1996:66 trans.]

It is very difficult to promote reproductive health as a “new concept” when the emphasis appears to remain resolutely on family planning promotion and when, as I was to discover, other reproductive health areas such as smear tests for cervical cancer were considered apart from and separate to this programme, at least within Los Altos. Officially this was not the case, but doctors and *pasantes* referred to this as separate in practice. If there is little to distinguish the new concept from the old, or it is imply a reinforcement of it, and considering that many doctors seemed to have trouble in conveying what family planning was in the face of cultural differences, in what new ways can it be explained except in terms of more of the same thing? How is this supposed to change client perceptions? It becomes more difficult when one realises the problems that doctors have in communicating at all with large proportions

of illiterate indigenous woman in rural Chiapas who are likely to be either monolingual Mayan or who speak Spanish as a second language.

Ensure that individuals and couples are able to enjoy risk-free reproductive health and contraceptive methods so that they can freely decide the number and spacing of their children [Gobierno del Estado de Chiapas, 1996:66 *trans.*]

For doctors to ensure that individuals or couples can enjoy a life of “reproductive health” without risks is very difficult if one considers that this would, or should, entail a discussion about sex and sexual practices, incorporating risks of STDs and AIDS. One gynaecologist working in Altamirano explained to me that it was difficult to ask about sexual behaviour or to carry out gynaecological examinations:

We hardly ever ask about this. If its about pregnancy, okay, we can ask about when the last period was, and see how the baby is, these kinds of things. But their sexual activities, well, in these we can't intrude because it's taboo. Well, it's very taboo. It's embarrassing. You can bath them and wash their head, all of the body, but the genitals, no you can't wash there... You can't touch it because it's sinful. [Dr (Gynaecologist), Hospital San Carlos, Altamirano, February, 1997]

Dra Suárez of the ISSSTE clinic in San Cristóbal commented that when counselling women with regard to smear tests she must ask personal questions relating, for example, to the number of sexual partners the woman has had and the age when she began to have sexual relations. She said that some women get up and leave with angry comments on why she should wish to know such details about their personal lives. Sometimes she can manage to persuade them that these questions are relevant to their health but often they leave before she can explain. If sexuality and risk relating to sexual behaviour is a difficult discussion to raise in the city, how much more difficult does it become in rural areas?

Even within the urban area of San Cristóbal there is a reluctance to directly discuss sexual behaviour with strangers, including doctors. I spent a lot of time, for example, with Claudia before broaching the subject of men and relationships with her. She was happy to talk about which contraceptive methods she had used but not about

sex itself. It was not until the latter part of my fieldwork that she began to discuss how sexual intercourse was painful for her; and also revealed, with much embarrassment on her part, that she had had an abortion some years before, facilitated by a *partera* in the town.

Discussing risk and sexuality are necessarily entwined in family planning narrative because of the obvious link between sexual behaviour and risk. However, for the client, not only may this link be absent but personal risk, based as it is upon known experiences of the self or others, may be linked directly to seeking clinic treatment. Few doctors have the time or inclination to invest in overcoming the preconceptions of women like Claudia, such as fear of ill-treatment by clinic staff and of operations, and her belief in a big book full of medicinal treatments for every illness.

Moving from risk to sexuality, indigenous people are unlikely to engage in discussions with a mestizo doctor (male or female) about their sexual lives. In fact, the emphasis on the individual makes it more difficult to question patients about *their* experiences. I came to realise that most indigenous people were happier discussing life generally and answering questions in the third person rather than the first. Meaningful dialogue is much more difficult to achieve in a direct manner, especially if one considers gender relations and the place of machismo within both mestizo and indigenous society. Yet dialogue about sexual behaviour in the context of family planning services is an important consideration in highland Chiapas because in rural areas, though it is frowned upon, men may have more than one partner. In the city the chances of having multiple partners is greater. Health staff are aware of this and as a consequence family planning promotion, in seeking to ensure that people can enjoy risk-free sexual health, should emphasise an awareness of STDs and the importance of smear tests as an integral part of the programme. However, perhaps because gynaecological examination is so taboo and discussion of sexuality difficult, if not impossible, and given the importance of targeting contraceptive methods, these other important areas of reproductive health are marginalised within the programme, at least in practice.

Gynaecological examinations are taboo regardless of who the examiner is. Even with indigenous health promoters from their own communities women do not like to be examined gynecologically or have IUDs inserted. María Elena told me about the *pudor* (shame) attached to *that part* of the body. She herself was government trained in family planning promotion and could insert IUDs and give injections (contraceptives and vaccinations). María Elena believed that women resisted her male counterparts who also offered these services:

The women don't want them. If it's a man who is the promoter in the communities the women won't allow them to insert IUDs because they are very inhibited about their bodies.

- And what about smear tests?

It's very difficult because even though we are all women and they are mothers, well, they are always embarrassed (*tienen vergüenza*).

If indigenous women express this *vergüenza* with other women who are health promoters from their own communities, how much more difficult must it be for male and female mestizo doctors to deal with sex, or intrauterine contraception and internal examinations? Even indigenous birth attendants rarely have to insert their hands into a woman's vagina before, during or after birth. These women are simply not used to internal examination. As María Elena says of the *parteras*: "*No necesitan tocar sus partes*" (they don't need to touch their parts/genitals).

It is important to note that meanings attached to risk are often constructed upon perceptions of past experiences for many clients, and the socially constructed taboos relating to sexuality often overcome clinic perceptions of future risks. The risks of venereal disease, female cancers, and pregnancy are built on medicalised avoidance narratives constructed by the medical establishment [cf. Frankenberg, 1993:222]. But for many women the existence of clinic solutions to problems they themselves may not perceive present their own risks, whether of side-effects of contraceptive methods, ill-treatment by clinic staff or undergoing intimate examinations.

There are a number of other problems inherent a policy intention which focuses on the importance information and choice. One relates to what it means to be "well informed". Another, which I shall deal with first, concerns the relationship between knowledge and action. Here there is an assumed correlation between reproductive health information (including contraceptives) and actual planning by clients with regard to numbers and spacing of children. The assumption is that knowledge about these aspects of health care will result in the prescribed behaviour which the government would like to see couples following. There is an incredible arrogance in policy making formulated as though human behaviour can be planned like a flow-chart resulting in neat, robotic outputs from policy information inputs. Prescribed actions cannot be assumed to follow policy edicts. What one does with knowledge and information is contextually variable and constructions of knowledge cannot be assumed to result in a uniform understanding for all people from the same pieces of information, even within a culturally-bounded group. As Bourdieu points out:

Action is not the mere carrying out of a rule, or obedience to a rule. Social agents, in archaic societies as well as in ours, are not automata regulated like clocks, in accordance with laws which they do not understand. In the most complex games they put into action the incorporated principles of a generative habitus. [Bourdieu, 1990:9]

Negotiation is part of the social process upon which the imposition of structural policies may have an effect, but not necessarily that which was intended. Family planning policy appears as a top-down structure which expects certain behaviour to follow in the wake of family planning information and promotion. However, at the bottom of this hierarchical structure the recipients of this information will respond not to simple health-welfare/child spacing-few children formulae but will rely on a whole host of experiences and local knowledge which will affect the likelihood of their accepting family planning services. Rappaport, paraphrasing Bourdieu's arguments, refers to action influenced by experience and past events [1998:200]. She is particularly interested in historical processes and the construction of the past in the present as a way to claim moral power and legitimacy for current

political strategies. In essence, she is echoing the work of Robert Paine who, considering *ethnicity* as the politicisation of culture, refers to dominated groups turning physical powerlessness into moral power for political ends [1985:190]. Following Paine I would argue that social action resulting in resistance can take on apparently more mundane forms than open resistance to the dominating society, such as a rejection of government services.

We have a situation whereby policy inputs of information are assumed to result in an output of rational behaviour [cf. Pyper and Freely, 1994]: rational because the policy is promoted as something which is good for the recipient and when the recipient is in receipt of this information they will understand that it is good for them. For the policy makers the rationality involved in equating birth-spacing and fewer pregnancies with better health and economic well-being is simple: *pocos hijos para vivir mejor*¹. Leaving aside issues of policy in practice and what effect this has on policy edicts and information passed on to recipients for the moment, information per se is incorporated by the individual or the group within a spectrum of existing local knowledge which runs the gamut of myth, history, ritual, symbols and religion, and any politicisations of that knowledge. Not only does this indicate the distance between the “ideas and practices of development agencies and those of ‘local’ people” [Grillo, 1997:25] but *where* the information comes from could be crucial in terms of how it is understood and incorporated into the local sphere.

Why do so few indigenous people in Los Altos use clinics let alone family planning services? The clinic and the mestizo staff represent an opposing power in various manifestations. They have the power of the school teacher over the child; the doctor over the patient; the government over their lives. The cultural gulf between a male mestizo doctor and an indigenous woman in rural Los Altos transcends any language barriers they may face and yet upon going to have her baby’s cough seen to in a clinic she will be told (usually via an interpreter) that fewer children will improve her life. How is this bit of information, along with an array of objects - a packet of pills, an IUD, a diagram of the ovaries with a line representing a cut across each one (female sterilisation), to be incorporated into the world view of an indigenous woman, a monolingual Mayan speaker, who cannot read, who lives in an adobe

house with a dirt floor and a latrine at the end of the *milpa*, who has no electricity or running water, and who expects to have many children? How should she and her family or community understand this piece of wisdom handed down by a man or woman who inhabits a different world? Mestizos are so obviously different: they speak a different language; they dress differently; mestizos have money and eat in restaurants; they live in large brick houses. Mestizos have power: they are government officials, politicians, bankers, doctors, academics, anthropologists and such like. Why then should the dominated society be interested in doing something that is *good* for the dominated and the marginalised? Why, if the dominated group has bolstered its marginalisation for political purposes², should they then accept mestizo interference? The source of information may predicate its incorporation into local knowledge with the result that policy-makers are frustrated in their goals and groups remain unable to utilise reproductive health services in a free and informed manner because their knowledge of them is mediated by past and present experiences and negotiations with the providers.

Likewise, the providers' knowledge of the local group is subject to similar constraints. When doctors tell me that women (and men) don't use modern contraceptive methods *por la cultura* they generally say that this means because of their indigenous ways and beliefs; because of their ignorance about side effects and their invention of ridiculous possibilities. So when women discontinue contraceptive methods because they fear that if they get pregnant the IUD will get stuck in the baby's head or in part of their own bodies they are deemed to be irrational and ignorant. Yet looked at in another way, if a woman has felt pressurised into having an IUD fitted or taking the pill, or if she fears sterilisation, what better way of resisting something you are told will be good for you than to justify reasons for not wanting it [cf. Zimmerman *et al.*, 1990:92]? In this case it does not matter if a woman really believes that the IUD will stick in the baby's head (though it seems to indicate that she does not believe it will prevent pregnancy), or that contraceptive pills will form a ball inside her womb which will cause her harm. What is important is that a justifiable argument is formulated against the use of a modern contraceptive method that is not wanted or ill-understood; or where community pressures proscribe such use. Perhaps such social constructions of contraceptive knowledge are simply

general unspecified fears of secondary effects or government intentions verbalised in a way that allows an excuse not to use this paternalistically offered panacea for a woman's physical and material ills which, with few examples around her, she has little proof of.

In much the same way that Evans-Pritchard cites Azande witchcraft beliefs as a "system of values which regulate human conduct" [1991:18] the invention or construction of terrible side-effects from modern contraceptive methods allows a response to their imposition by a higher authority. What is important is not that witchcraft is a causal link in an unfortunate event or illness amongst the Azande but that the apparent cause prescribes or allows certain responses. Similarly women who do not want to use modern methods of contraceptive for whatever reason need only to cite unpalatable scenarios to justify rejection of modern contraceptives. Seemingly irrational fears about side-effects are thus a rational response when considered as a reaction to an unwanted commodity offered from a source which stands in cultural and social opposition to one's own community or group.

María Elena laughed when I told her that a number of doctors had put forward this image of indigenous women not wanting IUDs because they feared that it would somehow become embedded in their flesh or the head of a new baby during pregnancy. "No, no, no!" she laughed. She did, however, comment that women were afraid generally (*tienen miedo*) of what might happen to them if they adopted contraceptive methods. Though she herself was trained and well informed (*bien informada*) she was emphatic that sterilisation was not a method she would choose for herself. She would not elaborate on her fears other than that the operation itself scared her and yet she had been responsible for informing and bringing women from her own native community in Chenalhó to San Cristóbal for that same operation:

Well, I talk to them about planning because there are many who are afraid - afraid of the operation. When I first did it I brought one or two women from the community [to San Cristóbal for sterilisation] and everything went well. After that more women came.

- But some women who don't want more children don't want to be sterilised either.

Me neither! I haven't had the operation!

- Do you want more children?

No! No I don't want any more. It's difficult enough [she had earlier complained about the cost of clothes and education]. I have four children and that's enough.

- Do you use a method then?

Yes, I am planning but at my age [39] my husband says I should go for the operation, but I am afraid (*tengo miedo*). There are some who are well after the operation and some who are not.

Despite being trained in family planning promotion and able to graphically describe the process of female sterilisation María Elena nevertheless remains afraid of being operated on herself and understands that other women are too. However, she continues to tell other women that the operation is simple, that it only needs a night in hospital and that afterwards everything will be fine. As an indigenous *promotora*, one of those people upon whom the government relies to convince the local population of the good intentions of the government, María Elena herself remains unconvinced.

Encourage a change in the reproductive behaviour of the population [Gobierno del Estado de Chiapas, 1996:66 *trans.*]

What does the phrase "to encourage change in the reproductive conduct of the population" actually mean? Are we talking about safe sex in relation to STDs or procreation? It is not immediately clear. From studying the policy it is obvious that one change is to reduce the number of children women or couples have. To do this family planning services are provided which are purported to allow people to have more control over their lives by planning their families in a way which can benefit them in health and material terms. To begin, with these benefits are given from a medical and material viewpoint, and from an opposing culture, and are not necessarily those that will be perceived by the indigenous population. In carrying out fieldwork many doctors saw it as their duty to convince (*convencer*) the indigenous population of the benefits of family planning. The decision that change is for the good has already been made by the doctors and policy makers - the important thing

then is to *convince* the target population. What implications does this have for the concept of informed consent and choice, especially when notions of acceptability of contraceptive use, and risks associated with use and pregnancy, are culturally disparate vis-à-vis the two main groups of players: the providers and the recipients of these services?

Choice and risk

Part of the information and promotion which is provided about family planning services concerns the risks of frequent pregnancies to a mother's health and the drain on material and mental resources of too many children. Supposing that a woman or a couple have enough information, and understanding of it, to make an idealised conventionally western-style informed choice to use a family planning method and which one to use, this choice will inevitably involve a risk. Like benefits, risks are also perceived by users of family planning services, not through the supposedly neutral assertions of policy makers but through culturally-bounded perceptions of what they mean. So where policy makers assert the use of risks of morbi-mortality in terms of maternal and child health, women may be more preoccupied with risks of side-effects from contraceptive use or group perceptions of their morality connected to promiscuity or husbands' reactions. The individual or the community may perceive the risk in terms of government efforts to reduce the indigenous population for political reasons; or they may see a risk in terms of a reduced population as something which will affect their self-sufficiency or their security throughout the life-cycle. The latter risks are firmly grounded in the community sphere. Policy makers ignore such influences in assessing risks and consider risk as physical to the extent that they affect the body: risk of contraceptive use is concerned with health affecting side-effects; risk of non-use of contraceptive methods concerns illness and death of individual women due to child bearing and pregnancy, assessed in conglomerate terms for statistical analysis. We might put the assessment of risks into two contexts: objective risks and subjective risks, policy makers dealing with the former and ordinary people with the latter. Subjective risks are much more difficult to assess than the objective ones which policy makers look

for, in part because they do not lend themselves well to statistical analyses or controls.

In terms of assessing side-effects, objective/subjective approaches play a large part in illustrating the differences between providers' approaches and users' experiences or fears. In medical terms risks associated with contraceptive methods are generally split into two groups: the more serious contraindications and precautions which indicate women who should either not be prescribed certain methods or with whom caution should be taken [cf. Dorflinger, 1994:4578] and the "minor" side effects such as headaches, acne, weight gain, nausea, mastalgia - in other words, side-effects which are not life threatening. These risks are scientifically assessed and categorised and then find their way into both policy documents and medical manuals. Policy makers use this information to denote acceptable and non-acceptable risks. While few would argue that death and serious illness are unacceptable risks to run from contraceptive use, the issue of acceptable risks, and the suggested continued use of contraceptives once the risk becomes a reality, is a far greyer area. Contraceptive users will assess side-effects as they themselves are affected physically and mentally, and in terms of community perceptions about acceptability. Furthermore, other non-medical risks will be incorporated which may prove to be more important determinants of use or non-use. In this sense the minor side-effects such as headaches, spots, prolonged menstrual bleeding or weight-gain attributed to some contraceptive methods and not considered to be reasons for non-use by policy makers and doctors may be crucial to the individual or the group. For example, prolonged bleeding associated with hormonal contraceptives may not greatly concern policy makers regarding health risks but for women who don't have access to sanitary wear this is a serious problem [cf. Maternowska, 1996: 124-5]. Moreover, prohibitions exist in some religions which forbid a woman to cook or have sexual relations during menstruation [Akhter *et al.*, 1993:579; Polgar and Marshall, 1978:333]. Prolonged or unpredictable bleeding patterns therefore adversely affect such women's ability to partake in everyday social relations [cf. Sivin, 1988:87; Riley *et al.*, 1984:256].

How do people consider risk in terms of contraceptive use? It is obviously an important question regarding changes in behaviour desired by policy makers but not one which they allow themselves to become befuddled with. Whereas “minor” side-effects such as acne and weight gain are immediately more visible, and consequently unacceptable to many women, trying to assess the more serious contraindications requires medical training and understanding which might be outside of the user’s grasp even when explained in lay terms. If one cannot understand the risk then making an informed choice becomes difficult. Moreover, if risky behaviour is not understood as such by the individual concerned then it is not a risk in their terms and there is no reason for them to change that behaviour. As for the likelihood of death due to too many pregnancies in quick succession, few can logistically work this out for themselves. How real does this risk appear to women going about their daily lives? Pregnancy is an everyday event and perceptions of the risks attached to it vary greatly. These are not questions policy makers seem to ask people - presumably because it brings the subjective into their objective formulae of calculations and yet these are important questions in terms of risk-taking behaviour.

Mary Douglas draws out crucial points relating to policy making and risk. She refers to the “professional objective ... to get at the real essence of risk perception before it is polluted by interests and ideology [and that in order] to avoid the charge of bias, they exclude the whole subject of politics and morals” [1994:11]. She refers also to the paradox of “the public” not seeing risks in the same way as the experts, and how one of the reasons why there is so much confusion regarding this paradox is the “practitioners’ commitment to methodological individualism” [*ibid.*]. For me, this is the crux of the problem in the whole question of informed choice (and risk taking) in contraceptive use. Where the methodological focus on risk is individualistic and “scientific” in nature, so this is translated to the policy prescription aimed at the individual without the subverting effects of the group. The individual’s right to choice, as with the individual’s likelihood of death, sickness, becoming fat or getting acne with regard to use or non-use of contraceptive methods, are embedded in a cognition which leaves out the societal elements and replaces them with the laboratory test-tube which incorporates a medicalised hierarchy of risk gravity.

Clearly this construction of risk in relation to family planning is insufficient. With regard to morbi-mortality the risk normally refers to countries perceived to be underdeveloped where fertility is generally higher than in the developed world. The solution then is to introduce widespread family planning services to cut the fertility rate and increase health prospects for women. Many researchers I met in Chiapas working in the health sphere were angered by this approach. Ideologically, they approved of widespread family planning service availability but complained that death rates attributed to child-birth could be lowered significantly if other problems such as access to water, nutrition and sanitation were addressed in meaningful material terms. As a local medical doctor and anthropologist pointed out, the problem of government spending on, and prioritising of, family planning services results in an imbalance between this and other important areas in the health services.

Other risks perceived by health providers who work in Los Altos include a lack of information about contraceptive contraindications and side-effects and of how to use contraceptives effectively, leading respectively to lack of *informed use* and *mis-use* of methods. Cecilia, the Tzeltal *promotora* at the Grupo de Mujeres, is involved in sex education in rural areas and as such she is reasonably well informed about contraceptive methods and the pitfalls of poor provision:

A lot of people do not go to the clinics because sometimes the doctors give out pills but they don't explain how to use them. We know of a case in Chamula - a woman was given contraceptive pills but the doctor did not explain things very well to her. Well, the woman began to take them and she gained weight, which she thought was good. They [other locals] saw that she put on weight, and for them this is good, so she began to give them to her children. This continued and another doctor went who discovered it because so many pills [had been given to the woman] so he asked her, "What have you done with them all?" and she replied, "I am giving them to my children because they make them fatter (*se engordan*), so that's why I give them." And after this was known the women, with the one who [gave the pills to her children], spread rumours that the pills didn't work and that there was no medicine in the clinic, only contraceptives.

Cecilia pointed to this lack of information as a serious problem and one which not only fails to help women, but turns them against the clinics. She herself claims to have experienced similar treatment:

There are a lot of doctors who don't ask anything and don't tell you what you have to do. I have experienced doctors who gave me [contraceptives] without asking anything.

There is an apparent gap between what policy would like to see happening - that patients are educated by providers and encouraged to adopt reproductive health initiatives - and what actually happens at the provider-client interface. A crucial question, not addressed here, is how informed doctors and *pasantes* themselves are on side-effects and contraindications of contraceptive methods, and thus how well equipped they are to properly inform their clients.

Ensure the participation of the male population in responsible parenthood
[Gobierno del Estado de Chiapas, 1996:66 *trans.*]

There are few specific references in government literature to responsible parenthood and what it means, what the current state of affairs are regarding male attitudes to paternity, or how to achieve an improvement. After the above brief reference to increased male participation in responsible parenthood there is no further mention of it. Similarly, in the Programme of Reproductive Health and Family Planning, 1995-2000, the only reference to men comes under "specific objectives of family planning", which states its aim as being to:

Strengthen the family structure, promote a responsible attitude amongst men and women with regard to sexuality and reproduction.

Encourage the active participation of the man in family planning and his co-responsibility in decisions concerning sexuality and reproduction. [Poder Ejecutivo Federal. [1996:13-14 *trans.*]

From these two statements we can assume responsible parenthood for men involves male responsibility in and for the family; responsibility for sexual acts and health; and an increase in male participation with regard to decision-making in family planning. In practice, male participation can often be reduced to one single factor: contraceptive use by the wife is prohibited by the husband.

At its most basic level responsible parenthood is the moral requirement to maintain and care for one's children's physical and mental maintenance and well-being. Taking the concept further, as is indicated from the above references to family planning, it also includes responsibilities for sexual behaviour with regard to both sexual health and procreation. Bruce refers to responsible parenthood as responsibility for the outcome of one's sexual behaviour, including the use of contraceptive methods, and responsibility for children, which she frames largely in monetary terms [1994:68].

Despite this dearth of specific details in policy papers, health staff in Chiapas were almost unanimous in their beliefs that men should share responsibility for family planning. There was an equally resounding unanimity in the belief that the majority of men took little or no responsibility in this area. The practical problem seemed to be in defining how this could be done. Some health staff said that promotional talks on family planning covered issues of male responsibility towards their partners and children but there seemed to be no monitoring or evaluation in place which could gauge the relative success of this strategy, and no other kinds of initiatives. What is clear amongst health personnel was the belief that men were not overconcerned about responsible parenthood, including issues of contraception.

Gendered realms

Issues of masculinity are pertinent to an area seen as a woman's domain: the realm of the home, which includes having babies and care of children. According to the SSA Coordinator of family planning for region II, women themselves maintain this division by using the notion of *machismo* as a controlling mechanism:

I believe that men should participate more on a family level. But during training sessions [for health promoters] the women laugh at the men if they appear to be interested in this area. They question their masculinity and this puts the men off. [Interview, August 1996]

Given that men are the ones who have control over most areas of life it is not surprising to find, that for women, keeping men out of issues where they have some

control is a way of ensuring that men cannot undermine their limited power in the family sphere. However, this is but one factor: many women I knew believed that most men were totally irresponsible in the area of family planning. Claudia's views extended to both men and women:

There are women who don't want many children ... but they don't know how to look after themselves [i.e. to use contraceptives] and because the men are very hot [*caliente*] and can't live without women. [She is embarrassed and laughs.] Yes, I tell you Mary, you will die laughing. It's a fact that not all indigenous women, or men, know how to take care [use contraceptives].

Gloria and her friend Rosa were very scathing about the reluctance of men to take responsibility for family planning:

Rosa: The men here don't want to have a vasectomy and won't use condoms. These men don't want to use anything!

Gloria: Them! No! [Communal hilarity.] No, no, the don't want vasectomy or condoms and it's more belly³, more belly and more belly. They want us to do everything, but it's not right.

As *amas de casa* (housewives), women in the rural areas are responsible for the care of children, preparation of food both for immediate consumption and for drying/storing, collecting water, weaving and washing clothes, helping the men in the fields and collecting fire-wood. In the marginalised semi-urban area on the periphery of San Cristóbal their remit is similar, except that women (particularly those from women-headed households) may engage in paid work in the town. Women and children sell *ethnic* tourist trinkets in the centre; some work as domestic servants; many have very small plots where the women grow maize for home consumption, keep a few chickens and grow some vegetables. For those on the invasion site water must still be carried varying distances from places where the public water system has been tapped or else pulled out of stagnant wells roughly hewn down to the water line.

Within these female spheres there is a knowledge and control of female behaviour, for example through gossip, and also a knowledge of who to go to during pregnancy and illness. With men away much of the time during the day in either rural

or urban contexts, or for longer periods working on the coffee *fincas* or in the cities, this is an area of life over which women maintain responsibility and control, at least for part of the time. If the men begin to involve themselves in these areas then women will be undermined. A way of avoiding this is a psychological attack on their manhood through laughter and gossip, as with the SSA Coordinator's example of women laughing at men who appear to be interested in issues normally in the women's sphere.

Birth and fertility are firmly grounded within the female sphere of influence and knowledge. It is to the *partera* or the *curandera* that most indigenous rural women look. So too do many of their sisters living in San Cristóbal, when they need something to *bajar la regla* (bring on menstruation), when they are in labour, or when they or their children are sick. In the last case *curanderos* or *rezadores* may be consulted, but this leaves an important, female-only area where women healers wield power. When I interviewed Don Mariano, the traditional medic working at the SSA clinic in Chamula (see chapter 11), he seemed rather put out to discover that my main interest lay in what traditional methods women might use to control their fertility. He wanted to tell me how useful *albahaca* [basil] was for all illnesses, whether in the country, the towns, or even amongst *my* people. He was delighted to be able to show me his book in which he had placed dried specimens of various plants, together with prayers for various afflictions. When I asked him about plants during labour and for fertility regulation he was annoyed:

I'm not a *partera*. No. I am - well, I'm not a *partera*. They deal with these things. Go and ask them. [Don Mariano, *Médico Tradicional*, Chamula, November 1996]

Don Mariano appeared unwilling or unable to discuss the finer points of those things connected with birth and pregnancy which were clearly marked off as being within the female realm. The knowledge and power to deal with these things belong to women. This point is emphasised in a small bilingual pamphlet published by a team of Tzotzil catechists from Chenalhó which comes under the diocese of San Cristóbal. Indigenous literature is sparse and these publications are part of a church project whereby catechists are encouraged to celebrate and record their own

traditions, albeit in a syncretic fashion within the Catholic church, as a way of taking both the traditional and the Catholic forward together. This in itself is another area of study, neglected here, but one of the pamphlets outlines the Rites of Birth (Rito del Nacimiento/Yich'el Muc' Svoquebal Olol). There is no space to quote at length from the pamphlet here but it illustrates the respect shown to the *partera* through gifts and homage, and recounts the rites she performs to ensure that the mother and child fare well during the delivery [Equipo Coordinador de Teología India de la Diócesis de San Cristóbal, undated (c.1996-7):1-10 *trans.*]. What the pamphlet does not illustrate is that the *partera*, apart from helping the woman through labour and checking the baby's position during pregnancy, will also give herbs to be taken orally, or inserted vaginally, if she thinks it necessary to "heat" the mother's womb during pregnancy or after birth. She will also have knowledge of plants which can be used for regulating menstruation and avoiding pregnancy. She is thus an important member of both rural and urban communities in Los Altos, and is an example of power within the female sphere. It is understandable that women such as *parteras*, who have some knowledge and power in this sphere, will not readily hand it over to men, a threat that many involved in government training programmes for health workers may perceive.

Men's participation in family life and the strength of the family, not to mention involvement in decision-making with regard to sexuality and reproductive health, does not only depend upon a willingness of men to be involved, but upon socio-economic circumstances which may affect the stability of the family unit. Though men are seen to dictate a woman's reproductive health behaviour (especially by policy makers and providers), both men and women are influenced by local attitudes to contraceptive use: promiscuity, sterility, genocide, side-effects, ill-treatment all feature in the malleable attitudes to contraceptive use and the intentions perceived behind the ardent promotion of family planning services. The government would do well to take such notions on board for consideration during staff training at the local level.

Whilst one component of reproductive health policy concerns increasing male responsibility another concerns the empowerment of women in general. Yet women

who are abandoned with their children or who leave their partners are further disempowered by the patriarchal policies which govern payments of maintenance. In rural communities the national law is rarely resorted to in such cases but settled by local *caciques*, often with single payments required to be made to the women. In San Cristóbal, abandoned women do not have the protection of traditional customs. Instead, their only recourse is to federal law. This is expensive, time consuming, and may achieve nothing for poor women without the education and staying power to fight their cases and frequently confront mestizo power-brokers. When a woman has children in *unión libre* then she requires a lot of energy, friends and economic outlay to prove her case and win maintenance. Most women I knew simply did not have the resources or the energy for such confrontations. Inasmuch as women were reluctant to attend clinics unaccompanied by a supporter, so were they reluctant to pursue legal redress through mestizo courts. Moreover, they may have provoked gossip and condemnation about their behaviour amongst their peer group.

Male opposition to contraceptive use remains an important sticking point for the success of family planning policy in many regions of the world [Bruce, 1994:17] and, low overall use of family planning methods notwithstanding, men in Los Altos appear to be reluctant family planners. Modern male contraceptive use is low and inasmuch as men accept contraceptive use at all it would seem that it is something they expect women to do. It will take time, patience and respect for local customs to make inroads into such attitudes on the part of local providers. It is an improvement, from a policy perspective, that men are at last being considered within this remit, but change is likely to come slowly.

The above selection of components taken from the Programme of Health and Social Assistance is typical of international policy edicts on reproductive health. They are presented as neutral, value free concepts which aim to have a "good" outcome on the health and lives of women and men through their adoption of family planning methods. As ideals they are presented in a vacuum far removed from the processes of social change which affect everyday life at the local level: land loss; political and military strife; economic insecurity; lack of basic amenities; abandoned women and children; gender relations, and such like. Appearing as lofty ideals

stripped of social processes they brook little argument against their validity and desirability. However, at the local level, the policies, or rather the effects of their implementation, are embedded in the processes which affect everyday life and often prove wanting. Knowledge and use of contraceptives is not then something which can be calculated and propounded upon in a vacuum affected only by policy inputs designed to generate desired outputs.

¹ "Few children to live better", the major slogan of the Reproductive Health Programme.

² Collier notes how land reform freed much of Los Altos from Ladino control and "transformed Indian communities from a patchwork of small Indian hamlets interspersed between Ladino properties into an area of consolidated and continuous Indian control" which has allowed the Maya to retain and re-emphasise their Indian identity [1975:150]. This emphasises the importance of land, on a material level, to the highland Maya of Chiapas in consolidating and maintaining an Indian identity in opposition to Ladino domination. It is an argument which is supported by Carlsen's belief that the highland Maya of Guatemala actually buttressed the region's marginal status in order to maximise their own sociocultural autonomy [1997:23].

³ "More belly" (*más panza*) refers to another pregnancy.

CONCLUSION

Power, Control and Empowerment

One of the prime concepts of current global development policy (see, for example, Rew 1996; Grillo & Stirrat, 1997) is to empower poor people, especially women, to take control of their own lives and destiny as far as possible, specifically through accounting for local knowledge and custom in planning¹. In development rhetoric participatory approaches should herald a bottom-up process with analyses of local conditions informing the policy makers and thereby empowering locals. There are various problems with this in the context of Chiapas, generally, and in the area of family planning in particular². In terms of the state of Chiapas the government have long perceived of the problem as a backward, largely indigenous population whom they want to see advance along the path of progress, as they envisage it, not least because Mexico's overall economic performance depends upon it. What we are left with is the rhetoric of development policy which suggests inclusiveness, encompassing and empowering those people on the bottom rung of the development ladder, juxtaposed with an exclusive economic policy which is concerned with Mexico's relationships in the global economy and in particular with the United States. These two positions in effect conspire against each other and despite any participatory goals policy makers and providers may have they continue to be controlled, as is the global norm, by economic dictates. Land, for example, is one of the hottest issues for Chiapanecos (indigenous and mestizo) and increasing privatisation one of the thorniest problems [cf. Mattiace, 1997:47-8; Rich, 1997; Reyes Ramos, 1994]. Privatisation does not lend itself to participatory, inclusive, development approaches but rather has a tendency to further marginalise poor sections of rural society and drive many into the cities where they have few prospects.

Family planning policy in Mexico is essentially linked to economic policy as a tool for controlling the population growth rate. The Government is candid about its population goals and expansive in expounding the idea of individual liberty in its reproductive health and family planning goals. But here again we have the dual

rhetoric of an exclusive population control policy where the ultimate goal is to reduce population growth levels, and an inclusive family planning strategy which allows, in theory, for participation, individual control and empowerment. In practice, despite the new consensus that these two ideals can be encompassed within the remit of sustainable development goals, it remains difficult to fuse these approaches. In Mexico family planning policy continues to work from a top-down approach, as we have seen from the previous chapters concerned with providers and targeting issues. The policy is fed down to the providers who must work with it, regardless of local constraints, and who then seek to impose the policy through the targeting of the perceived client population.

There is little room for manoeuvre by or participation of locals here. The long history of domination between mestizos and indigenous populations continues to play its part in everyday mestizo-indigenous relationships. When family planning providers bemoan the influence (i.e. power) of men who will not allow their wives to contracept, or who despair that people are not interested in family planning “*por la cultura*”, because they are a backward and traditional people, they are conducting a discourse within the bounds of their own perceptions of local power structures concerning local organisation and politics, gender, ethnicity and culture. They want to achieve a change which will see local people complying with the “rightness” of family planning policy, because it is for their own good, rather than something which they negotiate and then accept or decline on their own conditions [cf. Thompson, in press].

Between the policy edicts and the grass-roots provision there are institutional factors to be taken into account of. Competition and power within and between government health organisations affect the workings of policy in different ways and at different levels. For example, the arrival of foreign journalists, UNFPA officials and senior health management staff from Mexico City turned the SSA hospital in San Cristóbal into a place of panic overnight. They arrived to discuss the problem of overpopulation in Chiapas and what was being done about it, causing a lot of stress amongst local staff. There was a lot of quiet chuntering amongst the staff concerning the fact that these people had no idea of the problems local staff had to face with

such a culturally diverse population and, moreover, dissatisfaction that Chiapas had been singled out as one of the states upon which to focus. Numerical targeting is a direct output of this international and central government gaze upon the area and its perceived population problems.

Getting rid of targeting of methods would go a long way to dissipating the hostility people display towards the promotion of family planning services. It might also even give the planners what they want: a wider acceptance of family planning services and increased use amongst rural populations when family planning ceases to be promulgated with such unrelenting force. It would certainly make people less suspicious about the government's ulterior motives in this area. It is likely to help providers too, not only in their relations with locals, whom they would feel less inclined to pressurise into contraceptive use, but also by the removal of the "*nota mala*" for failing to comply with targeting objectives.

"Drogas y Soldados No, Paz y Maíz Sí"³

It will take more than the removal of targeting practices to advance the goals of informed choice in reproductive health. Informed choice is a central tenet of policy rhetoric, seen to be a worthy goal from a western perspective, and connected to the globalisation of citizen's rights. But herein lies another problem. To return to the opening chapters of this thesis in thinking about individual rights and informed choice: what do these concepts mean to different people in different parts of the world? And, to have access to individual rights, what political and economic conditions, under whose criteria, have to be in place to nominally guarantee such rights? In Chiapas, the current crisis is concerned with contested rights: rights to land; rights to democratic participation in the state; rights to autonomous self-determination; rights to education, health provision and drinking water, to name but a few. In rural communities the right to "peace and maize" is proclaimed everywhere on roughly painted signs, as is the desire to be free of "drugs and soldiers", who, it is alleged, use the excuse of drug searches to harass indigenous villages. No rights of any kind can be guaranteed in a conflict situation, and suspicion is understandable

when certain rights are promulgated, viz. health and family planning rights, when other rights remain elusive and non-negotiable.

The globalisation of international relations and economic imperatives in some senses exacerbates this. Chiapas is rich in resources and there is great multinational interest in investing and developing in the area, though this is tempered by the continuing conflict. Whilst we talk about individual rights in relation to social policy, economic policy often erodes sovereign rights of individual countries who walk the tight rope between unstable and, I would argue, immoral international capital adventurism and the bondage of debt repayments. Who then becomes responsible for ensuring those individual rights to health, food, water and so on, amidst the chaos of poverty exacerbated in the pursuit of neoliberal economic goals? International development agencies often step in demanding poverty alleviation and sustainable economic development schemes that poorer countries can ill-afford and so the debt cycle becomes exacerbated as they borrow more to finance the debt, which in turn finances the development and anti-poverty strategies: a veritable black hole which no amount of donations ever seem able to fill.

Reproductive health services

Promoting the idea of an informed choice in family planning decision making assumes first and foremost that modern family planning methods are acceptable to one and all and yet, as we have seen, in Chiapas this is a moot point. This issue is further complicated by local conditions which are characterised by an unequal distribution of power vis-à-vis the state between mestizo and indigenous groups, and where mestizo providers ignore local fertility regulating practices and traditional medical knowledge. Not that such knowledge would be freely shared by all indigenous healers with their mestizo counterparts. Local knowledge is also a buffer against a dominating mestizo society and may be utilised, as is ethnicity, in the politicisation of cultural differences between the two in Chiapas [cf. Wright, 1998; Paine, 1985; Schwartz 1982].

Indigenous rights and struggle continue to be the dominant theme in headline news about Chiapas, inferring a stark divide between mestizo and indigenous society, the very conditions which gave way to the current conflict; an outcome perceived by many as a natural result of the historical process of domination and resistance there. Whilst it is undeniable that such a divide exists the processes of negotiation and social change within this scenario are many and varied. Many *coletos* spoke to me of the city becoming a place of residence for more and more indigenous people of various groups. There is an expressed fear about this on the part of many *coletos* who see the city boundaries extended to accommodate this migration and who perceive more and more indigenous people living within the city boundaries. A *coleta* perspective concerning the problems with the perceived Indianisation of San Cristóbal is illustrated by Gutiérrez [1996]. Within the city centre the market has extended with indigenous groups, formed into syndicates, invading private *coleta* land to put up market stalls. This has led to a heightened fear of the “other” with many complaining about the invasion and the consequences they perceive such as dirt and degradation of their area from market-place residue, and noise. Others are more concerned that indigenous people have been forced into making such moves through the hostility of the government and government supported groups in the countryside, including the increasing militarisation and privatisation of land in rural areas and the threat of violence from paramilitaries. This increased hotchpotch in the city gives rise not only to contested and interchangeable identities in the city but also harbours exchanges of information and ideas, and gives rural people access to hitherto inaccessible institutions. Of course problems remain in that institutions are primarily mestizo and many indigenous people continue to be reluctant to use them; but change happens slowly, and when one woman starts to claim maintenance through mestizo legal channels from her ex-husband, others become at least interested in the process and the outcome.

This is true also of the health services. Rural and urban people know that they can go to the Clínica del Campo in San Cristóbal to receive free treatment while they will be charged for most things at the SSA clinic. The use of these institutions remains dependent upon many things not least of which are perceptions of the way people are treated by staff in these places. Whilst the government, in providing free

services, seeks to offer help to the poorest in society, these same people will scrape together the money to see a traditional healer if they believe that this is the right course of action to take for their particular predicament, and depending on past treatment in the clinics. Many young women with no resources, for example, will give birth at the Clínica del Campo because it costs them nothing while the care of a *partera* within the city is very expensive. However, for lesser treatments these same women will vary their practices, going one time to a healer, another to a clinic, and sometimes to both for the same problem, or they may seek to cure themselves.

Self-curing is popular in Los Altos and this principle applies equally to menstrual regulation. A late period may mean pregnancy but it may mean a cold womb or an infection. Self-curing with herbs, injections and pills is a preferred option for many women rather than using contraceptives on a regular basis. Providers and policy-makers could learn something from this in their approach to reproductive health and family planning. Post-coital contraception, at least in the city, is a subject which could be raised positively though it may remain a huge problem with regard to affordability for the Mexican government. In a sense, the choice of contraceptive use of the nation, at least amongst the *población abierta*, remains tied to international concerns because the government relies on donations both monetary and material. For example, in 1996 the UK's ODA was part of a UNFPA support project which donated 2,500,000 cycles of oral contraceptives and 300,000 IUDs to the Mexican Government in order to "support the government of Mexico's target of reducing the fertility rate whilst promoting reproductive choice" [Personal communication, ODA, 1996]. Here again we find the dual concepts of population growth and reproductive choice. What is interesting to consider is the lack of contraceptive options, such as the diaphragm, a wider choice of IUDs and pills, and post-coital contraception. Possible explanations for this range from policy concerns about method acceptability to financial constraints which make individual choice dependent on wider national and international issues of funding and donation. The case of Depo Provera mentioned in Chapter 10 is a classic example. It had been the preferred contraceptive injection promoted in government health clinics until the donations dried up, to be replaced by Cyclofem (monthly contraceptive injection) and

Norethisterone (two-monthly contraceptive injection). Now similar problems are arising with a glut of Cyclofem and a dearth of Norethisterone, at least in Los Altos.

A final word on *choice*

Choice is not something which is determined only within the clinic walls. It is determined by government policy and government constraints (viz. lack of finances and dependency upon international agents). It is also determined by local practices and beliefs. As Appell says, choice is constrained but not determined by the system of morality in which the choice is made [1988:34]. Similarly, Belaunde discusses morality and interpersonal relations as being the core of fertility regulation practices in her study of the Airopai [1997:142-3]. This is something that providers would benefit from taking into account. Whilst they can see that often men make the decision, the choice, not to use contraceptive methods within their family setting, they often assume that, were it not for the man, the woman would choose to contracept. This is by no means a certainty. Another important aspect missed by providers in considering fertility regulation in Chiapas is that menstrual regulation is acceptable and so too is the use of natural methods of fertility regulation. In not encompassing these ideas both providers and policy makers are continuing to see fertility regulation as two incompatible entities: modern and desirable vs. traditional and backward. Instead they might better seek to incorporate the two in a holistic, complementary vision of fertility-regulating possibilities. Not to do so denies women and couples the choice of non-invasive methods, which they may prefer per se, or which they may prefer to interchange with modern methods given the space to discuss all possibilities in a positive environment.

¹ For example, through a PRA (Participatory Rural Appraisal) approach.

² There is no space here to address a general critical analyses of participatory approaches as outlined by Rew, 1996:17-18.

³ Drugs and Soldiers, No - Peace and Maize, Yes.

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GLOSSARY OF SPANISH AND MAYAN TERMS

alcalde	Elected mayor/official with political and/or religious duties
ama de casa	Housewife
bajar la regla	Bring on menstruation usually through taking herbs, pills or injections
barrio	Neighbourhood/area of town
bodega	Grain store
cabecera	Main town of each <i>municipio</i> and seat of religious, political and administrative powers
cabildo	Town hall (also <i>presidencia</i>)
cacique	Local indigenous leader
caldo	Broth
campesino	Peasant
cancuqueros	Inhabitants of Cancuc, a <i>municipio</i> of Los Altos
catequista	Catechist but with great responsibility as they often stand in for priests, taking services
chiapaneco/a	(Inhabitant) of the state of Chiapas
Chol	Indigenous Mayan group of Chiapas and their language
chu'lel	Maya belief that every person has a Chu'lel (animal spirit) with which their human soul has a symbiotic relationship
cinturón	Woven belt
coletto/a	Native of San Cristóbal
colonia	Small residential neighbourhood
curandero/a	Traditional healer

dialecto	Lit. dialect - used to indicate that someone speaks an indigenous language though in fact <i>idioma</i> (language) would be more appropriate
dra/doctora	Female doctor
ejido	System of communal land tenure in Mexico
enfermera/o titulada/o	Qualified nurse
encargado/a	Person in charge
guardias blancas	White guards - paramilitaries - often considered to be Priistas
gringo/a	Usually a white (non-Mexican) North American. In Los Altos any white foreigner.
Grupo de Mujeres	The Women's Group
jefe/a	Boss
jkaxlan	Derived from Castellano i.e. Spanish. (Spellings and pronunciation vary according to each Mayan language.) This is a pejorative term often used by indigenous people to describe someone of their kind who has become mestizoised and is no longer an <i>hombre verdadero</i>
ladino/a	Person of Spanish or Spanish-Indian decent
milpa	Cornfield
muchacha	Girl (used for maid)
hombres verdaderos	Term used by indigenous groups to signify those within their racial and cultural boundaries (lit. <i>real people</i> but refers to those of same beliefs, faith and race according to Mayan mythology)
huipil	Woven blouse usually with embroidery or bright weaving around the neck/chest/shoulders. Each area has its own distinctive design
localidad	Locality - small hamlet within municipal boundaries

Los Altos	The highland area of Chiapas
machismo	Masculine pride/power; assertion of this
maíz	Maize
mestizo/a	Person of mixed Spanish/Indigenous race
municipio	Administrative area with a geographical boundary of which the <i>cabecera</i> is the seat of local authority powers. The <i>municipio</i> also marks ethnic group boundaries - changes between or within groups which could be perceived through changes in costume, language and practices
nagua	Black wool woven wrap-around skirt worn by indigenous women
ocote	Pine needles (often used in religion ceremonies)
paraje	Hamlet
partera	Traditional midwife
pasante	Person who is in his or her year of social service before qualifying as a doctor
perredistas	PRD officials or supporters
planificación familiar	Family planning
pox [pr. <i>posh</i>]	Cane liquor
presidencia	Town hall (also <i>cabildo</i>) - seat of traditional indigenous local authority powers situated within the <i>cabecera</i> of a <i>municipio</i>
priístas	PRI officials or supporters
promotor/a	Health promoter usually elected by the local community and indigenous to it
pudor	Sense of shame
pueblo	Large village to small town, often used with particular reference to one's place of birth
pulsera	Woven bracelet

ranchero	Rancher
rebozo	Shawl
retiro	Withdrawal method
revestido/a	Indigenous person who has adopted western clothing. Often a derogatory term when used by non-revestido Indian
rezador	Lit. one who prays
salud reproductiva	Reproductive health
sirviente/a	Servant
tamales	Maize dough, mixed with lard and often bits of meat, wrapped in maize leaves and boiled until cooked through
temascal	Small sauna - made of wood with a space for hot bricks at the back.
tierra caliente	“hot lands” (i.e. lowland Chiapas)
tierra fría	“cold lands” (i.e. most of highland Chiapas)
tortilla	Flat, round corn bread
traje	(Style of) dress
Tzeltal	Indigenous Mayan group of Chiapas and their language
Tzotzil	Indigenous Mayan group of Chiapas and their language
unión libre	Lit. free union. Common law marriage
vergüenza	Embarrassment or shame
zócalo	Town or village square, traditionally a ceremonial centre for the indigenous people

List of Abbreviations

CIESAS Sureste	Centro de Investigaciones y Estudios Superiores en Antropología Social del Sureste (South Eastern Centre for Research and Higher Studies in Anthropology)
CPR	Contraceptive Prevalence Rate
CRIACH	Consejo de Representantes Indígenas de los Altos de Chiapas (Council of Indigenous Representatives of Los Altos)
CSRC	Centro de Salud Rural - Población Concentrada (Rural Health Centre with Concentrated Population)
CSRD	Centro de Salud Rural - Población Dispersa (Rural Health Centre with Dispersed Population)
CSU	Centro de Salud Urbano (Urban Health Centre)
DIF	Sistema Nacional para el Desarrollo Integral de la Familia (National System for the Integrated Development of the Family)
ECOSUR	El Colegio de La Frontera Sur (College of the Southern Border)
ENADID	Encuesta Nacional de la Dinámica Demográfica (National Demographic Survey)
EZLN	Ejército Zapatista de Liberación Nacional (Zapatista National Liberation Army)
FZLN	Frente Zapatista de Liberación Nacional (Zapatista National Liberation Front)
GATT	General Agreement on Tariffs and Trade
ICPD	International Conference on Population and Development
IMF	International Monetary Fund
IMSS	Instituto Mexicano del Seguro Social (The Mexican Department of Social Security)

IMSS-Solidaridad	Instituto Mexicano del Seguro Social-Solidaridad (The Mexican Department of Social Security non-contributory wing)
INEGI	Instituto Nacional de Estadística, Geografía e Informática. (National Institute of Statistics, Geography and Information Technology)
INI	Instituto Nacional Indigenista (National Indigenist Institute)
ISSSTE	Instituto de Seguridad y Servicios Sociales para los Trabajadores del Estado (Institute of Social Security for Public Sector Workers)
ISSTECH	Instituto de Seguridad Social para los Trabajadores del Estado de Chiapas (Institute of Social Security for Public Sector Workers in Chiapas)
LAM	Lactational Amenorrhea Method
NAFTA	North American Free Trade Association
NGO	Non-Governmental Organisation
OMIECH	Organización de Médicos Indígenas del estado de Chiapas (Organisation of Indigenous Doctors of Chiapas)
PAC	Programa de Ampliación de Cobertura (Programme for Increased [Health] Coverage)
PAN	Partido de Avanzamiento Nacional (Party of National Advancement)
PRD	Partido Revolucionario Democrático (Democratic Revolutionary Party)
PRI	Partido Revolucionario Institucional (Institutional Revolutionary Party)
PRONASOL	Programa Nacional de Solidaridad (National Solidarity Programme)
PRODUSSEP	Promoción de Servicio y Salud en Educación Popular (Promotion of Services and Health for Popular Education)
SSA	La Secretaría de Salud

(Mexican Ministry of Health)

TAP	Técnico en Atención Primaria (Technical Assistant in Primary Health)
TFR	Total Fertility Rate
UAS	Unidad Auxiliar de Salud (Auxiliary Health Unit)
UMF	Unidad Médica Familiar (Family Medical Unit)
UMM	Unidad Médica Móvil (Mobile Medical Unit)
UMR	Unidad Médica Rural (Rural Medical Unit)
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Children's Fund
WHO	World Health Organisation

APPENDIX I

USE AND TARGETING OF CONTRACEPTIVE METHODS

Table 1

Contraceptive Promotion. Target Figures for Government Health Units in Los Altos, 1996-7										
Locality	Organisation	Type of Unit	Annual Target	Monthly Target	Pill	Condoms	IUD	Injectables	Female Sterilisation	Vasectomy
Altamirano	IMSS-S	C-H	648	54	6	0	17	N/A**	30	1
Amatenango	IMSS-S	UMR	420	35	0	0	20	N/A	15	
Amatenango	DIF	Prom	142	n.d.	39	21	59	23	n.d.	n.d.
Chamula	IMSS-S	UMR	852	n.d.	360* (118)	0	360*	N/A	120*	12*
Chamula	DIF	Prom	155	n.d.	50	50	5	50	n.d.	n.d.
Chanal	DIF	Prom	115	n.d.	50	40	5	20	n.d.	n.d.
Chalchihuitán	IMSS-S	UMR	300	25	5	0	5	5	5 (30)	5 (2)
Chalchihuitán	DIF	Prom	95	n.d.	20	60	5	10	n.d.	n.d.
Chenalhó	SSA	CSR-D	300	n.d.	-	-	-	-	-	-
Chenalhó	DIF	Prom	270	n.d.	80	100	10	80	n.d.	n.d.
Huixtán	IMSS-S	UMR	36	3	n.d.	0	n.d.	N/A	n.d. (15)	n.d. 2
Huixtán	DIF	Prom	375	n.d.	85	200	30	60	n.d.	n.d.
Larráinzar	DIF	Prom	100	n.d.	60	40	0	0	n.d.	n.d.
Las Rosas	DIF	Prom	205	n.d.	55	80	10	60	n.d.	n.d.
Mitontic	DIF	Prom	165	n.d.	80	100	25	60	n.d.	n.d.
Oxchuc	SSA	CSU	80	n.d.					(153)	(0)
Oxchuc	IMSS-S	UMR	96	8	3	0	3	N/A	2 (58)	0 (0)
Oxchuc	DIF	Prom	240	n.d.	80	100	50	10	n.d.	n.d.
Pantelhó	IMSS-S	UMR	216	18	4	0	6	4	4	0
Pantelhó	DIF	Prom	400	n.d.	160	120	20	100	n.d.	n.d.
San Cristóbal	DIF	Prom	185	n.d.	50	100	10	25	n.d.	n.d.
San Juan Cancuc	DIF	Prom	542	n.d.	202	160	80	100	n.d.	n.d.
Tenejapa	IMSS-S	UMR	36	3	0	0	3	N/A	n.d. (110)	n.d. (1)
Tenejapa	DIF	Prom	211	n.d.	100	50	11	50	n.d.	n.d.
Teopisca	SSA	CSU	492	41	10	10	10	10	1 (247)	0 (1)
Teopisca	DIF	Prom	140	n.d.	50	55	10	25	n.d.	n.d.
Zinacantán	DIF	Prom	190	n.d.	50	100	10	30	n.d.	n.d.
Zinacantán	IMSS-S	UMR	612	51	20	0	20	N/A	10 (0)	1 (0)

Source: Interviews with clinic staff, Los Altos, Chiapas, 1996-7

*Only annual data available

** IMSS-S units generally do not prescribe injectable contraceptives, though there are a few exceptions to this

Prom = Promotion only

(x) = total active users

Table 2

Combined Annual Target Figures for Government Health Units in Los Altos, 1996 as illustrated in Table 1										
Locality	Women of Fertile Age*	Annual Target incl. Condoms	Annual Target excl. Condoms	Annual Target excl. Condoms as % of Women of Fertile Age	Pill	Condoms	IUD	Injectables	Female Sterilisation	Vasectomy
Altamirano	3718	648	648	17.4	72	0	204	N/A	360	12
Amatenango	1389	562	541	38.9	39	21	299	23	180	0
Chamula	12280	1007	957	7.8	41 0	50	365	50	120	12
Chanal	1390	115	75	5.4	50	40	5	20	n.d.	n.d.
Chalchihuitán	1938	395	335	17.3	80	60	65	70	60	60
Chenalhó	6434	570	470	7.3		100 (DIF)				
Huixtán	3932	806	606	15.4		200 (DIF)				
Larráinzar	3106	100	60	1.9	60	40	0	0	n.d.	n.d.
Las Rosas	3946	205	125	3.2	55	80	10	60	n.d.	n.d.
Mitontic	1284	265	165	12.9	80	100	25	60	n.d.	n.d.
Oxchuc	7408	416	316	4.3		100 DIF				
Pantelhó	2907	616	496	17.1	20 8	120	92	148	48	
San Cristóbal	23570	185	85	0.4	50	100	10	25	n.d.	n.d.
San Juan Cancuc	4445	542	382	8.6	20 2	160	80	100	n.d.	n.d.
Tenejapa	5869	247	197	3.4	10 0	50	47	50		
Teopisca	4162	632	457	10.9	17 0	175	130	145	12	
Zinacantan	5248	802	702	13.4	29 0	100	250	30	120	12

Source: Interviews with clinic staff, Los Altos, Chiapas, 1996-7

*Calculated from INEGI, 1991 for Women of Fertile Age.

The data in table 2 are underestimated, including all of DIF's stated targets but only a few figures for IMSS and the SSA. Also, the figures relate only to *cabeceras* not *municipios* as represented by numbers of women of fertile age in 1991, figures for 1996 not being available when I left. However, they serve to give an idea of targets in relation to the numbers of women of fertile age in each *municipio*.

Tables 3 and 4 below show new or active users in government health units. Table 3 shows all data collected during interviews in an effort to give an idea of contraceptive use whilst table 4 gives only data available for the year 1996 so that the figures can be compared with numbers of women of fertile age in each *municipio*.

Table 3

New or Active Users, Government Health Units in Los Altos - 1996-7									
Locality	Organisation	Time Span	Total	Pill	Condoms	IUD	Injectables	Female Sterilisation	Vasectomy
Altamirano	IMSS-S	1996	597	166	n.d.	108	N/A	313	10
Amatenango	IMSS-S	1 month	30	16	3	6	N/A	5	0
Amatenango	DIF	1996	77	41	0	16	20	n.d.	n.d.
Chalchihuitán	IMSS-S	1996	127	50	n.d.	32	13	30	2
Chalchihuitán	DIF	1996	30	30	0	0	0	n.d.	n.d.
Chamula	DIF	1996	57	50	0	5	2	n.d.	n.d.
Chanal	SSA	1 month	89	26	18	6	33	6	0
Chanal	DIF	1996	145	50	60	5	30	n.d.	n.d.
Chenalhó	SSA	1 month	138	34	3	3	50	48	-
Chenalhó	DIF	1996	150	20	100	10	20	n.d.	n.d.
El Niz	IMSS-S	1996	4	3	n.d.	1	N/A	0	0
Huixtán	IMSS-S	6 months	92	50	2	36	4	0	0
Huixtán	DIF	1996	195	85	50	20	40	n.d.	n.d.
Larráinzar	SSA	1996	108	n.d.	n.d.	n.d.	n.d.	n.d.	n.d.
Larráinzar	DIF	1996	70	40	30	0	0	n.d.	n.d.
Las Rosas	SSA	1 month		16	161	13	61	2	0
Las Rosas	DIF	1996	220	60	20	30	110	n.d.	n.d.
Mesbiljá	SSA	1996	67	0	1	3	13	50	0
Mitontic	DIF	1996	265	80	100	25	60	n.d.	n.d.
Navenchaut	SSA	1996	71	24	n.d.	0	42	5	0
Oxchuc	SSA	1 month	113	26	17	32	38	0	0
Oxchuc	IMSS-S	1996	171	30	30	23	30	58	0
Oxchuc	DIF	1996	180	25	100	5	50	n.d.	n.d.
Pantelhó	IMSS-S	1 month	15	4	n.d.	4	3	4	0
Pantelhó	DIF	1996	359	160	120	20	50	n.d.	n.d.
San Cristóbal	ISSTE	1 month	100	51	16	19	0	14	0
San Cristóbal	IMSS-S	1 month	225	46	n.d.	70	N/A	106	3
San Cristóbal	IMSS-O	1996	768	51	326	68	N/A	304	19
San Cristóbal	SSA	1996	891	100	96	283	159	97	156 (2 yrs)
San Cristóbal	DIF	1996	125	0	100	0	25	n.d.	n.d.
San Juan Cancuc	IMSS-S	1996	54	20	n.d.	2	N/A	30	2
San Juan Cancuc	DIF	1996	660	400	100	20	40	n.d.	n.d.
Tenejapa	IMSS-S	1996	147	n.d.	n.d.	36	N/A	110	1
Tenejapa	DIF	1996	80	20	40	9	11	n.d.	n.d.
Teopisca	SSA	1 month	1339	581	269	243	232	14	0
Teopisca	DIF	1996	115	50	45	10	10	n.d.	n.d.
Zinacantán	DIF	1996	140	50	50	10	30	n.d.	n.d.
Zinacantán	IMSS-S	1 month	12	5	n.d.	7	0	0	0

Source: Interviews with clinic staff, Los Altos, Chiapas, 1996-7

Most of the figures represent contraceptive consultations for the month prior to the interview (June 1996-June 1997). Others represent the total active users for the year 1996, and one for the preceding six months. Numbers of active users are clearly low.

Table 4

Active Users amongst Government Health Units Serving the Uninsured Population, Los Altos 1996											
Locality	Women of Fertile Age (1991)	Organisation	Total incl. Condoms	Total excl. Condoms	Annual Users excl. Condoms as % of Women of Fertile Age	Pill	Condoms	IUD	Injectables	Female Sterilisation	Vasectomy
Altamirano	3718	IMSS-S	597	597	16.1	166	n.d.	108	N/A	313	10
Amatenango	1389	DIF	77	77	5.5	41	0	16	20	n.d.	n.d.
Chalchihuitán	1938	IMSS/DIF	157	157	8.1	80		32	13	30	2
Chamula	12280	DIF	57	57	0.5	50	0	5	2	n.d.	n.d.
Chanal	1390	DIF	145	85	6.1	50	60	5	30	n.d.	n.d.
Chenalhó	6434	DIF	150	50	0.8	20	100	10	20	n.d.	n.d.
Huixtán	3932	DIF	195	145	3.7	85	50	20	40	n.d.	n.d.
Larráinzar	3106	SSA/DIF	178	148	4.8	40	30	0	0	n.d.	n.d.
Las Rosas	3946	DIF	220	200	5.1	60	20	30	110	n.d.	n.d.
Mitontic	1284	DIF	265	165	12.9	80	100	25	60	n.d.	n.d.
Oxchuc	7408	IMSS/DIF	351	221		55	130	28	80	58	0
Mesbiljá		SSA	67	66		0	1	3	13	50	0
		Combined	418	287	3.8	55	131	31	93	108	0
		Total									
Pantelhó	2907	DIF	359	239	8.2	160	120	20	50	n.d.	n.d.
San Cristóbal	23570	SSA/DIF	1016	820	3.8	100	196	283	184	97	156
San Juan Cancuc	4445	IMSS/DIF	614	514	11.6	420	100	22	40	30	2
Tenejapa	5869	IMSS/DIF	227	187	3.2	20	40	45	11	110	1
Teopisca	4162	DIF	115	70	1.7	50	45	10	10	n.d.	n.d.
Zinacantán	5248	DIF	140	90		50	50	10	30	n.d.	n.d.
Navenchauc		SSA	71	71		24	n.d.	0	42	5	0
		Combined	211	161	3.1	74	50	10	72	5	0
		Total									
TOTALS	93026		5001	3959		1551	1042	672	755	693	171*

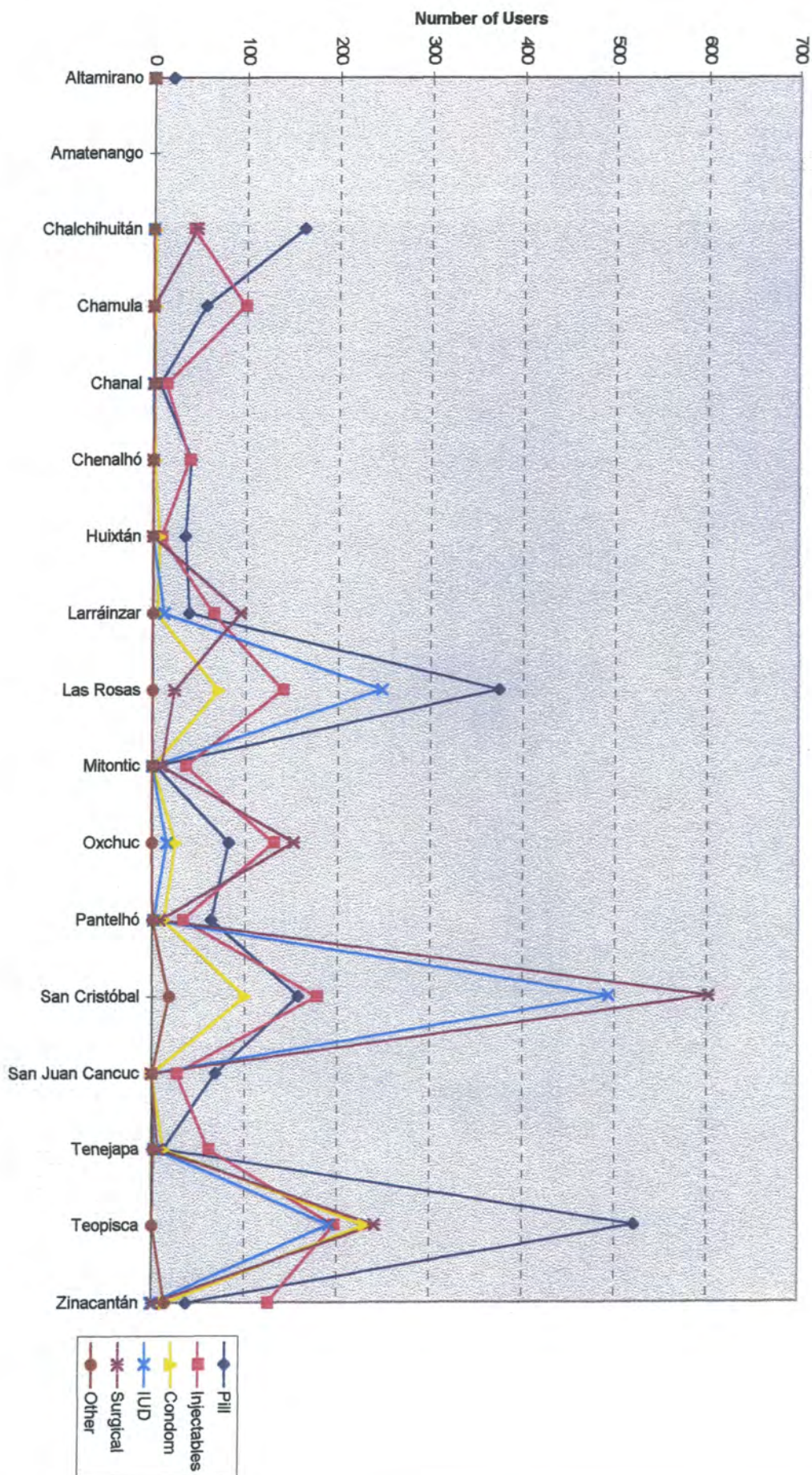
Source: Interviews with clinic staff, Los Altos, Chiapas, 1996-7

* Vasectomy figures for San Cristóbal are over two years - unfortunately I could not obtain a breakdown over 1995/1996. This highly inflates the numbers relevant to 1996. The figure surprised me given the apparent lack of success of *jornadas*. In October 1996, after a major promotional campaign throughout the 17 *municipios* of Los Altos, representing a male population of the age of 20 and over of 81,879 (calculated from INEGI, 1991), three men came forward for the operation.

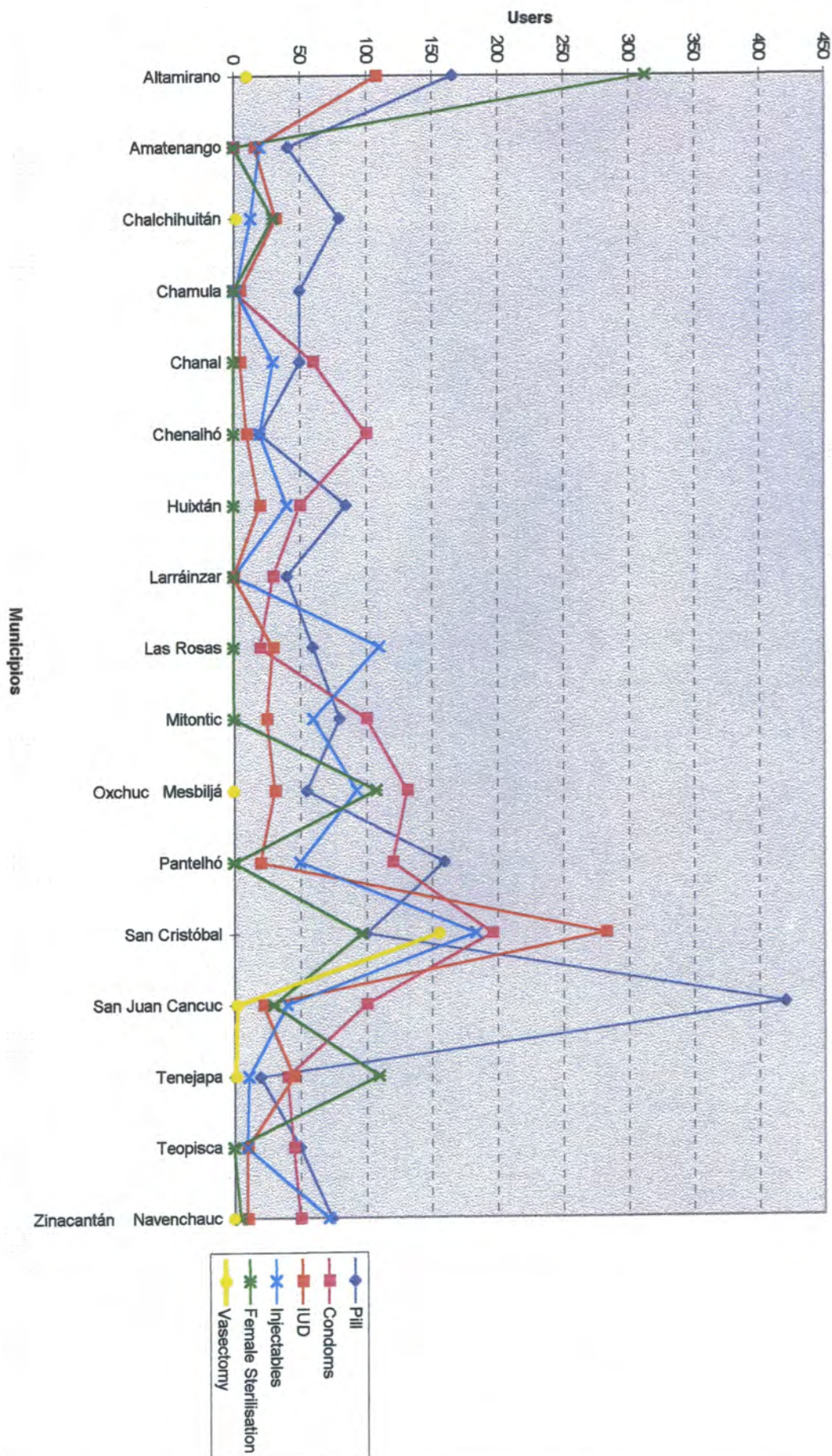
Of all those interviewed only units able to provide figures for the whole year of 1996 have been included here, which means again that there is some underestimation of users. The figures for women of fertile age are at *municipio* level whilst those for users only relate to the *cabecera* or locality of the clinic. However, contraceptive use outside of *cabeceras* is believed to be low to non-existent.

APPENDIX II

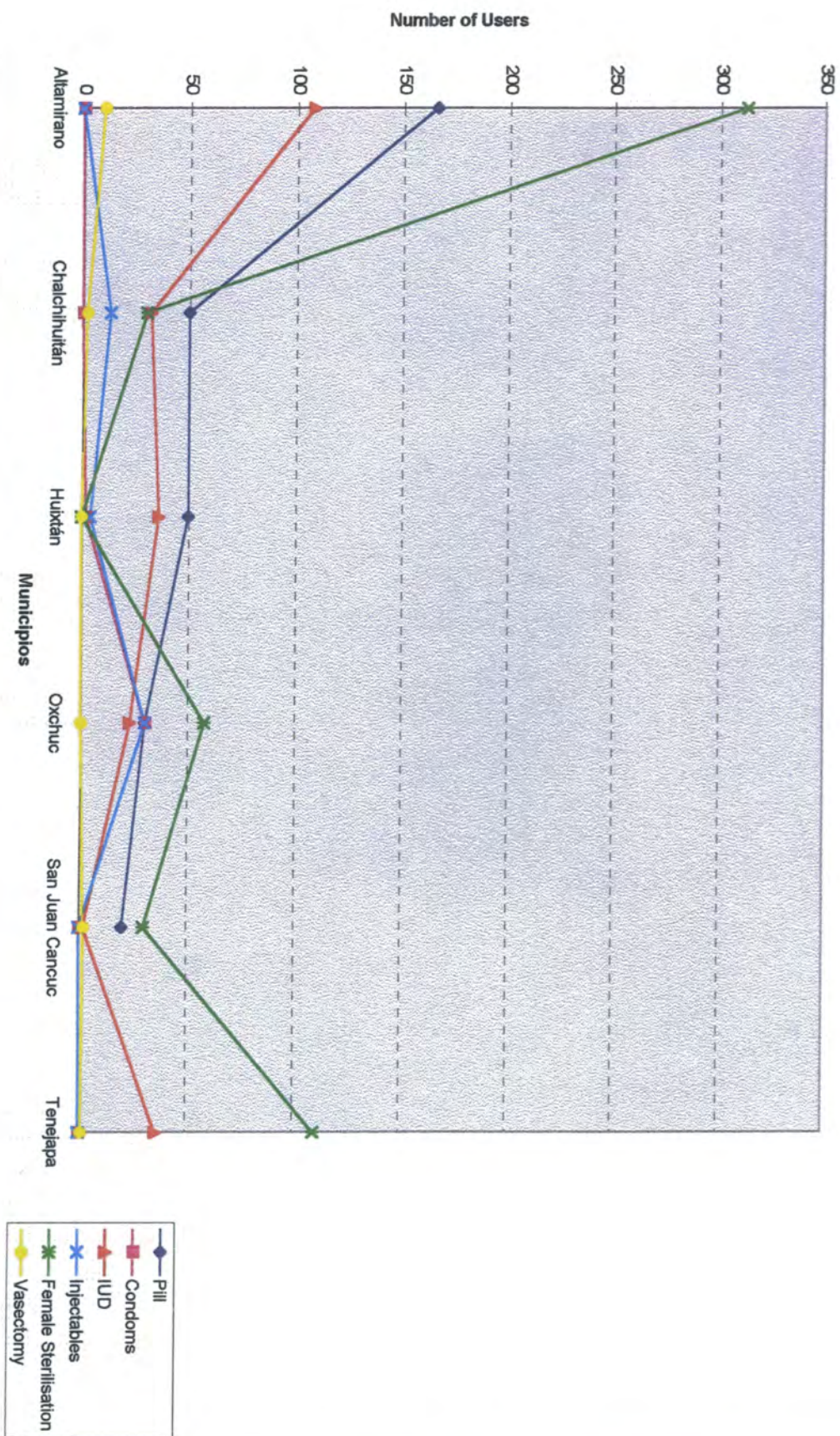
SSA Los Altos - Active Contraceptive Users, 1995



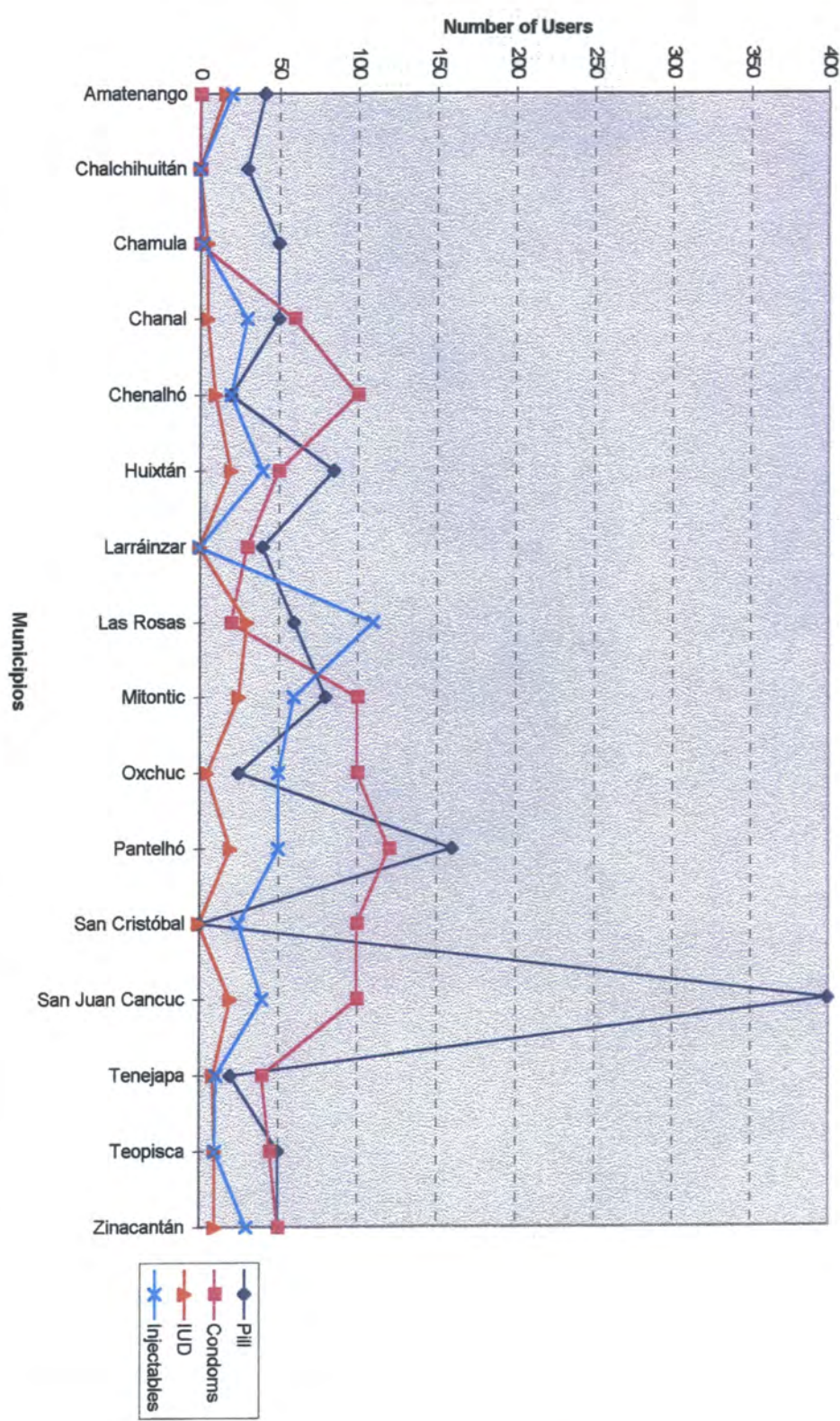
Contraceptive Use in Los Altos, 1996



IMSS Los Altos, Active Contraceptive Users, 1996 (Selected Areas)



DIF Los Altos, Active Contraceptive Users, 1996



SSA Reproductive Health Programme, Los Altos 1991-1995
Contraceptive Coverage: Targets and Users

