Health, Reproduction and Identity: Indigenous Women of Chiapas, Mexico

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ABSTRACT

Women are central to Primary Health Care strategies because of their social reproductive roles as family health carers, the health implications of biological reproduction, and the focus on family planning within related services. Such factors ensure that women have a close relationship with health policy and institutions. This thesis analyses the negotiation of differing paradigms of health and reproduction by indigenous women in the community of Amatenango del Valle in the southern Mexican state of Chiapas in relation to their ethnic and gender identities and to the context of social, economic and political marginalisation. The analysis reflects upon the divergence and convergence between this negotiation and the formulation of policy and service provision.

The conceptual framework of pluralism and subjectivity is applied both to understandings of "Western" and "traditional" health paradigms as fluid and intersecting, rather than fixed and oppositional, as well as to the multiple and unfixed nature of indigenous women's identities. Concepts of pluralistic health and hybridity drawn from post-colonial and postmodern feminist theories allow space for envisioning women's agency to negotiate different health services and reproductive decisions, albeit in ways strongly mediated by the context of poverty and marginalisation. The discussion of policy formulation and the case study data reveal how pluralism is often accommodated at the level of the individual, rather than being recognised in policy and provision of services. The findings also illustrate how the historical and contemporary marginalisation of indigenous peoples affects the health status of women and their families and their utilisation of services, including family planning services. The thesis concludes that learning from the ways in which women negotiate services, particularly those multiplistic services of traditional providers, could result in the formulation of policy and the implementation of programmes which more effectively meet health and reproductive needs and better respect cultural diversity.

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LIST OF ACRONYMS

CIACH	*Centro de Información y Analysis de Chiapas* Chiapas Centre for Information and Analysis
CONAPO	*El Consejo Nacional de la Población* National Population Board
CONPAZ	*Coordinación de Organismos No Gubernamentales por la Paz* Coordination of Non-Governmental Organisations for Peace
DALYS	Disability Adjusted Life Years
DFI	Direct Foreign Investment
DIF	*Sistema Nacional para el Desarrollo Integral de la Familia* National System for the Integral Development of the Family
ECOSUR	*El Colegio de la Frontera Sur* College of the Southern Border
EZLN	*Ejército Zapatista de Liberación Nacional* Zapatista Army of National Liberation
GDP	Gross Domestic Product
ICOMA	International Credit Orderly Market Agreement
IMF	International Monetary Fund
IMSS	*Instituto Mexicano del Seguro Social* Mexican Institute of Social Security
INEGI	*Instituto Nacional de Estadística Geografía e Informática* National Institute of Statistics, Geography and Information
INI	*Instituto Nacional Indígena* National Indigenous Institute
ISSSTE	*Instituto de Seguridad y Servicios Sociales para los Trabajadores del Estado* Institute of Security and Social Services for State Workers
IUD	Intra-Uterine Device
PHC	Primary Health Care

PROCAMPO	*El Programa de Apoyos Directos al Campo* Programme of Direct Rural Support
PROGRESA	*El Programa de Educación, Salud y Alimentación* Education, Health and Nutrition Programme
MCH	Maternal and Child Health Care
MDGs	Millennium Declaration Goals
MMR	Maternal Mortality Ratio
NAFTA	North American Free Trade Agreement
NGO	Non-Governmental Organisation
OCEZ	*Organización Campesina Emiliano Zapata* Emiliano Zapata Peasant Organisation
PAHO	Pan-American Health Organisation
PAN	*Partido de Acción Naciónal* Party of National Action
PEC	Programme for the Extension of Coverage
PRD	*Partido de la Revolución Democrática* Party of Democratic Revolution
PRI	*Partido Revolucionario Institucional* Institutional Revolutionary Party
PRODESCH	*Programa de Desarrollo Socioeconómico de los Altos de Chiapas* Programme of Socioeconomic Development of the Highlands of Chiapas
SAPs	Structural Adjustment Policies
SBA	Skilled Birth Attendant
SIPRO	*Servicios Informativos Procesados* Processed Information Services
SPHC	Selective Primary Health Care
SSA	*Secretaría de Salud* Ministry of Health
SPSS	Statistical Package for the Social Sciences

TBA	Traditional Birth Attendant
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

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INTRODUCTION

BACKGROUND

Since the 1930s, anthropological research has focused upon the indigenous communities of Chiapas, intensified with the Harvard Chiapas Project in the 1960s (see Nash, 1970; Vogt, 1969). Such work has documented the tradition and lifestyles of the indigenous communities of Chiapas. For instance, research has detailed the religious beliefs and religious/legal institutions of authority (the '*cargo*' system), cultural and social customs, and changes over time (Cancian, 1986; Esponda, 1993; 1994; Holian, 1985; Nash, 1970; Rus, 1995; Vogt, 1969).

However, as with the majority of written history throughout the world in which there has been "a selective recording of events influenced by the historian's individual interests and perceptions" (Wieringa, 1995: 2), there has often been bias in work on Chiapas towards a male perspective. Although the family is mentioned, the emphasis of the anthropological research mentioned above focussed upon investigating, analysing and presenting indigenous men's experiences and life-histories as representatives of the culture (see Moore, 1988, for discussion of this bias in anthropology). In general, the customs of societies are discussed in terms of men's experiences and women's experiences, if mentioned at all, are alluded to as a secondary and supporting factor. For example, in his analysis of settlement patterns, Vogt (1969: 194) (one of the key Harvard Chiapas Project anthropologists) writes of the two Tzotzil hamlets, Yaleb Taiv and P'ih:

> "These two hamlets, included by the Mexican Census with Chaynatik, are composed of families from Chamula...These families are now in the process of becoming acculterated to Zincanteco customs. While the old men still dress as Chamulas and serve cargos in Chamula Center, the younger generation has shifted to Zincanteco clothes, and at least one of the young men has recently served as mayor in Zincantan Center."

There is no mention made of how the women dress or how they might, or might not, have become acculturated to Zincantan, and so their experiences become invisible or, at least, assumed to be contingent upon, the experiences of men. When women's experiences are

mentioned on the basis of this contingency, the dichotomy of gender becomes obvious. For example, in his discussion of socialisation, Vogt (1969: 194) refers to girls having "fewer problems at an early age, since they learn useful work gradually", and not participating in sibling rivalry to the same extent as brothers because of being "separated at an adult stage by patrilocal residence". Also, when looking at "Courtship and Marriage", Vogt explicitly states that "It is always the boy...who selects the girl he wishes to marry" and "the girls have very little freedom" (ibid.: 195).

Recognition of gender issues is, however, reflected in the focus of more recent anthropological work. For instance, Nash (ibid.) discussed the "acceptable" nature of violence against women in the domestic context with alcohol being used as an excuse.[1] Flood (1994) has also focussed upon changing gender relations within one particular Tzotzil community of Chiapas in relation to indigenous communities" increased contact with the international market.

Other researchers have begun more interdisciplinary work, including studies specifically on indigenous women (Nash, 1995). For example, Brunt (1992) examines the gender inequalities in the former Mexican communal land system in a study regarding women's access to land and the use of social networks in Chiapas. Freyermuth and Fernandez (1997) discuss the social and cultural background to the registration of deaths of indigenous women and, in the field of reproductive health, Holian (1985) looks at the differing fertility rates between non-indigenous and indigenous women in Chiapas and factors affecting these rates.

There has also been international recognition of the need for further research specifically into issues related to indigenous women. The International Workgroup for Indigenous Affairs was formed as part of the UN International Decade for the World's Indigenous People. In Mexico, a national level governmental study on *"Mujer Indígena Hoy"*[2] was produced for the Beijing conference on women (Sanchez, 1995). This report concentrates upon differing aspects of indigenous women's lives, such as their socio- economic situation,

[1] See Chapter Seven for ethnographic detail and discussion of domestic violence and alcohol.
[2] Indigenous woman today.

nutrition, health and religion, so offering a comprehensive analysis. However, it is limited in so far as it seeks to encompass all indigenous groups of Mexico and in doing so offers a relatively superficial perspective, without the potential for examining the complexities of women's individual experiences. Nevertheless, it provides a basis for further work and, along with the other work in this area, indicates that increasingly efforts are being made to fill the previous gap in knowledge about the lives of indigenous women.

More recently, the explosion of academic attention generated by the *Ejercito Zapatista de Liberación Nacional* (EZLN) uprising in 1994 has partly addressed this gap through a focus on the political activities and demands of indigenous women within the "Zapatista" movement. This ongoing mobilisation of indigenous groups of varied ethnicities centres on demands for basic needs as well as "autonomy" in various forms (see Chapter Four). Within this, indigenous women have called for their own rights to be recognised including rights to own land, to choose marriage partners, for girls not to be exchanged for money in marital arrangements, and for access to contraception (Harvey, 1999). A variety of authors (Collier with Guaratiello, 1999; Freyermuth Enciso, 2001; Garza Caligaris and Hernández Castillo, 2001; Harvey, 1999; Hernández Castillo, 2001a; 2001b; Mattiace, 2003; Rus et al, 2003) have begun to include the gender dimensions and particularities of indigenous women's lives in their discussions of the political and economic themes relevant to contemporary Chiapas.

AIMS AND CONCEPTUAL FRAMEWORK OF THE THESIS

General aims and objectives

The aim of this study is to contribute to this work on the lives and needs of indigenous women by confronting their experiences of health and reproduction, thus engaging in a field of study which women themselves recognise to be critical to their everyday realities and life histories. This thesis analyses the negotiation of differing paradigms of health and reproduction by indigenous women in relation to their ethnic and gender identities and to the context of social, economic and political marginalisation. In so doing, the analysis reflects upon the divergence and convergence between this negotiation and the formulation of related policy and service provision. A parallel is drawn between the complex and variable constructions of gender roles and of health knowledge in "non-Western" cultural

contexts. The empirical data reveals how these constructions are related to health care strategies, attitudes to family size, and methods of reproductive control but that the latter also reflect the pragmatic positioning and behaviour of women in order to cope with the realities of poverty, poor health status, and marginalisation.

Reproduction, health and identity constructions

As a result of their social reproductive roles as family health carers and the health implications of biological reproduction, women often have an especially close relationship with health policy and institutions. Therefore, the potential of Western medical institutions to operate as a technique of surveillance (Foucault, 1973) of health care and the family, and the formulations of policy which may facilitate this, are likely to particularly impact upon women. This thesis aims to understand how identity informs the ways in which individual women negotiate this relationship. Gendered experiences and roles differ according to varied configurations of socio-cultural norms and beliefs. The influence of the cultural context is clearly evident in the perceptions and experiences of women in the case study of this thesis. Women's experiences of the health environment (and their interpretation of the influence of this environment upon states of health), beliefs regarding health and illness, social reproductive roles as health carers and negotiation of health care and reproductive decisions are inevitably influenced by cultural customs and norms.

However, overlapping post-modern frameworks of post-development and postcolonial feminism allow space for recognising the agency of women, based upon an understanding that identities are fluid and transient and that, therefore, experiences and knowledge of health and reproduction are equally unfixed even within the same cultural context. This understanding also reflects the need to critique "Western" authority over knowledge and acknowledge the existence of other constructions but without resorting to a position of essentialism or prioritisation of this "other" knowledge. As Sundar Rajan (1996: 8) notes:

> "If the postcolonial intellectual position dictates the implicit deployment and critique of western sciences of knowledge, the wrestling with the problems of discovering a viable "indigenous" theory – which will not at the same time be complicit with various regressive forms of nativism, fundamentalism or reaction – is a constant accompaniment to such intellectual enquiry."

A critical approach to the deployment of Western biomedicine need not become a battle between two competing paradigms, visualised as "authentic" and "pure". Whilst Western health care policy-makers and policy makers may imagine a "scientific" dichotomy between the two paradigms, the reality is that Western biomedicine is itself a construction (and thereby open to interpretation, deconstruction and reconstruction in many forms) and "traditional" medicine increasingly incorporates methods from across the invented ontological boundary.

A note on terminology, dichotomies and power

The terminology available to describe the two paradigms and discuss the relationship between the two further adds to misconceptions. This debate is not only relevant to constructions of knowledge but also to debates around identity and development in which similar terminology is employed and "conceptual dichotomies in which the traditional is opposed to the modern...and authentic and objective local identities to inauthentic and constructed national ones (Purnell, 2002: 214) also create imagined boundaries.

Scheper-Hughes (1992: 21) notes that there has been an "anthropological obsession with reason, rationality, and "primitive" versus "rational" thought, as these bear on questions of cultural relativism". This relates to the controversy over the usage of terms such as "developing" and "developed" as well as "Western" and "traditional". The terms "developing/developed" and "Western" imply a geographical divide relative to a position of power and supposed advancement. "Traditional" contains connotations of backwardness and suggests a static essentialism, untouched by outside influences and standing in opposition to "Western" reason and scientific progress.

Although it is recognised that they are far from ideal and occasionally less controversial terms "North" and "South" are also used at points where the others appear particularly sensitive, these terms are employed throughout the thesis. Despite the inherent problems and the fact that the development paradigm is critiqued (see Chapter Three), such terms are at least recognisable in terms of the division they indicate and the term "Western" has particular validity in the context of this thesis. As Scheper-Hughes (ibid.) implies, the term "Western" relates to the development of "scientific" reasoning during the Enlightenment

period in Western Europe and, therefore, is representative of the epistemological underpinnings of biomedicine. "Traditional" is, however, yet more problematic and is used more for lack of another more appropriate term than for any other reason (terms such as "primitive" being even more politically charged and inappropriate). In this thesis, it is used to refer to systems of knowledge that do not base themselves on the same scientific reasoning described above.

However, despite employing these terms to indicate the supposed opposition between two paradigms, this thesis hopes to reveal that the line between the two is, in reality, more nuanced and blurred. This aim, then, fits with Scheper-Hughes' (1992: 23-24) assertion that anthropological work (or work which verges on the anthropological, as this research makes no claims to be purely anthropological) should address Western science's refusal to engage with the "other" and should attempt to "liberate truth from its Western suppositions". Accordingly, the blurring of the boundary between "Western" and "traditional" health paradigms is not necessarily recognised by providers of "Western" health care. However, observations of the hybridity of traditional health care provision as well as in the understandings of health and use of the services by indigenous women goes some way towards questioning the "philosophical commitment to Enlightenment notions of reason and truth", as Scheper-Hughes (ibid.: 23) suggests.

Poverty and policy

A recognition of the constructed nature of both Western and traditional medicines enables a conceptualisation of health pluralities which throws light upon the often contradictory behaviour of women as both providers and users of health care. However, despite a recognition of agency (as noted by postcolonial frameworks) in this behaviour, it is not unmediated by external factors outside of women's control. Indigenous women's negotiation of "plural" health in the marginalised state of Chiapas also represents pragmatic coping strategies in the face of poverty and marginalisation, resulting from centuries of social, economic and political exclusion of indigenous peoples. In particular, the indigenous peasantry in rural Chiapas has been excluded from productive land ownership and political representation and, consequently, authorities often fail to consider cultural diversity. This is especially compounded for women who are also marginalised within their

own communities and families and who may lack economic independence (particularly through lack of access to land), suffer from domestic violence, and who do not always have decision-making authority in relation to fertility.

At international, national and regional levels, poverty is key to the formulation of Selective Primary Health Care (SPHC) and population control policies, which are often incorporated within integrated poverty reduction strategies (such as PROGRESA). In particular, the focus upon family planning within SPHC strategies has become controversial in relation to the history of marginalisation experienced by indigenous communities in Chiapas and to the contemporary context of political conflict. Suspicions are raised regarding the motivations behind such policies and freedom of choice offered to women. At community and individual levels, poverty has heavily influenced health environments and the health status of indigenous women and their families and has impacted upon family level reproductive decision-making as well as the negotiation between traditional and Western health knowledge constructions and related uptake of services.

ORGANISATION OF THE THESIS

The opening chapter of this thesis begins by detailing some of the health issues affecting women in the developing world. These issues are related to their biological and social reproductive roles as health carers in the family and to their relationship with the gendered structures of health institutions. The chapter then continues with a discussion of the conceptual framework for understanding how women conceptualise health and family planning issues and negotiate between Western and traditional health services on individual levels. Postmodern theories of feminism, post-development and hybridity conceptualise identities as fluid and transient. Thus, women may be assumed to have some degree of agency in their negotiation of related services and experiences of health and reproduction can be envisioned as equally unfixed and constructed. Western biomedicine assumes authority on the basis of its assumption of scientific objectivity but gendered assumptions within its epistemological history are revealed in order to deconstruct this objectivity and highlight the multiple possibilities of plural health both in terms of women's provision and use of services. However, the chapter also outlines the ways in which their agency is mediated by external factors. Within a context of poverty and social exclusion, particularly

related to land ownership, women's health seeking behaviour necessarily also reflects coping strategies in the face of hardship.

The subsequent methodological chapter assesses the most appropriate methods for research within such a context of exclusion and cultural difference. The feminist rationale behind the methods adopted in the research strategy for this thesis and the practicalities of collecting data in a challenging political context are outlined. The inherent power relations in undertaking research with marginalised groups are discussed and some of the problems experienced in relation to dealing with these power relations on a personal level in the field are highlighted. Their implications for the use of quantitative and qualitative data and interpretation of these data are also examined.

The third chapter outlines the wider political context and policies which inform the provision of services which women negotiate. The relationship between Mexico's economic dependency and financial crisis, structural adjustment, and global trends towards Selective Primary Health Care and population control are examined. The latter trends are significant influences upon Mexican and Chiapanecan discourses and policies. The PROGRESA poverty alleviation programme represents a particular example of how these discourses are translated into national level programmes and also illustrates some of the challenges involved in implementing such policies within a context of cultural diversity and marginalisation, particularly in relation to the expectation of community participation. The links between health, family planning, and population policy are revealed in the formulation of such policies and programmes. Thus, the link between poverty and family size on the basis of neo-Malthusian population theory is also examined and critiqued in relation to the political context of Chiapas and to the realities of its implementation for women's freedom of choice.

Both Chapter One and Chapter Three illustrate the importance of understanding experiences of health, the provision of services, and women's negotiation of health issues and services in relation to broader exclusionary factors in each context. The fourth chapter of this thesis, therefore, specifies the realities of these factors in Chiapas. It begins by briefly tracing the social, economic and political background of marginalisation

experienced by indigenous peoples of Chiapas from colonisation through to the present day. The contemporary political struggles undertaken by indigenous groups engage in ongoing debates surrounding indigenous rights to land, cultural plurality and autonomy on the basis of ethnic identity. However, the issue is particularly problematic for women as the exclusion of indigenous people in general is compounded by discriminatory gender relations at community level and is not disconnected from issues of health and from family planning decisions as a result of the linkages made between poverty and family size. The final sections of this chapter illustrate the contemporary configuration of poverty and other exclusionary processes in the state and their impact upon health status and provision of health services.

Subsequently, Chapter Five briefly outlines the case study community that is the source of the empirical evidence in the thesis. As well as providing some historical, socio-economic and demographic detail about the municipality of Amatenango del Valle, information is also given about some of the participants. This information illuminates the way in which the broad socio-economic context informs everyday experiences of health and reproduction.

Leading on from this, Chapter Six discusses how the particular health environment in Amatenango is constituted. Employing a holistic perspective on "health", the influence of a variety of socio-economic factors (examined at household level) upon health status is analysed from the perspective of Western biomedical and social models of health. Subsequently, women's own perceptions of such influences upon their own health status and that of their families are represented. Gender distinctions in perceptions of health status are noted and the relationship between understandings of the influence of poverty and specific cultural conceptualisations of health and illness related to spiritual factors is examined.

Whilst Chapter Six reveals women's understandings of health, Chapter Seven expounds the reasons why these understandings are particularly crucial to capture in examining how health care comes to be significant for women via the cultural construction of women's social reproductive roles in Amatenango. Particular consideration is given to the way in which these roles are initially formulated through the marriage process, the specific cultural

formulation of private and public sphere roles (looking at domestic violence as a key factor in this formulation) and the relationship between these roles, motherhood, and health care. Women's experiences of the latter both within the family and as health carers in the wider community are examined in particular detail.

A major component of formal health care provision in Amatenango is family planning. Chapter Eight discusses reproductive decision-making processes in the context of the social and cultural conventions of motherhood and health discussed in the previous chapters and the wider debates surrounding population and reproduction. The latter include Safe Motherhood strategies, which stress the dangers of maternal mortality and question the skills of traditional birth attendants, and neo-Malthusian population policies, which negatively link poverty and family size. Such perspectives combine with other cultural and economic factors in influencing women's own perspectives on birthing practices, maternal health, contraception, and family size. The relationship and contradictions between these factors is analysed in order to investigate the complex environment in which reproductive decision-making occurs.

The conclusion summarises the findings of the case study within the conceptual framework of the thesis and discusses the implications of the interplay between plurality and poverty for health and reproductive policy-making and the implementation of related programmes. It suggests that learning from women's multiplistic and pragmatic negotiations of understandings and services could result in more relevant policy and provision of services, which more effectively meet health and family planning needs in culturally sensitive and respectful ways.

CHAPTER ONE

HEALTH, REPRODUCTION AND IDENTITY: THEORIES AND ISSUES

INTRODUCTION

This chapter outlines the issues and conceptual framework which inform this thesis. First, an overview of the health status of women is given (from a Western biomedical perspective), detailing some of the health issues particularly affecting women in the developing world. The reasons why such health issues cannot be separated from both their biological and social reproductive roles are expounded and, therefore, the significance and interpretation of these roles both in terms of assessments of health risks to women and with respect to their roles as health-carers are examined in detail. Through this analysis, it becomes clear that women have a particular relationship with health institutions and this chapter also illustrates the gendered structures of Western medical institutions and how they may potentially operate as a technique of surveillance of health care, especially of women.

The above discussion occupies the initial sections of this chapter and represents the broad context of debates relevant to this thesis. Subsequent sections take a more person focussed perspective in attempting to understand how identity informs the ways in which individual women negotiate this context. Concepts of difference and ethnicity in relation to feminist constructions of identity are central to this study, as are understandings of the socially constructed and culturally bound nature of health and reproductive knowledge, institutions and behaviours. Employing the overlapping postmodern frameworks of recent feminisms, post-development and hybridity, it is possible to conceptualise identities as fluid and transient and thus understand that experiences of health and reproduction are equally unfixed. In order to comprehend and give due credence to the variety of possibilities open to women in their own understandings and negotiation of health, it is necessary to question the unstable nature of the "objectivity" claimed by Western biomedicine. Therefore, an illustration of the gendered assumptions inherent within biomedical epistemological history is given. By acknowledging the constructed nature of Western biomedicine in this way, it

is thus not only possible to envisage the pluralities of health knowledge constructions and related behaviour but also to provide insight into the overlap between various postmodern theoretical debates relevant to gender identity, reproduction and health. The conceptual framework of "plural health" arises from these debates and is relevant to women both as users and providers of healthcare.

Through these discussions, this thesis proposes that experiences of health and reproductive issues should be understood through the lens of subjectivity and in the context of differing identities and experiences. However, such experiences also need to be analysed in relation to processes of social exclusion and poverty. These are key experiences for many women in the developing world and ensure that women's negotiation of plural health is not an unmediated one but also may represent pragmatic coping strategies in the face of hardship. In rural Mexico, poverty is particularly related to the exclusion from productive land ownership for indigenous peoples and, especially given the politicised nature of such exclusion in the state of Chiapas, health and reproductive issues can also not be separated from these influences. Therefore, the final sections of this chapter deal with such issues.

WOMEN AND HEALTH

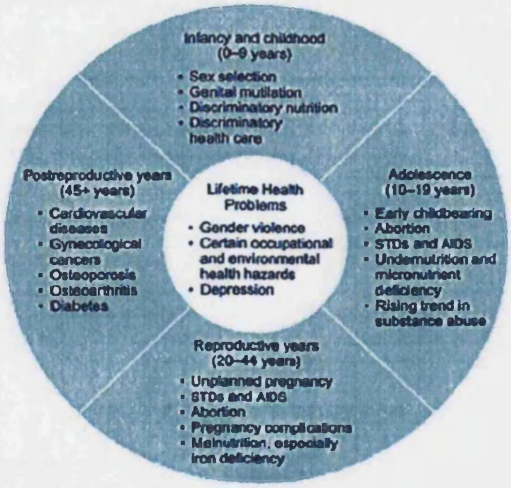
Women's health issues

At an international level there has been no lack of gender analysis of health and reproductive issues. Many feminist debates concerning women's health have centred upon notions of women being the primary victims of poverty and the dangers reproduction places upon their health (Gaytán, 1997; Sayavedra, 1997a; Sayavedra, 1997b; Sayavedra and Flores, 1997; Smyke, 1991; Stein, 1997; Sundari Ravindran, 1997; Young, 1993). International agencies have similarly emphasised such themes as rationales for their primary health programmes and population control policies.

The health of both men and women in developing countries suffers as a result of their economic status. The 84 per cent of the world's population who live in low and middle income countries "account for only 18 per cent of world income" and yet they benefit from only "11 per cent of global health spending ($250 billion or 4 per cent of GDP in those countries)...[and] bear 93 per cent of the world's disease burden" (WHO, 2000: 6). As

Chant with Craske (2003: 100) notes of Latin America, "diseases of poverty" such as gastro-enteritic illness and diarrhoea are "eminently preventable and curable" yet "rank among the ten leading causes of death in the continent". In many cultures women's low status within the household and the community has particularly profound implications for their state of health throughout their lives (Gaytan, 1997; Hillier and Scrambler, 1997; Sayavedra, 1997; Sayavedra and Flores, 1997; World Bank, 2000), as Figure 1.1 illustrates. In prosperous countries, women's life expectancy is an average of seven years longer than that of men. However, in situations of poverty, women's life expectancy is reduced to 94 per cent that of men on an international level (Stein, 1997: 93). Whilst in Latin America women maintain an advantage in terms of comparative longevity of life, this "places them at greater risk of age-related degenerative diseases, such as cervical, uterine, ovarian and breast cancer" (Chant with Craske, 2003: 114). Women's low status often means they have less access to nutrition and hard labour and long working days result in a poor state of health (Stein, 1997: 97-98). Gender violence and its direct effects on women's physical and mental well being also reflect inequalities (see Chapters Six and Seven). The World Bank notes that gender inequalities in health may begin in childhood as "discrimination in the treatment of girls can negate their innate biological advantages. In many developing countries girls are in poorer health than boys because of inadequate nutrition and health care" (World Bank, 2000: 3).

FIGURE 1.1: HEALTH AND NUTRITION PROBLEMS AFFECTING WOMEN EXCLUSIVELY OR PREDOMINANTLY DURING THE LIFE CYCLE



(Source: World Bank, 2000: 16)

The organization further comments that:

> "Biological and social factors affect women's health throughout their lives and have cumulative effects. It is therefore important to consider the entire life cycle when examining the causes and consequences of women's poor health. For example, girls who are fed inadequately during childhood may have stunted growth, leading to higher risks of complications during childbirth"
> (World Bank: 2000: 3; see also Chant with Craske, 2003)

Much of the information on the health of women in the developing world has often related to pregnant or lactating women and to consequences for infant survival and health (Momsen and Townsend, 1987: 33; Oxaal with Baden, 1996; Stein, 1997: 96, 99; Sundari Ravindran, 1997), as opposed to considering the severity of these problems solely in the light of women's health. As recently as 1999, the joint WHO, UNICEF, UNFPA and World Bank statement on maternal mortality exemplifies this trend. While the opening paragraph is an alarming presentation of figures concerning maternal mortality and morbidity (see WHO et al, 1999: 1), its second paragraph quickly turns to the effect this reproductive stress indirectly places upon their children:

> "The poor health and nutrition of women and the lack of care that contributes to their death in pregnancy and childbirth also compromise the health and survival of the infants and children they leave behind. It is estimated that nearly two-thirds of the 8 million infant deaths that occur each year result largely from poor maternal health and hygiene, inadequate care, inefficient management of delivery, and lack of essential care of the newborn" (ibid.).

Whilst these indirect health outcomes for children are clearly also important, this linkage has at times implied that the importance of women is contingent upon their reproductive role and the necessity of a healthy "mother figure", rather than women's significance as individuals in their own right (Oxaal with Baden, 1996: 2). Feminist debates focussing on citizenship have revealed the central role of women's biological and social reproductive duties in nationalist projects as mothers and as the producers of the next generation (Yuval-Davis and Anthias, 1989; see also Craske, 1999). The construction of women as citizens with rights but also with gendered responsibilities is echoed in these discussions of maternal health. Motherhood, as this study will reveal, is a central part of the majority of women's lives in many cultures. The care of others forms part of their social reproductive

roles and it is necessary to recognise associated responsibilities and skills in order to appreciate women's status and decision-making capabilities. However, an emphasis upon women's health is important in its own right because of the status and well being of women themselves. The WHO constitution of 1946 formulates health as a human right, stating that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being". This is regardless of gender. Therefore, the implication that the good health of women is primarily important because of the effect of their health on others is potentially problematic. It suggests that women's human rights (with respect to health) are partly dependent upon gendered social and biological responsibilities, rather than being unconditional and solely for their own well-being.

Women's health and reproduction

Women's biological reproductive function is, however, particularly influential on their own state of health, as the above statement about maternal mortality reveals (see also Chant with Craske, 2003). Forty-three per cent of all women, compared to 34 per cent of all men are anaemic in the developing world, a condition which greatly increases the risk of maternal mortality and morbidity (Wach and Reeves, 2000). In Mexico, 41 per cent of pregnant women were anaemic between 1975 and 1991 (Chant with Craske, 2003: Table 5.1). Aside from the well-documented impact of AIDS on women, they also suffer from minor illnesses related to their reproductive health, such as menopausal problems, cystitis and pelvic inflammatory disease among others (United Nations, 1992). According to the World Bank, one third of DALYS (Disability Adjusted Life Years)[1] lost by women aged between 15 and 45 in developing countries result from reproductive health problems (World Bank, 1993).

It is also in the arena of biological reproduction where women's bodies are most susceptible to intervention, or even control, by others, whether on the part of other family members (often partners) or by the state in terms of population policies which attempt to control

[1] Metric system to quantify the burden of disease and injury on human populations with the use of a time based indicator of health outcome. Formulated and introduced by the WHO for the 1990 Global Burden of Disease Study (see WHO, 1998).

fertility, and, by extension, have influence over women's bodies. Primary health care concentrates upon preventative health and constitutes reproductive control within this remit. Bandarage (1997: 94) notes that the World Bank is now "explicitly focussing on reproductive health and Safe Motherhood rather than reducing population growth for family planning efforts in Latin America" as a result of the sensitivity of the issue. In terms of national and international development strategies and health policies, it is at times difficult to distinguish between policies aimed at improving individual women's state of health and the objective of population control as related to national economic development. Women's bodies, then, are potentially at the mercy of the nation-state and macro-level development.[2]

Contemporary population policies emphasise the negative effects on women's health of having a large family (Bandarage, 1997: 92-101). It is certainly the case that a large number of closely spaced pregnancies can be a danger to women's health, particularly in environments of poverty (see Jejeeboy and Rama Rao, 1998, for discussion of the Indian context). The case for the hypothesis that a reduction in the absolute number of pregnancies reduces maternal mortality rates or improves women's resistance and morbidity rates is less convincing. Indeed Bandarage (1997: 93) argues that "[t]he emphasis on family planning has undermined public health care and maternal and child health (MCH) in many countries". Women's health needs would perhaps be better served by an emphasis on such factors as a rise in age of marriage, education, employment, better living conditions and general awareness among women (Bandarage, 1997: 96; see also Correa, 2002; Thaddeus and Maine, 1994). Reproductive health and control programmes which contain a secondary, or even primary, agenda of population reduction are problematic in their potential to interfere with individual choice. The human right of "health for all", as stated by the WHO, is difficult to balance with the right to choose family size and have control over one's own body in instances where individual choice may dictate against "objective" analyses of the "best" health decisions.

Reproductive choices are a prime example of this. The debate over whether women's

[2] Also see Chapter Three for discussion of the limitations / possibilities of nation-state autonomy in determining population control policies in the context of globalisation and influence from international organisations.

control over their own bodies is a human rights issue has long been on the feminist political agenda. Traditionally, this has been formulated in terms of the right to limit family size and particularly the right to abortion (Craske, 1999). However, this concentration reflects the middle-class preoccupations of mainstream feminism. The right to have children is the converse of the debate and is also about control over women's bodies in the light of family planning programmes in the developing world. The issues are complex and will no doubt continue to be subject to heated debate. Arguably, both sides of the camp are attempting to safeguard women's interests: one side by reducing women's reproductive burden in order to impart a healthy well-being and increased life options and the other by allowing women free choice and control over their own bodies.[3]

Individual choice in terms of reproductive decisions must always be weighed against the perceived health benefits. Fertility is now recognised to be a complex phenomenon. High fertility is no longer always assumed to be unintentional and unwanted (Bandarage, 1997: 97; Petcheskey, 1998: 1). For many parents, children are essential to their self-esteem, social status and lead to life-satisfaction (Bandarage, 1997). Contrary to improving women's life options and status:

> "In societies where women derive social status from childbearing and – rearing, family planning programs which do not accompany reductions in infant mortality threaten women's status." (ibid.: 97)

It is also important to recognise children's work input into household productivity as a factor influencing fertility behaviour of parents in peasant societies. Children may serve as protection and insurance for old age and in times of sickness and crisis. Fertility is a social as well as a biological phenomenon. Its meaning and significance vary greatly from one social group to another, strongly defined by the mode of production, social class, and, as this thesis argues, by ethnicity. One of the most important aspects of any discussion of population control is to recognise the cultural specificity of reproductive decisions – the role of ethnic identity particularly – and not to uniformly impose Western cultural values upon situations where they may not necessarily be appropriate or where they will need to be negotiated with existent practices and values.

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[3] Such debates also often ignore the difficult issue of men's reproductive rights.

GENDER AND WESTERN HEALTH CARE

Social reproduction: Women as health carers

As noted above, reproduction, and related decision-making, is not only related to biological reproduction but also to social reproduction. An important aspect of women's social reproductive identities – their identities as mothers - often includes health care. Women's cultural relationship with health issues extends not only to issues associated with their own health (and reproduction) but also to their roles as family health-carers. This relationship is of especial importance in the developing world. In industrialized societies, the state and/or the private market provide much health care. In those areas that are not covered by such services, such as care of the elderly and disabled in the community, women frequently take up responsibilities. In many developing countries, where there is less formal health care, women's responsibilities for health care are yet greater and it is usually they who are responsible for, and who have control over, health in the private sphere. Aside from the biological reproductive function of women, they are also very much responsible for the social reproduction of the family: through caring for the every day needs of children, partners and relatives, preparing food, providing clothing, collecting water and caring for the sick. Women, therefore, are primary actors within the sphere of health and having this important role recognised at a public level can do much for their status (Castillo and Viga, 1994). However, one of the problems of Western health care programmes is their patriarchal nature, instituted by their "professionalism" and the gaps that necessarily ensue from this between the layperson, the woman who looks after her family's health, and the medical professional. This neither takes advantage of the wealth of knowledge and experience of women, nor provides them with the necessary recognition of an important role, which they are likely to be performing effectively (Bandarage, 1997).

Indeed, normalising discourses of biomedicine can often seek to regulate social reproductive roles and, therefore, potentially disempower women. The case study chapters of this thesis will illustrate how a child's good state of health is taken as indicator of superior motherhood. In Western societies, concepts of good maternal care anticipate that a mother should know when to refer to authority and that she should fulfil certain societal expectations in respect of ensuring that her children remain healthy. This role construction

and the societal expectations that play a part in its construction are means by which women become subjects of normalising discourses:

> "In the ordering of human existence [medicine] assumes a normative posture, which authorizes it not only to distribute advice as to a healthy life, but also to dictate the standards for physical and moral relations of the individual and of the society in which he lives" (Foucault, 1973: 34).

Foucault may not have specifically been referring to the controls placed upon motherhood but this dictation of "physical and moral relations" is clearly relevant to surveillance over the maternal norm. If a child's health is not perceived to meet the normative standards of the health care system, and society in general, there are many mechanisms for control. Doctors, school health visitors and social workers (amongst others) figure amongst these mechanisms in industrialised societies. The institutionalisation of Western influenced practices of health care in the developing world means that health care systems themselves, and the discourses and mechanisms that constitute them, can become techniques of surveillance. At the extreme, and employing a Foucauldian analysis, they may even be interpreted as technologies of domination that control, discipline and normalise. Women are frequently the subjects of this surveillance in their roles as mothers and health carers. For example, nutritional payments made to mothers under PROGRESA[4] in rural Mexico are conditional upon family visits to the clinic and children's attendance at school.

Health is an area of decision-making and expertise for women and, if it were to be recognised as such by women themselves, would be an important step in their realisation of their self-worth and towards their empowerment. The 1978 WHO Alma Ata declaration made a significant step towards this (see Chapter Two). Arguably, however, the policy has undergone change from conception to grassroots practice with women being retrained into Western health care skills and used as a cheap source of labour rather than providers of valuable knowledge and existing skills.

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[4] *El Programa de Educación, Salud y Alimentación* (Education, Health and Nutrition Programme). See Chapter Three for discussion of this programme.

Gender roles in Western health care systems

This policy to implementation shift is perhaps related to the gendered structure of Western health care systems, within which it is often still men who operate in the echelons of power. Not only does this give them a particular relationship with biomedical knowledge (Hillier and Scrambler, 1997: Also see below) but it also translates to the patriarchal assignment of roles in Western health care systems.

In the nineteenth century, nurses were constructed primarily as physical caregivers. They were generally nuns or women "down on their luck". Lorber (1997) pinpoints Florence Nightingale as particularly instrumental in professionalising the service and reconstructing nurses as medical assistants to the doctors. In the mid-twentieth century, the emotional caring aspect of nursing was, for the first time, given emphasis so giving rise to the dual role of nurses today. They are professional medical assistants – a role requiring a certain degree of medical knowledge – but also they are expected to fulfil a mothering role in caring for the emotional well-being of the patients. Lorber writes that nurses assume the "mother" role in the hospital environment whilst the doctor is the "father", with the patient assuming the status of "child" (ibid: 39).

This analogy clearly does not cover the whole spectrum of specialisations and hierarchies within contemporary nursing and it is certainly true that gender roles and relations in modern health systems are shifting. Nevertheless, in general, it remains the case that "nurses' structural position in the Western medical care system remains subordinate to physicians...who are generally men" because the doctor is the one who has "ultimate authority over and responsibility for patient's treatment" (ibid.; see also Gamarnikow,1978: 97; Hillier and Scrambler, 1997: 131). This is reflected in the professional-layperson relationship, which can serve to alienate women in both Western (Hillier and Scrambler, 1997: 127) and non-Western nations.

This is not to suggest that the majority of individual health practitioners and policy makers have been conscious of these exclusions. The vast majority of both past and contemporary practitioners and policy-makers do not purposefully practice gender exclusion. Nevertheless, the discourses, history and structures within which they operate mean that

they will be unlikely to be able to entirely avoid such exclusions, even in today's more gender equitable and aware systems. Of course this may equally be the case for "other" health beliefs and practices. However, given the dominance of Western biomedicine in global health strategies, it is perhaps especially important that its exclusionary processes be recognised.

POST-MODERNIST FRAMEWORKS: IDENTITY, AGENCY AND KNOWLEDGE

Thus, a broad perspective on women's health and reproductive issues notes the social disadvantage of women's health status (often primarily related to reproductive health) in the developing world, the ways in which women play crucial roles in health in the family in relation to their social reproductive roles, and the problems of "surveillance" an encounter with Western health systems may entail. This discussion provides the general context to this thesis. However, such detail is relatively limited in its contribution to understanding women's complex and individual experiences of their own health and the health issues they confront as mothers and family carers. In many ways, the discussions above employ singular "Western" referents, including the assumption of a disadvantage suffered by women based upon their reproductive identity and compounded by poverty and a biomedical experience and explanation of health. Whilst this may assist our understanding of the issues with which women contend, one of the central questions posed by this thesis is how women deal with these issues with respect to their own individual experiences of poverty and marginalisation, gender relations and ethnic identity.

The related conceptual frameworks provided by post-modern feminism, post-development and post-colonialism provide means to investigate the complexities of women's own understandings, experiences and behaviour related to health and reproduction in non-Western societies. Such theoretical debates allow for conceptualisations including the fluidity of identities, agency in the context of development and post-colonial societies, and the deconstruction of knowledge (particularly biomedical constructions of the female body). This therefore allows us to formulate both "health" (including for women the important aspect of reproduction) as a subjective and multiplistic concept as well as the ways in which individual women relate to health and reproduction. It is thus possible to

reject universalist assumptions (both related to gender and ethnic identities as well as to health knowledge and behaviour) in favour of plurality and more nuanced understandings.

Gender, ethnicity and difference

Whilst some radical feminists continue the protest against technological and biomedical interference with women's bodies in the form of family planning which began in the second half of the nineteenth century (Correa, 2002), the majority of mainstream national and international feminist movements have campaigned for the improvement of women's health and the necessity for access to Western health services as well as the right to methods of reproductive control (Correa, 2002; Peake and Trotz, 2002). Whilst previous feminist debates have acknowledged difference between distinct groups of women, political mobilisation around certain key issues (such as reproductive rights) has effectively tended towards an universalisation of the experiences not only of developing nations and poverty but also of women whatever their cultural and ethnic background. They take only a limited account of issues of identity and how this may change the relationship differing cultures and the individual women within them have with poverty and issues of health and reproduction.

More recently, however, post-modern feminists have shown that it is necessary to question the notion of the category of "women" in order to understand that "gender interests", or for that matter "women's roles" are not necessarily identical across culture, class and ethnic boundaries. Indeed these boundaries themselves are not conceptualised as fixed but rather are as fluid and temporal as the complex gender identities, roles and political priorities formulated within, and between, them.

The type of feminism that emerged as a result of radical and materialist feminist movements in the 1970s put into play a notion of the "universal woman" or of a general oppression of women. Whilst many feminists are wary because of its destabilization of the political project of feminism, postmodern feminist analysis has shown this idea of a generalised patriarchy to be unrealistic. As Moore (1988:189) states:

> "...there can be no universal or unitary sociological category "woman", and therefore...there can be no analytical meaning in any universal conditions,

> attitudes or views ascribed to this "woman" - for example, in the "universal subordination of women" and the "oppression of women". The term patriarchy is deconstructed. This does not mean that women are not oppressed by patriarchal structures, but it does mean that the nature and consequences of those structures have to be identified in each instance and not assumed."

The feminist philosopher, Luce Irigaray (1993: 15), also highlights the cultural specificity of sexual difference:

> "The status of sexual difference is obviously related to that of our culture and its languages...Sex is said to be a matter separate from civilization. A degree of thought and enquiry will show that it is nothing of the sort..."

Postmodern feminism points out that increasing access to differing influences in today's rapidly globalising world has led to a fragmentation of identity. People formulate their identities, and therefore their priorities, based, for example, on their gender, their nationality, their region, their community, their ethnic origin or varying combinations of these. Such multiple subjectivities may lead to conflicts of interest. The self not only reflects experience and reality, but is also constructed as a result of historical context and discourses (Marchand and Parpart, 1995). The complexities of these processes, therefore, require analysis and, as contexts and discourses are fluid and shifting, so the subjectivities which interrelate with these experiences are equally arbitrary and fickle.

Foucault (1988) relates the construction of the self to the exclusion of others, giving the example of the exclusion of the insane from society and so providing a theoretical framework for understanding the construction of ethnic (and gender) identity based upon otherness and marginality. He also discusses how the self is "...developed through antiquity down to now..." (Foucault, 1988: 146). In this way, it is obvious that any study of indigenous women must be firmly situated within their social and historical context, explicitly the colonial experience and their own experiences of culture. Foucault writes that "...through some political technology of individuals, we have been led to recognise ourselves as a society, as a part of a social entity, as a part of a nation or a state" (ibid.). It is precisely this reasoning that would tempt alignments to be made with other women facilitated by the idea of a society of women. However, the assumption of the existence of a shared feminine identity, the commonality of gender, has somehow transcended the

existence of other forms of difference" (Moore, 1988: 189). This analysis is based upon the "primacy of gender difference...because gender as a social construct has a variable reference to biological difference, whilst racism as a social construct does not..." (ibid.: 190).[5] However, as Moore goes on to point out "gendered individuals experience the social construction of gender rather than biological determinants" (ibid.).

Indigenous women's self perceptions may be based more upon an understanding of themselves as constituted as part of their individual cultural history and community which operates as a nation more concretely than any relationship to the Mexican nation-state[6] and so perhaps than seeing themselves as "Mexican" women (see Purnell, 2002). For indigenous women, their identity may be forged upon historical experience based upon their exclusion from, rather than inclusion within, Mexican nationhood. This echoes Harvey's (1999: 12) postmodern conceptualisation of Chiapenecan identities as united in the sense that they are constructed "from the fragments of multiple struggles against oppression" (see also Purnell, 2002). Similarly, Mattiace (2003: 27) discusses the central importance of united reactions to "the imposition of neo-liberal policies" (amongst other factors), as well as the existence of "inherited cultural symbols", to political mobilisation on the basis of ethnic identities.

However, the post-modern feminist perspective argues that analysis of the subjectivities constructed by "otherness" is also insufficient and that neither this historical experience nor its contemporary configuration of exclusion can be reified or unified. It is at this point where postmodernist feminism arguably loses its political focus on women and shifts to a focus on marginalised identities. For indigenous women, the cultural processes, institutions and strategies are different from those of *mestizo*[7] women but they may also be individualised between and within indigenous women themselves.

This does not, however, mean that communal or social identities based on a shared ethnic

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[5] Feminist theorists, such as Butler (1993), take this further and indeed argue against the biological existence of sexual difference (as discussed later in this chapter).
[6] See Mattiace (2003) for related discussion about the changing constructions of identities on the basis of ethnicity in the region and their political significance. Also see Chapter Four.
[7] Mixed race (the majority Mexican non-indigenous population).

identity do not exist. What is problematic about alignments on the basis of gender is the assumption of a desire to erase differences on the basis of ethnicity or race. This is also suggested by the notion of racism as a social construct. This is unarguable. However, political identities are perhaps no less valid for being invented or based upon group consensus, rather than upon community essentialism. It may be political expediency on the behalf of earlier feminist theories, as well as of *mestizo* Mexico, to invoke the notion of race as a social construct. If indigenous peoples have no essentialised ethnic identity, then, likewise, neither does *mestizo* Mexico. To suggest that indigenous peoples should relinquish their traditions, culture and identity on this basis is to align with indigenist politics and its "constant effort to integrate individuals into political totality...indispensable for the state" (Foucault, 1988: 161-162). This "totality results from a constant correlation between an increasing individualism and the reinforcement of this totality" (ibid.: 163). Recent political events in the region have clearly illustrated that the majority of indigenous peoples of Chiapas prefer plurality to homogenisation. Indeed, Mattiace (2003) describes how "[b]eginning in the 1980s, a number of Mexican Indian...intellectuals and leaders began participating in international forums where issues of autonomy, sovereignty and multiculturalism were discussed extensively". Whether this plurality (as reflected in the term "multiculturalism") is on the basis of an essentialised identity or the desire to maintain communities of socialised identities is irrelevant. Although the "indigenous community", like any other, is a "political construct" (Gledhill, 1997: 76; also see Anderson, 1983; Purnell, 2002; Radcliffe and Westwood, 1996; Sieder, 2000a, 2000b; Weber, 1996) and is stratified along gender lines, this is no different from the stratified category of gender (itself a social and political construct) along the lines of ethnicity (amongst others).

These imaginary communities themselves, either in terms of regional ethnic groupings or formally constituted nation-states, rely upon a notion of a shared ethnic identity. Gender identities, particularly in terms of women's roles, play a part in the political processes that create these communities. Yuval-Davis and Anthias (1989: 7) summarise the ways in which women participate in ethnic and national processes as:

- "biological reproducers of members of ethnic collectivities, as "mothers of the nation"s reproducers of the boundaries of ethnic/national groups;

- as participating centrally in the ideological reproduction of the collectivity and transmitters of its culture;
- as signifiers of ethnic/national differences - as a focus and symbol in ideological discourses used in the construction, reproduction and transformation of ethnic/national categories;
- as participants in national, economic, political and military struggle".

Agency in post-colonialism and hybridity

One of the important contributions of post-modern feminism is the understanding that the ways in which women participate in these processes will not be identical even within a particular culture or "invented community". Gender identity is not a singular formulation in any particular cultural context, as this would imply a hierarchy of culture over individual experience. As Moore (1988:190) states, "humans are not simply passive receptacles for cultural meaning: rather, individuals select, negotiate, and interpret meanings as they socially position themselves, participate in cultural discourses, constitute their self-identities, and relate to one another during the course of their daily lives". Women may become empowered by taking part in cultural discourse, as opposed to discourses acting upon them. In discussing the *"Grupo de Mujeres"* (Women's Group) in San Cristóbal de las Casas, Enciso and Guerrero (1995: 972) employ Tarrés' concept of *"campo de acción"*[8] which "refers to the control that women develop over different areas of their everyday space, as determined objectively as well as by definition that women themselves give to this space". The involvement of women in cultural formulations of health care, then, can be perceived as women actively defining their own ethnic identities as well as being defined by their ethnicity. It can perhaps be positively perceived as a process of women assuming agency in the family and in the community alongside an acceptance of the invented and consensual concept of communal identity (see the discussion of social identity later in this chapter). Health care and the reproductive roles of women, then, may count amongst the political processes Yuval-Davis and Anthias mention. However, women are not necessarily to be viewed solely as victims of these processes, even when they are associated with the power relations found in post-colonial communities and inherent in "development".

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[8] Field of action.

Post-development theorists have equated development interventions with the exercise of power in the former colonies against which the marginalised "other" (including women in the "third world") is conceptualised as powerless. Such theory (Escobar, 1995; Esteva, 2003a; Latouche, 2003; Sachs, 2003; Sidaway, 2002) has drawn upon post-modern thought in questioning the basic tenets of post-War development, which equate development with expanded political freedom, social justice, and economic wealth. The failure of the development "project" is highlighted along with the arrogance of the inherent assumption that development equates to Westernisation. The popular notion of globalisation envisions a world shrinking by enhanced communication and an expansion of the global marketplace and speaks of cultural neo-colonisation and "Coca-colarisation". Indeed, the overt political attempts of the political elite of some societies to impose integrationist policies upon indigenous peoples in an attempt to create a homogeneous, rather than multicultural, society (Sieder, 2002) add weight to such arguments regarding the processes of "development".

However, post-colonial and identity theorists (Bhabha, 1996; Fanon, 1993; Hall, 1996; Loomba, 1993; McEwan, 2002; Mishra and Hodge, 1993; Spivak, 1993) have critiqued this vision of homogeneity and posited in its place a world of regionalism, heightened difference and resistance of local cultures in the face of globalisation. Hybridity and agency replace, therefore, wholesale adoption of Western values and different cultural expressions readjust and negotiate global influences. Western culture also shifts in response to "Other" influences within the process of globalisation and change. There may be more power and weight behind the project of Westernisation but, nevertheless, the global marketplace does not extinguish different cultural expressions. Foucauldian analyses of power and recognition of the complex functioning and contradictions of discourses and processes, and particularly of discourses of *resistance,* are obvious influences on these debates. Indigenous women, then, whilst in part defining themselves in alignment with their ethnicity and community, may take up multiple and shifting positions which reflect both exclusionary processes as well as their own negotiation of, and resistance to, these processes.

Post-modernism and the deconstruction of knowledge

One of the ways in which post-development, post-colonial and post-feminist theories have expressed resistance to the Western project of development in conjunction with a questioning of patriarchal power is by deconstructing their epistemological foundations. It is at this point that postmodern theories offer insights which constitute overlapping frameworks for deconstructing both gender identities and debates over health authority and knowledge. The parallel between the two is the hierarchal nature of knowledge constructions and the inherent assumptions both of notions of women's experiences and of the knowledge underlying biomedicine (Brook, 1997). Both rely upon gendered assumptions of "truth" and feed directly into one another. Thus, the easiest way to illustrate this parallel is by deconstructing some of the basic tenets of biomedicine which illustrate the socially constructed nature of its gendered foundations.

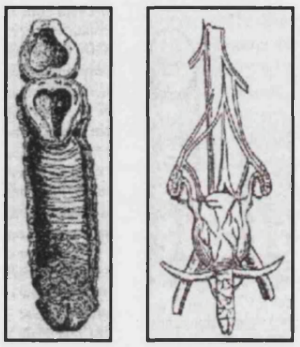
PLURAL CONSTRUCTIONS OF HEALTH

Women's bodies and biomedical epistemology

Feminists have interpreted the epistemological basis of Western biomedicine to be gender biased, revealing the construction of bio-medicinal scientific knowledge, which underpins the Western health care system, to be masculinist in its assumptions. Scientific knowledge is understood to be objective and rational by the very logic of Enlightenment thinking. In many ways, the very assumption of "objectivity" inherent in biomedicine is a source of both patriarchal and global Western power through the dominance given to its knowledge discourses. Therefore, questioning its "truth" becomes difficult. However, identification of clearly gender-biased assumptions within the history of Western medical knowledge aids its deconstruction. In particular, feminists have pointed to the construction of the female body as "Other" and the use of such interpretations in controlling female sexuality. For instance, Laqueur (1997) points out that until 1797 medical students were offered no representation of female anatomy in the form of a female skeleton. From the seventeenth century[9] until as late as the mid-nineteenth century, female reproductive organs were represented as merely an inversion of the male, as Figures 1.2 and 1.3 illustrate.

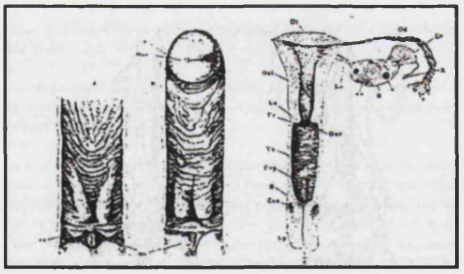
[9] In the seventeenth century, anatomical studies became acceptable in Europe for the first time.

FIGURE1.2: SEVENTEENTH CENTURY DEPICTIONS OF FEMALE REPRODUCTIVE ORGANS



(From *The Anatomical Drawings of Andreas Vesalius*, without date, depicted in Laqueur, 1997: 225)

FIGURE 1.3: MID-NINETEENTH CENTURY DEPICTION OF FEMALE REPRODUCTIVE ORGANS



(From Jakob Henle, *Handbuch der Systematischen Anatomie des Menschen*, Vol. 2., 1866, depicted in Laqueur, 1997: 226)

Understandings of the female reproductive system have constantly been reformulated since the Enlightenment period. Many of these formulations are inconceivable today but represent constructions designed to limit female sexuality. For example, as recently as late nineteenth century England, the clitorectomy (now commonly referred to as "female circumcision", "female genital cutting", or the more value laden "female genital mutilation") was promoted as a "harmless procedure" to cure many female maladies. In

particular it was seen as a cure for epilepsy, which was understood to result from excessive masturbation (Sheehan, 1997: 327).

With reference to historical examples such as the representation of female reproductive organs in Figures 1.2 and 1.3, post-modern feminists have shown how men have constructed this knowledge in their own image (in a kind of God-like analogy) so that the norm of the human body is socially constructed to be male. Arguably, this historical ignorance of the female body represents the ontological foundations of present day Western understanding of health and reproductive issues for women. Whilst understandings of the female body have clearly been radically reviewed in the last 150 years, the seemingly arbitrary nature of the location of this anatomical and surgical knowledge supports Foucault's thesis of the socially constructed body. Contemporary feminist theorists, such as Butler (1993), have taken up this notion. She argues "the very concept of nature needs to be rethought, for the concept of nature has a history" and that the materiality of the body needs to be "recast" in order to comprehend that "the matter of bodies will be indissociable from the regulatory norms that govern their materialisation and the signification of those material effects" in discourses of power (ibid.: 532). As such not only can the very understandings of bodies (the primary sites of biomedical interventions) be understood to be culturally bound (in a similar way to that of identity), but also it is possible to illuminate the construction of the female body as the "Other" within Western scientific knowledge. It is marginal and understood in relation to the male body rather than in its own right. Indeed, Butler (ibid.), like Foucault, interprets the very sexing of the body to be socially constructed. That is to say, it only exists in discourse and not in any notion of "reality".

Similar to the concerns of radical and liberal political feminists in relation to the fluid gender identities proposed by postmodernism (discussed earlier in this chapter), the deconstruction of the sexing of the body necessary to understanding its social construction also presents a challenge to feminism, some forms of which have been characterised as "gynocentric" (Bulbeck, 1998: 13). It gives "women" no real fixed ground to locate their oppression, particularly forms of oppression which are directly related to the sexed identification of their bodies, such as rape, domestic violence and abortion for example

(Ramazanoglu and Holland, 1993). This is, then, a theoretical development that can on the one hand be liberating for women but at the same time is problematic.

Nevertheless, there are also gender advantages and implications to these debates. For instance, conceptualising the construction of women's bodies as "Other" provides at least partial explanation for the universalist objectification of their bodies in population policy, which does not necessarily consider women's bodies, personhood or rights in a holistic or individual way (see Chapter Three). A universal approach to understandings of women's bodies and their reproductive functions is clearly vital in the formulation of health and reproductive programmes. However, the ways in which such programmes are received and negotiated may depend in part upon entirely different conceptualisations to those of Western scientific knowledge. By deconstructing the central tenets of biomedicine (even to the level of the sexing of the body) and questioning its certainty, the perhaps infinite variety of such other constructions becomes visible. We are educated to accept the contemporary formulations of scientific knowledge on the basis of scientific investigations. Students of medicine in nineteenth century England, however, were no doubt equally convinced of its objectivity (also see Foucault, 1973). With a recognition of the socially constructed nature of its historical origins, the location of power with biomedical masculinist discourses through Enlightenment scientific reason may thereby be challenged. It also becomes possible to acknowledge that cultural differences will play key roles in understandings of health and reproduction and that women in particular may have differing relationships to such issues.

Fluid cultural boundaries and "biopower"

Western biomedicine is, then, not as objectively neutral as might be assumed and this insight allows for the conceptualisation of plural knowledge constructions in relation both to gender identity and to health. Indeed, Brook notes that there are "distinct parallels between postmodernism and feminism" in terms of the critical positions adopted towards the narratives of western Enlightenment" (Brooks, 1997: 93). Like the development process itself, and many other patriarchal constructions, the sphere of health and medicine is not exempt from discourses of power and knowledge. As the above discussion indicates, its gendered epistemological basis can be deconstructed. Similarly, the role of medicine

within the development process is open to critique. Indeed, the role of "the clinic"[10] as a political process of control and regulation has been particularly demonstrated by Foucault (1973: 1984). His work in the sphere of medical practice shows that "biopower" has been given to dominant (Western) rituals, practices and understandings of the body and the factors involved in generating physical health and illness through biomedicine's "scientific" claim to universal truth and knowledge. The location of power with such rituals, practices and understandings can be understood in relation to Enlightenment notions of scientific progress. Lock (1999: 45) summarises the hierarchical attitude of health professionals in "normalised Western society":

> "An assumption is made that in the heartland of the so-called developed world those of us with education have in effect advanced beyond culture, except in its usage to describe aesthetic sophistication. Culture, implying a way of life of a group of peoples, remains struggling, usually not very effectively, to catch up."

This perspective is clearly echoed in the position taken by the WHO (2000: 11) towards "traditional practices":

> "Throughout the world, traditional practices based on herbal cures, often integrated with spiritual counseling, and providing both preventive and curative care, have existed for thousands of years, and often coexist today with modern medicine. Many of them are still the treatment of choice for some health conditions, or are resorted to because modern alternatives are not understood or trusted, or fail, or are too expensive...But until the modern growth of knowledge about disease, there were few cures for ailments and little effective prevention of disease"

Western conceptions of health, however, are unquestionably as bound to cultural processes and institutions as any other conceptions. They are formulated out of specific sets of historical discourses, which have their origins in the medical institutions of post-Enlightenment Europe. The influence of Enlightenment thinking based upon "reason" and intellectual and scientific "progress" means that those bound to Western constructions are inevitably convinced of their scientific objectivity – their ultimate truth – and, therefore, the

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[10] As Sheridan, the 1973 translator of "The Birth of the Clinic" (Foucault, 1973) notes, "When Foucault speaks of *La clinique*, he is thinking of both clinical medicine and the teaching hospital". The term is used to signify the ontology and practice of biomedicine in the modern European context.

benefits they may bring to other societies. Nonetheless, it is a matter of equity (and humility) to give due credence to differing conceptualisations of health, particularly in the case of post-colonial nations. Giving voice to the "marginalised Other" and realising that different, and generally dismissed, health discourses do not easily fit into the Western model may help ensure that neo-colonial processes do not accompany global health interventions and strategies. The first step is a difficult one as it necessitates a repositioning of Western knowledge and recognition of its constructed nature.

There has been a multiplicity of theories of health in Western medicine (for detail, see Stein, 1997: 74-86). Historically, however, these essentialised biological explanations have specifically and solely located pain and illness in the physical body without reference to the individuality of the person. For example, eighteenth century classificatory medicine instituted a mathematical evaluation of illness in which "[i]f one wishes to know the illness from which he is suffering, one must subtract the individual, with his particular qualities" (Foucault, 1963: 14). More modern interpretations of disease may be rather more qualitative than this "medicine of species" but nevertheless the scientific influence is telling. Identification of key transmittable diseases to be targeted by global health strategies by international agencies reflects this influence. Lorber (1997:1), however, emphasises the "social construction of illness" in stating that:

> "In every society, the symptoms, pains, and weaknesses called illness are shaped by cultural and moral values, experienced through interaction with members of one's immediate social circle and visits to health care professionals, and influenced by beliefs about health and illness."

As Lock states, it is only with this realization can we then perceive that the "body functions consciously and unconsciously, as a medium for the expression of distress" and this is itself an experience which is "culturally mediated" (Lock, 1999: 44; see also Tones, 2000: 43-44).[11] Health and illness then are subjective definitions, which are interlocked with cultural and social constructions of identity:

[11] It is important, however, to note that this cultural mediation is not unchanging. Cultures, and their norms, are not static. Lock also makes this point, stating that a "reinvented history" is often invoked and "frequently imagined as one uncorrupted by the effects of colonization, by contemporary participation in a pluralistic society, or by the global homogenization of modernity" (Lock, 1999: 45).

> "...self and identity concepts [are used] ...to understand human thought, feeling and action...Self related concepts are crucial in accounting for interrelationships between the individual and larger sociocultural institutions and systems. Self and identity, as important constructs in social and behavioural research, ought to be useful in facilitating understanding of those social and behavioral factors associated with physical well-being and disease" (Contrada and Ashmore, 1999: 4).

Global health strategies; local negotiation

Acceptance of the complex nature of health and reproductive issues and particularly of the culturally and socially constructed nature of health and illness at individual levels is, however, difficult to maintain alongside global health strategies, which draw upon Western biomedical techniques. Such techniques have been exported to societies, such as Mexico, in forms ranging from curative and clinical disease control to the more recent Primary Health care (PHC) models.[12] These Western models have been represented as a superior alternative to the previously existing "traditional" medicines and, indeed, as oppositional to these "other" medicines, although reality is more plural and shifting. The perspective of scientific objectivity and progress, described above by Lock, results in the "other" often being perceived as backward and indeed dangerous (Coronado, 2005).

There is clearly an issue of power and regulation involved in this exportation and participatory development (Cornwall, 2002) is making an effort to redress this balance. Nevertheless, there are also practical issues at play. The existence of global health strategies and targets based upon normative (Western) evaluations of health mean that it is difficult to secure funding and initiate programmes which are based upon a more integrated and culturally equitable approach. Global targets are clearly altruistically motivated and serve a significant role in drawing attention to key issues. However, there are also disadvantages both from a practical and an ethical point of view. Firstly, an ignorance of "indigenous knowledge" may be to the detriment of global society, which could benefit from knowledge of different techniques and medicines (Coronado, 2005). Secondly, Western clinical and concepts of disease and illness may, initially at least, be alien in many societies. In such contexts, funding aimed at promoting purely "Western" medical practice

[12] See Chapter Three for detail on developments in global health policy.

(without effective negotiation of other concepts and practices of health and illness) is perhaps being wasted:

> "...there is an increasing gap between the concepts and models professionals use to understand reality and the concepts and perspectives of different groups in the community" (Grandstaff et al, 1987; see also WHO, 1973).
>
> "The biomedical interpretation and understanding of diseases, supported by studies carried out in laboratories, is in many cases different from the understanding embedded in local culture and history...Second, many factors, cultural, historical, socio-economic and political, which are difficult to measure have a crucial influence on the outcomes of interventions and efforts to improve the health of people: "[Development work] cannot ignore these factors and pretend that the world outside the laboratory is the same as inside" (De Koning and Martin, 1996: 1).

Pluralistic health behaviour

In the case of Mayan communities of Chiapas, illness is often seen as a product of envy and witchcraft performed upon the spirit. Western medicine is perceived as having the potential to control the symptoms of resulting illnesses. In some cases this may be sufficient. However, it is not usually understood to be able to cure the underlying cause. A *curandero*, or traditional healer, is perhaps better qualified to treat this. This explanation of illness, however, appears alien to those of us grounded in Western medical conceptualisations of the body and illness and many scientific biomedical practitioners may see it as "primitive". Nevertheless, perhaps it is only as meaningless, or meaningful, as the rituals and practices of Western medicine, many of which Foucault reveals to have little grounding in logic or potential beneficial outcome. Indeed it may be that the knowledge of the many herbs and plants, which is incorporated with religious rituals, could be acceptable to Western visions of medicine. Both perhaps have something to offer and neither should be disregarded. In adopting this perspective, it becomes possible to replace "objective" definitions of health with more inclusionary, subjective definitions (Coronado, 2005; Dutta-Bergman, 2004).

These subjective definitions are inclusionary not only with respect to consideration of "other" health beliefs from the perspective of Western health policy-makers and practitioners. The conceptions of illness and treatment of its symptoms and causes in Mayan Mexico (described above) also illustrate that individuals themselves are

inclusionary in terms of their pluralistic perspectives on health and its treatment. As noted earlier in this chapter, post-development theorists are noting hybridity in local resistances to globalisation. Health seeking behaviour is no exception and the negotiation of different health beliefs and services is widely acknowledged, even in those circumstances where strong concepts of ethnic difference and spiritual explanations of illness and the body exist. For example, in discussing "post-colonial health communication" as informed by the "subalternity of marginalised people" in Santalis, India, Dutta Bergman (2004: 250-251) notes that:

> "Multiple contradictory meanings play a fundamental role in the Santali conceptualization of health. Most pertinently, they have mixed motivations, understandings, experiences and feelings about the different treatment options available to them...[D]espite the belief that modern medicine does not eradicate the true cause of the disease...Santalis narrate that they treat disease and illness with homeopathic, allopathic and ayurvedic medicines, accompanied by visits to the ojha or local Hindu temples."

Similarly, whilst Coronado (2005) acknowledges resentment on behalf of indigenous users at the contempt expressed by Western health care providers towards their "strong beliefs formed by different models for understanding health and disease, and different methods for healing", he also notes that they are "able to accept some of the others' views and transform them into their own worldview, so long as they provide practical, effective, low cost treatments" (ibid: 175).

Pluralistic, inclusionary, perspectives on illness and health care services do not necessarily imply a rejection of cultural heritage (or the communal ethnic identities discussed earlier). As noted in the discussion of gender and ethnic identities in this chapter, individuals take up shifting positions in relation to global and local influences.

Plural medicine and women as negotiators

The existence of non-Western cultural beliefs and practices is likely to make a significant difference to whether, and how, women accept Western perspectives on health and reproduction (see the discussion of pregnancy and childbirth in Chapter Eight). The existence of services based in "other" paradigms of health does not, however, imply a dichotomy between services neither in terms of utilisation nor of provision by women.

Rather, many current debates over the uptake of healthcare refer to pluralistic perspectives on healthcare and pragmatic "healer-hopping" (Ernst, 2002; 2) on the part of users. Similarly, just as contemporary Western healthcare models are increasingly borrowing from "alternative" medicines, so "traditional" health care providers are more pragmatic and accepting of the incorporation of biomedicines into their practices in ways which call into question the "authenticity" of either paradigm. Indeed, research has shown that local healers may act as "cultural brokers" between the different systems (Digby and Sweet, 2002). For example, the *"inyangas"* (traditional healers) of Swaziland counter the dangerous or immoral forces causing illness and misfortune" (Reis, 2002: 99) in a similar way to Mayan *curanderos*. They do so by "practising combinations of herbalism, divination and biomedicine, with some even using alternative techniques derived from Asian or Western contexts" (ibid: 99-100). Nevertheless, despite this inclusive approach, ethnic identity is still emphasised by *inyangas* with a public image of being "ancestor-inspired" (ibid: 101). Similarly, the institution of *curanderismo* in other Mexican indigenous populations has been seen as a basis upon which indigenous culture might be reproduced as a cultural matrix in which tradition is both transformed and dynamically regenerated (Bonfil, 1987).

Such discussions regarding pluralistic medicine often draw upon the wider theoretical frameworks of cultural hybridity and post-colonialism in which "localism" becomes a byword for the means by which those in developing countries adapt and negotiate global trends without wholesale adoption or relinquishment of traditional cultural values and customs (Bhabha, 1996; Fanon, 1993; Hall, 1996; Loomba, 1993; McEwan, 2002; Mishra and Hodge, 1993; Spivak, 1993). In this case, this implies that medical practices are "multiply determined" and "locally emergent" (Ernst, 2002; 14) in response to the existence of Western medical systems rather than acting in opposition to such systems.

Users of such services may be part of the motivation for such incorporation and their pluralism as exposure to the benefits of other services creates demand for certain aspects within those traditional services with which they are most accustomed. Indeed, in the example described above from Swaziland, some diseases are the domain of biomedicine and some of traditional healing. However, "therapy choices are ultimately made by the

patients themselves" (ibid: 100). The theoretical framework of post-colonialism, therefore, also offers much for the conceptualisation of women as users and providers of healthcare in developing societies. As noted earlier in this chapter, previous feminist debates often constructed women as "victims" of patriarchal health services (Hillier and Scrambler, 1997). Within post-modern (and related post-colonial) feminist models, however, women are no longer envisaged as merely victims of patriarchy or global processes but rather as agents in their negotiation at local levels (Brooks, 1997; Mendoza, 2002; Sampaio, 2002; Saunders, 2002; Sharpe and Spivak, 2002). The nature of this agency may be disputed in a world itself envisaged as shifting and contingent (Brook, 1997), but Butler (1990) offers a resolution in the proposition that the possibilities of variation created by multiple discourses themselves allow for the assertion of agency. Sampaio (2002) applies this "pluralistic model of resistance" (Brooks, 1997: 107) to an analysis of the political movements of indigenous women in Chiapas, understood in terms of a duality between "subordination and agency", and who possess "unexpected ways of enabling creative forms of resistance" to processes of marginalisation (Sampaio, 2002: 187).

For non-Western health services at least, the choices employed by women users may play a role in shaping and reconfiguring the services which are offered. The relationship between women and such processes has been particularly examined within the field of postcolonial cultural studies where it is noted that:

> "Our understanding of the problems of "real" women cannot lie outside the imagined constructs in which and through which women emerge as subjects...Culture, then, viewed as the product of beliefs and conceptual models of society...as well as the everyday practices, the contingent realities, and the complex process by which these are structured, is the constitutive realm of the subject. As a result, culture appears as the chief matter and consequence of dominant ideological investment, powerfully coercive in shaping the subject; but since it is also heterogeneous, changing and open to interpretation, it can become a site of contestation and consequently of the reinscription of subjectivities." (Sunder Rajan, 2003: 10)

In this case, this contestation and reinscription is reflected not in a cultural expression (in terms of writing or similar forms of expression) but rather within the everyday spaces of

daily life and, in the context of this thesis, in women's negotiation of both their preferences for formal health care providers, as well as of their own roles as providers of health care.

Development interventions and debates have often viewed women as themselves backward and, as such, oppositional to the rationality of the Western world and Western women (Mohanty et al, 1991). This is reflected in the notion of women as "victims" of "dangerous" non-Western practices, of which traditional health care (or the preference for large families) is a prime example. In reality, however, women (and their families who may be equally important in health seeking decision-making) are not passive recipients of healthcare and cultural practices. On the contrary, women themselves are likely to be active actors and hold their own beliefs, which are reflected in their health care and reproductive preferences. Therefore, the pluralistic reproductive and health behaviour and perspectives described in the case study chapters of this thesis indicate a pragmatic response to the existence of differing sources of information, the negotiation of ethnic identity (as expressed in non-Western health care), and the existence of other health and reproduction paradigms. This response will not necessarily be binary or dualistic – a fixed choice between one paradigm (or set of services) or the other - but rather women become inclusive, rather than exclusive, and shifting in their choices.

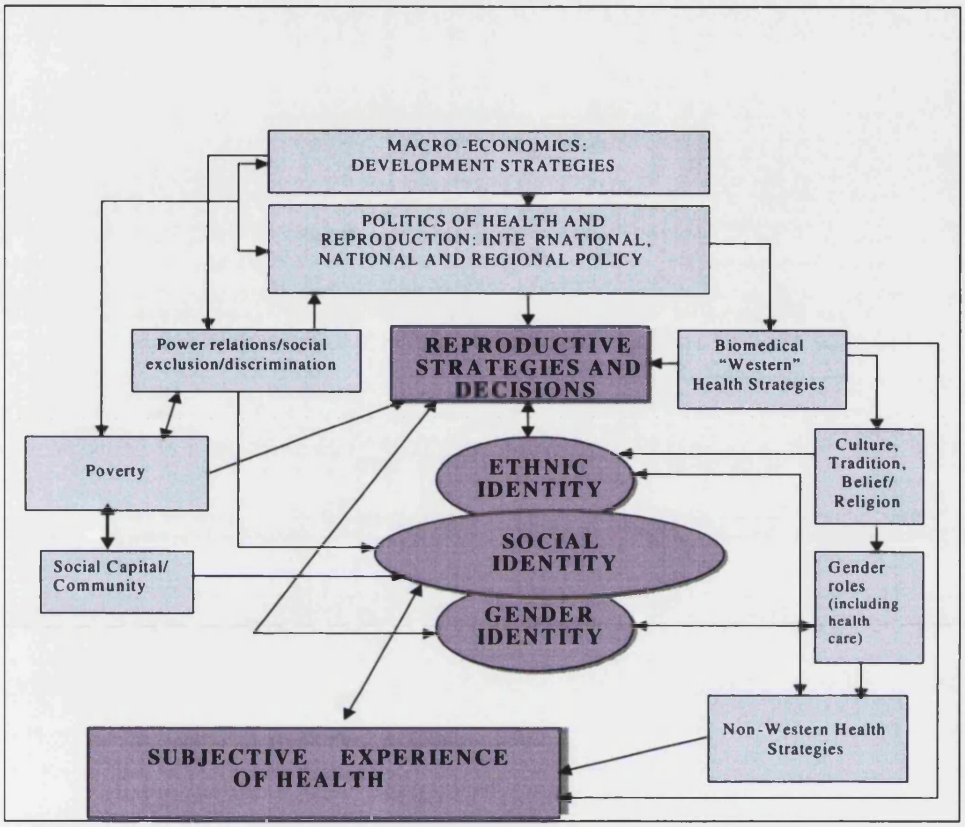
This, however, is not the whole picture. As Bulbeck (1998: 53) notes, "postcolonialism has been accused of playing down the power relations between cultures" and "indigenous women can construct their subject position as they like but it will not necessarily shift the dominant discourse" (ibid: 15; see also Purnell, 2002). Whilst women may find their own means of operating around dominant practices and existent realities, which may function on some level as a form of contestation, these realities persist. There is scope for shifting the local realities of traditional services which are themselves marginal to the dominant discourse of Western biomedicine. However, health services based on the latter paradigm reflect more powerful influences, often in the form of international and (related) national policy. In addition, other realities, principally those of exclusion and poverty, continue to operate as unchangeable contexts to women's agency (see chapters three and four). Therefore, their pragmatic responses and negotiations also necessarily reflect coping strategies and the search for cost-effective, and acceptable, services within such contexts.

EXPERIENCES OF HEALTH AND REPRODUCTION: POVERTY, EXCLUSION AND IDENTITY

Understanding women's relationship to health (both understanding of illness and health behaviour) and reproduction is clearly not simply a matter of epistemology and cultural identity. There are many differing factors at work in experiences of health and reproduction. Subjective experiences of health and reproduction are complex relationships between identity and external processes. The latter include international and national discourses of power, represented by policy debates and trends (see Chapter Three), as well as influences closer to home. Such influences include cultural beliefs and practices but experiences of marginalisation and poverty are also particularly significant. Subjective experiences of health are formulated in relation to the construction of social identity. The latter is perhaps best conceptualised as individuals' self-conceptualisation in response to socially and individually experienced influences and negotiations of these influences, rather than as a fixed identity. Ethnicity and gender intersect and are the keys to this self-conceptualisation. However, the precise ways in which these identities are constructed are subject to multiple influences, which affect behaviours, decisions and subjective experiences of health and reproduction, as well as the inter-relationship between reproductive and health issues themselves. Figure 1.4 illustrates some of these influences and relationships. It is not a comprehensive picture of the multiplicity of directions and linkages but highlights some of the most significant issues and debates with which this research engages and which are relevant to women's experiences. By its very complexity, it also indicates that the debates involved in health, reproduction and identity should not be oversimplified and that the context of health and reproductive policies must always be taken into account. As noted above, this is not a fixed conceptualisation as the relationships represented are shifting and similarly the ways in which women negotiate these different factors will not be uniform.

Health and illness are relative concepts based upon personal experiences and individual contexts. These contexts not only differ in relation to ethnic knowledge constructions but also in relation to economic status. The 1948 WHO constitution (WHO: 1992) gives a universal definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" and states that the achievement of this

FIGURE 1.4: FACTORS INVOLVED IN HEALTH AND REPRODUCTIVE EXPERIENCES



state is a fundamental human right. This definition of what constitutes good health reflects Foucault's suggestion that medical practice includes a "normative posture" in which "[m]edicine must no longer be confined to a body of techniques for curing ills and of the knowledge that they require: it will also embrace a knowledge of healthy man, that is, a study of non-sick man and a definition of the model man (Foucault, 1973: 34). However, as Foucault states, this model healthy man is a normative construction. The definition of the healthy state using the adjective "complete" and including the "absence of disease and infirmity" suggests that Western medicine continues to institute an oppositional relationship between good health and illness. This is residual of the nineteenth century preoccupation with the "healthy/morbid opposition" and the "medical bipolarity of the normal and the pathological" (ibid.: 35). However, the highest possible achievement of this state of well being is necessarily defined according to relative standards of living and expectations (Chant with Craske, 2003; O'Byrne, 2000; Phillips and Verhasselt, 1994). How we may

classify illnesses, or good health, in the prosperous North will entirely differ from classifications, understandings and definitions given in a context of poverty and marginalisation, where experiences and identities differ radically and where processes of social exclusion have multiple effects on relationships to health.

Land and social exclusion: health and reproductive issues

The formulation and implementation of health care and reproduction policies do not occur in a vacuum. The latter should be viewed in the context of more general gender and ethnic exclusionary discourses. The prominence given to the Western model of health care to the exclusion of "other" ethnic formulations of health in the developing world not only relates to assumed objective analyses of its benefits to the poor and a lack of recognition of the subjective nature of health and illness. It also relates to relative economic and political participation in general terms. The term "social exclusion" has its origins in the European policy making arena of the 1990s and relates to the political context of individual society in providing a more holistic vision of poverty and a lack of ability to participate in society (see Benn, 2000; also Anthias, 1997; Coates et al., 2001; Faist, 1997; García, 1997; Rodgers, 1995; Samers, 1998). Social theorists such as Luhman (1990, 1998) later took it up. Despite its European origins, the theory is also useful in the context of the developing world. Burchardt et al (1999: 231) identify five key areas that constitute normal societal participation:

1. "Consumption activity: being able to consume at least up to some minimum level the goods and services, which are considered normal for the society...

2. Savings activity: accumulating savings, pension entitlements, or owning property...

3. Production activity: engaging in an economically or socially valued activity, such as paid work, education or training, retirement if over state pension age, or looking after a family...

4. Political activity: engaging in some collective effort to improve or protect the immediate or wider social or physical environment...

5. Social activity: engaging in significant social interaction with family or friends, and identifying with a cultural group or community..."

With reference to these inclusionary activities, it is clear that social exclusion has a dual impact on health and reproductive issues in the developing as well as in the developed world. First, without effective societal participation, it is difficult to influence the policies that affect marginalised communities and individuals, including health and reproductive policy. Conversely, without good health, it becomes difficult to participate fully in society. Health, then, can be considered not only as a fundamental human right but also as a "democratic right". Many of the indigenous groups of Chiapas constitute socially excluded groups from all of the above categories of social exclusion mentioned above precisely because of their marginalised ethnic identities.[13] Of particular importance in terms of their ability to influence health policies directed towards them is their lack of political and economic participation on a national level. As the WHO (2000: 13) notes, this lack of participation has historically meant "[c]olonial powers in Africa and Asia, and governments in Latin America, had established health services that for the most part excluded indigenous populations". These exclusions have persisted into the twentieth, and now twenty-first, century.

Secondly, social exclusion has obvious impact on states of health, as discussed earlier in this chapter (also see Chapter Six). For instance, poverty influences decision-making processes in terms of which health services are chosen. It is particularly influential on reproductive decision-making where the correlation between poverty and family size is made in international and national neo-Malthusian population policies. The use of family planning is similarly rationalised at local and individual levels. In the rural environment of Chiapas, family planning is promoted with particular respect to restricted access to land. The issue of land has played a key role both in pre-revolution and post-revolution Mexican history (Purnell, 2002). It persisted as a politically prominent issue throughout the 1930s Cárdenas land reforms and remains so until the present day. Neo-Malthusian population policy links poverty and access to economic resources. This is the basis for viewing population expansion as problematic (see Chapter Three). In the majority of rural contexts in the developing world, "economic resources" signify "productive land" (as well as the ability to participate in a fair trade for the produce of such land). The data from this

[13] See Chapter Four for detail on the historical processes that have created the contemporary social exclusion of the majority of indigenous groups in Chiapas.

research reveal that it is access to land, and the ability to work this land, which is given as justification for limiting family size both by local level medical professionals and by respondents themselves. Therefore, whilst inclusion in political activities is important in terms of influencing the direction of health policies, inclusion in (agrarian) productive activities is significant in terms of how existing policies are negotiated.

The referents of "inclusion" are no doubt different from those of the industrialised world, particularly for marginalised groups in the rural context. However, the term is yet more relevant as a result of present trends of globalisation, which serve to heighten the levels of exclusion. Contrary to the inclusive rhetorical aims of European governments (see Coates et al.: 2001), recent governments of developing nations have little choice but to follow the neo-liberal path of structural adjustment, the restrictions of which potentially further exclude marginal groups (see Chapter Three). Therefore, in the context of the developing world, the concept of "social exclusion" is one that requires international, rather than solely national, referents and definition. In Chiapas, increasing levels of social exclusion, resulting from the globalising tendencies of the Mexican state, have not been without protest and recently there has been a resurgence of interest in the state of Chiapas because of the conflict initiated in 1994 by the *"Ejército Zapatista de Liberación Nacional"* (EZLN).

Although the EZLN uprising was not the first peasant uprising in the region, it was the first to gain international attention (Collier with Guaratiello, 1999: 54). Amidst a plethora of articles, research has begun on the causes of the conflict and related political and economic issues. The great majority of rural indigenous communities of Chiapas rely upon subsistence agriculture (see Chapters Four, Five and Six). Agrarian issues, then, are of particular relevance. Agrarian reform can contribute to exclusionary processes and, as such, may influence health (as discussed above). Land issues also particularly impact on reproductive decision-making. The institutionalisation of NAFTA (the North American Free Trade Agreement) necessitated reform of Article 27 of the Constitution. This altered the *ejido* system formulated in the 1917 Constitution and allowing for the formal privatisation of *ejidal* land and was the major catalyst for the EZLN conflict. Collier's work (1994), however, reveals that the previous agrarian system had also excluded

indigenous peasant farmers. The study details the theoretical collectivity of the former system in being a "framework for collectively managed, community-based production on small holdings" (ibid.: 106) but suggests that, in reality, this utopian ideal had always resulted in the more marginal land being placed in the hands of peasants while the more productive and irrigated land remained in private ownership. In addition, although in the previous law, *ejido* land was only to remain in the possession of a particular *ejidatario*[14] whilst he himself is working it and cannot be rented to others or sold, in practice this had not been the case. Many *ejidatarios*, who for one reason or another were unable to personally work their land, rented out or illegally sold their land to others so the communal, non-class stratified system was always, at least to a certain extent, a utopian ideal (also see Purnell, 2002).

The *ejidatarios* then have a history of marginalisation from productive land. Only radical reform could be expected to have a great impact. Given these realities of land usufruct history noted by Collier, it is doubtful whether the recent privatisation of land will substantially worsen levels of social exclusion (and reproductive and health decisions made on the basis of this exclusion). This privatisation is, however, symbolic of a change in attitude from a rhetorically paternal state to a globalised, neo-liberal form of government. Theoretically this may be linked to the Foucauldian notion of a change in analysis of the state. In a reworking of the Machiavellian model, "the aim of a government is to strengthen the state itself" (Foucault, 1988: 150). In this case, the state is internationalised and so a strengthening processes has little relation to domestic, paternal concerns of assuring productive land for the peasantry. Instead, the Mexican state is primarily attempting to strengthening its position internationally, "to hold out against the others", (ibid: 151) because "[p]olitics now has to deal with a irreducible multiplicity of states struggling and competing in a limited history" (ibid.:152). This struggle, in Mexican terms at least, is at the expense of its dispossessed:

> "...since the governments must have for an exclusive aim not only the conservation but also the permanent reinforcement and development of the state's strengths...From the state's point of view, the individual [only] exists insofar as what he does is able to introduce even a minimal change in the strength of the state, either in a positive or negative direction' (ibid.: 153).

[14] Peasants who have usufruct over *ejido* (communal state) land.

When the Zapatista army stormed the municipal buildings in San Cristóbal de las Casas on January 1st, 1994 they were forcing recognition of their existence. Formally, the catalyst was the institution of NAFTA. This agreement was only a part of a general shift. They were reacting against a state which had been changing over the previous decade (Esteva, 2003b). Its previous corporatist structure had allowed interest groups a stake in government policymaking. Constitutional protection of the *ejido* system had also given at least rhetorical assurance to peasant interests. However, Salinas'halt to "revolutionary" agrarian reform brought about a final end to this peasant relationship with the state (Collier with Quarantiello, 1999). Since "Salinastroika",[15] the Mexican state had been "democratising" along North American lines under pressure from the World Bank and the IMF.

CONCLUSION

This chapter has shown how it is important to analyse and acknowledge difference when examining health and reproductive issues. This "difference" is not one of opposition but rather should be understood within a conceptual framework of pluralism and subjectivity. This conceptual framework applies both to women's identities as well as to the ways in which these identities interact with health and reproductive care and traditional / Western services as users and providers. A pluralistic perspective offers a potential space for understanding women not as victims but rather as negotiating agents. However, this agency is strongly mediated by coping strategies in relation to the context of poverty (particularly with respect to social exclusion and land rights issues) and the health and structural issues confronted by women generally in the developing world (as described in the first sections of this chapter).

This chapter has emphasised the social, economic and political context in which health and reproductive policies are experienced and has indicated that social exclusion negatively affects participation in the formulation of policies, which in turn informs the ways in which services are provided. Chapter Three deals with similar issues by revealing the broader

[15] An ironic euphemism for the Salinas presidency, which increased the rate of major neo-liberal reform begun in the Madrid presidency (1982 – 88) (See Collier with Quarantiello, 1999)

issue of poverty and the power relations encompassed in development discourses and processes, which profoundly influence the formation of global, national and regional health and reproductive strategies that affect the case study region. Chapter Four then notes the particular history of the exclusion of indigenous peoples of Chiapas which has forms the context of their reception of such policies as well as the reasons for their lack of influence upon policy which affects them.

However, previous to these discussions, Chapter Two will relate the issue of difference expounded in this chapter to the methodological approach employed by this research, thereby highlighting the inextricable link between research process and content.

CHAPTER TWO

METHODOLOGICAL ISSUES IN RESEARCHING GENDER AND DIFFERENCE

INTRODUCTION

In this chapter, I aim to briefly outline the methodological rationale and the methods employed in undertaking this Ph.D. research. As such, I will touch upon the epistemological and ethical issues involved in undertaking a piece of research whose content is centred upon theoretical concepts of difference and power in terms of gender and ethnicity. More specifically, the content of this research questions the power dynamics of the relationship between Western and non-Western worlds and their differing knowledge constructions. Therefore, as a researcher with a Western identity with a focus of research in a non-Western environment, it is critical to examine the contradictions and issues that arise. Equally, it is necessary to discuss the issue of exclusion and the appropriate model of research that might fully allow marginalised voices an appropriate space.

This chapter commences with the latter discussion, building upon the analysis of the previous chapter. It also refers to relevant previous research in order to compare the methods and subsequent findings with those of this thesis. The particular issues faced during fieldwork are then discussed in relation to a feminist rationale of difference in order to highlight the inextricable link between methods employed and theoretical framework. Finally, a thorough presentation of these methods is combined with a discussion of their benefits and limitations in order that the origins and motivation for selection and analysis of data provided within the rest of this thesis is transparent and clearly justified.

METHODOLOGICAL RATIONALE

Researching the social context of reproduction and health in Chiapas

An understanding of the social exclusions discussed in the previous chapter, both in terms of indigenous ethnic communities as a whole and specifically in terms of indigenous women, is necessary in order to fully appreciate the context in which the relationships between health, reproduction and identity occur. This research complements a body of empirical research work particularly focussed on similar issues in Chiapas. There is substantial locally initiated work on health and reproduction in the region, although that concentrating particularly upon indigenous women (rather than women as a whole in Chiapas) is relatively sparse. In addition, much work has been quantitative in approach rather than qualitative. Whilst useful for gaining a broad perspective, quantitative methods can restrict cultural and social analysis that would aid understanding of the social and cultural context of health and reproductive issues.

Most recently, a 1997 compilation of research studies undertaken by *El Colegio de la Frontera Sur* (College of the Southern Border / ECOSUR) deals with a variety of themes relevant to this study, ranging from the contraceptive practices of non-indigenous women in Chiapas (Nazar *et al.*, 1997: 11-33) to cultural factors involved in the sub-registration of indigenous female deaths in the region (Freyermuth and Fernandez, 1997: 33-55). The former presents demographic information taken from censuses and makes analyses on the basis of historical change and geographical differences within Mexico, referring to variables such as level of education, age, marital status, fertility and child mortality rates. The analysis is hindered to a certain extent by its lack of profundity and little social or psychological analysis. However, it provides an insightful overview of contraceptive practices of Chiapas and how they differ from those of other regions. Yet it provides no information about the contraceptive practices of indigenous women and it appears that no such analysis yet exists. This is no doubt because the use of contraceptives by indigenous women is a relatively new phenomenon and because of the difficulties of obtaining data owing to the remoteness and closed nature of many indigenous communities, the low levels of female literacy and the unstable political situation in recent years.

Freyermuth and Fernandez's work (1997) relating to the registration of deaths of indigenous women, however, does discuss in great depth the social and cultural background of death registration. As such, many of the findings are related to the focus of this study. Although statistical information is also provided, the emphasis is very much upon qualitative analysis. For example, the authors note that the registration of fewer female deaths may be partially explained by a lower rate of female registration at birth. This, in turn, is caused by the cultural constructions of gender roles and the belief that men alone need such registration in order to complete school studies and hold religious and political posts of authority (ibid.: 41).

Other ECOSUR publications have also focused upon health both in Southern Mexico and in Guatemala (see, for example, Halperin and Montenegro, 1996). However, in contrast to the latter work and this thesis, these studies primarily base their findings upon quantitative analysis. Other notable research includes that of Holian (1985), which looks at the differing fertility rates between *ladino*[1] and indigenous women in Chiapas and factors affecting these rates in the last decade, and work by Page Pliego (1996) relating to religious and political influences on the medical practices in a Tzotzil community of Chiapas. This in-depth study of one community's religious beliefs regarding medicine and its political interaction with the Catholic Church is illuminating, although it lacks gender analysis.

These studies provide a useful background to this work but either do not endeavour to delve into social and cultural contexts or have a specific focus other than health and reproductive issues for indigenous women in the region. The analysis of the relationship between health and reproductive issues and identity construction attempted by this thesis shows that women should not necessarily be regarded as victims. Indeed their roles and interaction with Western and "other" health and reproductive beliefs and practises may indicate agency in constructing ethnic and gender identities. However, this must be weighed against experiences of social exclusion on the basis of a combination of ethnic and gender identity.

[1] Non-indigenous or indigenous peoples acculturated to *mestizo* lifestyles.

The household as the unit of analysis

The most effective methods of conducting an investigation that fully appreciates these differing facets of exclusion and agency are perhaps debatable. The particular methodological approach taken by this research has been to use the household as the primary unit of analysis but also to look at individual women and processes *within* these households. Many social research projects, and particularly those concerned with quantitative representations of poverty, well-being and health trends, concentrate upon the household unit as the focus of analysis. This is a convenient model and one that is a source of much socio-economic data. The "household" is generally signifies a functional arrangement which includes "co-residence, economic co-operation, reproductive activities such as food preparation and consumption, and socialization of children" (Varley, 2002: 330). As such, it is a useful model for study. However, it potentially draws attention away from relations *within* the family and, therefore, individual experiences of culture and poverty. It is a perhaps hindrance to studies aiming, as this one does, to highlight difference on the basis of ethnic, and particularly, gender identity. It is particularly necessary to recognise that households are "cultural constructs" and, as such, "[w]e should not assume that our own society's understanding of "household is shared by others" (ibid.). The present study adopts an approach that combines the analysis of quantitative data with qualitative data obtained at an individual level. The limitations of the household model are recognised, particularly with respect to the Western cultural assumptions contained within such an approach. Nevertheless, despite the difficulties, it is hoped that the usefulness of the functional aspects of the household model may be retained whilst cultural differences in structure are taken into account and the perspectives of individual women will go at least some way to overcoming its inherent cultural assumptions.

Similarly, previous work on related topics has highlighted the need for more analysis *within* the household. Of particular interest is work on women-headed households (for example, see Chant, 1997a; 1997b; see also Bradshaw, 1995). In contrast to prevailing public opinion regarding women-headed households in many industrialised countries, Chant (1997) recognises that women headed households are not always to be regarded as vulnerable. It has been illustrated that women-headed households are not necessarily the "poorest of the poor" and indeed that female household heads compare well with female spouses within

male-headed households, particularly if the definition of poverty is enlarged. An emphasis on material poverty alone "negates psychological, demographic, legal-institutional factors...important in the formation and survival of women headed households which may mean more in terms of personal perceptions and experiences of hardship than economic factors per se" (ibid.: 2).

This emphasis upon processes within the household and upon individual actions and perspectives is useful to any study of women, whatever their household status. It is particularly important when looking at issues of identity where perceptions are perhaps more important than "objective realities". Negotiation and bargaining will constantly be taking place in order to maintain the household structure (Sen, 1985). However, these strategies are likely to be subtle and women's power may be operating in ways which are not immediately obvious and which require an open perspective in order to perceive them. This is certainly true of women's power with regards to health and reproduction. Women in the marital home are perhaps likely to suffer in terms of food allocation and other benefits. However, simultaneously, they may be putting into place subtle strategies by which they exercise and maintain their power in this important sphere of household dynamics. Whilst it is difficult for an outsider, such as myself, to completely access the subtleties of these dynamics, the process of listening to women's perspectives is certainly a learning process towards this objective of understanding.

Consideration of the internal mechanisms also serves a purpose in the political pursuit of feminism, in this case in terms of recognition of women's roles in healthcare in the public sphere and the factors that effect reproductive decisions. The household is a major focus for many feminist researchers. Often this is represented in terms of the disadvantages women suffer within the household. For instance, Karl (1995) discusses how women's participation in the world outside of the family may be limited by their status and responsibilities within it. However, control over health and reproduction, having this control recognised in a public and official context and, most importantly, the recognition by women themselves of their control over this aspect of their own lives and that of their family, may affect change and recreate the discourse. Researching health and reproductive

issues in this light is to acknowledge the agency of women in the Third World, not to "see them as passive victims of barbaric and primitive practices" (Waylen, 1996: 9).

FEMINIST RATIONALE

Avoiding universalism

As has been noted, women's experiences cannot be universalised. This research aims to become a part of the discursive process itself in representing "the plurality of women's experiences themselves" (Wieringa, 1995: 6). The essence of contemporary feminist research is that it places itself *within* the process of creating meaning, rather than objectively standing back and observing:

> "Feminism is...a discursive process, a process of producing meaning, of subverting representations of gender and re-creating new representations of gender, of womanhood, of identity and the collective self." (ibid.: 5)

The understanding of sexual difference gained from Irigaray (1993; see previous chapter) and, more specifically, the effects of societal differences ensures that research, like the political process, must not take place in a cultural vacuum and that cultural specificity must always be adhered to. We cannot assume that all women face similar problems and need to deal with identical issues. This understanding requires a certain sensitivity of approach, which was attempted, if not always ultimately achieved, during the data collection and analysis of this research. "Difference" as a theoretical tool can provide a thread, which links both the methodology and content of contemporary feminist research. However, not only can it be almost impossible to constantly and totally dismiss one's own preconceptions but also at times, it is difficult to maintain this approach whilst simultaneously satisfying the traditional demands of social science conventions for research. The choice of methods used in this research has been motivated by ethics and political positioning as well as practicality, even if failures inevitably often occurred in their execution.

Applying difference in the research process

In some ways, the practical problems confronted during research themselves serve as a catalyst for a realisation of the importance of such ethical and political questions. One

particular experience highlights this. For the interview component of this research,[2] I aimed to find representatives of each of the following criteria:

A/ Married women with children who used methods of reproductive control:
B/ Married women with children who did not use methods of reproductive control:
C/ Widows
D/ Separated women
E/ Never married women

However, in retrospect, I realise that I was possibly playing a role in creating my own research results by creating such categories. One of the difficulties of conducting research in such an environment is my own alien identity – my own "otherness". I am a white, middle class, educated woman from the Western world and unavoidably bring to research my own assumptions and presumptions. In presuming that these categories are valid, I am assuming that these identity markers make sense not just to me, but, more importantly, to the interviewees, to the women themselves. As I quickly discovered, this was a mistake. In interviews, I realised that the categories were beginning to merge. In particular, widows, separated women, and never married women gave themselves, or were given by others, whichever of these identities they decided. This seemed not so relevant as the fact that, at that moment in time, they were effectively "single" whatever the reason. For example, I interviewed one woman who told me she was a widow at the beginning of the interview, and towards the end began to describe how her husband had deserted her for another woman. There were also similar examples for women of the other "categories". It was necessary to relearn how I looked at relationships and priorities – it was not the categories in which I sought to place women that were important but rather the categories in which women placed themselves.

The same was true for certain issues that were brought up in interviews. For example, as discussed in greater depth in Chapter Seven, the issue of domestic violence is construed in somewhat different terms in Amatenango than in most instances in the West (see Harvey, 1994; Moore, 1994). Given our own societal taboos, the apparent acceptance of such violence was difficult to accept in the interviewing situation (Harvey, 1994) and it was a personal challenge to maintain a non-judgemental distance. On review of the interview

[2] See below for detail of structure of fieldwork and the methods employed.

transcripts, it is clear that at times lines of questioning could be construed as having been suggestive to women that they should not be so accepting. The implications of how to understand this within the broader conceptualisation of cultural difference and human rights are analysed in the context of the ethnographic data. However, in terms of a methodological approach, it is necessary to recognise that there will be many moments in research when one's own position needs to be recognised and analysed as it stands in contradiction to that of the respondents. Similar to comprehending the constructed nature of biomedical knowledge, understanding of another culture can only be attempted with the recognition of the constructed and relative position of one's own. Indeed, Scheper-Hughes (1992: 25) contends that knowledge emerges from the interaction between the different positions held by the researcher and the researched, rather than being "extracted from naïve informants".

For me, then, in effect, I had to attempt to learn a different cultural "language". There were also related linguistic challenges, as the interviews were conducted in Spanish. Although I made an attempt to learn Tzeltal, it never reached beyond a basic level and certainly not a level at which interviews could be conducted (as had been the original intention). This was, without doubt, a disadvantage. Lack of comprehension of Tzeltal limited me from a "true" participant observation experience (I could only realistically take on board conversations which included me and which were, therefore, conducted in Spanish for my benefit). More importantly perhaps, although the vast majority of women spoke Spanish fluently, there were many concepts and discourses which lost a degree of meaning in the translation from first to second language. Comprehension of a language offers much more than a literal translation; it may also offer a means of entry into different forms of thinking about the world, sometimes precisely in the lack of a literal translation for some concepts. Approximate translations into a language associated with a certain position of power is likely to imply understanding discourses from that perspective, rather than from the perspective of the "marginalised" group. In addition, the further translation of the Spanish into English for the purposes of writing this thesis means that meanings will be yet more approximate. It should, therefore, be accepted that the discussions and conclusions of this thesis must, unfortunately, be regarded with a certain degree of caution as to their "authenticity". Like Scheper-Hughes (ibid.), I attempt only to "offer a fair and true

description and analysis of events and relationships as I have seen them" and leave it to the reader's discretion to decide which of my interpretations appear valid and which too greatly influenced by my own position.

This then brings into play another issue for a white, middle-class, educated researcher such as myself, that of power relationships. Obviously this is inherent to a certain degree in any interviewer-interviewee relationship. However, in an environment where racism and exclusion have been key experiences, this is a yet more crucial factor in the interview process. This power relationship has been much examined in feminist literature and research methodology (see Hammersley, 1992; Maynard, 1994; Opie, 1992; Ramazonoglu with Holland, 2002). It is often rightly assumed within this literature that the researcher is always "exploiting" to some degree those "researched". Certainly it felt uncomfortably like this at many points during data collection, which led to some lack of confidence with the inclusion and interpretation of some data in the analysis (particularly data gained during participant observation, rather than through formal interviews, which often felt particularly exploitative). However, it should also be recognised that there have always been, even within traditional social science methods, spaces for the researched to assert their authority (Cotterill, 1992). On most occasions, the latter decide whether or not to take part in a research project, which questions to answer and how to answer them (although they may feel obliged to answer once having agreed to be interviewed). In many of my interviews, women were at times evasive or indeed silent on particularly sensitive issues. Although this was often frustrating during an interview, it is important that the women felt able to maintain at least this degree of control. Newer participatory approaches allow the agenda of research to be set by the participants themselves (Moser and McIlwaine, 1999) and I tried, as far as possible, to do this.[3]

However, despite these qualifications, the power relationship ultimately remains skewed in favour of the researcher. Although there may be some opportunities for those "being researched" to play a role in interpretation, it is generally the researcher who has the most

[3] My original plan of research had been somewhat different and unfortunately became impossible due to political changes (see later in the chapter). The current research focus was decided upon mainly as a result of the obvious interest and concerns about reproduction and health expressed by the women whilst carrying out the questionnaire survey.

control over deciding the questions and, at the end of the day, edits and interprets the information gained (Holland and Ramazonoglu, 1994; Opie, 1992; Scheper-Hughes, 1992). As discussed above, this editing and interpretation was clearly undertaken according to my own presumptions, bias and world-view to a certain extent. In addition, in an environment such as this particular research location, the connotations and implications of my own different identity as part of a historically dominant group had an impact upon the way in which my presence and work was interpreted. The participants themselves were obviously not ignorant of the differences between us, in terms of inclusion and exclusion, and of power and vulnerability.

I cannot, of course, claim to have resolved this problem of power. The only way in which I at least attempted to partially resolve this issue was get to know the community, and, more importantly, for them to get to know me as well as possible. In this way I (perhaps naively) hoped that I would be a "person" rather than, or at least as well as, the "researcher". At any rate, the objective distance often relied upon by researchers is impossible in such a situation. A higher education at British universities may equip one for many tasks but it certainly did not endow me with the necessary skills for survival in the rural context. I was reliant upon the family with whom I stayed and other members of the community to assist and teach me. They undertook these responsibilities with good humour, attempting to allay my embarrassment at my inadequacies by remarking upon the differences between our skills, with comments such as "You do your work with your papers, here this is our work" or "you don't know how to do this – it's different in your country, isn't it?". In this way, they drew attention to the fact that my own education was only one sort and there are many other, equally valid, education systems, which may not necessarily take place in the classroom. I hoped that this concentration upon differences in skills would level out the inequalities between my interviewees and myself, although, in reality, it is impossible to erase centuries of inequality so simply. However, in a sense, both they and I were attempting to level out inequality by acknowledging and stressing difference, rather than ignoring it and emphasising similarities.

METHODS EMPLOYED

Qualitative versus quantitative research methods

Both the recognition of the importance of difference and of being an "individual" appears to indicate the palpable necessity of those methods that have long been proclaimed by feminists as "appropriate" tools of ethical research. Primary amongst such tools are life-histories, oral narrative, in-depth interviewing and biographical interviewing (Letherby, 2003: 88). The unstructured nature of such techniques gives the participant the opportunity both the dictate the agenda to a certain degree and to express herself in as free a manner as possible so that "they do not fracture life experiences" (ibid; 89). Equal value is given to the participant's construction and representation of reality as to that of the researcher, yet it is recognised that the positioning of the researcher will always have an effect upon the production and interpretation of this representation (in addition to the problem of language and interpretation noted earlier). Research, then, becomes a process of interacting subjectivities. This stands in contrast to the positivist position. The latter views research as an objective pursuit of truth by scientific methods of investigation. Quantitative data are privileged and the "anecdotal" evidence provided by qualitative research is regarded with suspicion.

The majority of the data used in this research is indeed qualitative and is drawn from semi-structured interviews, with a limited amount also from focus groups and participant observation. Nevertheless, quantitative data are also relied upon. Given the above discussion, and the apparent epistemological persuasions of this thesis, this is no doubt somewhat contradictory. However, although there are ethical, practical and epistemological concerns, quantitative data are not necessarily entirely problematic in themselves. Rather, the way in which such data are often employed can be so, as statistics are often misguidedly used as explanation rather than description and are accepted as "truth" or "fact". Here, such data are employed not to make an argument in themselves but in order to illustrate theoretical or substantive points. Unlike many positivists committed to the objective gathering of facts, it is recognised that the issues of positioning and bias described above will have similarly come into play in the generation of such data (see the discussion later in this chapter of the problems of undertaking surveys in indigenous communities). Equally, these data are not relied upon to arrive at the ultimate "truth" of

any situation in a way that should necessarily be generalised to other groups in different situations but rather to provide a snapshot of particular groups of people on a specific issue at a precise moment in time. Such illustration of trends can be regarded as useful illuminations in the context of the wider discussions contained within this work in much the same way as the qualitative data. The depth of the latter, however, also implies that we can give much more weight to its explanatory nature than to the broader perspective offered by the quantitative data.

The research strategy

The fieldwork consisted of a household questionnaire survey[4] of 100 households, in depth semi-structured interviews[5] with 37 participants, observation (whilst living in the community)[6] and three focus groups with 8 of the participants.[7]

All participants were indigenous women as I considered it particularly important to gather their perspectives on the issues pertaining to this thesis. Policy-makers were not interviewed as the views and perspectives of such powerful groups have been well-documented and are clear through the analysis of dominant discourses in the public domain. An ample stock of grey (policy documentation) and secondary literature analyses such discourses from many different perspectives. Therefore, I felt little would be gained from such interviews. For similar reasons, medical practitioners were not included in the sample, although one interview was conducted with the local doctor in Amatenango. However, this interview material is only referred to on a peripheral level as maintaining anonymity would have been difficult and the views of only one practitioner would perhaps have been an unfair representation. Ultimately, research strategies always involve deciding between different possibilities and priorities. In common with many feminist researchers who wish to capture lost genealogies and who are in a privileged position to be able to do so (see Scheper-Hughes, 1992: 29), I felt that priority needed to be given to those who previously have had little space or opportunity to give voice to their perspectives and representations of realities (particularly given the focus of this thesis).

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[4] See Appendix A.
[5] See Appendix C.
[6] Observations were recorded as soon as possible in an electronic fieldwork diary within Microsoft Access.
[7] Some of the questions of the original interview guide were used in the focus groups.

The sample group of 37 women interviewed during the course of my fieldwork of Amatenango del Valle, therefore, display a marked consistency in many demographic respects in terms of, for example, income, living conditions and occupation. This consistency is unremarkable when their traditional subsistence and pottery production lifestyle and the tight knit constant community, which forms their world, are considered.

Nevertheless, the group of women are of varied ages, marital statuses, family structures and personal circumstances.[8] One aim of this thesis is to find consistencies in representations of their own varied experiences of health and reproduction which might then, despite these variations, be understood to relate to women's gender and ethnic identities formulated in the context of their social and economic worlds.

All the women who were interviewed in-depth had previously been interviewees for the questionnaire survey. For the questionnaire survey, I had initially used the snowball technique to approach possible interviewees. I employed the oldest daughter of the family with whom I lived in the community to introduce me to neighbours and extended family members. I found this to be a very effective method. Not only was I introduced to the majority of my interviewees (given that Amatenango del Valle is such a close knit community, one family can be the key to vast number of others via kin and social contacts) but also being introduced by a member of the community meant that there was a greater level of trust than if I had been a mere stranger. However, when these contacts began to wane, I found it increasingly more difficult to find potential interviewees precisely because I was unknown and often assumed to be a government representative undertaking a census and thus treated with suspicion (see below for further discussion of the political context). Much time was spent touring houses to persuade women, often in vain, to take part in the survey. The result of this process was quite clearly a non-representative sample. Given the difficulties in obtaining willing participants as well as the lack of complete knowledge of the population, it would have been impossible to attempt a representative sample. Furthermore, even if this might have been attempted, it is extremely unlikely that I could have achieved a number sufficient to fulfil the statistical requirements for probability

[8] See Appendix E for demographic details of the participants who are directly quoted in this thesis.

testing, given that it was not a self-completed questionnaire, I was undertaking the research alone, and within a limited timeframe.

At the second stage of the process, I used a combination of techniques to identify and approach potential interviewees for in-depth interviews. On the one hand, I used the snowball technique, asking women known to me to suggest which of the women with whom I had previously completed the questionnaires might be interested in being subjects for in-depth interviews. Secondly, I "followed-up" upon the questionnaires, revisiting homes of women who had seemed particularly interesting during the questionnaire stage and who had been keen for me to return. I was not necessarily as free as may be ideal to select a sample based on the research aim criteria as the availability and willingness of potential candidates naturally limited me. However, as far as possible, I aimed to find representatives of criteria mentioned earlier in the chapter.

As I rapidly discovered during the survey and interview process, the great majority of women whom I interviewed were connected directly or indirectly via a complex series of marital and family relations. This was often originally unknown to me and would only be revealed when, in the middle of an interview, I would be asked "You live with Luisa, don't you?" or "Weren't you just talking to María who lives below here?". The follow-up remark to this was usually, "she's my sister-in-law, my cousin, my niece, my daughter-in-law...". I do not know of any research on the significance of having a sample group of inter-connected subjects but in a closed community, such as Amatenango, it was impossible to select any other.

One particular demographic group that is not represented is that of unmarried women <u>with</u> children. As will be discussed in later chapters, social norms in Amatenango do not allow for never-married women to openly have, and keep, their own children. Although another interviewee reported the existence of one unmarried woman with children to me, I was not able to locate her and other women denied her existence. I also do not represent any married women who do not use reproductive control whilst not having any children (implying that they, or their partner, are unable to have children). In the 100 household questionnaires, there was only one woman who reported this situation and, unfortunately,

she was unwilling to be interviewed in depth. I do, however, have second-hand reports from other women about this situation and an interview with a young mother who waited several years before becoming pregnant.

Some of the women discussed were more important actors in the development of the qualitative data than other. For example, eight of them were participants in the focus groups. These were undertaken after the in-depth interviews and were conducted by a research colleague from *El Colegio de la Frontera Sur.* As she was already conducting focus groups with the same participants for her own research, I asked if she could also include two on themes relevant to mine. I was interested not only to clarify certain points from the interviews but also to discover if the dynamics of a focus group would alter the nature of the data generated.

Data were also gained through informal conversation and observation as is routine in "participant-observation". As all members of the community with whom I was acquainted were fully aware of my purpose in being there, there were probably no real ethical issues with obtaining data in this manner. However, my unavoidable personal feeling was that the process was potentially sensitive and perhaps even exploitative at times (as noted earlier in this chapter) and it is likely that this has limited the amount of use I make of data obtained in this way. Nevertheless, there are certain informants (particular Luisa and the other female members of the family with whom I stayed) who are quoted more frequently than others. Most often, the views they represent also reflected other conversations I overheard or was involved in with other women and I make most use of those quotes and life stories which do represent more generalised discourses. Because the family were perhaps more aware of the objectives of my stay, I feel more comfortable in quoting them. Indeed, Luisa and other members of the family would often remark in conversation how the particular topic would no doubt be of interest to my work, showing a remarkable amount of insight into both the research process as well as into the conceptual linkages pertaining to the research topic. However, in whatever way and to varying degrees, all the participants provided useful perspectives on the issues that this research discusses and were my guides through my often fumbled attempts at understanding the complexities and dynamics of the ways in which they deal with these issues.

The influence of the political context

Several aspects of the research strategy and the primary data collection were unavoidably affected by the political context of Chiapas at the time. The timeframe for the data collection and, indeed, the direction of the research itself were heavily influenced by this context. In particular, I had a major "false start" to my fieldwork, due to the changing political climate in the region. I had begun research in conjunction with an indigenous women's organisation based in San Cristóbal de las Casas, named Kinal Antzetik. I worked for them as a volunteer assistant with the women's textile co-operative they ran as well as assisting with the organisation of some political and awareness raising events. The organisation was also then in the process of putting together a household survey into socio-economic and health conditions of women living in several indigenous communities, principally in the Zapatista supporting municipality of Chenalho. As this fitted with my own intentions, I worked with them on this, putting together a survey which would fit both our objectives. We began to conduct this in late 1997 and my intention was to follow this with in-depth interviews in the same communities once the survey was complete. Unlike the ultimate sphere of work, the original objective of these interviews was to have been focussed more on women's political participation, including around the issue of reproductive rights.

However, in late December 1997, a massacre occurred in Acteal, Chenalho, in which more than 40 women and children were killed, and many more injured, by paramilitaries[9]. As well as being a traumatic event for all of directly and indirectly concerned, this had several wider political consequences which impacted significantly upon the process and remit of the research. First, fear of subsequent attacks resulted in substantial displacement of communities from the whole of the Chenalho municipality. Second, the government reaction to the massacre included a high degree of militarisation of the region as well as heightened suspicion of foreigners working in the state of Chiapas[10]. Changes in the law facilitated deportation of foreigners and the numbers of such deportations rapidly increased

[9] See Hernández Castillo (2001a) for discussion of the events of the Acteal massacre and their particular impact upon violence in indigenous women's lives.

[10] Harvey (1999) notes that government officials' version of the history behind the EZLN uprising has often been one in which outsider "leftist" movements have been interpreted as the motivating influence. Therefore, the suspicion of foreigners after the Acteal massacre was a continuance of this discourse. However, Collier with Quarantiello (1999: 54) state that originally at least this suspicion was more of Guatemalan or Central American guerrillas than of influences from further afield.

in subsequent months. As a result, it was not only difficult to access the region to continue the survey but also to continue working with Kinal Antzetik, who understandably became cautious of associating themselves with foreigners. It also became clear that continuing to work in Zapatista communities and with a focus on political participation would be an inadvisable strategy if I wished to secure my position in the country. Therefore, I was forced to take the difficult decision to abandon these first months of research and begin again in a less politically contentious environment. I was fortunate to be able to gain a position as a visiting researcher at the *Colegio de la Frontera Sur* and, through their knowledge and contacts, begin work again in the more politically stable municipality of Amatenango del Valle. Although the lost work was clearly very unfortunate, I did learn many lessons from that initial process which were invaluable (including being able to more appropriately rework the survey questionnaire) when starting the process again.

As noted earlier in this chapter, the shift to the current focus of this research occurred as a result of having listened to the themes which preoccupied women during my first few months in Chenalho, with the women who worked with Kinal Antzetik, and in Amatenango. I realised that the issues relating to women's negotiation of health and reproduction in relation to their cultural, economic and political contexts was of primary importance to most women, given their gender roles. Therefore, there was an advantageous side-effect to a difficult situation in that the research I finally conducted was probably more appropriate to the real concerns of women, rather than to my own presupposed interests as a rather politically motivated, and somewhat naïve, outsider. Similarly, whilst I continued to confront difficult issues in working in a highly militarised and politicised environment (for example, much of the interviewing was conducted in mid to late 1998 in the run-up to the October elections, which increased suspicions of strangers asking questions), these added to the depth of the understanding I was gaining about indigenous marginalisation as much as detracting from the process of research.

Secondary data

As remarked upon above, some of data were gathered from my own questionnaire survey at the municipal level. However, a large amount were also gained from Mexican census material and data collected by international agencies such as the United Nations, the World

Bank and the World Health Organisation. In general, the latter provides the global perspective whilst the Mexican sources generate national, state and regional level data. The Mexican census data were obtained whilst on fieldwork in Mexico through research in the Mexico City and Tuxtla Guttierez offices of the *Instituto Nacional de Estadística Geografía e Informática* (National Institute of Statistics, Geography and Information / INEGI). These data relate to the eleventh national census in 1990 with some limited data from the 1995 mid-point count. Both of these were published in 1996 and were the most recent information available. The subsequent census was in the year 2000. However, the complete results of this were not available at the time of writing this thesis.

Non-governmental organisations, such as Human Rights Watch and Amnesty International, also provide some relevant background information at the national and state level. In addition, statistics and other qualitative evidence are gained from reports and compilations from local level non-governmental organisations as well as regional governmental reports and plans. Some of these data result from original research carried out by these organisations whilst some is a product of their own compilations of INEGI and other data. There is also occasional use of statistics and other factual information gleaned from relevant work by other authors. Where possible, the original source of this is indicated along with the location of the citation.

DATA ANALYSIS

The questionnaire survey

As noted above, my own questionnaire survey was the source of some of the statistical data used in this thesis. These data proved helpful in representing a variety of trends, although the survey's effectiveness as a source of reliable and valid data on some issues proved disappointing upon analysis. Although 100 questionnaires were completed, problems of non-response to certain questions and contradictory answers to others (see below) meant that the actual sample group for analysis of certain variables was actually somewhat smaller than this.

After beginning the survey process, other local researchers had warned me that this might be the case. Inhabitants of indigenous communities are notoriously private and evasive,

particularly on issues they fear might evoke envy with their neighbours should facts be broadly revealed and the consequences for their health and well-being this might imply (given that witchcraft is a common "occurrence"; see the discussion in other parts of this thesis). This particularly includes information relating to income or land, for example, but might also be relevant to health issues in terms of expectations of payment to *curanderos*, for instance. This problem was compounded by the unfamiliar nature of the process. Whilst the purposes of the questionnaire were explained to the best of my ability, it is clear that this process is very far removed from the experiences of everyday life in indigenous communities (other than government censuses). Relatively few people attend secondary school and a university level education is almost unheard of. Therefore, understanding the purpose and rationale for research, particularly in such a structured form (which would not even have the appearance of a normal "conversation") and without the possibility for negotiation of issues to fit a different world-view is likely to have been very difficult. The process must have seemed strange and, as such, also suspicious. Answers, therefore, were no doubt often given in a haphazard way as the importance of the accuracy of the response would not necessarily have been clear or paramount to the respondent. It is also not impossible that some answers were given on the basis of what women felt I would like to hear rather than what was really the case, especially for those respondents with whom I was more familiar. For many others, the types of information sought would not be routinely maintained or remembered by households.

The preset nature of questions within such a survey heightens the problems of imposition of a world-view and priorities for analysis which I felt to be precisely so problematic even in the relatively unstructured qualitative data collection. Even seemingly straight-forward questions, such as, for example, the ages of household members would often cause consternation and take quite some time to work out. Indeed, frequently, the answers to subsequent questions would reveal a high degree of inaccuracy in the final answers given. Similarly, questions relating to household task and expenditure responsibilities would often be answered uniformly as being communal (and as if irrelevant) as it seemed that thinking on a individual level in this way did not come naturally for the more communal nature of indigenous lifestyles. This was oppositional to the intention of looking inside the household (as described earlier in this chapter) and many of the contradictions and

information gaps were only overcome with further discussion during interviews and, particularly, by observation of everyday life. Although the questionnaires had been piloted in another community (as described earlier in this chapter) and changes to the questionnaire were made as a result of this pilot, it was difficult to find a way of entirely overcoming such issues as they represented a very large gap between the priorities of social science research in the "Western" world and those of indigenous communities.

Notwithstanding these problems, undertaking the questionnaire had been a lengthy business and, therefore, despite acknowledging that some of the data would have to be regarded with caution and the fact that they would not stand up to tests of external validity or reliability, the data were inputted into SPSS (Statistical Package for the Social Sciences). Although the questionnaires could potentially produce a substantial amount of data, only that data which were usable and relevant to the eventual structure of the thesis were inputted. Although the questionnaire had been formulated with this data analysis in mind, variable codes and labels were only assigned at this stage in order to facilitate its relevance to the thesis themes and, during the process of analysis, recoding was undertaken as required.[11] It was then subjected to a basic level of manipulation as represented in Chapters Six, Seven and Eight. Given the epistemological basis of this research (see earlier in this Chapter) and the intentional use of statistics as descriptive rather than causal,[12] and in a way which does not necessarily imply generalisability, the lack of tests of significance is not regarded as problematic.

Despite the acknowledged problems with the survey method, the real value in undertaking it was perhaps not so much the eventual data generated, but rather the process itself. Given that it took some time to complete and involved visiting many households, it was an extremely useful way to grasp the dynamics of the community and for participants to get to know me and my work. Also, during this time and by means of the various conversations stimulated by the questionnaire, I was able to more concretely define my research agenda in

[11] See Appendix B for variable and code information.
[12] Some attempts at revealing causal relationships have been made. However, in these cases, the limitations of these relationships are indicated.

a way most appropriate to the preoccupations of the participants themselves prior to undertaking the qualitative data collection.

Secondary quantitative data

Unsurprisingly, the majority of the secondary data reflects purely Western perspectives on health, reproduction and other substantive matters that are critiqued in other areas of this thesis. Despite this, it is appropriate to refer to such data, as the intention here is not to prioritise non-Western perspectives but to give equal validity to both and to show the fluidity between the two paradigms.

In some cases, these data are replicated in their original format, whether that is as a diagrammatic, graphical or tabular representation. In others, however, data are extrapolated, manipulated and reformatted to meet the descriptive requirements of the particular point it is to illustrate. This is done with the use of Microsoft Excel as the lack of the original dataset does not allow for the more sophisticated analysis of SPSS. There are inevitably some ethical and practical problems with such manipulation of secondary data. Whilst it is obviously being used in ways other than originally intended, every effort is made to ensure the accuracy of the subsequent representation.

Qualitative data

The interviews and focus groups were recorded, subsequently transcribed and collated with the observation notes from the fieldwork diary. At this stage, serious consideration was given to anonymising the data. Although this is often necessary on ethical grounds, this was not done on this occasion for which echo those given by Scheper-Hughes (1992: 19) who felt that her informants were protected by the "social invisibility" of the research location and moreover that they "enjoyed seeing their names in print". Similarly, in my own case, I feel that the location of the research is so remote as to make it extremely unlikely that those who know the community well would access this research. Those few who may know them would be likely to recognise the participants, even if anonymised, given the size of Amatenango and the personal details that this study necessitates revealing. Also, the majority of participants were (like those working with Sheper-Hughes) glad to

have their voices heard, given the previous silencing of their perspectives. All were aware of the purpose of the research and no assurances of anonymity had been given.

Only those quotes used in the thesis itself were translated into English. As the majority of respondents spoke it fluently, all in-depth interviews were conducted in Spanish. Some of the older respondents of the questionnaire survey did not speak Spanish or preferred to speak in Tzeltal. In these cases, Nicolasa acted as interpreter. None of these respondents were subsequently selected as in-depth interviewees. Obviously there are associated problems with conducting interviews in a second language (both for myself and my interviewees) that may have led to occasional misinterpretation, as discussed earlier in this chapter. As far as possible, any potential confusion was clarified with requests for further information during interviews. No doubt, some still remained and this was perhaps not the ideal circumstance. However, it was the most practical as no professional Tzeltal / Spanish translator was available and, at any rate, I would have felt his or her presence intrusive in the interviewing situation.

A coding framework was developed to structure the data in the transcripts into various categories according to the structure and themes of the thesis.[13] The transcripts were then manually coded according to this framework. The use of qualitative analysis computer programmes, such as NUDIST and ETHNOGRAPH, was considered but judged impractical and unnecessary, given the nature and quantity of data. Furthermore, such programmes would perhaps have further distanced the data from myself in ways that would not have allowed for the personal experience of interviewing and relationship with the participants to mediate the interpretation. For the same reason, less use is made of the focus group material. Although some interesting data were generated, the fact that I had not conducted the discussions myself meant that I was reluctant to interpret and use this material. Equally, the coding itself was undertaken in as flexible and loose a manner as possible in order not to lose the context and the individuality of the interview and participant. Feminist researchers have criticised the process of interpretation as itself a selective production of truth that reflects the purposes of the researcher, rather than the participant's representation of their reality (Stacey, 1991). This is no doubt the case to a

[13] See Appendix D.

certain extent but it would be difficult to avoid unless there were no element of selection or interpretation whatsoever. However, participants are quoted as fully as possible in order to obviate this. In this way, it is hoped that the data's high level of internal validity has been maintained.

To the same end, there is little attempt made to interpret women's discussion regarding health and other matters into a Western conceptualisation. Not only was the material gained through the interviews and focus groups itself rich enough to gather meaning without such "translation", but also the particular aim of the qualitative data is to represent the women's perceptions as closely as possible and to highlight the importance of the discourses themselves. Therefore, remarks by women regarding possible reasons for death or illness, for example, are accepted at face value. Biomedical definitions are generally not attempted as this would both be out of the range of my expertise and also contrary to the epistemological foundations of this research. Furthermore, it is not necessary to categorise issues in this manner to contemplate their importance. As Sundari Ravindran (1997: 20) notes, in relation to similar community-level research on women's health, it was not necessary to calculate the infant mortality rate or to classify diseases "to know that something was terribly wrong". Above all, one of the primary purposes of such research should be to "challenge the specialists' monopoly over information on what ails women; and to generate information on women's health from life experiences and perceptions of affected women – information that takes into consideration women's whole selves and circumstances" (ibid.: 22).

CONCLUSION

The methodological approach of this thesis, then, is to use data from a wide variety of sources, both primary and secondary, and quantitative and qualitative. The latter provides the richest and ethically sound data from the perspective of feminist research and is therefore the mainstay of this work. Nevertheless, it is hoped that the combination of data and the methods used to generate it (despite the problems noted) provide a solid grounding for the discussion of health, reproduction and identity in the subsequent chapters.

CHAPTER THREE

HEALTH AND POPULATION POLICIES: GLOBAL, NATIONAL AND REGIONAL INTERVENTIONS

INTRODUCTION

Chapter One of this thesis outlines the overall picture of the health and reproductive issues facing women in the developing world, as well as the ways in which women can be conceptualised as negotiating these issues on individual levels. Post-colonial and post-modern theoretical frameworks offer spaces for thinking of women's agency in relation to the use and provision of services, as well as a means of deconstructing biomedical knowledge and understanding health as plural and subjective. However, it was also noted that, whilst women may find means of negotiating biomedical health services, the possibilities for shaping these services is limited because of the external influences upon them and the policy environment in which they are formulated.

The formulation of health and reproductive policies in Mexico and Chiapas cannot be understood in a vacuum. As is the case with the majority of developing countries, ownership over such policies is limited. Unequal political and economic relations, recently involving severe financial crisis, have necessitated exchanging national sovereignty over some aspects of public and economic decision making for foreign trade investment and debt assistance with conditional adherence to the policies of international financial and economic institutions, such as the World Bank and the IMF. Population control and health policies are often viewed as integral components of development. As such, they are subject to macro-level decision-making which often assumes causal relationships between poverty, health and population growth. The setting of such policies at international and global levels can potentially limit cultural diversity in perspectives on health and reproductive rights at the level of the individual.
This chapter analyses the relationship between economic dependency and crisis, international discourses on development, health and population control, and the particular policies of Mexico and Chiapas. I begin by briefly outlining the historically

constructed dependent structures, the contemporary environment of debt crisis and structural adjustment, and the related global health policies that represent the context of Mexican and Chiapanecan health and reproductive policies. The latter are analysed in relation to this environment and the influence of global policies, with particular reference to the PROGRESA poverty alleviation programme and its significance for the state of Chiapas. The links between health and population policy are also drawn out. Within this analysis, Selective Primary Health Care, relevant concepts of civil society (in relation to the participation of the community in the delivery of health services), and neo-Malthusian population theory are critiqued.

THE POLITICAL AND ECONOMIC CONTEXT OF POLICY MAKING

Dependency and development

Mexico's health and reproductive policies are set in a context of economic and political development inextricably linked to the economies of industrialised nations. With few exceptions, post-colonial developing countries have found it difficult to escape ties to industrialised nations after independence. Parson's version of modernisation theory asserts that such countries are inherently "backward" and, therefore, on an evolutionary path trailing behind the more developed nations (Parsons, 1951; see also Harrison, 1988). In this social Darwinist conceptualisation "successfully industrialised societies" (Parsons, 1967: 471) "...enable an improvement in living standards, along with certain concomitant benefits, in the form of higher levels of consumption, greater economic security, better health, and the like" (ibid.: 469; Parsons, 1951). There is, however, little evidence of this polemic between backwardness and societal advancement within the history of colonisation, which involved violence, manipulation of cultural differences and pragmatic exploitation of intra-societal disputes (see Chapter Four).

Dependency analysis, on the other hand, conceptualises the dependent relations between post-colonial nations and core industrialised nations as a relationship in which:

> "...some countries can expand through self-expulsion while others, being in a dependent position, can only expand as a reflection of the expansion of the dominant countries, which may have positive or negative effects on their immediate development." (Hunt, 1989: 200)

Core nations expand by exploiting periphery nations in their production processes in a "fundamentally asymmetrical" relationship (Gereffi, 1991: 323). This dependency trap is an obvious residue of former colonial relationships (both political and economic) (O'Connor, 1970 (1991): 277; Wallerstein, 1983). However, at the end of the 1960s, limited development in some areas of the periphery motivated the coinage of terms such as "dependent development", "Newly Industrialising Countries" (NICs) and the "semi-periphery". Frank (1967) accounted for such development with reference to the differing impact of colonialism, because of differing population densities and characteristics, modes of production and, importantly, natural resources. He points to the ease of creating a mining economy and the presence of resources such as sugar and gold as critical in allowing rapid capitalist penetration in Latin America (Frank, 1967: 22).

The large, reasonably literate population also facilitated initial industrialisation in Mexico. However, such industrialisation often had limited benefits for developing nations because it was primarily facilitated by a co-operative relationship between the elite of developing nations and the interests of the Centre (Wallerstein, 1983). Further self-perpetuation of the core was promoted as it increased dependency upon foreign investment. Initial industrialisation in Latin America after the Second World War relied upon "import substitution", instituting a set of production relations incapable of self-sustained development. In the 1970s, these problems were noted by international institutions. The limited development and financial dependency had led to debt crisis in many Latin American nations, including Mexico (see below) and most recently Argentina. New strategies, known as Structural Adjustment Policies (SAPs), to deal with these crises were developed throughout the 1980s and 1990s (Rus et al, 2003: 11). They would restrict, rather than promote, government intervention in development strategies and would be modelled on Western style neo-liberalism.

Contemporary post-development theory argues that the development project may have "failed" because of an assumed lack of agency and too little consideration of the resilience of "other" cultural traditions and practices (See Chapter One). With the advent of structural adjustment, "development" was yet more concretely linked to the idea that all nations would benefit from mimicking the Western neo-liberal model. It was a stance that

was articulated in Fukuyama's (1992) Darwinist claims that the neo-liberal model, embodied by America, is the ultimate endpoint at which all societies should, and would, eventually arrive in order to ensure democracy, equality and economic prosperity.[1] However, development as "progress" will only succeed as a doctrine if it is universally believed that the endpoint is desirable. The formulation of programmes based upon pursuing the Western ideal perhaps ignores some of the real problems facing developing nations. For instance, rather than regarding the broader global relations of power to be at least partially responsible for poverty and marginalisation, increased incorporation into these same neo-liberal relations are seen as the development solution. As such, the responsibility of relieving such problems primarily rests at the level of the nation-state, rather than at the global level.

This body of theory has to date been mainly restricted to academic questioning (although it is now beginning to have wider resonance in anti-globalisation political movements as well as in the calls for more equitable global trade structures by some developing countries). The ideology of development continues to be pursued by the major international institutions and to impact upon the political, economic and social worlds of developing nations. Arguably, the pursuit and failures of this development project have played a part in the current financial circumstances of such nations, of which Mexico provides a key example.

Mexico and economic crisis

Mexico's pursuit of development has taken the nation through a variety of stages. The apparent successes, and the underlying weaknesses masked by these successes, of this pursuit led the economy into eventual financial and debt crisis, with the accompanying need for structural adjustment.

Initially, Mexico had little chance of becoming anything other than a *de facto* American satellite state after independence from Spain. The first phases of industrialisation took place under conditions of "dependent development" (Gereffi and Evans, 1981: 31) and Mexico continues to be reliant upon not only foreign finance and loans but also upon direct

[1] Fukuyama (2002) has recently argued instead for the infinite possibilities of science to increase and alter our understanding of human nature and, thereby, shift the possibilities for international politics.

foreign investment (DFI) in the form of foreign ownership of industry. The United States has primarily regarded Mexico as a source of cheap labour and a market for its products. Nevertheless, the country succeeded in developing its own industrial base and is now regarded as "semi-peripheral".

Historically, foreign investment has been encouraged by the state, under various models of production from primary product exportation, horizontal import substitution, vertical import substitution and, most recently, diversified export-orientated industrialisation. As a result, Mexico managed to maintain relatively healthy growth rates until the early 1980s. Indeed, the nation's per capita gross domestic product (GDP) figured amongst the top ten for Latin American countries during the period from 1960 to 1979 and, along with Ecuador and Venezuela, Mexico had the strongest export purchasing power of the region (Alejandro, 1987). However, these figures masked an accumulating hidden debt. Alejandro (ibid.: 13-14) points out Mexico may have had a significant net debt by 1970 but that this was obscured by "direct foreign investment, the use of reserves, concessional aid or expansions in debt". The early 1980s, however, marked a sea change in ability to expand or finance this debt. Increased interest rates and an abrupt policy shift in the increasingly cartelised foreign lending institutions rapidly increased the bargaining power of such creditors. Despite holding substantial non-official Latin American assets (calculated at some U.S. $160 million), international banks indicated a reluctance to continue lending.

This signalled crisis point for Mexico and, in August 1982, the government suspended payment of the external public debt. This suspension continued into 1983 (Thorp and Whitehead, 1987: 1). By the late 1980s Mexico had a fiscal deficit equal to 17 per cent GDP (Herzog, 1993: 2). Such severe debt, and inability to fund repayment, led to "a series of drastic remedial measures: severe devaluation, unprecedented exchange controls, an "unthinkable" nationalisation of the private banks and, of course, an emergency agreement with the IMF" (Thorp and Whitehead, 1987).

Structural adjustment

This emergency debt agreement with the IMF not only pre-empted the implementation of the North American Free Trade Agreement (NAFTA) in 1994, but also immediately

necessitated enforced compliance with International Monetary Fund (IMF) and World Bank structural adjustment programmes. This was essential to secure loans and reschedule outstanding debts through the international credit orderly market agreement (ICOMA), an agreement formulated under the leadership of the IMF to encourage banks to maintain their lending positions (Alejandro, 1987: 19). The attached condition of structural adjustment programmes (SAPS) is wide-ranging. They have implications for many spheres of society, including public policy and spending regarding health and reproduction. The liberalisation encouraged by structural adjustment has meant that the state devotes its energies to encouraging international capital via privatisation and relaxing foreign controls, creating agri-business (at the expense of *ejidos*), abolishing the minimum wage, reducing benefits and other measures to cut public spending and eliminate the public deficit (Ros, 1987).

THE IMPACT OF STRUCTURAL ADJUSTMENT: FROM PHC TO SPHC

Reforms to the Mexican health system reflect global shifts in health care provision. The environment of debt and financial crisis in Latin America has not only meant that government spending on health has been reduced but there has also been necessary conformity with the politics of international organisations. There has been a concerted effort to formulate a global health policy, which is in line with the neo-liberal ideology of structural adjustment. Spending on health has been predominantly financed by loans from the World Bank and the IMF with the aim of putting into place programmes which will alleviate the adverse affects of structural adjustment on the well being of the poor (Gómez-Dantés, 2000). Within programmes such as PROGRESA (see below), there has also been a shift away from state responsibility for health care and towards community participation. The reduction in public health spending has meant that health care has become increasingly selective in terms of the types of health care offered. The Primary Health Care model (PHC), which was taken as the standard after the 1970s, has been altered to become a "Selective Primary Health care" model (SPHC).

Primary Health Care

PHC has been the focus on international and national levels in recent decades. Until the mid 1970s, health policies promoted by international agencies and adopted by national governments in the developing world exported the technological model of medical care

from Western industrialised countries. Finance and personnel as well as the latest equipment and drugs were important components of overseas trade and aid to developing countries. Gender concerns regarding this approach revolve around its increasing professionalism of medicine and alienation of those traditionally involved in basic health care, principally women. However, more mainstream concerns arose over the inadequacy of technological forms. The groups being served by these technological services were overwhelmingly urban as expensive technological equipment and specialised personnel meant that resources were centralised. In addition, as technological advances became increasingly rapid and expensive in the latter half of the twentieth century, it became obvious that even the needs of urban populations could not be met.

In the 1970s China joined the World Health Organisation. Their model of health care concentrated upon locally trained health-workers working at community level to deliver minimum basic needs health care. This influence led to a major policy rethink. In 1978, as part of its Alma Ata statement, the World Health Organisation declared a new commitment to "Primary Health Care" (PHC). It was a part of the more general aim of gaining "Health For All By the Year 2000". The new holistic conceptualisation that formed part of this health package also borrowed from Chinese influences. This involved not only a healthy physical and biological state but also began to look towards a "complete physical, mental and social well-being" and towards conceptualising health as potentially positive and complex. A practical element of this conceptualisation was the recognition of the need to improve the environment affecting health and to bring individuals (particularly women) into the process of improvement. The Primary Health Care was characterised by a concentration on the rural environment and a flexible approach to health information and preventative health care. In particular, there was a concentration on sanitation, living conditions, diet, vaccination, and family planning (Momsen and Townsend, 1987: 123).

Despite its many positive elements, this concentration on limited aspects of preventative health also arguably reduces "health" to a conditional and limited definition. Within PHC strategies, health interventions are aimed at creating the conditions for a good state of health in which individuals can then promote and ensure their own good health, rather than providing everything that would be needed in all health care situations. For example, the

WHO provides a list of "essential drugs" in order to reduce the risk of over-prescription or irrational drug use. The latter risk is certainly significant in scenarios where health workers' salaries are linked to drugs sales. However, it can also potentially support the ideology of limited state responsibilities.

A cross-sectoral approach to health education (involving primary health care, schools and the mass media) is a particularly important and integral strategy of PHC. The aim is to improve people's knowledge and skills to enable them to improve their lifestyles and health environments. The emphasis on community participation in PHC has been an important ideological component of global health care policy over the last three decades. It has formed part of a strategy to encourage genuine needs based health provision and to encourage community ownership. However, financial considerations have also been an important consideration. PHC was primarily promoted partly because of its affordability in comparison with technology based health care provision. In practice, "community participation" has at times amounted to the community supporting those services which the government is not able to provide. The limitations in government provision can be compounded by a lack of motivation for the private sector to participate in isolated and non-profitable situations. Therefore, it has often proved necessary for "civil society" to provide financial support and resources, particularly in the form of voluntary labour. However, even with such participation, PHC has proved a lot more expensive than anticipated (Diskett and Nickson, 1997: 73) and has not achieved the objectives that were so idealistically proclaimed. Post-2000, it is clear that the goal of "health for all" has not been achieved. Governments continued to face significant health problems and spiralling costs in the face of financial crisis. One possible solution lay in the reformulation of PHC and the introduction of Selective Primary Health Care (SPHC).

Selective Primary Health Care: The health safety net

The cuts in public spending recommended by SAPs are a means of reducing government deficits. The further reduction in state responsibilities in the area of health reflected in the shift from PHC to SPHC can, then, primarily be understood as a response to economic necessity. One way of reducing public spending in health is by charging fees for health

and other social services under schemes such as "user-financing and cost-recovery". These are often instituted through community financing schemes, which include the following:

- Fees for services given, or fee per consultation;
- Drugs sales and revolving drug funds (i.e. standard charges for drugs whatever their cost which goes into a central drugs fund – rather like the British prescription charge);
- Personal prepayment schemes (insurance)
- Income-generating schemes (community or individual labour/fund-raising activities/raffles/donations etc.)

(Diskett and Nickson, 1997: 75)

Criticism of such schemes revolves primarily around the regressive nature of the charges. Firstly, and most simplistically, the poor tend to get sicker more, so they pay more for health care than other more socially and economically advantaged groups in society. Secondly, because the charges tend to be fixed, not income related, the poor are likely to pay a greater proportion of their income for health care.

The initiation of SAPs also has indirect effects on health, aside from the reformulation of health care services. The state of health in many countries undergoing structural adjustment has, in many cases, deteriorated. The combination of direct and indirect negative effects has particularly impacted upon women's and infant mortality and morbidity. Decreased coverage and uptake of maternal care and increased dietary problems (and related diseases) in children has been observed (see Lugalla, 1995, for evidence from Tanzania). In many Latin American countries undergoing structural adjustment, similar problems have been noted (Stewart, 1995). For example, in Mexico, Nicaragua, Peru and Uruguay, maternal and child mortality and morbidity have risen in conjunction with decreased food security and calorie availability (CISAS, 1997; Cordera Campos and Gonzalez Tiburcio, 1991; Curto de Casas, 1994). The decline in real wages not only affects the amount of disposable income available to be spent on new health care charges but also adversely influences states of health, as do removals of food subsidies and the introduction of fees or levies imposed on schools. Reductions in mortality and morbidity rates – as indicators of improved health and nutritional status - have historically been achieved by sustained economic growth as well as, and perhaps even more importantly than, medical

interventions. There is, however, little evidence of a direct correlation between increased GDP and improved states of health, which, it seems logical to suggest, are likely to be improved by more equal distributions of income or "well-being".

The alleviation of the health problems associated with cost-recovery motivates the implementation of SPHC strategies. Rather than attempting universal coverage, there is a concentration on selected key areas of health care (for example, sanitation) and on selected, particularly poor, communities. "Safety nets" exist for the short-term ill effects of cuts in public health spending. These measures are necessarily short-term because of the nature of political agenda setting and the intended long-term benefits of economic restructuring on the well-being of populations. Despite their temporary nature, the World Bank has noted that such measures have huge benefits for the poorest communities and the most vulnerable within these communities. For example, it is claimed that illness has been reduced by twenty per cent amongst children benefiting from PROGRESA (described below) by twenty per cent (World Bank, 2003).

Health reform in Mexico: PROGRESA and "basic capacities"

In response to the impact of such cuts upon the poorest in society, Mexico developed poverty alleviation programmes during the 1990s in conjunction with the international agencies (Gómez-Dantés, 2000). This involved reform of Mexican health system. In an overhaul of IMSS-Solidaridad and PRONASOL, the latter which had provided primary health care services to the rural poor since 1989 (Gómez-Dantés, 2001), the aim was to move away from health as political patronage, to decentralise services (Abel and Lloyd Sherlock, 2000; Londoño and Frenk, 2000) and to concentrate upon provisions to those sectors of society with little or no access to formal health care services. Within the Programme for the Extension of Coverage (PEC) for the period 1996 to 2000, four states (Chiapas, Guerrero, Hidalgo and Oaxaca) were identified as target populations (Gómez-Dantés, 2000). The provision of health care services within this programme required changes to the social security and health system and a move towards provision of basic care by a "plurality of public and private providers" (ibid.; see also Londoño and Frenk, 2000). It also limited the boundaries of such health care, concentrating upon twelve interventions:

- Basic household sanitation measures
- Family planning
- Prenatal, natal and postnatal care
- Nutrition and growth surveillance
- Immunisation
- Treatment of diarrhoea at the household level
- Treatment of common parasitic diseases
- Treatment of acute respiratory infections
- Prevention and control of tuberculosis
- Prevention and control of hypertension and diabetes
- Prevention of accidents and initial treatment of injuries
- Community training for health promotion

(ibid.: 139)

Central to these interventions was PROGRESA (*El Programa de Educación, Salud y Alimentación* / Programme for Education, Health and Nutrition). Begun in 1997, this was a poverty alleviation programme that integrated education, health and food within its "basic capacities" remit (Gomez de León et al, 1997). The safety net strategies discussed above are precisely the strategies adopted by PROGRESA and include food subsidies or grants for key foods, social funds for short-term specific programmes funded by loans from international agencies (PROGRESA's funding came from the International Monetary Fund) and social initiatives focussed upon getting people involved in improving their own health (Goméz de León et al., 1999; Handa et al., 2000).

The practicalities of the linkages involved in this basic capabilities strategy include, for example, educational grants and nutritional support conditional upon school attendance. For example, 260 thousand such grants were offered in 2001 (Dirección de Información y Difusión, 2001). However, these grants are also dependant upon monthly visits to the local clinic for health monitoring, advice and vaccinations. In common with the general ethos of SPHC, the programme has been specifically targeted to the poorest communities, particularly those located in rural, marginalised regions and characterised by high levels of

illiteracy, extreme poverty and poor living conditions (Goméz de León et al., 1999; Handa et al., 2000).

Health Issues in Chiapas

The poverty experienced by the majority of indigenous Chiapenecan populations has a profound impact upon health and make the state an obvious recipient of schemes such as PROGRESA. The scheme covers the six regions (out of nineteen) in the country which are considered the most disadvantaged in socio-economic and geographic terms and, in 2001, this coverage extended to 1 million, 922 thousand, 736 families (Dirección de Información y Difusión, 2001). Of all Mexican states, Chiapas had the most number and proportion of households that benefited from PROGRESA in the year 2000. Overall 41.8% of Chiapenecan households benefited from PROGRESA, amounting to a spending of $922 million pesos (Alianza Cívica, 2000).

Health problems in the state have been acute and specific illnesses date back to colonial times (see Chapter Four). The average lifespan of 67 years in Chiapas was the second lowest in the country in 1992 (CIEPAC, 1999)[2], with only 3.1 per cent of the population over 65 years of age (Trujillo et al., 1996: 3). These figures indicate the poor states of health in the region. Many of the problems are precisely those which PROGRESA was designed to tackle as they are, in general, associated with poverty and the lack of amenities and opportunities. In particular, "chronic alcoholism, malnutrition, and diseases such as tuberculosis, typhus and intestinal parasites [have] plagued Indian communities" (Benjamin, 1989: 230).

Malnutrition and the diseases mentioned above are directly linked to this economic hardship, poor diet, close and cramped living quarters (which allows disease to spread quickly amongst family members and neighbours), and the lack of basic services, such as, for example, drainage and clean drinking water. Accordingly, CIACH, CONPAZ and

[2] Although yearly variations in such figures mean that they should be treated with some suspicion (CIEPAC, 1999).

SIPRO[3] (1997: 30-31) report that the seven principal illnesses that affect the Chiapanecan population are:

- malnutrition
- anaemia
- intestinal infections
- stomach tumours
- perinatal infections
- tuberculosis
- respiratory infections

- and that 66.74 per cent of the population suffers from some degree of malnutrition, giving Chiapas the highest national level of malnutrition.

The causes of many such illnesses are linked to social and economic conditions, as indeed are other related chronic conditions. For example, alcoholism is a significant problem in many indigenous communities and, according to much empirical research, is likely be associated with depression, stemming from poverty and a perceived lack of autonomy, or "control", to improve personal and family socio-economic conditions (see Ross and Huber: 1985; Mirowsky and Ross, 1984; Peirce et al, 1994). In the past, however, the state authorities have generally responded as if "the lack of health is owing to the ignorance of the population in terms of correct habits of hygiene and alimentation and in the ways of preventing illness (Freyermuth Enciso, 1993: 25) (my translation). The responsibility of indigenous communities for taking care of their own health is further emphasised in Page Pliego's (1996) work. In his analysis, the Chiapanecan state's response to health care is viewed as typical of that of a capitalist state in assuming ill health to be a "response to social pressures" and an "attempt to allude social responsibilities" (ibid.: 213). As such, indigenous communities are assumed partly responsible for lack of good health resulting

[3] Respectively, the Centro de Información y Analysis de Chiapas (Chiapas Centre for Analysis and Information), the Coordinación de Organismos No Gubernamentales por la Paz (Coordination of Non-Governmental Organisations for Peace; dismantled in late 1997), and Servicios Informativos Procesados (Processed Information Services).

from their ignorance, as Freyermuth Enciso states. As a result of these assumptions, health provision in the state has historically concentrated upon intervening directly in health issues, rather than concentrating upon the related infra-structural causes.

As far back as the late nineteenth century, attention has been called to the health issues affecting indigenous populations in the state on a governmental level. In the last decade of that century, the activist governor, Francisco León, increased the role of state government in public health provision by a reorganisation of the institutions of health. In 1897 the Office of Inspector General of Public Health was created which, amongst other tasks, had the power to oversee medicine sales, outbreaks of contagious diseases and to deal with all other matters associated with public health. At the end of León's term of office, the state first publicly supported hospital had practically been built (Benjamin, 1989: 57-59).

It was not until many decades later, however, that the authorities explicitly linked health to structural problems of exclusion and poverty. In the 1950s, the *Instituto Nacional Indígena* (National Indigenous Institute / INI) began a "program of social and economic improvement by constructing roads, building schools and health clinics, organising co-operative stores and introducing modern agricultural methods" (ibid.: 227). However, given the extent of the economic and social marginalisation within many indigenous communities of the State, the programmes were too limited to have much real effect. These developments did not provide a decent living for the majority of the inhabitants of rural Chiapas (ibid.: 228).

Development policy and health in Chiapas

In recent years, development policy for the region has recognised the need to both vigorously and directly address health issues which affect the marginalised communities of Chiapas as well as tackle the related social environment. National and regional development plans which affect Chiapas are laid out within *El Plan Estatal de Desarrollo de Chiapas* (Chiapas State Development Plan) and *El Programa de Desarrollo de la Región de Chiapas* (Development Programme for the Highlands of Chiapas). Additionally, state level policy specifically related to health and related social assistance is detailed in the *Programa de Salud y Asistencia Social* (Programme for Health and Social

Assistance). Given that such plans reflect policy directions, objectives and general strategies rather than detailing the formulation of specific programmes designed to fulfil these objectives, PROGRESA is not explicitly mentioned. However, the issues focussed upon in all of these plans reflect the selective foci of "basic capacities" and SPHC for the period 1995-2000. Indeed, *El Plan Estatal de Desarrollo de Chiapas* (p.11) states that "...the most fundamental part of social demands is related to the coverage of basic services of health, education, housing, potable water and sanitation...". Similarly, the plan focuses upon the marginalisation of indigenous communities, remarking that "the mortality rates present amongst the indigenous are primarily caused by gastro-intestinal diseases and by respiratory problems. In the particular case of the infant population, high rates of malnutrition are registered, which are also a cause of mortality" (p.50). All these problems are precisely those identified as the "action points" of PROGRESA.

Whilst the problems of Chiapas are fully expounded, there is relatively little detail on the action to be taken to confront these problems within these plans. For example, with reference to health, *El Plan Estatal de Desarrollo de Chiapas 1995-2000,* proposes only that:

> "The coverage of Primary Health Services will be extended, through technicians for Primary Health Care (TAPS), proposed by the communities themselves and capacitated by the health sector, without forgetting the strengthening and development of traditional indigenous medicine" (p.162).

This reference to the involvement of communities themselves in responsibility for their own health directly reflects the aim of PROGRESA, as part of which over two thousand local level courses on health, nutrition and hygiene had been given by the end of 2001 (Dirección de Información Y Difusión, 2001). Whilst the Chiapas development plan also proposes that primary health services should be "guaranteed" for all the population through a "basic package of detection of needs" and that "programmes related to over-population" (p.177) should be strengthened, there is no detail on how these objectives will be achieved. Given the extent of the health problems noted in earlier sections of the document, these appear rather limited proposals, albeit ones which match the ideological framework of individual responsibility for health underlying SPHC strategies.

The lack of specificities in such policy overviews means that it is difficult to know how these strategies have realistically been implemented. The case study chapters of this thesis reveal some of the ways in which women, in particular, negotiate those services offered at community level by the government health services under the direction of such policies and thereby indirectly offers some insight into their provision. However, a look at the infrastructure of health institutions operating in the state indicates that even the delivery of these limited health services is likely to be a challenge.

Contemporary health care provision in Chiapas

In Chiapas today, the governmental health institutions noted in Table 3.2 are active. Of these the most relevant to indigenous communities (whose members are unlikely to be in state employment) are the *Unidad Médica Rural de Solidaridad* (Rural Medical Unit of Solidarity) of the IMSS, DIF and INI. However, these institutions have, even in theory, only the capacity to reach 68.51 per cent of the population of Chiapas and this coverage is of a "population [which is] potential and not really covered" (Trujillo et al, 1996: 20). In fact, other figures point to the number of actual users being even less at 55.8 per cent, only 2,699,351 of the 554, 357 rightful claimants in 1994 (CIACH et al., 1997: 29). This figure is unsurprising, given that in 1994 there was only one doctor per 1,132.85 persons and one nurse per 1,315 inhabitants in Chiapas (ibid.). A substantial proportion of health services are for state workers which also puts indigenous communities at a disadvantage in terms of health services and the ten *municipios* with the least number of rightful claimants to health care are all indigenous (ibid.).

Although the temporary provisions of PROGRESA cover some basic health care services in selected communities (as noted above), the lack of proper and appropriate health care provision for the majority of indigenous communities by the government is evidenced in the additional provision by many local non-governmental organisations, such as *Grupo de Mujeres* and *Kinal Antzetik*, of voluntary health divisions to help serve needs. The hospital at Altamirano, run by Catholic nurses, also provides such a service. In addition, there are several doctors who work independently in conjunction with local and international non-governmental organisations and often in physically, and politically, remote areas that governmental services do not reach. However, the additional services provided on such a

voluntary basis are minimal in comparison with similar regions, such as Huehuetenango in Guatemala (Trujillo et al, 1996: 20).

TABLE 3.2 HEALTH INSTITUTIONS IN CHIAPAS

Name	Abbreviation	English Translation
Secretaría de Salud	SSA	Ministry of Health
Instituto Mexicano del Seguro Social	IMSS	Mexican Institute of Social Security
Instituto de Seguridad y Servicios Sociales para los Trabajadores del Estado	ISSSTE	Institute of Security and Social Services for State Workers
Sistema Nacional para el Desarrollo Integral de la Familia	DIF	National System for the Integral Development of the Family
Instituto Nacional Indigenista	INI	National Indigenous Institute

(Trujillo et al, 1996: 19)

In present times, the provision of health care is also complicated by the political conflict. Many indigenous people do not wish to attend government hospitals and clinics as they believe government officials posing as doctors will question them about their political tendencies or activism. Supporters of the EZLN or the PRD (*El Partido de la Revolución Democratica* / Party of Democratic Revolution) feel excluded and discriminated against by such services. Mobile services and health workers are also unlikely to be accepted as outsiders are subject to suspicion, unless they enter with the backing of a trusted non-governmental organisation. During the fieldwork for this thesis, this exclusion was remarked upon by many local NGOs (who operate their own outreach health services), doctors who work outside of the government health sector, and health researchers. It was also precisely the motivation for the entry of *Medicins San Frontieres* into autonomous Zapatista regions in 2000 to offer basic health care and vaccinations, suggesting that PROGRESA had not reached, or been accepted by, these marginalised communities. This gives credence to the comments by some interviewees in the case study region of this thesis that only those households which were government supporting could be recipients of the programme's benefits. However, there is little or no "official" evidence to support this.

Whether or not the services exist, lack of access remains an issue. In areas with a high level of militarisation, people (and women in particular) are reticent to travel far from their homes, as they fear they will be subject to harassment from the military. The nursing sisters in Altamirano report that women are subject to sexual taunts, threats of rape and, on some occasions, actual violations when they travel outside of their communities. Displacement of communities following violence can also create related problems with access to health care. For instance, Hernández Castillo (2001a) relates the experiences of one displaced indigenous woman from Chenalho who was bleeding for several days as a result of a prolapsed uterus before daring to seek medical attention in a government hospital, who was treated with contempt by hospital staff when she eventually did and who eventually died. In addition, the presence of army camps has meant an influx of prostitutes into the area, a phenomenon alien to indigenous cultures, thereby increasing fears and insecurities. Governmental health services are also usually only provided in Spanish, which is an obstacle for many indigenous people (especially women) who only speak their own ethnic languages.[4]

SAPs and SPHC: Global policy making and local responsibility

Despite such political and logistical challenges in Chiapas (as in many other areas of the developing world), global ideology and local practicalities of health service delivery require that the particularly marginalised communities which benefit from "safety net" schemes also contribute to the promotion of healthy environments in a holistic sense and, in some cases, play an active role in aspects of health service provision.

PHC programmes have long since included an element of voluntary labour to replace and reduce financial costs, borrowing from the Chinese model of grassroots health promoters. This focus on community involvement has been emphasised through numerous international conferences and declarations on health promotion. The Ottawa Charter (1986) defined health promotion as the "process of enabling people to increase control over, and to improve, their health". The Adelaide Conference of 1988 and the Sundsvall Conference of 1991 also promoted a comparable model of health as social investment.

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[4] The majority of women of Amatenango, the case study area, have the unusual advantage of being more-or-less fluent in both Spanish and Tzeltal (see Chapter Four).

Critically, and more recently, was the Jakarta Conference of 1997, the conclusions of which informed the WHO 1998 policy on Health for All in the twenty-first century. This included the following aims:

- To promote social responsibility for health
- To consolidate and expand partnerships for health
- To increase community capacity and "empower" the individual in matters of health

These three aims in particular indicate that the future of health care in developing countries necessarily involve a continued reliance on community input (alongside increased privatisation of health care provision).

The World Development Report of 1993, which focuses on health, is one of principal resources spelling out this global health policy. Policies are designed to be country specific, decentralised and, most importantly, cost-effective. The key recommendations fall into three broad spheres:

- Fostering an enabling environment for households to improve health
- Improving government spending on health
- Promote diversity and competition in health services

Terminology such as "fostering" and "enabling" reflects a stepping back of direct action by the State. Passing responsibility to the "household" (and particularly to women as health carers) forms part of this strategy.

The promotion of community participation reflects a reformation of the ideological basis of government structures towards a neo-liberal, market orientated state. In particular, the notion of accountability is promoted, in terms of the customer (in this case, the patient) operating under a transparent state structure and within an open "civil society". Equally, individuals have the responsibility to encourage an effective state and to promote a healthy environment for themselves using networks of trust and reciprocity (Putnam, 1993).

In this sense, civil society constitutes the individual as an actor with both rights and responsibilities. In so doing, it necessitates that all such actors should share the conservative vision of community embodied in the notion of social networks and should share world-visions in a wider sense. Indeed, the suggestion of communities of citizens itself assumes homogeneity in society. "Sub-cultures" of "Other" perspectives on health and on reproductive decision-making may differ from those of the Western world and international institutions and realities of life in politically and economically marginalised communities stand as obstacles to such ideals (see Hernández Castillo, 2001a; 2001b). The conducive democratic environment in which all members work towards a common end with shared means of achieving this end is, therefore, perhaps often unrealistic.

Civil society and "other" belief systems regarding health

The configuration of this commonly constituted health environment is particularly problematic in varied ethnic contexts such as that of Chiapas, where "Other" belief systems and health practices can make the formulation and achievement of common aims difficult. *El Plan Estatal de Desarrollo de Chiapas, 1995-2000* (p.9) states that "the possibility of development" (within which health is conceptualised as a principal component) is based upon the "participation of all society". However, one of the most important factors to be considered in any study concerning health and health care in Chiapas is the high prevalence of non-Western cultural beliefs regarding health, illness and its treatment. In the great majority of indigenous communities, *curanderos* or *hierberos* are still very active and are widely used. Traditionally, their services have been envisaged as oppositional to the allopathic methods of governmental health care systems, although the contemporary relationship is, in reality, more nuanced and complex (see Chapter One). Despite the latter complexity, many Western health care practitioners regard "traditional" methods as homeopathic, superstitious and a hindrance to the effectiveness of Western, or "biomedical" (Hahn and Kleinman, 1983: 305) health care. As commented above, indigenous communities are indirectly "blamed" for their own ill health. Their continued reliance upon "traditional" medicines in the face of "proper" scientific systems is regarded as an obstinate unwillingness to accept the "modern" system.

However, the Mayan knowledge and utilisation of the vast variety of herbs and plants available in the mountains and jungles of Chiapas in treating illnesses is increasingly subject to Western scientific investigation. This is a rapidly expanding focus of study in pharmaceutical research projects, such as those run by the governmental research institution, *El Colegio de la Frontera Sur* (Freyermuth Enciso, 1994: 123). Freyermuth Enciso's work concerning the relationship between "traditional" and mainstream Western medicines notes the developments made in the past few decades. She points to the initiation of the IMSS-Coplamar programmes in conjunction with INI at the beginning of the 1980s, which:

> "definitively marked a new form of study and recognition of the 'other'...[and]... recognises the importance of indigenous curative practices as a form of response and eventual solution to the problems of health-illness, giving rise to works of research centred upon their impact on all levels of health, their coverage and points of coincidence between both practices" (Freyermuth Enciso, 1993: 13) (my translation).

One of the problems with the research programmes subsequently undertaken was their generalised nature with state level data and little local information (ibid.: 14) but the mere fact of their existence was perhaps an obviously important step forward. More recently, however, such research has been a source of discontent amongst practitioners of traditional medicine. Indeed, in 2002, representatives of 31 indigenous communities from 20 Mexican states announced a "unilateral moratorium on all research activities, exploration and prospecting of natural resources" in their territories (La Jornada, 19/09/2002) (my translation) because the lack of transparent agreements meant that resources and traditional knowledge could be abused.

In practice, traditional medicinal practices continue to be regarded with suspicion by many. Nevertheless, part of the Mexican State's response to economic crisis and neo-liberalisation in the last decade (see Peabody, 1996) and, as a result of China's incorporation of "traditional" health care into the WHO and the Alma Ata, has been to decrease their direct responsibilities in health care (Freyermuth Enciso, 1994: 122). A gradual reduction of state health services to marginalised areas has shifted the responsibility of primary health care towards families themselves (therefore, to the remit of women) and towards traditional

health carers, *curanderos,* within indigenous communities. The formulation of PROGRESA echoes this shift in responsibility with its focus on strengthening the capacity of local health promoters through the training courses mentioned earlier in this chapter.

This has two consequences. The first is the increased absorption of costs by the communities themselves, especially of the costs of primary health care (Freyermuth Enciso, 1994: 123; Page Pliego et al, 1995: 273). The second consequence is that the official reliance upon *curanderos* brings them under the jurisdiction and legislative control of official channels (Page Pliego et al, 1995: 271-273). Although the 1980s series of programmes ostensibly had as one of their principal objectives "the fortification and recognition of traditional medicine, privileging activities aimed at the organisation and contact with indigenous medics through meetings and workshops" (Freyermuth Enciso, 1994: 123), this official reliance upon traditional medics may have some less positive and more restrictive implications. Although it no doubt represents a liberal and open-minded step by some towards the incorporation of different cultural beliefs and an attempt to absorb them into official health care, it may also be used in practice as a means to limit and control their influences. Contrary to being an expression of respect for their expertise, experience and "Other" versions of medical/religious knowledge and holistic health care, this system can often merely use them as an effective and cheap resource in the limited areas focussed upon by SPHC, such as activities concerned with improving the sanitary environment of communities, vaccination, and oral rehydration (ibid.).

Page Pliego and colleagues (1995) comment that the production of Chapter Four of the Law of Health in the State of Chiapas in 1990 (which deals with the issue of "traditional medicine") was without any consultation with the indigenous communities, whom it was directly to affect. This, then, was in clear violation of the International Labour Organisation's mandate that communities have the right to determine their own priorities in development (Sieder, 2002b) and also contradicted Salinas' rhetorical emphasis upon the importance of recognising the cultural plurality of the nation. In effect, the law represented "a clear tendency to generate legal mechanisms that facilitate the gradual displacement of indigenous medicine" (ibid.: 275) (my translation). For Page Pliego and his colleagues, the document demonstrates a "Western and integrationist spirit" (ibid.: 276) (my translation) in

its stated aim of controlling the exercise of traditional medicine by the compulsory training to be meted out to indigenous medics. The analysts comment that the tone of the law is such that it is as if "the communities and indigenous medics were awaiting the first opportunity to get rid of their medicine...[and leave] to one side the historical importance which traditional medicine has for indigenous groups, being one of the customs that, in the greatest measure, has contributed to their physical and cultural survival in the face of the constant battering of colonial society" (ibid.: 277) (my translation).

In this way, then, it is obvious the significance health care has to the maintenance of distinctive ethnic identities for indigenous communities in Chiapas and, for this reason, the political battlefield it has the potential to become. Western medicine, assuming itself to be based upon an external, objective science, "apparently isolates itself from the rest of the socio-economic context, making itself appear a socially autonomous, ahistorical practice, dressed with a character of neutrality, altruism and humanism; aspects which mask the economic, political and social determinants to which it is subject, as are all social practises" (Page Pliego, 1996: 212) (my translation). It is as much a culturally embedded, and politically driven, practice as is "traditional" medicine in Chiapas.

This discussion does not merely relate to the equal consideration, and politics, of traditional medicine but also to problems encountered in implementation of Western health services, when the cultural specificity of Western medicine is not acknowledged and sensitivities of cultural difference are not taken into account. The implementation of PROGRESA in Chiapas is no exception. For example, *parteras* (traditional birth attendants) embarked upon a campaign against the smear tests offered as part of PROGRESA in 2002. The campaign did not necessarily revolve so much around the unacceptability of smear tests *per se*, but rather the ways in which they were carried out which they claimed resulted in a "psychological torture" for women in which "cancer had been converted into a threat for indigenous women". It was claimed that the tests themselves had been enforced because otherwise women feared that they would be removed from the PROGRESA scheme" (La Jornada, 19/09/2002). This lack of sensitivity in the implementation of certain PROGRESA interventions was seemingly compounded by inappropriate educational

strategies for indigenous adolescents, characterised as "pornographic" and "out of context" (ibid.).

Women and responsibility for health

The community participation necessitated by safety net schemes such as PROGRESA, then, are problematic in terms of their implied homogeneity and lack of consideration of cultural difference in health care practice. Similarly, there are also significant gendered implications. As women are often community and family health carers, they are given particular responsibilities in this conceptualisation of an enabling community health environment. In many cases, the local health promoter is a woman and / or health information and programmes are aimed at women (see the case study chapters of this thesis for related data). There are, however, some problematic assumptions inherent in this concentration on women:

- *Women have the available time to commit to voluntary health care.* It is therefore assumed that they do not hold a public sphere paid position, that their labour is concentrated in the private sphere, and that these duties are of little consequence. This may be unrelated to the reality of women's lives in many cultures where they are involved in farming activities or their domestic activities may involve duties away from the home in, for instance, collecting firewood or water.

- Health care is a private, family concern and one which is related to the gendered motherhood role (the social reproductive role)

- Paid professional health care, if replaced by female labour and reduced to this social reproductive role, then becomes unremunerated. In other words it loses its professional and financial value.

The conservative vision of community discussed above views women (in particular) in a traditional light – as mothers and wives with duties, roles and identities understood in Western terms (see Chapter Seven). Within the deliberate gender focus of PROGRESA, for instance, women are given the responsibility of collecting the bi-monthly allowance. The latter has two aims. One part of the allowance relates to children's education, which increases incrementally according to how many children are in school and the level of their education. The second part relates to health and nutrition. This part of the allowance is to allow the family to provide themselves with the necessary nutrition and supplements to maintain good health, particularly for the children and pregnant women. This allowance,

however, is dependent upon each member of the family attending the local health clinic for monthly check-ups. Both parts are clearly related to women's assumed social reproductive roles as mothers and health carers. Therefore, although the collection of such grants is designed to "empower" women (Adato et al, 2000), it also assumes certain gendered responsibilities that run alongside the rights and benefits afforded.

POPULATION, REPRODUCTION AND HEALTH: POLICY LINKS

PROGRESA, reproductive health and family planning

Another of PROGRESA's specific aims also has particular impact upon women's lives. The promotion of family planning falls within the basic capabilities remit of SPHC, as noted earlier in the chapter, and is integral to the programme. Whether or not she requests the information or not, any doctor treating a woman of childbearing age who is a recipient of PROGRESA must inform her about family planning methods and the woman must sign a form to show that she has had the methods explained to her. This information is given during the regular clinic visits upon which the PROGRESA payments are contingent.

As noted earlier in this chapter, the implementation of reproductive health strategies within PROGRESA is not without problems. In the reproductive health educational campaigns, cultural differences can present obstacles, particularly when full explanations are not given or are given out of an appropriate context. In addition, the distinction between "family planning" as a means of promoting reproductive health and choice and population control has proved difficult in practice. Indeed, some health workers have employed PROGRESA as a means of "encouraging" the use of contraceptive methods, with some using the threat of withdrawal of the schemes' services and benefits as a way of ensuring that women accept "medical procedures, including PAP smears, IUD insertion, and even surgical sterilisation" (Kirsch and Cedeño, 1999: 419).

With the incorporation of integrated strategies of health, family planning and social assistance within its remit, PROGRESA makes an obvious link between reproduction and health. On an official level, policy directives clearly do not promote the kinds of activities by health workers noted above. Indeed, as Kirsch and Cedeño (ibid.) note:

> "Since 1973, Mexican legislation has guaranteed the right to decide in a free and informed manner the number and spacing of pregnancies and states that a violation of this right is punishable. At an institutional level, official documents encourage informed consent. However, in the field the government health workers lack both information and sensitivity with regard to an individual's right to decide."

This lack of information and capacity for sensitivity is no doubt compounded not only by a generalised discriminatory attitude towards indigenous peoples (see Chapter Four) but also by an equally clear public discourse on the problems of population explosion and poverty, and the related existence of quotas for sterilisations and other procedures in PROGRESA (ibid.). In addition, there is another inherent link. A "population explosion" may also be a positive indicator of improvements to the health of the population as it may relate as much to a drop in mortality rate as to a increase in fertility rate. In his 1959 discussion of population, Geisert refers to the improved health in Latin America:

> "The expectation of life at birth has been rising steadily in all countries of the region...This has been the direct result of public health campaigns to reduce or eliminate the incidence of malaria, yellow fever, smallpox and other infectious diseases. However, much progress is still to be made in promoting sanitation and the gastro-intestinal diseases still rank as a major cause of death." (Geisert, 1959: 22).

This is an early focus upon the need for PHC. It is an indication of the relationship between the "population explosion" and improvements in health, resulting not only from improved health care programmes and clinical developments to eradicate disease but also from improved living conditions and sanitation. However, whilst a "population explosion" may be taken as an indicator of improving living standards (particularly in respect of health), it is also viewed conversely as standing in the way of such improvements. For example, *El Plan Estatal de Desarrollo de Chiapas 1995-2000* (p.40) notes that the 1993 infant mortality rate in Chiapas had dropped to 42.4 per 1000 live births from 57.9 in 1988. This drop is put down to "the advance in health programmes" and especially those programmes focussing upon selective primary health care interventions such as "the use of antibiotics, vaccines, and rehydration salts...at an early age" (my translation). However, the implications of this are ambiguous, given that the discussion immediately preceding these observations focuses upon the negative impact of population growth in the state (see below). In addition, the plan later states that "[c]omplex and diverse factors have

conditioned the state of health of the Chiapanecan population, factors driven by the demographic explosion on the constituency" (p.55) (my translation), thereby recognising the relationship between population and health is by no means straightforward.

In this sense, programmes such as PROGRESA are perhaps contradictory. Their concentration on improving living standards and health necessarily implies an increase in population as mortality rates drop. By the economic logic of Malthus (described below), this very increase is problematic. It is hardly surprising, then, that, with a lack of available public spending to improve access to land and other infrastructural issues programmes such as PROGRESA must include a concentration on family planning. If assumed to be successful in their objectives regarding health, they are, in effect, controlling their own side effects by also focussing upon family planning and reflect global thought on the logic behind processes of population, health and development.

Malthusian and neo-malthusian population policies

In a similar way to health, population policies have been profoundly influenced by the ideology embedded in structural adjustment. Population policy has gone through many phases in the past few decades. These have negatively linked the "problem" of population to economic development and "modernisation" of developing nations in one way or another. They have either represented development as the solution to over-population or, later, reversed the coin to show how control of population helps development. Governments operating under the conditions of structural adjustment are often compelled to commit to reducing population growth (Hartmann, 1997: 80), based on the argument that reducing fertility rates will promote economic growth and thereby indirectly improve living standards for the whole of society. In this way, governments and international bodies have attached a moral justification to interventions in the private sphere and, indirectly, in women's decision-making regarding reproduction and, therefore, by extension, their own bodies.

Such arguments are contemporary versions of Malthusian population policy. In 1798, English clergyman Thomas Malthus published an Essay on the Principle of Population. This conservative vision of population issues was a pessimistic outlook on human nature

and on the future of earth's resources. Malthus theorised that population was likely to increase geometrically (i.e.1, 2, 4, 16 etc.) but that the earth's resources are limited. Therefore, overpopulation will lead to natural resource depletion, poverty and social disorder:

> "Through the animal and vegetable kingdoms, nature has scattered the seeds of life abroad with the most profuse and liberal hand. She has been comparatively sparing in the room and the nourishment necessary to rear them...The race of plants and the race of animals shrink under this great restrictive law. And the race of man cannot, by any efforts of reason, escape from it. Among plants and animals its effects are waste of seed, sickness and premature death. Among mankind, misery and vice." (Malthus, 1798 (1976): 20)

Present day neo-Malthusian policies differ in some respects to those of Malthus. As a clergyman, Malthus did not advocate artificial birth control but rather celibacy and delayed marriage, stating that "[i]t is clearly the duty of each individual not to marry till he has a prospect of supporting his children" and that "moral restraint [is] the only virtuous mode of avoiding...incidental evils" (Malthus, 1798 (1976): 132).

Whether or not abstinence should realistically be promoted is subject to heated debate in the contemporary world of population control and family planning. However, the theoretical influence of Malthus has proved strong on both sides of this debate. In 1991, more than 70 population and environment organisations in the US signed a "Priority Statement on Population" which concluded that the rise in the population growth was the greatest concern to the world's future. In 1993, the "Population Summit" in New Delhi called for efforts to achieve "zero population growth within the lifetime of our children" (see Bandarage, 1997, for detail on international political discourses on population). These calls for population control link issues of economic development and poverty to environmental calls in, like Malthus, stressing problems of the earth's scarce resources.

A clearly Malthusian influenced view is expressed by the Mexican agency for population, CONAPO, in a 1986 report:

> "The demographic behaviour of a population, at the same time as having deep and diverse roots, has consequences whose effects are not exhausted within the conglomerate of men and women who are integrated within this population, but rather transcend to the physical environment in which it is situated, and give rise to effects which are of interest to all dimensions of social society. In relation to the latter, a relationship can be spoken of between demographic and a variety of other variables, such as the availability of remunerated employment, the availability of living spaces, the capacity of the school system, the extension of medical services and the quantity and variety of food supply." (CONAPO, 1986: 4) (my translation).

Similarly, *El Plan Estatal de Desarrollo de Chiapas 1995-2000* (p.40) notes that "the population growth of the next years will impact substantially on the state. On the one hand, there will be increased pressure upon the tenancy of agricultural land and demand for food, population expulsions from the rural zone, the existence of a large quantity of manual workers, and the requirement of social welfare resources, amongst other necessities". These statements make clear the correlation between issues of population control and the broader social and economic issues relating to health. This linkage further clarifies the multiple functions of PROGRESA in that, whilst seeking to address poverty alleviation and primary health care needs, also focuses upon reproductive health and, arguably, plays a key role in reproductive control through its family planning remit. Not only is economic development linked to population but the health environment (see Chapter Six), which provides the necessary requirements for achieving and maintaining a healthy status, is also seen to be inextricably linked within the Malthusian derived logic underlying such programmes.

However, Furedy (1997) shows this linkage of economic development (and, indirectly, health) and population to be suspect and to have little ground in empirical evidence. Such policies ignore the fact that, despite high fertility rates in the developing world and decreasing rates in the industrialised world, it is the latter that is abusing and decreasing the world's resources. The "development" advocated by the West with its consumerism and materialism is one which has the potential to destroy the environment at a far greater rate than the lifestyles of those who have more respectful and balanced approaches to the use of the world's resources.

Furthermore, Furedy states that the policies may have more to do with industrialised nations' fears of being overcome by the increasing population of the "other" nations than any true belief in the economic ramifications of population growth. It may also be related more to the spreading of Western ideologies of culturally specific "family values" and the promotion of the "nuclear family" and the cultural imperialism this implies, rather to any altruistic intentions. Should this be the case, the state, and indeed international level, control over women's bodies is less justifiable as it cannot claim the validation of improving the well being of the general population. The insistence upon Western notions of reproductive decision-making precludes difference in the factors and considerations which are taken into account and which may reflect entirely different ways of envisaging the family, children and their roles in society.

Trends in Mexican population policy

The history of Mexican population policy has reflected differing positions on the link between population, poverty and development. Following the revolution and in the midst of the great demand for improving the economic vitality of the nation, the president, Miguel Alemán instituted the 1947 *Ley General de la Población.* Unlike its later reformed version, this law sought to dramatically increase Mexico's population in order to create a healthy supply of labour for foreign investment and to boost the nationalist project as a continuation of the revolutionary spirit. As a result, Mexico experienced a demographic boom during these years. Latterly, however, this boom has not been seen as part of the economic modernisation programme but rather, conversely, that the desire for economic modernisation and industrialisation was a result of the population boom. Indeed, the 1983 Report on the Latin American Conference on Population and Development discussed "the way in which the population increase of the post-war period was absorbed in the work force and, in particular, in the urban workforce of Latin America" (IUSSP Papers, 1983: 22). The project of increasing fertility has been criticised for hindering Mexico's economic development, exit from debt crisis and the dependent poverty trap. However, the country's poverty can also be interpreted as resulting from the fragility of post-colonial economic modernisation programmes and resulting rapid urbanisation, together with uncontrolled foreign investment and lending. The direction of cause and effect, then, are difficult to determine and may ultimately depend upon political positioning.

Mexico faces many domestic infrastructural and societal problems when attempting to live up to international expectations and population targets drawn up at a world level. Population programmes for the developing world are increasingly controversial and their politics debatable. However, for countries in economic circumstances such as those of Mexico, it is difficult not to follow the trends. Discussion of the "population problem" is commonly linked to development programmes. The bulk of one paper presented at the influential Latin American Conference on Population and Development held in Mexico City in 1983 is summarised briefly in the following terms:

> "In terms of policy formation, the author distinguishes two components necessary for the integration of population and development: a) a conceptual methodological linking of population and development; and b) the institutional-operative integration of population policies within development planning." (IUSSP Papers, 1983: 26)

However, the above proposal to address the relationship between population and poverty at a policy level does not, like much subsequent policy, first provide the evidence to prove that the relationship exists. Throughout this same conference, the reproductive health issues connected to population are given less significance in comparison to the broader economic picture. The family is mentioned frequently and the rights and equality of women alluded to on occasion.[5] However, it is the overriding concern with the labour market and demographic and social structural changes aiding, or hindering, the development of such a labour market that is most striking throughout the whole report.

As early as the 1950s, the assumption of a causal relationship between population, poverty and development in Mexico was made at both at macro and micro (individual) levels. One 1959 article entitled "Population Problems in Mexico and Central America" sums up the tone and content of popular debates. The following statement, for example, is made concerning the micro-level issues:

> "The necessity for supporting so many dependants places the worker at a disadvantage in trying to improve his level of living and in saving money which could be used for capital investment" (Geisert, 1959: 5)

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[5] See Teresita de Barbieri's paper, 'The Incorporation of Women into the Urban Economy in Latin America' (IUSSP, 1983: 22-23).

This is true to a certain extent. However, it is perhaps unrealistic to expect workers in the developing world to be able to save much capital, no matter how many children they have. It also does not take into account the lack of a welfare system in most developing countries, which means that children may be the only means of support in old age. The author continues to reveal the macro-level crux of the population problem:

> "A large proportion of children also complicates the problem of economic development because of the amount of time and energy devoted to their care...the most serious economic problem is the enormous increase in the size of the population." (Geisert, 1959: 16)

Geisert does note that, "[t]he economic development of the region is complicated by the inadequacy of basic facilities such as transportation, electric power, fuels, shortages of capital investment, and low productivity" (Geisert, 1959:17). However, solutions to these issues are not directly proposed and it is overpopulation itself that is referred to as the basic, most easily solvable "problem".

Women and reproduction in Mexico

The emphasis on population control at both global and national levels implies a significant responsibility for women. With the linkage of reproduction and development, women become responsible for the future of the nation in their role as mothers. In Mexico, President Luis Echeverría institutionalised the legal basis for this ideology in the 1974 *Ley General de la Población.* These legal reforms included not only advancement in gender equalities (such as educational and political equity) but also a promotion of women's reproductive control through a focus on reducing birth rates and the production of fewer, healthier children. As such, "women emerge as the locus for social change tied to motherhood, family well-being and the nation's population problems" (Berger, 1997: 1-2). Women, therefore, are officially being ceded responsibility but the adequate exercise of this responsibility is provisional, to a certain extent, upon state intervention. These reforms constituted "a renewed state-family relationship... [in]...defin[ing] appropriate size, parenting responsibilities, and maternal-infant care"(ibid.: 2). The steps forward in the rights of women are thereby qualified by attempts to control their fertility, social reproductive roles and, ultimately, perhaps even their bodies for the benefit of the entire nation.

During the same era as the second *Ley General de Población*, Echeverría also annulled Article 24 of the Health Regulations Code in direct contradiction to the mandates of the Catholic Church. The government body, *El Consejo Nacional de la Población* (CONAPO), and the Mexican Social Security Institute (IMSS) began "Fertility Regulation Research". By assigning this role to an institution concerned with health issues, control of reproduction was overtly linked with issues of health.

In Mexico, where the 1995 population figure stood at 91,158,290 (INEGI, 1995a: 88), fertility control programmes are still active and widely advertised. CONAPO organises highly visible television campaigns, stressing that even unmarried couples should be concerned with family planning. Many local IMSS clinics make family planning one of their primary aims. Specific governmental programmes (such as the PROGRESA programme) aid this emphasis upon family planning.

The pursuance of population control is, however, not without its challenges. Although technically divorced from the political process, the influence of the Roman Catholic Church plays an important role in the formation of attitudes towards contraception and family planning. This stands in contradiction to the Mexican government's enthusiasm for controlling the "population problem".

Unlike some other Latin American countries[6], abortion is legal "in cases of rape, severe genetic abnormalities and endangerment of the mother's life" (Barry, 1992: 219). Terminations are widely practised, although it is impossible to know the true number taking place each year. However, the illegality of abortion in circumstances other than those mentioned above and cultural, religious and economic restrictions makes its practice potentially dangerous and access often difficult, particularly for poorer women. In 1991, the Mexican state made an attempt to universally legalise abortion and, for its experiment, chose one of the poorest states, Chiapas (perhaps motivated by this particular health risk for poorer women). However, as a result of much pressure from religious authorities, its legality was short-lived and overturned soon afterwards, despite population concerns. Today, in all states, abortion outside of the specific criteria is a federal crime and

[6] In El Salvador and Chile, abortion is illegal in all circumstances.

punishable by a one to eight year prison sentence.[7] In Chiapas, the women's organisation *"El Grupo de Mujeres"* (Women's Group) reports that women who go to IMSS hospitals in the state with a miscarriage may be reported to the authorities by doctors if it is suspected that the miscarriage was self-inflicted. In such a case, the legal stance is that women will have to prove her innocence or face a prison sentence.[8]

Despite these contradictions and challenges, family planning programmes have succeeded in reducing the national fertility rate from 3.1 to 2.5 in the two decades following their introduction (Ortega et al., 1998: 155). However, infrastructural problems have also sometimes hindered the implementation of population control policies. Appropriate contraceptive supplies are not always available and women in some areas have very little information with which to take informed decisions (Oxfam, 1993: 55). This is particularly true in the rural context where access to health centres or pharmacies may be difficult and those to which they may have access often hold supplies of only limited forms of contraceptives. The lack of information and availability has perhaps influenced a particularly high rate of permanent contraceptive methods. Female sterilisation accounts for 43 per cent of contraceptive use in Mexico (Chant with Craske, 2003: 83). Therefore, whilst reproductive control is primarily considered to be the concern of women, they may not necessarily have access to the necessary practicalities to make valid decisions, such as appropriate facilities and supplies, information or decision-making authority (see Chapter Eight for related data).

Population politics and family planning in Chiapas

In one of the poorest states of Mexico, such concerns are prominent and the need to reduce population as part of a strategy of poverty alleviation remains a focus. In an overview of the challenges facing the state, *El Plan Nacional de Desarrollo de Chiapas 1995-2000* (p.26) notes that "Chiapas confronts a series of contemporary challenges related to the demographic explosion and the consequent impoverishment of its resources" (my translation). In reality, given accompanying decreases in infant

[7] The length of sentence varies according to various criteria, as specified in Article 330 of the Penal Code.
[8] Unlike English law, but in common with the majority of other Latin American countries, Mexico's legal system is based upon the Napoleonic Code (the body of French law first enacted in 1804) in which the accused is presumed guilty and must prove their innocence in front of a court (rather than vice-versa).

mortality rates, the confrontation of these challenges translates to a need to reduce fertility.

Obtaining rates of usage of family planning for Chiapas is difficult and it is especially difficult to find data that differentiate between indigenous and non-indigenous women, as a result of sub-registration, errors and omissions in many indigenous communities (Garza Caligaris and Cadenas Gordillo, 1994: 93; Garza Caligaris and Freyermuth Enciso, 1995). However, on a state-wide and non-ethnically specific level, the percentage rates of usage for 1992 were as follows:

TABLE 3.1 PERCENTAGE RATES OF USAGE OF CONTRACEPTIVE METHODS

	Surgical	IUD	Oral	Injection	Condom	Other	Total
1991	31.8	9.4	36	14.8	6.6	1.4	32,488
1992	32.6	8.7	33.3	17.2	6.4	1.8	39,394

(Source: Family Planning Programme. Coordinated Services of Public Health in the State of Chiapas, 1991-92. Quoted in Hernández et al., 1996: 43)

The usage of contraception, then, increased slightly in the space of only one year in Chiapas. However, the official rate is still low with only 5 per cent of women of fertile age in the state using a family planning method (Hernández et al., 1996: 43).[9] This, then, may in part explain the high rate of fertility even amongst non-indigenous women, which was an average of 6.83 in a sample group of 1, 764 interviewed by researchers from *El Colegio de la Frontera Sur* (ECOSUR) in 1994. This is 77.9 per cent more than the national reported national rate in 1987 (Nazar et al, 1997: 20).[10]

However, population politics are hotly contested in this Southern state. Whilst some regard reductions to population as a prerequisite to development for the most marginalised communities, others question whether part of the motivation may be the state's desire to control, and reduce, a problematic rural and ethnically "Other"

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[9] This does not include single, sterile, pregnant, or breast-feeding women.

[10] It should be noted that this is an overall fertility rate and not necessarily an indication of family size. It does not account for infant mortality, high rates of which may be influential in increasing fertility rates (see Chapter Seven).

indigenous population marked by extreme poverty. Reding (1994:15), for example, claims that the subsistence existence of this population is of little relevance to the overall national desire of industrialisation. Similarly, after noting that a population explosion puts pressure on agricultural land tenancy, *El Plan Nacional de Desarrollo de Chiapas 1995-2000* (p.41) also comments that "[t]he pressure on the land is one of the structural causes of internal conflict, voluntary migrations and / or expulsions from indigenous communities of Los Altos and the Sierra Madre of Chiapas" (my translation). This statement implies that at least some of the responsibility for the discontent and political problems of indigenous populations lies within these same communities (rather than being a governmental issue of political and economic marginalisation and land reform; See Chapter Four) and relates, at least in part, to fertility control.

Similar to questions raised at international levels, the underlying ideology of population policies and their subsequent implementation in family planning within the health care environment in Chiapas is also questioned. Garza Caligaris and Cadenas Gordillo (1994) point out that even intimate relationships "can involve interests much greater than those of the individual, the couple, or family" as in reality personal decisions "form part of societal projects" (ibid.: 94) (my translation) in the repressive political climate of Mexico. This is particularly true of Chiapas with its history and contemporary problems of ethnic conflicts and denial of human rights (see Chapter Four). Furthermore they comment that the inequalities of Chiapas and the alarming figures in respect to basic services, health infrastructure and resources, and mortality and morbidity mean that the reproduction debate does not simply concentrate itself upon the rights of women or society's control to "contain or control the sexuality of women". The debates may be subject to many sub-agendas, which in the "terrain of culture and indigenous groups...can result in being particularly problematic" (ibid.) (my translation).

The emphasis upon population control in the state is an obvious answer to the need to eradicate poverty within indigenous communities. It is perhaps significant that Chiapas was chosen as the experimental state for legalising abortion in 1991 (although this was subsequently overturned). It is indeed true that the birth rate in Chiapas is high at "a staggering 4.5 per cent, which translates into a doubling of the population every 16

years" (Reding, ibid.: 16). However, this is perhaps not necessarily problematic given that Chiapas is a large state rich in resources (see Chapter Four). Therefore, pinpointing over-population may be an overly simplistic response to the causes of the poverty.

Within the *Programa de Desarrollo de La Región Altos, 1995-2000* (p.100), the only statement on projects to address reproductive health is the following:

> "The overarching focus of reproductive health considers family planning as one of the fundamental pillars of complete health because it includes safe motherhood, promotion of breastfeeding, prevention of sexually transmitted diseases including AIDS, early detection and management of reproductive tract carcinomas, particular attention to the perspective of gender, facilitating the emancipation and respecting the rights of women to reduce poverty and improve the quality of life of the population." (my translation)

As well as being lacking practical detail, this statement appears to conflate individual rights of women with those of the population and to imbue women with responsibilities for the well-being of others, rather than simply themselves, as well as to co-opt women's health issues and a gender perspective to a view which supports the link between fertility and poverty. It is, therefore, indicative not only of the way which population control is inseparable from reproductive health in the state of Chiapas, but also the lack of genuine consideration of women's rights at policy level. As one doctor in the region commented:

> "It isn't a reason to be happy that many women are now taking to using family planning methods. They aren't using them because they would like to go out to work or study more or because they have just decided there are other things they would like to do with their lives. They are using them because they can't afford to have the children they would like to have. That is obviously very sad".[11]

Family planning, therefore, may not necessarily be a cure for poverty but rather often a symptom of it. As such, the state's implementation of family planning programmes, the focus on family planning within PROGRESA, and the uptake of contraception arguably indicate not a mark of success but rather a mark of failure in dealing with the key

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[11] The fact that this doctor wished to retain his anonymity in relation to this comment indicates the political interpretation it might be given and, therefore, the potential harm to his position by association with such a viewpoint.

problems causing poverty. In areas, such as Chiapas, where options for women are limited because of their cultural status and ethnic marginality[12] (and their related economic and educational circumstances) the uptake of family planning should perhaps not to be considered a triumph for women's rights, but rather an unfortunate indicator of their circumstances.

Within the traditions of indigenous culture in Chiapas, the majority of women's worth, not only from the community's perspective but also from her own perspective of her-self, comes from her role and identity as a mother (see Styker, 1977; Styker and Serpe, 1994; Nuttbrock and Freudiger, 1991, for detail on, and critique of, this phenomenon). Although Eurocentric feminist values may lament this limited role and see family planning as a means to increase women's options, it is perhaps sad that women's own desires for self-fulfilment in motherhood should be limited in this way. For indigenous women in Chiapas, having fewer children is not necessarily going to impart greater life-choices. Obviously, it would reflect positive steps towards women's equality, should they have greater life-style choices and choose family planning as a means to have the option and freedom to participate to a greater degree in society. The increasing use of Western family planning methods reflects an acceptance at individual level of the assumption of a causal relationship between poverty, population and development. However, family planning is unlikely to increase the family's overall economic circumstances in an environment such as Chiapas. It will not imply the provision of more productive land, a better health care system, a more adequate educational provision or clean water and electricity. They may have a little more money in the short term to provide for themselves and the children they do have. However, in old age and infirmity, there will be fewer offspring to help with the continuing work in the field and help support them. Indeed, Reding (1994) in his macro-analysis of the political situation in Chiapas, analyses the situation from precisely this viewpoint, perceiving population growth to be a result of poverty, rather than the reverse:

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[12] This is not to suggest that indigenous men's options are not also limited. They too suffer from racism and the economic disadvantages of poverty. However, women suffer from the added disadvantage of their sex that further limits their options within the traditional patriarchal structures of their cultures and traditions.

> "People who have no savings with which to confront disease and old age instead rely on their children as a form of social security. Where infant and child mortality is high, as in Chiapas, that means having a lot of children to ensure some will survive." (ibid.: 16)[13]

This is not to say that, given the infrastructural problems of poverty, a high rate of fertility is not problematic. It is certainly true, for example, that Chiapas is amongst the states leading the figures of maternal mortality with more than 8.5 per 10, 000 inhabitants (Garza Caligaris and Cadenas Gordillo, 1994: 96) (my translation). The reasons for this, however, are complex and the relationship between high fertility and maternal mortality and morbidity is difficult to determine. Lack of quality health care during pregnancy, a poor health status as a result of poverty, and lack of access to quality health services in the event of complicated childbirths may be more significant than the excess of pregnancies. There are, of course, obvious health risks associated with repetitious, closely spaced pregnancies. Therefore, pregnancy spacing is clearly beneficial. However, it is anecdotally reported that the most frequent form of contraceptive for indigenous women in Chiapas is sterilisation[14]. Even on a state wide level, sterilisation is a popular method (see Table 3.1) with approximately eleven women to every one man undergoing sterilisation operations, usually by the laparoscopic method of inserting a silastic ring (Hernández et al, 1996: 42). This occurs *after* the woman has had the number of children that the family considers they can afford, need or want and so may not greatly impact upon fertility rates (Kirsch and Cedeño, 1999: 419). In addition, she may have started her pregnancies at a very young age. She is also likely not to have spaced out her pregnancies using other contraceptives and so not have avoided the associated health problems, in particular anaemia (which is also associated with poor diet).

Sterilisation is a cheap and final method with no aftercare and, as such, is preferred by many health workers who promote it. Women are collected from their communities free of charge and transported to clinics for the operation. Both the organisation "*El Grupo de Mujeres*" in San Cristóbal de las Casas and the Catholic nuns who run a

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[13] This perspective also assumes a causal relationship between poverty, population and development (albeit in the opposite direction). Any purely economic explanation of reproductive decision making is questionable. However, this is perhaps more logical as a partial explanation than its opposing stance.

[14] Reports made by the *Grupo de Mujeres* and the nuns of the voluntary hospital at Altamirano.

charitable hospital in Altamirano report that indigenous women are often brought in by the truckload to clinics where they are operated on an almost conveyer belt like system. In addition, they claim that indigenous women are often sterilised without either their permission or knowledge when they visit government hospitals for unrelated health problems.[15]

Garza Caligaris and Cadenas Gordillo (1994) also report that such "institutional coercion", particularly as a result of the "1986 State Programme of Family Planning in Chiapas", has been facilitated by "ethnic oppression, monolingualism and illiteracy" (ibid.: 97) (my translation). According to their findings, many women have had abusive experiences in *Unidades Médicas Rurales* (Rural Medical Units), which in addition to the enforced sterilisations remarked on above, included the insertion of IUDs immediately following birth, refusals to remove them, the application of injectable contraception by deceit, or in spite of contraindications. As discussed earlier in this chapter, similar accusations have been made of medical practitioners operating within the PROGRESA remit (Kirsch and Cedeño, 1999: 419). Even in situations where women may make choices, "complete and adequate information" is not always given, thereby making it difficult to "take an informed decision" (ibid.) (my translation).

CONCLUSION

Reproductive rights should be based upon consensual, autonomous and informed choice to facilitate women's control over the own bodies and families' rights to choose the number of children they wish to have. Perhaps universally these decisions are never truly autonomous of societal pressures. However, in Chiapas, these decisions are further complicated and problematised by poverty, the history of oppression experienced by indigenous groups, and the influence of neo-Malthusian population politics. In this context, global level policy-making complicates the relationship between macro-level policies and individual autonomy and context.

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[15] Reports made to the 1997 delegation organised by the 'Pastors for Peace' non-governmental organisation based in the United States, of which I was a member. The aim of the delegation was to report upon the human rights situation of women in Chiapas. Also see Chapter Seven.

Neo-Malthusian logic also indirectly links population to health environment and status. However, attempts to confront health issues in Chiapas face considerable challenges. Not only do indigenous communities in the state have to deal with significant health issues as a result of centuries of social and economic marginalisation but global and local strategies which focus upon the incorporation of communities in the delivery of health care also face issues of political and cultural context. Freyermuth Enciso (1994: 3) notes that "[t]he breach that exists between the two medicines cannot be overcome by decree and the politics of health cannot remove the existence of two distinct visions of the world, and, ultimately, of health" (my translation). Whilst it is possible to conceptualise this boundary between these two visions as rather more blurred and to accept that this duality does not necessarily hold to the extent it may have done previously (see Chapter One), this perceived dichotomy of differing systems of knowledge and world visions has many similarities to the confrontation of two worlds, which occurred at the Conquest. In many ways, the perception, if not the actuality, of such a confrontation is a result of the history which succeeded the Conquest. As much as being related to broader issues of marginalisation and related policies, such as Structural Adjustment and population control, health care for indigenous communities is an issue of the right to cultural plurality and "Other" ethnic identities based upon differing constructions of knowledge. For this reason, the very demand by the EZLN for long-overdue adequate resources for impoverished rural communities, whilst maintaining a central ideology based upon the right to cultural plurality, is inherently politically controversial.

The spheres of health and reproductive policy making are by no means apolitical. Their formulation most often reflects Western ideologies and theories. The neo-liberal ideology of limiting state responsibilities in public services coupled with the promotion of the involvement of a homogeneously envisaged "civil society" may restrict "otherness" and "difference", whether conceptualised as a binary relationship or in terms of hybridity. In many ways, these processes can act to continue the exclusion of indigenous communities of Chiapas that began during colonisation and which themselves resulted in many of the health problems faced today. Therefore, the subsequent chapter outlines this important context in terms of the history of marginalisation and the resultant political and social realities of indigenous communities in the region.

CHAPTER FOUR

INDIGENOUS IDENTITIES AND EXCLUSION IN CHIAPAS

INTRODUCTION

As illustrated in previous chapters, health and reproductive issues cannot be viewed in a vacuum. They are contingent upon socially constructed identities, political realities and often historical and contemporary experiences of economic and cultural exclusion. In this chapter, I outline the context to the case study, which provides the empirical data for this thesis. I describe here the history of the state of Chiapas and its indigenous inhabitants, dating back to colonisation. My intention here is not to go into a detailed description of this history, but I point to some of the most salient happenings and interpretations of history which are particular crucial to the indigenous peoples of Chiapas. An understanding of this history is vital as history, or at least a society's formulation of history, plays a central role in the development of today's identities. This is especially true for those identities that envisage themselves, and are envisaged by others, to be excluded from mainstream society and whose identities are constructed on the basis of difference from this society (Wilson, 1993).[1] Contemporary Mayan identities are inextricably linked to the notions of their ethnic and cultural ancestry as well as their present day realities (see Chambers, 1979; 61-62; Wilson, ibid.). Also, many of the political issues that affect present day Chiapas, and particularly Chiapanecan indigenous communities, have their roots in the conquest and colonisation (Vos, 1997: 30). They, therefore, can only be understood within these contexts.

Although peripheral factors and relations may have altered, indigenous marginalisation has remained a constant fact through the history of Mexico. In many ways changes at national

[1] In framing the discussion in these terms I am presuming an understanding of ethnic identity based on that formulated by Richard Wilson (Wilson, 1993). This seeks to avoid the dichotomy between the structuralist perspective, which focuses upon boundaries and ignores 'cultural content', and essentialist viewpoints, which focus principally upon the latter. Instead ethnic identity is understood to be more fluid and encompassing of both historical experiences and contemporary social conditioning as well as reacting against 'boundaries' in the context of difference and 'otherness'.

political level have had little effect upon the realities of indigenous rural lifestyles. Here, I deal briefly with the long period between the radical changes provoked by the conquest and the more recent happenings of the twentieth century. I point only to the radical changes provoked by the conquest and colonisation and to some of the formal political changes, which directly affected indigenous lifestyles. Although my focus here is primarily upon Chiapas, I inevitably refer to those broader national happenings that would particularly have affected the indigenous populations of the state.

The most recent political events are particularly important to observe. This thesis may appear far removed from the political. However, any discussion of indigenous identities, difference, or issues such as health and reproduction in the politically troubled Chiapas (and no doubt in the majority of other post-colonial societies) is itself political and inevitably engages in the ongoing debate surrounding indigenous rights to resources and cultural plurality. The chapter continues from the historical background to an overview of the contemporary political, economic and social situation in Chiapas. This serves to reveal the continuity of exclusion and the contemporary environment in which identities are formulated and in which health and reproduction debates take place.

A HISTORY OF MAYAN CHIAPAS

Mayan Mexico and the conquest

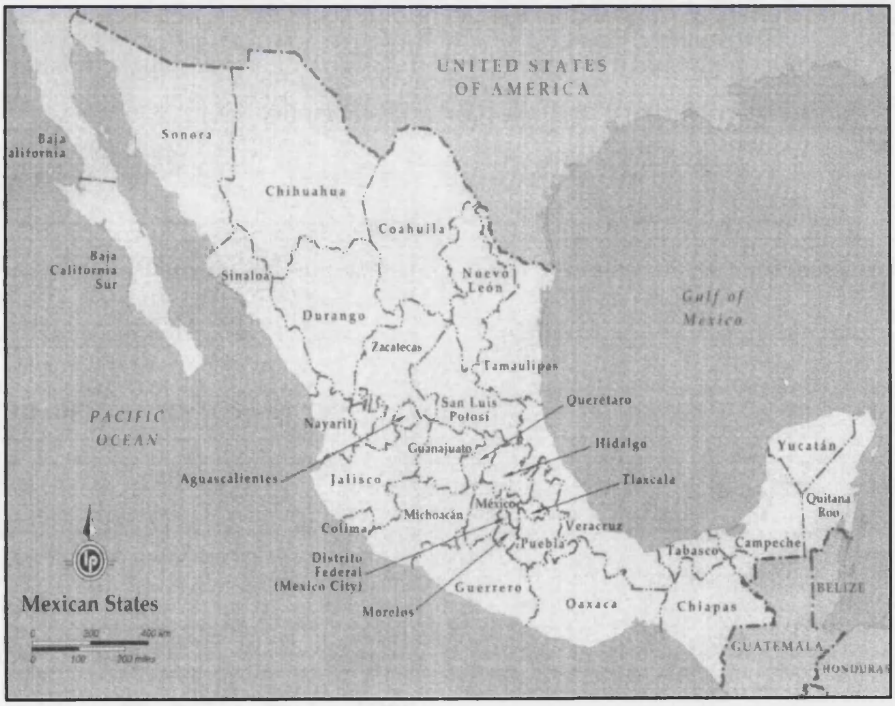
As Figure 4.1 illustrates, the southern state of Chiapas is situated in the southeast of Mexico, between 14° 32' and 7° 59' northern latitude and between 92° 22' and 94° 15' western longitude. To the north it borders the states of Tabasco, to the northwest Veracruz, to the west Oaxaca and to the south the Pacific Ocean and Guatemala (Trujillo *et al.*, 1996: 2). The border with Guatemala is particularly important as Chiapas shares many cultural features with its southern neighbour.

Archaeological evidence now shows the tropical lowlands of state of Chiapas to have been occupied by "complex" Mayan societies as far back as the late second millennium B.C., subsequently moving westwards through Chiapas in the middle of the first millennium

B.C.. These societies, were not, as was earlier assumed, "the poor cousins of the Olmec and the highland peoples, but the authors of their own cultural history, creators rather than merely borrowers" (Hammond, 1986: 400 - 403).

By the Late Preclassic period / beginning of the Early Classic period (respectively, the second half of the first millennium B.C. / the third or fourth century A.D.), agricultural organisation and production had intensified.
The Mayan powers were controlling "larger and denser populations, dwelling in more numerous, denser and more complex communities that had previously existed" (ibid.: 404). This, therefore, required the construction of impressive cities of ceremonial temples, pyramids, public buildings and major earthworks for defence and water works (ibid.: 404-407). Archaeological discoveries of Mayan hieroglyphic writing have proved a "sophisticated combination of literacy, numeracy and imagery" to have developed in these societies (ibid.: 410).

FIGURE 4.1 MAP OF MEXICAN STATES



(Source: The Lonely Planet, 1998)

The Mayan civilisations, whose ruined cities have become popular tourist attractions in recent years are the direct ancestry of the indigenous Mayan communities which still populate the state today and which maintain many adapted forms of the customs, traditions and ideas (Vos, 1997: 35. See also Collier with Quarantiello, 1999). The Mayan civilisations were vast and wealthy, exactly the type of civilisations for which the Spanish were searching. Unlike other European explorations, they were not searching for "virgin lands where they could establish populations" but rather "rich countries that they could commercialise" (Carrasco, 1994: 286) (my translation). The civilisations of pre-hispanic Mesoamerica were exactly this.

In the fifteenth century, the expeditions of Cortés and the Spanish arrived in the Yucatan and proceeded to what is now Mexico City. Several attempts were made to conquer what is now the state of Chiapas but it was not until the arrival of Diego de Mazariegos in the 1520s that this was achieved (Collier with Quarantiello, 1999). Although early archaeological research attempted to show much of the region to have been depopulated before the arrival of the Spaniards, more recent research has refuted this (Thompson, 1997: 73). A combination of fortuitous coincidences, manipulation of existing ethnic conflicts and religious beliefs and disease brought in by the invaders as well as massacre succeeded in defeating the indigenous populations (Toscano, 1994). The "indices of depopulation were catastrophic" particularly between the years of 1531 and 1535 (García de León, 1981: 43) (my translation). Thompson (1966, 1997) discusses the different endemic and epidemic diseases brought from the Old World and the particular regions they affected (see also Collier with Quarantiello, 1999: 19). For example, the introduction of malaria, measles, small pox, yellow fever, dysentery, hookworm and tuberculosis probably accounted for much of the rapid decreases in population sizes in various Mayan regions. In some cases, populations of certain areas dropped by 90 per cent in just 50 years (Thompson, 1966: 25). Many of these diseases are still dangerously prevalent in these regions today. In the first fifty years after the Conquest, indigenous populations of the whole region were decimated by anything from conservative estimates of 75 per cent to more extreme estimates of 90 per cent (Thompson, 1966: 24; 1997: 77), although flight from Spanish jurisdiction may account for some of the drop in population (Thompson,

1966: 27). Direct fighting with the Spanish invaders also no doubt substantially reduced the male population (ibid.: 28). By 1570, the indigenous Mayan population had been reduced by at least 50 per cent (Harvey, 1999: 38).

Those that remained were to be subject to community reorganisation, religious conversion and servitude, the inheritance of which can be observed to the present day. For reasons of easier taxing by the new masters, indigenous communities in Chiapas were moved from their pre-Hispanic dispersed and isolated communities, which were based around ceremonial centres. Their new municipalities are those in which they are located today (Vos, 1997: 105). In his discussion of the contribution of the psychological effects of colonisation upon the population declines, Thompson (1966) also describes this change in lifestyle and geography. He asserts that a lack of a will to live may have resulted from the disappearance of "the sense of participation" and "security against the indemnities of gods and neighbouring peoples...had gone; the world very much shrunk to a village very much on its own" (ibid.: 35). The world was certainly to be very much changed for the indigenous inhabitants of New Mexico who were governed as subordinates and viewed as "less than fully adult" by the Spanish (Collier with Quarantiello, 1999: 21). Their status had been altered (perhaps forever) in their own lands:

> "In Chiapas, as in other regions of America, the arrival of the Europeans provoked an alteration of human life at all levels. A population, which until then had been owner of its own territory and all of which had been constructed within it, was obliged to share its space with a small but aggressive conquering group. Above and beyond the existing linguistic, political, social and cultural differences, the natives were reduced, without exception, to the global condition of "*indio*". This word did not only express their membership of a distinctive race to that of the Hispanics; it also indicated the enforced conditioning of the majority sector of the society whose destiny, from that moment on, would be to serve a small but powerful group of new masters" (Vos, 1997: 26) (my translation).

As this citation indicates, slavery of the entire *indio* population was introduced with the new Spanish masters and the *encomienda* system (see García de León, 1981; Toscano, 1994), despite royal rulings and humanitarian legislation such as the previous 1512 Law of Burgos and the New Laws of the Indies for the Good Treatment and Preservation of the

Indians of 1542-43 (Sherman, 1979: 9-12; Vos, 1997: 106).[2] Although there were various figures for the numbers of *indios* enslaved at any one time, Bartoleme de las Casas protested the existence of three million indigenous slaves in New Spain and Central America during the early colonial years (Toscano, 1994: 344; Harvey, 1999: 38). Many of these early slaves were "released" in the late fifteenth century. All of these, however, remained "salaried" on the properties of their former masters (ibid.: 345; Collier with Quarantiello, 1999: 22).

The new colony was administrated and organised in a model of Spanish towns with local *caqiques* (indigenous chieftains or leaders) rewarded for acting as intermediaries between the communities and the dominant society (García de León, 1981: 43-44). Cuidad Real (now San Cristóbal de las Casas) was built by enslaved Indians (Collier with Quarantiello, 1999), founded in March 1528 and was to be the administrative capital of the state. The region of Chiapas, then named merely Chiapa, was under the political jurisdiction of the *Audencia de los Confines*, which also included what is now the area of Central America above Panama (Sherman: 1979, 3). The period of the conquest itself lasted from 1524 to 1544 and almost three hundred years of colonisation from 1545 to 1821 were its result.

Mayan ethnic identity and the effect of colonisation

The Catholic Church played a key role in the conquest and colonisation of New Spain (see García de León, 1981; Harvey, 1999) and both the missionaries and the *conquistadores* promoted the notion of the conquest as a holy war. The conquest was represented as a necessity for the *indios* themselves to save them from the excesses of their ways. Indeed, one *conquistador*, Ruy González, retrospectively defended the war in a 1553 letter to the emperor by stating '.... the war and conquest of this kingdom do not appear so severe and senseless as certain ill-educated people affirm and maintain...these people were barbarous,

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[2] See Sherman (1979) for more detail. Sherman also reports that a system of slavery pre-existed the conquest in Central America and refers, amongst others, to the Tzotzil slavery system in Chiapas, where slaves formed a distinctive social class and could be either taken as a result of war or purchased (Sherman, 1979: 15-32). Therefore, it is essential neither to romanticise indigenous lifestyles previous to the conquest nor to view the Spaniards as uniquely barbaric. However, the effects of Spanish slavery were disruptive to pre-Hispanic social systems as the system was based upon very 'different pretexts' and was effectively of a whole race. Its prior existence, nevertheless, 'served to reinforce the justification for its continuation' (ibid.: 19).

idolatrous, sacrificers and killers of innocent people, eaters of human flesh, most filthy and nefarious sodomites' (González, 1553, quoted in Adorno, 1992: 213). The roots of present-day institutional and *mestizo* racism towards indigenous peoples can perhaps be seen to have its roots in this interpretation of cultural and religious difference on the part of the "Other" encountered in the new continent as somehow less human or less civilised.

It is ironic, then, that in the energetic and innovatory process of converting the whole of New Spain to Christianity, many of the traditional beliefs and customs of the Mayan peoples were purposefully combined with Catholic ontology (Radcliffe and Westwood, 1996: 17; see also Harvey, 1999). Indeed, even live sacrifice was accepted and, up to the present day, chickens are killed and alcoholic and soft drink offerings are made to the Catholic 'saints' in some indigenous churches.[3] Many of these conversion methods were strongly disapproved of by the Vatican and the Crown (Harvey, 1999: 39). However, the priests and missionaries at the "front line" of the conversion conquest believed that in persuading the Mayan peoples that their beliefs, and the symbols representing these beliefs (such as the Mayan cross), were a part of the understanding of the world offered by this new religion, conversion would be much easier and quicker to achieve.

There is perhaps debate, however, over the direction of this process of incorporation. The missionaries may have misjudged the bias in this process and the Mayans were perhaps pragmatically and subversively adapting their own beliefs to incorporate the new ideas, rather than the reverse.

Nevertheless, whatever the direction of the process, the incorporation worked as the record for "conversion" to the new brand of Catholicism was practically absolute and permanent. By the time of the 1824 constitution, Catholicism would be declared the only religion of the newly independent nation (Aboites Alguilar, 1997: 39). Whilst the indigenous inhabitants of Chiapas would possibly have had little choice in the matter anyway given their practical

[3] The most famous of these is the church of San Juan Chamula.

enslavement, the use of such methods, or a belief in such methods, at least ensured a somewhat smoother ride to Catholicism and colonisation.

Early literature had suggested that contemporary indigenous cultures owe more to the inheritance of Spanish ideas and reorganisation than to older thought systems and traditions. However, it is now assumed that, despite the changes mentioned above, many aspects of Mayan cultures are constant with pre-Conquest Mayan civilisations. In a discussion focussing primarily upon Guatemalan Mayan societies, Carlson and Prechtel (1991: 24) argue that "...the accumulation of anomalies [in previous research] seems to indicate that, despite Spanish efforts, Maya culture has been far more resilient and self-directed than many scholars have believed. Evidently, the conquest of a people requires more than military subjugation". Previous research casts the indigenous peoples as "total victims of the Spanish and utterly powerless to influence their own destinies [and] elements such as adaptation, self-determination and subversion are deemed irrelevant and are therefore ignored" (ibid.: 24). However, Carlson and Prechtel discuss various elements of the Atiteco Guatemalan culture that can be traced directly to ancient Mayan beliefs. In particular, they point to the centrality of the "World Tree", which is present in both Tzotzil (a Chiapanecan ethnic group) and Atiteco belief systems and can be traced to earlier Mayan myths. This illustrates the similarities and connections between ethnic groups in Mexico and Guatemala, providing concrete evidence of the continuity of Mayan traditions and also of the practical irrelevance of nation-state borders (drawn up as a consequence of colonisation) to strong, pre-existing, and still existing, ethnic identities.[4]

New beliefs were often encompassed into existing beliefs, such as the "cult of the saints" [which] undoubtedly constitutes one of the most salient aspects of post-Conquest Mesoamerican religiosity" (Carlson and Prechtel, 1991: 36). Mayan communities deified Catholic saints (and still do to the present day) and attached traditional qualities of local religiosity to each. These include, for example, "Conception (impregnation and planting),

[4] See Goldschieder (1995) for further discussion of the conflictual relationship between ethnic identities and nation-building. Radcliffe and Westwood (1996) also discuss this issue in the particular context of Latin America. José del Val (1991), however, discusses similar issues but setting forth an understanding of identity as a hierarchical, layered process of which ethnic identity may form part of national identity.

San Nicholas (shamanic doctoring), San Juan (midwifery) and San Francisco (death)" (ibid.: 36). Carlson and Prechtel (1991: 37) explain this as "a reinterpretation of intrusive elements according to characteristically Maya paradigms" understandable as "the general human tendency to attempt to process information according to previous experience, on the grounds of routinised paradigms". Reworking and adaptation of long held beliefs and ideas is not evidence of the breakdown and disruption of a culture but rather were a necessity for its continuation as all cultures must be able to adapt to a changing environment in order to survive.

Neither is it necessary for all members of a society to hold exactly the same version of these adapted beliefs to assert that historical belief systems still hold true and are instrumental in the formation of attitudes and identities. Carlson and Prechtel (1991: 26) state that "[i]t would be incorrect, however, to assume that all Atitecos have equal religious knowledge". Similarly, in the community of Amatenango del Valle in highland Chiapas, the understanding what exactly constitutes the spirit differs from person to person. Some state specifically that the spirit takes on an animal form and is able to leave the body at night whilst others are unable to define exactly what the spirit is, yet are convinced of its existence (see Chapter Six). Although knowledge such as this may differ from individual to individual, these general ontological schemas shape societies in one way or another and provide the social and cultural context for the construction of individual ethnic identities. For inhabitants of Amatenango, as in other Tzotzil and Tzeltal communities (see Vogt, 1965; Gossen 1975), whatever the definitions of the spirit, a belief in the reality of the concept is crucial to understandings of bad fortune, ill health and death of themselves and of others.

Whatever the changes provoked by the Spanish Conquest, a strong concept of ethnic difference remained then and can be evidenced in the list given by Carlson and Prechtel of the maintenance of "local modes of production, understandings of lineage, legends, indigenous languages, and so on" (Carlson and Prechtel, 1991: 38; for details of language maintenance despite geographical relocation; see also Thompson, 1966, 1997). To these I would add, a division of family and community roles, and, importantly, body

manifestations of difference in terms of distinctive locally produced cultural clothing (see Figure 4.2).[5]

Emphasising the continuation of cultural traditions and beliefs, however, is not to lessen the reality of the destruction and devastation wrought upon indigenous communities of Chiapas by colonisation. Rather it serves to reveal that indigenous peoples were not just passive victims but used their agency pragmatically and subversively in order to maintain their historical ethnic identities.

FIGURE 4.2 PHOTOGRAPH OF ZINACANTAN WOMAN WEAVING ON A BACKSTRAP LOOM

However, the preservation of ethnic identities was not only through such pragmatic strategies of negotiation. There were several attempts at rebellion during the Conquest and colonial period (see Harvey, 1999: 38) and these have been well documented by Spanish records of the time. For example, as early as 1542, 40 thousand Tzeltales and Choles in Tecpan-Pochutla refused to pay tribute to the authorities and succeeded in cutting off all communications with Tabasco, Campeche and the Yucatan from the North. Although defeated on this occasion, this group´s constant uprises are documented as lasting at least

[5] Although it is the case that indigenous peoples were required to wear their traditional clothing to maintain their difference, and that in many cases, this *traje* was altered to be more acceptable to the Spaniards (for example, by men wearing trousers rather than just a short tunic), the *traje* has been reclaimed as a mark of cultural and ethnic identity by the indigenous groups themselves.

until the 1560s. Indeed, the Lacandon populations living deep in the jungle and the regions of Ocosingo and Comitán in Chiapas were not effectively colonised until the beginning of the twentieth century (García de León, 1981: 46). Even almost a century into colonisation, indigenous communities in Chiapas were not prepared to be completely subjugated, evidenced in perhaps the most important rebellion of the colonial period: the Tzeltal rebellion of 1712. Such rebellions, however, were usually brutally suppressed (Harvey, 1999: 42).

POST-COLONIAL INDIGENOUS HISTORY

Reform and rhetoric

Independence for the Mexican nation came in 1821. The republic revoked the official classification of Indians as inferior (Collier with Quarantiello, 1999: 23) and slavery was officially abolished in 1829, following a declaration by the then President Guerrero (Aboites Alguilar, 1997: 38) It was, however, merely transformed into peonism,[6] continuing the exclusion of indigenous peoples from socio-economic and political life (Collier with Quarantiello, 1999: 23). The long dictatorship by Porfirio Diaz succeeded the ousting of the French emperor, Maximilian, in 1867. During *Porfiriato*, the constitution was amended in 1873 to supposedly ban peonism. However, as late as 1909, the governor of Chiapas stated that this change has "proved a dead letter in remote districts and that further legislative action was needed to enforce it" (paraphrased in Beard and Hayes, 1909: 747). In addition, during the period of *Porfiriato*, new laws were passed which broke up, and blocked access to, indigenous lands as the state became a resource for export production, particularly of coffee and timber, and private land holdings expanded (Harvey, 1999). On many of these new foreign owned plantations, indigenous workers became "virtual debt slaves" (Collier with Quarantiello, 1999: 24; see also Rus et al., 2003). Racism against indigenous groups was institutionalised in conjunction with the encouragement of foreign colonisation to boost population growth. Growth of the indigenous population was not favoured as public opinion, the politicians, journalists, intellectuals and scientists all held that the indigenous mass did not favour national progress

[6] Unskilled labourer or farm workers bound in servitude to a landlord creditor. See Page Pliego (1996; 183-184) for a description of the average peón's duties in Simojovel, Chiapas.

because of their "indolence [and] limited education" (Aboites Alguilar, 1997: 43). As early as the nineteenth century, then, the official link between population policy and control of the indigenous population was being forged.

The dictatorship was defeated in the 1910 revolution and the rhetoric of the revolutionaries appeared to offer much for indigenous peoples. In keeping with the revolutionary heroes, such as Emiliano Zapata, the needs of the "*indio*" and the importance of these needs for building of the general *mestizo* nation were theoretically recognised within the newly constituted Mexico. Manuel Gamio, the then director of the *Dirección de Estudios Arqueológicos y Etográficos* and an official in the revolutionary government, asserted that 'the Indian can no longer be ignored. He forms more than half the population. There will be no solution [to Mexican lack of development] until he is given his proper place' (paraphrased in Starr, 1918: 131). Gamio asserted that his place should be central and instrumental in the formation of not only Mexican development, but also the new Mexican identity. Starr summarises Gamio's tract which reflected the national fervour for the creation, or re-formation, of a truly Mexican character, which would exclude all things foreign, as "Life, thought, achievement, must be Spanish-Indian, not Indian-Spanish. The native, not the invader, must supply the foundation..." (Starr, 1918: 133). In particular, Gamio emphasised pluralism in ethnic political representation, writing:

> "In order to legitimately represent the different ethnic groupings of our population, the respective legislators ought to be named by them, or at least to be intimately permeated by their mode of being. Further, the electoral mechanism should be that which said groupings choose, even though some of them in comparison with others appear very primitive. In effect, native families preserve deeply rooted the patriarchal system in electoral nominations, in the settlement of domestic questions etc., etc.; neither the federal government nor the state governors have a right to interfere with such methods of procedure, so long as they do not prejudice the collectivity."
>
> (Gamio, without date, quoted in Starr, 1918: 133)

However, Purnell (2002: 214) notes that nation-building in Mexico often "required that the villages become places where individuals happened to live, rather than their primary sources of cultural and political identification and loyalty" and that attempts were made to

replace "communal identities with a national one based on economic and political individualism". Indeed, despite the rhetoric, it is commonly stated that the revolution never reached Chiapas. Harvey (1999: 52-53) asserts that it was the local highland elites who benefited from the fall of Díaz and that the indigenous populations were manipulated on all sides. For those living in more remote rural areas of Chiapas, the revolution's dreams, and later reforms, were slow to be realised (see Collier with Quarantiello, 1999).

Early twentieth century realities

In 1946 Tannenbaum reported upon an investigation for which research of 3,611 rural villages in Mexico had taken place between 1931 and 1933 with the co-operation of the Mexican Department of Education and the Federal Census Office (*Estadística Nacional*). He described the demographics of exclusion characterising rural Mexico as it approached the middle of the twentieth century, and the geographic racial and economic divides of the nation "The picture is clear. The north is white and *mestizo*, the central and southern part of the country *mestizo* and Indian." (Tannenbaum, 1946: 368). He noted that the inhabitants of rural communities suffered infrastructural social and economic exclusion, as a result of lack of amenities and communications, such as local markets, systems of communication or transport and postal systems (Tannenbaum, 1946: 374-375).

Such social exclusion is not so different to that experienced by contemporary indigenous groups. Tannenbaum emphasises that "[i]t is an important fact that in all items here considered...the Indian communities are visibly poorer than the others" (ibid.: 379).[7] This contrast was illustrated in striking terms:

> "There is one doctor to every 48,270 Indians, one lawyer to every 77,232, one engineer to every 77,232, one druggist to every 20,873, one priest to every 8,045. The *mestizo* communities are about four times as well off; they have one doctor to every 10,231 inhabitants and so on down the line."
> (Tannenbaum, 1946: 381)

[7] In Chiapas, 70 per cent of the entire population is rural and the vast majority are indigenous.

Land reform, and the *ejido* system, was instituted with the new constitution in 1915 / 17 and reworked and revitalised during the Cárdenas presidency of the 1930s (Meyer, 1994: 1227-1251). This allowed for the rightful use of land to be transferred from the landowners to the peasants without full compensation and thousands of hectares of land were officially redistributed in Chiapas during this period (Collier with Quarantiello, 1999: 31). The cultivable land parcelled out by the system could be farmed either collectively or "parcelled out and farmed individually" (the common practice). "The *ejidatorio* may receive a land title which can be passed on to an heir, but in principle has no right to sell, rent, lease or mortgage his allotment of land" (Nguyen and Martinez Saldivar, 1979: 625).

The theoretical reforms made by the politicians in Mexico City, however, were slow to come into effect. Many of the claims to land in Chiapas dating back to the original land reform programmes have never been followed through (Collier with Quarantiello, 1999) and much of the land that had been expropriated from indigenous groups prior to the revolution (Rus *et al*, 2003: 4) was not returned. Even when land reform did lead to genuine land redistribution, much of the land was of poor quality (Benjamin, 1989: 227) and the promise of land reform was often more politically than economically significant to gain peasant loyalty for the government and divide different marginalised groups (Collier with Quaratiello, 1999). The 1946-52 presidency of Miguel Alemán saw the initiation of rulings that allowed large landholders to "delay transfers of title by filing writs of protection (*amparos*) in local courts. Since peasants and impoverished communities cannot afford lawyers, let alone match the bribes afforded to judges, they have been subject to unprincipled casuistry". This process has been worsened by the transfer of "formal title of portions of their estates to relatives...to masquerade as small farmers, permanently blocking transfers of land to nearby communities" (Reding, 1994: 13).

Recent realities and indigenous politics of the last 30 years

Politically and economically, indigenous peoples were to remain excluded throughout the twentieth century (see Collier with Quarantiello, 1999). Many of the infrastructural and communication problems to which Tannenbaum referred can still be witnessed today and the long PRI corporatist administration (ended only in the 2000 elections) went hand in

hand with political corruption. Elections have occurred, unlike in the military regimes of other Latin American nations. However, they have been marked by fraud. Social reform and programmes in Chiapas have been many but in reality predicated upon political loyalty to the PRI through the *cacique* (chieftain) system (see Mattiace, 2003). Representation at state level by indigenous peoples has been practically non-existent. During the 1970s, however, protests against the institutional discrimination and exclusion from the formal political processes began to take on a more open and organised form and a "political consciousness" was more overtly formed (Rus *et al*, 2003: 7). Indigenous peasants began to organise public protests and take practical matters into their own hands by taking lands from ranch owners, reversing the centuries' old trend that had seen lands taken from them. The repressive state government, however, effectively quashed such protests with brutal and open action using the combined forces of the military, the police and the so-called "white guards" (legalised private "police forces" employed by wealthy landowners).

An important consequence, however, of these heavy-handed tactics was the beginning of co-ordinated organisation involving different ethnic groups in Chiapas and the initiation of the direct participation of the church and, in particular, of the Bishop Samuel Ruiz, on the ideological basis of "liberation theology". The turning point was the "*Primer Congreso Indígena*" (First Indigenous Conference) in San Cristóbal de las Casas in 1974, called for by the diocese of San Cristóbal and, surprisingly, the state government (Harvey, 1999: 91). In contrast to the previous lack of co-ordination between them, different ethnic groups agreed to act together to protest their demands such as land reform and lack of credit (Collier with Guaratiello, 1999; Mattiace, 2003; Rus et al., 2003), form co-operatives and, as a last resort which was beyond the original intention of the meeting, invade local ranches (Gonzalbo, 1995: 17-18). Although some of these groups were later co-opted by the government (depending upon the political persuasion of their communities), others continued the more radical struggle. Their activities culminated with the formation of the "*Organización Campesina Emiliano Zapata*" / OCEZ (Emiliano Zapata Peasant Organisation) in 1980. The organisation took its name and ideology from the revolutionary leader and the struggle at the beginning of the century (see Figure 4.3), reflecting a general

trend for political organisation around issues facing the "rural proletariat" (Collier with Guaratiello, 1999: 70).

Despite the fact that the "peasants" in the region were becoming increasingly less reliant upon agricultural land (Collier with Quarantiello, 1999; Rus *et al.*, 2003) and that only 40 per cent seeded corn by 1983 (Mattiace, 2003: 17), the central struggle of OCEZ (and other similar organisations) was for land. This was a demand central to popular consciousness in Mexico (Collier with Quarantiello, 1999). Other militant, class based "unions" with a primarily indigenous membership were also created around this time, (Mattiace, 2003: 35). Amongst the most notable was the "*Unión de Uniónes Ejidatoriales y Grupos Marginados de Chiapas*" (Union of *Ejidal* Unions and Marginalised Groups of Chiapas). This group, as others, was declined official registration. Despite this, it continued its protests and campaigns (Gonzalbo 1995: 20-21).

FIGURE 4.3 PHOTOGRAPH OF OCEZ DEMONSTRATION IN SAN CRISTÓBAL DE LAS CASAS

(Photograph courtesy of Steve Spencer, 1991)

The federal government did not, however, ignore the impoverished situation in Chiapas. There was, arguably, a determined effort to combat poverty, resulting in the initiation of the *Programa de Desarrollo Socioeconómico de los Altos de Chiapas* (Programme of Socioeconomic Development of the Highlands of Chiapas / PRODESCH). This programme took over many of the previous remits of *Instituto Nacional Indigenista* (INI), which had been set up in the 1940s to achieve "rural development through education, improved health and extension agriculture" for indigenous groups in particular (Collier with Guaratiello, 1999: 35). PRODESCH continually increased expenditure in the region during the 1970s (Benjamin, 1989: 229. See also Collier with Guaratiello, 1999). However, institutions such as INI and programmes such as PRODESCH have been interpreted as government attempts to secure political support from the rural poor (Collier with Quarantiello, 1999: 36) and much of PRODESCH's expenditure was, in reality, aimed at macro-level economic improvements to take advantage of the vast resources of the state, such as investment in the oil fields and the hydroelectric industry. The product of these developments was certainly the creation of much employment, especially in construction. However, the side-effect was a much increased cost of living, a submerging of productive land by lakes and a skewing of material benefits away from the migrant employees whose wages had stagnated at an average of 1000 pesos (about eight dollars) a month. In sum, the creation of such temporary employment "upset the balance of regional life" (Benjamin, 1989: 230).

Persecution of the organised groups who were protesting such debilitating conditions was widespread and gathered particular momentum in the early 1980s under the governorship of Absalón Castellanos Domínguez (Collier with Guaratiello, 1999: 81). Some authors have directly implicated the local authorities and Mattiace (2003) notes the documentation of 165 political assassinations in Chiapas between 1974 and 1987. In March 1984, Amnesty International visited Chiapas to investigate claims of human rights abuses. The subsequent report did not substantiate deliberate selected killings in some areas. However, concern was expressed about "apparently deliberate political killings" in the Central Highlands area where the "majority of reported victims were supporters of independent peasant organisations or rural trade unions" and "in nearly all cases [the killings were] in the

context of long-standing land disputes". Amnesty found no evidence of the direct involvement of official security forces but "concern arose from repeated allegations that the killings had taken place at the instigation of, or with the consent of, local municipal authorities, and that the state authorities had not brought those responsible to justice" (Amnesty International, 1986: 65).

By the late 1980s, however, many of the groups had been co-opted by different political parties and the OCEZ had begun to separate into three uncoordinated and distinct groups. In 1988, elections were held. The disorganisation of the groups meant that few opposition triumphs were witnessed (and these lost again by fraud) and the PRI continued its control of the state (Collier with Guaratiello, 1999: 81-83). In addition, Chiapas had been playing host to an ever-increasing flow of Guatemalan refugees. This created numerous associated problems, not least in providing excuse for an increasing militarisation of the state and fuelling resentment on behalf of the economically impoverished indigenous Chiapanecans as they witnessed United Nations aid being channelled to these refugees (Gonzalbo, 1995: 21-23).

However, during the 1980s, many of the socio-economic problems of Chiapas were again recognised at official federal level. The Chiapas Plan was outlined in 1983 and initiated in 1985. Undeterred by the failures of PRODESCH in addressing the distribution of income and material standards of living by the same macro methods, the programme was again to function by fully exploiting the immense agricultural and energy potential of the state's natural resources. Its aims, nevertheless, were overtly stated to include the achievement of social justice and development (including cultural integration) and thereby satisfy the many basic needs of the state. These basic needs included clinics, improvements to homes, and clean water provision to villages which all appear commendable (Gonzalbo, 1995: 26). However, more ominously, these provisions were to be aided in their effectiveness by "the concentration of the rural population to facilitate the provision of these basic public services" (quoted in Gonzalbo 1995: 26) (my translation). This bore resemblance to the forced geographical reorganisation of communities during colonisation and would obviously also be beneficial politically in order to keep wayward remote societies under

control. Despite official rhetoric, then, the programme paid little attention to cultural plurality and autonomy. Indeed, Harvey (1999) interprets the Chiapas Plan as being more concerned with the state's strategic position in terms of national security and questions whether it ever really aimed to achieve equality in development.

Gonzalbo (ibid.: 31) understands the changes in the political atmosphere in Chiapas, as in the rest of Mexico, as resulting from the neo-liberal path followed by recent governments (see also Collier with Guaratiello, 1999; Mattiace, 2003; Rus *et al*, 2003). This appears probable and, perhaps more importantly, it is perceived to be the case by those excluded from the benefits of this "modernisation". The distance of the neo-liberal state is more alienating even than the previous rhetorically paternal attitude that had been adopted by governments after the revolution and throughout the earlier decades of the twentieth century (see Chapter One. See also Mattiace, 2003). The neo-liberalising Mexican government could not incorporate the traditional covenant that had previously been maintained with the indigenous and non-indigenous peasantry (Collier with Quarantiello, 1999). Despite the initiation of anti-poverty programmes such as Solidarity during the Salinas period (ibid.: 140), the neglect of indigenous groups was to prove too ingrained (Rus *et* al, 2003: 10) and their alienation was to have its inevitable conclusion in less than a decade after the introduction of the Chiapas Plan. At the beginning of 1994, the successor of the indigenous organisations of the 1970s and 1980s brought Chiapas into international focus at the beginning of 1994. The *Ejercito Zapatista de Revolución Nacional* (Zapatista Army of National Liberation / EZLN) harked back to the revolutionary mentor in attempting to claim land rights which had never been given. It was a new type of organisation in that they were claiming these rights on the basis of cultural marginalisation and co-ordinated ethnic identities that the state had previously attempted to maintain divided for political reasons (Mattiace, 2003). However, despite the fact that "peasant politics" in the earlier part of the twentieth century had "explicitly downplayed" ethnic identities (ibid.: 29), the political and cultural claims they reasserted (Harvey, 1999) were not too far removed from those detailed in Gamio's writings mentioned earlier in this chapter. Indeed, Collier with Guaratiello (1999) claim that the origins of the movement were more peasant based than cultural or ethnically motivated, although the precise history

of the movement is unknown (ibid.: 53), and Rus *et al* (2003) discuss how the claims for rights under previous movements (described above) had also on the basis of cultural identities.

THE POLITICS OF INDIGENOUS WOMEN'S RIGHTS

Whatever the debate over precisely how innovative the rights demanded really are, the EZLN is characterised as a "new social movement" (Harvey, 1999; also see Mattiace, 2003, for related discussion). As such, it is one which is seen to promote "greater gender equality, more decentralized structures and respect for cultural diversity" (Harvey, 1999: 16). Since the EZLN uprising in 1994, the term "autonomy" has become an "umbrella demand encompassing a host of cultural, political, economic and social grievances" (Mattiace, 2003: 20. See also Collier with Guaratiello, 1999: 162; Aubry, 2003; Esteva, 2003b; Purnell, 2002). However, whilst Esteva (2003b: 254) defines a version of autonomy which seeks "recognition of and respect for *what the indigenous people already possess*", this definition neither corresponds well to the situation of indigenous peoples in general nor particularly to the situation of indigenous women. He goes on to state that a more appropriate position in relation to the political struggle in Chiapas is that the call for "autonomy" reflects a desire for the recovery of "faculties and competencies that the state has taken away from them" (ibid.). However, for women in indigenous communities, such rights have not necessarily to be recovered nor were they ever possessed but rather they must be achieved and it is perhaps not only from the state but also from indigenous authorities themselves that they must be demanded. This position is not necessarily incompatible with the EZLN's central aims. Indeed, Purnell (2002) notes that "indigenous organizations call for respect for Mexico's many cultures and languages" but that "the right to follow "customs and traditions" in local governance" is imagined quite differently by different groups.

The EZLN's position in relation to gender equality and autonomy for indigenous women has not been without its problems or discontents. Their call for retrospective land rights according to the former system of *ejidal* rights does not itself recognise the gendered inequalities of the former agrarian system. Indeed, much of the work on indigenous

inequalities, marginalisation and poverty related to agrarian issues, and reform, work such as that of Collier (1994) ignores this important factor in the social exclusion of indigenous women. Brunt (1992), on the hand, indicates such inequalities in the Mexican *ejido* system in a study including case study data regarding women's access to land and the use of social networks. Brunt (ibid.: 79) found that:

> "...it was men who occupied the front stage...and it was men who tried to influence local decision-making in their favour...Women seemed to be "non-actors" in the whole affair. [T]he absence of women on the front stage can be better understood by focusing on the structural constraints faced by women in their local context. These structural constraints arise from a particular land tenure system, from a certain kind of dominant gender ideology and practice, and local and regional interventionist practices...At best, [women's access to *ejido* land] is tolerated, but at worst is severely undermined, if not prevented".

In principle, women have been explicitly equal in differing formulations of the Agrarian Law. Indeed, domestic responsibilities that may prevent them from farming the land themselves are also taken into account in some of the later 76 and 78 Articles (ibid.: 80-81; see also Arizpe and Botey, 1987: 79). As Brunt (ibid.) points out, however, discrimination does not occur at the national level, but rather at the level of the *ejido* community "where mechanisms ...obviously exclude women from being beneficiaries of the agrarian reform". She notes that, in practice, the only way that a woman could gain access to *ejidal* land was through inheritance as usufruct of parcels of land from household head was passed to a "designated heir". However, even in these cases, there have been many ways by which the community avoids this. One of the most common ways was by her right being claimed by a male relative (ibid.: 82 -99). Brunt understands this opposition in the context of *ejidal* status and its adjoining rights of authority within the communities, which have traditionally been male. It is necessary, then, to examine the gendered processes that lie behind, and cut across, institutional legalities in order to comprehend the history and complexities of gender relations in indigenous communities.

The debates regarding land rights and cultural plurality echo others in which the issue becomes one of aligning individual rights with the right to communally constructed cultural

"diversity" which may include traditional, restrictive, ways of envisaging women and their roles. Nevertheless, it is argued that the EZLN has played a part in creating spaces for such gender relations to be reappraised (Harvey, 1999: 223). It is certainly the case that the many forums for debate over indigenous demands for autonomy which have taken place since 1994, including the San Andres peace negotiations, have featured insistence by indigenous women that their rights also be considered. Questions have been raised over how one "distinguish[es] between "good" indigenous traditions that the state should sanction and "bad" traditions that the state should abrogate" (Mattiace, 2003: 134). This debate has not, however, been entirely successful as many academics and indigenous women have protested that the "Indian rights legislation" negotiated by the Mexican Senate in Spring 2001 and passed in the same year (Rus et al, 2003: 21) legalises abuse of indigenous women (Mattiace, 2003: 134).[8] Also, although EZLN female commanders stress that the organisation itself is gender-neutral, they also agree that this has not yet translated into greater gender equality, increased women's participation in the daily life and decision-making of indigenous communities and that exclusion from ownership of land remains a problem (ibid.: 136).

However, others have argued that processes even before the EZLN had been increasingly favourable to the status of indigenous women. Collier with Guaratiello (1999: 113-116) observe that changing economic relations and the access to a cash economy in Zinacantan have meant that the balance of power between generations and the sexes is changing. Harvey (1999: 224) notes that women had been incorporated into agricultural and textile co-operatives since the 1970s and had played important roles in health and educational programmes. These are clearly important "public sphere" roles. However, the real motivation for, and realities of, involvement of women in such programmes are debated elsewhere in this thesis. In addition, whilst the state encouraged indigenous peasants to join national level organisations such as the *Confederación Naciónal de Campesinos* (National Peasant Confederation), (Mattiace, 2003: 31) which previously linked members to the state in a corporatist system (Rus et al., 2003), they have been "loathe to open up top positions to

[8] The passing of this law was not approved by the EZLN as it was not seen to fulfil the 1996 San Andres more generally as well as in relation to women's rights.

Indians or to women" (Mattiace, 2003: 24). Therefore, an indigenous woman is likely to suffer a double disadvantage.

Equally, whilst there may have been some developments which have improved women's participation in public life, there are many restrictive aspects of indigenous women's private lives which indicate that the line between ethnic custom and individual rights remains easily blurred. In describing women's everyday experiences of violence in the Chenalho region (before the massacre in Acteal), Hernández Castillo (2001a) notes that it is customary for women to be subjected to abusive relationships with their husbands, that help is not generally forthcoming, and that obstacles to the ownership and inheritance of land mean that it is difficult for women leave such relationships. For example, she relates the experiences of one woman whose father refused to take her back or grant her own land with which she could live autonomously from her violent husband, replying that "[m]y land has all been divided up among your brothers and you are a woman. You had better get back to your husband and make him content and live happily" (ibid.: 23).

The existence and acceptance of violence against women and the reluctance to change discriminatory practices related to land and inheritance should not, however, necessarily be viewed simply as cultural tradition. Garza Caligaris and Hernández Castillo (2001) argue against such a "simplistic" analysis, posing in its place the proposition that such internal community dynamics need to be understood in relation to some of the wider political, economic and cultural realities described earlier in this chapter. For example, they claim the Porfirio Díaz regime to be responsible for determining the general direction of politics in the region and that the exploitation of indigenous women on plantations at the end of the nineteenth century by *mestizo* landowners was significant in influencing gender relations. However, it is also important to not entirely "blame" external processes. Collier with Quarantiello (1999) point out that the "idealization of indigenous peasants is inaccurate...because some of the inequalities in the countryside are the result of stratification within peasant communities, not merely the result of injustices heaped upon them from the outside". Although writing particularly about class and more generalised power relations within indigenous communities, this analysis could equally be applied to

gender relations in order to understand that the discrimination is neither wholly internally nor externally generated and that needs and solutions need to be addressed at various levels.

Whatever the origins and changing dynamics over time, discrimination against indigenous women remains a reality in Chiapas. Hernández Castillo (2001a; 2001b) reports that local religious and civil organisations, such as *Las Abejas* ("The Bees"), are often used as means of attempting to claim rights for women. Similarly, many grassroots movements with members including co-operative advisors, artisans, academics, health promoters and NGO workers have used official channels to protest discrimination against indigenous women. The institution of the Zapatista "Women's Revolutionary Law" and the *Convención Estatal de Mujeres Chiapanecas* (State Convention of Chiapanecan Women) in 1994 called for rights which impinge upon the culturally formulated roles mentioned above. These demands do not seek to entirely reject traditional customs but rather "reinvent them under new terms which contradict indigenous essentialism" and the "unquestioning defence of cultural traditions" (Hernández Castillo, 2001b: 122). Nevertheless, they have addressed issues related to economic autonomy and land as well as demanding the right to choose marriage partners, for girls not to be exchanged for money in marital arrangements (*pedidas*), and for access to contraception in order that women can decide their own fertility (Harvey, 1999. See also Hernández Castillo, 2001b).

As noted above, discrimination against women either at community level or in relation to the wider political context of Chiapas is inseparable from family planning issues. Chapter Three of this thesis described the controversial nature of population politics in the region. The lack of autonomy of women within the household, particularly maintained by violence and economic restrictions, means that it may be difficult for individual women to make their own decisions about the use of family planning (see Chapters Seven and Eight for discussion of gender relations and examples of such experiences from the case study region). The general history of marginalisation of indigenous groups from political, economic and social life has also led to suspicions of the family planning components of health programmes (such as the recent PROGRESA programme) (see Chapter Three). These suspicions link their intent to a more general "policy of extermination towards these

groups [which have been] marginalized and excluded from national progress", and which is said to have included the removal of foetuses from pregnant indigenous women during the Acteal massacre (Freyermuth Enciso, 2001). In addition, the over-riding ideology of population politics, which associates poverty and family size (see Chapters Three and Eight), is transmitted in clear messages at local levels as part of primary health programmes. These messages combine with the history of marginalisation of indigenous groups described in this chapter and its resultant contemporary state of poverty. Women, therefore, are restricted in their family planning decisions not only as a result of their lack of autonomy as women but also as members of poor and marginalised indigenous groups.

CONTEMPORARY CHIAPAS

The socio-economic environment

At the end of the twentieth century and beginning of the twenty-first, the situation in Chiapas can in many ways be seen to be stagnant. Collier with Quarantiello (1999: 9) note that "cultural isolation, political exclusion, and economic depression have combined to leave people in what is commonly called Mexico's "last frontier" without hope and without even the most basic necessities of life". The state still has the highest percentage of indigenous population in the country and not coincidentally (given the history described earlier in this chapter) is one of the poorest states of the nation. Of its 3, 584 786 population, 70 per cent is rural and the great majority of the indigenous *municipios* (municipal authorities) are officially classified as "very poor" (INEGI, 1996: 94), with only 11 per cent of adults earning "moderate incomes" (Collier with Quarantiello, 1999: 16). This is despite the fact that the state is one of the most naturally rich in resources in the nation. It is abundant in fertile agricultural land (producing principally timber, cattle, coffee and corn) and its hydroelectric schemes generate 60 per cent of the nation's electricity (Physicians for Human Rights & Human Rights Watch / Americas, 1994: 10. See also Collier with Quarantiello, 1999). However, "land tenure remains highly skewed in favor of large landowners" (Physicians for Human Rights & Human Rights Watch / Americas, 1994: 11) and Chiapas is "almost an internal colony for the rest of Mexico, providing...[resources] ...but receiving very little in return" (Collier with Quarantiello,

1999: 16). In particular, the indigenous *municipios* have been very much disadvantaged in terms of land tenure. This is compounded for women by processes which exclude them from land tenure at local levels, as discussed above.

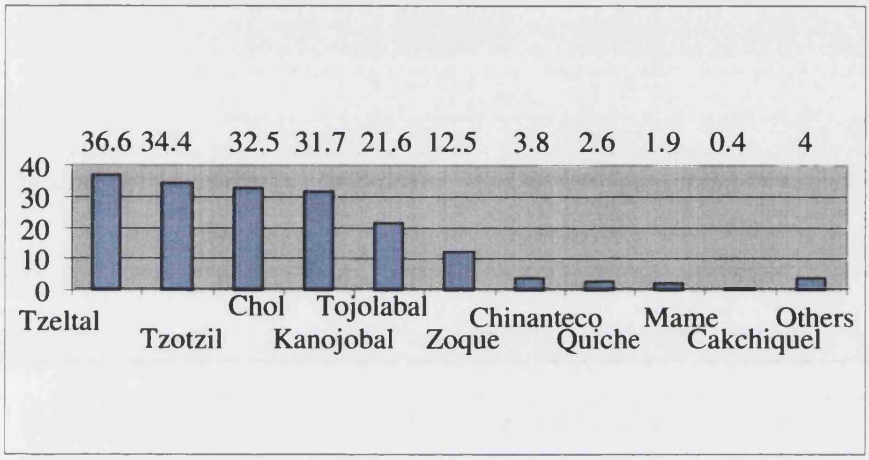
There are seventeen different indigenous languages in the state corresponding to the different ethnic identities. According to INEGI statistics, which classify indigenous identity by language spoken (INEGI, 1993a), there are 716, 012 indigenous language speakers in the state and 32 per cent of these are monolingual (although this is likely to be an underestimate as those who do not speak Spanish are perhaps less likely to be responding to census surveys). The monolingual population (according to 1990 figures) is proportioned, as detailed in Figure 4.4.

Of this monolingual population, the difference by sex is marked as 64.4 per cent are women and 35.6 per cent are men (INEGI, 1993a: 17), as Table 4.1 reveals in greater detail. This degree of monolingualism brings many of the problems associated with not speaking the official language of the nation (for example, access to employment, education, social services, and understanding of legal rights). The illiteracy rate stands at 54 per cent of the adult indigenous population of Chiapas (above fifteen years of age), again with much of the corresponding exclusionary problems that this can bring (similar to those of monolingualism). This compares drastically to a national rate of 12.4 per cent. For women, the rate is considerably higher still, standing at 87.9 per cent for indigenous women above the age of 35. This situation is likely to only change very slowly with time as still the percentage of indigenous children between the ages of 6 and 14 attending school is much lower than the national average at only 62.1 per cent compared to the national average of 85.6 per cent and the state average of 71.8 per cent (INEGI, 1993a: 22-25).

The 111 *municipios* of Chiapas are currently divided between the nine economic regions (see Table 4.2). Many of the communities within these nine regions are physically isolated, being situated in remote areas of the highlands or jungle. Chiapas is a very diverse state in terms of climate and physical environment, ranging from hot and humid jungle areas to the highland regions where the temperature can drop to freezing at some times of the year.

There are, therefore, a range of demands to satisfy basic needs. Many of the indigenous communities, however, lack drainage, electricity and a running clean water supply which are officially considered the "basic services" of living accommodation (INEGI, 1993a: 72). In reality, "access to public services is based not on need, but on political affiliation" (Collier with Guaratiello, 1999: 125).

FIGURE 4.4 PROPORTIONAL MONOLINGUALISM BY LANGUAGE, 1990



(Source: INEGI, 1993a: 13)

TABLE 4.1 BILINGUALISM / MONOLINGUALISM BY GENDER

Bilingualism/Monolingualism					
Speak Spanish		Don't speak Spanish		Not specified	
Total		Total		Total	
453 508 (100%)		228 889 (100%)		33 615 (100%)	
Men	Women	Men	Women	Men	Women
264 710	188 798	81 580	147 309	13 280	20 335
58.37%	41.63%	35.64%	64.36%	39.51%	60.49%

(Source: INEGI, 1993b: 5)

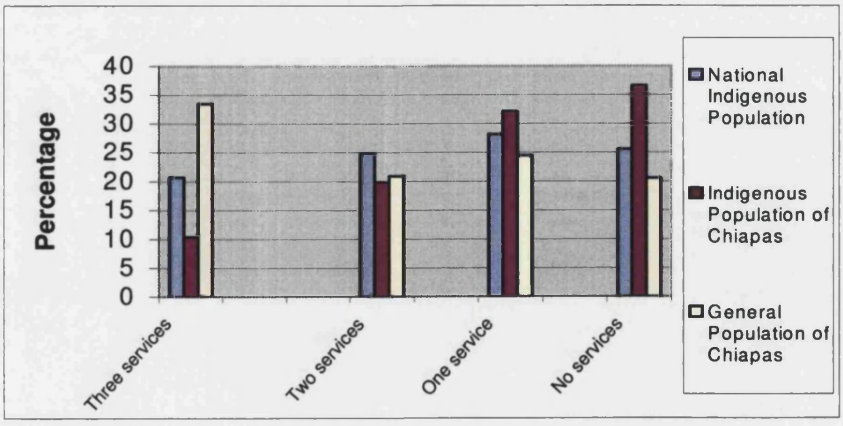
Indigenous living accommodation fares badly in comparison both to the general population of Chiapas and the national indigenous population (see Figure 4.5). Nationally, Chiapenecan indigenous populations also have the highest average room occupancy, according to 1990 statistics (see Table 4.3). The basic construction of much indigenous

living accommodation also indicates a comparatively lower standard of living and poverty in comparison to national and state populations. Particularly striking is the fact that 80.7 per cent of the indigenous population of Chiapas live in houses with a mud floor, in comparison with 56.7 per cent of the national indigenous population and an average of 48.7 per cent for the whole of the general population of Chiapas ((INEGI, 1993a: 80). Indigenous groups are also the most likely to be living in wooden houses with 45.8 per cent of households doing so, compared to only 25.3 per cent of the general population of the state and 23.1 per cent of the national indigenous population (Source: INEGI, 1993a: 79). Living is mainly agricultural subsistence with 83 per cent of the economically active population engaged in primary sector activity as compared to 58 per cent of the entire population of Chiapas, as Figure 4.5 exemplifies.

TABLE 4.2 ECONOMIC REGIONS OF CHIAPAS

REGION	NAME	CAPITAL
I	Centro	Tuxtla Gutiérrez
II	Altos	San Cristóbal de las Casas
III	Fronteriza	Comitan
IV	Frailesca	Villaflores
V	Norte	Pichucalco
VI	Selva	Palenque
VII	Sierra	Soconusco
VIII	Motozintla	Tapachula
IX	Istmo-Costa	Tonala-Arriaga

FIGURE 4.5 PERCENTAGE DISTRIBUTIONS OF BASIC SERVICES, 1990



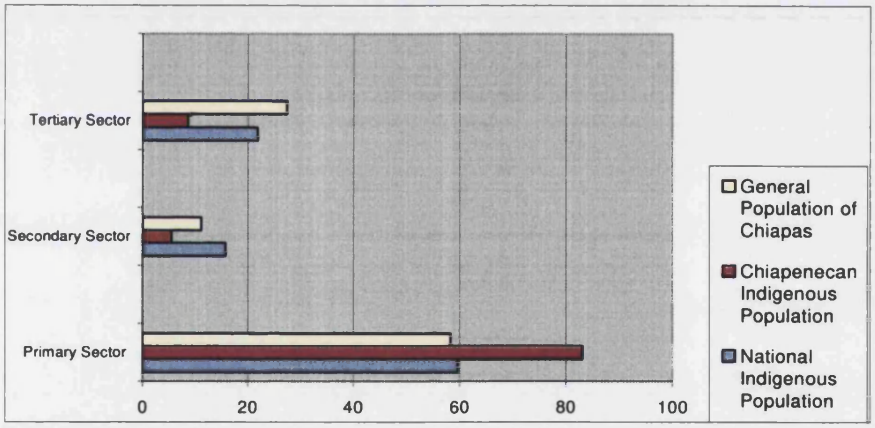
(Source: INEGI, 1993a:72)

TABLE 4.3 ROOM OCCUPANCY, 1990

Populations	Number of residences	Number of occupants	Average occupancy
National Population	16, 183, 310	80, 889, 977	5
National Indigenous Population	1, 537, 982	8, 373, 700	5.4
Indigenous Population of Chiapas	168, 431	971, 041	5.8
General Population of Chiapas	596, 696	3, 193, 168	5.4

(Source: INEGI, 1993a: 75)

FIGURE 4.6 PERCENTAGE DISTRIBUTION OF POPULATION BY ECONOMIC SECTOR, 1990



(Source: INEGI, 1993a: 51)

The primary sector activities noted in Figure 4.6 consist mainly of the cultivation of land, animal farming, fishing and the collection of wild products. For the 32.5 per cent of the indigenous population which receives no monthly income (INEGI, 1993a: 52), these activities are on the subsistence level, although there will be some peripheral marketing of excess products.

This is also complemented by seasonal migration male employment (which may have significant effects on women's living standards and security) and female handicraft production for the developing tourist industry. However, as the latter is not recognised in INEGI figures which solely differentiate between the "active" and "non-active" economic population for women and do not appear to take account of home industries, economic participation of the female indigenous population above 12 years of age is officially only 8.6 per cent (INEGI, 1993a: 49).[9]

The political environment

As asserted by Gonzalbo (1995: 14), "[i]t is well known that there is a backwardness in the social and political organisation; Chiapas is often spoken of as still living in a semi-colonial condition" (my translation). Although Harvey (1999) discusses the various discourses which claim that the situation of indigenous peoples had been improving in recent years, he also notes that the EZLN uprising was not one which had the objective of overthrowing the government but rather sought only to claim basic rights (ibid.: 11). The absence of such rights makes it clear that the contemporary situation has not developed greatly from the five hundred years of colonial history and the events discussed earlier in this chapter. This is not only true of social and economic conditions but also of political representation and access to power. Although the ruling PRI was partly maintained by seemingly overwhelming support from the rural South (Collier with Quarantiello, 1999: 17), the authenticity of this support is doubtful. Electoral fraud was previously estimated to be the worst in the nation (Physicians for Human Rights, 1994: 12) and, as in the majority of rural, southern Mexico, elites often managed to co-opt much of the vote during recent years. Where this was not possible, remarkable records of turnout for elections and overwhelming percentages of the PRI vote during their long era of power indicated the high levels of fraud. Reding (1994: 20) comments that Salinas owed his presidency to massive fraud in rural Mexico and in Chiapas where he gained 90 per cent of the vote, "Tzeltal Mayans complained that officials stamped their identification cards without their ever having seen a

[9] In figures for the non-gender specific indigenous population, figures for artisan production are given. These, however, are not broken down by gender.

ballot". In the 1996 state elections, during which I was an observer, *casillas*[10] were burnt either by Zapatistas or *Priistas*[11] posing as Zapatistas. In many areas, the papers did not arrive. Nevertheless, the election was still considered valid and the obviously non-representative results upheld.

Even when fraud could not be used, political control has remained tight. Despite Mexico's impressive record on human rights legislation, this control has been maintained by harsh measures:

> "Since the mid-1980s, national and international human rights organisations have documented violations of human rights and the denial of justice in Chiapas. Violations include the murder by hired guns of rural organisers, lawyers, and journalists; the arbitrary detention and imprisonment on trumped up charges of peasants involved in land conflicts; widespread torture and ill-treatment; violent land evictions and the destruction and theft of property; and the harassment of advocates of Indian rights, particularly of priests and human rights workers at the Diocese of San Cristóbal de las Casas" (Physicians for Human Rights, 1994: 13).

The social, economic and political exclusion of many of the indigenous populations of Chiapas has brought inevitable political problems for the Mexican State, the culmination of which was the EZLN uprising in January 1994. As Guillén (1995: 7) states:

> "In the first days of 1994, the serious problems and backwardness of Chiapas came into public light. National and international publications were bringing attention to the misery, the abandonment, the discrimination and furthermore the contradictions that from time past had gestated in the region and, finally, had had their catharsis in a movement which challenged the regime with arms in its hand." (my translation)

Amongst the most recent political changes were those made to Article 27 of the Constitution between 1990 and 1991 of the Salinas presidency. This was the direct provocation for the EZLN uprising. The changes laid the groundwork for the signing of the North American Free Trade Agreement (NAFTA) in 1994 and revoked the agrarian reforms allowing for the *ejidal* land rights (discussed earlier in this chapter). Gonzalbo

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[10] Voting booths.
[11] Supporters of the governing PRI party.

(1995) understands this shift as not only creating a polemic between a "modernising" regime and the demands of the traditional peasant population of Chiapas but also concentrating power within certain groups in a context where previously there had been no necessity to be loyal to a "patron". As a result, other groups became increasingly marginalised and their identity as political enemies of the most powerful groups was strengthened. This strengthened identity in turn fortified their organisation, as they became prepared to struggle for their own "distinctive social order" and differences (ibid.: 11-12).[12] This fortification obviously unnerved the establishment evidenced in the increasing level of imprisonment and death of leaders of these organisations and the systematic blocking of all attempts at popular organisation (ibid.: 16). However, it has also seen more positive results as the 2000 state elections saw the defeat of the PRI, partly on the basis of the gap between rhetoric and reality highlighted by the EZLN rebellion (Rus et al., 2003:20). Although there was a high degree of abstentionism, the narrow victory of Salazar, a governor standing in opposition to the PRI was historic (ibid.:21) and may mark a shift in the political relations of the state.

The EZLN and indigenous health issues in Chiapas

When the *Ejercito Zapatista de Liberación Naciónal* stormed San Cristóbal de las Casas and several other towns in Chiapas on the 1st January 1994, it was not only a reaction to recent provocation, but also a response to centuries of social exclusion and marginalisation of the state's indigenous population (see Harvey, 1999). The Zapatistas represented a feat of civil organisation and utilisation of social capital by those who had little other form of capital at their disposal (Fox, 1996). Their demands amounted to a general call for recognition and rights for the impoverished indigenous population of Chiapas embedded in an ideology of cultural plurality and anti-neo-liberalism. Amongst these demands was the call for adequate health care provision. Their first "Declaration from the Lacandon Jungle" after the uprising of the 1st January, referred to the conditions in which indigenous communities live as the justification for their need to revolt:

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[12] See Gledhill (1997) in which he discusses the political history of the EZLN and problematises claims to speak for indigenous identity groups in Chiapas and demands for cultural plurality on the basis of such a "defence of tradition" (ibid.: 94) (see also Sieder, 2002). Also see Chapter One of this thesis for similar discussion related to the constructed nature of communal identities.

> "...we are dying of hunger and curable diseases...we have absolutely nothing, not even a dignified roof, nor work, nor health, nor food, nor education, without having the right to freely and democratically choose our authorities, without independence from foreigners, without peace and justice for ourselves and our children." (EZLN, 1994: 33) (my translation and emphasis).

This declaration reveals that, for the EZLN, the right to health, and the basic needs that aid the maintenance of good health, are human rights. They are inextricably a part of the democratic process in that there are certain necessities for human existence. These include both the concrete matter of health, and the conditions for maintaining health, as well as abstract notions of a voice in society. Both sides of the coin contribute to personal autonomy and full membership of society. In a later statement, on the 18th January 1994, "Subcommandante Marcos" (the elusive orator of the EZLN) refers to the "our democratic dead" who died "natural" deaths of "measles, whooping cough, dengue, cholera, typhoid, mononucleosis, tetanus, pneumonia, malaria, and other pulmonary and gastrointestinal" problems (EZLN, 1994: 90) (my translation). These statements suggest that the demand is for the medicines and adequate healthcare to combat these diseases to be supplied by the national government. This is made yet more clear in the later message of September 1995, which states that "[t]he government remains blind. Hunger and disease drown out entire communities..." (EZLN, 1995: 440) (my translation).

However, this is problematic in the context of the EZLN's demand for cultural autonomy, centred upon the right to "elect freely and democratically, authorities of whatever type is considered appropriate and demand that they be respected" (EZLN, 1994: 40). There is no doubt that indigenous communities should be able to express themselves and their cultural identities without oppression whilst at the same time expecting certain basic needs, including those of health, to be adequately be provided for by the government. However, when cultural plurality includes "different" cultural formulations of understandings and treatment of health, the matter becomes more complex. The calls for democracy on the level described above, framed within harsh criticism of the "world order that destroys nations and cultures" (EZLN, 1995: 440) (my translation), is perhaps contradictory as democracy implies consensus and necessarily a submission to the mainstream majority.

Therefore, can indigenous communities, even if they did really exist in a consensual democratic nation, expect governmental provision to tailor itself specifically to their own particular needs? This was the sentiment expressed by one PRI government official I heard in a political discussion programme of "TV Azteca" in Mexico whose assertion was that since, unlike in other Latin American countries such as Bolivia and Peru, the indigenous population was very much in the minority, there was no justification for "special treatment" and laws to accommodate cultural difference. This statement appears abhorrent to anyone concerned with human rights, particularly those of minority groups, but perhaps the reality is that the institution of a world order based upon democratic neo-liberalism, submitted to by the Mexican nation, makes such pluralities difficult to cater for.[13]

CONCLUSION

Therefore, the negotiation strategies of women, which are discussed elsewhere in this thesis, are a necessity in a context where pluralism must be created and accommodated at the level of the individual, rather than being recognised in state level policy and provision of services. For indigenous communities in Mexico, the issue of health cannot be a simplistic demand for an input of resources on the behalf of federal and state government. In Chiapas, the colonial history described above, its resulting exclusion of Mayan culture from the constructions of mainstream Mexican identity and economic and social marginalisation of indigenous peoples, and the very demand for respect for cultural plurality by the EZLN, makes the issue complex and fraught with contradictions and political tension.

This chapter reveals the particular historical, political and economic context of the indigenous peoples of Chiapas. Within this context, women's rights, health and reproduction become complex issues, which cannot be disentangled either from this history or from identities which have been constructed as a result of it. These identities result, at least partly, from a strong sense of cultural continuity and equally from the marginalisation

[13] See Sieder (2002b) for discussion of the history of "legal pluralism" in Chiapas and Guatemala.

and exclusion that followed colonisation and still exists today. Health and reproduction are not solely clinical matters but, as importantly, they are social and cultural issues. They go to the very heart of personal and community conceptions of their own selves and ethnic and gender identities. In many ways they may also represent cultural survival of traditions and beliefs in the face of the extreme adversity of colonisation. As such, they reflect the centuries of marginalisation and the continuing social exclusion of indigenous peoples in both the continuance of cultural practices and the pragmatic negotiation around these and other practices in response to hardship.

As in much of the world, it is women who are the primary operators in the spheres of health and reproduction. It is often women in particular who pragmatically negotiate cultural practices and understandings with the practical realities of economic hardship within the context of governmental and local "traditional" services. Their own changing and traditional gender roles, in terms of their socially constructed roles as mothers in terms of insuring the survival of their families, are central to their own self-perceptions and identities. Subsequent chapters will reveal the particulars of these relationships and conceptions for women in the study of one particular *municipio*, Amatenango del Valle, in the highlands of Chiapas.

CHAPTER FIVE

THE CASE STUDY REGION: AMATENANGO DEL VALLE

INTRODUCTION

The case study of this thesis is the municipality of Amatenango del Valle in Chiapas. Here, I firstly give a brief insight into the history and contemporary make-up of the community in order to contextualise the discussion of health, reproduction and identity in the subsequent chapters. I then introduce a few of my most significant women participants who provide some of the qualitative evidence for the case study, drawing attention to some of their personal details and economic circumstances. Such contexts play a role in shaping identity and experiences of health and reproduction. These details include factors that directly impinge upon states of health, both for the women themselves and for the families for whom they act as health carers.

AMATENANGO DEL VALLE

In many ways, Amatenango del Valle is a traditional Mayan indigenous community,[1] which holds onto its ethnic identity and traditions. However, although the experiences for all indigenous communities in Chiapas since colonisation have been of exclusion and marginalisation (see Chapter Four), each has responded to oppression in differing ways. Whilst there are many uniting factors, some have fared better than others. This has often depended much upon the resources available to them. Amatenango has been more prosperous than many others. Therefore, although it is important to observe it in the context of Chiapas and indigenous issues as a whole, it is also important to highlight its internal variations.

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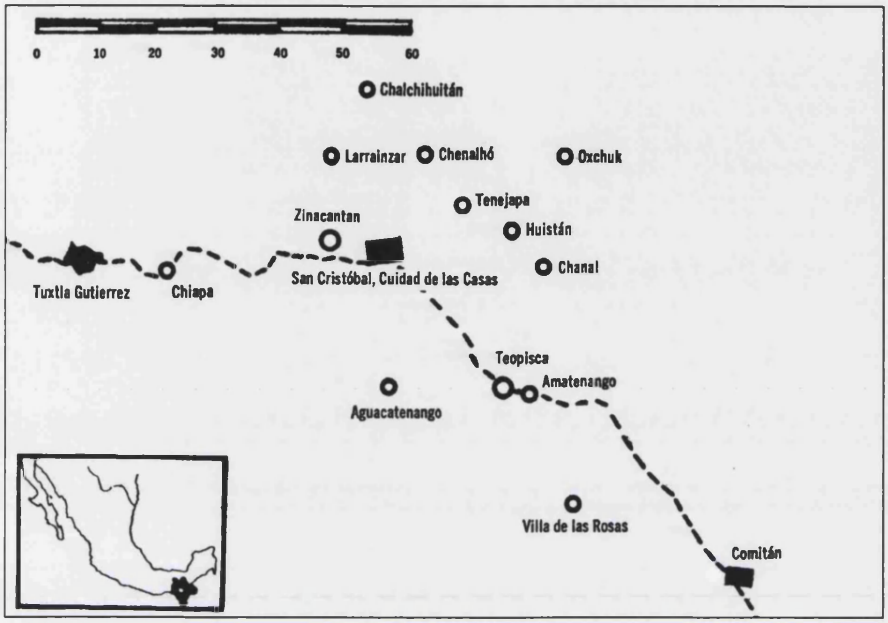
[1] The term "community" is used here to refer to the *municipio* (or municipality) of Amatenango as its direct translation *comunidad* is in common usage both by inhabitants of Amatenango and, more generally, by other indigenous peoples and NGOS to refer to rural indigenous settlements (both formal and informal). It does not refer to communities within Amatenango.

Amatenango del Valle has been a well-studied community, having first attracted anthropological research in the 1950s, most significantly, in the shape of Nash's In the Eyes of the Ancestors (1970). At the beginning of this book, based entirely upon Amatenango, Nash provides a working summary of the geographical positioning and history of this community, emphasising the deep Mayan cultural roots of the people. The town is located in the highlands of Chiapas, less than forty-five metres from the Pan-American Highway, forty kilometres southeast of San Cristóbal and approximately 2000 metres above sea level (see Figure 5.1).

Archaeological findings prove that sites at such an altitude were not occupied prior to Spanish colonisation. Although it's ancestral heritage is clearly much older, Nash discovered that it was first mentioned in tribute lists in 1528 under both the Nahuatl name, Amatenango, as well as its Tzeltal name, Tzobontaghal. Therefore, it is possible to conclude that the community, at least partly, was a product of the restructuring of indigenous municipalities during the colonial period. Nash notes that the first Mexican census of 1778 showed a total population of 576, of which 374 were men and 202 were women and that the ethnic composition of the town included "8 white, 2 negro and *mestizo*, and 566 Indians" (ibid. 2). By the time of the 1824 census this population had increased to 1, 670 and, during the land reforms of the 1930s, the municipality acquired *ejido* lands which extended its agricultural boundaries to lower territories (now known as *tierra caliente* or "hot lands") (ibid.).

By the time Nash published her book, the population had again increased to 3, 179 and the 1995 total stood at 6,775, of whom 3, 287 were male and 3, 488 were female (INEGI, 1995a: 591). However, the ethnic make-up of the settlement remains very much constant with few outsiders accepted. The first language is Tzeltal and this is commonly spoken within the home. Although some older women speak only Tzeltal, the majority of women speak good Spanish as a result of their proximity to the Panamerican Highway and *mestizo* towns of Teopisca and San Cristóbal, to which they travel to sell pottery.

FIGURE 5.1 MAP OF AMATENANGO AND SURROUNDING REGIONS



----- = Pan-American Highway

(Source: Nash, 1970: 4)

This knowledge of Spanish is particularly unusual for indigenous women of the region as most are effectively monolingual (see Chapter Four). Even in cases where they are bilingual, many lack the confidence to converse in Spanish. Despite changes that have occurred in the last half-century, Amatenango remains a traditional community. It holds on to the principles of its culture and beliefs that have been maintained for centuries. Older women are rarely seen wearing anything other than the traditional dress of a white *huipil*[2] with a brightly embroidered square of mainly red silk or cotton thread, a red *faja*[3] and a heavy blue cotton skirt (see Figure 5.2). Many of the younger women, however, now choose to wear the brighter, shorter costume of the neighbouring community of Aguacatenango (see Figures 5.1 and 5.3). They will, however, frequently receive the traditional Amatenango outfit for their wedding.

[2] The traditional blouse.
[3] A long woollen scarf-like corset, which is wrapped around the top of the skirt.

FIGURE 5.2 PHOTOGRAPH OF LUISA MAKING POTTERY

The religion is predominantly Catholic, with 92 per cent (n=92) declaring themselves to be Catholic, although there have been a number of conversions to Evangelism (8 per cent / n=8). These conversions have not adversely affected the cohesion of the community to a great degree. Mattiace (2003: 13) notes how the spread of evangelism since the 1970s has resulted in "religious cleavages...and expulsions of thousands of highland Indians from their communities" (see also Collier with Quarantiello, 1999). However, unlike other *municipios*, such as San Juan Chamula[4], the Evangelists and the Catholics in Amatenango have been able to live together.[5] The patron saint of the town is *Santa Lucía* and the

[4] San Juan Chamula is known for its intolerance of other religions. Many evangelists have been ejected from this community and other *municipios*. (See Collier with Quarantiello, 1999, for detail and related discussion of the animosity between Catholic and Protestant groups in Eastern Chiapas).

[5] Although there was some original tension and continued suspicion in Amatenango, representatives of the two religions remain in the community, albeit concentrated in different areas of the town.

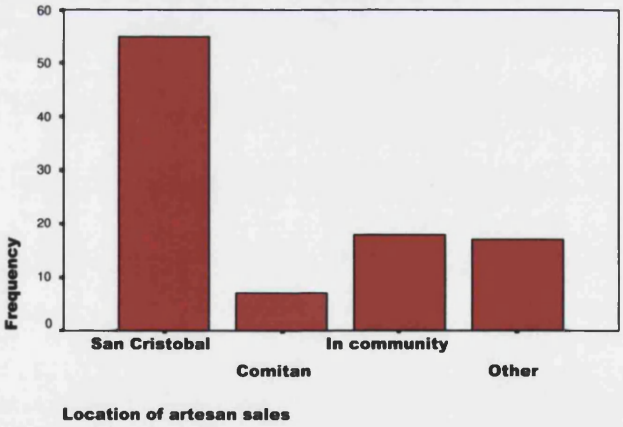
corresponding *fiesta* (holiday) in December is celebrated with great festivities. However, many beliefs date back to before colonisation and are combined with the official Catholicism (see Chapter Four). *Hierberos* or *curanderos*, the local healers, still play an active role in society and undertake many ceremonies of protection and healing. Their power is maintained by the overriding belief that ill health or misfortune is caused by *envidia* (envy) on the part of others. This is the motivation for witchcraft to be employed in order to damage the spirit and, thereby, bring about ill health or even death.

That said, the construction of the adjacent Pan-American highway means that Amatenango has had considerable contact with surrounding non-indigenous communities, particularly with San Cristóbal de las Casas and Comitán (see Figure 5.1). This contrasts with many other indigenous communities of the region, which remain physically isolated. The pottery making tradition of the women of Amatenango has also facilitated this contact. Women frequently travel to these surrounding towns to sell their products and are also visited in their homes by commercial buyers and, increasingly, by tourist groups. Figure 5.4 illustrates the primary locations of pottery sales (also see Figure 5.1). The majority of women who declared the location of their pottery sales (56.7 per cent / n=55) travel to San Cristóbal de las Casas to sell their pottery. This trip is usually undertaken either weekly or fortnightly and takes just over an hour. A further 7.2 per cent (n=7) travel to Comitán (a journey of approximately one hour) and 17.5 per cent (n=17) travel to other locations.

Therefore, while women's roles are still very much restricted, there have been obvious changes since the first research carried out by Nash (1970). As a result of their pottery making economy, the women of Amatenango are powerful within the community and the home. In particular, the development of women's co-operatives to facilitate the merchandising of their pottery has led to increased public activity among women.

FIGURE 5.3 PHOTOGRAPH OF NICOLASA AND HER COUSIN

FIGURE 5.4 LOCATIONS OF POTTERY SALES



However, this is relative to the lack of power exercised by women in comparable situations in other indigenous communities and not in comparison with *mestizo* women. Indeed the pottery cooperatives are themselves very much resented by the men. In the 1970s, Petrona, the leader of a pottery co-operative, sought to become the municipal leader, "*la presidente*". In reaction to her "presumptuousness", she was shot and murdered. Her murderer was never found. Although most people believe they know who it was, they will never comment openly. Nevertheless, her very desire to be president reflects the great

difference between women of Amatenango and those of other communities, where it would be unthinkable for a woman to even conceive the idea of occupying such an elevated position. For many years after Petrona's murder, fear then halted the activities of many women's co-operatives within Amatenango.[6] Although they appear to be recovering somewhat these days, many women are still reluctant to admit to taking part. My visits to the co-operatives revealed a seemingly good supply of products. However, only 14.3 per cent (n=14) of women state they are members of a co-operative.

Despite more contact with the *mestizo* world relative to other indigenous communities, Amatenango remains insular. Societal norms are maintained by internal mechanisms. Given the historical and contemporary exclusion of indigenous peoples from official institutions and processes, the legal authorities of *mestizo* society are seldom involved in times of dispute and violence. Problems arising from "anti-social" behaviour and transgressions against acceptable norms are resolved and punished within the community. I came across such a process while staying in the community. I was told that one man had been murdered and another injured in a dispute in *tierra caliente.*[7] The surviving man was the son of the murdered man and both he and the body of his father were to be brought back to the community the next day. They were reported to be known *ladrones* (thieves) and this was given as the reason for the dispute. However, the whole situation was to be discussed and resolved with the input of the whole community upon their arrival. However, the family with whom I was staying advised me that I should not attend the meeting as such meetings frequently became confrontational and violent. If I were to be associated with one side of the dispute, it would greatly prejudice my continued research in the community. Although it is common for indigenous disputes to be resolved through such public meetings, Amatenango has long been alleged to be one of the most violent of regional indigenous communities and incidents such as these are not uncommon.[8]

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[6] June Nash originally brought this history to my attention and I further investigated the story in informal conversations with women in Amatenango.

[7] Literally, "the hot land", this refers to the areas where some of Amatenango's *ejido* lands are held and where, therefore, men go for days at a time to work.

[8] June Nash also related an incident that occurred during her 1960s fieldwork. Her then husband almost became involved in a gun fight with a local Amatenango man over a family dispute in which they had inadvertently become involved.

Despite the violent reaction to Petrona's desire to transgress local society's strict gender norms, the economic power of the women due to their pottery making skills has certainly had an impact upon their community. While Amatenango experiences poorer standards of living than average Mexican standards, it is characterised merely as "poor", whereas all other indigenous communities of Chiapas are classified as "very poor". In comparison with many other indigenous communities, Amatenango is well provided for in terms of public services. The town has a small clinic, which is situated in the *colonia* (neighbourhood) named *La Grandeza*, about a fifteen minute walk from the centre. The clinic is staffed by one doctor and two nurses, all female. From Monday to Friday, it is open from 8 am until 1 p.m. and then again from 3 p.m. until the last patient has left. At the weekend, one of the nurses is present to deal with medical emergencies. There are two primary schools, one monolingual, teaching in Spanish, and the other bilingual with teaching in both Tzeltal and Spanish. There is also a kindergarten and a small secondary school.

Although the economic advantages of the municipality and its accessibility to the Pan-American highway partly explain the existence of such services, another of the reasons why Amatenango is relatively well equipped may be because it previously had a strongly supportive Priista local government. In common with other similar communities, it has been rewarded for its loyalty (Reding, 1994; Collier with Guaratiello, 1999) with such services and with governmental schemes such as PROCAMPO[9] and PROGRESA. Although the majority of other communities are also Priista supporting, many are nominally supportive, many others have high degrees of opposition support and conflict, and widespread electoral fraud in the region complicates the picture (Collier with Guaratiello, 1999). Amatenango is not a majority Zapatista community and neither is it situated within the militarised zone. In terms of health care, this means that it does not suffer as severely from the some of the political problems related to access to health care described in Chapter Three. However, there are Zapatista activists and *simpatizantes* (sympathisers), in the community, even if the politically sensitive nature of the subject means that it is difficult to

[9] The governmental scheme to provide individual peasant farmers with resources for fertilisers and seeds etc. to promote their crops.

quantify this revolutionary support.[10] Indeed, it is an interesting and perhaps unique community in respect of politics. In the majority of Chiapenecan communities, differing factions have led to dual authorities, open conflict, expulsions or displacements. However, Amatenango is a politically split community which has managed to avoid, to a large degree at least, such open violence. The last local government during the time of fieldwork was the PRD, the left-wing opposition party, often associated with supporters of the EZLN, although in the election of October, 1998, the PRI again gained control, taking over the presidency in January, 1999. Although these changing results may be seen as reflecting national trends (following, for example, the election of Cárdenas to the governorship of Mexico City), much of Amatenango's politics has little to do with the national political parties. Rather it reflects opposing families and kin-groups playing out their historical disputes. For example, the present members of the PRD reflect one particular extended family grouping and are, reportedly, former supporters of the PRI who were thrown out because of corruption. The present supporters of the PRD generally all live in one particular region of the municipal centre and the PRI supporters on the other.

In terms of communications, Amatenango is less advantaged. There are no private or public telephones, except one in the municipal building, which also has a fax machine. However, use of these is dependent upon the availability of certain authority figures and their express permission. An application in 1998 from a local woman running one of the co-operatives to have a private telephone line installed at their own expense was greeted by an obstructive reaction from the officials at the national telephone company. It was claimed that Amatenango was too remote to have further telephone lines installed (despite its proximity to the highway and the *mestizo* town of Teopisca).
There is a small, locally run post-office. However, it cannot deal with larger packages thereby proving a major obstacle to women attempting to promote the sales of their pottery by marketing their products further afield.

Despite its proximity to the highway, there is no organised system of public transport that stops at Amatenango. This is in contrast to some indigenous

[10] I met several men and women who declared themselves to belong to "the liberation army" during my time there.

villages such as San Juan Chamula where transport runs directly between the municipal centre and San Cristóbal de las Casas. Travel to the nearest town of Teopisca or to Comitán in the other direction, and from there further afield, means standing at the side of the road and flagging down a passing *combi* (privately run converted Volkswagen vans which run along the Pan-American highway between Comitán and Teopisca or San Cristóbal) or *camión* (converted animal trucks covered with a tarpaulin with wooden benches in the back which are run by locals to Teopisca and carry goods as well as people). There is also no market (again unlike in Chamula, for example). That of Teopisca is the closest. There are, however, a handful of small shops run by locals which sell everyday essentials such as soap powder, a small selection of fruit and vegetables (usually tomatoes, onions, chillies and bananas), eggs and, popularly, returnable bottles of Coca Cola. There are also locally run *"depositos'* for selling beer, again with returnable bottles. Those who run these businesses are guaranteed a healthy income and also a good deal of authority in the community, given the importance of alcohol in religious ceremonies and as an expression of male social relationships (see Chapter Seven).

THE INTERVIEWEES

The information detailed above reveals a community that, while more prosperous than many other indigenous communities of the region, is socially and economically disadvantaged in many respects. In order to illustrate how this impacts upon the life and health experiences of residents, I outline here brief life histories of four of my most active and closest participants throughout the fieldwork process.[11]

By far the most significant of my interviewees was Luisa (see Figure 5.2). Luisa is the wife and mother of the family with which I stayed. She was important as a personal supportive friend throughout my fieldwork in Amatenango. Also, being a talkative, intelligent and open woman, she was an invaluable source of information on the lives and attitudes of women in the community more generally.

[11] See Appendix E for brief demographic details on all of the participants who are directly quoted throughout the thesis.

Luisa had completed primary education. At the time of the fieldwork she was 42 years of age and she lived in a household of 10 (11 including myself). She had married at 16 and still lived with her husband, Marîano, of the same age. All of her children are living and she had had 10, 4 boys and 6 girls, with ages ranging from 24 years down to 18 months. She had never used contraception. Although she claimed never to have been ill up until that point, she became ill with severe pains in her abdomen and lower back in the summer of 1998 whilst I was staying there. This was diagnosed at the local clinic as a collapsed uterus.

Luisa's oldest daughter, Nicolasa, was also an interviewee (see Figure 5.3 – on the left). She was 19 years of age and as yet unmarried. She is also an intelligent and astute young woman with strong opinions about the direction she wished her own life to take and about the lives of other women in the community. She had completed primary education and had begun secondary education by distance learning but had given up before taking her first exams. She was particularly illuminating as an interviewee as she could give an insight into the changing perspectives of younger women upon lifestyle and marriage in Amatenango. Also, as an eldest daughter, she could reveal the pseudo-mothering responsibilities adult women in the household take on. Both Luisa and Nicolasa were the primary producers of pottery in the household, although Nicolasa's was of a higher standard and attracted more regular *marchantes* (buyers) from further afield.

The house in which these two interviewees lived consisted of one room constructed of concrete (a small second wooden room added on the side to accommodate me), with a tiled roof and concrete floor. As with all living arrangements in Amatenango, the kitchen (containing the traditional fireplace for cooking) was separate from the living quarters and consisted of a small *adobe* (mud) building with a tiled roof with only the space between the walls and the tiles for smoke to escape. The household had also recently come into possession of a latrine, in a small concrete outbuilding. In comparison with many families in Amatenango, their living standards were relatively high, with a reasonable stock of land, and, given their advantageous position near the centre of the town, a good trade in pottery.

Another important interviewee was Evangelina, the daughter-in-law of Luisa. She had married José at 18 and was now 22, with an 18 month old daughter, Silvana. She had had

a difficult experience in birth having been one week in labour. She did not use contraception and had completed primary education. They had lived with Luisa's family until two years previously when they had moved to a plot of land given to them by Marían (her father-in-law) in the *barrio* of Pie del Centro (a fifteen minute walk from the centre of Amatenango). There they had constructed their own wooden house with one room and a separate wooden kitchen room. There is no piped water in this area of Amatenango but a small river runs near the house.

Carolina was one of the most interesting and open interviewees in terms of health problems and contraception. She was also a young woman, of twenty-one years of age, and had been married to Evangelina's brother since the age of fifteen. She lived in the centre of Amatenango in the most impoverished circumstances of all of the interviewees. The one-roomed house was small, although with a separate kitchen, both roughly constructed of wood. She had one daughter, aged three, but had had two other children who had died. She had used birth control in the past but had had many associated problems. She suffered from health problems connected to malnutrition. She did produce pottery for sale but it was of a poor standard as her mother had not been from Amatenango and so she was learning as an adult, instructed by her mother-in-law.

CONCLUSION

In many ways Amatenango is a "typical" indigenous community. Although it does not suffer such severe poverty as others in Chiapas, the descriptions above illustrate that its inhabitants suffer from social and economic exclusion relative to the majority of Mexican society. The following chapter illustrates how these socio-economic circumstances impact upon the health environment of Amatenango, as well as examining women's own perceptions of their resulting state of health.

CHAPTER SIX

THE HEALTH ENVIRONMENT AND HEALTH STATUS IN AMATENANGO

INTRODUCTION

This chapter follows on from the previous in looking at how the context described there translates to a "health environment" and, therefore, health status in Amatenango. First, quantitative data at community and household level from the questionnaire survey are analysed to reveal the health environment in Amatenango. The latter holistic perspective is adopted in order to highlight the general state of health of women and men in the community without necessitating analysis of the incidence and prevalence of specific diseases and conditions from a Western bio-medical perspective.

From the same standpoint, the following section highlights how health status is viewed from the perspective of the female participants and which health issues they consider most pertinent to the community. These data are based upon both survey and qualitative data and include a discussion of women's perceptions of their own health and that of others. These perceptions also represent women's analyses of gender and ethnic differences in health issues and, particularly, the centrality of marginalisation and poverty (and related lifestyle) to ill health. The ways in which women manage to align these understandings of the factors involved in health and illness with other more spiritual explanations are also discussed.

AN HOLISTIC APPROACH TO HEALTH STATUS: THE HEALTH ENVIRONMENT

The brief details of the lives of four women at the end of the previous chapter indicate worlds in which experiences are clearly dominated by social and economic marginalisation. Health is no exception. Indeed, it seems likely that health status is particularly linked to socio-economic factors. This is a contentious statement as evaluations of health status are often fraught with difficulty because of "a lack of a common language" and the "[p]ower

politics [which] cannot be ignored" (Shuftan, 1999: 611), particularly between practitioners and researchers from different disciplines and institutional realms. However, much research reaches the same conclusion as analyses of the variables of socio-economic status and health consistently reveal a positive relationship (Winter et al., 1993: 1351).

Health especially cannot be separated from the factors integral in the composite concept of "socio-economic status" when the understanding of health is a holistic one. This holistic understanding is currently accepted by the World Health Organisation, amongst other international and national agencies involved in health. Health status is seen as not only the absence of disease (although this forms a part of health) but also the presence of the conditions which promote and maintain healthy lifestyles. This was the original basis of Primary Health Care, which has the key aim of improving sanitation and living conditions which impact upon health status. Although there are arguably problems with the fragmented and reductionist nature of this approach (especially with the introduction of Selective Primary Health Care), many involved in health are convinced of the necessity of maintaining the perspective.

On the basis of research into women's health status in the state of Oaxaca, Mexico, Winter et al. (1993: 1357) conclude that improving economic well-being is key to improving health as "[i]mproved economic well-being can...mean better nutrition and less hard, physical labor necessary for survival". On a more general level, Phillips and Verhasselt (1994: 5) comment that:

> "General social development, particularly education and literacy, has almost invariably been associated with improved health status via improved nutrition, hygiene and reproductive health. Socio-economic development, particularly if equitably spread through the population – although this is rarely the case – also enables housing and related services to improve."

In a study relating gender and education to health status in Jamaica, Handa (1998: 325) notes that the biomedical world is now coming to grips with this holistic approach and that "current medical research indicates that chronic disease is related to diet, stress and lifestyle, which are all influenced by socio-economic variables such as age, gender, region

of residence and income." This position has long been accepted by many development practitioners and theorists. For example, Sidel (2000: 356-357) links health to human rights and writes that "[i] n addition to an adequate standard of living, necessary conditions for health and well-being include access to basic services, such as education, housing, nutrition and public health...". He also notes that "[o]f the 4.4 billion people living in developing countries, nearly three-fifths lack access to safe sewers, a third have no access to clean water, a quarter do not have adequate housing and a fifth have no access to modern health services of any kind...". In analysing the health status of women, Zaidi (1996: 723) states that:

> "The problem of a lack of access to resources, poor nutrition, lack of education, poor basic infrastructural facilities such as water and sanitation, and a lack of preventative and curative health facilities, are not only one of the most important causes of the ill-health of women alone, but of the ill-health of entire nations, regions and classes composed of both men and women."

Furthermore, in relation to her study of "sickness" amongst women in Mexico, Finkler (1994: 6) notes that "sickness is embedded not only in physiological impairments but also, simultaneously, in conditions of life, social relations, unresolved contradictions, and moral evaluations". Similarly, Zaidi (1996: 723) expands upon the relevance of economic well being to include associated institutional, cultural and behavioural factors. She summarises the main causes of ill health (as related to gender inequality) in "under-developed" countries within four main themes that are particularly relevant to this case study:

1. "Lack of resources and poor access: lack of access to health care; poor communication and transport; lack of prenatal and medical care during pregnancy; insufficient nutrition; few opportunities to earn income; poor access to educational opportunities.

2. Legal constraints: a male orientated legal system...

3. Lack of participation: women not part of the health (or any other) planning and participatory process...

4. Gender discrimination: preferential treatment for food intake and medical treatment for boys.

5. Values and norms: social values, customs, cultures, religion, traditional societies, seclusion, exclusion – all discriminating against and restricting the contribution and role of women in society"

From the perspective of holistic health status, it is important to analyse these factors. They make up the "environment of health". This can be used as an indicator of health status as opposed to the more fragmented clinical concentration upon incidence or prevalence of specific conditions and diseases. Using the health environment as a basis for analysis also means that it is possible to assess the potential for a positive healthy status, as well as the negative aspects of illness and disease. At any rate, an analysis of the latter factors from a biomedical perspective would be almost impossible given the understandings of health held by the participants in this case study context (see later in this chapter) and without a detailed study of health facility records (if they were to exist). It would also be contrary to the aim of this thesis, which seeks to explore women's perspectives in a manner free of the arbitrary imposition of Western definitions of health and illness. As asserted by Finkler (1994: 6), "[t]o focus on conditions of human existence in tandem with their contradictions and the meanings people give to them is to attend also to the cultural context". In this way, the distinction adopted by biomedicine "between 'signs' – regarded as manifestations of real disease and real pain – and symptoms - understood as patients' subjective experience, lacking objective reality" (ibid.: 11) can effectively be dispensed with. It is precisely the environment promoting, or providing obstacles to, a healthy status and the symptoms dismissed as subjective by biomedicine, which form the experiences of health for women in Amatenango.

THE HEALTH ENVIRONMENT IN AMATENANGO

The following sections of this chapter examine the "health environment" affecting health status, as incorporated into the first theme noted above by Zaidi (1996), before looking at some of the principal symptoms of ill-health noted by women participants. Many of the other factors mentioned by Zaidi come into play in subsequent chapters regarding women's roles in the family and the community, health care and decisions regarding the family and reproduction. The environment to be examined here focusses on some of the most basic

needs as indicators of social and economic well being and, therefore, the potential for a healthy status. Much research in Latin America assesses socio-economic status by including a "level of living score" composed of "a count of the number of appliances and furnishings present in the dwelling" (Winter et al., 1993: 1355). Similarly, research into childhood nutritional status by the International Food Policy Research Institute relies upon a "possession index" amongst other factors (Ruel et al., 1999: 9). These scores and indexes are argued to be more reliable than assessing household income because of inaccuracies in the reportage of the latter. Such a problem with income was encountered during this research (see below). However, equally, the "level of living score" would be unlikely to yield helpful results given that very few of the households own any of the appliances listed (such as gas or electric cooking stoves, refrigerators, blenders, televisions, etc) and had an extremely basic level of furnishing (usually only wooden beds without mattresses, each one shared by two or three household members). It is, therefore, necessary to take the level of assessment down to a more fundamental level.

The Universal Declaration of Human Rights adopted by the General Assembly of the United Nations in 1948 proclaims that "[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services". The factors to be examined here are based upon these minimum requirements for health and so include living conditions, particularly household construction and occupancy density, income levels and activities, sanitary and services provision, diet and sources of diet. In this context, these are some of the major variables composing the over-riding concept of "socio-economic conditions" or as Zaidi (1996) states "lack of resources and access". They are, then, critical in examining the health status of women and men of Amatenango.

Quality of housing

One of the major factors which, in the absence of some form of asset or possessions score, can denote socio-economic status and which is also related to health environment in other more direct ways is the quality of housing. Ruel et al. (1999) include variables relating to the "construction material for roof, walls and floor...the source of drinking water, and the

availability of sanitary facilities" amongst other factors to be analysed alongside the assets index previously mentioned. In the absence of the latter, these factors become our principal means of assessing the socio-economic / health environment. Indeed, for Smith and Haddad (1999: 4), this "health environment" itself "rests on the availability of safe water, sanitation, health care and environmental safety, including shelter".

In Amatenango, the quality of housing rests upon several of these key factors and, therefore, this section will look at the construction of walls, roof and floor as well as the availability of household services before looking at the related factor of occupancy levels.

Construction

As alluded to in the brief descriptions of participants' lives earlier in this chapter, the construction of houses in the community is at a basic level. However, dwellings are usually permanent in nature with mud and, increasingly, concrete used as building materials for the walls and tile as the predominant roof material, as Figures 6.1 to 6.3 represent.

The men of most families are responsible for the construction of the household's residence and, as might be expected, the quality of materials is likely to depend not only upon the finance available but also the building skills of the men. However, although adobe (mud) would have been the traditional material for constructing the walls of property, the more sturdy concrete is now increasingly being used. 45 per cent (n=45) of houses are of mud construction and 35 per cent (n=35) of concrete with some houses also having wooden walls (17 per cent / n=17) and a small minority constructed from the more expensive and labour intensive brick (3 per cent / n=3). Figure 6.2 shows that the material used for roofs, however, is much more consistent with 88 per cent (n=88) using tiles and 5 per cent (n=5) using concrete. Again, a small minority also use other less hardy materials with 6 per cent (n=6) using laminate and 1 per cent (n=1) using wood. From the point of view of health, the lack of adequate flooring in much housing is perhaps of most concern. Figure 6.3 reveals that the majority (62 per cent / n=62) have a mud floor in their houses. The remaining 38 per cent consists of 36 per cent (n=36) who have a concrete floor and 2 per cent (n=2) who have a tiled floor. The latter two materials are clearer a preferred option as

they are able to be cleaned and are not so readily subject to weather conditions. The level of construction of houses in Amatenango is, then, basic but in most cases provides at least a rudimentary level of shelter with a degree of permanency, with mud flooring the most subject for concern in terms of sanitation.

FIGURE 6.1 CONSTRUCTION OF WALLS

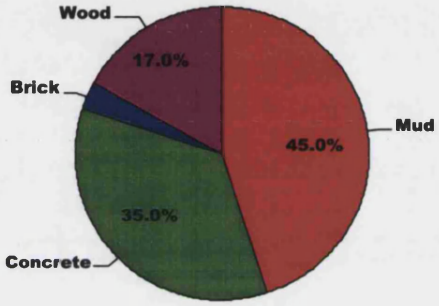


FIGURE 6.2 CONSTRUCTION OF ROOF

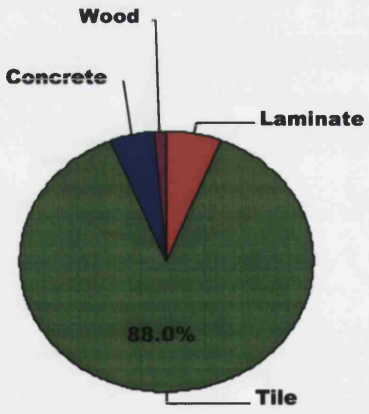
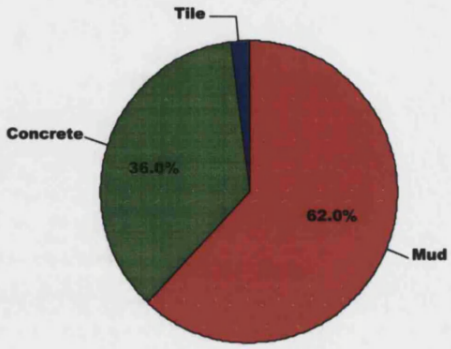


FIGURE 6.3 CONSTRUCTION OF FLOOR



Services

Level of sanitation is often one of the principal assessments of the health environment. Provision of household services, particularly water and drainage, are key to these evaluations. In a review of cross-cultural research into child malnutrition, Smith and Haddad (1999: 12) found that "access to safe water" was often used as a "proxy for sanitation" and that "countries with high safe water access are likely to have good health environments" (ibid.: 22). Equally, dealing with waste is an important aspect of sanitation, as "safe sewers" (Sidel, 2000: 356. See also WHO, 2003) are crucial to a sanitary physical environment and the prevention of illness.

Every house in the municipal centre of Amatenango has piped water (see Figure 6.4). In the settlements outside of the centre, there is no piped water but there is a nearby clean water supply in the river coming from the mountain. There is, however, no drainage system in the community and only 36 per cent (n=36) of households have a latrine (see Figure 6.5).

FIGURE 6.4 WATER SERVICES PROVISION

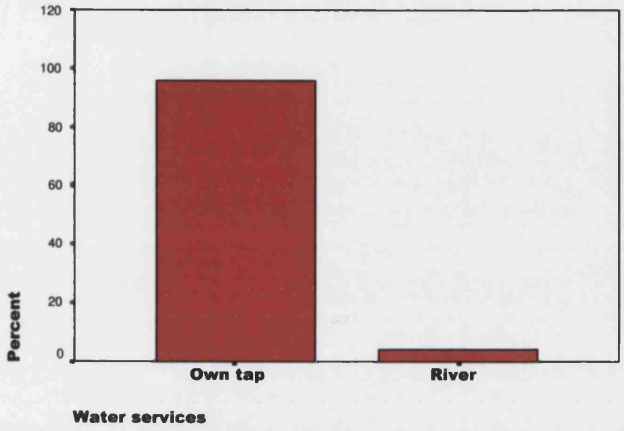
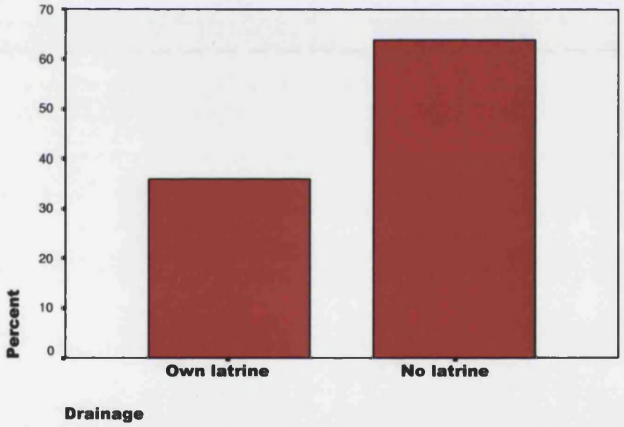


FIGURE 6.5 POSSESSION OF LATRINE



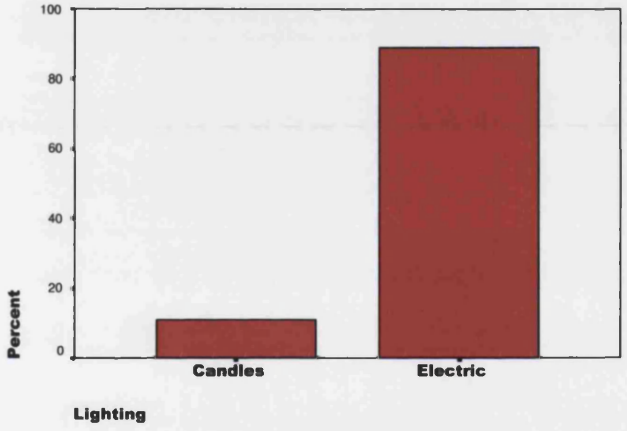
Although not always included within assessments of quality of housing, the source of lighting is also a key measure in this context given that it can substantially improve standards of living as well as health and safety. In this case, it is one of the only measures of such living standards available. The WHO (2003: 7.2) notes that:

> "Poor indoor lighting can have many harmful effects on health and well being. A poorly lit working environment in the home can lead to eyesight problems, for example. This is a particular concern for women working in indoor cooking areas. Poor lighting within the home can also make people

> feel more depressed...[I]f a house is dark, it is more difficult to see dust and dirt and thus more difficult to clean properly."

In Amatenango, the majority of houses have very little natural light. This is particularly the case with those that are constructed of mud, which seldom have windows. Those windows that are present are usually small and unglazed (and are, therefore, shuttered in poor weather). Whilst the WHO (ibid.) emphasises the importance of natural light, the provision of adequate electrical lighting is particularly important in these circumstances. There is an electricity supply to houses and 88.9 per cent (n=88) of houses have electric lighting, with the remainder using wax candles (see Figure 6.6).

FIGURE 6.6 SOURCE OF LIGHTING



However, cuts in power are frequent and often politically motivated.[1] In addition, the majority of households when commenting upon their electricity supply noted that they did not pay their electricity bills so in reality the use of candles as the most frequent form of lighting is likely to be much higher, although an electricity supply may be present.

[1] The PRD supporters (often a byword for Zapatista supporters in the region) refuse to pay their electricity bills as they claim the bills to be too expensive. Therefore, the supply of electricity to all households is periodically cut off, often for a couple of days at a time. Similarly, Collier with Guarantiello (1999: 125) assert that access to services in Chiapas is often on the basis of political affiliation, rather than need.

Occupancy

The basic condition of living accommodation and household services affecting health status will clearly be exacerbated by overcrowding. Over-crowding is not only key to assessing socio-economic status but is especially problematic from the perspective of sanitation and infection. The local doctor commented upon the particular need to improve occupancy to room number rates in the community in my interview with her. Similarly, the World Health Organisation (2003: 7.4) advises community health workers that;

> "[o]vercrowding in homes causes ill-health because it makes disease transmission easier and because the lack of private space causes stress. Overcrowding is related to socio-economic level, and the poor often have little choice but to live in cramped conditions. In principle, increasing the number of rooms in a house should improve the health of the people who live there but increasing house size is often difficult".

This reflects common practice in the developed world where over-crowding is included as an indicator of "housing deprivation" and, though still under-researched, is noted to figure amongst the factors influencing both physical and psychological ill-health (Marsh, 1999).

In Amatenango, household occupancy rates are varied, as shown in Tables 6.1 and 6.2. Interestingly, these tables reveal no single occupancy and show that, while household occupancy ranges between 2 and 10, the mean occupancy is 4.92. In terms of distribution, the inter-quartile range is between 3 and 6 with a median occupancy of 5. This distribution is represented more graphically in the box plot of Figure 6.7, which shows a skewed distribution towards the lower end of the inter-quartile range.

In terms of assessing over-crowding, it is clearly crucial to analyse how these occupancy rates relate to number of rooms. Here, the picture is more straightforward as, while occupancy rates are varied, the number of rooms per property is very much more uniform, as Table 6.3 and Figure 6.8 illustrate.

TABLE 6.1 NUMBER OF OCCUPANTS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2.00	8	8.0	8.0	8.0
	3.00	24	24.0	24.0	32.0
	4.00	16	16.0	16.0	48.0
	5.00	13	13.0	13.0	61.0
	6.00	18	18.0	18.0	79.0
	7.00	8	8.0	8.0	87.0
	8.00	8	8.0	8.0	95.0
	9.00	3	3.0	3.0	98.0
	10.00	2	2.0	2.0	100.0
	Total	100	100.0	100.0	

TABLE 6.2 AVERAGE OCCUPANCY

Statistics

Total number of occupants

N	Valid	100
	Missing	0
Mean		4.9200
Median		5.0000
Percentiles	25	3.0000
	50	5.0000
	75	6.0000

FIGURE 6.7 OCCUPANCY DISTRIBUTION

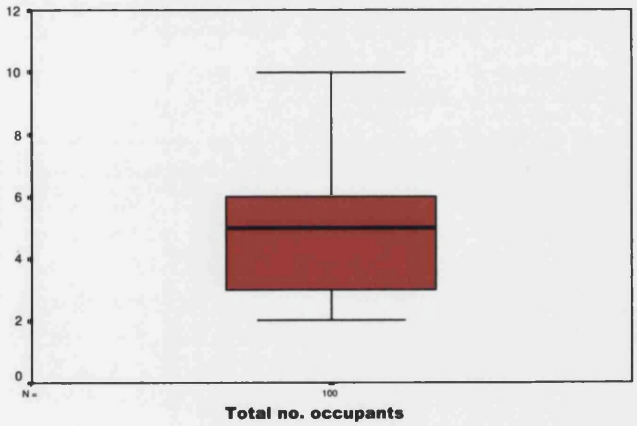
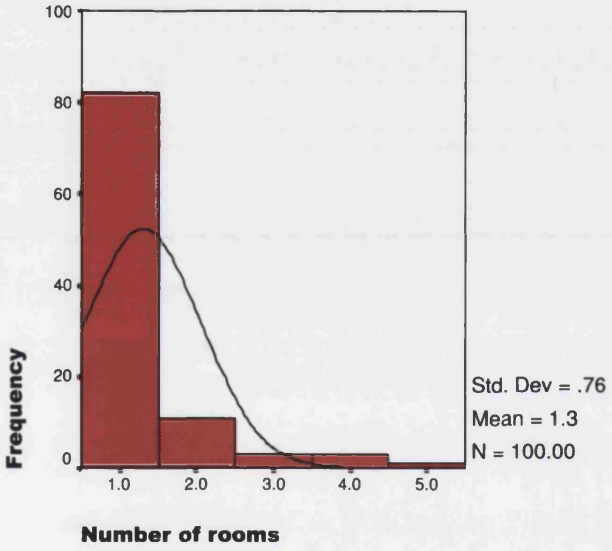


TABLE 6.3 NUMBER OF ROOMS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	82	82.0	82.0	82.0
	2.00	11	11.0	11.0	93.0
	3.00	3	3.0	3.0	96.0
	4.00	3	3.0	3.0	99.0
	5.00	1	1.0	1.0	100.0
	Total	100	100.0	100.0	

FIGURE 6.8 NUMBER OF ROOMS DISTRIBUTION



The above show that the vast majority of properties - 82 per cent (n=82) - have only one room (not including the kitchen outbuilding, which is always located away from the main living space). The most number of rooms of any property in the questionnaire sample is 5. However, only one household amongst the 100 surveyed could count with this number.[2] A closer look at the cross-tabulation of occupancy by number of rooms (Table 6.4) reveals that 96.9 per cent (n=31) of the lower quartile range of 0-3 occupancy live in a one-roomed house whilst 76.6 per cent (n=36) and 71.4 per cent (n=15) of those with higher occupancy

[2] There were no missing responses for variables relating to the construction of the houses as this was often completed by observation when conducting the questionnaire. However, occupancy rates relied upon information from the participants, which was not always available.

rates in the mid and higher quartile ranges respectively also live in one room. The latter two higher occupancy rates are the most cause for concern from a health point of view in situations where higher density of occupation is likely to mean less sanitation and more possibilities for infection. This may be compounded by the close proximity of houses to one another, particularly in the centre of the town.

Table 6.4 also indicates that number of occupants appears not to correlate to any great degree with number of rooms with relatively little variation between the percentages of occupants within number of rooms and over one third (36 per cent / n=36) of the overall total living in one room with occupancy between 4 and 6 persons (inclusive). It is far more likely that land and overall economic status of the household would have a greater impact upon the number of rooms constructed within a house than occupancy. Unfortunately, the data obtained on household income were somewhat haphazard in their accuracy owing to underreporting of income. It is, therefore, not of sufficient quality to undertake such an analysis.

TABLE 6.4 TOTAL OCCUPANCY BY NUMBER OF ROOMS

			Number of rooms					
			1.00	2.00	3.00	4.00	5.00	Total
Total Number of Occupants	0-3	Count	31	1				32
		% within Total Number of Occupants	96.9%	3.1%				100.0%
		% within Number of rooms	37.8%	9.1%				32.0%
		% of Total	31.0%	1.0%				32.0%
	4-6	Count	36	7	2	1	1	47
		% within Total Number of Occupants	76.6%	14.9%	4.3%	2.1%	2.1%	100.0%
		% within Number of rooms	43.9%	63.6%	66.7%	33.3%	100.0%	47.0%
		% of Total	36.0%	7.0%	2.0%	1.0%	1.0%	47.0%
	6 >	Count	15	3	1	2		21
		% within Total Number of Occupants	71.4%	14.3%	4.8%	9.5%		100.0%
		% within Number of rooms	18.3%	27.3%	33.3%	66.7%		21.0%
		% of Total	15.0%	3.0%	1.0%	2.0%		21.0%
Total		Count	82	11	3	3	1	100
		% within Total Number of Occupants	82.0%	11.0%	3.0%	3.0%	1.0%	100.0%
		% within Number of rooms	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		% of Total	82.0%	11.0%	3.0%	3.0%	1.0%	100.0%

Income

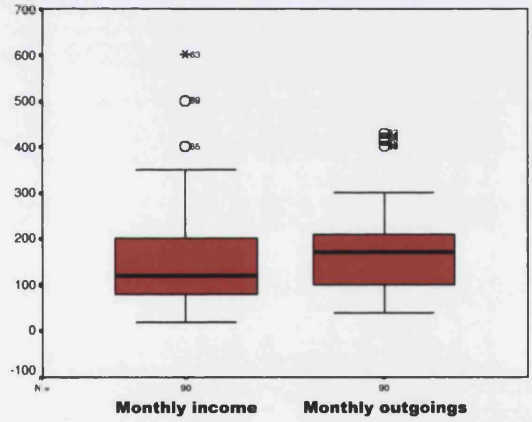
However, it is possible to look at the overall distributions of income and outgoings in order to get a snapshot of how the two measure against one another, as Table 6.5 and Figure 6.9 illustrate.

TABLE 6.5 AVERAGE INCOME AND OUTGOINGS

Statistics

		Monthly income	Monthly outgoings
N	Valid	91	97
	Missing	9	3
Mean		153.7912	182.6804
Median		120.0000	170.0000
Mode		100.00	200.00

FIGURE 6.9 MONTHLY INCOME AND OUTGOINGS DISTRIBUTIONS

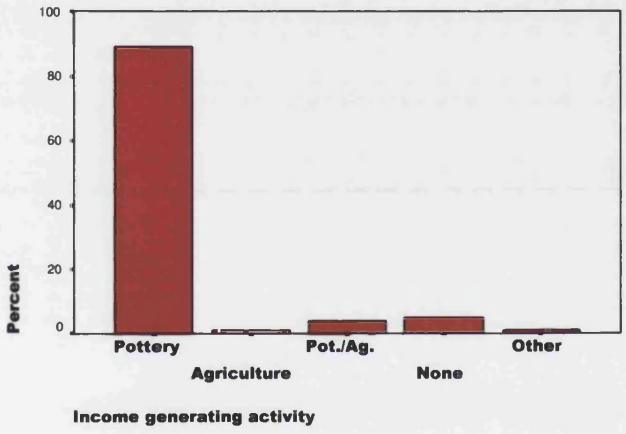


Both Table 6.5. and Figure 6.9 show low mean and median average household incomes of 153.79 pesos and 120 pesos respectively (approximately $14.25 U.S. and $11.20 U.S.). However, an indication of the under-reporting of this income can be noted by the fact that average monthly outgoings are slightly higher with a mean of 182.68 pesos and a median of 170 pesos (approximately $17 and $15 respectively). The box plots of Figure 6.9 are a clearer representation of the latter distribution and the discrepancy between income and outgoings. This figure also reveals the concentrated nature of the distribution around the

stated median income and outgoings and the skewed nature of this distribution (towards the top of the inter-quartile range for income and towards the bottom for outgoings).

It is probable that the stated outgoings give a more realistic picture of income since it is unlikely that, at these levels, there is much surplus income and saving. Clearly, whatever the exact figures, levels of income are extremely low. This is not surprising given the income generating activities of the population, which are both uniform and consistently split between the sexes, as Figures 6.10 and 6.11 highlight.

FIGURE 6.10 INCOME GENERATING ACTIVITY (FEMALE INFORMANT)

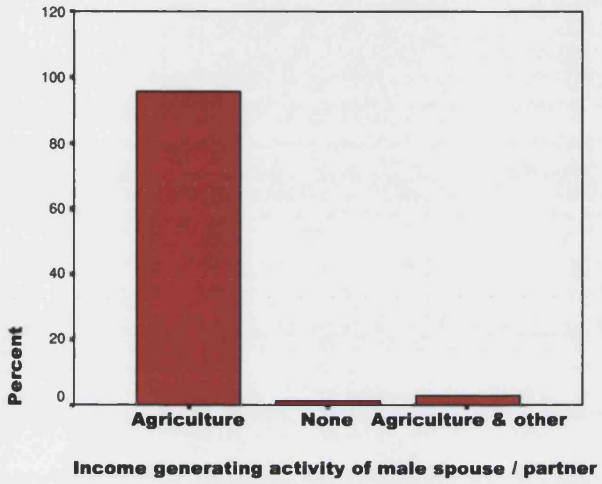


The vast majority (89 per cent / n=89) of the women informants are involved in pottery making (as discussed above) with 4 per cent (n=4) also undertaking agricultural duties, 1 per cent (n=1) only working on the land and 5 per cent (n=5) not working. The latter represents older women who are likely to now rely upon younger female members of the household to produce the pottery for sale.

For the men, the picture is yet more stark as no men work in pottery production and 95.9 per cent (n=71) work solely in agriculture. A further 2.7 per cent (n=2) are also involved in other income generating activities and 1.4 per cent do not work (n=1). Whilst theoretically noted to be income generating, men's agricultural work is usually subsistent in

nature. Only when there is excess production is the produce sold. Therefore, the income noted in Table 6.5 and Figure 6.9 mainly relate to the pottery production of the women.

FIGURE 6.11 INCOME GENERATING ACTIVITY OF MALE SPOUSE / PARTNER



Diet and food security

A central motivation for analysing income levels and activities when assessing the health environment is not only that the socio-economic level can itself serve as a proxy for health status but also because there is an especially close relationship between income, diet and food security. This is particularly important where income levels are low and subsistence production is largely depended upon, as it is in Amatenango.

The relationship between diet and income is more complex than might be expected. Ruel et al. (1999: 10) found that childhood nutritional status was linked to household hygiene and that the latter was "highly correlated with most of the household socio-economic variables", including housing quality and income. They concluded that insufficient income is a factor in calorie availability, although it may be operating indirectly via effects upon formal educational level and caring practices, rather being directly determinate.

Smith and Haddad (1999), however, place a greater emphasis upon the importance of income, locating it within the broader concept of food security. The latter incorporates

"[t]he resources necessary for gaining access to food [which] are food production, income for food purchases, or in-kind transfers of food (whether from other private citizens, national or foreign governments, or international institutions)" (ibid.: 4). The level of food security is likely to be important in determining level, variety and consistency of diet and is directly related to the "underlying determinant" of income.

The direct determinants of malnutrition and disease are the "immediate determinants" at the level of the individual human being. The relationship between diet and health status has long been accepted although the precise nature of the relationship between these is again open to debate. Stein (1997: 148) comments that "the closer one looks, the more elusive, complicated, and confounded is the pattern" and that "[t]he interaction of nutrition on multiple levels only complicates the already cloudy relationship between nutrition and health". However, with reference to childhood nutritional levels, Smith and Haddad (ibid.) are more assertive in their conclusions:

> "[Immediate determinants] include dietary intake (energy, protein, fat and micronutrients) and health status. These factors are themselves interdependent. A child with adequate dietary intake is more susceptible to disease. In turn, disease depresses appetite, inhibits the absorption of nutrients in food and competes for a child's energy. Dietary intake must be adequate in quantity and quality, and nutrients must be consumed in appropriate combinations for the human body to be able to absorb them."

This study emphasises the importance of adequate nutrition for children. However, the effects of malnutrition can be noted into adulthood, particularly by stunted growth, low BMI (Body Mass Index[3]) and susceptibility to diarrhoea, fever and other chronic illnesses and disability (Ruel et al., 1999; Smith and Haddad, 1999; Shultz, 1997). Shultz (1997: 149) also states that:

> "indicators of childhood and adult nutrition are selected because of their high correlation with childhood and adult mortality. Although these nutritional indicators are less well documented as predictors of mortality,

[3] This is the most widely used measure of adult nutritional status across the world and represents weight for height squared. A low BMI affects the individual's capacity to undertake "energy-demanding tasks" (Shultz, 1997: 148). This suggests that the relationship between diet and income may be cyclical.

> they nonetheless may summarise parsimoniously the cumulative repercussions of disease and nutrition on adult well-being and the quality of life"

It is difficult, then, to decipher the correct emphasis that should be given to diet. Nevertheless, even Stein (1997: 148) concludes that "[w]hatever the evidence, the provision of an adequate diet (the word adequate is poorly defined) is still considered to be necessary for health. And hunger, whether or not it has any long term effects on health, is personally debilitating, greatly affecting quality of life". Indeed, Graham (2003) notes that the production of food plays a significant role in indigenous people's lives in Cuyo Cuyo in Peru and, therefore, becomes central to the conceptualisation of their own states of health.

As noted above (Stein, 1997; Smith and Haddad, 1999) some Western health analysts maintain the importance of a diet not only adequate in quantity but also one that is sufficiently varied in order to avoid these health problems. How this "variety" should be constituted is questionable, as suggested by the constant media attention in the developed world given to changing Western scientific advice on what people should and should not be eating. For the purposes of analysis, the following section deals with the key foods available to the households of Amatenango. The aim is to establish to what degree, within the limits of these foods, a varied diet is achieved. The level of food security is also assessed by looking at the sources of these foods, and relating these to the variety in diet.

There is a quite remarkable degree of consistency in the diet of Amatenango households, as Table 6.6 reveals.

TABLE 6.6 TYPICAL DIET

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Tortillas and salt	1	1.0	1.0	1.0
	Tortillas and beans	79	79.0	79.8	80.8
	Tortillas, beans, eggs	1	1.0	1.0	81.8
	Tortillas, beans, fruit/vegetables	17	17.0	17.2	99.0
	Tortillas, beans, other	1	1.0	1.0	100.0
	Total	99	99.0	100.0	
Missing	System	1	1.0		
Total		100	100.0		

A total of 79.9 per cent (n=79) of the households in the questionnaire sample have a typical daily diet consisting only of tortillas and beans. The usual mid-morning meal of *pozol* is also included within this as it consists of the same basic ingredients in being the tortilla *nixtomal* mixed into water and salted. Only 17.2 per cent (n=17) of households include fruit and vegetables as a regular part of their diet and 1 per cent (n=1) eat only tortillas and salt on a daily basis. The following charts (Figures 6.12 to 6.17) indicate dietary intakes that may supplement this typical diet. These food stuffs are not meant to indicate those which may represent a balanced diet (given the debates over what this means) but do include the basic requirements of carbohydrate, protein, vegetables and fruit. As such, the variety of these foodstuffs can be taken as an approximation of a healthy diet, an indication of food security (see above), and of the overall income level of the household (given that many of these foodstuffs would have to either be grown in addition to the basic crops of corn and beans, relate to the possession of animals, and/or would be purchased).

FIGURE 6.12 VEGETABLE CONSUMPTION

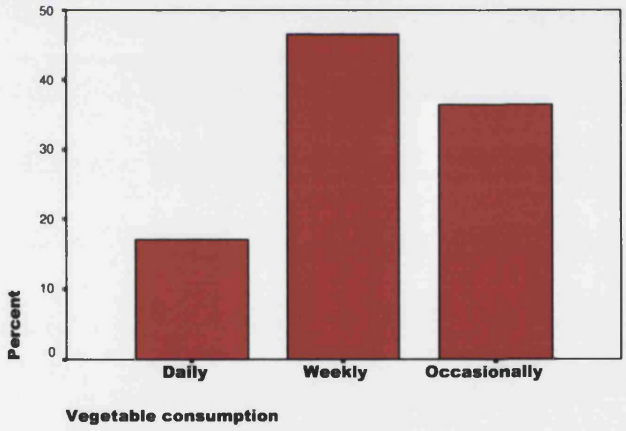


FIGURE 6.13 EGG CONSUMPTION

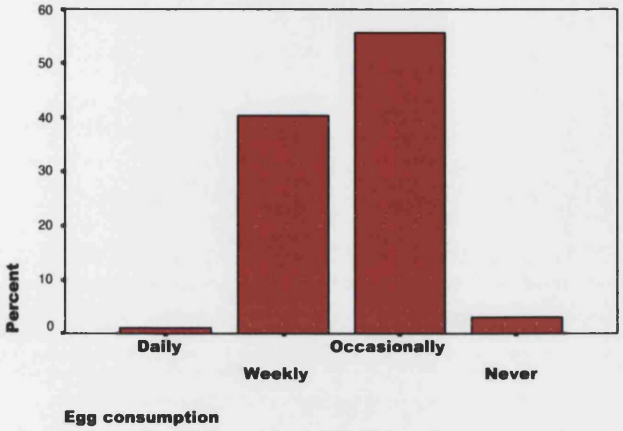


FIGURE 6.14 CHICKEN CONSUMPTION

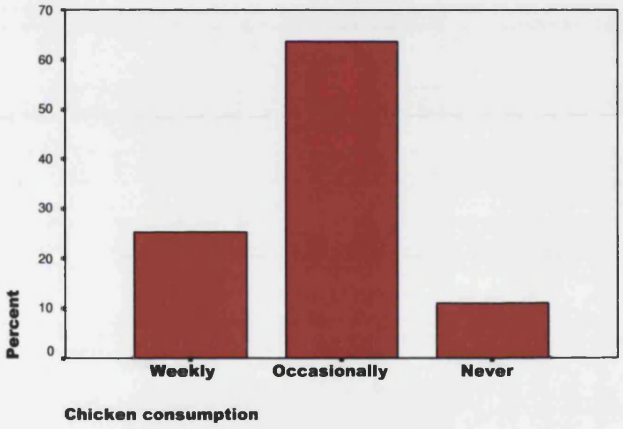


FIGURE 6.15 RED MEAT CONSUMPTION

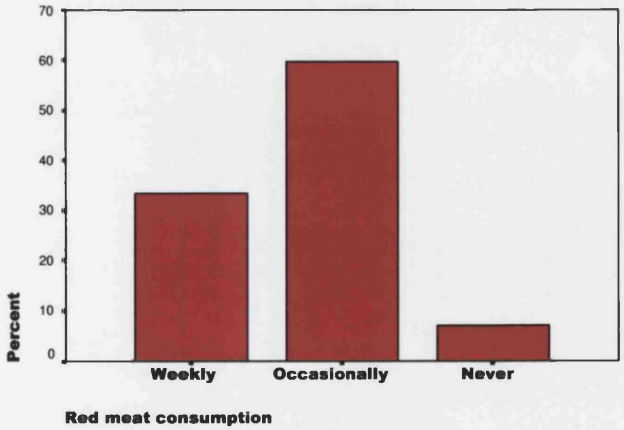


FIGURE 6.16 RICE CONSUMPTION

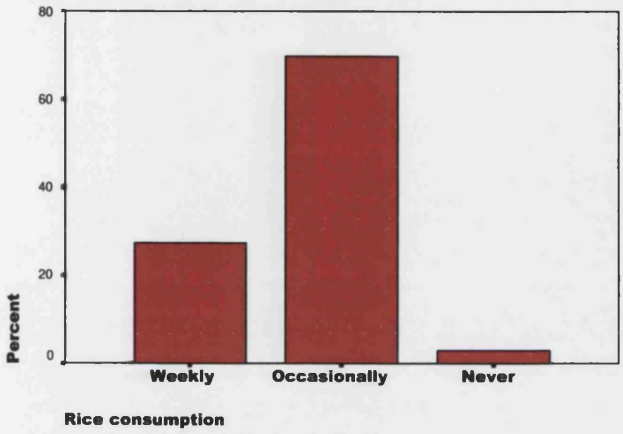
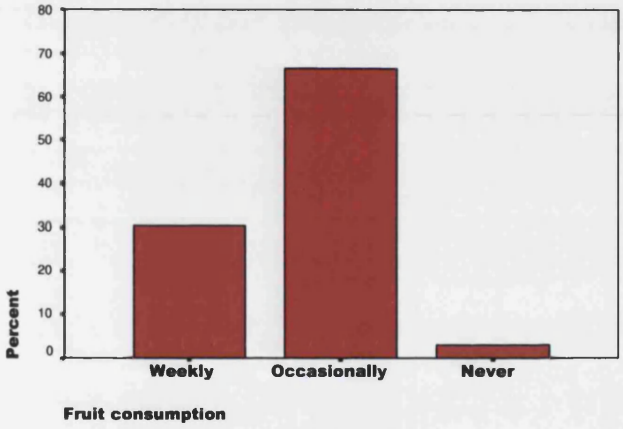


FIGURE 6.17 FRUIT CONSUMPTION



It is clear from these charts that, although foodstuffs may be incorporated on a weekly or occasional basis, tortillas and beans remain the daily diet for the majority of residents. As noted in the previous section, much male activity is agricultural and this work provides the subsistence diet of households, as the crops traditionally grown are corn and beans. The additions of fruit and vegetables tend to be either bought or are grown on the land around people's houses (as opposed to on *ejido* agricultural land). Red meat, chicken and eggs are also either bought or obtained from the few chickens and pigs that people keep on their property. The rice supplement is the only one that is not a possible subsistence food, as households do not grow rice crops. Therefore, rice will either be purchased or will be

provided as part of the school breakfasts that children often bring home.[4] The following chart (Figure 6.18) illustrates the sources of diet for households:

FIGURE 6.18 SOURCES OF FOOD

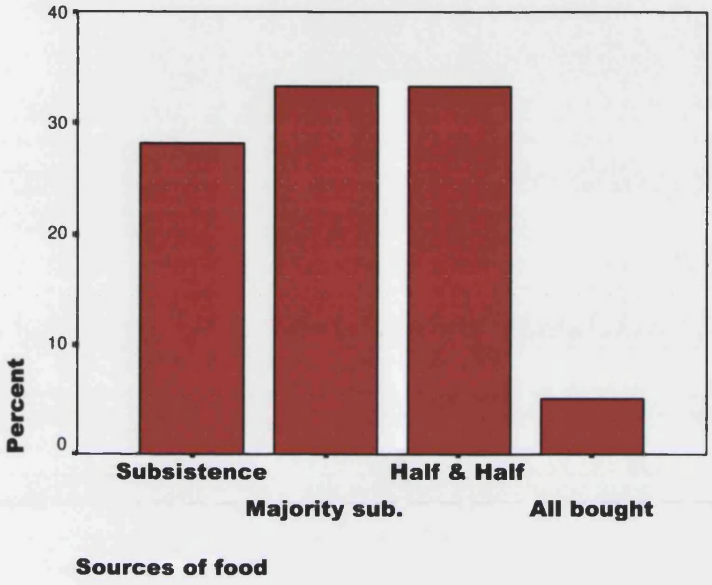


Figure 6.18 also reveals that two thirds of households buy in at least some of their food. Exactly equal proportions (33.3 per cent / n=33) state their sources of food to be majority subsistence or approximately half subsistence / half bought. A further 28.3 per cent (n=28) state that they are totally subsistent for their food and only 5.1 per cent (n=5) buy all of their food[5]. A cross tabulation of sources of food by typical diet offers further insight into this (see Table 6.7).

[4] These breakfasts are part of the provisions of PROGRESA. The rice dish may also include soya, although this generally seems unpopular (see Linkogle, 1998, for discussion of the role of soya in international food aid in Nicaragua).

[5] Sample size for this variable was 99, as there was one missing response.

TABLE 6.7 SOURCES OF FOOD BY TYPICAL DIET

			Typical diet					
			Tortillas & salt	Tortillas & beans	Tortillas, beans, eggs	Tortillas, beans, fruit/veg.	Tortillas, beans, other	Total
Sources of food	Total subsistence	Count	1	27				28
		% within Sources of food	3.6%	96.4%				100.0%
	Majority sub./some bought	Count		26	1	6		33
		% within Sources of food		78.8%	3.0%	18.2%		100.0%
	Half sub./half bought	Count		23		9	1	33
		% within Sources of food		69.7%		27.3%	3.0%	100.0%
	All bought	Count		3		2		5
		% within Sources of food		60.0%		40.0%		100.0%
Total		Count	1	79	1	17	1	99
		% within Sources of food	1.0%	79.8%	1.0%	17.2%	1.0%	100.0%

Table 6.7 indicates that 96.4 per cent (n=27) of those who are totally dependent upon the land have a typical diet of tortillas and beans. Interestingly, even 60 per cent (n=3) of those who buy in all of their food still live primarily on tortillas and beans. This not only suggests that these are the cheapest foods available but also that culture possibly plays a role in determining diet. However, the 40 per cent of those buying in all of their food who eat fruit and vegetables regularly represent the largest percentage of any group within sources of food to supplement their diet in this way (although the numbers here are very low with this representing only 2 households). This is followed by 27.3 per cent (n=9) of those who buy in half of their food having a typical diet that includes fruit and vegetables. None of those who are totally subsistent supplement their diet on a daily basis (other than with salt) from just tortillas or tortillas and beans. This suggests, unsurprisingly, that the poorest households with little or no disposable income also have the most restricted diet. It also perhaps indicates that egg, fruit and vegetable production is minimal and that either that which is produced is only enough for occasional supplements or that these food products must be bought.

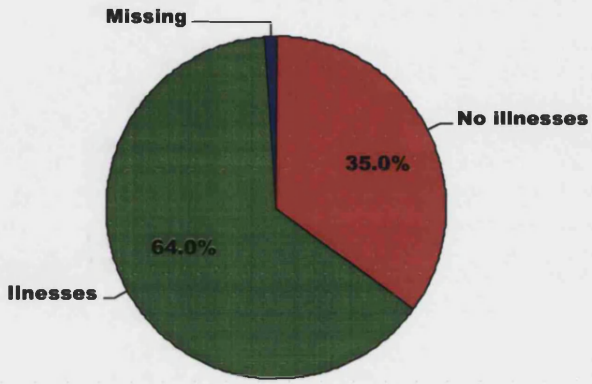
PERCEPTIONS OF HEALTH STATUS

Such quantitative analysis can illuminate factors that affect health and which contribute to constituting a health environment, which is clearly far from satisfactory in Amatenango, and, in turn, suggests that health status in general is poor. However, experiences of health and illness within this environment are individual because, as discussed in the first chapter of this thesis, the way in which people interpret their health is a subjective matter. For women in the community, "health" is a part of the reproductive role of women that extends into other areas of general community care (see Chapter Seven). This affects, and is affected by, the ways in which women perceive "health and reproduction" in terms of their own states of health and those of other family and community members. The role of women as health carers makes it particularly important to understand their own conceptions of health. Therefore, rather than relying upon official statistics which are often guided by predetermined categories and priorities, this thesis is concerned with the women's own perceptions of health issues and the following discussion deals with these perceptions.

Self-reported illness

Women's perceptions of their own state of health and that of others were generally reflected in whether or not they reported any illnesses. During the survey, women were asked to report illnesses suffered by different family members during recent years. Those who did not report any illnesses were those who claimed that "*estoy bien*" ("I'm fine") or "*no tenemos enfermedades*" ("we don't have any illnesses"). Figure 6.19 indicates the proportions of those who, in this and similar ways, figured amongst the "healthy" and those who did report illnesses to be experienced by women of the household.

FIGURE 6.19 WOMEN REPORTING ILLNESS



Using the non-reportage of illness as a proxy for a self-assessment as "healthy", the above reveals that only slightly more than one-third consider themselves and other women of their households to be healthy. Almost two-thirds report recent episodes of ill health. For many of the women whom I interviewed, ill health appeared to be regarded as an unavoidable fact of life. Trying to obtain meaningful answers as to the deciphering of which particular groups in their own society and those of non-indigenous societies were more susceptible to ill health or more likely to maintain good health often proved difficult. This suggested that identifying factors in ill health was not a general practice or, if it was, it was not a conscious one. The latter is perhaps more likely, as in other more informal conversations, indirect commentary about the health of others was forthcoming.

Obtaining information about specific illnesses was also difficult, if not totally impossible, as illness is often partially understood within a different knowledge system, central to which are the concepts of witchcraft and envy. Women, therefore, would either not know or easily forget the bio-medical names of the illnesses although they would be able to describe the symptoms proficiently. Such symptoms are represented in Table 6.8. The questionnaire did not include a pre-determined list of symptoms and, therefore, those represented here are direct translations of those mentioned autonomously by the women.

TABLE 6.8 REPORTED SYMPTOMS (WOMEN)

Category Label	Count	% of Responses	% of Cases
Fever	36	38.3	57.1
Cough	8	8.5	12.7
Diarrhoea	10	10.6	15.9
Headache	9	9.6	14.3
Pains (body/bones)	15	16.0	23.8
Influenza	5	5.3	7.9
Stomache-ache	5	5.3	7.9
Other	6	6.4	9.5
Total Responses	94	100.0	149.2

Clearly, fever receives the most number of mentions at 38.3 per cent (n=36). This is followed by "pains", noted to be suffered in either the body or the bones by 16 per cent (n=15). Both of these symptoms could be accounted for by bio-medical explanations of disease and the effects of daily physical activities (such as fetching firewood). However, more spiritual explanations could also provide reasons (see below). The symptoms of coughs (8.5 per cent / n=8) and diarrhoea (10.6 per cent / n=10) are perhaps more likely explained by biomedical explanations which relate respiratory disease and diarrhoea to poor living conditions, inadequate diet and poor hygiene (Ruel et al., 1999; WHO, 2003).

Perceptions of factors governing ill health

Deciphering factors governing relative susceptibility to ill health proved a difficult task (see Greenway, 2003, for similar difficulties experienced in rural Peru). However, when pushed for answers in the formal interviewing situation to direct questions ranging from, for example, "Who gets ill more often, men or women?" or "Do old people get ill a lot?" to the extreme of suggesting possible reasons for ill health and asking for agreement or disagreement with the statement, some analysis on this basis was eventually given. Such direct questioning with suggested answers may not be an ideal way of obtaining such data. However, the replies revealed an understanding of some of the factors at play in health as they are conceived in Western terms. In particular, the role of poverty and the hard lifestyle imposed by it were identified, often contrasted with spiritual explanations depending upon

the person concerned and the precise circumstances of illness. María (3), for example, was prompted to give her evaluation of the factors involved in ill health:

> "Q: And those who are old, they get ill a lot?
> M: Those that are really old, they get ill because of their age now, not because of *daño.*[6]
> Q: Because of so much work?
> M: Yes.
> Q: Do people work a lot here?
> M: Yes, when they go to work early in the morning, to check the *milpa*[7], then they return at five or six in the afternoon. If it is near, they leave at seven and then they return at lunchtime.
> Q: And the women?
> M: They stay cooking, washing or mending clothes...
> Q: And people from here, do they get ill more than people from other places?
> M: Yes.
> Q: Because of the work?
> M: Yes.
> Q: Because they don't have food?
> M: Yes, because sometimes they don't have beans, they don't have corn..."

Another María (4), a 24 year old mother of two, also indicated that poverty and the hard life style needed to survive means there is more ill health in Amatenango than in other areas:

> "We carry the firewood, when we fire the pots, the heat...There are places where they don't get ill but they don't do anything. Here everyone works a lot."

Teresa similarly claimed that "people here get ill more often than in Teopisca". Although she pointed to the factor of there being more witchcraft in Amatenango than in Teopisca, she also indicated the contributing factor of "so much work" because "life is hard".

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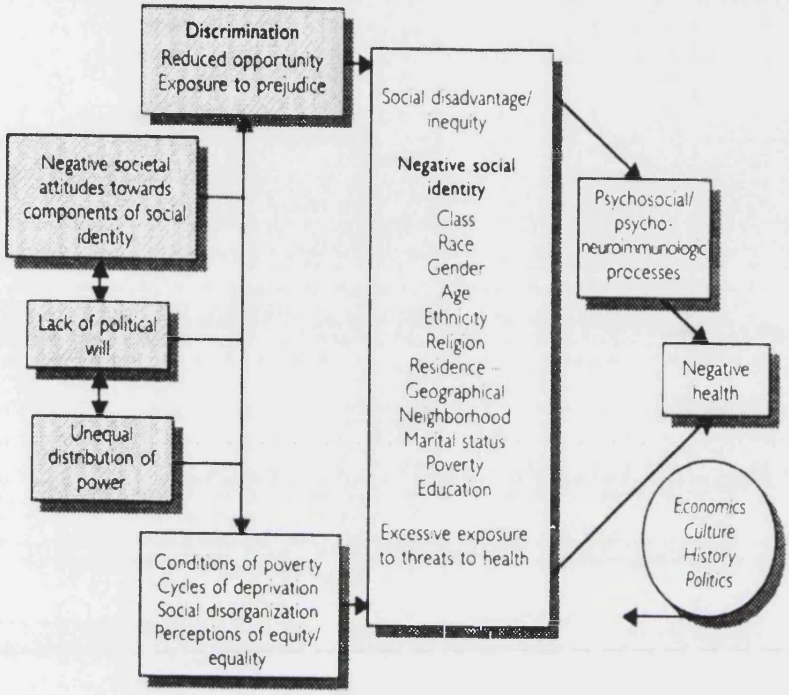
[6] *Daño* literally means damage but, in Amatenango, is used to signify damage to the spirit by witchcraft.
[7] Corn field

This assessment of health status echoes the importance given to socio-economic status in the analysis of the health environment above. Specifically, this identification of the role of poverty in ill health is present in Stein's work (1997) on factors affecting women's health. She discusses, amongst others, factors such as geography and climate, local environmental conditions, work conditions, population and fertility control, gender-based violence, the organization of society, social disadvantage and poverty as potential risk factors. Stein closely relates the factors of social disadvantage, and poverty in particular, in a cycle that would fit well under the umbrella term of "social exclusion", although she does not refer to it as such. She comments that "[p]overty is also closely related to other aspects of social disadvantage such as race, ethnicity, gender, age and residence" (ibid.: 135). She refers indirectly to the subjective nature of health, and its relationship to social exclusion, in stating "much of the research on poverty and health has been more concerned with the internalisation and perpetuation of long-term poverty" (ibid.: 137) and that:

> "Oppression and social marginality reduce both one's adaptability and the available social supports, thereby increasing susceptibility in a non-specific manner that leads to many different diseases and illnesses" (ibid.: 138).

She relates this directly to "social organisation" and to what she terms "negative social identity" (see Figure 6.20). This theory is developed in the context of North America and does not emphasise the culturally subjective interpretation of illness. Also, it does not fully illustrate the complex relationship between health, reproduction and identity that is the focus in this thesis. Nevertheless, on a general level, it is a useful paradigm for understanding the multiple factors that influence health.

FIGURE 6.20 NEGATIVE SOCIAL IDENTITY AND HEALTH STATUS DIAGRAM



(Source: Stein, 1997: 141)

Many of the factors to which Stein alludes were indeed mentioned by my respondents, particularly the role of relative poverty and disadvantage. Many women indicated that old age resulted in vulnerability to illness. Teresa and María, like the majority of interviewees, also referred to the role of geography in health, comparing their health to that of people from other areas. Both of the factors of geography and poverty implicate ethnicity in particular and social disadvantage in general as factors influencing their state of health.

GENDER DIFFERENCES IN HEALTH

Gender roles and poverty

Stein's focus is particularly upon the role of gender disadvantage in health. Quantitative data from the household survey does demonstrate some difference between levels of reported illnesses for women than for men (see Table 6.9).

TABLE 6.9 HEALTH ASSESSMENT DIFFERENTIATED BY GENDER

			No women's illnesses		
			No reported illnesses	Reported illnesses	Total
No men's illnesses	No Reported Illnesses	Count	32	17	49
		% within No men's illnesses	65.3%	34.7%	100.0%
		% within No women's illnesses	91.4%	28.8%	52.1%
		% of Total	34.0%	18.1%	52.1%
	Reported Illnesses	Count	3	42	45
		% within No men's illnesses	6.7%	93.3%	100.0%
		% within No women's illnesses	8.6%	71.2%	47.9%
		% of Total	3.2%	44.7%	47.9%
Total		Count	35	59	94
		% within No men's illnesses	37.2%	62.8%	100.0%
		% within No women's illnesses	100.0%	100.0%	100.0%
		% of Total	37.2%	62.8%	100.0%

Here, 62.8 per cent (n=59) of women report that illness is experienced by themselves or other female members of the household, as opposed to 47.9 per cent (n=45) of male household members who are reported to experience illness episodes. This 14.9 per cent difference may be due to that fact that the female figure includes self-reported ill health, rather being composed entirely of perceptions of other's experiences (for the men). However, the evidence from the interviews does not indicate a propensity to underplay male illnesses in comparison to female. Although Larme and Leatherman (2003) report that reproductive stress and gender related household tasks place a significant strain on indigenous women's health in the southern Peruvian highlands, this was not borne out in the perceptions of women in this study. Indeed, for the majority of my interview respondents, gender differences in health were perceived to be less marked than the non-gender specific factor of poverty.

Most women suggested that gender roles in household labour placed an equal burden upon the physical state of men and women. María (3) stated that the content of work is different but that the effect on health is the same:

"Q: Do men work more than women?

> M: The same. We are in the shade, cleaning the beans, grinding the *pozol*,[8] washing, sewing, and they are in the heat.
> Q: Do men get ill more than women?
> M: Both of them get ill."

Carolina, like the majority of women, also claimed that "Men get ill the same as women", although for her reasons were less connected to poverty and work patterns but illness was a result of there being "bad spirits and good spirits".

However, Josefa, an older woman, claimed that women get ill more than men. She did, however, dismiss the idea of a difference between married and unmarried women in terms of health:

> "Q: Do women get ill more than men or the same?
> J: Women get ill more.
> Q: Do married women get ill more than single women?
> J: The single ones get ill the same as the married ones. Look, my daughter has this rash. . . ."

Josefa did not give reasons for her assertion that women get ill more than men. Micaela, in her twenties, however, agreed stating that she did not really know why but "perhaps it is because of the blood, we are weaker", referring to women's menstruation rather than workloads. She, therefore, naturalised gender differences in illness rather than referring to socially constructed factors, such as the gendered division of labour.

Changes in the gendered division of labour, particularly in the increase of men becoming involved in the collection of firewood, may, in fact, be having positive effects on women's health. Firewood collection can take half a day and is heavy work. Headaches were a frequent complaint amongst women, noted by 9.6 per cent (n=9) of women (see Table 6.8). This may be a result of carrying bundles of firewood with a strap across the head. However, as Figure 6.21 indicates this task is now less strictly gendered and more men are undertaking this responsibility, with 55.2 per cent (n=48)

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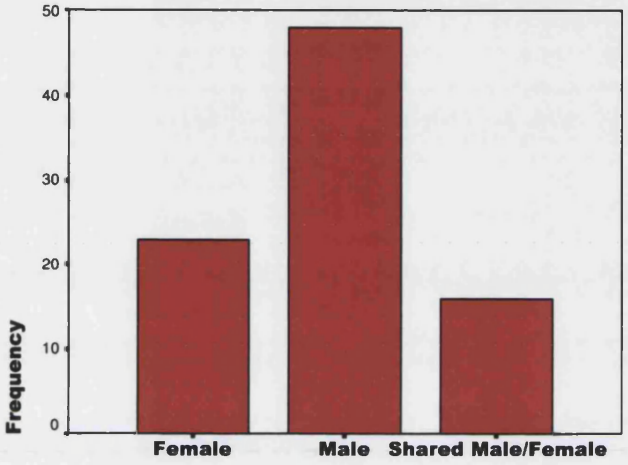
[8] A drink made from ground corn and water, drunk with salt and chillies. In other areas of Mexico and Central America, there are sweet versions made with sugar.

stating that firewood is collected by the male members of the household, 26.4 per cent (n=23) stating this to be an exclusively female task, and 18.4 per cent (n=16) stating that it is shared between both male and female members of the household.

FIGURE 6.21 COLLECTION OF FIREWOOD BY GENDER



Other frequent complaints, such as eye strain and backache, may also result from more specifically gendered tasks, such as the production of pottery, which involves close work in often poor light and sitting on cold floors for long periods of time. None of the respondents themselves, however, identified these as factors. Cooking over floor level open fires in kitchen huts with poor ventilation is likely also to have a detrimental effect on eye health and cause respiratory problems as well as being a factor in the back problems mentioned above. Some of the younger women who had been advised by the *promotoras* to redesign their cooking facilities recognised this to a certain degree. However, they did not specifically comment on this as a women's health issue. There has been much research on the impact of women's social reproductive work upon their health, particularly in situations of poverty (see, for example, Chant, 1996; Gómez-Gómez (ed), 1993; Oxaal with Cook, 1998; Stein, 1997). The lack of emphasis upon gender in this case perhaps indicates that women wished to particularly emphasise the

role of poverty and the marginalisation of their ethnic group as a whole rather than fragmenting this experience by gender.

Aside from the odd comments regarding menstruation, such as that of Michaela, the reproductive stress on women was scarcely noted in direct questions focussed upon gender differences in health. As a worldwide phenomenon, however, reproductive stress has been shown to combine with the effects of poverty, leading to problems such as chronic anaemia, for example, which in turn is associated with maternal mortality as well as affecting women's quality of life and capacity to work. Gueri et al. (1993) note that the prevalence of anaemia in pregnant women in Latin America is one of the most serious nutritional problems and that 13.8 per cent of non-pregnant women between 12 and 49 years of age in Mexico had haemoglobin levels lower than 12 g/dl in 1990. Women's health, particularly at an "objective" as well as a subjective level, represents an accumulation of lifetime's experiences (Smyke, 1991: 3) and this was indeed represented in my data, with the frequent comments about the difficulty of life in Amatenango. When prompted by direct questioning about reproductive experiences (as discussed in Chapter Eight), women were forthcoming in giving details about problems. However, this was not brought up when questioned about general and comparative "health" issues. Therefore, whether the accumulation of lifetime experiences and its impact on health is recognised by women to be differentiated by gender is debatable.

Alcohol, domestic violence and health status

Drink, and associated problems of alcoholism, was one gender difference in health that was frequently remarked upon by women of all ages and status. It was, without doubt, the most commonly attributed cause of death for men given by women amongst the interview participants. For example, Teresa, a widow whose late husband's heavy drinking habits are described in Chapter Seven claimed that he had eventually died "because of the drink". Josefa, a forty-three year old married woman, also commented that, "My brother killed himself. He drank a lot of *aguardiente* and he died" and later attributed the exactly the same cause to the death of her younger sister's husband.

Conversely, however, the physical problems women may suffer as a result of domestic violence (often the consequence of alcoholism) were rarely remarked upon. The exception was in one extreme case that happened to one of my interviewees whilst I was there. Luisa, the mother of the family with whom I stayed, described the over-zealous nature of the beating and indicated that it was criticised outside of the family. Despite the fact that the beating was not condoned, Luisa did qualify her criticism by stating that it was María (1)'s "crime" as she had not prepared her husband's supper upon his return from the fields. However, the mother of the victim, María (2), a fifty-three year old married woman, also described what had happened. She not only gave a different version of events but also was clear that no blame should be laid with her daughter:

> "...It's now been four times that my daughter has left him, with what she is putting up with. He beats her a lot...when they made my son's house, he beat her near the corral. She went there with his lunch as she had been given chicken to eat at night. She took it to him and found him in the corral and he beat her. She came here with her nose dented, the swelling went down and she left with her face all bruised.
> Q: So she left here?
> M: Yes, I had her here and I told her, "Don't leave. Let him die of hunger, the *maldito*".[9]

I had interviewed María (1), the victim of the beating, on an earlier occasion, and although she had alluded to being hit by her husband, she was not as vocal as others. The subject was perhaps too sensitive for her to speak about with ease but her lack of emphasis upon violence, despite obviously being a frequent victim, may also reveal a certain element of shame and guilt for not completing her tasks as she felt she should, especially as others had criticised her for not doing so.

Domestic violence has come not only to be recognised as a clear issue of human rights for women but also as a health issue (see Ramirez et al, 1997, for discussion in the Latin American context; also see Chant with Craske, 2003). Aside from the actual physical injury caused, it has long-lasting psychological and physical effects. In discussing the

[9] Evil person.

failure of medical institutions to adequately deal with incidents and victims of domestic violence in the North American context, Wilkerson (1998:129) details these effects:

> "...battered women have long been known to experience the physical manifestation of chronic stress, such as "severe tension headaches, stomach ailments, high blood pressure, allergic skin reactions, and heart palpitations...along with anxiety and depression. A woman's body manifests the daily assaults on her sense of self through chronic tensions and anxiety, prompting her to seek a medical remedy that may be her only safe outlet for addressing the multiple harms, medical or otherwise, that the batterer inflicts on her."

Kristeva's work on the sacrificial subject reveals how "women's lives are shaped by and always are vulnerable to violence (Reineke, 1997: 12) in a "typology of violence whose nuances attend to sexual difference". Psychoanalysis relates the experience of violence to the biological essentials of sexual difference. This, and Kristeva's work formulated on its basis, is inherently disruptive to the feminist project in the rejection of social constructivism, particularly in the claim that "Violence is enacted as matricide" (ibid.: 84). In privileging sexual difference, it is also transcultural and transhistorical. Therefore, it naturalises a theoretical perspective on gender that is formed out of Western philosophical traditions.[10] The precise manifestation of the psychological and physical effects, which Wilkerson discusses above, will be different in each context due to the subjective experience and interpretation of health, particularly according to culture. However, perhaps we may at least go along with Kristeva's categorization of the "sacrificial" nature of violence in saying that it is logical that persistent subjection to violence will damage the self-esteem and physical well-being of women, however varied the precise cultural reasons for the violence and the multiplicity of experiences and articulations resulting from it. Domestic violence, then, or "gender violence" as it is often referred to, is one of the most clear cut ways in which health can be related to gendered identity. It is violence related to gender roles, control and power relations. Through it, we can see how it reflects these and also how it affects them: an effective policing method of the status quo through damage to health, both physical and mental.

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[10] See Chapter Seven for related discussion of the Western philosophical tradition of private and public spheres and the use of such a paradigm in gender and development interventions.

TRADITIONAL BELIEFS RELATING TO HEALTH STATUS

This discussion illustrates that the causes of illness are not assumed to be simple or unitary by the women of Amatenango. The intersecting roles of poverty, related lifestyle and environment, as well as violence, are implicit in understandings. However, other explanations related to the belief in witchcraft and *envidia* are also commonly given for the occurrence of illness (see Miles and Leatherman, 2003, for related discussion of the relationship between socio-economic realities and cultural identities in medical practices and beliefs throughout Latin America).

Often allusions to such factors involved in sickness were slipped into interviews alongside mention of factors related to poverty, life-style and other factors from the health environment. Some of the participant's explanations already included in this chapter have made reference to such multiple understandings of the reasons for ill health. For instance, Teresa mentioned the existence of witchcraft alongside the influence of "hard-work". Equally, María (3) noted that "Those that are really old, they get ill because of their age now, not because of *daño*". The latter suggests a differentiation between reasons for ill-health depending upon age as younger people are less likely to suffer as badly from the effects of accumulated hard-work and poverty and so are more likely to be considered to have been victims of witchcraft. The existence of these spiritual explanations for sickness may also explain why participants did not differentiate levels of ill health on the grounds of gender. Clearly defined gender roles suggest different health status because of differing health related behaviours of men and women from a Western health perspective. However, there is no reason to suggest that men or women would be more or less affected by witchcraft.

The balance and particular relationship between the "health environment" as analysed above and spiritual understandings of sickness is by no means universal or consistent. For some, illness is far more related to spiritual phenomena than to the socio-economic health environment than for others. This appeared not to be linked to age or socio-economic status. As noted earlier in this chapter, Carolina's understanding of illness made no mention of a connection to poverty at any level. This is ironic given that her

particular condition of chronic anaemia (as diagnosed by the local clinic) would be most clearly linked to her extremely poor living conditions (and particularly a poor nutritional status) from a Western biomedical perspective. Nevertheless, her explanations of illness were solely related to witchcraft:

> "Because of people's *envidia*, if someone has money or other things...When the people don't like you, they put a spell on you."

Similarly, the older Marcelina attributed her husband's death to witchcraft:

> M: His belly swelled up.
> Q: Was he ill for a long time?
> M: Just one day with the *mal*[11].
> Q: You didn't go to the doctor?
> M: We didn't have time, just one day
> Q: Nor for the *curandero?*
> M: No, because of the *brujeria*[12]
> Q: Did you know who did it?
> M: No
> Q: Does it happen a lot here?
> M: Yes, here there are people who do it.
> Q: Why do they do it?
> M: Because of *envidia*...
> ...Q: How do they do it? Do they go to the *brujo*[13]*?*
> M: Yes, and they do it to the spirit.
> Q: Everyone has a spirit?
> M: Yes, everyone.

María (2) understood her daughter's death in the same way:

> "Because of *envidia.* Just for having a little corn, beans, a horse...That's why they did it. They put a spell on her stomach. Her legs swelled up from the top. Then there was the cough and the headache. And the pain when she urinated. She would go to the toilet and there she would scream with the pain. We took her to the *curandero* and he told us that it wouldn't pass, that her spirit was being eaten."

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[11] Spell.
[12] Witchcraft.
[13] Witch (here in the masculine)

There were few who totally dismissed explanations of illness based to some degree or other upon ideas of witchcraft and damage to the spirit. However, one of the younger respondents of the survey had remarked that she did not believe in anything related to the activities of *curanderos.* She was training to be a *promotora*[14] with the local clinic (and, unfortunately, did not want to be interviewed in-depth). María (3), who had previously expressed some kind of belief in *daño,* also registered some doubts about the explanations of illness given by *curanderos*:

> "Q: What do the *curanderos* say?
> M: That it is not good, that we have had spells put on us. That's what the *curanderos* say, but I'm not sure if it is that. I don't believe it much...there are many who do believe, but I go to the clinic and there I get better...
> ...Q: Why do you think people get ill?
> M: I don't know. Because we work a lot, the women, the men."

Some, like Carolina, were totally convinced by spiritual explanations. Most, however, fell somewhere in-between and accepted the influence and explanations of Western biomedicine whilst maintaining more spiritual beliefs connected to witchcraft.

Specific explanations of precisely how illness occurred through witchcraft were difficult to ascertain and, here too, there appears little consistency in level or content of belief in spiritual matters (see Greenway, 2003, for discussion of how conversations about illness in rural Peru were rarely as she had expected them to be). For example, Evangelina described an instance when she had become ill after her marriage. Her knowledge of the reasons for the illness was connected to the absence of her spirit but her precise knowledge of how and why this had happened was sketchy. She appeared to have directly gleaned the information from the *curandera* at the time of her illness, rather than having prior complete knowledge of her spirit and its connection to illness:

> E: "I was ill...when I got married and came to live here... The illness got hold of me. I had a lot of fever and cold. I had a lot of pain around my waist and I couldn't walk.

[14] Health promoter

Q: And were you like that for a long time?
E: Yes, about two months. Then I got better, I was cured.
Q: Did you go to the clinic?
E: No, just here with the *hierberos*.
Q: Here in Amatenango?
E: Yes, the *hierberos* cured me, and so I got well but after two months I got ill again. So the *señora*[15], Cecilia, came from just over there. She knows how to cure. She is a *partera*[16] but she also knows how to cure.
Q: What did she say?
E: That it was because my spirit was still in my house. So she brought it here.
Q: Your spirit is part of you?
E: Yes, I think so. She said that it stayed where I was born and it had to come here.
Q: What did she do to bring your spirit?
E: She called it over with the leaves. From "Chau", that's what she called the green lotion that she blew onto my clothes.
Q: And when your spirit came here, you got better?
E: Yes."

Similarly, María (1) noted that:

> "*curanderos* cure the spirit. They do the candles for you and they sweep you. Then it will return and everything will be fine."

María (2) also connected illness to the absence of the spirit but, for her, the spirit leaving the body was a normal occurrence. Problems occurred from the malevolence of others when the spirit was separate from the body:

> "As the spirit leaves the body when we sleep, those that know how can do damage to it then. They do witchcraft and beat the spirit".

In an explanation corresponding to that of María (2) and Evangelina, Carolina, who had clearly linked illness to other people's envy, stated that "the curanderos cure you of *espanto*[17]...they bring your spirit back if it is very far away". However, she later contradicted her own explanations as she stated at another point that "I don't have a spirit

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[15] Lady
[16] Traditional birth attendant / midwife
[17] The notion of *espanto* literally means fright (to the spirit) and is commonplace not just in Amatenango but in many parts of Mexico and Latin America (e.g. see Greenway, 2003, for evidence from Peru).

and neither does my husband, only the places". Confusingly, she also talked about the existence of good and evil spirits unconnected to the body:

> "There are good and bad spirits. There are spirits in the places. They do ceremonies to cure the house. You buy drink, candles and a live chicken. My house is not cured. That's why the demons come in – you can see them in the night."

Despite these contradictions and differences, certain trends of explanation for specific illnesses do occur. Fever is frequently explained by the spirit being in cold water or being exposed to heat or fire when separated from the body as a result of witchcraft. Carolina gave a similar explanation, also relating headaches and pains in the body to witchcraft:

> "You know if they are putting a spell on you because it feels like your skin is being pricked, you get fever, headache and pains in your body"

The different symptoms noted by women (see Table 6.8) can be accounted for both by Western explanations of ill health and by traditional spiritual explanations. In particular, the existence of understandings of physical damage caused to the wandering spirit may be related to the high level of reportage of the incidence of fever and pains (see Table 6.8) (see Greenway, 2003, for discussion of the significance of "soul loss" in Peru).

Whatever the precise depth and content of belief, the widespread nature of belief in ill-health being ultimately a result of more fundamental damage than provided by Western medicine's body-based explanations was evidenced in the frequent remark that *curanderos* or *hierberos* would be resorted to "*si no funciona la clínica*" (if the clinic does not work). The implication was clearly that the *curanderos* were more effective than the services provided by the clinic. Subsequent discussions, which then related ill-health to some version of spiritual damage or *daño*, suggest that biomedicine is considered to have only a superficial knowledge of ill-health (see Greenway, 2003, for similar findings from Peru). Finkler (1994) refers to biomedicine's distinction between "signs" and "symptoms" in a manner which privileges Western biomedical practitioners" comprehension of the body above that of the patient. Here, this distinction is disrupted as the symptoms are

considered to be the sole realm in which Western biomedicine operates. The underlying "sign" is different from that understood by secular Western science. In the latter, the sign relates to complex functioning of the physical body, which cannot be understood by the uneducated patient but which can be investigated and cured through positivist investigation and resulting medical techniques. However, here the sign relates to the unseen spirit and, therefore, requires a spiritual investigation and cure (Greenway, 2003).

The distinction between the sign and symptom also perhaps relates to the multiple causes of ill health noted by participants. When a symptom is present, it may be that it is entirely caused by the socio-economic health environment or other related factors, such as age as mentioned by María (3). Therefore, Western medicine will be called upon to relieve the symptom. However, when it does not work, the other, more fundamental and spiritual sign is investigated.

It is perhaps difficult to see how it is possible to believe in both socio-economic causes of illness as well as these more spiritual beliefs. However, even within Western conceptualisations of ill health, multiple explanations of illness often occur. A clear instance is that of the common cold, noted both to be "caught" from other infectious sufferers, to be caused by exposure to damp or cold conditions and to result from stress which is "proven" to lower immunity to opportunistic infections. There is also increasing use of "alternative" medicine in the West. Although much of the latter is based in entirely different conceptualisations of the functioning of the body, many people combine the use of such treatments with biomedicine. In the Western world, we manage to align these contradictions so it is perhaps unsurprising that other cultures can do the same. Indeed, examples of this abound. For example, Crandon (2003) discusses the ways in which "modernisation" in rural Bolivia has led to the influence of indigenous medicines on Western medicine and *mestizo* peoples, as much as vice-versa, and that the multiple explanations generated serve as "mechanisms" for understanding complex social realities.

Indeed, to some extent, the integration of Western and traditional notions of symptom and illness has been effectively achieved in Amatenango. The external symptom may be

caused by conditions of life and be treated by Western biomedicine, while more serious conditions and / or the underlying cause (or disease) have other spiritual explanations, which can only be cured by the healing methods of the *curandero*. This is not to suggest, however, that explanations are not frequently contradictory. As with the average layperson's grasp of biomedicine throughout the world, knowledge is seldom complete and contradictions often occur. It would be illogical to expect that other cultures manage to achieve a more integrated and comprehensive picture of health and sickness. Therefore, multiple explanations of ill health based both upon the Western influenced understandings of a socio-economic health environment as well upon more spiritual beliefs are perhaps to be expected.

CONCLUSION

Analysis of the health environment in Amatenango reveals a community marginalised by poverty whose residents are unlikely to have positive experiences of health. Precise analysis of health status is difficult without resorting to data on the incidence and prevalence of illness and disease categorised by Western biomedicine. However, the subjective health status of the women of Amatenango – their own perceptions of their states of health and those of members of their families – are more important from the perspective of holistic understandings of health. These perceptions reveal that women themselves relate their poor health to experiences of poverty and marginalisation, and associated survival strategies, as well as to cultural understandings based upon the spirit and witchcraft. These multiple definitions indicate that individual cultural experiences of health are not always those that can be easily accounted for by Western analysis alone. However, they are not necessarily dissimilar to the contradictions that exist in the developed world, where expanding choice in terms of health knowledge has led patients to adopt and adapt competing discourses.

The negative health status of women in particular, as suggested by Stein (1997) may also be related to their gender roles, activities and identities. Although the women of Amatenango registered a greater degree of ill health to be suffered by women than by men in quantitative

terms, they generally refuted this differentiation in interviews. The influence of alcohol as a factor in male mortality was the only exception to this but the related issue of domestic violence was discussed only indirectly. Rather than emphasising gender differences, women preferred to concentrate upon the non-gender specific factor of poverty and the hard work this implied for both men and women. Chapter Seven, however, attempts to delve deeper into women's roles, particularly discussing the shaping of marriage and roles within the family. Discussion of these roles not only further illuminates the particular health environment for women in Amatenango but is also the basis for understanding women's identities as mothers and their subsequent role of health carers, both within the family and the community.

CHAPTER SEVEN

GENDER IDENTITIES, SOCIAL REPRODUCTION AND HEALTHCARE

INTRODUCTION

The previous chapter illustrated how the social and economic marginalisation of indigenous peoples in Chiapas has resulted in a health environment characterised by poor (and insecure) diet and living conditions in the particular community of Amatenango. Women themselves revealed their own interpretations of the effects of this environment on their health status and noted the interrelationship of these effects with more spiritual explanations of ill health. In this chapter, this health environment and subsequent health status are placed in their gendered social and cultural context as the role of women in caring for the well being and health of their families and their negotiation of the differing health services available is discussed. The theoretical basis for this is that "illness episodes must be understood in the broader context of human relations, communities and politics" (Lock, 1999: 43). For women in particular, health care responsibilities result from constructions of gender identity and the roles that express this identity.

For indigenous women in Chiapas, as in many others areas of the world, gendered identities are centrally formulated around their identities and roles as wives, mothers and family carers. The health care of others in their family and community is part of these social reproductive roles. I discuss here the institutional practices and customs through which such roles come to be defined in this cultural context by firstly looking at conventional, and changing, practices of marriage (an important and particularly gendered rite of passage into social reproductive roles) and, secondly, at gender roles in the family after marriage. Particular space is devoted to the subject of domestic violence, not only because it is a widespread phenomenon in the community but also because its practice has been highlighted by feminists as marking the family as a site of oppression for women and because it clearly defines gendered spaces and roles (as well as being an important consideration in women's health, as discussed in Chapter

Six). I discuss how we might understand both domestic violence and the gendered division of labour in differing cultural contexts and specifically in this context. The application of the public/private paradigm is interrogated and redefined, in order to be able to focus on the social reproductive roles of women as caretakers of health. In the private sphere, these roles include women's general care for their children's well being and their choices of health care for their family, particularly for their children. The extension of such "caring" roles to the public sphere sees women as *curanderas* (traditional healers) and *parteras* (traditional midwives) as well as biomedical health assistants in taking up *promotora* responsibilities for the local clinic.

MARRIAGE CUSTOMS

Ethnic continuity and tradition

Marriage in Amatenango, as in the majority of indigenous communities in Chiapas, tends to follow a traditional pattern, although this pattern is changing somewhat in recent years. As such, it is particularly revealing of the processes by which young girls come to be defined into their adult social reproductive roles and, therefore, subsequently how they come to be identified as health carers by association with the caring responsibilities of motherhood. In Amatenango, family and community pressures associated with marriage and the restrictive nature of marital practices mean that such responsibilities can be non-negotiable.

The two eldest daughters of the family with whom I stayed, Nicolasa and Juana, explained how marriage worked within their traditions and stressed how "different" these were to those of other cultures. They felt this was an essential step in my process of understanding life in Amatenango. One evening they sat me down in front of the fire in the kitchen to undertake the lengthy task of explanation, at times with certain embarrassment but with great enthusiasm, as they competed with one another to tell the various stages of the year leading up to marriage. Obviously their fascination with the subject related to their age and stage in life, as Nicolasa (aged eighteen) and Juana (aged fourteen) were on the verge of adulthood. Marriage symbolises this rite of passage and the procedures and traditions involved reveal

much about the purposes of marriage and about dominant perceptions of women's roles and status.

Traditionally, marriages are arranged between the proposed husband (usually with his parents) and the father of the proposed bride without consultation with the young woman. There are certain customs to be followed by the young man, and/or his father and mother, who "ask" for the daughter. These include the payment of monies and gifts to the girl's family in the form of a "bride price". The payment, as well as this ritualised procedure of marriage, dictates certain expectations about the identity and roles a woman should fulfil both as a daughter and as a wife. This often happens at a young age (in her early to mid teens), and therefore, the young woman is left little space for adolescence, passing directly between these two roles. In both, her life is traditionally decided by key male figures. According to custom, then, women are constructed as passive and dependent members of society clearly located within the conceptual space of the male headed household.

Nicolasa explained that girls of Amatenango:

> "...don't get close to the boys. If your dad sees you, he will punish you. They don't have boyfriends here, they just come and ask your dad for you. And you don't know them. If your dad says yes, that's how it is. And they are going to pay for her. The father is going to say how much. For María [sister-in-law], it was N$1200.[1] And they have to come and ask three times. Each time they bring bread, chocolate, *trago,*[2] soft drinks....It costs a lot. Up to a year can pass by between the three *pedidas.*[3] They have to get the money together. And they shouldn't get to know each other...the young people. Not at all...Then they go to the church to arrange with the Father when they are going to do it. But sometimes the boy doesn't want to...sometimes, after all that, he doesn't have any more money, and they aren't going to go to the church. But if they do go, it has to be decided if the bride is going to put on a white dress or the *traje*[4] of Amatenango. And

[1] About £95. A substantial proportion of the average monetary income. The latter is difficult to quantify with any degree of security, given secrecy due to fears about envy and witchcraft. However, Chapter Five gives some detail on income obtained from survey data.
[2] Alcoholic drink. Usually refers to spirits, rather than beer, and usually to '*aguardiente*', a homemade rum made from sugar cane or corn.
[3] Literally, 'engagement' or 'requests'. In this case it refers to the formal visits made by the prospective husband to the girl's household to 'ask' her father for her.
[4] Traditional clothing.

> then it has to be sewn. And this is at the girl's expense. And then they are going to get married and they are going to have a party on the day with *tamales*[5] and *trago* and bread...".

Juana and Nicolasa stated that practically all members of the community marry within Amatenango. They only knew of one girl who had married a soldier from Monterrey and gone to live there. The young men who went to work in Mexico City always return to Amatenango to get married, even if they have girlfriends there. Their brother, José, had been in Mexico City for several years, only coming to visit for a week every year at "*fiesta*" time. He had a girlfriend from Oaxaca but "he left her" and had come back to Amatenango to get married the previous year. Other interviewees supported the ethnically and geographically insular nature of marriage. The husband of a twenty-three year old informant, Alberta similarly explained that inter-ethnic marriages are rare:

> "...the men don't bring women from other places here. Those that are married, when we go to work,[6] we go out with women but we don't tell them we are going to marry them. They are just friends. They want to come and live here. For example, the last time I went to Mexico,[7] I met a girl who told me that, if I didn't have a girlfriend here, she would come and marry me. But as we don't understand Spanish very well[8] and she didn't understand Tzeltal very well either, she just stayed there."

Juana and Nicolasa were very aware of the differences between their own customs and those of the *mestizo*, or wider Westernised, world and how these customs may be negatively perceived by this world. Juana was embarrassed (laughing and covering her face as Nicolasa said that "she doesn't want to say it") when she was telling how much their parents had paid for María, the wife of José, indicating that she realised that the payment would be considered unacceptable to outsiders. As described in the previous excerpt, the traditional customs of marriage may, or may not, culminate in

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[5] Steamed corn dumpling stuffed with beans, meat or cheese. In Amatenango, they are usually stuffed with beans.
[6] Referring to the occasional migration of young men to large cities for building work.
[7] The capital, Mexico City, is commonly referred to as 'Mexico'.
[8] The problems of conducting interviews in a second language are discussed in Chapter Two. However, this particular respondent, as the majority of others, spoke very good Spanish. His exaggeration of difficulty with Spanish was probably an attempt to emphasise ethnic differences (see Chapter Eight for discussion of children and language).

an official religious marriage ceremony but this appears of less importance than the traditional customs of gifts and monies. The assertion of ethnic identity through marriage, then, is prioritised over religious (Catholic) identity – the colonised identity.

Changing marital practices

Interestingly, this explanation given to me by the youngest of my informants differed from some of the explanations given by several of my older informants and indeed by their own mother. Nicolasa and Juana stressed the lack of control over their own lives, and the control by the fathers. They had been keen to impress upon me the restrictive nature of relations between unmarried girls and boys and the traditional nature of marriage:

> "There are some who just run away together. But he looks for them afterwards, the father of the girl. And when they find them, more has to be paid. And they are going to get married by the church and *el civil*.[9] There are also a few who just get together. They just meet in the street...and they get together. But they aren't many. There are many more *pedidas*."

Others gave the impression that customs were relaxing to a much greater extent and that women are taking more control. The contradictory nature of these narratives and the stress the younger women placed upon tradition may be because Juana and Nicolasa, being more knowledgeable of other cultures, wished to emphasise the comparative strictness of the society in which they lived. However, the two major changes reported by other informants are that: firstly, as referred to above, young women and men are meeting outside of the family home and having an interim period of "courtship" much like Western teenagers, before either deciding between themselves to get married and the young man approaching the father (who they naturally hope will agree to the match) or before the two run away together and set up home, usually initially with the young man's family. The second change is that women are refusing to marry and instead remaining in their parents' home.

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[9] Civil wedding.

Even in the case of "courtships", the father will usually demand monies from the young man and may take up the matter with the municipal community authorities if he refuses to pay. Micaela, a twenty-eight year old married mother of four, described her own arranged marriage and compared it with young couples who run away:

> "Q: Are there women who don't get married?
> M: Yes, the men come and they say no.
> Q: And their parents don't say anything?
> M: They don't say anything.
> Q: And do they have a boyfriend?
> M: Sometimes. If so, they don't tell their parents.
> Q: Did your husband *pedir* you?
> M: Yes, I didn't know anything. I was only a girl. I was fifteen years old. My dad told me that I was leaving with him, that he was my husband now. I told him "no". My dad told me that the gift had already been received and that was the deal. I didn't want to go. I was afraid.
> Q: Did you know the man?
> M: No, I was afraid. I didn't know how I was going to live.
> Q: Here, everyone does it like that?
> M: Yes, with the *pedida*. But some run away and make the deal that way.
> Q: And what do their parents say?
> M: They get angry and punish their daughter and when the anger passes, they make the deal."

It is difficult to say how far such contemporary marriage strategies really differ from those of previous generations. Several older informants had also merely got together with their "husbands" thus avoiding the usual ceremonies and traditions. However, there was often a great deal of shame attached to such partnerships, as Teresa, a fifty-four year old widow who now lives with a new partner, describes:

> "Q: How old were you when you got married?
> T: I didn't get married – we just got together.
> Q: When you got together, how old were you?
> T: About fifteen and he was twenty-five.
> Q: Did he come and *pedir* you with your parents, or did you just get together?
> T: We just got together and, from then, my mother said we should have a wedding. But my husband didn't want to. They asked him why he didn't want to, because I was ashamed, because I should get married. But, well, they saw it as it was, but it's not good to not get married.
> Q: Are you married to this husband?
> T: No, he got married to a different wife.

> Q: Is he widowed as well?
> T: Yes.
> Q: But your mother wanted you to get married with the first one?
> T: Yes, my mother told me "Get married". Well, I said to her, "Where is the boy? He doesn't want to get married." Now I think it is a shame that I didn't get married, as I have seven children. I am always going to pay God if I am not married."

Previous descriptions of marriage both in Amatenango and in other Mayan communities stressed the traditional nature of marriage ceremonies and illustrate the lack of control exercised by women over the betrothal process:

> "The betrothal, or c'om, is an extended series of negotiations in which the boy's representatives plead with the girl's family to accept the suit. Any time in a boy's late teens or early twenties, he may initiate the suit by speaking to his father, or the father may undertake to find a wife for his son."
>
> (Nash, 1970:125)

Many women with whom I spoke vehemently claimed that traditional procedures of marriage were still the norm and that there were no meetings or "running away" amongst unmarried couples. Others, on the other hand, either openly or in embarrassed whispers, admitted to the existence of "*novios*".[10] It is probable that this was also happening in the past but that it is becoming more culturally accepted these days. The descriptions Nash (1970) gives of marriage procedures during the 1950s and 1960s emphasise the importance of tradition and ceremony at key transitional moments, taken as a signifier of the maintained Mayan identity. Nash identifies this in terms of the creation of kin networks through ceremony and the continuity of tradition:

> "The ceremonial occasions marking baptism, betrothal and death define the network of bilateral relatives, neighbors, and *compadres*[11] who will guide and help a person through his life. These people make up the group called the *me?iltalil*.[12] They constitute a corporate group, but one which is tied to a single transaction. The sense of corporate identity is strengthened by the same group being called upon to act in subsequent household

[10] Boyfriends.
[11] A similar relationship to a godparent but more significant in signalling a person who is a lifetime companion and source of support and guidance.
[12] The question mark indicates the phonetic translation of a Tzeltal clicking sound.

> celebrations...The behavior during these ceremonials is marked by formality and replication of a limited number of ceremonial acts. Through this replication, the rituals dramatise continuity with the past and foster a sense of changelessness." (Nash, 1970:116)

If, however, continuity of tradition and strengthening of ethnic identity is necessarily at the expense of women's autonomy, it appears the situation is changing to some degree. The second way in which women are now taking control of marriage and their own lives, in terms of their marital status, is by refusing the man who comes to request them for marriage. Even Juana and Nicolasa, who were so keen to stress the lack of control over their own lives, referred to this possibility. Both said that they did not want to get married and that they did not like the idea that they would not get a say ("what if I don't like him?"). Many of the older women whose daughters had not yet married or who had refused partners supported their decisions and/or stated that whether or not they choose to marry was their own decision. For example, Josefa was ambivalent about her daughters' marital status and felt that they were financially independent enough to make their own decisions in contrast to her own youth:

> "Q: And your daughters, are they going to get married?
> J: Who knows!
> Q: Would you like them to get married?
> J: Whatever they want. Who knows if they want to get married or not?
> Q: If they want to stay here with you, that's OK?
> J: Yes, that's fine.
> Q: Are there many women who don't want to get married these days?
> J: Oh yes, there are quite a lot.
> Q: More than before?
> J: Yes, well, because now they work with the pottery. That's why they don't want to get married.
> Q: What happens when the men come to *pedir* them, they just say no?
> J. Yes, if they don't want to.
> Q: And what do their parents say?
> J: Nothing. If the girls don't want to, they don't oblige them to.
> Q: And was it like that before?
> J: No, before you were obliged to leave with the man."

Josefa clearly made the point that the fact that women are now being asked their opinion and that fathers are not so anxious to rid themselves, and their household, of their daughters is related to the gendered economic changes in the community over the past couple of decades. These days women have commercialised their production

of pottery, thus being a financial asset to the family. Whilst not reducing family relations and marriage to a purely mercenary financial relationship, this reflects the harsh realities of families that live in poverty and must develop difficult survival strategies. Aside from the occasional sale of agricultural products and spurts of temporary paid agricultural or migratory construction labour, women often supply the only monetary income of the household (see Chapter Six). With this economic power, women have increased personal autonomy and may opt out of the marital, and therefore, mothering role if the circumstances do not appeal to them. This does not mean, however, that they opt out entirely from male control or the mothering role, as elder adult daughters tend to take up pseudo-mothering roles (see Chapter Eight) and are usually subject to control by fathers and/or brothers within the family.

When the parents die, customs make life hard for older single women in a society where women living alone are not usual, as Micaela states:

> "Q: And those that don't get married, where do they live?
> M: In their parents' house. If their mother and father die, they will left there alone and have to work to keep themselves.
> Q: They have to work hard?
> M: Yes, because they aren't married. They have to pay so that they bring their firewood, they have to buy corn."

Although Micaela made this statement about never married women living alone, I only heard about one never-married woman who lived alone in my time there. It is rare for a single woman to live alone or in an entirely female household, although widowed or abandoned women and those who have no other immediate male family occasionally do so. However, the refusal to marry can be considered one of the primary means a woman has control over her own body and, to a certain extent at least, over her life in general. It also signifies taking control of identity, in terms of individual identity rather than communal, or community, identity. By not taking part in an important transitional ceremony and ritual, such women challenge the "changelessness" of the Mayan identity and break with the continuity of their ancestors. Single motherhood is practically unheard of and so this is perhaps the most important reproductive choice they can make. By remaining unmarried, and therefore childless, as adult female members of the household but with considerable

economic power, they risk altering or foregoing their "corporate" ethnic identity and changing the nature of their traditional gender identity.

GENDER ROLES WITHIN THE FAMILY

The mother-in-law relationship

For those who do marry, however, customs remain somewhat constant. Following marriage the great majority of couples go to live with the husband's family for at least the first year or two. All of my respondents referred to this as going to live with the "*suegra*" (mother-in-law) indicating that, for the bride, the private environment of the household is defined by the female, rather than male, head and the significance of the mother figure in the household. A newly married young woman will not immediately become this key "mother" figure, even when she has had children. This role goes to the oldest woman in the household: the mother-in-law. She takes on the mother role not only for her own children, but also for the spouses of her male children and grandchildren who live with the family. This extended family arrangement appears problematic from the point of view of the daughter-in-law. Many are somewhat bitter at the treatment they receive and welcome a move to their own home, as Feliciana, a thirty-four year old mother of six, commented in a typically understated manner:

> "Q: Did you live with your mother-in-law?
> F: Yes, but only for one year.
> Q: Then you came to live here?
> F: Yes. I like it much better as I'm on my own."

Others, however, were considerably more outspoken about their relationship with their mother-in-law. Marcelina went so far as to deny her existence:

> "Q: And your mother-in-law?
> M: I don't have one...she's bad. She is mad."

Unusually, she and her husband had not gone to live with his family after their marriage but with her mother:

> "Q: When you got married, did you go and live with your husband's family?
> M: No, with my mum. My mother-in-law is no good. She tells us off a lot.

> Q: And what did your husband say?
> M: Let's go with your mum. He didn't want to be with her either because he could see what she was like"

The criticism of mothers-in-law extended to that expressed by mothers of their daughter's new mother figure. María (2) was damning of the lack of care given to her daughter in her new home:

> "Oh God, when she came, you wouldn't believe it...she was so thin, her throat tiny, like that, her head down...she was so thin from so much anger because her sister-in-law and her mother-in-law are so bad...the only good one was her father-in-law."

María went on to describe how she would not mistreat her own daughter-in-laws in such a way, giving the financial investment in them as the reason:

> "I don't hit my daughter-in-laws...because it costs us to get a daughter-in-law...we spend a lot in bringing her here. In just one *pedida*, we spend one and a half million.[13] In two *pedidas*, it's three million."

Though it may be partly because of culturally typical reticence to express emotion and attachments, even relatively smooth relationships between "*suegra*" and "*nuera*" are often motivated by pragmatism rather than affection. The kinship groups which are formed in marriage rituals and represented as positive tools to "guide and help a person through his life" in Nash's work (ibid.) are not so non-contentious as they may appear. Hierarchies of power, economic survival techniques and preferential alignments with blood relatives create tensions and, although solidarity of women is not absent, it cannot always be assumed. This finding is echoed in other research into arranged marriages. In China, for example, tensions between daughter-in-laws and mothers-in-law can be cause for divorce (Croll, 1983: 83). This has obvious implications for development projects, including health and reproductive programmes, which increasingly seek to utilise assumed existing stocks of social capital through gender networks of trust and reciprocity (Putman, 1993).

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[13] Many people in Amatenango, as throughout Chiapas, continue to refer to amounts in old pesos. The conversion to new pesos would be n$1500 (about £115).

Some positive accounts were given of the relationship between daughter and mother-in-law, however, such as that of Carolina, who lives on the same piece of land as her mother-in-law in an adjoining house and spends the majority of her day in her company. She stated firmly: "One can't tell the daughter-in-law what to do. I work a lot with the children, buy them beans, give them their food and now there is corn for us all". Despite this emphasis on household chores, she appeared to have a good bond with her mother-in-law. When I first interviewed her for the household survey, her mother-in-law was present and there was obvious mutual respect and affection as the two competed with each other to tell of Carolina's misfortunes. However, this did not appear to be the norm in the majority of such relationships.

The gendered division of labour

Despite the tensions, most women exist in this exclusively female world. Indeed such tensions may partly result from their constant companionship with other female household members. This female world is generated from the clear division of labour along gender lines that appears to separate the family into defined public and private spheres. This separation has been the baseline for many gender and development interventions (see Chant and Gutmann, 2000, for summaries of the different related schemas) and, in Amatenango, it appears to have some validity. Women and men rarely spend a great deal of time in each other's company. Home is the sphere of women, whilst men exist in the world of field labour and the municipal authorities.

The chores of women include lighting (and keeping lit) the fire, making the "*nixtamal*" (cooked corn) and subsequently tortillas, preparing and serving meals (firstly to older male family members, subsequently to the children and lastly, for themselves and other adult females), cleaning, washing clothes and feeding animals. The majority of the day, however, is spent in pottery making with other female family members. These household tasks and the pottery production may be interspersed with visits to female neighbours and extended family members and many women also spend several hours away from the home in the collection of firewood.

For men, most of the day is spent away from the household working in the fields, fetching and cutting firewood, participating with communal municipal tasks (such as constructing roads), helping male relatives with building new houses, or chatting and drinking with other men in public spaces around the "plaza" and the municipal building.

"Delitos" and "regaños"

This gendered division of tasks is socialised and internalised. Women themselves were often strongly critical if they judged another woman not to be carrying out her household tasks to the best of her ability. This again illustrates that solidarity amongst women is not always a given. However, the stark division of gender roles and relations is also "policed" by the use of physical violence, which is often "punishment" for not being a good wife or a good mother.

In Nash's early work on betrothal in Amatenango stated that the expectations explained to the boy who is to marry include:

> "...he should not leave her tomorrow, he should not beat her, he should bring home corn and beans, and all will be well" (Nash, 1970:125).

This is complemented by the advice given to the bride:

> "The girl is told that she should prepare her husband's meals and be waiting for him in the house when he comes home from work" (Nash, 1970:125).

Although this advice is not always given so formally these days, the general expectations of gender roles in marriage persist. In reality, a woman's non-fulfilment of duties nulls the husband's second obligation to "not beat her". Women would often use the term *regañar,* meaning to punish or tell off, to describe a beating or literally say *"era su delito"* ("it was her crime"). Others would go into further detail saying that the victim "doesn't like to work, she just likes to go around to her neighbours' houses", implying laziness and non-fulfilment of household chores to be justification for domestic violence.

Radical feminism asserts that the family is the primary location of oppression for women and has conceptualised violence as a repressive tool to restrict women to the household sphere and ensure their dependency upon men. For example, Rich (1980) notes that patriarchy necessities the use of "violent strictures" in order to ensure that women remain emotionally and erotically loyal and subservient to men, rather than being drawn to women. However, the complicity of women is also required. Women who criticise other women are an integral tool in the perpetuation of violence and "reproduce" an ideology of acceptance in their reproductive roles as mothers and within communities of women.

Alcohol and violence

There are, however, other reasons for domestic violence. Alcoholism is a widely recognised problem in many indigenous communities. Everyday a number of drunken men hang about the streets and several interviews were interrupted by the appearance of inebriated male members of the family or neighbours. At times of "*fiesta*", the majority of men consume vast quantities of *aguardiente* and/or beer.

Early twentieth century indigenist arguments "conflat[ed] drunkenness...into an overarching construction of "Indianness"" (Garrard-Burnett, 1998:4). This construction resulted from observations of their "childish depravity...[in] traditional Mesoamerican religions [in which] the consumption of alcohol had long been an important component of religious practice, where inebriation (or hallucination) was considered to be an essential part of attaining the proper religious spirit" (Garrard-Burnett, 1998:6). However, Garrard-Burnett claims that alcoholism originally stemmed from *mestizo finca* owners who capitalised upon, and manipulated, alcohol dependency for their own purposes, encouraging workers to drink heavily and "recompensate the debt with his labor" (1998:7-8).[14] Anthropologists indicate the importance of ceremonial and religious drinking of alcohol as the expression of personal relationships between men and "as the most usual means of payment for special services" (Wilson, 1973: 123). Clear social and personal relations are

[14] Also see Harvey (1994: 68) for discussion of the tendency to "disassociate drunken violence from indigenous culture and attribute it to the negative influences of Western mestizo lifestyle".

indicated through drinking patterns (ibid.: 125) and the combination of social drinking amongst men (to express personal relations) and the frequent ceremonial and religious use of alcohol (where women's drinking tends to be confined) is a dangerous one that can often lead to alcoholism and to its attendant problems, including domestic violence.

However, Bradby (1996: 3) comments that a Zero Tolerance society is one which:

> "...views all male violence as a crime and does not admit circumstances that have been constructed as extenuating, such as "provocative" behaviour from women or drunkenness on behalf of men."

Nevertheless, widespread domestic violence makes it crucial to understand that its social context includes heavy drinking, as well as ingrained notions of hierarchical gender roles and duties. The latter emphasise the role of perpetrator, the man, and the need to work with the social and cultural construction of masculinity in order to combat domestic violence.[15]

Domestic violence as "cultural construction"?

Despite their justifications of violence, women do not condone heavy drinking and the excessive beatings that are often its result. The apparently contradictory relationship women have with domestic violence can cause problems for outsiders (see Harvey, 1994 for a similar study of domestic violence in the Peruvian Andes). On occasion, I heard commentary from (male) development workers suggesting that, because the women did not openly challenge domestic violence, then it was acceptable because of "cultural difference".

There is perhaps a contradiction in maintaining respect for cultural differences and "tradition" alongside a notion of universal human rights. It is a complex debate with which feminists and other concerned with indigenous rights must grapple in Latin America and throughout the world (Castillo, 2002; Molyneux and Craske, 2002; Molyneux and Razavi, 2002; Jelin, 1997; Nussbaum, 1995; Phillips, 2002; Radcliffe,

2002; Sieder, 2002). The aforementioned development workers in effect declassify domestic violence as "violence", because of a respect for cultural difference. Definitions of violence are complex, multiple and fraught with contradictions, particularly in terms of cultural norms and socialization:

> "The process of defining violence depends upon the social and cultural matrix that underlies the legitimisation of an act of physical coercion.... the normative values imbued in members of society in turn affect the nature of social interactions..."
>
> (Eiser, 1998:161)

Eiser's work suggests that cultural difference can be used to understand the nature of violence but that this is not an unchanging norm. All norms are the product of socialization and, as such, are subject to change. Foreign workers in previously colonised developing nations often relate to discomfort at imposing Western norms at the expense of relative cultural values. Work on the ethnocentricity of "universal" human rights reflects such discomfort. Penna and Campbell (1998) emphasise the need to "distinguish between national and international discourses on rights" (ibid.: 8) whilst tying together universalist and cultural relativist debates by focussing upon cultural symbols:

> "Symbols are powerful and effective means of discourse... Unfortunately...[s]ymbols can also lose meaning when viewed across cultures. In human rights discourses, the majority of the positive symbolism used is Western. When non-Western symbolism is invoked, Western analysts often criticise the symbol (an event or tradition) as unworthy or uncharacteristic of the norm the symbol is employed to stand for. What is ignored is that an equally rigid criticism of Western symbols would be forced to conclude that Western symbolism was equally inappropriate."
>
> (Penna and Campbell, 1998: 9)

The solution is to adopt a "cross-cultural approach to human rights", which attempts "the incorporation of non-Western symbolism into international human rights discourse" (Penna and Campbell, 1998: 9). In this way, violence, despite being

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[15] Chant and Gutmann (2000) focus upon the need for involving men in gender and development work and stress the importance of working with men's masculine identities in order to confront what have previously been regarded as "women's issues".

culturally defined, remains an important issue but is a personal experience of a culturally and socially constructed phenomenon:

> "...violence is culturally constructed...it is in essence only a potential – one that gives shape and content to specific people within the context of specific histories. Little can be said about the concrete form of violence outside of the constraints of society and culture." (Robben and Nordstrom, 1995: 3)

Whatever its "shape and content", however, the experience of violence "is not enjoyable, except perhaps for the pathological few" (ibid.: 3). Therefore, despite the difficulties presented by the fluidity of violence as a concept and changing definitions and justifications according to the cultural context, it is necessary to find a way to confront it as a rights issue. Human rights and respect for cultural difference are not necessarily incompatible if we understand that violence is experienced in multiple forms and within a variety of contexts but, whatever its form or context, it is not enjoyable and is degrading.

This compromise answers some the concerns Nussbaum (1995) has with the alignment of cultural relativism and feminism, related to its "alarming implications" (ibid.: 64) for women including "educational deprivation, unequal healthcare, and premature death" (ibid.: 66). Domestic violence could slip easily into this list. However, this fails grasp that, by decrying "Other" practices, Nussbaum not only privileges the Western position but also conceptualises women of non-Western cultures as victims who require protection and re-education. The implication is that women who do not vocalise open opposition to abuse simply do not realise their oppression. However, objections raised to violence may be expressed in multiple forms. I often heard women refer to their neighbours having "luck" if their husbands did not drink, and therefore did not beat them, and would quietly advise their daughters they should also look for men who did not drink. These recommendations replicate findings by Chant (1997) who shows that *mestizo* Mexican women's similar characterisation of an ideal husband is of someone who is not "a drinker" or "a wife-beater" (Chant, 1997:216). Harvey (1994: 66) also notes that women who are beaten in the Peruvian Andes "were perfectly willing to complain to others about their treatment". Likewise, Teresa characterised her former husband as being a good man

precisely because he did not beat her, despite the fact he did not work and was a heavy drinker:

> "Q: And he wasn't a good man, your first husband?
> T: He was good, he didn't hit me. But he drank a lot, he didn't work, didn't do the *milpa*,[16] didn't bring home any money, just spent the money on drinking. With his uncle, *El Panela*, he went out from the moment he got up.
> Q: But he didn't hit you when he drank?
> T: No, he just came back to put his head here to sleep.
> Q: Is it a long time ago that he died?
> T: Yes, because of the drink."

Women's justification of violence with reference to women's "crimes" does not necessarily imply the acceptability of domestic violence but rather that the complex relationship between cause and effect is a negotiation of differing factors. Most significantly, however, these comments by women are different, perhaps subtler, criticisms and interpretations of violence than those of the Western world. This is not to suggest that the experience of domestic violence is the same, just expressed in different terms. Violence is experienced differently according to the individual context (see Vadera, 1997, for related discussion of India). As Robben and Nordstrom (1996: 4) reveal:

> "...the ontics of violence – the lived experience of violence – and the epistemology of violence – the ways of knowing and reflecting about violence – are not separate. Experience and interpretation are inseparable..."

Despite such differing experiences, reasons and articulations of violence, the right not to be subjected to violence, in whatever form, is a "cross-cultural" right. However, the priority that is given to different forms of oppression can only be decided by the particular women themselves. To state that women cannot recognise, or do not care, that they are badly treated is to assume an ignorance and a lack of self respect on behalf of women that obviously is not the case. Indeed, although it is not the norm for the majority of indigenous women to speak out in such a way, the San Andres agreements between the EZLN and the government had included the need to:

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[16] Didn't go to the fields to work.

> "Revise and modify the penalisation that the current legislation imposes for sexual crimes, harassment of women and domestic violence"
> (EZLN/*Gobierno Nacional de México*, 1996) (my translation).

The inclusion of such provisions reflects the participation of indigenous women in the EZLN and their proposals to "reinvent tradition" in order to promote the rights of indigenous women (Castillo, 2002). However, the apparently contradictory relationship women have to domestic violence also reflects pragmatic as well as cultural motivations. A single women living alone with children is not only culturally unacceptable but also economically vulnerable. Therefore, women can usually only leave violent situations if their family agrees to take them back, as María's family did. Although studies have revealed that women household heads may be empowered by their status (see Chant, 1997), it is not easy for indigenous women to own land, the mainstay for survival. Importantly, to live alone by choice would be to transgress the society's norms. Testament from one Tzotzil woman accounts to this:

> "...a woman without a husband is a *cualquiera*[17], whether she is divorced, abandoned, widowed or a single mother, she is not worth anything. She has to have a husband, even if he is only an adornment, she has to support him, even if he is a drunk..."
> (Rovira, 1997: 33) (my translation)

Women are harshly critical of men who do not fulfil their duties. However, although women voiced these criticisms to me, they would be unlikely to express them either to the men concerned, or indeed in the presence of any man. Women, on the whole, were silent or more subdued in the presence of men and usually let them speak for them and dominate conversations. Men frequently go unchallenged by women and their lack of work is only directly criticised if another man (usually an older male authority figure) chooses to intervene.

[17] The term "*cualquiera*" implies a women of ill-repute. Similar terms in English would be "slut" or "common" but neither of these incorporate the holism of the Spanish term.

SOCIAL REPRODUCTION AND HEALTHCARE

The public / private dichotomy and cultural difference

The household responsibilities of women, the division of labour and worlds along gender lines and the domestic violence that often characterises the relationship between these worlds reflect the Western feminist preoccupation with the gendered nature of oppositional and restricted spheres, defined as "public" and "private". Not only does this dichotomy have a profound influence on the autonomy women have over their own lives (as described above) but it has also influenced the assumption of women as health carers within the family and the community as an extension of their private sphere roles. The public world of politics and decision making as well as wage earning outside of the home has been denoted "masculine" by feminists, and other social philosophers. The private world of the home and the family, with its "typically female spheres of activity like housework, reproduction, nurturance, and care of the young, the sick, and the elderly" (Landes, 1996: 144) is defined as feminine. In Marxist terminology, this is the separation of two worlds into "productive" (public) and "reproductive" (private).

This dichotomy, therefore, is particular important for understanding how the reproductive roles undertaken by women are associated with motherhood and, therefore, with health care. However, just as the conceptualisation of "acceptable violence" may be questioned for its cultural relevance, the distinction between productive and reproductive worlds is also perhaps overly Eurocentric and bourgeois. The ethnic, geographical and cultural context and indeed the actual tasks being undertaken by each gender are radically different from those imagined by the original political philosophy in the post-industrial first world. Much of the classical philosophy of these public and private spheres can be found in the work of Habermas (see Habermas, 1962. Also Thompson and Held, 1982, for critical debate).[18] However, Landes (1998:136) asks whether "Habermas's normative subject is sufficiently multi-dimensional, embodied, or gendered enough to account for the organization of power in different cultural settings". For one thing, the dichotomy of

[18] See also the work of Hannah Arendt which poses an opposition between the social and political and discusses the separation between the "public" world and the private (Arendt, 1951; also Maruzzi, 2000; Hill, 1979 for critical discussion of Arendt's work).

public and private relies on Enlightenment notions that assign gendered identity traits – amongst others, reason and scientific rationality as masculine and emotion and superstition as feminine. These "masculine" and "feminine" traits, however, are not universal and, in many cultures, it is acceptable for men to be emotional and "superstition" is a linchpin of cultural belief for both men and women, as in Amatenango (the division between "rational" science and "irrational" superstition not existing).

It is furthermore necessary to recognise that this very distinction between public and private, with all its bourgeois roots, is based upon normative, ethnocentric constructions of masculinity and femininity, which reflect the fact that "...Westerners' constructions of themselves as women, men, reformers, workers, mothers... were in part shaped by reference to exotic, alien, inferiorised 'others'" (Groot, 1996:34; see also Callaway and Helly, 1992 for related discussion). The very notion of women's roles as mothers, then, may have been partially defined in opposition to the roles undertaken by the "Other" which non-Western indigenous women represent but ironically are the same roles we assume them now to occupy.

In Latin America, women have been historically constructed in this light (Chant with Craske, 2003; Craske, 1999). Indeed, such roles have been the basis for political strategies adopted both by governments and political parties in attempting to co-opt the participation and mobilisation of women for national or revolutionary objectives (see Chuchryk, 1994, for discussion of such issues in Chilean politics). Women's movements themselves have also focussed upon the rights of women as mothers and wives in particular, formulated in terms of social and domestic issues (Craske, 1999: 5). In particular, "[t]he notion of women's interests tends to evoke ideas of child-care, flexible working hours and, particularly in the case of Latin America, service provision" (ibid.: 18). Writing about the history of Mexican feminism, Escandón (1994) notes that the formation of the women's organisation, *Frente Unico pro Derechos de la Mujer* (United Front for the Rights of Women), in the 1930s "concentrated upon practical measures to improve the daily lives of women" (ibid.: 203) and that the 1980s economic crisis saw women organising co-operatives for

"buying, cooking and producing food staples" (ibid.: 209) (also see Feijoó *et al*, 1994, for discussion of the *Madres de la Plaza de Mayo* (Mothers of the *Plaza de Mayo*), the National Movement of Housewives and other feminist movements in Argentina). Similarly, NGOs in urban areas have responded to women's "practical gender interests" in the provision of communal kitchens and related services, rather than responding to "strategic gender interests such as abortion, domestic violence and sexual and reproductive freedom" (Jaquette, 1994: 6). Aside from other problems associated with this distinction of interests (see below), this is problematic as, whilst practical strategies merely seek to improve women's status within the private sphere (as envisaged in Western, middle-class, terms), strategic objectives would question this construction and seek to release women from its confines.

The use of paradigm in the developing world to theorise development interventions is, therefore, problematic. Not only is it questionable politically given its historical imperialistic construction and lack of challenge to women's occupation of the private sphere but it may also be inappropriate on a practical level. Dandekar (1998:169) remarks upon the failures this has resulted in on an international scale:

> "Industrial development has conceived of women as nonautonomous dependents, a characterization which falsified the developing societies...First, women were regarded as non-productive consumers. Second, poor women were characterised as analogous to the disabled."

Otsyina and Rosenberg (1999) comment on the potential pitfalls of assumptions of the construction and content of private and public spheres. They highlight the common problem that not only do "[t]imetables for development activities often take no account of the time women spend on household chores", they also do not account for other productive responsibilities, such as "heavy responsibilities for farming" (Otsyina and Rosenberg, 1999:45).[19] As Momsen and Townsend (1987:42) stress,

[19] Moser's (1983) schema for development relies heavily upon notions of productive and reproductive work and is commonly implemented in gender and development work. Although it does usefully recommend timetabling in communities to highlight the working days of both men and women, it also attempts to categorise tasks into productive and reproductive as well as needs into "strategic" and "practical" – it is, however, often difficult to create such divisions in practice (see also Moser and Levy, 1986; Moser, 1983).

women's economic activities "are still grossly underestimated" on an international level as the "conceptual problem of 'work' is not agreed by all countries".

The assumption of women as unpaid health carers, then, is reliant upon this notion of women who are solely conceptualised with reference to their reproductive role and economic devaluation of this role. Health care strategies in the developing world tend to rely heavily upon the contributions of women as part of a generalised move towards community participation. As discussed in Chapter Two, these contributions are directly associated with women's assumed reproductive responsibilities, an association which relies upon the following suppositions:

1. Women have the available time to commit to voluntary healthcare.
2. Healthcare is a private, family concern and one which is related to the gendered motherhood role (the social reproductive role)
3. Paid professional healthcare, if replaced by female labour and reduced to this social reproductive role, then becomes unremunerated.

These suppositions are clearly reliant upon notions of women's occupation of the private sphere, their non-productive, "reproductive" labour within this sphere, and, problematically, these notions are conceptualised in Western terms.

The answer to this problem may lie in deconstructing the bilateral dichotomy of public and private spheres. We need to recognise that the boundaries between the two are not universally fixed, are changeable with time and context, and to pluralise meanings of the terms – so that the "public sphere" becomes "public spheres", and the same for private. The nature of "production" and "reproduction" equally may not hold, especially in non-industrialised environments. Their content and construction will not be identical in every culture and society (see Dandekar, 1998). It is necessary not to rely uncritically on the paradigm in every case and to critically

analyse its relevance in each context.[20]

For Amatenango, the public labour sphere is not of paid productivity but of agricultural work outside of the home, which provides essential non-monetary income (in the form of corn and beans) for the family. The private world of women is generally restricted to the home but we cannot assume that this home to be identical to the nuclear family norm of Western society and fall into the trap of "[p]olicies that presume Western style social structures in which a male head of household supports his wife and one or two dependent children" (Dandekar, 1998:171). In Amatenango, this home often consists of a non-nuclear family and communities of women, sharing and dividing tasks that would be unfamiliar in the industrialised Western world and which, for them, imbue completely different meanings on their identities and experiences of the gendered world. Their work can also be characterised as classically "productive" rather than, and in addition to, reproductive work (although based within the private sphere of the home environment) as it is generally the women who produce the only monetary income of the family through their pottery production. Healthcare, then, is still a role associated with women but it is one that may be shared by extended family members and a responsibility that must fit around other productive and reproductive roles undertaken by women in the household.

In the developing world in general, and in the rural context in particular, the situation is likely to differ to a great degree from the world Habermas and similarly focussed feminists envisage. In some situations, no doubt, the distinction between public and private does not hold at all. However, the public/private sphere can be seen to exist in the case of indigenous communities in Chiapas, even if in differing forms and with

[20] The dichotomy between public and private spheres also does not always function as a means of analysis of situations in the Western world. Not only does it no longer take account of the multicultural nature of most industrialised societies, it is also biased towards heterosexuality, as it does not reflect the diversity of lesbian and gay lifestyles and gender identities (see, for example, Oerton, 1997).

different content. One factor may be that, in previously colonised nations, political, social and economic structures are, to a certain degree, sharing some of the same European influences, although altered when diffused with the colonised cultures and other influences.[21] The spheres of public and private are not unchangeable in any society, as reflected in changes in gender roles, and influences can come from a multitude of sources. Although the distinctions remain generally marked, there have been clear shifts in gender labour divisions in the past decades, which imply a shifting of the boundaries between public and private. When Nash (1970) wrote of life in Amatenango, it was the men who travelled out of the community to surrounding towns to sell pottery. These days, however, it is almost always women who undertake this task. Also, men have taken over certain of the household tasks relating to the home production of pottery, most significantly, the fetching of clay (for the pottery) and firewood both for the "*quemada*" (the pot firing which occurs every couple of weeks for most households) and for everyday consumption for cooking. In the past, the latter task belonged to the women and children of the household. This is not to say that this task is now exclusively male but it now appears to be one of the few tasks where gender lines are not clearly marked (see Chapter Six).

Motherhood and the care of children

The association of women with the private sphere, in whatever form, is clearly associated with their roles as social and biological reproducers. In an extension of their biological function, women are socially and culturally constructed as mothers in a broader sense. This motherhood role is closely related to health care, particularly when health is conceptualised holistically (as discussed in Chapter Six). Care, whether it is of a sick dependent or in terms of preventative health and creating a healthy environment, is closely related to social reproductive responsibilities, such as sanitation and food preparation, for example. As noted in Chapter One, Western health care systems are structured on the basis of such gendered roles, associating both care in the home and the "caring" role of the nurse directly with motherhood

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[21] This is not to suggest that this is a one-way process. Colonised nations have also impacted upon the colonisers (see Chaudhuri, 1992 and Thapar-Björkert, 1996 for discussion of the Indian context) and "[d]iffusion of subordinate, not to imply inferior, culture into a dominant one is a major effect of colonial rule" (Chaudhuri, 1992:232).

(Gamarnikow, 1978; Hillier and Scrambler, 1997; Lorber, 1997). The customs associated with marriage, the gendered division of labour and domestic violence illustrates precisely how these caring roles come to be assigned to women in Amatenango and how these roles and responsibilities are maintained. In terms of creating and maintaining a good health environment, such roles are key to understanding a major part of women's health care responsibilities. In many ways, such caring roles are also associated with the emotional aspects of care inherent in motherhood (Lorber, 1997).

For women in Amatenango, motherhood, and therefore care in its various forms, does not relate solely to care of children by the biological mother. The micro-communities of women created by the extended families in many households and the clear division of labour along gender lines creates a family structure in which children may be cared for by older or younger female members of the household and in which adult female members of the household may be "mothered" by the female household head. Nevertheless, the bond between the child and the mother is great and, ultimately, it is the biological mother who is held responsible for the welfare of her children. Evangelina remarked that her husband only "helps" with her baby daughter, "Sometimes. When he gets back from work". Younger women in particular referred to their continued reliance on their mothers into adulthood. Micaela, for example, remarked on this:

> "Q: So how old are children, when they don't need their mother to take care of them anymore?
> M: At eighteen years old.
> Q: But do you keep asking for help from your mum?
> M: Yes, if I have some problem or I am missing something in the kitchen, I go to her..."

A mother of four boys, she then referred to the hard work involved in child rearing and completing other household duties as the only woman in the house without other female companions or daughters to share the work, saying, "As I don't have any help,

so I don't make pottery, because I am going to raise the children, wash, make the food..."

Carolina, a young mother herself, also commented upon her continued close relationship with her mother:

> "There are sixteen of us. I'm the youngest, we all lived. At sixteen years old, you don't need your mum anymore. But I miss my mum, I go and visit her and chat with her about my problems."

The emotional care of a mother for her child often continues, then, into adulthood. The responsibility of mothers for the physical care of their children may also continue into adulthood in cases of injury and physical abuse (see Chapters Six and Eight for discussion of the latter) and of disability. Disability is clearly conceived to be problematic in a community which relies heavily upon physical labour and which has no recourse to public support. Whilst she can, it is the mother who takes up the responsibility for a disabled dependant. However, this may be a short-term solution as Luisa noted of one young woman who had been crushed by collapsing earth whilst digging out clay. She was now paralysed and could not move from her bed:

> "What is going to happen when her mother dies? Who is going to look after her? Better to put a bullet in her now."

For most women, whether they were or were not mothers themselves, the absence of the mother was directly correlated with the absence of a caregiver. Similarly, schemes such as PROGRESA clearly construct women as the health carer of the family. For example, it is they who receive the appointment cards, and subsequently the money, for taking their children to the clinic for check-ups and vaccinations. Their social reproductive tasks are also central to the dietary provisions of PROGRESA. Those children who attend school will be able to eat breakfast there. Mothers and other female family members work on a rota system whereby groups of four take it in turns to cook this breakfast. It is the women, therefore, who are given instruction in how to cook the foodstuffs provided, which are not a usual part of their diet but include such items as dehydrated flavoured *atole*, soya and tinned tuna.

(Each family also has to contribute 5 pesos a month for the extra ingredients such as coriander, tomatoes and onion that go into the specified recipes.) The mothers work from 8 am until 1 p.m. preparing the food and washing the dishes.

The clear assumption inherent in PROGRESA, then, is that women's other reproductive and productive responsibilities are peripheral. As Luisa noted, however, in reality:

> "Many women don't want to because it is a lot of hours and they have to go and get firewood or sometimes they have a lot of work to do [making pottery]. If they have an order, there is no time.".

Similarly, another informal conversation with a group of women on the subject invoked great resentment at the tasks they were expected to fulfill in order to receive the PROGRESA payments. Most were agreed in their frustration that if they complete these tasks, they have to forego other tasks which contribute to the household food production or well-being more generally. Such problems echo the criticisms made by Dandekar (1998),Otsyina and Rosenberg (1999) and Momsen and Townsend (1987) that development projects not only fail to recognise cultural differences in the construction of the private sphere and, therefore, in women's responsibilities but also do not conceptualise these as "work".

However, although women noted such difficulties, the gender association of this extension of their social reproductive roles was unquestioned as the involvement of men in such responsibilities is inconceivable. Equally, they themselves perceive their children's health and well being as central to their responsibilities. Indeed, many women emphasised the health of their children and, particularly, the lack of child mortality within a family, as an indicator of their "good motherhood". Luisa, the mother of the family with which I stayed in Amatenango, frequently remarked with pride about the health of her children and the fact that none of them had died. She strongly implied that this good fortune was a result of her good mothering skills, commenting on the vitamins that she gave them as babies and on the sacrifices she had made for her children. This was a repeated theme in many interviews and conversations as women would remark about how their care resulted in their healthy

status of their children. In one informal situation, an older woman lamented the death of her oldest son who had been murdered at age 20, stating that it was particularly sad because she had raised him to be so healthy.

Such sacrifices by mothers are often substantial in cases of serious illness. Luisa also described an occasion when her youngest son, Sergio, had fallen seriously ill:

> "He was about three years old and he went to sleep. He had some bad dreams that the house was falling down and that there were spiders on the walls (the walls weren't like this – they were mud in those days). And when he woke up, his legs were hurting a lot and he stayed like this [indicates a fixed position with arms stretched stiffly downwards] – he couldn't move anything! He stayed like that for six months. He was dying. The doctors didn't know what it was. We went to see many *curanderas*. And we had to pay a lot of money. Every time he came, it was 100 pesos as well as the passage. So much money. In the end, a *curandero* from Chenalho cured him. He was called Don Manuel and he came all the time for months....He cured him with his candles and prayers to the saints. And he also gave him some injections. I think they cost 30 pesos each – and that was almost ten years ago – I don't know how much it costs now. I was crying all the time...oh, all the time....because of the money! But we don't leave the children...we cure them. My husband had a sort of farm then and we had to sell it all. Now we don't have any cows. At last, one day he started to move again but he still had to learn to walk again. That's why Sergio didn't walk until he was almost four years old. And his leg still hurts. When he has to walk a lot, he tells me that it hurts. That's why, I don't want him to work in the fields...".

Clearly the sacrifices described by Luisa relate not only to herself as Sergio's mother but to both parents. Nevertheless, she frequently used the first person to describe choices regarding Sergio's treatment, her own personal distress at Sergio's illness and her current concerns regarding its longstanding effects.

Others also referred to accidents that occurred to other children, often blaming the mother for being away from the home. One such incident involved a toddler of a year and ten months who had been knocked down and killed by his own grandparents. The "*muchacha*" (the girl, here referring to the young mother) had not been at home and was blamed by most women who related the incident for not taking better care of the child.

Knowledge of such accidents seemed to convince women of their sole responsibilities for the care of their children and that these responsibilities clearly necessitated their exclusive location in the private sphere. For instance, Luisa noted:

> "What is going to happen to my children if something happens to me? They are going to be alone. They need their mother...it's better that I stay here to always be able to look after the children. We always need our *mama* but more when they are little."

At the same time, however, women treated minor accidents which happened to their own children as simple unavoidable facts of life, easily remedied by home treatments or accompanying the child to the clinic, where men are infrequently seen. When asked to describe their most recent visits to the clinic, many women would relate an instance involving cuts and bruises to their youngest children. Luisa once related to me, on return from a day interviewing, how her youngest child, Veronica, a fifteen month old toddler, had strayed onto the hot *comal*[22] on the fire and burnt her feet:

> "She screamed and screamed...*la llorona.*[23] All her feet were red, red, red, but I poured cooking oil on them. Now they will be OK. It's good, cooking oil. Also, the white of eggs, that's good for burns too."

I also observed other women using similar home remedies to treat minor injuries of children, including an occasion when Tiburcia (a 30 year old single woman) who dampened and applied leaves from a plant growing around her house to the swollen head of her neighbour's young son after he had knocked it. I could not get ascertain what the plant was as she only knew the name in Tzeltal and I did not recognise it. However, other women present all seemed to be familiar with the process.

Decisions about family healthcare

Given women's location in the private sphere and their responsibilities of care, it is usually women who make the first decisions about where to seek health care. This use of the clinic as the first port of call for mothers and their children is the most common response of women to illness and injury. Figure 7.1 indicates that the local

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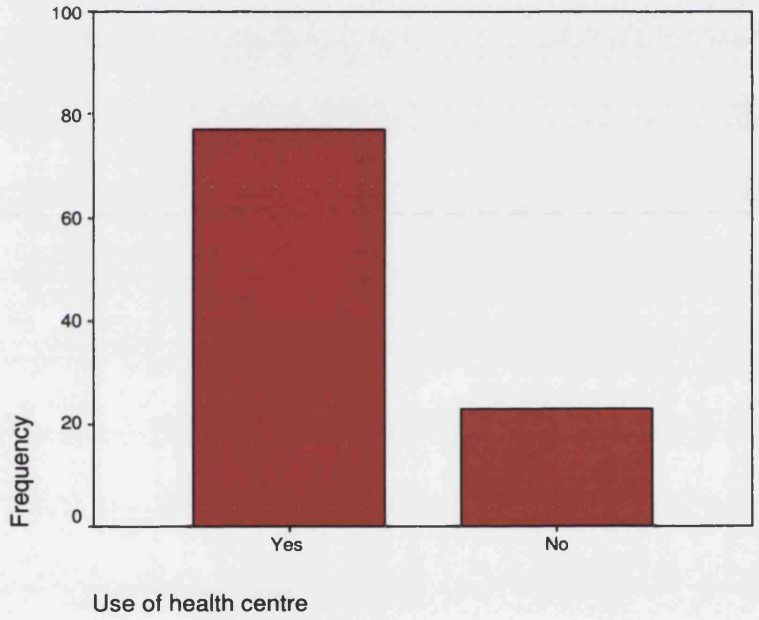
[22] The round flat metal plate used to cook tortillas.
[23] Someone who cries a lot – cry-baby.

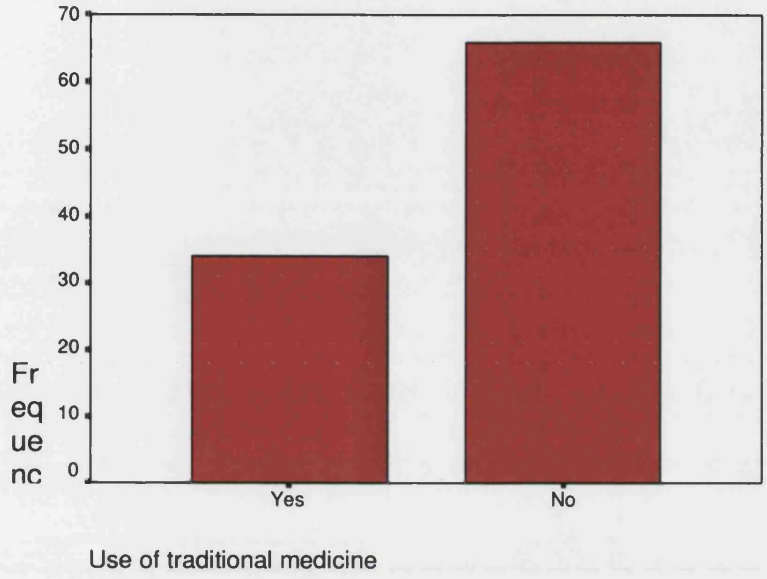
health centre is widely used as 77 per cent (n=77) reported regular visits in the household survey. From observational evidence within the clinic, it certainly appears a popular choice for women and their children. It is very much a female dominated domain. Indeed, during my own visits to the health centre, very few men were ever in evidence. Furthermore, protests by women about the previous male doctor had led to his replacement by the current female doctor, so completing the exclusively female environment of the health centre.

FIGURE 7.1 USE OF THE LOCAL HEALTH CENTRE



In terms of "traditional" healthcare, the numbers reporting usage is substantially less, as Figure 7:2 demonstrates.

FIGURE 7.2 USE OF TRADITIONAL HEALTHCARE



This "traditional" healthcare includes visits to *hierberos* or *curanderos* as well as the *hueseros* (bone setters) found throughout Latin America (Oths, 2003). It also includes the home use of herbs and teas and the like (see Oths, 2003; Wayland, 2001; for evidence of similar practices from the northern Peruvian Andes and the Brazilian Amazon region). The two-thirds (66 per cent / n=66) of women householders who state that they do not use any such methods of healthcare is extremely surprising. Certainly, it does not align with observational evidence gained whilst living in the community when it appeared that almost all women could recount an experience of visiting one or other of the local *curanderas* and would instantly be able to come up with a household remedy for many minor illnesses and conditions, including colds and minor stomach upsets. The latter would often involve the use of herbs grown around their houses.

It appears, then, that this figure of non-usage is another incidence of under-reportage. It is likely that this occurred for the same reason as the under-reporting of income. Visits to *curanderos* are generally costly and, therefore, women would be loath to admit to having this disposable income for fear of *envidia* and reprisals of witchcraft

(which would itself cause ill health). Indeed, many of the interview participants who had stated in the questionnaire survey that they did not visit *curanderos* recounted experiences of visits during the more private context of the interview (questionnaires were frequently conducted in the presence of extended family members or neighbours). Those who spoke of using *curanderos* would state that they were the second choice option for healthcare "*si no funciona la clinica*" (if the clinic doesn't work) precisely because of the cost involved in consulting the *curandero*. In addition, the *mestizo* doctors and nurses at the clinic do not regard the use of traditional methods of healthcare highly. Several respondents described the doctor as "*loca*" (mad) because of the *regaña* (telling off) they received. Others were afraid of both the doctor and nurse because of their dismissive attitudes. Such treatment appears to be a common occurrence across Latin America. For example, Greenway (2003: 94) reports how Quechua people in the southern Andes are loathe to use the local medical post as they are "treated rudely by staff". This may be another reason for the under-reporting of traditional healthcare to an outsider. The staff's somewhat disrespectful treatment of women who do attend the clinic, but who also are known to use "traditional" treatments, may also contribute to their lack of trust in the clinic's services and, ironically, make them further inclined to use traditional services.

On one occasion, after a break from the community, Luisa told me she had been ill for two weeks and that, although having first visited the doctor and bought the tablets recommended, she compared the clinic unfavourably with the *curandera* (in this case a woman: see chapter eight):

> "All my body hurts...a lot in my abdomen and everywhere. I'm always tired and I haven't got any energy. That's why I'm not working...I just about made these three pots in the last few days. And I have no appetite. Yesterday I didn't eat anything...until I felt like I wanted to be sick. I took these tablets that the doctor here gave me but they didn't do anything...I went to see a *curandera*... she is also a *partera*. That's why I went to her because it is my womb that hurts. Many people from here go to her...now she is very old. Here in the clinic, the doctor put these metal things here [points at both sides of abdomen] but she just used her hands [indicates how the women felt her abdomen with her fingers]. She gave me a different prescription - these – I took them yesterday and this morning and I feel a little better. I'm going to Teopisca tomorrow to buy some more".

For many women, more trust is placed in natural, traditional methods of curing and in more informal discussions some women noted discomfort at the ways in which the doctor in the clinic *"revisa la cuerpo"* (examines the body). The ability of the *curandera* to assess the problem without modern implements is clearly associated with genuine skill. However, most *curanderos* also use injections and other Western medicines. Rafaela, a widow in her forties, noted of *curanderos*:

> "They tell us what medication we need and they get it for us."

Petrona 1 (in her fifties) noted, with no obvious sign of contradiction, the inclusive nature of the different health paradigms in the *curandero's* practices:

> "They come to look at the house, they have to pray. You have to buy the candles they tell you to buy and the medicine as well."

This evidence of pluralistic practices by traditional healers echoes Oth's (2003: 64) findings from the northern Peruvian highlands where healers "mix and match the techniques for which they have acquired knowledge, facility and a reputation". It may be that the familiarity with known persons and techniques contributes to trust in the explanations of illness given at the expense of those given by health personnel in the clinic. However, neither the clinic nor the *curandera/o* are economical solutions as both may signify the private purchase of medication and cost was often cited as a significant factor in which services are chosen. For example, Tiburcia, a 30 year old single woman, cited one occasion when the cost of seeking the doctor had been prohibitive:

> "We saw a doctor and he charged us 700 pesos [for medications and an operation]. We didn't accept that because we only had 200 pesos and it wasn't enough, so then we went and found the *señora* [a traditional healer]."

María (1) expressed a reluctance to visit the clinic, other than in limited circumstances, including the treatment of injury but would go to acquire the basic free medication held in stock:

> "Q: Do you go to the clinic?
> M: No, because I don't like it. I go just below here in the storeroom sometimes...they give syrups [medicine], tablets for fever.

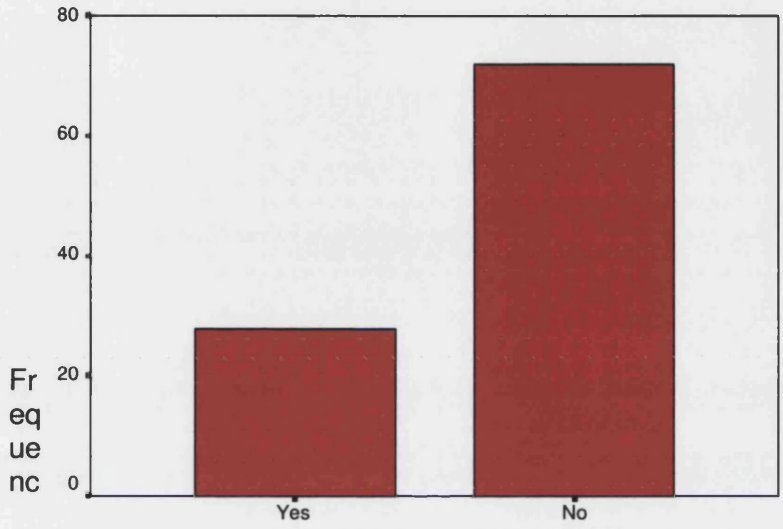
> Q: If someone in the family has an accident, do you go there?
> M: Yes."

As Luisa, María's preference was for the services of *curanderos*. However, the above quote appears to suggest that she appreciated the free clinical supplies, if not the advice, of the clinic. When María (2)'s daughter fell ill, traditional services were the first point of call and, unusually, Western healthcare was a last desperate option:

> "First I went to the *curandera* from just below here and she told me that she couldn't do anything because the spell was very strong. We went to the other *curandera* and she said that it had already got hold of the spirit but it wasn't going to pass because she was sentenced...She was going to die straight away.
> Q: So the *curanderas* couldn't do anything?
> M: No, they called the spirit...after that we took her to the clinic in San Cristóbal but they couldn't save her."

Despite having sought Western health care, this clearly did not equate to a total acceptance of a biomedical explanation of illness. It is also interesting that the local clinic was not judged adequate, further illustrating a lack of trust in its services. The existence of other services (such as facilities outside of the community) indicates that there are further options for women deciding the healthcare for themselves and their families. Figure 7:3 indicates that a minority of 28 per cent (n=28) report using "other" health services.

FIGURE 7.3 USE OF OTHER HEALTH SERVICES



These health services include the use of health care facilities outside of Amatenango, particularly in Teopisca and San Cristóbal de las Casas, as María (2) noted. However, interviews revealed that the most common of these "other" health services was self-medication. Whilst Luisa had been relying upon medical advice in her purchases of medication, purchases from the pharmacy in nearby Teopisca are often made without advice from either a biomedical doctor or a *curandero.* Self-medication and extensive use of the pharmacist's advice is a common practice throughout Mexico. This is again, however, an expensive option especially given the low levels of income noted in the previous chapter and the relatively high cost of medicines. In contrast, medicines from the clinic's *bodega* (store-room) are free albeit limited in variety and stock. As María noted, many visit the bodega regularly for basic medications. Nevertheless, a lack of trust was also expressed in the effectiveness and quality of these medications by some respondents (see Chapter Eight).

WOMEN AS CARETAKERS OF HEALTH IN THE PUBLIC SPHERE

Community health care and "empowerment"

One of the primary decisions associated with women's health care roles, then, is to decide when and which health care services to consult. However, aside from the important role of women as health carers within the family, the care of health has diffused to the undertaking of responsibilities of health within the wider community. In effect then, women are also an integral part of these same services. In terms of development programmes, it is essential that the importance of these roles be recognised. Not only will an understanding of their centrality to health and reproduction enable any project to function effectively and with respect for indigenous beliefs and culture, but recognising the crucial role of women can also promote their empowerment. The centrality of women's health roles is seen across the Latin American continent. For example, Vieira Machado (1993) discusses how women have played crucial roles in health and, therefore, were instrumental in mobilising for health in northeastern Brazil in a broader context of feminist empowerment. However, the danger of increasing medicalisation along Western lines is the patriarchal nature of this model, which alienates women from their traditional knowledge and indeed transfers healthcare from the private sphere into the public. In so doing, women are often disempowered. For example, Wayland (2001) discusses the need for policy makers to pay attention to women's knowledge of health, particularly medicinal plants, as a source of their authority in communities. Also, research in Yucatan, Mexico by the International Development Research Centre reveals that:

> "The success and efficacy of any policy, program, or community development plan, must consider the population as actives subjects of these processes. That is, researchers must recognise and accept that the populations have the capacity to identify their own problems, and the ability to establish the most appropriate actions to solve them...The participation of women was fundamental to the study. Women demonstrated great effort, time, and interest to solve the challenges faced by the communities for the achievement of family and community well being."
>
> (Castillo and Viga, 1994:154)

Thus, whilst women's responsibilities for healthcare should not be assumed, as they are likely to also have many other crucial reproductive and productive responsibilities, those health care responsibilities that they do undertake should not be diminished. Women's existing skills and potential in this area need to be recognised. The important healthcare roles undertaken by women in the public sphere of Amatenango include those of *"parteras"* (mid-wives), *"curanderas"* (traditional healers), and *"promotoras"* (local women trained by the clinic to visit homes and advise on sanitation and general health care prevention). All these roles are now monopolised by women.

Curanderas and Parteras

In respect of *curanderas*, this monopoly represents a stark contrast to former years when almost all were men. Although there are reportedly now both men and women, I personally only came across women *curanderas* and many of my interviewees asserted that there were in fact only women *curanderas*. The precise number of *curanderas* in the community was also disputable but, in general, the number seemed to average at about five. I was aware of the exact identity of three of them. The confusion over the exact number of *curanderas* and their identities is reflected in the following commentaries and may result from the secrecy surrounding the practice. Josefa, for example, remarked on the young age of today's *curanderas* and their dual role as *parteras* and *curanderas:*

> "Q: But are the *curanderas* young or are there only old *curanderas*?
> J: There are only the two young ones, it seems to me.
> Q: And they are *parteras* as well?
> J: Yes, they are both."

María (3), a fifty-two year old mother of five living children, however, contradicted this information, stating that the *curanderas* are old and also reflected on the supernatural nature of their power base in society (see Greenway, 2003; Miles, 2003, for similar discussion of the supernatural power assumed by traditional healers in Peru and Ecuador):

> "Q: Are there young *curanderas*?

M: No, just the old ones. Now they have their spirit, they have power.
Q: How do they get their spirit?
M: Who knows, they say it is their luck."

María (2), however, gave more detail about the contentious position this power can give *curanderas* and the present trend for women *curanderas*. She spoke initially about one particular male *curandero* who cured a member of her family in the past:

"Q: He knew a lot, the *curandero*?
M: Yes, he knew a lot. That's why he was killed.
Q: Who killed him?
M: We don't know who it was. Not even his daughters noticed. They killed him inside his house with a gun. He was already an old man then.
Q: And he was killed because he knew how to cure?
M: Yes, because he knew how to cure well.
Q: And people didn't like that?
M: No, because they said that he cured well and earned a lot of money, because of envy. But it wasn't paid, it was just up to you if you wanted to give five or six pesos.
Q: And those that are curing now, they aren't as good?
M: They don't know, they are younger.
Q: And how to they get to become *curanderos*?
M: It's that it is their luck, they already have it from birth. From their spirit.
Q: Are there women who are *curanderas*?
M: Yes, there are women who know.
Q: And were there before?
M: Not before, there was only one.
Q: And has she died now?
M: Now she has died.
Q: But there are more women?
M: Yes, now there are some five or nine."

Teresa also stated that all the *curanderas* are now women and that a previous *curandero* was murdered:

"Q: Are there women and men [*curanderos*]?
T: They are women. There was a really old man who lived down here, he was killed.
Q: Why was he killed?
T: Who knows.
Q: Was it because of envy that they killed him?
T: Yes, it was actually. It was said that he was thrown off the roof."

The increase of women *curanderas* is a particularly interesting development, given that *curanderas* traditionally command much respect in the community and that their duties are often well paid (despite María (2)'s contention that it is a voluntary minimum payment). Indeed, Miles (2003) describes traditional healers in Ecuador as "entrepreneurs" and notes that previously they had been denounced for charging "exorbitant fees" (ibid.: 107). The role also requires women to be free of male authority in visiting homes whenever and wherever the need arises. This move reveals much about the increasing economic and personal authority women are commanding in the community. This can be taken as an indication of the changing boundaries of the public and private spheres or, to some extent at least, the de-gendering of these spheres. As noted in the discussion of changing gender roles and tasks in the household, men are taking up tasks related to the private sphere, such as collecting firewood. With the growing number of women as *curanderas*, women are also moving into the public sphere.

It is, however, by default that they have become *curanderas* as a result of a lack of men declaring themselves to have the ability. Many men may have been frightened of doing so as the benefits of being a *curandero* appear to be counterbalanced by the danger of the post. Given this danger associated with the power of the post, then, it is likely that women as *curanderas* appear less threatening as they are not traditionally conceived to be powerful figures within the community in their own right. With the lack of male *curanderos*, women merely increased their traditional healthcare roles to encompass this further role. Women have always been the *parteras* of the community, a clear extension of their maternal roles (see Chapter Eight).

Many of the women who are now *curanderas* are also *parteras* (as Josefa indicated). Therefore, the undertaking of the wider healing tasks may be seen as an extension of their identity as mothers. It is likely that the role of *curandera* has become an ambiguous one in terms of gender identity. As men reject the role, it has been reinvented and reclassified. It is now "feminine" in that it is an extension of women's private sphere reproductive roles, yet it is one which takes place in the public sphere and one to which responsibility and respect are given. It is perhaps an

example of how tradition and belief may continue but be "re-gendered" to allow women more access to public authority, even if it is only by default. What remains to be seen, however, is whether this "re-gendering" will also result in a devaluing of the role in the future as it becomes more associated with women. At present, the role still seems to command authority but it is possible that upcoming decades may reveal changes in attitudes to *curanderas* and conceptions of their power.

Promotoras

Women are also taking up other more public roles, which relate to their traditional reproductive identities. A prime example of this is the role of *promotora.* These local health promoters are generally women and their tasks include visiting homes to advise other women on ways of better fulfilling their household responsibilities. Carolina described the kind of tasks they are advised upon:

> "They tell us that we should keep the house clean, boil the water, make the food and tortillas well. We do what they tell us."

Modesta, a thirty-two year old separated respondent who lives with her brother's family, gave more detail about the *promotoras*:

> "Q: Are there also *promotoras* in the clinic?
> M: Yes.
> Q: Are they all women?
> M: Yes, they are women from here. From Amatenango.
> Q: And what do they do?
> M: It's them who take the people to the doctor.
> Q: And the doctor says what to do?
> M: Yes. The *promotoras* don't know. They come to give classes.
> Q: What do they tell you?
> M: That you have to sweep, you have to clean the house and the toilet.
> Q: How do they know about it?
> M: They learn from the doctor.
> Q: Are there many promotoras?
> M: Only three."

Like Carolina, Modesta respected the advice of the *promotoras.* However, their limited role as advisors on household tasks is also stressed in the excerpt above. Nevertheless, although it may be that the role of health promoter is "considered to be

"naturally" feminine and is undervalued" (Lange et al, 1994:194), it also can have positive impacts for women. Not only does it accustom the community to seeing women actively participating in the public sphere and valued in this role by an external authority, *promotoras* in Chile indicated it had given them increased "self-reliance [and]...self-esteem as well as [increasing] their autonomy to make decisions. From a gender perspective, it contributed to the improvement of the position of women in society" (Lange et al., 1994:195).

CONCLUSION

There are very clear gender roles and identities in Amatenango, which differ from those often conceptualised in Western philosophy and development interventions. For women, much of their identity centres around their occupation of social reproductive roles in the private sphere (symbolised through the marital process) and is based particularly upon their identities as mothers, but this private sphere and these roles are ones constructed specifically according to the particular cultural context. Their roles in health and family care are, however, a key part of these identities. Women are the primary decision-makers in the family in relation to use of health services and their negotiation of the different services on offer is as revealing of their pluralistic perspectives on health, as it is of issues of trust in biomedical services. Women appear to express more trust in the services of *curanderos* but not to the exclusion of biomedical services, which they consult for minor injuries and often as a first point of call in the case of other types of illness. It is likely that the distrust in the advice given by biomedical health providers is linked to their attitudes to traditional beliefs and practices, and in turn translates into a continued reliance upon *curanderos*. However, cost also plays a significant role in health care choices and women have become accustomed to the medications offered by Western medicine and will seek these from the clinic when they are freely supplied. They also welcome their incorporation into traditional healing methods.

The more public extensions of the social reproductive role in terms of health, particularly the appearance of women *curanderas* and their monopolisation of this role, appears to be indicating a greater personal and public authority by women.

Tradition is still obviously strong, however, and controls over women great (particularly the use of physical violence) and, therefore, it is perhaps necessary to sound a note of caution before over-emphasising these changes.

The next chapter further reveals how the private sphere occupied by women comes to be configured in looking at reproductive decision-making. It draws together data both from this chapter and the previous in highlighting how the importance of motherhood and the constraints of a poor socio-economic and health environment can complicate such decision-making.

CHAPTER EIGHT

REPRODUCTIVE DECISIONS: GENDER, CULTURE AND POVERTY

INTRODUCTION

In the previous chapter, I discussed the nature of the relationship between gender roles and identity, particularly those of motherhood, and health care. In doing so, I focussed upon how women come to be defined both by themselves and by their community neighbours as wives and mothers and subsequently outlined how healthcare, both within the family and in the wider community, is an integral part of gender identity. In this chapter, I lead on from this discussion by looking further into the practicalities and the social and cultural conventions governing how women become mothers. The various influences upon reproductive decision-making relate both to constructions of ethnic and gender identities as well as to survival strategies adopted to cope with poverty.

There are many factors that govern decisions regarding family size. Here I reveal those that are most significant in Amatenango, including cultural norms and economic constraints as well as official interventions. The chapter is divided into four main sections. The first considers safe motherhood. The health implications of motherhood for women, particularly in terms of maternal mortality, are an important factor in reproductive decision-making. In relation to this, the cultural context of pregnancy and birthing is discussed in terms of choices between "traditional" or "skilled" care. The subsequent section looks at child mortality and the complex issue of poverty as influential factors on decisions about family size. The experiences and perspectives of women in relation to contemporary contraceptive usage are presented in the penultimate section and the final discussion revolves around the practical and cultural reasons for promoting the value of children in the household.

SAFE MOTHERHOOD

As noted in previous chapters, the debates surrounding reproduction often focus on the issue of population at the national level, and inversely relate population growth to economic growth. Many discussions, however, are also centred upon safe motherhood and the

necessity of limiting family size for both the health of the mother and of the infant. Links between the two objectives are noted and often the two are interwoven in family planning policy and programmes so that it can be difficult to judge which is the primary motivating factor. This section discusses the issue of safe motherhood, both at the level of policy and at the level of the experiences and perspectives of individual participants.

Maternal mortality and morbidity

Discussions surrounding safe motherhood are based primarily around the dangers of maternal mortality, a phenomenon which has become rare in the industrialised North but which is common in many developing countries. As the WHO et al (1999: 1) remarks, "[t]he tragedy is that these women die not from disease but during the normal, life-enhancing process of procreation". Statistics measuring maternal mortality are notoriously unreliable as methods for collecting data differ between countries and many deaths go unrecorded for various reasons (WHO et al, 2000). However, even those limited statistics that are available mark a clear distinction between developed and developing nations. The MMR (Maternal Mortality Ratio) is the statistic commonly referred to in measures of maternal mortality. As its name suggests, it functions as a ratio rather than a percentage, showing the rate of maternal mortality per 100, 000 births. The WHO et al (2000) estimates that there were approximately 515, 000 maternal deaths in 1995. Only 2, 800 (less than one per cent) of these occurred in the industrialised world. More than fifty per cent of these deaths (273, 000) were in Africa. However, there were also approximately 22, 000 maternal deaths in Latin America, accounting for four per cent of the total throughout the world for the year. The WHO (ibid.) also notes that the overall global MMR is around 400 per 100, 000 live births but regional statistics differ dramatically. The MMR for Africa is clearly the highest at 1000, followed by Asia (280) with Latin America's MMR for 1995 standing at 190.

Although figures are equally difficult to determine, a high MMR also suggests a high incidence of maternal morbidity as "[f]or every woman who dies, many more suffer from serious conditions that can affect them for the rest of their lives" (WHO et al, 1999; 1).

Most recently, fistula[1] has been identified by the UNFPA and other organisations as a common post-natal condition arising from complications during birth and implicating an extremely poor post-natal quality of life for many women in developing nations. The condition can mean permanent disability for the woman and also results in long-standing anaemia, incontinence and sterility, with an array of social consequences.

In comparison with many developing nations, the MMR in Latin America as a whole is relatively low at 190 and the MMR in Mexico is yet lower, standing at 110 (Langer et al, 2000: 668). Nevertheless, in comparison with a figure of 28 for Europe and only 11 for Northern America, this figure is worrying and negative changes to these figures as a result of increasing poverty in some regions may also be expected. For example, CISAS (1997) notes that maternal mortality rates in Nicaragua rose during the 1990s. Furthermore, the national figure masks regional differences. As noted in previous chapters, Chiapas is amongst the most impoverished states in Mexico. It is perhaps more likely that the state would experience similar rates to neighbouring Guatemala, where rates are estimated to be approximately 270 (Hinojosa, 2004), than to the rest of Mexico. Like Guatemala, specific figures on Chiapas are difficult to obtain, not least because of the high proportion of indigenous populations that are characterised by many of the factors that make maternal mortality statistics unreliable. These include, for example, low levels of formal health care coverage, remote rural communities, lack of registration of both female births (meaning that corresponding female deaths are unlikely to make it into death statistics) and deaths, and low rates of births attended by skilled birth attendants (Garza Caligaris and Freyermuth Enciso, 1995). Despite the absence of reliable statistics suggesting a high incidence, the risk factors similar to those reported of Guatemala (Hinojosa, 2004) of a poor health environment, high levels of poverty and inadequate healthcare coverage suggest that maternal mortality (and therefore morbidity) is likely to be more of a problem than official statistics can ascertain. Indeed, Freyermuth Enciso (2001) conceptualises the issue of maternal mortality to be not only widespread but also highly politicised in the state.

[1] Often known as "foot-drop", the condition is caused by protracted labour, which results in a wound between the vagina and the bladder or the rectum.

For many women, the danger signs may already be present during pregnancy, as Carolina's analysis of her own state of health indicates:

> "Now I am three months pregnant again but I feel weak, my head hurts and I don't have any appetite. I have been to the clinic. They tell me I am weak and that I need vitamins but there is no money to buy them"

Evangelina mentions the potential consequences of such a poor health status during pregnancy:

> "Q: Are there women who die [during childbirth]?
> E: Yes. There are quite a lot.
> Q: Why do they die?
> E: I think it's because they have no strength left."

The threat of maternal mortality, however, is not merely abstract as Micaela indicates her own, and her husband's, fear of death during childbirth and its implications for her family:

> "...I wanted to have more children but I was afraid of so much pain. I could die and he was going to be left with four children, that's what [my husband] thought..."

For Micaela and Evangelina, then, the risks involved in childbirth are real, whatever the absence of official statistics. For them, these risks relate to the combination of the poor health status of the woman and the physical demands of childbirth. However, global health policy also identifies other risk factors. Amongst these are the birthing environment and practices. Traditional birth attendants are specifically singled out as problematic.

Birthing practices

One of the aims of Safe Pregnancy initiatives is to increase the number of births that are attended by a skilled birth attendant (SBA). This, in turn, is an integral part of the Millennium Declaration Goals (MDGs) that aim to reduce maternal mortality. The perspective of the World Health Organisation towards traditional birth attendants (TBAs) has undergone various shifts throughout the last few decades. Although dismissed during the years previous to the Alma Ata when Western medical technology was promoted, the implementation of Primary Health Care strategies involving grassroots community health carers also involved the incorporation of TBAs into local health systems.

However, more recently, this strategy has been judged to have had little or no effect on rates of maternal mortality and there has been a policy U-turn, incorporated into the WHO's "Making Pregnancy Safer" initiative and specifically the key objective of their recent "Global Action for Skilled Attendants for Pregnant Women" strategy. At present the UNFPA estimates that 58 per cent of births worldwide are assisted by a TBA. For Mexico, this figure stands at 69 per cent, in common with its neighbour, Guatemala, where the Pan American Health Organisation estimates that 60 per cent of births are attended by *comadronas* (Hinojosa, 2004). The objective is to achieve the presence of skilled birth attendants at all births and a stricter definition of what constitutes an SBA is in place. Alongside requirements related to general pregnancy care and advice and normal birth management, this definition includes biomedical related skills such as recording "maternal and fetal well-being on a partograph or modified partogram", the ability to "actively manage the third stage of labour, including ocytocic drugs" and "arranging for emergency evacuation to a referral centre if it becomes necessary" (WHO, 2002: 2).

Whilst the details, then, are increasingly specific, the basis for this policy shift is rather unstable. It seems somewhat illogical to, on the one hand, maintain that data relating to maternal mortality rates are unreliable, while on the other, refer to these same data in noting that TBAs have been ineffective in reducing maternal mortality. Equally, such a dramatic U-turn, without first examining the reasons why TBAs might be ineffective, is a potential waste of funds. There may be reasons such as, for example, lack of sustainable support and training and of ongoing funds for birthing kits, or simply that, whatever the efforts of a trained TBA, the influence of poverty and poor health environments dictate against safe motherhood. In addition, the practicality of aiming for the presence of a SBA at every birth is questionable. In remote rural areas with poor healthcare coverage, it is unlikely to be possible. Equally, SBAs may fail to understand the cultural practices and understandings surrounding birth that influence women's decisions to seek a TBA. Although Hinojosa (2004) discusses how the incorporation of TBAs in Guatemala has effectively implied a strategy of training them almost exclusively in biomedicine, integrating TBAs into the system could be undertaken in ways implying a greater respect for such cultural differences and may also be the more practical and pragmatic solution, whatever the limitations. Even if we were to accept the necessity of SBAs, cultural contexts of birthing practices and pregnancy care do not merely emanate from TBAs. To

suggest merely replacing TBAs with SBAs is as if to suggest that women are passive recipients of healthcare and cultural practices in pregnancy. On the contrary, women themselves are likely to be active actors and hold their own beliefs surrounding birth and pregnancy. The existence of such beliefs and practices is likely to make a significant difference to whether, and how, women accept Western perspectives on safe pregnancy and childbirth.

This is clearly evidenced in Amatenango. Evangelina, for example, had a particular difficult experience during the birth of her only daughter and yet did not seek the assistance of the doctor, as she describes here:

> "Q: How long were you in labour?
> E: When she was born...it started on Sunday. Then it stopped and came back to me on Monday, Tuesday, Wednesday, Thursday, Friday...until the Sunday at about three in the afternoon when she was born.
> Q: Were you here?
> E: Yes, I couldn't go anywhere...
> Q: Was *Doña* Cecilia attending you?
> E: Yes.
> Q: All the time?
> E: Just when the pain started...she said that it was fine.
> Q: The doctor didn't come?
> E: No.
> Q: And you didn't want to go to the hospital?
> E: No, because my mother-in-law told me that I had to wait. As she has had ten children, she knows and I didn't want to go.
> Q: The hospital is in San Cristóbal?
> E: Yes, it's a long way....
> Q: Are there women who do go there?
> E: Yes those who have a caesarean, they go. In a normal birth, [the *parteras*] attend to you here.
> Q: They know when you have to go?
> E: Yes, because they can feel if it is going to be normal or if it is going to be a caesarean."

For Evangelina, not seeking the assistance of a SBA was related to her own trust in the *partera* as well as in her mother-in-law's experience and advice. She did not rule out seeking biomedical assistance if the *partera* had advised it. It is, however, difficult to know at what point this referral would have come, given that it was not made during a whole week of labour. Similarly, Teresa, an older woman, noted that the births of two of her children had been difficult, but said:

> "I was only with the *partera*. She knows about the birth...The hospital knows as well but it is far. It is San Cristóbal."

A minority of women dismiss the services of *parteras*, preferring to give birth in hospital. Alberta linked maternal mortality in the community with the lack of a doctor during childbirth:

> "A: Because here there is no doctor, whereas there is there.
> Q: Are there women who have died here then?
> A: Yes, here it's dangerous."

Micaela, however, discusses the practical reasons why women choose not to go to visit the doctor during pregnancy. For her, the existence of biomedical pain relief during birth is vital, but such interventions are made via the *partera*, rather than directly from a SBA:

> "Q: There are women who just go to the *partera* and don't go to the clinic? Why?
> M: Because they don't speak Spanish and they don't understand what the doctor says to them. But now the *parteras* accompany the women who don't know Spanish to the clinic so that they can explain to them.
> Q: So now the *parteras* work with the clinic?
> M: Yes.
> Q: Do all women go to the *partera*?
> M: No, now they go with the doctor. It's dangerous if there is no doctor, there's no injection.
> Q: Did you have your sons here?
> M: Yes, I had them at home.
> Q: But there are women who go to the hospital?
> M: Some go to the health centre, others don't.
> Q: But not you?
> M: Me, just normal with the *partera*.
> Q: And was your *mama* there? Your mother-in-law?
> M: They were both there...to take care of me.
> Q: So you didn't have any problems?
> M: No, with the first I went through about four hours of pain, until the *partera* gave me an injection. The clinic had given her the injection so that you don't have so much pain."

The *partera* was clearly the preferred option of the majority of women in Amatenango and, when questioned about their preferences, it usually appeared as if this was an automatic choice, rather than reflecting weighing-up between different options. However, this is not at the expense of biomedical services, which are combined into the traditions of the *partera* birth. Many women remarked upon *"las inyecciones"* (the injections) as an essential

component of the *partera's* knowledge and services. In addition, referral to the hospital in San Cristóbal was relied upon in births which may prove difficult. Nevertheless, at all points, the *partera* or other more senior female members of the family (often the mother-in-law) are entrusted gatekeepers to these services. The existence of the *partera* as the local TBA is an essential component of biomedical health services in this context.

One of the reasons *parteras* are preferred to other biomedical services is because of the prevailing cultural practices surrounding birth. Whilst biomedical interventions of pain relief in particular may be welcomed, there are also other more traditional healthcare practices undertaken. For example, Petrona (1) noted the practice of drinking *atol*, a thin corn gruel, after birth:

> "With a little chili, so that the milk comes down."

Similarly, Petrona (2) described the necessity of drinking *atol* and other precautionary methods:

> "P: It's just a little [spicy]. It has a little chili and a bit of black pepper....
> Q: Just for women after the birth?
> P: Just for women. The men don't drink it and it's only when the baby is born. When we are ok, then we don't drink it anymore.
> Q: Do you drink it for a long time?
> P: Just a few days, that's all.
> Q: And you can't touch cold water, is that right?
> P: No, that lasts for some months – that we can't get hold of cold water, or drink cold water."

In relation to the heat of the body during birth and other herbal measures given by the *partera*, María (2) explains that:

> "They give you a herb, a herb that's very bitter. They give it to you very strong so that it gives heat to the body...When it's free [of the baby], you drink chamomile so that the body can rest..."

Carolina also notes the ceremonies of protection for the newborn baby undertaken by the *partera*:

> "The same *partera* cures the baby when it is born. She lights twelve candles to protect the child from envy."

Whilst it may be difficult for Western biomedical practitioners to understand their necessity, such practices are an important part of cultural identity in Amatenango. An SBA who does not incorporate such protective measures may be poorly received, albeit the lack of an "appropriate" birth environment is deemed to increase the risk of maternal mortality and morbidity and women might otherwise welcome the clinical services they also offer. However, if women are unlikely to seek out an SBA in the first place, it may be more pragmatic to integrate biomedical approaches and the cultural practices of TBAs as well as being more respectful of cultural difference.

REPRODUCTIVE DECISION-MAKING: FAMILY SIZE

Child mortality and fertility

The shifting debate over the appropriate birthing environment is representative of the whole debate over maternal mortality, the reasons for which are complex and poorly understood. Perhaps because of the lack of understanding, the strategies adopted to combat it are simplistic and, as well as improving conditions of birth, usually involve advocating fewer pregnancies. It is a matter of logic that fewer births will imply less maternal mortality. However, there appears little evidence to suggest that maternal mortality proportionally decreases with reduced rates of fertility. Nevertheless, such strategies fit well with more macro-level population control policies and are also a means of attempting to contain the problem whilst a more precise understanding of the factors involved is formulated and without having to address wider infrastructural problems relating to poverty reduction and adequate and appropriate health care coverage.

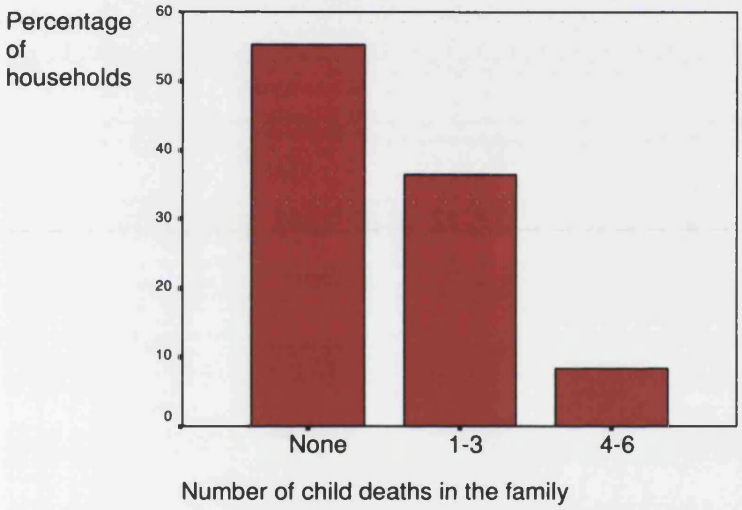
These efforts may, ironically, be hampered by a high incidence of child mortality, which implies that more pregnancies are necessary to achieve a balanced family of healthy living children. Child mortality is a related issue to that of safe motherhood as the survival chances of infants are linked to the health status of their mothers. In a clear correlation with maternal mortality, child mortality is sharply differentiated along economic lines. Mexico, in particular, experiences an:

> "...epidemiological polarisation, an unequal distribution of health needs between the northern and southern states of the country, between urban and rural areas and between social classes...[which includes a rate of] infant mortality [that] is twice as high in the five poorest states than in the five

> richest states of the country...[and the fact that] children of women living in extreme poverty are 2.5 times more likely to die before the age of one than the children of women who are not poor".
>
> (Gómez-Dantés, 2001:1)

Given these statistics, it is hardly surprising that child mortality is a common occurrence in Amatenango (see Figure 8.1).

FIGURE 8.1 CHILD MORTALITY



The above graph demonstrates that, while a majority of 55.2 per cent (n=53) of all families have not experienced child mortality, a substantial total of 44.7 per cent (n=43) have experienced at least one child death. This overall percentage consists of 36.5 per cent (n=35) who have had between one and three children die and a smaller percentage of 8.3 per cent (n=8) who have been unfortunate enough to suffer more than three child deaths in the family and who may have had up to six children die.

As noted above, reductions in absolute numbers of pregnancies are recognised to be related to improvements in maternal health by those involved in safe motherhood initiatives and that improved maternal health is linked to decreased child mortality and improved child morbidity. However, the cycle may be a difficult one to break as high rates of child mortality may also be an influential factor in the number of pregnancies a woman will

experience. Families who lose, or expect to lose, children are perhaps more likely to have more pregnancies to cope with, and balance out, these losses, especially in situations where children are essential to the maintenance of the household (Grimes, 1998; Kibirige, 1997; Panopulou and Tsakloglou, 1999; Mamdani, 1981). The levels of infant mortality across Latin America are high (see Chant with Craske, 2003) and evidence suggests that "fears of losing children play a part in maintaining high-order births among some segments of the population" (ibid.: 74. See also Scheper-Hughes, 1992, for similar ethnographic evidence from one deprived community in Brazil). Such "segments" include the illiterate and those living in extreme poverty – characteristics which also mark the community of Amatenango.

TABLE 8.1 TOTAL FERTILITY BY CHILD MORTALITY

			Total Fertility			
			1-3	4-6	7+	Total
Child mortality	No child mortality	Count	28	16	3	47
		% within Child mortality	59.6%	34.0%	6.4%	100.0%
		% within Total Fertility	80.0%	55.2%	11.5%	52.2%
		% of Total	31.1%	17.8%	3.3%	52.2%
	Child mortality	Count	7	13	23	43
		% within Child mortality	16.3%	30.2%	53.5%	100.0%
		% within Total Fertility	20.0%	44.8%	88.5%	47.8%
		% of Total	7.8%	14.4%	25.6%	47.8%
Total		Count	35	29	26	90
		% within Child mortality	38.9%	32.2%	28.9%	100.0%
		% within Total Fertility	100.0%	100.0%	100.0%	100.0%
		% of Total	38.9%	32.2%	28.9%	100.0%

Table 8.1 reveals a complex picture of the relationship between total fertility (number of children including those which have died) and child mortality. Both the row and column percentages appear to indicate a positive relationship between child mortality and total fertility. To take the two extremes, the most striking comparison is between that of 88 per cent (n=23) of those who have had seven or more children <u>have</u> experienced child mortality and 80 per cent (n=28) of those having only had between one and three children have <u>not</u> experienced child mortality. Similarly, 53.5 per cent (n=23) who have experienced child mortality have a total fertility of seven or above. Those who have not experienced child mortality appear to restrict their family size as 59.6 per cent (n=28) of them have between one and three children, 34 per cent (n=16) have between four and six children and, only 6.4 per cent (n=3) have had seven or more children. This figure also indicates that, although

fertility may be relatively high, very large families are actually not the norm as this small minority of 6.4 per cent represents the only families with seven or more living children.[2]

Individual family experiences substantiate these statistics. Evangelina, for instance, described the deaths of her own siblings:

> "E: I have a brother, but three died. The first died, the second is the one that's still here. Then I was born. After me, my little sister, who died five months after she was born.
> Q: What did she die of?
> E: I don't know if from fever. After her, another was born that died as well. Then my sister was born who is still here... There are four of us who are living."

In a similarly manner of fact tone, Josefa noted how many children she had had and how many had died:

> "Ten, eight sons and two daughters. Of the sons, four died and four are alive"

Equally María (2), now 53 years old, listed her living and deceased children without prompting:

> "My first daughter is María León. My second son is called Cresencio. After that, there was a son who died, then my daughter, Modesta, another - my Pablo. Then followed the two twins who died...They died when they were born."

This high rate of child mortality may mean that narrowly focussed family planning initiatives, which aim to reduce family size for the sake either of improvements to safe motherhood and / or (misguided) attempts to solve poverty are problematic. Perinatal health problems link a mother's health to that of her children but the over-riding factor in both (and therefore, in high total fertility rates) is no doubt that of poverty and the poor

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[2] The sample size here would make tests of significance meaningless and, therefore, the relationship was not subjected to such tests. The statistics also do not necessarily represent completed families, as participants from within and past the reproductive age span were included. However, despite these reservations, the statistics do illustrate interesting trends and reflect similar findings from other research (referenced above) in which "[f]ertility is found to be...positively related with the levels of infant mortality" (Panopulou and Tsakloglou, 1999).

health environment this implies (see Chapter Six). The World Bank (2000) notes that the inadequate diet that girls may receive during childhood can result in stunted growth and that this, in turn, leads to higher risks of complications in pregnancy and childbirth. Equally, it, along with the World Health Organisation, UNICEF and the UNFPA recognised in 1999 that "[t]he poor health and nutrition of women and the lack of care...contributes to their death in pregnancy and childbirth..." (WHO et al., 1999: 1). This implies that, until the issue of poverty reduction is addressed, child and maternal mortality and morbidity are likely to remain high.

Poverty and family size

Conversely, however, efforts to limit numbers of pregnancies have also been regarded as a step on the way to poverty reduction. The aim of reducing absolute fertility not only relates to maternal and infant health but also relates to the broader aim of population control and its linkage to poverty reduction and economic development at the macro-level, as has been discussed at length in previous chapters of this thesis. The translation of this latter linkage to micro, family-level, decision-making regarding family size is evident. Goméz de León and Hernández (1998: 300) note that this trend is by no means simplistic but that in conditions of extreme poverty the connection is clearly being made:

> "poor women made less demand for contraceptives than non-poor women (77.2 per cent and 82.3 per cent respectively). Nevertheless, it should be noted that among the extremely poor women, there is a very high proportion of couples who wish to postpone or definitively limit their pregnancies."

Participants echo this trend in their discussion of the cost of children. Alberta, with only one young child, remarked that:

> "A: It's just that things are expensive – that's why I don't want to have a lot of children...only two. Like my sister, she has two children.
> Q: And what does your *mamá* say?"
> A: Nothing good. She had ten children and she had to work a lot."

For many women, their decisions about restricting the size of her family are influenced by their own extended family experiences and advice regarding the cost and work implications of a large family. It was usual for women to compare their own families (favourably or

unfavourably) with that of their more distant relatives or with their neighbours in this way, and to draw conclusions about the decisions that they should take regarding family size. The overriding narrative amongst practically all the women I interviewed and with whom I held more informal conversations was that lack of land and other economic resources meant that they would have to restrict their family size. It quickly became clear through these conversations that this common discourse emanated particularly from the official advice given in the local clinic, as Micaela (herself sterilised after having had 4 children) describes:

> Q: What did they say in the clinic?
> M: That you shouldn't have many children, because you don't know how they are going to eat. So we listen to them and then the *papá* thinks about it."

Similarly, María (2) talks of the present trend of limiting family size and the origins of this trend:

> "Now they have three or four children. The doctor tells them that life is expensive these days, clothes, food..."

Other participants also imply more subtly the source of their advice, as did Evangelina who uses the common term "they" to describe the opinions of "outsiders":

> "...Because it costs a lot for their clothes and their food. That's why they are thinking now that the women here will have only a few children. There are some who only have two or three."

Josefa explained why she had used injections after having had ten children and until her menopause three years ago, also referring indirectly to advice given in the clinic:

> " I didn't want any more children...they say no more. That they want clothes, their food..."

As well as food and clothes, one of the most frequent preoccupations of women in relation to providing for their children is related to lack of land, as Petrona (2) notes:

> "Q: Did you want to have more children?
> P: No, with six, it's OK. Why have more children when we don't have much land...?"

The relationship between land and family size is clearly based upon the subsistence lifestyle of the families of Amatenango. As was noted in Chapter Six, 28.3 per cent (n=28) of all households are totally subsistent upon the production from their land for their food supply with a further 33.3 per cent (n=33) relying upon their land for the majority of their food supply. Therefore, the frequent comments about lack of food for children by most women can be translated to the limited availability of productive land, as well as lack of income. There is another implication, however, to such comments as land is also traditionally given to children upon marriage.

The relationship between poverty and family size is a complex one. On the one hand, poverty and the related health environment affect maternal morbidity and infant mortality rates. Infant mortality is influential in increasing total numbers of pregnancies. However, fear of maternal mortality may play a role in restricting fertility. Equally, poverty plays a more direct role in influencing ideas about reducing family size because of doubts about providing for the children, as the data above reveal. This latter factor gives credence to the "adaptation perspective" of fertility control, which suggests that couples reduce their fertility in relation to "changing social and economic conditions". This stands in contrast to the "innovation" perspective upon reproductive control, whereby all couples, regardless of economic circumstances or ethnic identity begin to control their fertility because of the appearance of new technologies (Parrado, 2000: 421).

These two perspectives exert influence over the methods undertaken by family planning programmes to promote family planning as:

> "...proponents of the innovation approach emphasise informational and contraceptive constraints as central obstacles to lower fertility...Proponents of the adaptation approach, on the other hand, maintain that fertility falls in response to changing socio-economic conditions".
>
> (Parrado, 2000: 422)

THE USE OF CONTRACEPTION

Much of the information and advice referred to by women emanates directly from the provisions of PROGRESA. Whilst, in some senses, PROGRESA may fit well into the innovation perspective in that, rhetorically at least, information regarding family planning is central to programmes, the connection between socio-economic conditions and

population control is perhaps more apparent. Alongside other poverty reduction strategies relating to children's education and family nutrition, family planning has been a key objective (Gómez-Dantés, 2001). The requirements of health service provision within areas identified as PROGRESA recipients necessitate regular clinic visits in order to receive income supplements and food (Gertler, 2000). These are aimed primarily at women as part of an overall strategy for improving women's status and increasing their activities in public life (Adato et al, 2000). Alongside health monitoring and vaccinations, PROGRESA also requires that all women recipients of PROGRESA who are of reproductive age should be participate in, or be subject to, *platicas* (chats) in which they are given information and advice about family planning methods.

Unwanted pregnancy

Previous to these biomedical interventions, traditional methods seem to have offered little or nothing in the way of family planning. Older participants in particular note the implications of this lack. For example, Josefa notes that:

> "Before there was no operation, there was no *remedio*. Now there is. As there was nothing before, that's the only reason there were so many children"

María (2) also stated the difference knowledge about family planning methods would have made to her own reproductive decisions (although she exaggerates somewhat how many children she did have!):

> "I had thirteen...If I had known about family planning, I would have had seven, six children. I had 13 children, and one miscarriage. Fourteen."

This suggests that large families have never been solely a matter of choice, thereby lending weight to the innovation perspective upon fertility decline in that couples would have reduced their rates of fertility in the past, should the technology have been in place (Parrado, 2000). This then indicates a previously substantial "unmet demand" for contraception. The latter term is frequently used by theorists and practitioners and is explained by Goméz de León and Hernández (1998: 299):

> "*family planning demand*...refers to the expressed desire of fertile married or cohabiting women to limit or space their

> pregnancies....It can therefore be considered that if a woman expresses her desire to limit or space births, but does not practice contraception, this is an *unmet demand*. On the contrary, if the woman uses contraceptives, the *demand* is *satisfied*."

As well as the lack of traditional methods of birth control, and in the context of limited autonomy within the home and the gender roles discussed in the previous chapter, the lack of methods of birth control methods is viewed as problematic by many women. Abstinence appears not to be a viable option and indeed many women were amused by my suggestion that men would agree to refrain from "bothering" them. For example, Micaela discusses the issue in the following way:

> "Q: But there was nothing before?
> M: No.
> Q: And the *hierberos* didn't give any herbs or anything so that people couldn't have children?
> M: No, only in the clinic. The *hierberos* don't give anything – just the doctor.
> Q: So before [the clinic] people couldn't do anything...they had a lot of children?
> M: Before there was nothing...even if there was medicine, people didn't know it existed.
> Q: But they couldn't say no to their husband?
> M: No, it's difficult."

Proponents of natural family planning methods note that in much of Latin America "the prevalence of use of family planning methods based on fertility awareness is higher than of some of the so-called modern methods" (Diaz, 1997: 303). These proponents contend that, for many more, low acceptance of such methods is merely because "users do not have the opportunity of choosing them in a context of free choice because the methods are not adequately offered"(ibid.: 304). This perspective clearly aligns with that of the Catholic Church, which dismisses all forms of artificial contraception but fails to adequately account for existing gendered power relations. Whatever knowledge a woman may have over her own body, she often does not have sufficient power within her personal relations to control sexual activity, as most of my informants suggested.

The lack of effective and realistic methods of birth control previously meant that unwanted pregnancy constituted a major problem. For those who wish to use methods of reproductive control but who cannot do so for whatever reason, this is likely still to be the

case. The illegality of abortion in Mexico and the social and cultural taboos surrounding pregnancy termination meant that discussions of the subject were practically impossible. Although in interviews and informal discussions, the subject was tentatively broached, little information was forthcoming. However, one Amatenango woman who unusually no longer lived in the community and was now a single mother resident in San Cristóbal de las Casas related her own experiences regarding a miscarriage. Her teenage son had misunderstood and believed her to have brought on the pregnancy termination herself. It was many months before he would believe her and, during this time, their relationship had been extremely strained. This example is revealing of the attitudes towards abortion, both within and beyond the community of Amatenango where even the suspicion of a miscarriage being self-inflicted can lead to condemnation of the woman.[3]

It is likely that self-induced abortion is practiced within Amatenango as within other indigenous and *mestizo* communities throughout Mexico. One study estimated that in Brazil, where similar laws regarding the illegality of abortion exist, 1.4 million illegally induced abortions are performed every year (Misago et al, 1998: 833). Such abortions constitute a major threat to women's health as complications from such procedures often result in maternal mortality (ibid.). Indeed, de Barbieri (1999: 135) reports that illegal abortions rank third as the cause of maternal mortality in Mexico.

It was only with those women with whom I had built the most trust that such issues could be addressed at even a peripheral level. For instance, in one of very few comments in relation to self-induced abortions in Amatenango, Carolina remarked that:

> "There are some women who don't want children. They throw them away after they are born, or they do things to not have them. Just the sluts."

Equally, Luisa, the mother of the family with whom I lived in Amatenango, hinted at self induced abortions on a number of occasions, although she would not talk openly. Ironically, however, she and other women talked relatively freely about mothers who abandoned their babies to die immediately after birth. Several women described a

[3] Although she was not initially a participant, she was aware of my work and later gave permission for me to include her experience.

particular unmarried woman who was rumoured to have recently left her newborn child in a river. Attitudes to this event were again very much ones of condemnation with no sympathy expressed for the predicament in which the single mother might have found herself. This predicament is clearly illustrated by the attitude of women towards single motherhood. This did not represent a key theme in my interviews but when I asked questions in more informal situations, women were highly judgemental and their language allowed little room for a nuanced understanding of circumstances. For instance, Feliciana demonstrated the community attitude towards single motherhood in the following cutting remark:

> "Q: Are there women who have children who don't have a husband?
> F: Yes, but they are bad. How is the child going to grow up without a father?"

It is impossible to know what degree of truth the stories of infanticide contain and how much was merely unsubstantiated gossip. However, the mere fact that the episodes were related illustrates that these actions may be deemed necessary in certain circumstances and unwanted pregnancy constitutes a problem, in the absence of legal and safe abortion and the lack of effective contraception and in the eyes of an unforgiving community.

Contemporary family planning options

Misago et al (1998) found that most women who undertook the dangerous procedure of self-induced abortion had not been using contraception at the time of conception. In this context, the provision of contraception and methods of limiting family size is welcomed by many women. The range of options provided in the local clinic are those that might be expected in such an environment and include the contraceptive pill, injections, female sterilisation and the IUD. Most women indicated that that the clinic allows for autonomy in deciding between these different family planning methods and showed a own sound understanding of the different functions of particular methods of contraception. However, many women would also instantly begin to concentrate upon the potential side effects of these methods, suggesting that women still have some concerns. For example, Micaela gave her own explanation of the side effects as she understood them:

> "Q: But many women don't have the operation – they use other things instead?

M: Yes, there is the pill or injections.
Q: What does the clinic say about those?
M: That it's up to you. If you want to have another child when this one has got big, they give you the pill.
Q: But you never took the pill before?
M: No, nothing before.
Q: Are there women who have problems with the pill?
M: Yes, they say that sometimes they get pains in their waist, that when they are going to have their period they get pain, because of the pill.
Q: And the injections?
M: The same – it depends on a person's blood."

Similarly, Feliciana told of her own negative experience with taking the pill:

Q: And you didn't want to take the pill?
F: No, my heart doesn't like them.
Q: You have taken them before?
F: Yes, before my daughter. I got the pills but I didn't feel well. They gave me headaches, that's why I didn't want them. That's why the operation is better..
Q: And you haven't used anything else, just the pill?
F: Before yes, I just took one and I felt bad so I left them.
Q: And what did the doctor say?
F: No, I bought them myself, because before the doctor frightened me."

Many women repeated the connection between taking one or two birth control pills and immediate side effects, often taking the form of a headache. They were often those who had bought the pills themselves in the pharmacy in Teopisca, with no prior medical advice. However, equally some women expressed a lack of confidence in the resources provided by the local clinic as did Josefa, referring to the problems some women had encountered with the birth control pills supplied to them directly from the *bodega* (store-room) of the local clinic:

"Some women get sick. They say it is because the tablets from the *bodega* are no good."

The lack of a good relationship with the local doctor (clearly indicated by Feliciana's comment that the doctor "frightened" her and by many other women's open condemnation of the ways in which they are treated in the local health centre), trust in their health services and clear advice appears, then, to be instrumental not necessarily in the uptake of contraceptives but in women's confidence in them and continued usage. One of the ways of avoiding such problems seems not necessarily an emphasis upon improving these services or relationships but an increased reliance upon methods that are more permanent in

nature and are not dependent upon patient "compliance". This indicates the paternalistic trend for providers to be "trained to decide for their "patients"..." in a context where "[c]ommonly , a woman comes to a physician with an illness expecting to be healthy, putting the power of decision in the physician's hands" and in which they "historically have not had power to decide about issues relating to their own bodies" (Diaz, 1997: 306).

The emphasis upon more permanent methods of fertility control also marks a distinction between two forms of fertility regulation, that of "stopping" and of "spacing" pregnancy (Parrado, 2000: 422). Although Parrado (ibid.) notes these two forms to be "complementary", the stopping methods are clearly preferred by local health services in Amatenango and primarily include the IUD and female sterilisation, the most common birth control methods amongst women in Amatenango. According to the survey conducted as part of this research, 6.1 per cent (n=6) of all the participants reported using an IUD and 7.1 per cent (n=7) reported having been sterilised. However, in interviews some women who had not reported using such contraception described their experiences. It may be that, as it was often impossible to conduct the surveys in private, rates of usage are higher than would be revealed in front of other family members or, at times, neighbours and before more trust had been established during the in-depth interview situation. Certainly, the use of IUDs and the take-up of female sterilisation appear to be more common based upon the anecdotal evidence during interviews than suggested by the survey data. This would equate with the findings of the Physicians for Human Rights who report a female sterilisation rate of 30 per cent in Chiapas (Kirsh et al., 1999: 419) and with the national figure stated by those involved in assessments of PROGRESA who declare that "[m]ore than half of the users of family planning methods living in extreme poverty have opted for a definitive contraceptive method, such as bilateral tube occlusion" (Goméz de León and Hernández, 1998: 307). Equally, in Mexico as a whole there is a preference for semi-permanent and permanent contraceptive methods, particularly female sterilisation (see Chant with Craske, 2003; also see Chapter Three of this thesis).

Frequently, participants reported the uptake of these methods immediately after birth. For some, this is a positive experience and such methods may be preferred to other options, as was the case of Alberta:

"Q: Do you use family planning...?
A: Yes.
Q: Which method?
A: The IUD
Q: Have you used anything else before that?
A: No, just that.
Q: How long have you been using it?
A: Since my son was born.
Q: And you haven't had any problems?
A: No, I don't have any problems.
Q: Have you been to the clinic so they can check you?
A: No, not since the child was born. They put it in me in San San Cristóbal and now we go to the clinic there.
Q: Did they tell you about it or did you tell them that you wanted it inserted?
A: I told them.
Q: And what did they tell you in the clinic [in San Cristóbal]?
A: Nothing of much use. The doctor said to me that she was going to give me an apparatus and how it worked.
Q: Did you know other people who used [an IUD]?
A: Yes.
Q: Your sister who has the two children?
A: No, she has had the operation...
Q: And you didn't want the pill or injections instead?
A: No, because there are some people who take the pill and then they say that they are pregnant...And I don't like injections."

Similarly, Feliciana described how she had gone to hospital to give birth to her sixth child, despite having given birth to all the others at home. One of the primary reasons for this hospital birth was so that she could be sterilised immediately after the birth:

"F: I left at about one and the next morning I came back. I gave birth to my little girl and then they operated on me.
Q: That was what you wanted?
F: Yes, I didn't want anymore.
Q: And what did your husband say?
F: He said that he wanted them to do the operation.
Q: Did you tell the doctor?
F: Yes, as it's a big enough family now."

Large families as a positive choice

However, limiting family size is not desired by all women. Women may make the choice, or be persuaded, to take up birth control methods after already having had a large family, as Goméz and Hernández (1998: 307) recognise in relation to the high proportion of extremely poor women who have been sterilised:

> "It should be pointed out that even when poor women use contraceptive methods, this practice is adopted relatively late in their reproductive lives.... This situation, however, is reached once there is a high fertility level and 80 per cent of the poor women who have been sterilised did so when they had four children or more."

This is certainly frequently the case in Amatenango. From my Westernised perspective, it appeared to me that most of the women I spoke to who were considering, or who had already undergone, sterilization were relatively young (many in their mid to late twenties) but had usually already had a large family (by Western standards at least). For example, Josefa notes of her younger sister:

> "...My little sister had her baby. But she is going to go to the clinic, they are going to operate on her now that she has nine children. She was with the injections but they say that the operation is better".

Many women were proud of their large families. Luisa, for instance, was clear that giving birth to ten children (all of whom were living) was a positive achievement. For such women, decisions taken immediately after birth to take up some form of birth control are problematic. The experience may be particularly negative when the method adopted is permanent in nature and the woman does not play an active role in the decision-making process. Micaela, now 28 years old, expanded upon concerns about childbirth related earlier in this chapter and described how she had recently been sterilised after having had four children, despite her reservations:

> "Q: And now that you have four children, you have had the operation?
> M: Yes.
> Q: How did you decide to have the operation?
> M: The *papá* decided. I wanted to have more children but I was afraid of so much pain. I could die and he was going to be left with four children, that what he thought. So he went to talk to the clinic and they operated on me eight days after my baby was born. In San Cristóbal.
> Q: Did just you and he go?
> M: With my *mamá*. She brought the baby.
> Q: What did you say? Did you say that you didn't want to?
> M: Well, he thought about the money, for clothes, the food. It's good, he said...
> Q: You haven't had any problems since?
> M: I don't feel well. I don't have any energy...
> Q: Did you have to rest after the operation?

> M: Yes, they told me that I shouldn't lift heavy things for a year. It's embarrassing because you have to take care of yourself. [They said] that if you don't take care of yourself, it could rip – open up.
> Q: Have you been to the clinic after the operation so they can check you?
> M: The doctor came, as I couldn't walk far. She checks that it's not swollen or there's no pus.
> Q: But you didn't have any problems like that?
> M: No, just the first few days, it swelled up. After eight days it started to get better."

Micaela was visibly upset about her sterilisation and returned to the subject at many points during this lengthy interview. The physical consequences described hint at problems with female sterilisation in circumstances where the general health environment may be poor, women are expected to undertake hard physical work and health services for follow-up care are inadequate. The fact that the pressure from her husband and her concerns were presumably either not noted, or were not taken into account, by medical personnel undertaking the operation also reveals a worrying lack of consideration for the feelings and opinions of the woman. These data substantiate other anecdotal evidence from NGOs and doctors working on a voluntary basis in the region who note the conveyer-like process of female sterilisations of indigenous women in the region. It also gives further credence to the case brought by 32 indigenous women from the state of Guerrero in 1999, relating to the way in which family planning services were being delivered. They complained that "health workers threatened to withhold services from...PROGRESA, if the women did not accept medical procedures including PAP smears, IUD insertion, and even surgical sterilization" (Kirsch et al, 1999: 419). Government doctors report pressure "from all levels of the hierarchical health system...to urge poor women to accept birth control and IUDs immediately after they have given birth, irrespective of the patient's wishes or responses" and that what consent was obtained may have been given during the most painful stages of labour (ibid.). Informed consent is crucial to reproductive control and to evade this responsibility is to violate national and international human rights law (ibid.). The combination of these issues indicates that female sterilization is not necessarily an unproblematic solution, particularly in circumstances where it is difficult to be sure how far the decision has been taken freely.

Men's participation in reproductive decisions

The experience of Micaela and others like her indicates some of the problems with the promotion of family planning in circumstances where women do not always have autonomy over their own lives and bodies (Diaz, 1997), despite the relative household power experienced by women in Amatenango in comparison to other indigenous communities. Many women described joint decision-making regarding family planning between men and women in their households, as Alberta notes:

> "Q: And your husband, does he also want to wait to have more children?
> A: Yes, he wants to wait as well. We've talked about it."

However, this is not the case of all households and other women would strongly suggest that the male household head retains the ultimate position of authority, as Micaela suggests:

> "Q: But the *papá* doesn't go to the clinic?
> M: No, just us. But we come back and tell him what the clinic tells us and he says what is to be done."

Despite equitable decision-making in some households, the emphasis upon giving information solely to women in the clinic is likely to imply problems. It may an advantage to the woman to maintain control over information regarding contraception, and therefore, potentially increase her control over her own body should she wish to be selective about the information passed on to her husband. The concentration upon increasing women's role in intra-household bargaining was indeed one of the objectives of PROGRESA (Adato, et al., 2000). However, in reality, the responsibility for information and reproductive decision-making is assumed to be the realm of the woman whilst the man may have the last word on the matter in many cases.

PROGRESA, as with the majority of reproductive health programmes throughout the world, emphasises the participation of women. Whilst attempts to improve the status of women are to be commended, the exclusion of men within the existing unequal environment of gender relations is problematic. Diaz (1997: 303) argues that:

> "...this lack of participation resides more in the characteristics of services than in men's unwillingness to participate. Most family planning services

> are part of women's health services, where men do not feel comfortable because a specific space for them is not available and providers are not skilled at working with men. A few experiences in Latin America, i.e. Propaterna in Brazil and Profamilia in Colombia, have shown that when services encourage men's participation, the response of men is very positive."

Those men who do discuss matters of reproductive control equitably with their partners indicate that there is a demand for information and participation of men in family planning programmes. Equally, for those men who receive the information indirectly from their partners and who subsequently take control over decision-making, it can only be beneficial that they receive this information first hand and, indeed, equitable decision-making could be emphasised within this context.

Official Advice

The primary source of influence over reproductive decision-making in Amatenango is the local clinic, however this information and influence may be diffused through to, and within, the household. The identification of family planning as a key element of PROGRESA, a poverty reduction strategy, unmistakably marks the Mexican government's acceptance of neo-Malthusian logic regarding population and poverty (also see Appfel-Marglin and Sanchez, 2002, for discussion of how the Bolivian state implements family planning policy on the basis of similar rationales but without addressing the structural needs related to poverty and, particularly, land access). The provision of information and advice regarding contraception and family planning services are clearly to be welcomed. However, the over-zealous nature of their promotion is problematic if the aim of population control over-rides individual women's autonomy (Kirsch et al, 1999). In particular, the existence of institutional quotas for IUD insertion and sterilisation (ibid.) may lead to insistence upon family planning in circumstances where it is neither necessary nor sensitive.

Although many women welcome the provision of family planning services and talked enthusiastically about the potential for limiting family size that they offer, the latter problem is also apparent in Amatenango in certain cases. The repetition of the same discourse regarding clothes, land, food etc. (even often down to the same sentences and words) from the women with whom I spoke about the issue strongly suggests that the advice given to promote family planning appears to be uniform whatever the individual

circumstances of the woman. In some cases, this appeared rather inappropriate. For instance, Evangelina had had much difficulty in falling pregnant and had waited several years before becoming pregnant, described the advice given to her during her antenatal visits:

> "Q: Did you go to the clinic [when you were pregnant]?
> E: Yes.
> Q: Just for check-ups?
> E: Every eight days during the pregnancy.
> Q: For examinations or for advice?
> E: Advice, nothing else.
> Q: And what did they tell you?
> E: [She asked me] if I wanted to use family planning after having my baby. She asked me but I don't like the idea."

It seems somewhat strange that the priority advice to be given to a young woman experiencing her first pregnancy after several years of attempting to become pregnant should focus upon family planning or indeed that family planning is emphasised so strongly during any pregnancy. The experiences of many women, however, suggested that the requirements of PROGRESA are rigorously adhered to with little sensitivity to individual circumstances and may indeed be prioritised before advice regarding healthy pregnancy, which is itself another of the key objectives of PROGRESA (Gertler, 2000).

THE VALUE OF CHILDREN

A gender balanced family: Mothers and daughters

Whilst the advice given by the local health services is clearly related to reducing family size, the advice received from family members and neighbours may very well relate to the importance of children. As noted above, many women are proud of their large families and will only choose to begin family planning after completing such a family. Children are very much active members of the household and are expected to play their role in its maintenance.

These roles, like those of their parents, are clearly divided along gender lines. Male children are seen to be of value to their fathers. They will contribute to the agricultural production of the family, often accompanying their fathers and brothers to the *milpa* as young as the age of ten. However, this contribution does not translate to son preference. If any preference was indicated (which was rare) it was towards having both male and

female children in the household. It is testament to the increasing power of women in Amatenango that female children are equally valued as their future economic contribution to the household is also taken into consideration. As previously noted, pottery production often brings the only monetary income into the family and girls will begin to learn their craft at an early age. Often mere toddlers are already "playing" with the clay, making the first attempts at what will later become their skill. Carolina notes these different contributions to the household by girls and boys:

> "The girls work with the clay and the boys in the fields. If boys work with the clay, it's looked on badly by people. They make fun of them because it is girls' work. Although girls also go to work in the fields, to see the *milpa* and bring corn – the son does the rest. From eight or nine years old, the girls help with the pottery. They work the same as us, although boys go out to play...the girls help look after the house"

Female children, then, also help with the everyday tasks of the household. Although many older women emphasised the heavy load of household duties both in the household survey as well as in more informal conversations, it is actually the case that very few older women (unless they are the only woman in the house) will undertake these tasks. Their role is usually one of delegation – the younger women in the household will be the ones who sweep, arise first in the morning to grind the *nixtamal* and the youngest female children are often the ones who are responsible for the washing of clothes.

The other important role that girls fulfil in the household is that of emotional support. Many women clearly stated that they wanted to have female children, as they are "company" for them. Micaela, with only four sons and now sterilised, expresses both the practical and emotional advantages of having a daughter:

> "Q: So you would have liked to have more children?
> M: Yes, I would have liked to, as I wanted to have a girl. I only have boys...but the *papa* didn't want to. I only wanted to see if a girl would be born up to number six.
> Q: The girls help with the pottery?
> M: Yes, and they help in the kitchen, with sweeping up. If you go out, she stays sweeping and when you get back, everything has been done. Not like with just sons...if I go out and I don't wash the dishes, I have to come back to do them. It's a lot of work just for me alone. It's nice when there is help

> for the *papa* and the *mama*. The *papa* is happy because he has help in the fields, but I don't have any company."

As described in Chapter Seven, women occupy distinctly female worlds in which pottery making and household tasks are communal affairs (see Figure 8.2). It is hardly surprising, then, that the lack of female children is likely to imply a somewhat limited and lonely social and work environment and many women, though generally culturally reticent in expressing their emotions, demonstrated particularly close bonds with their daughters.

Equally, the expression of the desire for a gender balanced family was not uncommon. On the occasion when I asked women about whether they wanted more children, the answer more often than not came back in relation to the need for children of both sexes. When asked about her next child, Evangelina expressed similar desires for both male and female children and spoke of the company her young daughter provided. She also indicated that, in the choice between male and female children, cost was not an issue:

> "Q: Do want a boy or a girl?
> E: Boys and girls...both. Two and two...It's better to have girls because they are company. Before when I didn't have my baby, I stayed here all on my own...it's better with the baby..
> Q: Do boys cost more or girls?
> E: They are the same."

FIGURE 8.2 LUISA AND DAUGHTERS MAKING POTTERY

Petrona (1) noted, however, that the company and support provided by girls is limited until marriage, although it may then be substituted by that of daughter-in-laws:

> "Because the girl gets married and then we can't work together, she'll work in her mother-in-law's house...The men get married and they bring their woman to the house. The girls get married and they go to the man's house. It's always like that."

It is not only the emotional support of girls that is valued then but also their input into the work of the household and the communal nature of such work and women would also frequently refer to the hard work involved in household duties when expressing their desire for female children and in relation to their affection for their daughters In early childhood, this is perhaps less significant than when girls and boys reach puberty. Despite the strict categorisation of gender roles, there is some degree of flexibility for younger children, which perhaps relates to the gender-less identities of children until they reach the age of puberty. Very small boys, for example, will freely take part in pottery making, particularly making the small animals for sale to tourist visitors. Both girls and boys will fall upon any visitor to the community, using skilled sales tactics and emotional manipulation to sell their *animalitos.*[4] Girls will often go the field with the male members of the family, particularly at times of harvest. Although it is also the case that adult women will go to the field, this is usually only at times of extreme need for labour. Wherever possible the "mother" figure of the household will stay at home.

Pseudo-mothering

Apart from the obvious value of daughters for their economic contribution to the household in respect of pottery production and their assistance with household tasks, another important role that female children fulfil is that of pseudo-motherhood. It is common to see a girl as young as seven or eight carrying around her baby sibling, wrapped in a shawl and fastened to her back (see Scheper-Hughes, 1992, for further evidence from Brazil of the importance of older female siblings in the care of children). To those unaccustomed to the sight, this can appear alarming, as often the baby they are carrying is half the size of the girl herself. However, for mothers who may have since had another child and / or who are

[4] Literally, "little animals" – small clay animals made by the children and sold to tourists.

concentrating upon their pottery production, the help that their older daughter can provide is invaluable (see Figure 8.3).

It is not only, however, young girls who help their mothers in the household. As noted in previous chapters, it is becoming increasingly common for adult daughters to refuse the man who presents himself as a potential husband and for parents, particularly fathers, to no longer force them into marriage. They then become permanent fixtures in the household. They are adult offspring who play a full and vital role in contributing to the productive and reproductive tasks of the household.

Many mothers appeared enthusiastic for their older daughters to remain in the household, or in the case of marital problems to return to the family home, as was María (2):

> "I talked with my husband, that my daughter should come home, that he shouldn't have hit her and she shouldn't go back to him. My husband said that it was her decision and she didn't want to go back...The man wanted her to go back, but straight away I told him that I wasn't going to give him back my daughter."

The possessive and protective nature of María (2)'s relationship with her daughter indicates the close bond that persists into adulthood. Her enthusiasm for her daughter's return to the parental home was no doubt related to the emotional and practical needs expressed by women in wanting to have female children in the first place.

Cultural constructions of motherhood: Infertility

Alongside the practical reasons that women, and families in general, may have for wanting to have children, cultural factors are of equal importance. The role of women in Amatenango, as in other indigenous communities in Chiapas, is clearly that of motherhood as has been discussed. Given these practical and cultural reasons, infertility is likely to be a difficult issue. In my time in Amatenango, I only met one woman who appeared permanently childless, although others reported having waited a great deal of time before managing to become pregnant or giving birth to a healthy child. Unfortunately this woman did not wish to be interviewed in depth. However, from speaking with other women, it appeared that childless women are generally the subjects of pity from other women. In particular, women expressed the doubt that men would wish to stay with a woman who

does not provide a child (which may explain why so few were to be found – they perhaps account for some of the marital breakdowns and women who had returned to the parental home). Clearly the notion that the reason for infertility may lie with the man is uncommon.

FIGURE 8.3 JUANA WITH YOUNGER SISTER, VERONICA

Evangelina, for example, remarked upon the marital problems of her neighbours who seemed unable to have children:

> "E: ...my neighbour here has no children and now she has been married for years.
> Q: And what do people say?
> E: The people don't say anything but her husband punishes her because he doesn't have any children. They have started to fight.

Q: What does he say? That it is her fault?
E: Well, I don't know. But, her husband wants [them] even if it is by force.
Q: What's going to happen if they don't have children?
E: They will separate.
Q: Do many people separate because they don't have children?
E: Yes.
Q: And do they get married again?
E: Yes, he looks for other women...[but] I think she is going to stay alone."

The impact of infertility, then, appears to have more of a profound effect upon the lives and status of women, than of men. As well as being a consequence of the assumption of "blame" for infertility lying with the woman, this is no doubt associated with the construction of women's identities on the basis of their role as mothers. Infertility, however, may also have serious practical consequences for women and men in terms of family support in income generating activities and in subsistence agricultural activities.

Family, care and social mobility

One of the reasons that a lack of children is problematic, and that family planning may be postponed until after a desirable family size is achieved, is the value of children as security in old age and illness. In the industrialised context the paternal state acts as proxy family through the provision of a welfare system. However, there are few, if any, safety nets in Amatenango, as Carolina indicated:

"If I don't have children, I won't have anyone to look after me if I am ill"

Similarly, Feliciana expressed her expectations of reliance upon her children in old age:

"Q: When you are old, will [your children] look after you?
F: Yes, then they will look after me. The daughters have to look after me.
If I didn't have daughters, who would take care of me?

For many women, then, children continue to fulfil a practical role into adulthood as the caring roles of parent and child are exchanged. In the industrialised West, the nuclear family has dispensed with much of this responsibility. This shift has, in part at least, been motivated by increased social and geographical mobility, often facilitated by education. Such changes have meant that the lives of children in industrialised nations are now distinct from those of their parent's generation. Access to education in Amatenango has also improved from generation to generation but its effects upon mobility have been limited.

Some women expressed reservations in the value of education. Teresa, for example, preferred that her sons went to work in the fields and did not force them to go to school as the "teachers hit them a lot". However, most mothers expressed much pride in their children's educational achievements. Josefa insisted upon the necessity of her children attending school and compared it to her own experiences:

> "...because they will know how to write and read. We only just speak Spanish. I grew up as an orphan and I didn't go to school. My children have their *papá* and their *mamá* so they can go to school."

For many women, the opportunity of education for their children seemed a matter of family pride, with frequent comments that their children could speak much better Spanish that they could and that they knew how to read and write well. However, education is seen as a means of obtaining these basic skills such as literacy and fluency in Spanish. In contrast to industrialised societies, it is not generally perceived as a means of social and geographical mobility. Rafaela, a single woman, noted the functional skills that her own education had given her:

> "It was necessary [to learn Spanish] to sell our pots, and for talking with other people not from Amatenango. That's why we went to school until the third grade and we had a teacher who spoke to us in Spanish."

Indeed, the majority of participants who were keen for their children to gain an education and learn Spanish simultaneously expressed their desire that their children remain in Amatenango in adulthood, as did Alberta:

> "Q: When your son grows up, do you want him to continue going to school?
> A: Yes.
> Q: Secondary school as well?
> A: I don't know about that, he'll go if he wants to go...
> Q: Do you want him to speak Spanish?
> A: Yes, I want him to.
> Q: Do you speak to him in Spanish?
> A: No, because we don't know it very well. We didn't go to school.
> Q: So he will speak Spanish at school and Tzeltal at home?
> A: Yes.
> Q: Do you want him always to stay in Amatenango or would you like him to go somewhere else?
> A: No, here in Amatenango."

The general ambivalence of most women over their children's attendance at secondary school also indicates that education is regarded solely as a means of acquiring basic skills. The majority of children will not attend secondary school and will begin full-time work in the household as they enter adolescence. The increasing availability, and cost, of education for children in Latin America is noted to be a factor in reduced fertility (Parrado, 2000). However, in this context, this is unlikely to be the case and indeed, when discussing the cost of children as a influential factor in reducing family size, the cost of education was not mentioned. This may relate to the existence of PROGRESA, which provides an income and food supplements for children in school. Indeed, Schultz (2001: 32) notes that the programme may have the possible side effect of increasing fertility, as "the educational grants would appear to subsidise parents for the cost of a child's schooling, which would reduce the private cost of an additional child of the same schooling level". However, given the lack of confidence in the continuation of PROGRESA and the clear lack of expectations that children will continue after primary level education (at an age when they become active contributors to the household), this is unlikely.

Speaking Spanish is identified as a social and economic necessity. Indeed, many families insisted that their children speak Spanish and although women spoke amongst themselves and with their husbands in Tzeltal, they would frequently change to Spanish to address their children. In the family where I stayed the young boy would be smacked for speaking in Tzeltal. The continuity of language may appear the most important indicator of ethnic continuity. However, in Amatenango, this insistence upon Spanish appears a pragmatic recognition of their ethnic marginalisation and the necessities of communication with life outside of the community, rather than an attempt at integration or social mobilisation. Although some young men may temporarily work away from the community in Mexico City, it is expected that they will return to the community to marry, as Carolina explains:

> "Some men go to work far away. My husband works in México [City] for three months as a builder's helper. The married ones come and see their wives here and the single ones stay there but they return here to get married."

Feliciana noted the effects on the family of those few who do not return, particularly emphasising the loss felt by the mother:

> "Q: Are there some who don't come back?
> F: Oh yes, they find their woman there, that's why they don't come back...[Their *mamá*] is going to be sad. She's going to be sad that her son left and the family as well.
> Q: You wouldn't like that?
> F: No, it's better that my son stays in Amatenango."

Similarly, Evangelina spoke of the emotional wrench if children live away from their families:

> "Q: [Your children] will stay here then?
> E: Yes, because if they go somewhere else, they will be too far away. It's better that they stay here...If you go away, you won't be able to visit your family"

Whilst education and ability to speak Spanish may arguably weaken ethnic identity and cultural ties, these remain strong in other respects as children remain in the community, close to their families and living the same lifestyle as their parents. Whether it is for notions of ethnic continuity, practical support or emotional ties, the importance of family and children is unmistakable despite the fact that many women welcomed limitations to the size of this family.

CONCLUSION

Reproductive decision-making is a complex process in Amatenango. Whilst there are risks involved in high fertility, particularly within poor health environments and, arguably, where traditional birth attendants are commonly used, there are also many reasons why women actively choose not to use family planning until they have achieved a family of the size and gender balance they wish for. Cultural norms regarding the value of children, both male and female, play a key role in this and women in particular appear keen to have daughters in the household and for their children to remain close in adulthood.

Strict gender roles and power relations which do not always allow women to make these decisions freely are important both in decisions to take up family planning and in rejecting its usage. Equally, poverty has a central role to play although this is not straightforward. Poverty plays a key role in both maternal and child mortality and population politics advocate family planning to promote economic growth at the macro-level. By the same token, while child mortality rates remain high and there is lack of economic security, there

will be motivation for repeated pregnancies. It is impossible, then, to develop a "mono-causal approach to fertility control (Parrado, 2000: 425). The provision of family planning services in this context is likely to be a sensitive matter. It appears doubtful that the services provided by a government and health service with an over-riding agenda of population control strike the right balance between provision of information and family planning services to fulfil the demands of women to limit family size, and restrictions upon individual freedom of choice and autonomy over women's own bodies and decisions regarding reproduction.

CONCLUSION

PLURALISTIC PERSPECTIVES IN POLICY AND PRACTICE

IMPLICATIONS OF THE INTERPLAY BETWEEN PLURALITY AND POVERTY

The implications of this study have relevance for the formulation and implementation of healthcare and family planning policy in the developing world as a whole, particularly in what is increasingly a "post-development world". An understanding of the interrelationship between health, reproduction and identity is important to both policy-makers and health and development practitioners. There is a recognised need for an holistic approach to health and reproduction, which takes into account the effect factors such as cultural environment, traditions, beliefs and roles have upon the effectiveness of programmes. However, despite this recognition, confidence in the superiority of Western healthcare and reproductive strategies tend to be based on the "rationality" of such worldviews and the assumption of an dichotomous relationship between these and "traditional" beliefs and practices. Thus, the perception of the need to "educate" indigenous peoples persists in much development and health care policy and practice, to one level or another. This persistence is motivated by a genuine desire to improve the living standards and health of poor people. Yet there are equally ethical, political and practical reasons for adopting policies that recognise the subjective nature of both paradigms and more fully integrate indigenous and Western knowledge systems with greater equity.

This work has illustrated some of these theoretical and pragmatic reasons, both through the conceptual discussion and through the empirical examples of how women themselves negotiate health and reproductive decision-making in a pluralistic way in contexts of poverty. The conceptual framework of this thesis, as described in chapter one, is one of pluralism and subjectivity and can be applied to understandings of health paradigms as fluid and intersecting, rather than fixed and oppositional. Similarly, indigenous women's identities are constructed in multiple and unfixed ways which allows space for envisioning their agency to negotiate different health services and reproductive decisions, albeit in a

way which is strongly mediated by the context of poverty and marginalisation. The latter context affects the health status of women and their families, their utilisation of services (including family planning services), and the ability to influence the ways in which services are offered through political participation.

POLICY, POLITICS AND MARGINALISATION

Primary health care provision in Mexico has been configured, to a large degree, in response to economic crisis in recent years and according to the strategies recommended by those international agencies assisting with debt relief. Therefore, it has often been formulated to address both basic "selective" health needs as well as to address poverty through integrated strategies, which include a focus upon family planning and population control. However, global, national and regional level policy-making face considerable challenges in confronting health and reproduction issues in Chiapas. Indigenous communities in the state have to deal with significant health issues as a result of centuries of social and economic marginalisation. Domination of indigenous peoples during the Colonial years translated into several hundred years of exclusion, including not only political exclusion, but also economic (principally on the basis of exclusion from productive land) and cultural exclusion of "other" ethnic identities from constructions of mainstream Mexican identities.

Health care for indigenous communities has become a political issue related to the right to cultural plurality as well as to the existence of extreme poverty. Family planning has become a contentious issue reflecting, on the one hand, the need of indigenous women to have control over their own bodies and, on the other, controversy over the imposition of family planning policies without respect for informed choice and cultural diversity. The EZLN have called for long-overdue health resources for impoverished rural communities. This call has been configured amongst their other demands for land and, particularly, for the right to cultural plurality and autonomy.

Global and local strategies which focus upon the incorporation of communities in the delivery of health care clearly confront significant issues related to this political, economic and cultural context. Complex negotiation strategies are, therefore, employed by women precisely because of the difficulties faced by, and reluctance of, policy-

makers to incorporate plurality at international and national levels. Therefore, pluralism is often accommodated at the level of the individual, rather than being recognised in state level policy and provision of services.

UNDERSTANDING HEALTH AND NEGOTIATING SERVICES

Data from the case study in this research have illustrated the multiple explanations of ill health offered by women based not only upon their health environments and poverty but also upon spiritual beliefs. Such multiple understandings ensure that biomedical techniques are integrated with "traditional" practice. Women in Amatenango are willing to take-up both the local clinic's services and those of traditional healers for themselves and their children, although most appear to express more trust in those of traditional healers. There are also differences in the circumstances in which women feel it is more appropriate to seek the advice of *curanderos*, and when to consult a (purely) biomedical doctor. Women will often first consult biomedical attention from the local clinic and, for minor injuries and complaints, this may be the only port of call. In most cases, it appears that serious illness is usually considered to be the realm of the traditional healer because of the generalised belief in the spiritual causes of such conditions whereas other more minor illnesses are often associated with poverty related factors and the general poor state of the health environment. Nevertheless, the biomedical services offered as part of the traditional healer's approach are also valued, particularly during childbirth, and the free supply of medication from clinics is welcomed. The continued tendency to consult traditional healers, then, can perhaps be understood to relate not only to the existence of non-Western beliefs related to illness and reproduction but also to the coincidence of their existence with a feeling of alienation from local Primary Health Care services where there may be a lack of consideration given to cultural norms and practices. Accusations made regarding the insensitive implementation of the PROGRESA programme appear to substantiate this lack of consideration by health personnel.

REPRODUCTIVE DECISION-MAKING

However, at the same time, women are influenced by those providing these health services into accepting the ideology of population control. Family planning has become a central part of Primary Health Care services in the region and, most recently, has been a central component of the PROGRESA programme. Many women welcome the possibilities of contraception, although doubts are often expressed as to health consequences. It is

certainly an advantage for women to be able to make choices regarding their own body and fertility in ways they seem to have not been able to do previously. However, a majority of women who expressed a need for limiting family size did so in relation to poverty related factors, particularly those associated with lack of land ownership, therefore indicating that choosing to limit numbers of children was less of a health or cultural concern and more of a pragmatic coping strategy in the face of hardship. Equally, some women noted the importance of a gender balanced family, overriding the consideration of absolute family size, and there were a number who appeared to have had limited autonomy in reproductive decision-making. In this context, the wide spread use of sterilisation may be problematic and criticisms made of PROGRESA, and of family planning services more generally in the region, were substantiated by some of the experiences of women in this case study. It appears that inadequate consideration may have been given to the need for women to make free and informed choices. Also, advice given regarding family planning seems to be uniformly imparted, regardless of the particular circumstances of the woman.

APPLYING HYBRIDITY IN POLICY AND PRACTICE

The concept of "hybridity" (Bhabha, 1996) has been developed within cultural studies and contemporary post-colonial theory, referring to the fluid nature of identities in cultures across the increasingly globalised world in response to the negotiation and adaptation of different cultural influences. Such a conceptual framework could equally inform development policy and practice. If equitable cross-fertilization of ideas and practices were to become the norm, it may be easier to bring the benefits of Western health care to communities such as Amatenango whilst respecting cultural differences, beliefs and practices. For example, if there were to be genuine cooperation between traditional birth attendants (TBAs) and skilled birth attendants (SBAs), there may be a positive impact upon maternal mortality and morbidity rates (provided other necessary services were also in place). This, however, not only implies that "other" perspectives must be open to Western medicine (as they seem to be in Amatenango), but also that Western policy-makers and practitioners would be receptive to "other" ideas and systems. Indeed, by taking on board a recognition of hybridity, it is possible to acknowledge that the paradigm divide is artificial and that different cultural constructions of knowledge and practice can influence one another and adapt accordingly (see Crandon, 2003, for discussion of how *mestizo* Bolivians are coming to use indigenous medicines).

Traditional practices of medicine in Amatenango are incorporative of different perspectives and paradigms. The disregard given to "Other" cultural traditions and practices involved in health and reproduction by "Western" health policy makers and practitioners is partly because of a lack of acceptance of the validity of perspectives grounded, to any extent, in what are seen as "irrational" world-views. It is also because of the inability of indigenous peoples to influence dominant discourses and policy formulation, resulting from their long history of socio-economic and political marginalisation and, for indigenous women, discriminatory practices at community levels. However, learning from the ways in which women actually negotiate services and the pluralistic provision of services by traditional providers may be helpful. Ignoring the agency of women and marginalising "traditional" practices (without understanding their pluralistic nature) could result in ineffective health policy and programmes and a failure to genuinely meet health needs.

Also, by implementing policies which fit with the ways in which women understand and negotiate health in pluralistic ways, it is likely that interventions would not only be better received and negotiated in different cultural contexts, but would also allow for the empowerment of women in giving credit to their existing traditional skills and roles in health and reproductive care. Since the Alma Mater and the appearance of Primary Health Care in the 1970s, there have been moves towards the involvement of community members, particularly women, in health care strategies. However, these strategies have often been implemented by retraining community workers to take over basic responsibilities for health care and to get across "Western" ideas, whilst rejecting existing ideas and practices as ineffective or even dangerous. Indeed, in the case of traditional birth attendants, the policy of integration has been abandoned by the WHO in favour of a return to the promotion of (biomedically) skilled birth attendants. Many of the benefits of "Western" biomedicine are clear. However, claims of scientific "truth" are not always holistic or stable and may reflect dominant discourse and ritual, rather than universal fact (Foucault, 1963). The Western system of knowledge is only one of a myriad and it is important to recognise that an unmediated version of this "knowledge" may not be appropriate in all contexts.

As well as being pertinent to health policy, this awareness is also key to the formulation and implementation of the population control strategies that are an integral component of Primary Health Care. Fertility control may be a relatively simple "solution" to poverty but

it fails to grasp the complexity of the relationship between poverty, culture (including gender roles) and reproductive decision-making. Development policy should perhaps more closely interrogate neo-Malthusian assumptions of the relationship between poverty and fertility as the relationship is not necessarily as simplistic as assumed and can potentially contravene individual rights. With respect to balancing individual choice with the promotion of family planning, policy makers may need to take a broader perspective and examine how to give women, and families in general, real choice by improving their overall economic and social circumstances. Only in this context does information about family planning become an impartial expansion of knowledge (reflecting the innovation perspective on fertility control) (Parrado, 2000), rather than a survival mechanism.

In sum, it is important that the complex and fluid cultural constructions of gender identities and roles in relation to multiplistic and shifting traditions, beliefs and practices surrounding health and reproduction are examined in each case prior to the implementation of policy. Only with an understanding of how these individually and socially constructed factors interplay with the realities of poverty can programmes be formulated in ways which are more likely to be equitable and to be effectively negotiated by women and their wider communities.

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APPENDIX A

HOUSEHOLD QUESTIONNAIRE

Encuesta

Amatenango del Valle, Chiapas, México

1998 – 1999

Anna Coates

The London School of Economics and Political Science

(Investigadora Visitante: El Colegio de la Frontera Sur)

Numero de cuestionario.....

Nombre.....

Comunidad / Barrio.....

Locación de casa / Dirección:.....
.....
.....

Fecha de la entrevista.....

Sección A: Estructura Familiar

A1. Quisiera hacer una lista de los miembros permanentes de este hogar. Por ejemplo, ¿Cuántos años tiene Usted? ¿Cuántos niños tiene Usted (quienes viven con Usted)?

Nombre	Relación con informante	Edad	Sexo	Nivel de educación

A2. ¿Cuántos hijos tiene Usted que ya no viven aquí?.....
(si no hay, pase a A4)

A3. ¿Cuándo dejo(aron) de vivir con Ustedes y por qué? ¿Que edad tenían? ¿Volvieron a casa? ¿Por qué?

	Edad Ahora	Edad cuando se fue	Razón de salir	¿Volvió a casa?	Razón de volver
Hijo / a 1					
Hijo / a 2					
Hijo / a 3					
Hijo / a 4					
Hijo / a 5					
Hijo / a 6					

A4. ¿Cuál es su estado civil?

Casada.....	Viuda.....
Separada....	Unión Libre.....
Divorciada.....	Soltera..... (pase a A9.)

A5. ¿A qué edad se casó Usted o empezó Usted a vivir junto con su esposo / pareja (lo que haya sido primero)?.....

A6. ¿Qué edad tenía su esposo / pareja?.....

A7. ¿Cuántos años estuvieron casados / viviendo juntos (lo que haya sido primero)?.....

A8. Si casados, ¿Tienen Ustedes acta / papeles de matrimonio?
Si/No/NoSabe
(¿Fueron casados por el civil o solo por la iglesia?)
(Si no casada, pase a A9)

A9. ¿Cuales miembros de la familia tienen actas / papeles de nacimiento (incluyendo los que ya no viven con Usted):

Usted misma Si/No/No sabe

Su esposo / pareja Si/No/No sabe

Hijos: Todo/Ninguno/Unos: Si unos, ¿cuáles no la tienen?.....
No sabe

Hijas: Toda/Ninguna/Unas: Si unas, ¿cuáles no la tienen?.....
No sabe

A10. ¿Cual es su religión?

Católica..... Evangélico..... No tiene....

Sección B: Trabajo y Ingreso

Quisiera saber cuáles son los fuentes de trabajo en el hogar. Por ejemplo, artesanía, agricultura, otro trabajo, ¿Y cuáles son los fuentes de ingreso o comida?

B1. Informante:

Fuentes de trabajo	Locación (ej. dentro hogar, dentro comunidad, afuera comunidad)	Eventual/ fijo/ autónoma	Horario / Días Cada semana (generalmente)	Tiempo que ha estado en este trabajo	Para comer o para ingreso (dinero)	Ingreso cada mes (generalmente)
						Total:

B2. Su esposo o pareja (si tiene):

Fuentes de trabajo	Locación (ej. dentro hogar, dentro comunidad, afuera comunidad)	Eventual/ fijo/ autónomo	Horario / Días Cada semana (generalmente)	Tiempo que ha estado en este trabajo	Para comer o para ingreso (dinero)	Ingreso cada mes (generalmente)
						Total:

B3. Sus hijos (quienes viven con Usted):

Nombre	Fuente de trabajo	Propio trabajo o ayuda a padres	Locación (ej. dentro hogar / com., fuera com.)	Eventual / fijo/ Autónomo	Horario/ Días cada semana (general-mente)	Tiempo que ha estado en este trabajo	Para comer o para ingreso (dinero)	Ingreso cada mes (general-mente)
								Total:

B4. Sus hijas (quienes viven con Usted):

Nombre	Fuente de trabajo	Propio trabajo o ayuda a padres	Locación (ej. dentro hogar / com., fuera com.)	Eventual/ fijo / autónomo	Horari o/ Días cada seman a (genera l-mente)	Tiempo que ha estado en este trabajo	Para comer o para ingreso (dinero)	Ingreso cada mes (general-mente)
								Total:

B5. Otras personas quienes viven con Usted:

Nombre	Fuente de trabajo	Propio trabajo o ayuda a padres	Locación (ej. dentro hogar / com., fuera com.)	Eventual/ fijo / Autónomo	Horario/ Días cada semana (general-mente)	Tiempo que ha estado en este trabajo	Para comer o para ingreso (dinero)	Ingreso cada mes (general-mente)
								Total:

B6. ¿Tiene la familia otros tipos de apoyo o ingreso de los siguientes fuentes?

Fuente de apoyo	**Tipo de apoyo**						
	Dinero. ¿Cuánto/ cada cuando?	Comida	Medicinas	Ropa	Ayuda en / por el hogar	Ayuda en / por la tierra	Otro. ¿Cuál?
Hijo/as (quienes no viven con Ustedes)							
Padres							
Suegros							
Procampo							
Desayunas escolares							
De otros organizac lónes (ej. iglesia, organizaciónes civiles)							
Otro pariente ó miembro de la comunidad							

B7. Si trabaja algún miembro de la familia afuera de la comunidad, ¿donde trabaja?, ¿como llega ahí (en coche, en camión, a cabello, en bicicleta o a pie)? y ¿cuanto cuesta el transporte?

(si no, pase a B9)

Nombre	Ocupación	Lugar de trabajo	Distancia de aquí	Tipo de transporte	Costo de transporte

B8. ¿Cuánto tiempo pasa cada persona quién trabaja afuera de la comunidad en su lugar de trabajo? (por ejemplo, va diariamente, pasa la semana ahí, un mes, tres meses etc.)

Nombre	Tiempo ahí

B9. Si trabaja con artesanía, ¿Pertenece a alguna organización? ¿Cual?

.....
...

(si no trabaja con artesanía, pase a B14)

B10. ¿Qué tipo de artesanía elaboran?

.....

B11. Aparte de vender la artesanía con su organización (si pertenece), ¿la vende sin ella? Si/No

¿Quien la vende? (marcar todos)

Informante..... Hijas.....
Esposo o pareja..... Otras personas del hogar.....
Hijos..... Un vendedor.....

B12. ¿En cuáles lugares venden la artesania qué producen?

San Cristóbal.....
Comitan.....
Larrainzar.....
En la comunidad.....
Otros lugares..... ¿Cuáles?.....

B13. ¿Tiene la familia tierra para cultivar?.....

Ninguna.....(pase a B16)
Solo la tierra cerca de la casa.....
Menos que ½ hectar.....
½ hectar.....
½ hectar -1 hectar.....
Mas que 1 hectar.....

B14. ¿A nombre de quien esta la tierra?
.....
...
No sabe.....

B15. ¿Quien trabaja la tierra ?

Usted..... Esposo / pareja.....
Hijos..... Hijas.....
Otras personas.....

B16. Si no tiene la familia tierra, ¿trabajan la tierra de otras personas?
Si/no

Estas tierras que trabajan, ¿a quien pertenecen?

Pariente.....
Amigos.....
Conocidos.....
Otro. ¿Cual?

B17. ¿A qué edades empezaron los miembros de la familia a trabajar (mas o menos)?

Usted..... Su esposo o pareja.....
Hijos..... Hijas.....
No se acuerda.....

Sección C: Servicios y Gastos

C1. Quisiera saber unos datos sobre su vivienda. Por ejemplo, ¿de qué materiales están hechos los siguientes?

Paredes exteriores

Bloque de tierra.....
Bloque de concreta....
Ladrillo.....
Madera.....
Otro. ¿Cual?.....

Techos

Asbestos / lámina.....
Teja....
Cartón.....
Concreto.....
Madera.....
Otro. ¿Cual?.....

Pisos

Tierra.....
Concreto.....
Loseta.....
Otro. ¿Cual?.....

C2. ¿Qué servicios tiene su vivienda?

¿Cocina Usted con leña / gas?

Drenaje:
- Nada....
- Letrina compartida.....
- Letrina propia.....

Agua:
- entubada...
- del rio.....
- llave publica...
- servicio dentro hogar....

Luz:
- velas...
- gas.....
- servicio eléctrico.....

C3. ¿Cuántos cuartos hay?.....

C4. ¿Es vivienda propia / prestada / rentada?

C5. Si es propia, a nombre de quien están los papeles de propiedad?

No hay papeles....
Informante.....
Esposo o pareja....
Otro: Especifique.....
No sabe.....

C6. ¿Quien construyó la casa?.....
.....

C7. ¿Qué compran cuando van a Teopisca? ¿Cuánto paga por gastos mensuales (mas o menos)?

Gasto	**Costo**
Luz	
Transporte	
Materiales para artesanía	
Sal	
Jabón	
Renta (si paga)	
Gas (si tiene)	
	Total:

C8. ¿Reparten el dinero entre diferentes miembros de la familia para pagar diferentes cosas ó tiene la familia todo el dinero junto para pagar gastos?

Junto / repartido

¿Si es repartido, ¿quién tiene el dinero para pagar las siguientes cosas? (Si es mas de una persona, marcar todas)

	Informante	Esposo	Hijo(s)	Hija(s)	Otro. ¿Cuál?
Comida					
Materiales para artesanía					
Ropa					
Educación de los niños					
Diversiones (ej. para festejos, bebida alcohólica)					
Cosas para la casa (jabón, escobas, leña etc.)					

C9. ¿Y quien dice cuando, y cuanto, a pagar para los siguientes?

(Por ejemplo, ¿su esposo le dice qué tiene que comprar algo o que no puede comprar algo o viceversa?)

	Informante	Esposo	Hijo(s)	Hija(s)	Otro. ¿Cuál?
Comida					
Materiales para artesanía					
Ropa					
Educación de los niños					
Diversiones (ej. para festejos, bebida alcohólica)					
Cosas para la casa (jabón, escobas, leña etc.)					

C10. ¿Le mandan dinero o comida Ustedes a algún pariente o hijo que no viva con Ustedes? (Por ejemplo, un padre que no trabaja o un hijo que esta en la escuela en otro lugar)

No.... Sí.....
¿A quién?.....
¿Comida o dinero? Si dinero, ¿cuanto?.....
¿Cada cuándo?.....

C11. ¿De cuáles fuentes es la comida que la familia come?

Toda es de tierra propia.....
La mayoría es de tierra propia / un poco comprado....
Algo de tierra propia / algo comprado.....
Toda comprada.....

C12. Si compra comida, ¿cuando va a Teopisca, cuánto dinero gasta Usted a la semana para comprar la comida necesaria para todos los miembros de la familia?

.....pesos

Sección D: Salud

D1. ¿Qué es una comida típica? (Por ejemplo, tortillas y sal, fríjol, pozol, etc.)
.....
.....

D2. ¿Cuántas veces come la familia los siguientes?

	Verduras	Frijoles	Huevos	Pollo	Carne	Arroz	Frutas
Cada día							
Cada semana							
De vez en cuando							

D3. Quisiera saber sobre la salud de la familia y si algun miembro de la familia tuvo enfermedades. ¿Cuáles son las principales enfermedades de los niños (si han estado enfermos / han visitado al centro de salud)?
.....
.....
.....

D4. ¿Cuales son las principales enfermedades de las mujeres del hogar (si han estado enfermas / han visitado al centro de salud)?
.....
.....
.....

D5. ¿Cuales son las principales enfermedades de los hombres del hogar (si han estado enfermos / han visitado al centro de salud)?
.....
.....
.....

D6. ¿Qué tipo de servicio médico usa la familia?

Ninguna.....
La medicina tradicional de la comunidad.....
Centro de salud.....
Servicio de salud de otras organizaciones.....
Otro.
¿Cual?.....

D7. ¿Cuántos hijos ha tenido (incluyendo los que han muertos)?.....

D8. ¿Cuántos hijos han fallecido y de qué?
.....

.....
.....

D9. ¿Hacen Ustedes algo para no tener hijos (un metodo de planificación familiar)?

Solo tienen relaciones en una época mensual / abstención.....
Amamantar.....
Preservativos.....
Pastillas de control de natalidad.....
Diafragma.....
Otro. ¿Cual?.....
Ninguna.....

D10. ¿A qué edad tuvo su primer embarazo?.....

Sección E: Organización del Hogar

E1. ¿Quién se encarga del quehacer en esta casa? (Por ejemplo, ¿le dice su esposo que Usted o sus hijos deben que hacer algo o viceversa?)

Informante.....
Esposo.....
Los dos.....

E2. Hay alguna(s) persona(s) que le ayuda(n) con en el quehacer?
No.....(pase a E4)

Nombre	Siempre	A menudo	De vez en cuando

E3. ¿Cuáles tareas en particular son compartidas por estas personas? Por ejemplo, quiénes hacen los siguientes tareas?

	Nombre:	Nombre:	Nombre:	Nombre:	Nombre:	Nombre:	Nombre:
Molino de tortillas							
Cocinar							
Lavar trastes							
Lavar ropa							
Hacer compras							
Barrer							
Trapear							
Cuidar niños							
Acarrear agua							
Acarrear leña							

E4. ¿Cuántas horas le lleva al día en;

Hacer el molino de tortillas.....
Preparar comida.....
Acarrear agua.....
Acarrear leña.....
Barrer.....
Trapear.....

E5. ¿Cuántas veces a la semana hay que lavar la ropa de la familia?

	Duración de cada lavada
Diariamente	
Cada tercer día	
Una vez a la semana	

E6. ¿Tiene algún miembro de la familia otras responsabilidades afuera del hogar o de su trabajo? Por ejemplo, cargos religiosos, responsabilidades en la comunidad? ¿Y cuántas horas / días / semanas tiene qué hacerlos?

Nombre	Responsabilidad	Tiempo

APPENDIX B
HOUSEHOLD SURVEY DATA: VARIABLES AND CODES (SPSS)

LIST OF VARIABLES ON THE WORKING FILE

Name
Position

ID
1 Measurement Level: Nominal

INTERVWE **Interviewee**
2 Measurement Level: Nominal

Value	Label
1.00	Yes
2.00	No

AGE **Age**
3 Measurement Level: Scale
Missing Values: 99.00

AGESP **Age of spouse**
4 Measurement Level: Scale
Missing Values: 99.00

CIVSTAT **Civil status**
5 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Married
2.00	Separated / Divorced
3.00	Widow
4.00	Living together
5.00	Single

AGEMAR **Age at marriage**
6 Measurement Level: Scale
Missing Values: 99.00

AGEMARSP **Age of spouse at marriage**
7 Measurement Level: Scale
Missing Values: 99.00

MARPAP **Marital papers**
8 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Yes
2.00	No
3.00	Don't know

BIRTHCER **Birth certificate**
9 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Yes
2.00	No
3.00	Don't know

NOCHILD **Number of children**
10 Measurement Level: Scale
Missing Values: 99.00

RELIGION **Religion**
11 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Catholic
2.00	Evangelical
3.00	Other
4.00	None

INCACTIN **Income generating activity**
12 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Pottery
2.00	Agriculture
3.00	Pottery and agriculture
4.00	None
5.00	Other
6.00	Agriculture and other

INCACTSP **Income generating activity of spouse**
13 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Pottery
2.00	Agriculture
3.00	Pottery and agriculture
4.00	None
5.00	Other
6.00	Agriculture and other

INCACTSN **Income generating activity of sons**
14 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Pottery
2.00	Agriculture
3.00	Pottery and agriculture
4.00	Other
5.00	Agriculture and other

INCACTDT **Income generating activity of daughters**
15 Measurement Level: Nominal
Missing Values: 99.00

Value	Label

	1.00	Pottery
	2.00	Agriculture
	3.00	Pottery and agriculture
	4.00	Other
	5.00	Agriculture and other

MONINC **Monthly income**
16 Measurement Level: Scale
Missing Values: 99.00

INCOMSP1 **Other sources of income support**
17 Measurement Level: Nominal

Value	Label
1.00	School breakfasts
2.00	Procampo
3.00	Family help
4.00	None

INCOMSP2 **Other sources of income**
18 Measurement Level: Nominal

Value	Label
5.00	School breakfasts
6.00	Procampo
7.00	Family help
8.00	Other

INCOMSP3 **Other sources of income**
19 Measurement Level: Nominal

Value	Label
9.00	School breakfasts
10.00	Procampo
11.00	Family help
12.00	Other

ARTORG **Membership of artisan organisation**
20 Measurement Level: Nominal

Value	Label
1.00	Yes
2.00	No

ARTSALE **Location of artisan sales**
21 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	San Cristóbal de las Casas
2.00	Comitan
3.00	In the community
4.00	Other

LAND **Land ownership in hectares**
22 Measurement Level: Scale
Missing Values: 99.00

LANDPAP **Land ownership papers**
23 Measurement Level: Nominal
Missing Values: 99.00

Value	Label

	1.00	Yes
	2.00	No
	3.00	Don't know

LANDNAME **Land owner**
24 Measurement Level: Scale

Value	Label
1.00	Informant
2.00	Husband / partner
3.00	Son
4.00	Daughter
5.00	Other male relative
6.00	Other female relative
7.00	Don't know

WORKAGIN **Age started work**
25 Measurement Level: Scale
Missing Values: 99.00

WORKAGSP **Age started work (spouse)**
26 Measurement Level: Scale
Missing Values: 99.00

WORKAGSN **Age started work (sons)**
27 Measurement Level: Scale
Missing Values: 99.00

WORKAGDN **Age started work (daughters)**
28 Measurement Level: Scale
Missing Values: 99.00

EDUCAT **Level of education**
29 Measurement Level: Ordinal

Value	Label
1.00	Primary One
2.00	Primary Two
3.00	Primary Three
4.00	Primary Four
5.00	Primary Five
6.00	Primary Six
7.00	Secondary education
8.00	Post-secondary education
9.00	None

EDUCATSP **Level of education (spouse)**
30 Measurement Level: Ordinal
Missing Values: 99.00

Value	Label
1.00	Primary One
2.00	Primary Two
3.00	Primary Three
4.00	Primary Four
5.00	Primary Five
6.00	Primary Six
7.00	Secondary
8.00	Post-secondary
9.00	None

CHILATHM **Number of children living at home**
31 Measurement Level: Scale

CHILOTHM **Number of children who have left home**
32 Measurement Level: Scale

NOFEMCH **Number of female children**
33 Measurement Level: Scale

NOMALCH **Number of male children**
34 Measurement Level: Scale

FEMRES12 **Number of female children over 12 in home**
35 Measurement Level: Scale

MALRES12 **Number of male children over 12 in home**
36 Measurement Level: Scale

HMADULTS **Number of other adults living at the home (other than spouse**
37 Measurement Level: Scale

TOTOCCUP **Total number of occupants**
38 Measurement Level: Scale

WALLCONS **Construction of walls**
39 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Mud
2.00	Concrete
3.00	Brick
4.00	Wood
5.00	Other

ROOFCONS **Construction of roof**
40 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Laminate
2.00	Tile
3.00	Cardboard
4.00	Concrete
5.00	Wood
6.00	Other

FLRCONS **Construction of floor**
41 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Mud
2.00	Concrete
3.00	Tile
4.00	Other

DRAINAGE **Drainage**
42 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Shared latrine
2.00	Own latrine
3.00	No latrine

WATERSER **Water services**
43 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Own tap
2.00	Public tap
3.00	River

LIGHTING **Lighting**
44 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Candles
2.00	Gas
3.00	Electric

NOROOMS **Number of rooms**
45 Measurement Level: Scale

PROPPAP **Property papers**
46 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	No papers
2.00	In informant's name
3.00	In husband / partner's name
4.00	In someone else's name
5.00	Papers - unknown name
6.00	Don't know if there are papers

MONOUTGS **Monthly outgoings**
47 Measurement Level: Scale
Missing Values: 99.00

CONTMON **Control over spending**
48 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Informant
2.00	Husband / partner
3.00	Son (s)
4.00	Daughter (s)
5.00	Other
6.00	Shared

FOODSOUR **Sources of food**
49 Measurement Level: Nominal
Missing Values: 99.00

Value	Label

	1.00	Total subsistence
	2.00	Majority subsistence / some bought
	3.00	Half subsistence / half bought
	4.00	All bought

TYPFOOD **Typical diet**
50 Measurement Level: Nominal

Value	Label
1.00	Tortillas and salt
2.00	Tortillas and beans
3.00	Tortillas, beans, eggs
4.00	Tortillas, beans, rice
5.00	Tortillas, beans, fruit/vegetables
6.00	Tortillas, beans, meat chicken
7.00	Tortillas, beans, other

VEG **Vegetable consumption**
51 Measurement Level: Ordinal

Value	Label
1.00	Daily
2.00	Weekly
3.00	Occasionally
4.00	Never

BEANS **Beans consumption**
52 Measurement Level: Ordinal

Value	Label
1.00	Daily
2.00	Weekly
3.00	Occasionally
4.00	Never

EGGS **Egg consumption**
53 Measurement Level: Ordinal

Value	Label
1.00	Daily
2.00	Weekly
3.00	Occasionally
4.00	Never

CHICKEN **Chicken consumption**
54 Measurement Level: Ordinal

Value	Label
1.00	Daily
2.00	Weekly
3.00	Occasionally
4.00	Never

MEAT **Red meat consumption**
55 Measurement Level: Ordinal

Value	Label
1.00	Daily
2.00	Weekly
3.00	Occasionally
4.00	Never

RICE **Rice consumption**
56 Measurement Level: Ordinal

Value	Label
1.00	Daily
2.00	Weekly
3.00	Occasionally
4.00	Never

FRUIT **Fruit consumption**
57 Measurement Level: Ordinal

Value	Label
1.00	Daily
2.00	Weekly
3.00	Occasionally
4.00	Never

CHILDIL1 **Children's illnesses (1)**
58 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Fever
2.00	Cough
3.00	Diarrhoea
4.00	headache
5.00	pains (body / bones)
6.00	Influenza
7.00	Stomach-ache
8.00	Other
9.00	None

CHILDIL2 **Children's illnesses (2)**
59 Measurement Level: Nominal

Value	Label
1.00	Fever
2.00	Cough
3.00	Diarrhoea
4.00	headache
5.00	pains (body / bones)
6.00	Influenza
7.00	Stomach-ache
8.00	Other
9.00	None

CHILDIL3 **Children's illnesses (3)**
60 Measurement Level: Nominal

Value	Label
1.00	Fever
2.00	Cough
3.00	Diarrhoea
4.00	headache
5.00	pains (body / bones)
6.00	Influenza
7.00	Stomach-ache
8.00	Other
9.00	None

WOMIL1 **Women's illnesses (1)**
61 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	None
2.00	Fever
3.00	Cough
4.00	Diarrhoea
5.00	headache
6.00	pains (body / bones)
7.00	Influenza
8.00	Stomach-ache
9.00	Other

WOMIL2 **Women's illnesses (2)**
62 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
2.00	Fever
3.00	Cough
4.00	Diarrhoea
5.00	headache
6.00	pains (body / bones)
7.00	Influenza
8.00	Stomach-ache
9.00	Other

WOMIL3 **Women's illnesses (3)**
63 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
2.00	Fever
3.00	Cough
4.00	Diarrhoea
5.00	headache
6.00	pains (body / bones)
7.00	Influenza
8.00	Stomach-ache
9.00	Other

MENIL1 **Men's illnesses (1)**
64 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	None
2.00	Fever
3.00	Cough
4.00	Diarrhoea
5.00	headache
6.00	pains (body / bones)
7.00	Influenza
8.00	Stomach-ache
9.00	Diabetes
10.00	Other

MENIL2 **Men's illnesses (2)**
65 Measurement Level: Nominal

Value	Label
1.00	None
2.00	Fever
3.00	Cough
4.00	Diarrhoea
5.00	headache
6.00	pains (body / bones)
7.00	Influenza
8.00	Stomach-ache
9.00	Diabetes
10.00	Other

MENIL3 **Men's illnesses (3)**
66 Measurement Level: Nominal

Value	Label
1.00	None
2.00	Fever
3.00	Cough
4.00	Diarrhoea
5.00	headache
6.00	pains (body / bones)
7.00	Influenza
8.00	Stomach-ache
9.00	Diabetes
10.00	Other

NOILLCHD **No childhood illnesses**
67 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	No Reported Illnesses
2.00	Reported Illnesses

FEVCHD **Reported childhood fever**
68 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Yes
2.00	No

CGHCHD **Reported childhood cough**
69 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Yes
2.00	No

DHRCHD **Reported childhood diarrhoea**
70 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Yes
2.00	No

HDCHD **Reported childhood headaches**
71 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Yes
2.00	No

PNSCHD **Reported childhood pains (body/bones)**
72 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Yes
2.00	No

FLUCHD **Reported childhood influenza**
73 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Yes
2.00	No

STMCHD **Reported childhood stomach-ache**
74 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Yes
2.00	No

OTILLCHD **Other childhood illnesses**
75 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Yes
2.00	No

NOILLWOM **No women's illnesses**
76 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	No reported illnesses
2.00	Reported illnesses

FEVWOM **Reported fever (women)**
77 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Yes
2.00	No

CGHWOM **Reported cough (women)**
78 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Yes
2.00	No

DHRWOM **Reported diarrhoea (women)**
79 Measurement Level: Nominal
Missing Values: 99.00
Value Label
1.00 Yes
2.00 No

HDWOM **Reported headaches (women)**
80 Measurement Level: Nominal
Missing Values: 99.00
Value Label
1.00 Yes
2.00 No

PNSWOM **Reported pains (body/bones) (women)**
81 Measurement Level: Nominal
Missing Values: 99.00
Value Label
1.00 Yes
2.00 No

FLUWOM **Reported influenza (women)**
82 Measurement Level: Nominal
Missing Values: 99.00
Value Label
1.00 Yes
2.00 No

STMWOM **Reported stomach-ache (women)**
83 Measurement Level: Nominal
Missing Values: 99.00
Value Label
1.00 Yes
2.00 No

OTILLWOM **Other illnesses (women)**
84 Measurement Level: Nominal
Missing Values: 99.00
Value Label
1.00 Yes
2.00 No

NOILLMEN **No men's illnesses**
85 Measurement Level: Nominal
Missing Values: 99.00
Value Label
1.00 No Reported Illnesses
2.00 Reported Illnesses

FEVMEN **Reported fever (men)**
86 Measurement Level: Nominal
Missing Values: 99.00
Value Label
1.00 Yes
2.00 No

CGHMEN **Reported cough (men)**
87 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Yes
2.00	No

DHRMEN **Reported diarrhoea (men)**
88 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Yes
2.00	No

HDMEN **Reported headaches (men)**
89 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Yes
2.00	No

PNSMEN **Reported pains (body/bones) (men)**
90 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Yes
2.00	No

FLUMEN **Reported influenza (men)**
91 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Yes
2.00	No

STMMEN **Reported stomach-ache (men)**
92 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Yes
2.00	No

OTILLMEN **Other illnesses (men)**
93 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Yes
2.00	No

TRADMED **Use of traditional medicine**
94 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Yes
2.00	No

HEALTHCT **Use of health centre**
95 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Yes
2.00	No

OTHHEALT **Use of other health services**
96 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Yes
2.00	No

TOTFERT **Total number of children**
97 Measurement Level: Scale

CHILDMOR **Number of child deaths**
98 Measurement Level: Scale
Missing Values: 99.00

CHILMOR1 **Reason for child death(s)1**
99 Measurement Level: Nominal

Value	Label
1.00	Unknown
2.00	Fever
3.00	Measles
4.00	Tonsillitis
5.00	Diarrhoea
6.00	Accident
7.00	Murder
8.00	Other

CHILMOR2 **Reason for child death(s)2**
100 Measurement Level: Nominal

Value	Label
1.00	Fever
2.00	Measles
3.00	Tonsillitis
4.00	Diarrhoea
5.00	Accident
6.00	Murder
7.00	Other

CHILMOR3 **Reason for child death(s)3**
101 Measurement Level: Nominal

Value	Label
1.00	Fever
2.00	Measles
3.00	Tonsillitis
4.00	Diarrhoea
5.00	Accident
6.00	Murder
7.00	Other

FAMPLAN **Use of family planning**
102 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Breastfeeding
2.00	Condoms
3.00	Injection
4.00	IUD
5.00	Sterilisation
7.00	None
8.00	Pill

FIRSTPRG **Age at first pregnancy**
103 Measurement Level: Scale

RESTORT **Household member responsible for making tortillas**
104 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Informant
2.00	Husband / partner
3.00	Daughter (s)
4.00	Son (s)
5.00	Daughter-in-law
6.00	Son-in-law
7.00	Shared (female)
8.00	Shared (male)
9.00	Shared (male / female)
10.00	Other

RESCOOK **Household member responsible for cooking**
105 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Informant
2.00	Husband / partner
3.00	Daughter (s)
4.00	Son (s)
5.00	Daughter-in-law
6.00	Son-in-law
7.00	Shared (female)
8.00	Shared (male)
9.00	Shared (male / female)
10.00	Other

RESDISH **Household member responsible for washing dishes**
106 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Informant
2.00	Husband / partner
3.00	Daughter (s)
4.00	Son (s)
5.00	Daughter-in-law
6.00	Son-in-law
7.00	Shared (female)
8.00	Shared (male)

	9.00	Shared (male / female)
	10.00	Other

RESCLOTH **Household member responsible for washing clothes**

107 Measurement Level: Nominal

Missing Values: 99.00

Value	Label
1.00	Informant
2.00	Husband / spouse
3.00	Daughter(s)
4.00	Son(s)
5.00	Daughter-in-law
6.00	Son-in-law
7.00	Shared (female)
8.00	Shared (male)
9.00	Shared (male / female)
10.00	Other

RESSHOP **Household member responsible for shopping**

108 Measurement Level: Nominal

Missing Values: 99.00

Value	Label
1.00	Informant
2.00	Husband / partner
3.00	Daughter(s)
4.00	Son(s)
5.00	Daughter-in-law
6.00	Son-in-law
7.00	Shared (female)
8.00	Shared (male)
9.00	Shared (male / female)
10.00	Other

RESSWEP **Household member responsible for sweeping**

109 Measurement Level: Nominal

Missing Values: 99.00

Value	Label
1.00	Informant
2.00	Husband / partner
3.00	Daughter(s)
4.00	Son(s)
5.00	Daughter-in-law
6.00	Son-in-law
7.00	Shared (female)
8.00	Shared (male)
9.00	Shared (male / female)
10.00	Other

RESMOP **Household member responsible for mopping**

110 Measurement Level: Nominal

Missing Values: 99.00

Value	Label
1.00	Informant
2.00	Husband / partner
3.00	Daughter(s)
4.00	Son(s)
5.00	Daughter-in-law

	6.00	Son-in-law
	7.00	Shared (female)
	8.00	Shared (male)
	9.00	Shared (male / female)
	10.00	Other

RESWATER **Household member responsible for fetching water**

111 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Informant
2.00	Husband / informant
3.00	Daughter (s)
4.00	Son (s)
5.00	Daughter-in-law
6.00	Son-in-law
7.00	Shared (female)
8.00	Shared (male)
9.00	Shared (male / female)
10.00	Other

RESWOOD **Household member responsible for fetching firewood**

112 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Informant
2.00	Husband / partner
3.00	Daughter(s)
4.00	Son(s)
5.00	Daughter-in-law
6.00	Son-in-law
7.00	Shared (female)
8.00	Shared (male)
9.00	Shared (male / female)
10.00	Other

TORTHRS **Hours spent making tortillas per day**

113 Measurement Level: Scale
Missing Values: 99.00

FOODHRS **Hours spent preparing food per day**

114 Measurement Level: Scale
Missing Values: 99.00

WATERHRS **Hours spent fetching water per day**

115 Measurement Level: Scale
Missing Values: 99.00

WOODHRS **Hours spent fetching firewood per day**

116 Measurement Level: Scale
Missing Values: 99.00

SWEEPHRS **Hours spent sweeping per day**

117 Measurement Level: Scale
Missing Values: 99.00

MOPHRS **Hours spent mopping per day**
118 Measurement Level: Scale
Missing Values: 99.00

CLOTHWK **Time spent in clothes washing per week**
119 Measurement Level: Ordinal
Missing Values: 99.00

Value	Label
1.00	Daily (up to one hour)
2.00	Daily (more than one hour)
3.00	Every third day (up to one hour)
4.00	Every third day (more than one hour)
5.00	Once a week (up to one hour)
6.00	Once a week (more than one hour)

TOTOCCRC **Total Number of Occupants**
120 Measurement Level: Scale

Value	Label
1.00	0-3
2.00	4-6
3.00	6 >

PARTNER **Living status**
121 Measurement Level: Nominal

Value	Label
1.00	With husband / partner
2.00	Without husband / partner

RESWDMF **Collection of Firewood by Gender**
122 Measurement Level: Nominal
Missing Values: 99.00

Value	Label
1.00	Female
2.00	Male
3.00	Shared Male / Female

CDMORREC **Child Mortality**
123 Measurement Level: Scale

Value	Label
1.00	None
2.00	1-3
3.00	4-6

FERTREC **Total Fertility**
124 Measurement Level: Scale

Value	Label
1.00	1-3
2.00	4-6
3.00	7+

CHMOR1 **Child mortality**
125 Measurement Level: Scale

Value	Label
1.00	No child mortality
2.00	Child mortality

APPENDIX C
INTERVIEW GUIDE[1]

A. Health Status and Health Environment

1. Reasons for illness: Lifestyle (poverty/life-course/work) and/or religious/cultural beliefs?
2. Perceptions of comparative health status of men / women?
3. Priority for health care – men/women/male children/female children?
4. Relationship between pregnancy / birth and women's health?
5. Personal experiences of illness? (Especially illnesses related to pregnancy or childbirth?) Perspectives on reasons.
6. Experiences of child/infant death – perspectives on reasons.
7. Experiences of illness of other members of the family.
8. Who in the family makes decisions about treatment of illness?
9. Factors influencing these decisions?

B. Western Health Care

1. Information and knowledge: E.g. Hours of opening, consultancy procedure, registration of patients, provisions of the 'bodega', follow-up/referrals, '*promotoras*', sanitary advice given, workshops, services for women and children.
2. Family planning - advice and experiences (e.g. when is advice given, what does it consist of, family planning methods available, perceptions of success/ failure/ problems)
3. Consultancy during pregnancy
4. Confidence and trust in clinic / doctor?
5. Language - do the doctors speak Tzeltal? Does this make a difference?
6. General experiences of using the clinic and other "Western" health services?

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[1] This was a general guide which was flexibly followed according to the particular participant's experiences and the discourse which developed during the course of interviews.

C. Traditional Healthcare

1. Traditional remedies and practices?
2. Use of *curanderos* – practices and ceremonies / reasons for use / popularity.
3. *Curandero* identity – gender, process of becoming a curandero.
4. '*Hierberos*'?
5. Explanations and experiences of '*mal hecho*' and "*brujos*".
6. Explanations of the 'spirit' and connection to health and illness.
7. Traditional means of family planning? Do people still use these means?
8. Abstinence?
9. Abortion?
10. *Parteras* – preferences for traditional or Western? How do women choose one? If there is a problem during a birth, what happens?
11. Birthing ceremonies?
12. Hospital births – experiences and perceptions.

D. Marriage, Gender Roles and Children

1. Experience of process of marriage? (re: choice of husband / system of '*pedidas*' / religious ceremony)?
2. Experience within marriage?
3. Gender roles in the family?
4. Experience of returning to parent's home /separation?
5. Never-married women / rejection of husbands – perceptions?
    a. If not married, reasons for not getting married?
    b. Happy with not being married?
    c. Lack of children?
    d. Perceptions of women who do not have children?
6. Future – hopes / expectations of marriage for children?
7. Experiences and perceptions of motherhood and care of children?
8. Do/should men help with the upbringing/care of children? What is their role?
9. Work and lifestyle implications of having children?
10. Work roles and responsibilities of children – age / gender.

11. Land and children:
    a. Land sufficient to support children?
    b. Boys given land when they marry?
    c. Women / girls and land ownership?
12. Children and care of parents (illness / old age).

E. Family planning / reproductive decision-making

1. Sources of advice about having children (e.g. family, friends, doctor, religious leaders etc.)
2. Who WITHIN the family plays a key role / is most influential about how many children to have?
3. Other influences on family size decision-making?
4. Reasons for deciding to use / not to use family planning?
5. How are methods of family planning chosen? Satisfaction / dissatisfaction with choice?
6. Preference for sons / daughters? Why? (e.g. cost, family responsibilities)
7. When does responsibility for children end?
8. Relationship between children's care of elderly parents and family size?
9. Personal desire for family size?
10. Large families – a cultural tradition or other reasons?
11. Relationship between child mortality and family size?
12. Experiences of own family during childhood / number of siblings. Parents' opinions about children/family size?
13. Expectations for children:
    a. Education and language
    b. Remaining in Amatenango
    c. Gender difference in expectations?

APPENDIX D

QUALITITATIVE DATA CODING FRAMEWORK

A: Motherhood and Health		
General Topic	Code	Subtopic	Subcode
Conventional and changing Marriage	A1	Traditional marriage customs	A11
		Religious ceremony	A12
		Courtship	A13
		Running away	A14
		Women refusing partners	A15
		Attitudes to single women	A16
			A17
			A18
			A19
Gender Roles and the Family	A2	Suegras/Extended families	A21
		Household task division: men	A22
		Household task division: women	A23
		Gender roles in past and change	A24
		Buying in resources instead of labour	A25
		Domestic violence and decision-making	A26
			A27
			A28
			A29
Motherhood and the care of children's health	A3	Perceptions of 'Good mothers'	A31
		Perceptions of 'Bad mothers'	A32
		Single mothers	A33
		Health: Accidents	A34
		Health: Illness	A35
		General health care/prevention	A36
		Child death	A37
			A38
			A39
Women as caretakers of health in the community	A4	Promotoras	A41
		Curanderas	A42
		PROGRESA	A43
		Parteras	A44
			A45
			A46
			A47
			A48
			A49
Women's perceptions of relative health	A5	Men's health	A51
		Women's health	A52
		Children's health	A53
		Health of mestizos compared to indigenous	A54
		Other factors (eg. Relative poverty, age, etc.)	A55
		Death	A56
			A57
			A58
			A59
B: Reproductive Decisions, Poverty and Ethnicity			
Value of Children	B1	Male children	B11
		Female children	B12
		Pseudo-mothering	B13
		Adult children in household	B14
		Old age security	B15
		Cultural factors	B16
		Childless women	B17
			B18
			B19
Poverty and Family Size	B2	Costs of children	B21
		Land	B22
		Resources	B23
		Authority's discourses	B24
		Child death	B25
			B26
			B27
			B28
			B29
Ethnic Continuity: Children's futures	B3	Language	B31
		Education	B32
		Employment	B33
		Migration	B34
		Marriage	B35
			B36
			B37

									B38
									B39
Attitudes to family size: use of contraception				B4	PROGRESA				B41
					Use of: pros				B42
					Use of: cons				B43
					Information/knowledge				B44
					Religion				B45
					Tradition				B46
					Abortion				B47
									B48
									B49
Reproduction and women's health				B5	Perceived benefits to women's health				B51
					Perceived disadvantages for women's health				B52
					Official discourse/advice				B53
					Peri-natal/post-natal health problems				B54
					The role of the partera				B55
					Traditions surrounding birth				B56
					Western medical options				B57
									B58
									B59
Gender and reproductive decision-making				B6	Control over information				B61
					Male authority				B62
					Gendered decision-making				B63
					Other influences: family/neighbours				B64
					Other influences: authority				B65
									B66
									B67
									B68
									B69
C: Constructing Identity (Health and Reproduction)									
Interaction between trad/wes. Med/women's roles				C1	Traditional beliefs regarding health				C11
					The Curandera: history and gendered change				C12
					Choices & Reasons: traditional care				C13
					Choices & Reasons: Western care				C14
					Combinations: Use of both systems				C15
					Clinic's attitude to curanderas/parteras				C16
					Curanderas incorporation of Western medicine				C17
									C18
									C19
Identity, influence and decision-making				C2	Decision-making processes (community)				C21
					Decision-making in health				C22
					Decision-making in reproduction				C23
					Decision-making (other)				C24
									C25
									C26
									C27
									C28
									C29
Influences on identity construction				C3	Outside influences				C31
					The political environment: politicized ethnicity				C36
					Culture, tradition and continuity				C37
					Poverty and social exclusion				C38
					Health, reproduction and identity (general)				C39

CROSSREFERENCES

Subcode	Cross-Ref. Codes
A11	C37
A12	B45
A13	
A14	
A15	A13, A22, A23, A24, A26,
A16	A22, A23, A24, A26, A33, A55, B13, B14, B17, B35, C12
A17	
A18	
A19	
A21	A11, A24, B13, B14, B15, B64, C21-24, C37
A22	A51, B63
A23	A52, B63
A24	B16, C31-37
A25	
A26	A16-16, A32, A52, B62-63
A27	
A28	
A29	
A31	A23-24, A36, C12
A32	A26
A33	A16-16, A32, A52, B62-63
A34	
A35	A51-56
A36	A41, A56, C12
A37	A56
A38	
A39	
A41	A36, C16, C31-37
A42	C11-13, C15-17, C37
A43	B41, B65, C32
A44	B55
A45	
A46	
A47	
A48	
A49	
A51	A22
A52	A23, B51-52, B63
A53	A56
A54	A55, C38
A55	B22-23, A54, C38
A56	A37
A57	
A58	
A59	
B11	
B12	
B13	A16, A24
B14	A16, A24
B15	A21, C38
B16	A24
B17	A16
B18	
B19	

B21	A35, B32						
B22	A55, C38						
B23	A55						
B24	B44, B53, B61						
B25							
B26							
B27							
B28							
B29							
B31							
B32	B21, C33						
B33							
B34							
B35	A11-A16						
B36							
B37							
B38							
B39							
B41	A43, B61, B65, C16						
B42	B51						
B43	B52						
B44	B24, B53, B61						
B45	A12						
B46	B55						
B47	B52, B61-65						
B48							
B49							
B51	A52, B42						
B52	A52, B43, B47						
B53	B44						
B54	B57, C36						
B55	B46, C16						
B56	B46, C16						
B57	B54, C15-16, C31-37						
B58							
B59							
B61	B24, B41, B44, C21-24, C38						
B62	A26, C21-24						
B63	A22-23, A26, A52, C21-24						
B64	A21, C37						
B65	A43, B41, C21-24, C38						
B66							
B67							
B68							
B69							
C11	A42, C36-38						
C12	A16, A31, A36, A42, C17						
C13	C17, C36-37						
C14	C31-36, B64						
C15	B57, C17						
C16	A41-42, B41, B55-57, C32						
C17	A42, C12-13, C15, C31-37						
C18							
C19							
C21	B61-65, C36-37						
C22	B61-65						

C23	B61-65						

C24	B61-65						
C25							
C26							
C27							
C28							
C29							
C31	A24, A41, B57, C14, C17						
C36	B54, C11, C13, C21, C37						
C37	A11, B64, C11, C13, C17, C21, C36						
C38	A54, A55, B15, B22, B61, B65, C11, C32						
C39							

APPENDIX E
BRIEF CHARACTERISTICS OF QUOTED PARTICIPANTS

NAME	MARITAL STATUS	AGE	NO. OF LIVING CHILDREN	TOTAL FERTILITY
Alberta	Married	23	1	1
Carolina	Married	21	1	3
Evangelina	Married	22	1	1
Feliciana	Married	34	6	6
Josefa	Married	43	7	10
Juana	Single	14	0	0
Luisa	Married	42	10	10
Marcelina	Widow	39	2	2
María (1)	Married	36	5	5
María (2)	Married	53	4	7
María (3)	Married	52	5	5
María (4)	Married	24	2	3
Micaela	Married	28	4	0
Modesta	Separated (living with brother's family)	32	1	1
Nicolasa	Single	19	0	0
Petrona (1)	Married	50	4	4
Petrona (2)	Widow	48	6	7
Teresa	Widow (living with new partner)	54	7	10