

“WITHOUT MONEY YOU’RE NOTHING”: POVERTY AND HEALTH IN MEXICO FROM WOMEN’S PERSPECTIVE

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The objective of this qualitative study was to get to know poor Mexican women’s experience of poverty in relation to health care. Forty-nine interviews were carried out with poor adult women in Mexico (between 35 and 65 years old). Three central elements were detected in relation to the women’s experience of poverty and health care: their socio-economic dependence on their family; the notion of social belonging in their experience with health care rights, reflected in the idea and acceptance that, due to their poverty, they can only be attended at philanthropic institutions; and the existence of survival mechanisms when facing an illness. In recovering the experience of poor women in relation to their health care, we identified that there is a clear idea that, if women had had economic resources, their health problem would have been solved differently. They are also convinced that, due to being poor, they have to content themselves with bad-quality medical care. This conformity finally makes them resign to the fact of either losing a part of their own body, or even just waiting for death.

DESCRIPTORS: women; health; poverty; survival

“SIN DINERO NO ERES NADA”: POBREZA Y SALUD EN MÉXICO DESDE LA PERSPECTIVA DE LAS MUJERES

El objetivo del presente trabajo fue conocer la vivencia de la pobreza en relación al cuidado y atención de la salud en el caso de mujeres pobres mexicanas. Se desarrolló una investigación cualitativa que se llevó a cabo en México. Se realizaron y analizaron cuarenta entrevistas que se aplicaron a mujeres entre 35 y 65 años de edad. Se detectaron tres elementos centrales con relación a la vivencia de la pobreza y el cuidado y atención de la salud: la dependencia socioeconómica hacia su familia; la noción de una pertenencia social en la vivencia de los derechos de atención a la salud que se refleja en la consideración y aceptación de que a ellas debido a su condición de pobreza sólo les corresponde ser atendidas en las instituciones de beneficencia pública; y la existencia de mecanismos de supervivencia frente a un evento de enfermedad. Al recuperar la experiencia de las mujeres pobres en su cuidado de salud se identificó lo siguiente: existe una clara idea de que si se hubiera contado con recursos económicos suficientes su problema de salud se hubiera resuelto de otra manera; también se tiene la convicción de que por ser pobres deben conformarse con una mala atención médica y, esta conformidad provoca que, finalmente, se resignen al hecho de, o bien perder una parte de su cuerpo, o, inclusive, a esperar la muerte.

DESCRIPTORES: mujeres; salud; pobreza; supervivencia

“SEM DINHEIRO VOCÊ NÃO É NADA”: POBREZA E SAÚDE NO MÉXICO A PARTIR DA PERSPECTIVA DAS MULHERES

O objetivo do presente trabalho foi conhecer a vivência da pobreza em relação à assistência à saúde no caso de mulheres pobres mexicanas. Desenvolveu-se uma pesquisa qualitativa no México, realizando 40 entrevistas com mulheres entre 35 e 65 anos de idade. Detectaram-se três elementos centrais a respeito da vivência da pobreza e da assistência à saúde: a dependência socioeconômica para com a família; a noção de uma pertença social na vivência dos direitos de atenção à saúde, que se reflete na consideração e aceitação de que, devido a sua condição, somente podem ser atendidas em instituições filantrópicas; e a existência de mecanismos de sobrevivência diante de um evento de doença. Ao recuperar a experiência das mulheres pobres com relação à assistência à saúde, identificou-se que existe uma idéia clara de que, se tivessem contado com recursos econômicos suficientes, seus problemas de saúde teriam sido resolvidos de outra maneira. Também têm a convicção de que, por serem pobres, devem se conformar com uma atenção médica de má qualidade, e esta conformidade finalmente provoca sua resignação com o fato de perderem uma parte dos seus corpos, ou ainda mais esperarem a chegada da morte.

DESCRIPTORES: mulher, saúde, pobreza, sobrevivência

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INTRODUCTION

Women constitute a little more than half the world's population. However, in spite of efforts carried out in past decades, in general, women live under conditions of inequality and with fewer opportunities. Therefore, poverty* continues to be more acute in the case of women, who represent the greater percentage of the world's population living in absolute poverty. Some world-wide data show that 70% of the people that live in conditions of extreme poverty are women and that 2/3 of them are illiterate⁽¹⁾. In the rural areas, more than 550 million women live in poverty (more than 50% of the world's rural population). Two-thirds of the 1000 million illiterate adults in the world are women and a third of the homes are headed by a woman. As far as employment, all regions of the world demonstrate a greater rate of unemployment among the women than the men and in Latin America and the Caribbean, between 7 and 11% of the total beneficiaries of credit are women⁽²⁾.

Many women authors point out that poverty and inequality acquire different modalities when they are analyzed from the perspective of gender. Therefore, the population that lives in impoverished conditions is the principal victim of chronic illness and infections and have the lowest levels of health and the greatest indices of healthy life years lost⁽³⁻⁴⁾. But, when one analyzes the problem according to gender, it is observed that feminine poverty is a far reaching phenomena that affects men as much as women and that has repercussions for the whole family in terms of health care and services.

In the specific case of Mexico, recent data indicate that there are a total of 40.7 million poor and 22 million extremely poor people⁽⁵⁾. The data also indicate that as of 1992, the rural poor have been increasing from 2.7 to 3.4 times more than when compared with the urban areas in 2000. In addition, the indicators associated with poverty and marginality suggest more precarious conditions in the specific case of women; in relation to the illiterate population 15 years of age and older, it is observed that 7.4 % are men vs. 11.3 women; in relation to economics: 70.3 % of men vs. 29.9 % of women participate in some form of income generation⁽⁶⁾.

Various studies⁽⁷⁻⁸⁾ with a feminist perspective

have focused on giving visibility to the socially disadvantageous conditions that characterize a wide number of situations which women have experienced, among others, those related to poverty, inequality and health. As a result, gender inequities are manifested in diverse aspects: the division of work between the sexes, the lack of opportunities for education and employment, the prevalence of lower levels of well-being and health, the limited participation socially and in family decisions, which limits personal autonomy. These inequalities generate a series of disadvantages for women that are interconnected with other social asymmetries, ethnic or intergenerational, that expose them and make them more vulnerable to situations characterized by limitations and poverty.

Feminism and socio-structural analysis are fundamental tools to be able to understand the health of "poor women". The premise of these perspectives is that the underlying structure in society has produced a system of stratification that presents enormous inequalities in women's life options. This inequality has effects on the health of poor women as far as their behavior, morbidity and mortality and access to health care services. For an adequate concept of health in poor women, it is necessary to go deeper in the analysis of the health situation, into the social context within which it occurs, taking into account the position of poor women in society, the communities in which they live and the stressful events in their lives. The socio-structural analysis emphasizes that, currently, as a consequence of an economic model that widens social differences, one can observe what is called the polarization of wealth: few rich and many poor⁽⁹⁾. This situation, specifically in the case of women, has been reported mainly in quantitative studies⁽¹⁰⁾, without exploring the daily dimension of how women live and experience poverty and the health-illness condition.

Therefore, the objective of this study was to become familiar with poor Mexican women's experience of poverty in relation to health care.

METHODOLOGY

We used a qualitative design to explore and describe the Mexican women's experience of poverty

* Poverty has been defined as "the incapacity to reach a minimum level of living or to buy the minimum amount of goods and services required to satisfy basic needs; the poor are those who fall within this minimum level or line of poverty" (Pan American Health Organization 1992, p. 7)

in relation to health care. Qualitative data were obtained using taped semi structured interviews. We analyzed the qualitative data in Spanish through grounded theory procedures and techniques⁽¹¹⁻¹³⁾.

Participants

The unit of analysis of this study were adult women (ranging in age from 25 to 65 years old) users and non-users of health services. Were 49 women interviewed, five belonged to the 25 to 29 year old age group, four to the 30-34 year old age group, 15 to the 35 to 49 year old age group, nine to the 40 to 44 year old group, five to the 45 to 49 year old group, four to the 50 to 54 year old group, four to the 55 to 59 year old group and three were older than 60 years of age. With respect to place of residence: 15 women were from the southern region, 11 were from the northern region, six were from the central region, and eight were from the region considered to be highly marginalized.

Procedures

Health services in Mexico are organized as follows: the social security ones, which include that population who has a formal job and the open population services which attend the population who doesn't have a formal job and has no social security. This last case was the target population for this research. An analysis was made of the database that corresponds to the National Health Survey ("Encuesta Nacional de Salud" or "ENSA II") in Mexico*, which was carried out in 1994. A fundamental component of the survey was the inclusion of a qualitative component.

The total federal states were grouped into five study regions: Metropolitan Zone, Central, North, Southeast and the Gulf. In total, 192 in-depth interviews were carried out with five groups from within the population: a) sick persons who received medical care, b) sick persons who did not receive medical care, c) persons who were not sick and received medical care (e.g. vaccines, family planning,

birth control, early cancer detection and screening etc.) and, d) chronically sick women. Of all the interviews carried out (192), only 49 corresponded to women between the ages of 25 and 65.

The interviews contained the following themes: 1) Notion and perception of health and illness, 2) Sick women's career 3) Perception of health services and the economy of health, 4) Hospitalization. Each one of the themes investigated specific characteristics of three types of users, a sick woman who did or did not receive care, non-sick user, a chronically sick woman.

Data analysis

The proposal was approved by the Ethics Committee of the National Institute of Public Health. The interviews were taped with the approval of all those interviewed. They were transcribed, coded and processed using the program Ethnograph 4.0. The information was organized using the following codes: Care to others, Private arena, Public arena, Socioeconomic factors, Gender, Support Networks as to allow for the identification of other codes that emerged during the analysis. The emerging code was "feeling poor", which was defined as the fact of considering that in due of the social status the women only have right to one kind of health care: public, not enough and of bad quality.

Scientific adequacy

We used several strategies in the study to address qualitative rigor: credibility, dependability, confirmability, transferability⁽¹⁴⁾. Specifically, We used the following strategies: (a) verbatim transcription of audiotape recordings; (b) detailed observational notes included in the data analysis; (c) documentation of personal feelings and emotions and reactions included in the data analysis and coding; (d) documentation on authors own behavior and experiences in relation to the informant's experiences (e) feedback from women of a shared experience after the results were presented (f) our long-term commitment to working

* For this component, the methodological strategy that was developed was the following: to restrict the qualitative study to the urban areas and within them, middle and lower socioeconomic sectors. The urban centers selected from the four regions were: Chihuahua and Saltillo, from the northern region; Aguascalientes and Morelia, from the central region; Mérida and Veracruz, from the southern region; Chilpancingo and Pachuca, from the PASSPA region; these letters form the acronym for the program Health Services Support for the General Population ("Apoyo a los Servicios de Salud para la Población Abierta") which began in 1994 and which was made up of the following federal entities: Hidalgo Oaxaca, Guerrero, and Chiapas. (For more information you can consult: Bronfman PM et al. National Health Survey II. Qualitative Study regarding the determinant and modalities for the use of health services. Research notebook No. 5. PASSPA. November 1994;5-23)

with women's groups in impoverished areas of Mexico and to the field of gender aware personal empowerment.

RESULTS

Based on the analysis of the reading and codifying of the interviews, three elements were clearly identified in the way in which the women who were interviewed experienced health in poverty: social dependence on their family, the notion of social belonging -from poverty- in their experience with health care rights, and the development of different strategies to survive illness.

Social dependence

A form of social inequality for women of this age and especially women over 50 years of age is the economic dependence on their spouses and their children. Nine out of the 14 women in this study live in this situation, six of whom live in a region considered to be highly marginalized. If the spouses or children are unemployed, the family income diminishes, the quality of life for the whole family is affected and therefore, they have problems related to access to health care or healing. A woman, shares her experience:

Now unfortunately, my husband, when he can work, he works, and when he can't, he doesn't... because since we are old now, see how they don't give work to old people as they like no? when there is work, ok, but when there isn't, no. That is why I haven't gone to the doctor now. [Because you didn't have {the means}?] Yes, because I haven't had {the means} (Interview 215).

The poverty situation is also manifested in the dependence on one's children for access to health care, the following testimony is an example:

No, now my children are giving me money, the son that works, I tell you, he is giving me a little bit, he is helping me, when they pay him he gives me 200 [pesos] every 15 days, that is what I use for medicines. Where can I take [money], because what if I acquire debt, where will I get the money so that I can replace that money, you see, now a good amount of money is needed. (Interview 235).

Dependency on their children for health care becomes a central worry in the life of the women:

Well, that is what I often think, the day that I am very ill and don't have insurance, where will I go? Well, I do think that

because now the only son that supports us is the 20 year old son, he is the only one that helps us and this I tell you is to think about, but, well God is great and God will know... (Interview 164).

The central point is how to resolve the illness event –an urgency or unexpected event -, and how to strengthen health. These women don't like the fact that they depend on their spouses or children. They don't want to be an economic burden to others, they don't feel they have the right to ask for money for their health care consults needs.

Notion of social belonging -from poverty- and experience of health care rights

Another one of the factors which was clearly identified in the interviews is the concept that the women give to health care in relation to poverty. The women consider that there is a specific health care that corresponds to the poor; these may be the social security services, the services for the general population which the Secretary of Health provide, Family Health Services (Centros de Desarrollo Integral de la Familia, or "DIF") and the Red Cross. Poor women come to think that given their impoverished conditions, only certain types of services are for them. They internalize belonging to a certain social class, as a consequence, they automatically place themselves in certain arenas. This is expressed by a woman, in the following way:

Well, you can see that when one is poor, one always goes to the Red Cross because it is the main provider because that is what one as a poor person does (Interview 234).

This perception that there is a specific place for them because they are poor is accompanied by a series of inconveniences and barriers in the care and attention to their health: not having money to pay for a specialist or to simply see a general physician; not to be able to have a surgical intervention; not to be able to maintain a special diet; not to be able to have money to buy medicine or special treatment; not to be able to carry out continuous treatment, not to be able to be attended to immediately. This situation is expressed in the following testimony:

No, well I say, about one's economic state, well if [you go] to a health center, because if you had, well you would go to a private one and quick, they would attend to you and everything. Never, for that reason he is as he is, because I know for sure if I was being treated by a doctor or a specialist they would have operated on me immediately, they would have done X but with

money, because without money you're nothing (Interview 248).

Purchasing power is central for the women so that they can access health services that they consider to be good quality.

From the social perspective, social services are considered to exist for people of few resources and to be the way to resolve their health problems. The problem is that it is not sufficient to offer care because the people do not have resources to buy medicine or better to pay for their transportation, and much less for their diets or special care, the following experience confirms this:

Your illness is in a critical phase, such that you can no longer support yourself on your own feet and tend to fall, and for that reason you approached the health center and they have been seeing you but at times, for economic reasons, you don't go, or you don't buy the medicine, it is then when you resort to ointments or unguents (Interview 41).

Quality of care is another aspect which is linked to the social notion of what corresponds to being poor. The women know that a world of health care exists which does not belong to them, this sense of being distant and not belonging is taken to absurd levels:

Well, I didn't tend to myself for that reason, for lack of money, because if I had had money, of course I would have been attended to by a private physician and as my sister did, my sister, well everything was through a private physician, until I think that best that I didn't have the need to have my breast removed, I say no and they removed it, but that's the way it is, so it is, not even crying is good. If I had had a way to pay for a specialist, or to pay for some studies, if I had done it..., because to lose a piece of your body hurts a lot, we suppose that there is no pain once you are calming down, but to remain like that, it embarrasses me to walk around like that, I can't even put on a bra (Interview 23).

Among the poor, the sensation of normality with respect to health care rights which corresponds to them because they belong to a certain social class, form part of an ideology of submissive/passive acceptance. The women also observe that there is an inaccessible world for their care because they know that alternative medicines exist that could help them find relief from their health ailments but they cannot access them because they are not economically solvent.

These experiences of inaccessibility to health care, can reach such a level, that they are lived with a certain sense of conformity, while waiting for death. The following testimony is an example of knowing

that one day death will finally come because women can't receive care for their illness:

Look, when I am walking around with my abdomen swollen, at times I think to myself, oh my God!, if at any moment I'm going to bust because an infection in my abdomen, an ulcer, the bile, the gall bladder, I tell you that I am going to die, well what do I? (Interview 227).

The women live in extreme situations which are associated with access to medical care, their discourse constantly refers to the lack of economic resources to be able to take care of themselves, or their family, the following testimony confirms this:

Yes, because there isn't any money; we have the case of my brother. [What does he have ?] We don't know, because there isn't any money. We haven't been able to take him to a doctor. We treat him with what we can, nothing more. It must be about a month and a half since he arrived, but now nothing else, he just lays there, like he doesn't have any defenses. [Did they inject him with vitamins ?] The truth is that sometimes we don't have money for the appointment (Interview 19).

Poor women entrust the final decision about their health in their religious faith and divine help, as a last resort. Several testimonies associate poverty and God's help as their recourse; the following succinctly expresses the relationship between poverty, waiting for death and divine help:

That is why, it is better that we get smart, because without the help of the Social Security or anything, and without money, well, if we get sick, there, we are left only with the help of God. If the person gets up, good; if not, well, that's the way it is (Interview 74).

Life or death in poverty become elements of daily life. The following scheme summarizes that which has been explained in the previous paragraphs.

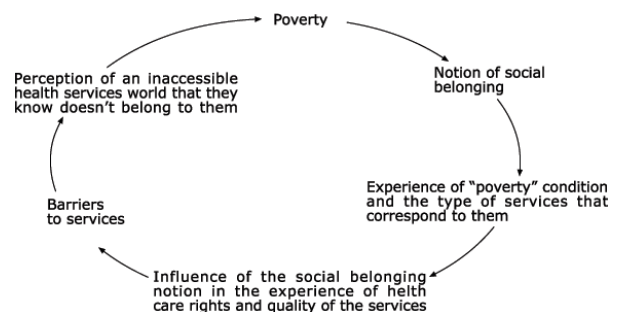


Figure 1 – Perception of adult women of the social world in health services: a cyclical perspective on how poverty reproduces itself

Survival strategies for illness

When women and/or their families don't have

the economic resources to pay for the medical care or attention they need, they develop mechanisms and strategies to overcome the poverty situation and health care and they approach their social network to obtain the economic and moral support of the parents of their godchildren ("compadres"), their godparents, brothers, sisters, parents, friends. Besides, loans are another mechanism to solve their illness-related problems, to pay with interest, signing credit documents or seeking loans from relatives are common strategies in these sectors of the population. The following testimony is an example:

Yes, to him also, the administration of the DIF [social services agency] helped us, they gave us the medicine for him, because we didn't have anything to care for him with. Well my husband asked for money. [Who did he ask?] A man... for a loan, with interest - he charged us ten percent (Interview 74).

These loans can pay for hospitalization costs, consults, the purchase of medicines and even food, the following testimony confirms this:

Well, since one is always asking, due that you don't have for food or anything, well, you approach those who have and he did us the favor of lending us money (Interview 230).

Other resources used, are the pawning of properties and the sale of animals:

At times we have gone into debt, we pawn what we have, we have sold one or two farm animals (pigs), we ask the whole family (Interview 158).

When poverty is manifested next to a health problem, an increase in economic expenses is supposed, a situation that increases the economic crisis of the families. As has been observed in the testimonies, if there are no economic resources to access the indispensable - such as food - when an illness occurs, one must resort to extreme mechanisms or situations to obtain the necessary money to confront the expenses generated by the illness.

To observe the way in which the poor people attend to their health is a way of verifying the social reproduction that passes from one generation to another; which is to say, just as the woman attends to her health in the places considered to be for the poor, the same thing happens for her children and her grandchildren. They express this in the following way:

Yes, when I was bad off just now, my son didn't give me few money and with that, some days we ate and some we didn't. [Your older son work, does he work?] Yes, at times, right

now he hasn't been working for a month, [Where does he work?] He is a mason too (Interview 156).

DISCUSSION

The current tendency between researchers is to resort to quantitative methodology to measure poverty; and not to approach to qualitative methods in order to report how persons live and experience that poverty⁽¹⁰⁾. The few qualitative researches that approach this theme consider the importance of including the analysis of the subjectivity in the complex poverty phenomena as a central factor which allows to get closer to the socio-cultural dimension of what currently signifies to be poor and to the challenges that need to be faced versus adversity in health care and attention⁽¹⁵⁻¹⁶⁾. This study contributes with rich life information regarding poverty in relation to health, which allows understanding the phenomena.

Poverty is a determining motive in the health care of women. A specific characteristic of adult women with respect to the poverty situation in which they live, is manifested in the fact that they are socially dependent on their spouse and grown-up sons or daughters. This is why they can't access health services, have economic support and/or be able to buy medicines. As a consequence of that, they tend to say they are healthy so their spouse and grown-up sons or daughters will not have to spend money on them. The situation generally presents itself when their spouses and/or sons and daughters are without work. They avoid, in that case, any commitment associated with their health (to go to a medical consult or to get medicine) so as not to have to utilize the economic help of their family members. They are adult women who don't have the educational opportunities and who have bad or none paid jobs. The State does not assume any social responsibility for this group of women.

The way in which the women perceive their social belonging to the most disfavored sector of the population, is clearly reflected in the experience of health care rights. This experience is initially understood as the condition of care which corresponds to the poor for the fact of being so. In agreement with this same condition, the barriers for adequate sanitary attention are made evident and are expressed in the concrete difficulties that prevent them from seeking out a private practitioner or alternative medicine, which are considered privileges of the social

classes with greater economic power. This way of perceiving restrictions in health care and in the cure of their illnesses, can be of such magnitude, that it results in a situation that becomes habitual: conformity when faced with the perspective that the disease will progress until death. This perception appears to be associated with poor persons because of the fact that they are victims of their own conditions without thinking that poverty is a socio-structural fact that can be transformed if economic policies favor the majority of the social groups.

Some mechanisms to react and confront the limitations imposed by poverty and illness exist when facing eventual medical urgencies. For example: financial loans, the sale of farm animals, the pawning of the scarce belongings (a radio, a television, etc.), support from their social network such as family and friends. Among these, the loan is the most utilized mechanism to confront a situation of urgency and crisis. Therefore, having the necessary resources for the daily care required to strengthen their health is difficult to achieve.

The women experience the situation of poverty and gender as something unalterable that has always existed and that will not likely change. A reaction or response to these imposed limitations is not observed. This phenomena can be approached from the perspective of a sociological analysis of the management of adversity; social inequality is not only expressed in the scarcity of material resources and limited access to health services but on the level of self – structure and the management of adversity. The women in this study, given the situation of poverty in which they live, have a poor self-structure that limits their development of more adequate social networks and more effective strategies to face the processes of health and illness⁽¹⁷⁾.

CONCLUSIONS AND RECOMMENDATIONS

When approaching to the experience of poor women in this research - in relation to their health- we identify the following: there is a clear idea that if women have had economic resources their health problem will have been solved in another way; they are also convinced that for being poor they have to content themselves with a bad quality medical attention, this conformity makes them finally resign to the fact of either loosing a part of their own bodies or even just wait for death.

These reflections give rise to certain questions: Why don't the women question their social situation in relation to the way in which they care for and attend to their health? How can we give social and political value to that which they realize with respect to health care in the home arena? These new questions open lines of questioning for future studies. It is important to be able to manage the concept of "empowerment", which is understood as the capacity to create, rediscover new ways of exercising their power for the benefit of themselves. The feminist theories make use of this concept using it in the analysis of social transformation, according to the feminist concept of the world, in a way that supposes a radical alternation of the processes or structures that reproduce the subordinate position of the women such as gender⁽¹⁸⁾.

Recovering the experience of poor women in relation to their health care in order to modify these personal experiences we propose, on one hand, that the stakeholders of health policies shall consider the improvement of access and quality of health care in public health services; and, on the other, that health professionals must be sensible in order to apply this policy in spite of the social status of women.

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