REPRESENTATIONS OF REPRODUCTIVE HEALTH: A STUDY ABOUT A MAYAN COMMUNITY IN THE WESTERN HIGHLANDS OF GUATEMALA

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To my mother, María de Lourdes and father, Héctor Alfredo
For the values founding all my undertakings

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ABSTRACT

This thesis investigates representations of reproductive health amongst the Mayan communities in the Western highlands of Guatemala. Representations are explored as local systems of knowledge, viewed as expressive of the community's lay knowledge, identity and cultural practices. By looking at the conditions of production and transmission of Mayan's representations and their expression in daily practices, two aspects of local knowledge are explored. First, the relevance of local knowledge in shaping practices towards reproductive health and official reproductive health programmes, and second, how local knowledge relates to other systems of knowledge coming from health institutions, the State and the Church. The theoretical framework that I have developed through this research is grounded in the theory of social representations (Moscovici, 1984), and draws on the ideas of liberation psychology (Martín-Baró, 1996), education for critical consciousness (Freire, 1972), and the analysis of positioning and identities (Hall, 1990; Moore, 1994). This conceptual framework guided the empirical component of the study, which was qualitative in nature and combined ongoing participant observation, 15 open-ended interviews with lay people and health experts, and 6 focus groups with 36 men and women in different reproductive ages. The analysis of textual data was supported by ATLAS.ti. Diverse source of data are woven together to explore how local knowledge and cultural practices mediate in the participation of the community in reproductive health services. The study shows that Mayan's representations of reproductive health are grounded on their productive activities and is shaped by their concrete conditions of living. This social knowledge is objectified through key symbolic practices, which are the expression of their cultural identity and of the Mayan cosmology. Mayan's representations of reproductive health are deeply related to the survival of the community as an ethnic group and express the crucial link between representations and identity. The data illustrate the different ways in which Mayan people construct their conceptions of femininity and virility through the value of motherhood and responsible fatherhood. I examine how these representations undermine or empower community's participation in health interventions by exploring the link between participation and resistance. The study suggests the implications of these findings for the construction of locally sensitive health programmes.

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Chapter 1

Introduction

> Once men begin to feel cramped in their geographical, social and mental habitat, they are in danger of being tempted by the simple solution of denying one section of the species the right to exist.
>
> Claude Lévi Strauss, *Tristes Tropiques*[*]

Nearly ninety per cent of all the births in the world occur in developing countries.[1] A figure that seems to remain unchanged within the most deprived regions. Universally, reproduction means the prolongation of cultures and nations. It represents the perpetuation of humankind, in a constant search for an expansion of the human being's creative potential, a quality that should be constructed by the combination of harmonious public and private domains, within which reproductive actions are fostered. To achieve this demand requires the attainment of the most basic needs of the social actors. It entails, among other things, the possibility to secure a healthy life and to facilitate access to it. That reality is far from being reached by the majority of the world's population.

As part of a whole concept of health, reproductive health implies the right of men and women to reproduce themselves in the best possible conditions, having the possibility to regulate their pregnancies, as well as to enjoy an active sex life. In this sense, human reproduction involves more than an aggregate of physical and social factors that facilitate or detract from the complete development of fertility control or the promotion of healthy sexuality. It requires the fostering of an acceptable quality of life for each newborn child, from before the moment of conception to the time of death.

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* In Hartmann (1995: xxii)

1 Tsui et al (1997).

It also involves an improvement of women's quality of life and living standards. In order to fully appreciate of this need, one needs to engage in a profound analysis of the social conditions that underpin gender relations, the value that each culture attributes to motherhood and the meaning of reproduction. Decisions of enrolling in health-enhancing programmes, acceptance of health services and the correspondent community participation are based on these complex social phenomena that may be understood if social analysis is deeply engaged with their conditions of production. In this view, and within the scope of the Third World reality, awareness of the complexity of reproductive health is deemed worthy of highlighting only when it provokes concomitant crisis in other spheres of the social arena, when it is evaluated as an impediment to a region's progress.

Taking part in the health-development initiative, the World Heath Organisation (WHO) launched the proposal 'Health for All by the Year 2000' in 1978. The idea of a healthy society certainly represents a powerful image for development, a proclamation that 22 years ago seemed quite attainable. Now, at the very beginning of this new millennium, this optimistic prediction appears to be quite unrealistic. What has impeded the complete fulfilment of this target? Which social factors are still generating the conditions of deprived reproductive health within the developing world? How far does the process of development have for these minimum targets to be reached? To secure a healthy reproductive life demands the extension of the scope of human reproduction, in which it is considered as a product of a social system that generates it and transforms it.

These questions prompted me to write a PhD thesis on health and reproduction within the field of social psychology. My interest is driven by a general concern about how people construct their conceptualisations of health and illness and how this knowledge permits them to build strategies of survival when there is an overwhelming scarcity of social resources. I also

have a personal interest in building up applicable social research, which may provide a contribution to the long journey towards health and development.

Particularising my research concerns, this work aims to endow a modest understanding of the Mayan people, the most excluded social group in the small multiethnic, pluricultural and multilingual Central American nation that is Guatemala. For the last 510 years a number of ethnic groups have conflicted and coexisted in Guatemala, constructing a society full of contradictions and contrasts. Those sharp disparities are more tangible between the two main ethnic-linguistic groups, the *Maya* – or descendants of the ancient civilisation – and the *Ladino,* the Spanish-speaking *mestizos.* At this time, the Mayan world is a living culture made up of six million people who speak 23 different languages and live in one of the 4,000 rural communities settled in the western highlands of Guatemala.

The Mayan population has been the focus of investigation within the fields of social and cultural anthropology, sociology and social medicine as they represent a legitimate cultural group that, for centuries, has resisted a process of acculturation. Some research efforts have contributed, in one way or other, to understanding their profound cosmology and have raised the profile of the Mayan culture. However, this body of scientific knowledge remains on the shelves of foreign libraries offering no opportunity for Guatemalan society to form part of the valorisation of our own culture. As such, the Mayan people very rarely enjoy the benefit of these insights, living still within a fundamentally deprived system. Against this backdrop, my attempt is to endorse locally-based research proposals, which may contribute to encouraging our society to move towards a fair contruction.

Yet, Guatemalan society merely acknowledges the Mayan culture as a resource for the folkloric tourist industry. Their deep-seated traditions symbolised in their colourful markets and their costumes are commercialised,

the profits of which the Mayans never enjoy. Historically, the social system has persuaded us to denigrate our own culture, denying its value and encouraging us to feel ashamed of our own roots. Unsurprisingly, the Mayans have been the focus of numerous rejections expressed in the form of civil wars, displacements, exiles and family disruptions. Interactions with other ethnic groups and different natural environments, as well as the experience of persecution and death, have transformed the relationship that constituted their sense of identity, producing a Guatemalan society marked by confrontation, but also potentially strengthened by its experience of diversity. It is only now that the Mayan people are gaining new spaces within society and, more than ever, are endeavouring to question the colonialist relationship that has been imposed on them.

It is within this public domain that private reproductive health practices are grounded. Each newborn child embodies a wealth of expectations for their families; a blend of emotions and concerns welcomes them and new hopes are built up for their future wellbeing. A child may be part of the continuum of an agrarian culture of sustenance, but also the prolongation of traditional values that kept alive a millenarian culture, values that are present in each practice of acceptance or rejection of health services. In this way, the provision of health services forms an arena in which two systems of knowledge confront and clash with one another.

Against this backdrop the thesis proposed here sets out a general aim: to investigate representations of reproductive health among the Mayan communities settled in the western highlands of Guatemala. Representations are explored as local systems of knowledge, viewed as expressions of the community's lay knowledge, identity and cultural practices. By looking at the conditions of production and transmission of Mayan representations and their expressions in daily practices, two aspects of local knowledge are investigated. On the one hand, the relevance of local knowledge in shaping

practices towards reproductive health services and official reproductive health programmes. On the other hand, I investigate how local knowledge relates to other systems of knowledge coming from health institutions, the state and the Church. In this sense, it is argued that local knowledge plays a crucial role in the construction of community resources and local practices, in terms of the acceptance of reproductive health services by the Mayan communities.

In order to accomplish my research aims, I have developed a theoretical framework based on several concepts which I believe are appropriate for the understanding of the *local* health reality of the Mayan communities. In this sense, I want to emphasise the contribution that social representations theory provides to the study of health beliefs and related practices (Moscovici, 1984). Social representations, as a theory of local knowledge, offers a key starting point for the analysis of health and illness conceptualisations, giving a general sense of reference from which empirical issues can be approached. I also consider it necessary to include several theoretical concepts, which can support a wider and deeper analysis of this particular social reality. The concurrence of theoretical constructions is also aimed at creating a social theory *for* a local reality, rather than proving and testing theoretical constructions. Therefore, in this framework I include the work of Mary Douglas on cosmologies (1984), Stuart Hall (1990) with his analysis of social identities in post-colonial societies, as well as Henrietta Moore (1994) on gender identity. From a more local perspective, I integrate the work of Ignacio Martín Baró (1996) who makes reference to a liberation psychology for our local realities and Paulo Freire (1972) with his analysis of education for critical consciousness. In this sense, as Martín Baró (1996) has extensively recommended, with this work I also want to contribute to the construction of a Latin American social psychology.

The conceptual toolkit of 'local systems of knowledge' is being presented through some central assumptions. Based on the social construction of local knowledge, I draw attention to the significance of the historical dimension of social facts, highlighting the role of social memory. I also advocate the analysis of contextual meanings, arguing that they reveal the social positions in which social actors are located within society. As social identities constitute a central domain for the construction of health conceptualisations and related practices, I highlight the relevance of the analysis of a 'stigmatised' identity. In this respect the concept of renovation of identities helps us to understand how social groups build a space of reality in which their identity can be expressed and negotiated. By attempting to analyse the acceptance of health services, I argue that in Guatemala social services promote an ideology of dominance and rejection of people's differences. The medical system of knowledge constantly competes and clashes with lay people's knowledge as each expresses distinct sets of experiences and interests. By promoting the recognition of this diversity, a process of dialogue and negotiation may be initiated.

By combining the exploration of feelings, doubts, knowledge and concerns of both genders; I also want to break with the paradigm of single gender based programmes, which regard reproductive health issues as being merely women's concerns.

The thesis comprises three parts and nine chapters. The first part corresponds to the theoretical exposition of this work, outlining my main concerns and aims. In Chapter Two I outline the problem of the reproductive health reality among the Mayan people. I present what scientific literature recognises as reproductive health, offering an analysis of reproductive health risks and situating Guatemala within the context of the Latin American experience. I also explore in detail some relevant historical and social aspects that have played a crucial role in shaping people's reproductive health knowledge and

correspondent practices. In this respect, I make an analysis of how the situation of reproductive health has been approached by international organisations and developmental agencies.

Based on the former empirical issues, in Chapter Three I present a review of the literature in this field, questioning the ways in which the problem of health services acceptability has been theoretically approached. I present a review, according to different levels of analysis, of the diverse models of healthcare behaviour that have served as a theoretical foundation for health promotion programmes in Guatemala and in Latin America. By doing so, I intend to highlight a theoretical need, by indicating the lack of locally-based conceptual models upon which culturally-sensitive educational programmes might be based. Given the absence of locally applicable theoretical constructions, in Chapter Four I put forward a proposal on how this theoretical need might be accomplished by presenting the conceptual framework of 'local systems of knowledge' described above.

The second part of the thesis focuses on the methodological issues. As such, Chapter Five seeks to justify why reproductive health beliefs and related practices may be a case study of the theoretical framework presented. By doing so, in the first part of the chapter I offer a brief description of the social setting in which fieldwork actions were conducted. In the second part of the chapter, I justify my methodological choices, which favour the use of qualitative methodology for the analysis of the complex social phenomena involved in reproductive health representations and practices. In this sense, the application of semi-structured interviews, focus groups and ongoing participant observation is analysed.

The third part of the thesis correspond to the data analysis, which is divided into three chapters. In Chapter Six, I give a general presentation of the data explaining the main themes that emerged from the 'bottom-up' framework

analysis. Three main points are analysed: generative representations of reproductive health, cultural practices and variation of data. By exploring these three issues, I state that representations of reproductive health are directly linked to the concept of territoriality, agrarian production and family. This social knowledge is objectified through key symbolic practices, which are the expression of the subject's cultural identity and of Mayan cosmology.

In Chapter Seven, I explore in greater detail two broad issues: reproduction within the household and family planning. I analyse the meaning of reproduction – having children – in both women and men, as well as their appraisals of family planning actions. In this sense, the data illustrate the different ways in which Mayan people construct their conceptions of femininity and virility through the value of motherhood and responsible fatherhood. Based on this conclusion, I argue that representations of reproductive health shape conceptions of gender identity.

Chapter Eight explores how the previous representations of reproductive health undermine or empower community participation in health interventions. I argue that participation implies diverse modes of resistance in the form of silence, the construction of special meanings, discursive and non-discursive practical ends. By doing so, people realise their participation and edify a space of reality in which their identity can be expressed. And finally, Chapter Nine corresponds to the conclusions of the thesis, in which I will discuss the implications of these findings for the construction of locally-sensitive reproductive health programmes.

PART I

THEORY

Chapter 2

Reproductive Health within the Context of Developing Countries

1. General Background
1.1 Guatemala and the health reality of the Mayan people
2 The Latin American reproductive health experience
2.1 Research on reproductive health risks
3 Historical background
3.1 The Mayan population: a brief synopsis
3.2 The Spanish Conquest and consecutive social systems
3.2.1 The outbreak of civil war: a deeper detriment to the Mayan communities
3.2.2 Religion as an instrument of ideological control
4 Towards a broader definition of reproductive health
4.1 The traditional link between health and development
4.1.1 Particularising the outcome of population policies
4.2 A switch to a more dynamic reality
4.3 Integrating a complex concept into an objective reality
5. Final reflections

In this chapter I aim to bring together the pertinent issues that characterise the problem of reproductive health within the context of the Mayan population of Guatemala. I argue that the issue of reproductive health practices among the Mayan communities has to be understood in relation to the wider socioeconomic, cultural and historical factors that have shaped people's health conditions, access to healthcare and acceptance of health services. I also argue that research and intervention on reproductive health has been characterised by a reductionist analysis, which prioritises the implementation of birth control actions in the interest of reducing maternal and child morbidity, with the negation of the other highly relevant aspects of reproductive lives. This chapter is divided into three sections.

Section one provides a general overview of the reproductive health situation in Latin American countries. In describing this, I will present, first, a short

examination of the Guatemalan context outlining the background of the health conditions of the Mayan communities. Second, I will introduce the subject of reproductive health in Latin America within the perspective of the biomedical literature. I will show what scientific literature recognises as reproductive health risks, analysing the strengths and weaknesses of this paradigm and arguing that a comprehensive research on reproductive health behaviour ought to include psychosocial and historical aspects into its analysis. Following on from this, in section two I will present the historical background of the Mayan population of Guatemala. I will argue that, historically, the social system in Guatemala has promoted a system of exclusion and deprivation of the Mayan communities, a paradigm that is extended to the social services they are provided with, including health services. Parallel to the social and historical context described above, in section three I shall examine how the problem of reproductive health has been treated at the macrosocial level by international institutions, aid agencies and private organisations. I will argue that population policies established in the 1970s, which focused on birth control strategies, had a very negative impact on people's beliefs and practices towards reproductive health services. Developmental aid aimed at changing people's negative attitudes towards contraceptive use without taking into consideration women and men's perceptions of their health problems and necessities. Bringing together each of these topics, I shall draw up some conclusions in the form of guidelines upon which the problem of reproductive health in Guatemala might be analysed.

1. General Background

> Reproductive health is a state of complete physical, mental and social wellbeing and not merely the absence of disease, in all matters relating to the reproductive health system and its processes. Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice (...) It also

includes sexual health, the purpose of which is the enhancement of life and personal relations and not merely counselling and care related to production and sexually transmitted diseases.

(World Health Organisation definition of Reproductive Health, in Tsui et al, 1997: 13).

The origin, reproduction and termination of humankind has always been a permanent concern of human civilisation. Human reproduction is one of the most complex issues studied by the social and biological sciences. As the above definition shows, reproductive health implies a variety of forms of reproduction starting from menarche to menopause. It is conceived as a human right, which emphasises the right of men and women to reproduce themselves in the best possible conditions for the mother and child, having the possibility to regulate their pregnancies, if they wish to do so, and to enjoy sexual life (Tsui et al, 1997). As human reproduction determines the prolongation of cultures, societies and institutions, it is legitimate to regard reproductive health as the starting point of analysis of human civilisation.

As societies settled and turned to agriculture, they became stratified and grouped into larger units and, as a consequence, populations increased and infectious diseases spread. Increased population rates were then considered to be negative aspects of development and prosperity, since social and economic resources were not sufficient to satisfy the needs of the population. It is through population control actions that demographic regulation was initiated in the context of introducing control of widespread diseases (Berelson, 1969). Under this principle, the establishment of disease control through demographic regulation has been the basis of what is considered a transition to development. Since the eighteenth century, family planning policies and programmes have been implemented in order to introduce fertility control and reduce maternal and child mortality (Germain and Ordway, 1989). The development of social and economic resources leads to a shift away from the prevention of mortality to improving the quality of life. As a result, the concepts of family planning, maternal health and childcare are being extended

to broader issues such as sexual behaviour, abortion and sexually transmitted diseases (Omram et al., 1992). Additionally, the concept of reproductive health gained currency in the 1980s as a symbol of a fresh perspective on women rights in relation to family planning and safe sexuality. This notion refers to an acceptance of the social nature of any sexual and reproductive behaviour which includes the role of women's health needs within the context of family and social relations (Dixon-Mueller, 1993).

Nevertheless, the situation in developing countries differs from what has been the case in the developed world. Poverty, unequal distribution of social resources, lack of, or inadequate, health services have all contributed to high mortality rates caused by infectious diseases. This situation reduces life expectancy and inhibits the possibility of an epidemiological transition; that is, a move away from mortality due to infectious diseases, characteristic of developing countries, to mortality due to chronic conditions, as is prevalent in the developed world (Alderson, 1992). In addition, underdevelopment and deprivation also carry other negative consequences for the population's wellbeing, such as high fertility rates, family disruption, unequal gender opportunities and problematic social relations. From a developmental perspective, it might be argued that the conditions currently endured by some populations from Third World countries can be compared with circumstances that developed countries experienced centuries ago. Work on reproductive health in developing countries focuses mainly on population control and safe sexuality with the broader social aspects of human reproduction rarely considered or completely overlooked.

In order to confront these inequalities in health, in 1978 the International Health Conference at Alma Ata proposed the goal of 'health for all by the year 2000'.[1] The former statement comprehends all aspects of healthcare including

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[1] International Conference on Primary Health Care, sponsored by the World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF), held at Alma Ata, USSR on 6-12 September 1978 (PAHO, 1993).

reproductive rights. Achieving this goal required governments, international agencies and private institutions to make a commitment to adopt comprehensive approaches to health. In the Guatemalan experience, reproductive health has always been a sensitive issue, in which political, economic, social and cultural interests come head to head. On the one hand, it has been traditionally related and approached with the sole interest of birth control, while equally relevant aspects such as sexual relations, gender opportunities and even sexual transmitted diseases have been entirely overlooked. This phenomenon is manifested in the fact that, in 1995, within the Guatemalan Ministry of Health the term 'family planning' was formally substituted by that of 'reproductive health', stating an explicit link between reproductive health and birth control (UNDP, 1998). On the other hand, due to political reasons and governmental inefficiency, actions related to reproductive health and birth control have historically been implemented by international and private institutions, which introduced diverse approaches and methodologies to tackle the problem. The combination of independent systems of reference has created sharp disparities among the target population, the most severely affected and seldom listened to.

Moving within the limits of the health reality in the developing world, it is easy to see that the World Health Organisation (WHO) definition of reproductive health is far from being realised. Its fulfilment does not only depend on the extension of the scope of the definition itself, for instance, to move from the 'birth control' paradigm. It also requires a profound analysis of the healthcare system as a part of a wider social system of social disruption. And this is precisely my intention in this chapter: to highlight some relevant social and historical factors which have played, and continue to play, a crucial role in defining the prevailing situation of reproductive health within the Mayan communities. In doing so, in the following section I will present a short overview of the diverse reality of Guatemala in order to analyse how the problem of reproductive health has been explored and approached.

1.1 Guatemala and the health reality of the Mayan people

Guatemala is a pluricultural and multilingual country situated in the middle of the American continent, with a population of 10.2 million. Within its relatively small size, it hosts four miscellaneous ethnic groups: The Maya, who represent 60 per cent of the total population, living mainly in the highlands and the countryside; the Ladino, who make up 39 per cent of the total population and reside mostly in the cities and towns of central Guatemala; and the Garífuna and Xinca who comprise the one percent of the total population living on the Caribbean coast (Smith, 1984). Each group has its respective language. The Mayan population speaks 23 different languages, which are divided into four main groups: K'iché, Mam, Poqomam and Kaqchikel. Furthermore, Spanish of the Indo-European family is spoken by the Ladinos; Garifuna of the Caribbean family is spoken by the Afro-Guatemalans and Xinca of the Pipil family is spoken by Xinca Indians. This linguistic variety has caused difficulties in access to educational activities, which are largely restricted to Spanish, the official language. Inefficiency, lack of interest and absence of a clear policy of social concern regarding the linguistic situation, are the causes behind a level of illiteracy that reaches 51 per cent of the total population. Of this figure, 70 per cent is concentrated in rural areas. The national economy is mainly agrarian, and as a consequence 52 per cent of the population are engaged in agrarian activities in rural areas; the highest figure in Latin America after Haiti. Despite this overwhelming concentration in agricultural activity, 80 per cent of the cultivable land in Guatemala, belongs to three per cent of the total population (UNDP, 1998).

Such an adverse socioeconomic context detracts from the effectiveness of the health services, not just in relation to the material provision but also in regard to the quality of delivery. Health services are characterised by being curative and based on prevalent necessities, with almost the total omission of preventive actions. The meagre national budget to health is mainly allocated

to the implementation of curative actions, paying little attention to health promotion activities (UNDP, 1998). These health services are mainly concentrated in the metropolitan region of Guatemala City, where private institutions also provide support for those with higher incomes. In rural areas, where the majority of the population lives and where the highest risk groups are concentrated, rural health technicians, community volunteers and rural health workers serve the population (UNDP, 1998).

Coupled with this problematic level of health services, other factors related to reproductive life are also immersed in a system of priorities and exclusions. Research and interventions are mainly directed towards fulfilling the requirements of what the 'experts' define as a priority. For that reason, research efforts are concentrated either, on determining the causes for the rejection of contraceptives, or on how to implement wider acceptance. As this topic is highly relevant to the critical analysis of the current health situation among the Mayan communities, I shall go on to give a general overview of what the scientific literature on reproductive health in Latin America presents as a priority to be investigated.

2. The Latin American reproductive health experience

To encourage human beings' creative potential and stimulate progress, it is important to secure a healthy life and access to adequate services. Unfortunately, as has been stated above, in Guatemala reproductive health services are dominated by a traditional paradigm which focuses on birth control actions, while omitting other aspects of reproductive life as stated in the WHO definition. This paradigm is reflected in research and intervention in Guatemala (Bertrand et al., 1979; Ward et al., 1992; Villaseñor de Cross, 1993; Population Council, 1998; Population Council, 1998a; ASECSA, 1998) and the rest of Latin America (Omran and Solis, 1992). This research has been characterised by an over-simplistic analysis of the social phenomena involved

in people's reproductive decisions. For instance, within this pattern of investigation, cultural aspects of reproductive health behaviour are studied as 'sociocultural barriers' to contraceptive use (Ward et al., 1992: 59), diminishing the complexity of people's cultural life. There is also an extensive literature concentrated in the study of demographic variables influencing population growth, describing the effect of demographic and epidemiological changes on fertility rates in Latin American countries (Omran et al., 1992).

Nevertheless, there are research efforts that have provided a valuable contribution to the development of reproductive health in Latin America. These are focused on maternal health and childcare, family planning acceptance and the role of socioeconomic factors that impede the accessibility of health services. For instance, some studies place great emphasis on the socioeconomic differentials of fertility and show that the economic and cultural heterogeneity of these countries is manifested in the way in which the population reproduces, establishing a link between low access to healthcare and high fertility rates (Tsui et al, 1997). This is demonstrated in the fact that differences between country averages in fertility levels are significant, running from 2.3 children per woman in Cuba to 6.3 in Honduras and Guatemala. Depending on the time and how far the processes of urbanisation and socioeconomic change have advanced in each country, very large differences are manifested among rural women. In addition, it is also evident that the countries with the highest fertility rates such as Guatemala, Honduras and Bolivia also have the highest levels of illiteracy and poverty (Omran et al, 1992). This confirms the hypothesis of the demographic literature, which has insisted on the differential impact of the varied educational levels on reproductive patterns (UN, 1996).

In the Guatemalan case, fertility rates display differences between rural and urban areas, as well as between illiterate or literate women. Women with less than three years of primary education will have 6.9 children per woman on

average, and married women or peasant women will have an average of 7.2 children (UNDP, 1998). Regarding this point, in a study of sociocultural barriers to family planning among Mayans in Guatemala, Ward et al. (1992) argued that there are several factors affecting fertility which differ greatly between Mayans and Ladinos, such as an the age at marriage, educational attainment and socioeconomic status in general. Similarly, results of prior studies have established some explanations for these wider fertility differentials, for example, physical accessibility of contraceptive services and the direct monetary cost of those services (UN, 1996).

Thus, differences in family income, lower educational status and adverse geographical location have all been widely cited as being the major factors hindering access to health services and, more specifically, leading to high fertility rates. All these factors increase the prevalence of what the biomedical literature calls reproductive health risks. The study of these reproductive health risks has been identified as a highly relevant aspect in the implementation of fertility control and prevention of maternal morbidity. Given their relevance, they will be analysed in the following section.

2.1 Research on reproductive health risks

According to the biomedical view, the human reproductive life cycle is punctuated by several critical points, which are characterised by specific biological changes. During the various stages of pregnancy and childbearing, medical knowledge has reported a number of risk factors affecting the reproductive health of the mother and the child. For example, the maternal age at the time of pregnancy can be a decisive factor for women's future health and survival (Nash Ojanuga and Gilbert, 1992). The highest risk groups comprise women under 20 years, women with multiple pregnancies before the age of 20 and women going through pregnancy over the age of 35 (Omran et al, 1992). This means that there is an age band in which it is relatively safe

to get pregnant, which usually extends from 18 to 35 years. Disease and conditions related to maternal age include, for example, foetal loss, perinatal mortality, infant mortality and low birth weight (UN, 1996). Given the recommendations drawn from these studies, in Guatemala family planning institutions and the Ministery of Health implemented an educational programme that encourages people to start their childbearing later in life. In rural areas and in urban slums in particular, childbearing usually starts well before women reach their twenties (MISPAS, 1995).

It has also been noted that the most crucial factor in reproductive health is child spacing (Omran et al, 1992; Tsui et al, 1997). During pregnancy the mother consumes her own biological and nutritional resources for the growth of her foetus. Time is needed after the birth to rebuild these resources and to get the mother fit for another pregnancy. These nutritional needs increase if the mother is breastfeeding. Thus, research suggests a minimum period of three-four year intervals for a safe birth (Nash Ojanuga and Gilbert, 1992). Regarding this point, Ward (1992) states that in studies on the acceptability of family planning in rural Guatemala, birthspacing was more widely accepted than having fewer children or talking about birth control. Therefore, after the development of several proposals from private organisations, in 1995 the Ministery of Health also started to implement the 'birthspacing strategy' of health promotion (MSPAS, 1995). This so-called 'qualitative methodology' (Enge, 1998: 9) was implemented within the context of health education. By distributing information, the phrase 'birth control' was substituted by 'birthspacing', a sudden switch aimed at persuading the audience about the differences between these new services.

The third well known factor in childbearing risks is high parity, which is the first thing that comes to mind when family planning is mentioned. It denotes the number of births per woman, and grandmultiparity is a term indicating higher parity of five or more (Omran et al, 1992). It has been noted that

women with high parity are themselves prone to higher maternal mortality and morbidity. In childbirth they run the risk of fetal loss, perinatal and infant mortality and mortality in early childhood (UN, 1996). As described above, in Guatemala the parity level of women in rural areas is of 7.2 children. According to several studies, the main reason for wanting large families is the urgent need for economic assistance. Children are perceived as an economic gain rather than a cost, since their labour force represents an alternative support for their parent's future life. The intervals between births is dictated primarily by chance and 'God's will" rather than an individual choice regarding fertility (Ward et al, 1992).

Overall, the avoidance of reproductive health risks and maternal/child morbidity is a priority to the health sector. There is a wide range of research studies that recommend the implementation of educational programmes which can transmit information about the negative effects of grandmultiparity, early pregnancy and low birthspacing (Population Council, 1998, 1998a). Within a formal educational methodology, these projects aim to implement behavioural change through the transmission of pertinent information.[2] Grounded on this model of education, intervention projects established in rural areas aim to train lay people; mainly community leaders and people who posses a 'minimum level of formal education', in how to promote to their communities the benefits of the birthspacing and maternal/child care strategies (Cospín and Vernon, 1998:7).

Moreover, similar research projects implemented among the Mayan communities make reference to widely recognised causes of contraceptive rejection (e.g., an early marriage, lower educational status, religious beliefs, a desire to have large families, etc.), but none of them go further than a descriptive analysis of the problem. They are based on a top-down analysis

[2] The theoretical basis of these models will be analysed in Chapter 3: Traditional Models of Healthcare Behaviour.

which neglects the role of men and women as participants in their own health development.

In the light of the above, it is fair to state that the current stage of Guatemalan reproductive health services, research and intervention is characterised by:

- A reductionist strategy, which seeks to implement fertility regulation programmes. As a result, the majority of research is concentrated on how to promote contraceptive use, while overlooking other important aspects included within the WHO definition.
- The psychosocial and cultural identity of the Mayan people is neglected or undervalued, socioeconomic factors are not investigated and the historical factors determining people's health conditions and accessibility and acceptability of health services are not included.
- Research on reproductive risks shows that there is a real need to reduce maternal/child morbidity in the developing world in order to eliminate conditions of poverty. Nevertheless, as will be discussed later in more detail, poverty will not be reduced merely by decreasing fertility rates within a population. It requires deeper social change in which health services form only part of larger macro-social transformation.

In an attempt to go beyond this traditional perspective, and to contribute to this field of research, in the following section I will give an overview of the historical and social conditions of the Mayan population which are directly related to the problem of reproductive health in Guatemala.

3. Historical background

In this section I will argue that reproductive health behaviour has been historically constructed. Actions undertaken during the Spanish Conquest and successive governments had serious negative effects on the social and economic wellbeing of the Mayan population. This produced the context of

poor reproductive health that predominates today. I will also show that health conditions were undermined during the period of civil war in which violence and impositions were permanent strategies of conflict resolution. Within this framework, the inclusion of population control policies detracted from people's acceptance of social services.

3.1 The Mayan population: a brief synopsis

The Mayan population has its origins in a civilisation that emerged some 5,000 ago in the western highlands of Guatemala and southern Mexico. They were characterised by their development in arts, politics, social organisation, astronomy and sciences. Among the most salient creations of the Mayans is the elaboration of a calendar system which represents a dialectical fusion between the reproductive cycle of women and the processes of germination of corn, a system of reference which is still in use by the indigenous people (Watanabe, 1992). It has been observed that their cosmology and way of living was actually based on the relationship between the cosmos and nature, a base from which three calendar systems were constructed. There is little information that can provide a real comprehension about their symbolic meanings as the majority of the Mayan codes were destroyed during the Conquest. Nevertheless, it is believed that one calendar consists of 260 days, nine months and 28 days, and is used for divination and crop control; the long count with 360 days which assigned a unique qualitative designation to any given day; and the 365-day solar year calendar, quantitative in nature and relatively similar to the Gregorian calendar (Copmagua, 1999). By 1250 AD, the highland Mayas were organised into five groups: the K'iche', Poqomam, Tz'utujil, Mam and Kaqchikel that in the present day constitute more than 23 linguistic communities along the Guatemalan highlands.

3.2 The Spanish Conquest and consecutive social systems

The Spanish invasion and subsequent European migration originated a 'fluid and complex system of Maya ethnic/linguistic groups, the legacy of which still rules ethnic relations in Guatemala' (Fisher and Brown, 1996: 9). According to Fisher and Brown (1996) although the material and ceremonial aspects of highland Maya culture were affected by the repeated invasions, Mayan people have struggled to keep their cultural traditions and their linguistic behaviour, which, until this time, remain relatively untouched.

The negative repercussions of the Conquest in Guatemala have been the focus of discussions between social scientists for decades (Guzmán Böckler, 1986; 1995; Fisher and Brown, 1996). I do not pretend to give a complete analysis of the social consequences of this event. However, in relation to the effects on the health conditions of the Mayan people during colonial times, there are some points of analysis that deserve special attention. For example, McNeill (1976) describes how one of most devastating effects of disease in history has been attributed to the complete domination of Latin America during the conquest through the diseases brought by the invaders. It is stated that Guatemala, Peru and Mexico lost 90 per cent of their populations within 120 years and suffered total cultural dislocation. In the case of Guatemala, it is said that the Indian communities that were living dispersed throughout the highlands were obliged to move down to large plantations and into forced labour, in a context of dehumanising working conditions. Due to the high death rate among the Indians, and the need for labourers to work their lands, the colonialists had to implement strategies to stimulate population growth among Indians and non-Indians (Guzmán Böckler, 1986). Similarity, Kunitz (1990) points out that different forms of colonialism created different health conditions, stating that:

> The Spanish and Portuguese imposed their authoritarian culture on their colonies, replicating the semi-feudal conditions at home. They brought rural poverty, early and universal marriage, crowded

> households, inadequate sewerage and malnutrition that increased the risks of early death and, right up to the present, have kept rural mortality higher that urban mortality. On the other hand, the British, while also bringing early marriage and high fertility, allowed private land ownership and use, which resulted in very good nutrition, low density of population and good health, with lower rural mortality (Kunitz, 1990 cited by Stein, 1997: 83-84).

Inequalities in the provision of social services and dispossession of the Mayan's human rights have been a permanent feature of colonial rule, extended by successive governmental authorities which have established the foundations of a system of multiple exclusion. Independence from Spain in 1821 did not return political or territorial autonomy to the indigenous nations. It brought the perpetuation of colonialism until the present day, leaving the indigenous rural communities marginalised and with the highest levels of poverty. Regarding this point, Guzmán Böckler (1995) noted that inequalities in Guatemala have been based on a system that protects landowners who pay extremely low taxes for the agricultural land or other social resources they possess and, at the same time, pay low salaries to the workers who live on their lands with no health and social services. Therefore, the economic and social system is recognised as being colonialist in nature, ineffective in its policies and aggressive in its methods towards the people, in which elements of racism are considered as being 'the most profound manifestation of a violent and dehumanising social system' (CHC, 1999).

The initial effects of the conquest on health were further expanded by 36 years of civil war. As will be analysed in the following sections, instruments of political, social and economical control were introduced in order to impede social organisation and cohesion. These actions produced a direct impact on the health conditions of the most affected populations. It is through the influence of these various events that the health condition of the Mayan communities must be interpreted.

3.2.1 The outbreak of civil war: a deeper detriment to the Mayan communities

One of the most arduous moments for the Mayan people during the history of Guatemala history has been the civil war, which ran from 1960 until 1996. The rise of guerrilla groups during the 1960s served as justification for the government to use methods of violence towards the Mayan people as part of a counterinsurgency war (CHC, 1999). The rural area was the main focus of civil war, and as the insurgents had their main bases in the indigenous populated western highlands, the national army destroyed entire Mayan communities and Mayan social institutions. This ethnocidal campaign targeted not only 'active subversives' but also 'potential' subversives that could be acknowledged as being guerrilla allies. Considering the extremity of the repressive acts, people were not allowed, and did not tend, to establish any kind of social organisation, communal activities and religious practices, as these were considered to be part of insurgent organisation against national security (Fisher and Brown, 1996). The specific targets of direct executions included figures of Mayan authority, such as communal leaders, healers, midwives, Mayan priests and spiritual guides. According to the Commission of Historical Clarification Report and The United Nations, these actions...

> ...were not only an attempt to destroy the social base of the guerrillas, but above all, to destroy the cultural values that ensured cohesion and collective action in Mayan communities (1999: 23).

This repressive atmosphere built up over several decades created a climate of social repression, instability and increased the levels of poverty in rural areas. The lack of attention to social services is reflected in the fact that until 1996, the government had destined just one percent of the national budget to health services, while the expenses of the army and national defence came to 4.5 per cent (UNDP, 1998). It also created an atmosphere of fear and concealment among the Mayan population in which the need for organisation in order to ensure the satisfaction of their needs was neglected and repressed. Regarding

this point, and in relation to the development of the women's health movement in Latin America, Portugal and Matamala (1993) observed that in Central America it is more accurate to speak of popular health movement that a gender based-one. They state that:

> Elsewhere in Central America, except in Costa Rica, armed conflicts tended to steer women's organisational initiatives and participation. The contribution of women in the area of health was more in keeping with their traditional role, although it did occasionally include a clandestine aspect in their educational and health interventions, especially in Guatemala and El Salvador. [Therefore] compared with the rest of the hemisphere, the women's health movement in this sub region is still incipient and has only had limited impact on public policies (1993: 275).

As a human necessity people find, whenever possible, forms of expression for their most significant beliefs and necessities. Within a context of social controversies, contradictions and contrasts, human beings construct diverse coping mechanisms to help them to deal with the demands of their daily lives. In Guatemala, strategies varied from spontaneous social organisations that could offer possible alternatives towards the satisfaction of their most basic needs, along with the confinement to their most significant religious beliefs and practices. Nevertheless, instruments of inspection and control were prevalent in a variety of forms, as a form of direct violence or as an ideological manipulation through religious beliefs. Religion was, and still is, one of the most profound mechanisms of control and ideological intercession that has been used throughout the history of Latin America (Martín-Baró, 1990). Therefore, given its relevance to the study of reproductive health, I want to highlight the role of religious Pentecostal movements and their effects on people's beliefs and practices of reproductive health.

3.2.2 Religion as an instrument of ideological control

The dynamic of religious beliefs within a multicultural nation is very complex. To try to scrutinise it within a single analysis is an almost impossible task. In

the case of Central America, and specifically in Guatemala, religion has always been the central core for the acceptance, enrichment, or rejection of any social services that require the active participation of the population. First, the Mayan religion and, later, conservative Catholicism have laid down the cultural boundaries of the nation until 1960. If we look back in history, it has been acknowledged that during the 1960s in some Latin American countries there was a growth of evangelical churches in countries traditionally dominated by Catholicism and indigenous religions, marking the beginning of a doctrine of subjection that could obstruct the growth of so-called communist ideas (Bouchey, 1981).

This doctrine, launched and applied by the USA government, was part of a strategy which acknowledged that 'military victory is not enough; it is essential to win the hearts and minds of people who generate, feed and support the insurgency' (Bacevich et al., in Martín Baró, 1996: 138). Martín-Baró (1996) argued that through this mechanism, religion was used as an instrument of psychological warfare that targeted the poorest populations of the region:

> ... a basic mechanism used to gain objectives in psychological warfare is the unleashing of personal insecurity: insecurity about ones own beliefs, judgement and feelings, about right and wrong, and about what should and should not be done. This insecurity finds an immediate and tranquillising response in the solution offered by those in power: to accept the official truth and to submit the 'established order' (1996: 139).

Faced with the growth of the evangelical churches, and keen to maintain its supremacy, the Catholic Church also introduced a movement that has been interpreted as a Counteroffensive Charismatic Renewal, which introduced a new existential dilemma for the people (McGuire, 1982). The combination of strong evangelical movements and radical Catholicism serves to impede people's participation in developmental activities. In countries like Guatemala, evangelical movements were directly lead by personalities such as

the president of the republic and the heads of the national army, who guided military actions in the name of 'Holy Salvation'. In the 1980s up to 50 per cent of the population in war-torn municipalities joined different charismatic or fundamentalist churches, most of them evangelical, and some Catholic (Ekern, 1997). For this reason, issues of intentioned evangelisation and its detrimental consequences are included on the agenda of the developmental initiative launched by the Commission of Historical Clarification for the period of civil war (CHC, 1999).

More directly related to reproductive health matters and, specifically, in terms of acceptance of contraceptives, the role of radical religious movements has been widely acknowledged as being an impediment to the introduction of health promotion initiatives (Rosenhouse et al, 1989; Ward et al., 1992; PAHO, 1994; Pineda et al., 1995; Population Council, 1998, 1998a). These studies note that strong religious beliefs associated with radical religious movements undermine people's acceptance of new technology. Nevertheless, their analysis is based on an elementary description of the determinants of contraceptive rejection, within which 'local religious beliefs' are squeezed into one sole category, excluding a deeper critique of the whole problematic. Unfortunately, given the centralism of local governments, it has been difficult to introduce new perspectives to deal with this issue. According to an unpublished governmental report, a new initiative launched by the Women's Commission with the purpose of drawing up the first national policy on reproductive health was rejected by the former First Lady of Guatemala, on the grounds that the policy was 'against the principles' of the Opus Dei charismatic movement, a radical religion that she professes (SEGEPLAN, 1997).

The discussion laid out over the proceeding pages shows that a historical perspective can help us to understand the present-day social situation in all matters related to health. In Guatemala, since its very inception, every social

actor was directly or indirectly involved in a system of social disparity and controversy in which violence and impositions were permanent strategies for resolution of problems. Unfortunately, the effects of this confused context cannot be isolated to social and political disturbance. Poverty and social exclusion within a convulsive context generate concomitant negative effects on private spaces and public spheres. That is to say, they affect family and social relations, establish codes of communication, motivate negative attitudes towards the public arena, decrease the quantity and quality of social services and the acceptability of these. In other words, they create a difficult background from which to construct reproductive health systems of knowledge. Therefore, in order to counter the widespread tendency to restrict the focus on women's health to reproductive and maternal functions, it is necessary to include the economic and sociopolitical factors encountered by men and women throughout different historical times.

Regarding this point and in an attempt to integrate the sociohistorical dimension, I shall go on to analyse the role that international organisations and developmental agencies have played in relation to reproductive health in Guatemala. I shall do this by describing how the concept of reproductive health has gone through a process of transformation over several decades, and how past policies have left their mark on the population they targeted.

4. Towards a broader definition of reproductive health

In this section I aim to analyse the effects of past policies and population control actions on people's reproductive health conditions and their acceptance or rejection of health services. I argue that population control policies established in the 1970s as part of an international plan seeking to eliminate poverty had profoundly negative social consequences on people's health beliefs and practices. In doing so, I will follow the development of the

concept of reproductive health, giving examples from the Guatemalan experience.

4.1 The traditional link between health and development

The problem of population growth has always been the main concern of reproductive health intervention initiatives, as it is considered to be one of the major causes of underdevelopment. In order to tackle this issue, the United Nations declared the years 1976-85 a 'Decade for Women' and launched several developmental projects to promote safe motherhood. Within this context, the health sector in developing countries contemplated family planning programmes that were considered as a strategy not only for reducing reproductive health risks, but also for eliminating the barriers imposed by numerous and closely spaced pregnancies, to enable women to participate more easily in the labour market under more favourable conditions. According to Cooper (1990), on this principle numerous family planning actions were implemented in Latin America and, as a result, the health sector concentrated its efforts in the reduction of fertility rates. In addition, these activities were inspired by the conception of health as part of the formation of human capital, viewing women's health as an investment in society's welfare.

After the Decade for Women, the World Health Organisation, the World Bank and the United Nations Fund for Population Activities (UNFPA) at the International Conference on Safe Motherhood in Nairobi, initiated The Safe Motherhood Initiative.[3] This project also focused on maternal health problems in developing countries, and stated that governments have to concentrate their efforts in preventing maternal mortality (Herz and Measham, 1987). Within the same paradigm, it was stated that women's health and prevention of mortality is one of the main issues of reproductive health actions and, as a

[3] Guatemala ratified this convention (Herz and Measham, 1987).

consequence, all women's health needs have to be understood in relation to their reproductive capacity. According to De los Ríos (1997) the hypothesis of this 'integrationist approach', is based on the idea that if women's health is improved and the number of children they have is reduced, their integration into development will be facilitated (1997: 6). Thus, reproductive health should be considered as a contributing factor towards equality and poverty alleviation.

Overall, these conventional approaches that conceive women's health as an investment in the economic structure of a society have received several criticisms. One of the strongest arguments is that reproductive health involves more than the delivery of maternal and child health or family planning services (Nash Ojanuga and Gilbert, 1992; MacCormack, 1992; Hardon, 1992; Hartmann, 1995). According to Hartmann (1995: 59):

> Since the 1960s Western policymakers, especially in the United States, have embraced 'overpopulation' as a primary cause of poverty and instability in the Third World. It was this concern – not concern for women's well-being – that shaped the initial pattern of family planning interventions overseas" (1995: 59 *stress in original*).

It is argued that although these initiatives were concentrated in reducing maternal morbidity, the underlying premise was an economic principle by which reproductive health problems were seen as solved by implementing widespread fertility regulation and safe sexuality. Factors such as men and women's needs and decisions of their future wellbeing, quality of life of the parties involved, family and social relations and social and cultural conditions arising from specific contexts, were neither relevant nor considered. For more than a decade this so called 'conventional model' shaped programmes of maternal health and childcare in the developing countries of Latin America (Cooper, 1990). These actions were mainly supported by international aid agencies with population control values such as the United States Agency for International Development (USAID) and the World Bank, which provide

funds and personnel as an integral part of foreign aid (Aguilera, 1981). In some cases, such aid has been made conditional on the recipient's acceptance of population control actions (Hartmann, 1995). It is, therefore, widely agreed by women's health advocates that the mainstream work on reproductive health and family planning programmes has had the effect of controlling women's fertility rather than meeting women and men's reproductive needs.

4.1.1 Particularising the outcome of population policies

In Latin America during the 1980s, women health advocates started to move against population policies, which were viewed as an expression of demographic interest on the part of governments rather than a real concern with the fertility needs of women. They were also considered as a manifestation of violence practised against women by medical institutions (Karl, 1986; Portugal and Matamala, 1993). These new social movements rejected the massive distribution of contraceptives such as Depo provera and the experimental research programmes on women with the new contraceptive Norplant (Portugal and Matamala, 1993). In the case of Guatemala, due to the nature of the state, there is no reliable published official documentation that can provide information about the massive use of such contraceptives and its negative consequences. However, non-official sources report that during the 1970s, while implementing vaccination campaigns among Mayan children, their mothers were also 'vaccinated' against pregnancy without their knowledge. Practices of sterilisation were widely implemented together with the administration of 'post-delivery IUDs'.

According to Hardon (1992) the most common argument levelled against critics of indiscriminate contraceptive use in the Third World, is that family planning in developing countries is much safer than childbearing, stating that:

> Agencies involved in the implementation of family planning programmes in developing countries have argued in favour of Depo

> Provera use, by pointing to the fact that Depo Povera is easily administrated and especially useful for women who have difficulty in remembering to take oral contraceptives daily. The 'non-visible' nature of the method is seen as an advantage to women whose husbands do not agree with the decision to practice birth control. (...) [Hence] cost-benefit analysis is different in developing countries, where many women suffer more health risks in pregnancy and childbirth than women in developed countries (1992: 755–6).

Similarly, Hartmann (1995: 185) argues that the use of high rates of maternal mortality to justify higher contraceptive risk in effect 'penalises the poor for their poverty'. She points out that high maternal mortality rates do not result from too many births alone, they are the result of inadequate nutrition, poor healthcare and other effects of poverty. Addressing these problems first would not only lower the risk of childbearing, but would establish a better foundation on which to build decent family planning services.

In Guatemala, injected contraceptives such as Depo Provera are widely used in rural areas (Cospín and Vernon, 1998). Research on family planning has shown that contraceptive use rarely depends on women's personal wishes; their husband's approval is a highly decisive factor (PAHO, 1994). Taking advantage of this social and cultural aspect, family planning agencies distribute non-visible contraceptives even though they are recognised as being harmful to women's health. Divergence of interests between providers and users dominates the context of family planning programmes, which do not respect women's reproductive rights. Therefore, the massive distribution of contraceptives which are considered harmful to women's health is actually a negative outcome derived from the population policies established two decades ago. We can not isolate the effects of such policies as being past events as occurred in other countries. In our local realities, as was pointed out earlier, women are not in a position to negotiate whether or not they want to accept these actions, as family planning tends to be strongly reactive 'accepting without question whatever contraceptive technology emerges from the laboratory' (Hardon, 1992: 763). Furthermore, past policies left their

negative effects not only on the population they targeted but on the providers of health services. The use of psychological and physical violence is still a prevalent issue within the macrosocial spheres of participation and in the doctor-patient relationship.

As part of development strategies, new policies were implemented and complex social concepts were integrated into the construction of a better vision of reproductive health. In the next section, I will discuss the implementation of a more generic concept of human reproduction, where a gender paradigm opens new perspectives in the analysis of men and women's reproductive health.

4.2 A switch to a more dynamic reality

As social life demands a deeper understanding of the reproductive life of human groups and as changes in reproductive patterns were not substantial, it was essential to develop new ways of approaching the problem of reproductive health. In relation to this matter, in 1994 representatives of nearly 180 countries at the International Conference on Population and Development (ICPD) adopted a programme of action that included a broader definition of the concept of reproductive health drawn up by the World Health Organisation (Tsui et al, 1997). It includes reproductive rights for the mother and child, freedom of choice and information, together with the acceptance of the other six components of reproductive health: sexuality, sexually transmitted diseases, infertility, healthy maternity, child survival and family violence. It was also stated that reproductive health overlaps with, but is not the same as, women's health. Reproductive health also includes health for men and rights for men. However, it was established that it is necessary to concentrate more on women's issues such as pregnancy care, safe delivery, contraceptive use, abortion and sexual violence as women are those who most suffer their negative consequences. Thus, women's health is also stated as a

priority for implementing healthcare actions, although they are considered as being active participants in their health actions.

The expansion of the concept of reproductive health makes it possible to integrate broader social aspects into its analysis. One of the most relevant achievements derives from a change in paradigm from a women-centred perspective to a gender analysis. This approach considers the social order as a problem and focuses on social relations between genders. Stating the case of Latin American health and development, De los Ríos (1993) suggested that a gender perspective ...

> seeks to identify and change the causes of the power-subordination relation that places women in a position of asymmetry and disadvantage when it comes to access to, and control over, healthcare resources for their own benefit (1993: 15).

According to the PAHO (1993) this shift from the integrationist approach to women's health to a gender approach demands intervention in various spheres that are not exclusively centred on women as an isolated social group. It requires, on the one hand, the implementation of several actions in the macro spheres of participation through the development of adequate policies that reflect people's needs. And on the other hand, in the micro spheres of society through the enhancement of community participation and empowerment.[4] This perspective also focuses on the identification of the health problems associated with the gender-based division of labour and differential patterns of socialisation. Therefore, the new perspective launched by the WHO seems to situate the problem of reproductive health within an perspective from which social reality can be profoundly appreciated.

[4] The concepts of community participation and empowerment will be extensively analysed in the Chapter 3.

4.3 Integrating a complex concept into an objective reality

By reviewing the concept of reproductive health I have tried to address the main elements of the Guatemalan reproductive health situation. As we have seen, as a result of feminist pressure, the reproductive health establishments have broadened to incorporate many gender and empowerment concerns into the reproductive health paradigm, but there are still many drawbacks. Clearly, family planning, adequate local policies on reproductive health, empowerment, patriarchy and so on are issues of vital importance to women and men in developing countries. However, unless and until the reproductive health establishments address the main causes that generate the poor reproductive health conditions in the Third World, the problem will remain.

Work on population control should take into consideration much needed reforms – such as land redistribution, employment creation, the provision of mass education, healthcare and women's empowerment. By implementing such social reforms, reproductive health conditions – and the problem of overpopulation – could undoubtedly be improved. Women would tend to have fewer children for the obvious reason that they would have other social options. As Bello notes (1992), a decline in fertility in Sri Lanka and in Kerala, India was...

> part of a more holistic strategy of fertility control, the centrepiece of which must be efforts to radically improve poor people's access to resources, promote the welfare of women and bring about a more equitable international economic system (1992: 6).

As such, the current stage of the reproductive health-related practices in Guatemala demonstrates that our national health services and policies indeed confront the problem of poverty by grounding their actions on a birth control cause-effect deterministic analysis. In this case, following the principles of a classical Malthusian logic of development.

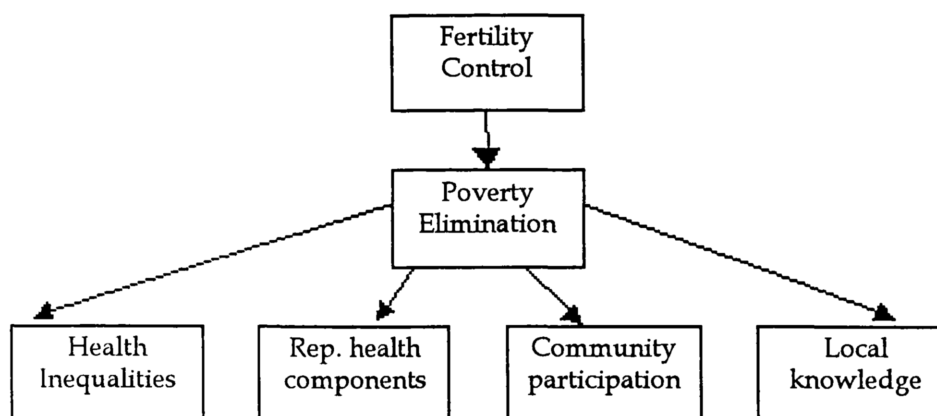

Figure 1. Cause-effect analysis of population control policies and intervention programmes

Following this logic, all other related aspects of reproductive life (sexually transmitted diseases, sexual health, reproductive rights), as well as the social context within which reproductive health practices are immersed (health inequalities, family violence, community participation and cultural differences), are included within the potential benefits of birth control policies. Additionally, the switch from a conventional developmental perspective to the more open gender approach was an enormous challenge as it allowed the exploration of the issue of reproductive health within a wider perspective. Nevertheless, experience has demonstrated that conceptual 'switches' cannot convey concomitant changes in social reality, as its complexity goes far beyond the scope of euphemistic conceptual frameworks. Actions and policies undertaken were established at the macro level of intervention (e.g., international organisations, local governments), but their effects clearly had an impact on local populations. In the Guatemalan case, political and economic interests have been a priority when it comes to policy implementation. Evidently, each country has its own particularities, history and socioeconomic conditions and the effects of such policies influence the population to a greater or lesser extent. But in attempting to evaluate the effects of those multifaceted policies and actions I can affirm that apart from being relatively effective for the purposes of maternal morbidity, they have had a major impact on people's acceptance of health services. Emphasis must

be switched from a birth control paradigm to a woman's control of her own fertility as part of an expansion of her options.

5. Final Reflections

My intention in this chapter was to discuss some issues relevant to reproductive health problems among the Mayan population of Guatemala. As the WHO definition states; reproductive health requires the right of men and women to reproduce themselves in the best possible conditions for the mother and child, having the possibility to regulate their pregnancies, as well as to enjoy sexual life. To extend the value of reproductive health to a more gender-based approach serves to highlight the psychosocial and cultural aspects of reproduction. That is to say, to pay attention to the value that motherhood has in each culture; the struggle that men and women have to face in order to secure their own existence; the social pressures from the community and families; and the lack of potential spaces in which men and women can discuss reproductive health matters. All these aspects are inherent to a specific community's sociocultural conditions, which cannot be considered as given, or immersed within a single definition. It is on the grounds of a gender-based and holistic approach that I want to locate my own research concerns. Therefore, the main issues concerning reproductive health in Guatemala may be summarised as follows:

1. The lack of acknowledgement of socioeconomic and historical factors that impoverish health conditions in general and reproductive health in particular. As has been extensively shown, differences in economic income between social classes carry concomitant negative effects in health status.

2. The reductionist analysis, which suggests that through the implementation of fertility control policies morbidity will be also reduced, together with the negation of other components of reproductive health.

3. Implementation of anti-popular policies that have had a tremendously negative impact on people's acceptance of health services, and a tendency to make generalisations in the belief that what was effective in one reality can be applied to other realities.

4. Lack of consideration of cultural differences and women and men's perceived needs. The more diverse nature of women and men's health problems beyond reproduction may increase the possibility of cultural discrepancy between their own perceptions of these problems and that of the healthcare providers; lack of consideration of the cultural values on which beliefs of health and illness are grounded.

5. Theoretical inconsistency in approaching the problem: several systems of reference tackle the same problem in many different ways; an absence of theoretical models which can make a real contribution to the problem.

The former statements were explicit throughout the content of this chapter. Multifaceted social analysis cannot be integrated within one specific category if constructive contributions are expected. Given the last point about the lack of theoretical consistency and absence of appropriate theoretical models related to the context, in the following chapters I discuss how social psychology can contribute towards a remedy to this situation. In the next chapter, I shall offer an analysis of the theoretical models that underpin health education activities in Guatemala, proposing an alternative perspective from which the problem of reproductive health-practices can be better comprehended.

Chapter 3

Prevalent Approaches to Health-Related Practices:

A Review of the Literature

1 General background
1.1 Theoretical models of healthcare behaviour
2 Individual level of analysis
2.1 The meaning of individual change: strengths and weaknesses of individual models
2.1.1 Linear causality versus a dialectical understanding
2.1.2 Individual aspects versus social aspects
2.1.3 The underlying ideology
2.1.4 The prevalence of quantitative, rather than qualitative, research
3 Peer level of analysis
3.1 Concepts derived from the social learning approach
3.2 Moving beyond an individual scheme: criticisms to peer level models
3.2.1 Reductionist analysis of individual/society relationship
3.2.2 A culture of competence
4 Community-level theories
4.1 Building participation in community health
4.1.1 Empowerment
4.1.2 Community participation
5 Cultural level theories
5.1 Individual models versus shared models
6 Concluding remarks: a call for the development of culturally sensitive theoretical approaches

In this chapter, I seek to analyse the different approaches towards factors associated with healthcare behaviour that have been used as a theoretical foundation for health promotion activities in Latin American countries. Considering the particular sociocultural conditions of the Guatemalan context, this chapter aims to demonstrate how the problem of reproductive health beliefs and practices has been theoretically approached, offering a critical analysis of the limitations and appropriateness of these studies. I argue that *first,* there is a broad gap between the theoretical underpinnings of these models and their applications to social realities outside the context in which

they are grounded. *Second,* despite the fact that such models intend to include psychosocial aspects in their analysis, social reality is either viewed as a static aspect to be controlled as a research variable, or it is reduced to solely the individual perception of social facts. *Third,* there is a tendency to view processes of health and illness as isolated elements derived from individual structures, rather than as social constructions in which cultural and historical constraints play a crucial role in shaping people's beliefs and practices. It is also argued that such approaches need to be situated within a social psychological perspective, which locates intra-individual and inter-individual processes within a context of broader community identity and social relations. In order to organise this discussion, I will divide the different approaches according to diverse levels of analysis: individual, peer group, community and culture. As a conclusion, I shall offer an alternative proposal on how this theoretical need could be met.

1. General background

In the previous chapter I discussed the problems inherent in the study of reproductive health in Guatemala, as a complex issue in which several social aspects are involved. Considering the broad and multifaceted definition of reproductive health given by the World Health Organisation (WHO), one might draw the conclusion that any research on health beliefs overlaps with several fields of study. In fact, several theoretical studies in the fields of sociology, health, social psychology and anthropology have made a contribution to the understanding of health-related practices, offering different levels of analysis. This diversity runs from an individualistic analysis of the factors associated with healthcare behaviour to the macro-social level of explanation, which considers the role of community norms and values within a sociocultural context. Unfortunately, although such theories always refer to the influence of the broader social and cultural contexts of reproductive health and related practices, social reality is generally viewed as a static dimension, which does not merit further analysis or, in some cases, is ignored.

As this research is founded in the heterogeneous reality of Guatemala, one ought to be aware of integrating theoretical concepts that might be functional for understanding its specific complexity. At a national level, health education programmes are grounded upon theories that target the individual or peer levels of analysis. The efficacy of these programmes is questionable, despite the fact that there have been successes in some contexts (Tsui et al, 1997). Gilles (1998), for example, points out that such approaches have greatest success among the wealthier and more educated sectors of the target population. Such theoretical models focus on the individual level of analysis failing to capture the social/community and cultural processes. On the other hand, these frameworks are grounded and applied within a western sociocultural context, a reality that differs greatly from the one in which people from developing countries live.

As a result, such approaches have not succeeded in changing people's reproductive health practices in terms of their accepting contraceptives and implementing maternity health and childcare in Guatemala. Considering the current state of health promotion and intervention in developing countries, there is a clear lack of culturally sensitive models able to make an effective contribution towards the understanding of the reproductive health practices in the Third World. An appropriate theoretical construction should take into account the wider the levels of analysis, to extend the scope of the object of study (Doise, 1986) [1].

1.1 Theoretical models of healthcare behaviour

The sections below will not be able to do justice to the research that has been done in the area of psychosocial factors and health, as there is a vast amount of research in this area and too little order to it. As a result of this

[1] It is not my intention here to give an account of the research that has applied such models outside the context of this study. Nevertheless, I shall provide some examples of applied research which are directly related to the inquiry on reproductive health in Guatemala.

inconsistency, classification of theoretical models of healthcare behaviour becomes a difficult endeavour. Several leading health psychologists have attempted to classify models according to various levels of analysis. However, their divisions often vary, situating complex psychosocial concepts indeterminately within intra-individual, inter-individual or community levels of analysis (Stroebe and Stroebe, 1995; Radley, 1994; Brach, 1999). This ambiguity may correspond to a concomitant inconsistency in the construction of the models themselves. For instance, 'traditional' models that seek to achieve individual behavioural change through the implementation of health education are founded on cognitive processes, although they also embrace affective states, which are not further analysed. In addition, the theoretical foundations of inter-individual level models, such as social cognitive theories, are in the process of reconstruction and in later publications they have showed a wider perspective by including societal aspects into their analysis (Bandura, 1997). And cultural models, which include in their analysis cultural and social aspects of health and illness as a system of social construction (Holland and Quinn, 1987) focus on the linguistic phenomena as the behaviour to be controlled.

Against this background of theoretical inconsistency, and, in order to provide an adequate analysis of the different theoretical models, in this chapter classification is based on the Gilles' (1996) 'onion model' of analytical levels. The model sees individual health as being shaped and constrained by factors at a number of different levels: personal, peer groups, communities, social institutions and systems of culture, politics and environment. Gilles argues that in order to provide a comprehensive understanding of the complexity of healthcare behaviour, any analysis should include a wider perspective in which not only individual factors are taken into consideration, but also societal and cultural factors. It is also stated that successful health interventions must be geared towards the total environment in which people live if appropriate health outcomes are to be expected.

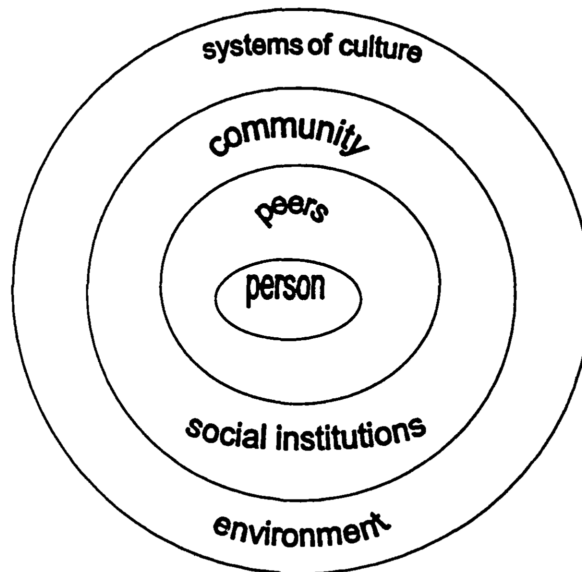

Figure 2. Onion model of analytical levels

In the light of this paradigm, I shall divide the analysis of the theoretical approaches into different levels.

2. Individual level of analysis

The role of traditional models of factors related to healthcare behaviour has been extensively reviewed within a wide range of social psychological research (Stroebe and Stroebe, 1995; Radley, 1994; Ogden, 1996). As stated earlier, these 'traditional' models tend to focus on cognitive processes as determinants of healthcare behaviour, although some also embrace affective aspects such as motivation, emotions and volition. Due to the strong influence of such models in designing health education programmes, it is highly important to become acquainted with the main underlying concepts in order to elucidate their applications and limitations. In doing so, in this section I shall examine the most influential theoretical models of healthcare behaviour applied in health education.

There are many individual level-change theories in health promotion literature (Fishbein and Ajzen, 1975; Ajzen, 1988; Rosentock, 1974a; Janz and Becker, 1984). The central premise of these theories is that people make behavioural decisions on the basis of reasoned consideration of the available information. These approaches examine individual characteristics, such as motivation, affective processes and cognition, as the unique factors that might enhance or decrease behavioural change. In fact, these internal constituents are considered to be of primary importance for individual decisions about implementing healthy practices. According to Campbell (1998b: 2) these 'KABP-type' theories, where the components are Knowledge, Attitudes, Beliefs and Practices, still have applications in health research and are reflected in the Health Belief Model (Rosentock 1974a; Strecher and Rosenstock, 1997), the Theory of Reasoned Action (Fishbein and Ajzen, 1975) and the Theory of Planned Behaviour (Ajzen, 1988).

The Health Belief Model states that prediction of behavioural outcomes comes from knowledge of a person's beliefs and attitudes (Janz and Becker, 1984). In doing so, it focuses on two processes of evaluation: the threat of illness and the behavioural response to that threat. For example, according to this model, people can perceive whether they are vulnerable to contracting any disease and, if they get it, they might evaluate the severity of that disease in order to take some curative action. Taking the case of sexually transmitted diseases, the theory states that the individual is capable of perceiving the benefits or barriers to condom use through a process of self-evaluation (Strecher and Rosenstock, 1997). Thus, any ill-health status is left solely to the responsibility of the individual and his/her own 'cognitive abilities' to recognise what is the best for their physical and psychological wellbeing.

Alternatively, other research has suggested variations to this model. It has been stated that, of the four components of the model — perceived vulnerability, severity, threats and barriers — the only adequate predictor of

behavioural change is perceived barriers (Terry et al, 1993; Bandura, 1997). These authors state that it is neither the perception of vulnerability to disease nor the perception of its severity that makes individuals take preventive actions. What is of high value is the individual perception of barriers and the perception of personal abilities for coping with the threat. Considering this statement, research guided by the Health Beliefs Model assumes that individual cognition of personal control and perceived barriers is a 'good predictor' of behavioural change. Again, the complex subject of health beliefs is reduced to the sole component of individual awareness.

In the same vein the Theory of Reasoned Action (Fishbein and Ajzen, 1975) and the Theory of Planned Behaviour (Ajzen, 1988) join the continuous series of intra-personal theories which are organised around the view that behaviour is rational and determined by attitudes and beliefs. According to the theory of reasoned action, behavioural decisions are seen to be the consequence of the person's systematic reasoning. This means that a person's decision to engage in a particular behaviour is influenced by the extent to which the person is *intended* to do so (Fishbein and Ajzen, 1975). Thus, it is assumed that the sole predictor of whether a person will change his/her behaviour is his/her *behavioural intention.* This intention is shaped by attitudes towards that behaviour and perception of how others will view that behaviour. This latter component corresponds to the norms and values of the social group to which the individual belongs and it is recognised as the social or environmental component of the model (called *subjective norm*). Thus, in measuring this component, the model is seen to be comprehensive as it integrates 'societal aspects' in its analysis.

An expanded version of the Theory of Reasoned Action is Ajzen's Theory of Planned Behaviour (1988), which adds a new element of behavioural control: the individual's perception of his/her abilities to control their behaviour. This last statement has a connection with the 'perceived barrier' component of the

Health Belief Model, which reduces health practices to the individual perception of a person's own capabilities for changing his/her behaviour. Both concepts are also interconnected with the notion of Bandura's (1986) Self-Efficacy within the Social Learning Approach, which will be analysed in the peer level section. In the following section I shall offer a critique of these theories.

2.1 The meaning of individual change: strength and weakness of individual models

While these individual-level approaches target individual change, they have the underlying notion that 'individual responsibility' is the key factor to be taken into consideration when behavioural change is required. And this is precisely the main thrust of information-based health promotion approaches: if individual beliefs, intentions, behaviour and so on are evaluated as individual psychological processes, information alone is necessary to change people's unhealthy behaviour. As a result, health promotion activities rely on the prerequisite that well informed audiences are able, through rational choice, to evaluate the advantages of engaging in healthy practices and to disregard those which are harmful to their own health. As these models tend to approach the understanding of the complex relationships between knowledge, attitudes and behaviour in a somewhat limited way, there have been several criticisms (Kippax and Crawford, 1993; Wilton and Aggleton, 1991; Hartmann, 1995) which can be analysed as follows:

2.1.1 Linear causality versus a dialectical understanding

The overvaluation of an individual's personal abilities for coping with illness imbalance is precisely the main shortcoming of these individualistic theories, which rest on a cause-effect linear analysis. This presupposition is based on the fact that cognitive processes, such as knowledge, perception of threats and

perceived personal abilities, are considered to be direct determinants of individual intentions, attitudes and practices towards health services. By focusing on this linear paradigm, individual-based theories reduce to individual cognition complex psychosocial processes, failing to grasp the social, cultural and historical aspects in which individual and social realities are dialectically constructed (Kippax and Crawford, 1993). Indeed, in opposition to a linear causality, the dialectical paradigm proposes to analyse healthcare behaviour not as a product of individual construction but rather as a social shared knowledge, which is understood to be socially generated (Campbell, 1997; Kippax and Crawford, 1993; Crawford, 1994; Farr and Markova, 1994; Jodelet, 1984).

For example, taking the case of HIV/AIDS research, Campbell (1997) observes:

> Information alone has not proved sufficient to bring about consistent changes in behaviour. If factual knowledge is merely one determinant of behaviour, a challenge for those interested in bringing about changes in sexual behaviour is to develop understandings of other co-determinants of high-risk HIV-related behaviours and to develop more innovative attempts to bring about behavioural change (1997: 273).

This observation reinforces the idea that individual cognitive factors are not the only determinants of behavioural change, which cannot be achieved merely with information-based programmes.[2] This has been the central issue of a series of critiques directed at these programmes. One of the most powerful arguments is the evidence that people often engage in risky and unhealthy behaviour even though they know it to be harmful to their health (Kippax and Crawford, 1993; Wilton and Aggleton, 1991; Campbell, 1997).

[2] Traditionally, the discussion about the factors related to health is framed in terms of *determinants*. This may also be an inappropriate term because it connotes an implicit causality, inferring a reductionist cause-effect framework analysis.

More directly related to the case of reproductive health in Guatemala, the 'KAPB' type models are widely used within the applied research forming the basis of the information-based programmes implemented among the Mayan communities (Bertrand et al, 1979; Newman and Ward, 1983; Ward et al, 1992; Enge, 1998; Population Council, 1998; Villaseñor de Cross, 1993). As stated in Chapter One, Guatemalan health services are founded on curative perspectives rather than preventive strategies. The meagre national budget for health is mainly allocated to the implementation of curative actions aimed at obtaining rapid outcomes, paying little attention to health promotion activities (UNDP, 1998). In addition, the few existing health education programmes are in the hands of foreign interests, applying paradigms from different sociocultural contexts. In the case of reproductive health, the programmes focus on providing new information about the benefits of contraceptive use, aiming at increasing people's knowledge and changing negative attitudes towards contraceptive use. Usually, these educational campaigns are followed by a subsequent distribution of contraceptives (ASECSA, 1998), a practice that is disseminated among Mayan communities, as the following quote shows:

> ... in addition to communications disseminated in Spanish for Ladinos, special attempts we made to appeal to the Indian groups through the use of basic educational and motivational messages. Radio spot announcements, for example, were translated into the Quiche and Kekchi dialects and pre-tested among members of the target audience to ensure that they would be understood. Similarity, a special series of posters was designed, depicting Indian families and carrying a family planning message (Ward et al, 1992: 238).

Such health education messages infer that those individuals with more conceptual skills assimilate information and use it more wisely than those who are deficient in such skills (Mechanic, 1990). By using bilingual educational messages, health promotion programmes are believed to have overcome the language limitation, diminishing the complexity of communication processes. Issues such as the social construction of knowledge through processes of social interaction, language and its modes of transmission, symbolic meanings and the value of shared knowledge are reduced to a mechanical cognitive

attribution, in which the individual is the only one responsible for their own choices regarding health matters.[3] This deficiency of theoretical approaches entails new demands for the social psychology of health, demonstrating the importance of analysing social and cultural aspects of a population as factors associated with healthcare behaviour.

2.1.2 Individual aspects versus social aspects

As new demands to theoretical development emerge, the paradigms used in some individualistic theories have to be reviewed and societal aspects that are considered to influence behavioural change introduced into such analysis. In this respect, the Theory of Reasoned Action (Fishbein and Ajzen, 1975) includes the 'social' component of *subjective norm,* which reflects the individual perception of a group's norms and values. Nevertheless, although this social aspect is included, it is analysed as a quantitative variable that can be controlled and measured, rather than as a social construction from which social knowledge emerges and evolves. By doing so, these models assume that knowledge is acquired in isolation and from direct experience, rather than through communication and social interaction.

Furthermore, taking into consideration that the individual is the focus of evaluation and change, the analysis of social facts is reduced to the individual's perception of these. In this respect, group norms and values are considered to be relevant to the analysis of health-related practices, but they are evaluated from an individual reference point. This supremacy of the individual personal structures over the social environment leads to an idea of an autonomous person who is able to control his/her own actions.

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[3] As the social construction of local knowledge and practices is highly relevant issue for this thesis, it will be extensively discussed in the next chapter.

In addition, cognitive processes such as knowledge about threat, perception of barriers and evaluation of possible outcomes, as well as affective states such as motivation, emotional enhancements, subjective norms and self-confidence in reaching personal outcomes (Strecher and Rosenstock, 1997; Fishbein and Ajzen, 1975), are indeed psychosocial processes which should be taken into consideration when health-enhancing behaviour is expected. Nevertheless, if they are based on theoretical constructions that diminish the wider social and cultural aspects, it would be impossible for them to lead to effective health interventions. A cause-effect linear inquiry that considers the individual as the main focus of analysis and intervention, while underestimating the wider societal aspects in which health related practices are immersed, actually reveals an ideological undercurrent that is of value to this analysis.

2.1.3 The underlying ideology

It would be delusive to ignore the ideological forces underlying individualistic theories. Crawford (1977, 1994) has accurately called the individualistic approach a 'victim blaming' ideology. As he states:

> In place of admittedly expensive and ineffective medical services, it is said, individual change must be the focus of the nation's efforts to promote and maintain health. These assertions perform the function of *blaming the victim*. They avert any serious discussion of social or environmental factors and instead locate the problem of poor health and its solution in the individual (1994:381).

Crawford argues that this victim blaming ideology is implicit in health education campaigns, which target individual responsibility. By disregarding the wider societal and political factors which actually undermine people's health, such as social deprivation, socioeconomic conditions and the quality of health services, the whole complex of health-related actions is made the responsibility of the individual. He also states that governmental actions should be taken into consideration as part of a whole preventive programme which goes hand in hand with an appropriate education programme, instead of blaming the victim for the health actions they do not accomplish.

In a similar vein, and related to family planning issues, Hartmann (1995) argues that 'KAP' type models help to serve political interests. Population agencies merely aim to estimate the 'unmet need' for contraceptives, so that they can justify even greater investment in population programmes. As she suggests:

> The continued use of KAP surveys, despite mounting criticism of their methodology, may have something to do with the fact that that they were not only intended to measure demand for family planning, but to serve the political purpose (...) In demonstrating to the elite that the people themselves strongly support the programme and in demonstrating to the society at large that family planning is generally approved (Hartmann, 1995: 60-61).

By viewing contraception acceptance as a measurable psychological stage, the population control approach establishes the ideological paradigm of 'contraceptive popularity' among society. By showing 'KAP' results, governments manage to divert resources away from basic healthcare and assign them to contraceptive distribution.

The ideological undercurrents are also reflected in the way in which educational activities are implemented in some developing countries. For instance, in Latin America, family planning has been primarily promoted through the governmental slogan of 'responsible parenthood' or 'everybody's wish' (Omram et al; 1992). Women are encouraged to have fewer children so they can provide more for the ones they have, thus appealing to their sense of responsibility and concerns for their children's wellbeing. Although this approach is assumed to be successful in many places (Population Council, 1998a; 1998b), as it claims to improve the quality of life for the mother and child (ODA, 1994), it has also been subject to repeated criticisms. These critiques are mainly derived from the experience of applied research in developing countries in which information-based promotional programmes are widely implemented (MacPhail and Campbell, forthcoming). I would like

to highlight some relevant aspects of these criticisms that are directly related to the context of this study:

i) The underlying assumption of these educational messages is that the poor are irresponsible, so the theme of responsible parenthood is inherently demeaning to the population it targets (Paolisso and Leslie, 1995).

ii) The assumption of 'responsible parenthood' is based on inappropriate theories that do not consider the sociocultural aspects of childbearing and the meaning that motherhood has in different settings. For instance, as has been pointed out in the reproductive health literature (ASECSA, 1998), in developing countries such as Guatemala childbearing is considered an economic gain rather than a cost.

iii) Research in other countries suggests that these approaches do not work with poor and illiterate groups. As Gilles (1996) suggests, information-based programmes do change health-related practices, but in one-fourth of the population, generally the wealthiest and most educated people.

As has been discussed, to expect to change people's behaviour through the study of individual cognition is quite unrealistic. The relevance of social relationships, community norms, issues of identity and sociocultural determinants plays a crucial role in shaping people's beliefs and practices (Berkman, 1995; Stone, 1992; Mechanic, 1994; Gervais and Jovchelovitch, 1998). These cannot be studied in isolation and require not only a shift away from individual towards the social and community levels of analysis, but also more effort to develop substantive qualitative research, which can provide a deeper understanding of the whole phenomena of health, illness and related practices. This argument forms the basis of the fourth critique.

2.1.4 The prevalence of quantitative, rather than qualitative, research

In evaluating health interventions in developing countries, MacPhail and Campbell (forthcoming) argue that there is an over-reliance on quantitative methodologies in research designs. They claim that there is a strong inclination to use large-scale surveys based on KAPB questionnaires, which can be statistically measured. By contrast, a very small amount of qualitative methodology appears in the literature on health-related practices in developing countries. It is also argued that the existing qualitative methodology lacks the scientific rigor that can provide valuable interpretations of the reality under study.

Looking at the Guatemalan case, the majority of research designs are based on quantitative methodologies which measure attitudes and practices of contraceptive use (Bertrand et al, 1979; Newman and Ward, 1983; Puac, 1993; Population Council, 1998a; Villaseñor de Cross, 1993). As reflected in the criticisms mentioned above, some studies do report qualitative findings but with a lack of systematic account of the social and community life, and these are full of authors personal impressions (Ward et al, 1992). Systematic research and large-scale surveys generate valuable descriptive data, but if they are carried in isolation and based on inappropriate theoretical approaches, they may also have undesirable practical consequences. Therefore, in order to achieve a real appreciation of the sociocultural problematic in which health-related practices are grounded there is also a methodological need: to develop well-structured qualitative research in which social and cultural phenomena can be evaluated. As this issue is highly relevant to this thesis, it will be addressed in detail in the methodological chapter.

The issues highlighted above indicate that there is a need for theoretical development which can look properly into the complex issue of health-related practices within a wider perspective. Individual-level models, which form the

basis of information-based educational programmes, might be functional when applied in a different sociocultural context from that of the developing world. I stressed the importance of reviewing individual-level approaches due to the high prevalence of such models in designing health promotion interventions in developing countries. In the case of Guatemala, KABP type models are extensively used, enjoying a primary position on health intervention among the Mayan communities. The failure of such models in Guatemala is demonstrated in the fact that they have not succeeded in changing people's negative attitudes and behaviour towards medical services, or increased the acceptability of contraceptive use (Schulte, 1998b; Ordóñez, 1997). In addition, as Hartmann (1995) suggests, success has typically been evaluated solely in terms of numbers of acceptors and of targets met, but not in terms of people's satisfaction with the services delivered. Taking into consideration the failure of the individualistic approaches, and in order to meet a theoretical and practical need; the importance of extending the levels of analysis emerges. Therefore, in the next section, the theoretical approaches that look at peer groups and community relations as determinants of health outcomes will be discussed.

3. Peer level of analysis

Explaining the interplay between knowledge, attitudes and behaviour has always been a challenge for psychology. The range of problems that have arisen from the traditional approaches have led to some level of revision. In order to present an integrated approach against the individualistic level of analysis, Bandura's (1986) 'Social Learning Theory' introduced the group or peer level of analysis. This is a motivational theory that takes the individual-society relationship, rather than just the individual, as its unit of analysis (Brach, 1999; Campbell, 1998). By taking into account the active role of social relations, the model widens the individualistic perspective. The model proposes that it is not just personal abilities that influence health behaviour,

but rather the social relations that individuals have with their close group of peers. From this perspective Bandura (1997) states:

> In this view, sociostructural influences work largely through self-systems rather than represent rival conceptions of human behaviour. Because influence flows bidirectionally, social cognitive theory rejects a dualistic view of the relationship between self and society, and between social structure and personal agency (...) Social cognitive theory, therefore, extends the analysis of human agency to the exercise of collective agency (1997: viii).

Through this named social element, the social learning approach recognises that simple cognitive acquaintance with new material is not enough to motivate individual change (Bandura, 1986; 1997). The approach also asserts that social norms and values shared by a group to which the individual belongs are highly important in influencing people's behaviour. This means that a change in social norms will contribute to a change in people's learning and their eventual behaviour.

Bandura's Social Learning theory introduces complex concepts which cannot be analysed within the scope of this review. To put it simply, the social learning approach considers that behaviour is goal oriented, which means that the individual is motivated to engage in behaviour the outcome of which is valued and which they feel capable of performing effectively. The former statement provides two interrelated key elements considered highly germane for the analysis of human behaviour: the role of expectancies and the role of behavioural choice. When an individual chooses to engage in a specific behaviour, he/she expects something out of it. Bandura names this expectation an *action-outcome expectancy* (Bandura, 1986, 1997), reflecting the degree to which the individual believes that an action will lead to a particular outcome, for example, that contraceptive use will reduce pregnancy. This outcome is then considered in terms of its value to the individual and is related to past experiences he/she may have had in relation to this event. The second set of expectancies is *self-efficacy* expectations (Bandura, 1977, 1986,

1997), which reflect the extent to which individuals believe themselves capable of controlling important aspects of their lives. As the concepts of behavioural outcomes and expectancies are highly relevant for understanding the social cognitive framework, I will go on to emphasise the analysis of psycho-societal concepts such as self-efficacy and social support derived from this paradigm.

3.1 Concepts derived from the social learning approach

- *Self efficacy*

The concept of self-efficacy has been extensively applied in health promoting behaviour (Elder et al., 1986; Berkman, 1995; Campbell, 1998). It implies a series of cognitive and affective states, such as motivation, self-esteem and self appraisal, that allow individuals to have control over their lives, which, in turn, are acquired through socialisation with the group of peers (Bandura, 1997). From this definition one can state that the exercise of self-appraisal, and the capability to produce valued outcomes and to prevent undesired ones, provide powerful incentives for the development and exercise of personal control. As this concept suggests, it is people's beliefs in their capabilities to reach their goals which are the major focus of inquiry. Similar concepts such as self-evaluation, self-esteem and personal control have always been related to the study of health-related practices (Rogers, 1978; Strickland, 1978; Ajzen, 1988, Bandura, 1986), including the concept of *empowerment* (Wallerstein, 1993; WHO, 1991), which will be analysed in the community level section. Nevertheless, some research has also stated that simply adopting a goal without knowing the reasons for doing so – and the ways through which it can be reached and the expectancy of the results of that goal – has no lasting motivational impact (Bandura, 1997).

In relation to the impact of the concept of self-efficacy on health, Campbell (1997) noted that:

> Firstly it affects the likelihood that people will engage in health-enhancing behaviour. The greater one's sense of perceived control, the more likely one is to engage in behaviours that are known to affect one's health status. Secondly, levels of self-efficacy impact on people's stress levels. Low levels of perceived self-efficacy may lead to anxiety and stress, and impact on health through a range of health-damaging stress-related behaviours and biological processes (1997: 16).

This position upholds the idea that a sense of self-efficacy might create positive health choices through the processes of self-recognition and evaluation, which may aid individuals to master their experiences enhancing their personal abilities to reach desired outcomes. Indeed, self-awareness about one's own health status is a basic and important element for implementing any preventive action. Nevertheless, as a psychosocial state, it cannot be taken as the sole factor associated with healthcare. In fact, it has been recognised that self-efficacy is also shaped by the quality of social interaction that the individual has with members of his/her social group; in other words, it is enhanced by the social support that he/she can get from his /her peer group or community (Berkman, 1995). Social support is, then, another theoretical concept that will be further analysed.

- *Social support*

The concept of social support has been under investigation ever since Durkheim (1951) showed that lack of sense of solidarity predicted suicide (in Stein, 1997). Thereafter, social support is an important theoretical construction derived from the social learning approach, which has been extensively investigated within the field of the social psychology of health. It has been described as an individual construction of perceived social support, or as a psychosocial state derived from social interaction with the environment (Lin et al., 1986). In relation to health, an extensive number of studies have focused on

the beneficial effects of social support for health outcomes (Cohen and Syme, 1984; Turner, 1983; Berkman, 1995). Turner (1983), for example, identifies four different types of social support: emotional, instrumental, informational and appraisal support. All of these involve the recipient's perception of support (subjective) and some measure of that support (objective).

Berkman (1995), for example, gives a broader definition of social support and establishes a relationship between self-efficacy and social support. He states that the former is shaped by past and present experiences and by the social environment through *social support* and *social networks.* As Berkman suggests, social support might become health promoting if it provides the individual with a sense of 'belonging' to a specific social group (1995: 251). In doing so, individual health depends not only on a person's own behaviour and social situation, but also on the interrelated behaviour and social situations of others in the network.

Similarity, Gottlieb (1981) considers social support as one of three features of social health, in association with social integration and social networks. According to this author, social or community participation is a complex matter which cannot be understood without the consideration of the three factors mentioned above, with the addition of a sense of belonging to social values.[4] And finally, regarding the relationship of social support and community participation, Rissel (1994) states that social support can help in the maintenance of social identity by providing validation of a shared worldview. Having made a review of some concepts derived from the social learning approach, I will now present the criticisms directed at them.

[4] The concept of community participation will be analysed in the community level section.

3.2 Moving beyond an individual scheme: criticisms to peer level models

The social learning approach is acknowledged as one of the most appropriate theoretical models within the field of social psychology and is widely used in health education. This fact is manifested in the following quote from the Panel on Reproductive Health in Developing Countries at the National Research Council of USA :

> The programs that have consistently appeared successful in meeting their goals have a number of common characteristics, (...) including a theoretical grounding in social influence or social learning theories, focus on specific behaviours, instruction on social influences and pressures (Tsui et al., eds., 1997: 36).

In relation to the Guatemalan experience, social learning theories are seen to be implemented in health education at the macro-social level of intervention (Cospin, 1998). But reviewing the published research, there is no evidence that can prove such application beyond small surveys carried out in private institutions (schools, universities). I include the analysis of these approaches due to their powerful influence in designing health promotional programmes throughout the continent. As such a model proposes to include a 'social element' within its analysis, it is important to review how it is conceived.

3.2.1 Reductionist analysis of individual/society relationship

The role of social support from the peer group or 'significant others' is widely assumed to have a positive impact on individual self-efficacy and, therefore, on health-enhancing behaviour (Aggleton, 1994). Indeed, focusing on the individual-society relationship, the social learning approach does represent a switch in paradigm away from what the individual-level theories could provide.

Nevertheless, Milburn (1995) has suggested that the concepts of self-efficacy and social support that are included within the peer level of analysis are still

entrenched within an individualistic approach. The role of individual perception of social norms, as well as the collective influence on people's decisions concerning behavioural change are too complicated processes to be explained in terms of simple learning principles. The concepts presuppose the idea that, if people possess a high sense of self-efficacy, it follows that they must be able to accomplish appropriate behavioural outcomes. Nevertheless, the complexity of social reality has shown that health practices necessarily involve considerably more than the mere efforts of people striving for self-efficacy. Personal agency must emerge from within community social relations and, therefore, sources of change must be constructed from the community's recognition of its own needs. Consequently, participation in promotional activities cannot be considered as a taken-for-granted aspect, which will emerge as a result of pre-given conditions, for instance, high self-efficacy and high levels of social support. Among other aspects, it presupposes negotiation and a mutual understanding between community members and participants of health promotion networks, in which common necessities and identities join them together in order to debate possible solutions to their own problematic.

Here, we come to two important points of analysis: *first*, the role of social identities in the performance of health enhancing behaviour, and *second;* the role of social relations based on an authentic dialogue and discussion, which, in turn, promote self-awareness and behavioural/social change. There are several arguments that criticise such a framework for analysis. For example, Campbell (1998) suggests that the failure of the health promotional programmes which draw on the 'peer group' approaches is due to the lack of recognition of the local identities in which these groups are immersed, as well as the lack of acknowledgement of the socioeconomic conditions which underscore people health decisions. Affiliation to a group that shares a common identification, constraints and behaviour might serve as a resource for a group's self-efficacy towards any aspects of their lives, including health.

Similarly, Rissel (1994) argues that social support can strengthen social identity by the sharing of a local worldview.

As social identities are constructed upon mutual social interaction, it is highly germane to take into consideration the value and quality of these social relations, as they constitute a resource for health-enhancing behaviour. It is important to discuss the way that communicative processes between two opposing poles can provoke resistance and disagreement. Here we come to the second point of analysis, which is based on the recognition of the complexity of communicative processes. In this sense, I want to highlight the contribution of Freire's theory of Education for Critical Consciousness (1972) towards the understanding of health and social relations. Freire's theory states that any situation of change needs to be elaborated and brought about by the interested parties involved. This idea is based on the assumption that in any educational process two or more divergent systems of knowledge confront and often clash. In order to find a way of understanding, the parties involved have to negotiate and critically reflect on their actions and design new actions based on those reflections (1972, 1971). It is stated that any transformation has to be locally acceptable in order to have an enduring impact on the community life. Hence, the confrontation of elements such as dialogue, discussion, self-reflection and consciousness represent key elements for processes of change.[5]

Individual and social relations cannot be reduced to learning principles, they in fact involve several complex processes such as a common negotiation and understanding. In relation to health education, Freire's ideas have had a great impact in implementing health promotion programmes. The idea of critical reflection and mutual dialogue between two parties (users of health services/providers of health services) has raised new paradigms in health education. This basic process enhances social relations and, therefore,

[5] The influence of Freire's ideas in health education will be taken up again in the community level section.

improves the quality of any educational process.[6] Therefore, in the quest to achieve a genuine communicative process which can promote culturally sensitive health education programmes, values such as self-efficacy and self-control cannot be imposed within a group, which might not consider them as a resource for behavioural change. This point forms the basis of the second critique, which will be detailed below.

3.2.2 A culture of competence

Concepts derived from the Social Learning approach, such as self-efficacy, promote a culture of competence in which values such as personal control and efficacious performance are highly valued for reaching personal targets. According to Oyserman and Markus (1998), within Western culture competence is an extremely valuable attribute which is linked to self-esteem, personal status, personal security and mental health. They suggest that the meaning of self efficacy is grounded within an individualistic world view which promotes judgement of self and others by the extent of personal success each has achieved. Therefore, any behaviour is established for the purpose of maximising personal gain. As they state:

> Within the North American cultural context, people are understood to be independent, bounded, autonomous. Within this cultural frame, individuals are construed, defined, appraised and evaluated for their achievement, and for their ability to strive, innovate and overcome obstacles. People are believed to create themselves and to control actively their environment. A need or desire for control is essentialised as a core feature of personality (1998: 109).

In this sense, health promotion is based on the highly valued Western principles of control and self-efficacy. As such values are seen as a paramount of personal achievement, it follows that successful health practices will be implemented. Rather than promoting dialogue and reciprocal understanding

[6] As both theoretical constructions, the role of social identities and dialogue between two different systems of knowledge, form the basis of the theoretical framework of this thesis, they will be extensively discussed in the next chapter.

between two diverse systems of knowledge, health promotion proposes a paradigm that is based on restrictions, surveillance and judgments. In order to facilitate the perception of community awareness and consciousness, and thus promote social support, individuals have to be their own constructors of such values. And by doing so, people foster different options of community change based on their own interests and gathered from what people consider to be the best for their lives. In this way, although the value of self-efficacy is implemented with the purpose of enhancing health status, if it is imposed on the community without an understanding of the particular local knowledge of such groups, it will not be beneficial to encourage behavioural change. Isolated concepts cannot be included as psychosocial mediators if community participants do not perceive their relevance. Hence, in order to promote self-participation and awareness, health promoters should appreciate local elements immersed within the community, such as local knowledge, community values and the peculiarities of the socioeconomic conditions in which such communities are founded.

As a final reflection on the impact of social learning models on health education, I can assert that it would be unrealistic to apply this paradigm in the analysis of a Third World reality. The consideration of the psychosocial mediators of health related practices is indeed necessary for a serious understanding of the whole problematic. As such, inter-group analysis is highly regarded in health education; as stated above, any health intervention has a greater probability of being successful if participants with a common identity share the same problem (Aggleton, 1994; Rissel, 1994; Campbell, 1998). Nevertheless, if these concepts are studied in isolation and as exclusive referents for understanding health-related behaviour, they might fail to shed light on the meaning of people's beliefs and how these are expressed in everyday practices. By promoting foreign values that might be 'efficacious' within Western culture, health intervention will only promote impositions and restrictions. In sum, if these models do not focus on the specific socialcultural

realities in which social relations are constructed, they will never succeed in implementing genuine community participation.

Social Learning principles, or psychosocial concepts that look at social agency and personal power, are widely reviewed in the literature on health enhancing. But taking their analysis a bit further, in the following sections I will extend the individual-society relationship to include the role of community in health-enhancing decisions. In doing so, I will explore several psychosocial and developmental concepts that improve our understanding of social power and community participation in health interventions.

4. Community-level theories

There is a large body of literature within the fields of community healthcare and development, which conceptualises the role of community in promoting healthy practices (Rappaport, 1987; Israel, 1994; Rothman, 1996; Stein, 1997; Wallerstein and Bernstein, 1988). To talk about community health in developing countries is to integrate concepts around the multiple potential elements related to healthcare such as psychosocial and physical factors, factors related to the organisation of society, the role of culture and history. It is not my intention here to draw on the extensive developmental approaches related to health-intervention from which the majority of the community-level concepts are derived.[7] Nevertheless, the organisation of this material is centred particularly around 'shared' concepts related to the social psychology of health and community life, which are, in turn, directly related to the object of this study. In the following sub-sections, I will explore two important social concepts, which define the role of the community partaking in its own decisions.

[7] For a compressive review see Barnes (1997) 'Care, Communities and Citizens'.

4.1 Building participation in community health

As stated in Chapter One, the 1978 Alma Ata Declaration on Primary Healthcare of the WHO, strongly emphasises the right and duty of local people to plan and implement their own healthcare programmes. Community level approaches refer, in the broad sense, to the mutual participation of the local community and health educators for the purpose of community change in terms of local development, social planning and social action (Rothman, 1996). It has been stated that the more effective community health programmes are those that are comprehensive, community supportive and built on existing local structures (Gillies, 1998; Zakus; 1998). This level of community participation in health may include the use of health services, cooperation with health services initiatives and participation in decision-making about health services (Stone, 1992). In this sense, it is considered that important aspects of the process of community involvement are community participation and empowerment (Bracht, 1999). Both concepts are interconnected as many fields in the social sciences contribute to their definition. However, I will separate them in order to distinguish their origins and limitations.

4.1.1 Empowerment

Definitions of empowerment may be seen from different perspectives, at the level of macro-social relations, community relations and as an intra-subjective status, which has been analysed in the former section. The utilisation of the concept of empowerment has its origins in the problematic of Third World countries, where the aim is to promote the participation of the community members through the enhancement of local resources (Stein, 1997). Therefore, according to the WHO (1986) empowerment should become a central construct for health promoters at the governmental and non-governmental level (Wallerstein, 1993; WHO 1986).

As stated earlier in the review of the cognitive theories, the concept of empowerment has its initial bases in the Social Learning approach, which promotes perceived self-efficacy or psychological empowerment of human agency. Under this paradigm, Rissel (1999) establishes the distinction between psychological and community empowerment. He defines the former as a 'subjective state of greater control over one's own life that an individual experiences following active membership in groups or organisations' (Rissel, 1999: 86). This concept is interconnected with Bandura's concept of 'perceived self-efficacy' and with Ajzen's concept of 'perceived barriers' analysed in the previous sections. Consequently, Rissel also states that community empowerment is a subjective state that social groups possess when they share a sense of community identity. This shared identity is a key factor for motivating and empowering people to participate in community-based health projects. Therefore, it is assumed that community empowerment can be achieved through collective participation in group actions in working towards their felt needs. In an attempt to provide some insights into this distinction, I will detail some criticisms to the concept of empowerment

Both terms (psychological/community empowerment) are grounded within the view that well empowered individuals or groups can build up self-supportive communities, which, in turn, will facilitate communities to find local resources for enhancing their health status. Under this paradigm, the former statement attempts to foster community self reassurance from an individual capacity to cope and overcome difficulties. Therefore, from this perspective, studies of empowerment fall again within the tendency of considering macrosocial aspects as being the result of self-perceptions from single individuals.

From a different perspective and based on Freire's (1972/1971) education for critical consciousness, Wallerstein and Bernstein (1988) constructed a model which proposed to stimulate dialogue and critical thinking about the central

problems of people's lives. In doing so, people can express their perceived necessities and find themselves a way of tackling the problem. Wallerstein and Bernstein define empowerment as a:

> social action process that promotes participation of people, organisations and communities in gaining control over their lives in their communities and larger society. With this perspective, empowerment is not characterised as achieving power to dominate others, but rather power to act with others to effect change (1988: 380).

The roots of the former concept are grounded in ideals of self-emancipation, equality, democratic participation and ideas of responsibility for self and others. Regarding this point, Rappaport (1987) notes that this concept of empowerment has to be included in more than one level of analysis – individual, household, family, group, community – if is to lead to positive results.

The former approach has served as the basis of health promotion in some countries in Latin America at the non-governmental level (Wallerstein, 1993). However, the evidence of the role of empowerment and health to date is speculative. According to Stein (1997), theory on empowerment and health is still in its initial stages as applied research fails to provide valuable scientific rigor. She argues that there is little consensus on how the components of empowerment can be truly investigated in relation to health, or how the concept can be adapted to different frameworks of analysis within diversity of cultures and different socioeconomic constraints. Hence, in an example from the Central American experience, she stated that from information gathered through informal observation of women participating in empowerment projects in Costa Rica and Honduras, it was clear that women increased their self-confidence after being 'empowered'. Empowerment helped them to gain access to health; but they did not succeed in obtaining mutual support from the partnership organisations, as they did not manage to reach mutual agreement on how to encounter the problem. Even though empowerment is

recognised as a key factor for implementing development programmes, if it is not considered within the constraints and problematic that an adverse context has, it cannot produce healthy positive outcomes.

Having analysed the role of local empowerment as a highly valuable factor for community health, I will go on to explore the role of community participation, another developmental concept which is also directly linked to health enhancing behaviour.

4.1.2 Community participation

The concept of community participation goes hand in hand with the concept of empowerment. It is a development concept which has been identified as a 'strategy whereby communities identify their own health needs and assume responsibility for their own health development' (Stone, 1992: 409). With regard to health development, this community participation is supposed to assume the relevance of the role of culture and local socioeconomic social contexts, as crucial factors for encouraging community participation and implementing promotional activities. Such actions are supposed to be promoted by local governmental authorities and development agencies, such as the WHO, through the implementation of friendly policies and facilitation of local resources.

However, there have been a number of criticisms regarding the practices arising from these concepts, which explain the failure of their application in developing countries. For example, it is stated that community participation is immersed within a *top-down* approach (Stone, 1992; Madan, 1987; Welch, 1987; Asthana and Oostvogels, 1996). One of the main arguments against this approach is that such strategies have the underlying attitude that health is the responsibility of the 'experts'. As such, community participation is regarded as a complementary action. For instance, Welch (1987) states that the administrative culture of healthcare supports a top-down procession of policy

and information throughout the bureaucratic levels of the systems. As she argues,

> (...) WHO sees itself as the knowledgeable partner in its relationship to member countries in the developing world, a pattern that replicates the relationship between central planners and village communities (1987: 106).

In the same vein, Stone (1992) suggests that the current focus on community participation appears to be an attempt to promote the Western cultural values of equality and self-confidence, which might be not shared by the local population; as a consequence, the local values of the non-Western societies are ignored. Similarly, Madan (1987) and Asthana and Oostvogels (1996) state that community involvement cannot be a substitute for governmental action. Following the logic of this argument, Gilles (1996) suggests the need to widen the context of health promotion by integrating mutual collaboration between partnerships at the micro level and macro level of intervention. She states that alliances between different sectors (governmental and non-govermental) should take into consideration 'the underlying structural influences upon health' (1996: 12). These structural influences include, for example, the unequal distribution of wealth and social class difference, which undermines people's participation in health activities and their health status.

The available evidence suggests that the concept of community participation can be employed by politicians as a 'euphemistic category', which might serve as a justification for their lack of interest and ineffectiveness in implementing social actions and policies aimed at improving health status among communities (Madan, 1987: 619). It is argued that in order to incorporate such issues as empowerment and community participation into community health development, existing political structures, local policy and healthcare delivery systems must be constructed with reference to people's interests.

From these critiques, one can assert that a wide range of factors often obstruct community participation and empowerment. First and foremost, unequal distribution of wealth and resources and lack of access to social services are the prime factors that undermine community participation in health issues. The former divergences lead to a complete absence of any real understanding of the health beliefs of the local culture and their traditional knowledge, problems that are further exacerbated by the manner in which educational activities are implemented by the providers of health services. Notwithstanding the value of education and empowerment, it is patronising to suggest that by learning those values people will automatically improve their way of life. In this sense, the validity of the terms 'empowerment' and 'community participation' is diminished by the lack of a genuine understanding of the richness of community life, cultural differences and socioeconomic constraints. It would be an illusion to undertake health promotional strategies based on empowerment if the local knowledge of a community is not apprehended. Therefore, the significance of studying local knowledge and cultural values is raised once again in order to enhance community participation and to initiate culturally sensitive promotional strategies.

In Guatemala, for example, research on empowerment and community participation is limited. It is mainly carried out by international institutions such as the WHO through the implementation of 'empowerment programmes' within some Mayan communities (PAHO, 1994). These projects aim at promoting self-supporting cooperatives (such as cloth-making cooperatives), from which local women may obtain a source of collective financial support and implement health-enhancing activities. As they assert, health interventions cannot promote behavioural change through empowerment as the 'empowered' communities do not manage to reach a self-sufficient status. The concept of empowerment often masks a top-down

approach and very rarely stems from ordinary people's own agendas. As a consequence, there can be no conclusive evaluation of empowerment projects.

I believe that the failure of such programmes is because a single psychosocial concept is applied in isolation. The majority of social interventions seek to 'extract' specific targeted groups (e.g., a group of women or groups of adolescents) in order to empower them to be self-sufficient. Nevertheless, these programmes do not include any realistic consideration of the societal aspects around them when empowered groups are ready to face an objective reality. Programmes are also grounded on the values and knowledge of experts, which are not necessarily understood in the same way by the targeted groups. Each culture has its own ways to find solutions to problems, to negotiate and to create a network of social relations. The role of a health educator might be to respect them, facilitating a constructive discussion based on existing local knowledge of the parties involved.

Having reviewed how the problem of health-related practices has been theoretically approached at the institutional level or through community intervention, I come to a highly relevant point which has been implied throughout this review: the role of cultural factors as a determinant of healthcare behaviour. Therefore, in the next section I will present some theoretical constructions which look at the cultural level of analysis.

5. Cultural level theories

In this section I seek to analyse some theoretical models that view the socio-cultural factors related to healthcare as the focus of analysis. As this thesis is based on the theoretical premise of social constructionism, it is highly

pertinent to explore some theoretical constructions that analyse how processes of ill health are valorised in different cultures.[8]

Since there is a growing interest in the development of culturally sensitive programmes that might be locally acceptable to communities, there is also a correspondent concern regarding the construction of models that conceive cultural factors associated with ill-health.

In this respect, Currer and Stacey (1986) discuss the development of such interests, which have been expanding since the 1970s. This interest seems to derive from two sources. The first is from healthcare delivery. It has been suggested that some of the numerous problems of communication between doctors and their patients result from their different conceptualisations, or health and illness ignorance, misunderstanding, or the medical dominance that only understands and accepts illness conceptualised in the mode of biomedical science. The second source of interest has been derived from a better understanding of the health problems of the Third World and a new application of the relevance and utility of indigenous healers and healing.

Therefore, as a result of such concerns, several theoretical models in the fields of medical anthropology and cognitive anthropology have arisen in America, among them Kleinman's (1976) Explanatory Model of Illness, Health and Care and The Cultural Models of Language and Thought developed by Holland and Quinn (1987). The Explanatory Model (EMs) of Illness, Health and Care is a theoretical construction derived from the field of medical anthropology, which represents a well-structured framework of cultural analysis of health and illness processes.

[8] The social construction of local knowledge and practices will be extensively discussed in the next chapter.

It basically states that any healthcare system articulates illness as a cultural expression, linking beliefs about disease causation, the experience of symptoms, decisions concerning treatment alternatives and evaluation of therapeutic outcomes. Kleinman considers that health beliefs and practices are part of a cultural system, therefore they need to be understood in respect to a wider relationship with the systems of culture. As he states:

> Our concern will be to understand how *culture*, here defined as a system of symbolic meanings that shapes both social reality and personal experience, mediates between the 'external' and 'internal' parameters of medical systems and thereby is a major determinant of their content, effects and the changes they undergo (1976: 86).

As health, illness and care are not isolated processes, they must be understood in a mutual relationship and analysed within the scope of what he calls 'the healthcare system' (1997: 87). This system integrates internal parameters, such as individual constructions and family bases, and external ones, such as the social arena, which in turn is constituted by the popular, professional and folk aspects. Furthermore, according to this model, in order to articulate and evaluate the participation of various spheres, it is necessary to look at certain clinical applications, focusing on the causes of illness contagion, course and treatment.

The EMs model also states that it is tied to a specific system of knowledge and values grounded on the different social sectors of the healthcare system. As a consequence, these conceptualisations of illness experience are more likely to be moulded by social structures and ideas about society than respective individual conceptions (Kleinman, Eisenberg and Good; 1978). As Kleinman states:

> Both inter- and intra-system comparisons of clinical realities should also reveal the nature and extent of historical, political, economic, technological and epidemiological influences on health care. That is, the health care system can be looked upon as a micro-record of these effects (1976: 90).

Kleinman's explanatory model is widely used within traditional cultures, such as Chinese societies (Kleinman, 1975). As an anthropological model that considers culture as a system of reference from which ideas of health and illness emerge, it introduces a wider perspective for the analysis of healthcare. The fact that it integrates the sociopolitical and historical dimensions of specific cultural settings, as well as the intra-personal and inter-personal (family and community relations) levels, provides an essential framework from which analysis of health-related practices of traditional societies such as Guatemala, may be derived. However, the model has also received some criticism.

Garro (1994) states that the EMs is specifically constructed for the analysis of clinical applications in which causes, course and treatment of illness are considered to be the focus of analysis (illness as an entity), rather than the sociocultural setting from which ideas of a wider world emerge (including ideas of health and illness). Similarly, Good (1986) also states that the explanatory models, despite pretending to concentrate on culture, are in fact centred on individuals. This partially leads to a situation where researches working within this paradigm often fail to address the interpretation of individual and cultural knowledge. If conceptualisations of health and illness are to be seen as a product of cultural systems, processes of health and illness should be understood as part of an extensive system of knowledge from which several aspects of social life emerge, including illness. In narrowing the analysis to clinical applications, this model fails to consider processes of health and illness as products of social relations in which several aspects, outside the limits of an illness entity, can emerge.

Within the fields of cognitive anthropology, Holland and Quinn (1987) present a model of illness representation. Drawn from the explanatory model, this framework considers that cultural models are schemas which are generally shared in a particular cultural setting and help individuals make

sense of given episodes of illness. Hence, the object of study is human cognition, which is concentrated in the study of knowledge: its organisation and its role in language understanding and the performance of other cognitive tasks. Therefore, the foci of analysis are these cognitive processes which are conceptualised as a 'schemas'. According to this model, schemas are cultural constructions where meanings are social and psychological in nature and, therefore, they can be expressed either by verbalisations with a conscious or unconscious content, or by actions (D'Andrade and Strauss, 1992).

In this way, discourse is considered to be one of the most important ways in which cultural knowledge can be understood. Through discourse people express, negotiate and reconstruct local knowledge. According to Good and Quinn, the fact that the model is based on what people say and do does not mean that knowledge is always translated into behaviour. The analysis of non-verbal activities, which are never expressed, is also considered.

Anthropological cultural models are widely utilised in health research in America. Application is expanded within indigenous cultures, where access is not easy due to language barriers and cultural constraints. As an example of this research, Price (1987) recorded narratives about illness in Ecuador and found that narratives about illness express social roles, expectations about the response of family members and others, healing strategies and characteristics of therapeutic alternatives. Similarly, Garro's (1994) research on cultural models of illness and the body shows that explanatory and cultural models are a way of understanding perceptions about illness, drawing on culturally based understandings.

More specifically in Guatemala, anthropological models are widely used among indigenous communities in an attempt to integrate them within the pre-established modern structures and prevent their isolation (Enge, 1998). For instance, the population centre of a national private university and The

Population Council implemented a study on the cognitive schemata of language and thought patterns of Mayan discourse in order to facilitate health education programmes on reproductive health (Enge, 1998).

Nevertheless, taking up the previous critiques regarding the value of explanatory models, there are some other comments on the construction of the cultural models.

5.1 Individual models versus shared models

As the cultural models focus on the linguistic phenomena which are expressed in discourse, stories and narratives, they are criticised for falling within a reductionist analysis of human cognition, as do the traditional models of social psychology. In this respect, Garro (1994) states that cultural models share similarities with social science theories of illness behaviour developed with reference to the North American context. In the same vein, Good (1986) also states that such theories 'are regarded not as models of how people are believed to act, but rather as ideological models of how people are believed to act' (1986: 22).

The authors suggest that usually any narrative or illness story contrasts significantly with the simplified world of the cultural model. As they are based on schemas of how to account for systems of culture, they drawn from simplistic forms of analysing culture and shared meanings. Human beings are studied in isolation, not in relation to nature, social life and history. In addition, research strategies used to sample individuals rather than communities of individuals or cultures, leading to an over-interpretation or misunderstanding of the real interactive process in which these beliefs manifest themselves.

The study of health beliefs signifies more than to elicit the ideas of one individual or another, without studying how these ideas interact. Schemas are not static, they are created through experiences and are modified by new experiences which are transmitted in a process of communication. Analysing those aspects could provide the opportunity not only for describing how health and illness beliefs are influenced by environmental, physical, socioeconomic, social and cultural factors, but also for the analysis of the processes of health and illness as representations of shared understandings about the world.

6. Concluding remarks: a call for the development of culturally sensitive theoretical approaches

The review of the health-related literature established within four levels of analysis leads one to think that when a group of individuals agree to use, or refuse to undertake, any health intervention, several factors play a direct or indirect role in their decisions. In reference to the key points of previous sections, I shall conclude by drawing out some observations, which, in turn, will serve as the basis of the theoretical proposal presented in the next chapter.

1. The need for more research on healthcare issues is indisputable. However, considerable information is already available that could be used more effectively to learn what people define as a priority. Current research is based on the paradigm that health is a concern of experts, therefore, priorities of research are based on what formal sectors and founding institutions establish, rather than an appeal to people's perceived necessities.

2. As several criticisms have showed, there is a tendency to promote and impose Western cultural values in health interventions, values which

might be not shared by the local population studied. Theoretical approaches might be an appropriate alternative to resolve the problem of health-related practices but these must be grounded in the social and cultural reality.

3. After reviewing the prevalent approaches to health-related practices, I conclude that there is a wide gap between the theoretical underpinnings and the social realities they seek to analyse within traditional societies and the developing world.

4. However, concepts derived from the peer level of analysis and community level, such as social networks, social support and empowerment are of value if integrated within a model which looks at the processes of health and illness from a wider perspective. That is, a theoretical framework that considers all these processes as social constructions. A system of reference that is constructed historically in which socioeconomic and cultural factors play a crucial role in shaping people's beliefs and practices.

5. In this sense, in order to develop community resources through the enhancement of social networks which can promote participation, dialogue and critical thinking, it is necessary to understand the systems of knowledge that underscore people's beliefs and actions. Divergent systems of knowledge promote and express diverse motivations and interests, pertain to different pasts and project distinct aspirations.

6. Regarding this point, I wish to highlight the contribution of Freire's (1971, 1973) ideas of critical consciousness, in which he proposes a mutual dialogue between opposing systems of knowledge in order to construct a real educational process. As he states:

> Authentic communication is not carried 'A' for 'B' or by 'A' about 'B', but rather by 'A' with 'B' (Freire, 1970: 82).

Taking Freire's point, I want to propose the study of local systems of knowledge as a form of representing local shared worldviews. This knowledge is grounded in a specific cultural context and expresses a sense of local identity shaped by past and present experiences. Therefore, by exploring the role of local knowledge from the perspective of social psychological research, I hope to contribute to the debate regarding the factors related to the acceptability of health services in developing countries. This debate will be expanded in the following chapter.

Chapter 4

Representations as Local Systems of Knowledge: Towards an Analysis of Health Beliefs

1	General background
2	Social representations: An overview of the theory
2.2	Social representations, beliefs and practices
2.2.1	Health and illness as a social representation
3	Local knowledge: an entrance to social life
3.1	Contextuality: the meaning of reality
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3.1.3	Ideological constitutions of social memory
3.2	Social positions and identity
3.2.1	Renovation of identities
3.2.2	The 'Lazy Latino' identity: the Guatemalan case
4	A link between local knowledge and health beliefs and related practices
5	Final reflections

The aim of this chapter is to lay down the theoretical underpinnings I will use to analyse my data. I will present a conceptual framework or 'toolkit' for examining local knowledge about reproductive health and its expression in daily practices among the Mayan communities of Guatemala. The contention of this discussion follows the presupposition stated in the previous chapter, which draws on the relevance of local knowledge for, on the one hand, the construction and development of community resources and, on the other hand, for building up local practices in terms of the acceptability of health services for the Mayan communities. These assumptions are based on the theory of social representations (Moscovici, 1984; Jodelet, 1984/1990), although they also embrace concepts drawn from the sociology of knowledge (Berger and Luckman, 1967), symbolic interactionism (Blumer, 1986), cosmologies (Douglas, 1982) and liberation psychology (Martín-Baró, 1996) among others. As I will show, social representations theory provides a key starting point of social analysis, giving a general point of reference from which empirical issues can be approached (Blumer, 1986). However, considering the complexity of the issues

involved, it is essential to introduce alternative concepts that can support a wider and richer extension of the levels of analysis.

In what follows, I will first give an overview of the theory of social representations as a theory of local knowledge. I will argue that the theory provides a fundamental switch in paradigm in opposition to the health-related approaches underpinning health educational programmes, since it considers processes of ill-health conceptualisations as social-historical constructions. From this perspective, in the following sections I shall draw out some general theoretical assumptions upon which I want base my work on representations of reproductive health. I argue that *first,* Mayan's local knowledge and practices have to be understood within their *historical dimension*. I shall identify the role of history in the construction of current representations, highlighting the relevance of collective memory and its symbolic construction. I argue that past representations of reproductive health are a central element in the construction of present knowledge and identities, which at the same time evolve an ideological meaning. *Second,* I draw attention to the analysis of *contextuality,* arguing that the meaning of social reality depends on the social positions upon which social groups emerge, transform and express their knowledge and construct their identities. In this respect I argue that the 'perceived' needs of the users of health services clearly differ from the ones that providers hold. *Third,* given the singularity of this study which states that local identities comprise a central core for the construction of community health resources, I emphasise the importance of analysing the concept of *renovation of identities,* establishing the historical and ideological dimension of a stigmatised identity and how social groups build a space of reality in which their identity can be expressed. Piecing together these issues, I argue that local knowledge about reproductive health and related practices has been shaped by a system of social exclusion that promotes an ideology of domination and denial of people's differences. As a result, health promotion services may be evaluated as part of this scheme of values and ideologies, which reinforces the segregation of a stigmatised social

group. Finally, I conclude by establishing a link between local knowledge and health beliefs and related practices, highlighting the contribution of social representations theory.

1. General background

> Many health problems in both rich and poor countries are still best explained by multiple weakly sufficient causes, or risk factors. Understanding their incidence, prevalence and distribution, as well as their prevention and treatment, may require intimate understanding of particular people and settings. This demands a different kind of science, one based upon local knowledge, social organisation, cultural beliefs and values (...) rather than simply universal knowledge of the behaviour of viruses and GNP per capita (Kunitz, 1990: 106, cited by Stein, 1997: 130).

The concept of a 'local system of knowledge' has been widely analysed within the fields of sociology, social and medical anthropology and social psychology and has been described as a cultural model by Holland and Quinn (1987), a cosmology by Douglas (1982) and as a social representation by Moscovici (1984), among others (Flick, 1994; Wagner, 1995). These approaches have a common interest in analysing 'what people say and do in their local context by trying to understand the reasons of what they talk [*sic*] and do and by taking talk and action as being a true expression of a local world view' (Wagner, 1995:1). Thus, the term local knowledge as an expression of social and cultural reality might integrate a diversity of psychosocial phenomena that are constructed and shared in a group, community or society and established within a specific sociohistorical context. It is precisely the social construction of every set of beliefs, images, metaphors and symbols that makes them a product of a collective creation. Therefore, as a way of capturing the diversity of this term, in this chapter I shall introduce a discussion of the concept of representations as local systems of knowledge in the fields of health-related practices research: how a representation is constructed and transmitted through different historical periods and how it portrays the local knowledge of a community, which, in turn, is expressed in their daily practices.

As discussed in the previous chapter, there is a wide gap between the theoretical underpinnings and the social realities they seek to analyse within traditional societies and the developing world. The majority of conceptual frameworks are ill-equipped to understand social settings outside the cultural and historical context in which they are grounded. This deficiency calls for the application of 'sensitising' concepts, which can make a contribution towards the comprehension of *local* settings. In this respect, Blumer (1986) made the distinction between the definitive concept and the sensitising concept:

> A definitive concept refers precisely to what is common in a class of objects, by the aid of a clear definition in terms of attributes or fixed benchmarks. This definition, or the bench marks, serve as a means of clearly identifying the individual instance of class and make-up that instance that is covered by a concept. A sensitising concept lacks such specification of attributes or benchmarks and consequently it does not enable the user to move directly to instance and its relevant content. Instead, it gives the user a general sense of reference and guidance in approaching empirical instances. Whereas definitive concepts provide prescriptions of what to see, sensitising concepts merely suggest directions along which to look (1986: 147-148).

Such direction is provided by the social representations theory which, in this thesis, is applied as a sensitising concept. Indeed, in opposition to traditional health approaches that underscore health educational programmes, social representations theory signifies a switch in paradigm and constructs a 'bridge' from which new knowledge can be discovered. Therefore, in the following section, I will provide an overview of the theory emphasising the health related practices of research.

2. Social representations: An overview of the theory

The concept of social representations encompasses a particular approach to social psychology: the way that individuals perceive and know the world forms part of more extensive 'systems of knowledge' that are shared in a society. In contrast to the strong individualist orientation of social psychology, this approach recovers its social and collective interpretation and meaning. As a

result, to study health beliefs from this perspective is to do more than record the aggregate of separate individual views, it is to formulate them into a collective way of understanding health and disease. This also gives direction not just to specific matters concerning health and illness, but also to the individual's wider relationship to society.

Initially, social representations theory claimed to attempt to solve the problem of how scientific knowledge becomes integrated in the everyday thinking of people in modern societies. Moscovici (1984) drew a distinction between 'common sense' knowledge and scientific knowledge, arguing that the latter builds up the basis of the former. This named 'naive form of understanding' explains objects and events so that they become accessible to everyone and correspond with the immediate interest. Subsequently, the interpretation of the term social representations was expanded by some other authors, such as Herzlich (1973) and Jodelet (1991), to the broad and controversial field of social and cultural phenomena, including health, illness and body functions. According to Wagner (1997: 4), in social psychology 'only a few approaches address the psychology of social facts and social representations theory is one of the most recent frameworks for understanding the genesis, reproduction and change of social facts at a collective level'.

As a definition of social representations Moscovici states that these are:

> 'systems of values, ideas and practices with a twofold function: first to establish an order which will enable individuals to orient themselves in the material and social world and to master it; and secondly to enable communication to take place among the members of a community by providing them with a code for social exchange and a code for naming and classifying unambiguously the various aspects of their world and their individual and group history' (Moscovici, 1973, in Farr and Moscovici 1984: xvii).

He also established that the main aim of social representations is to determine the link between human psychology and modern social and cultural trends by focusing on everyday life communication and thinking (Moscovici, 1988). This

combination of different forms of knowledge delimits the main assumptions of the theory, which have been analysed through broad applied research.

The structure and processes cannot be studied without reference to their content. In social representations the term social becomes a relational feature characterising the relationship between a person and an object, event or phenomenon which constitutes his/her own group (Moscovici, 1988). Due to the concern of social representations with everyday thinking and the variety of ideas which make sense of our beliefs, arguments and forms of knowledge have been transformed and reconstructed. These shared representations have been transmitted through processes of social interaction and communication. Most knowledge is supplied by communication which affects people's way of thinking and creates new processes (Moscovici, 1988). Moscovici also delimited the processes of anchoring and objectification. The former is the process by which a new, threatening or abstract object or idea becomes intelligible, less threatening and a part of the discourse of everyday life and thinking; and the latter consists in reframing the new or abstract entity in familiar terms and icons.

A social representation constitutes the material, social and symbolic worlds in which people live. During the representational processes of social interaction between the subject and his/her context there is the construction of different forms of knowledge -iconic and symbolic (Farr, 1987). Similarly, Jodelet (1984) defines social representations as a system of reference that allows individuals to interpret the reality through images, which combine multiple meanings and knowledge. Jodelet also suggests that all systems of classification and images are distributed within a society and imply a link with previous systems of knowledge and images. They are established in the collective memory, which reflects past knowledge and current information .

Social representations are grounded in social life and they express the peculiarity of the individuals who create, reproduce and transform them. Wagner (1997) has argued that a group, society or culture constructs its world through the minds of its members. The social component of social representations is in the concrete context where individuals and groups are situated in the process of social communication. It is also present in their cultural background, social codes, values and ideologies in relation to specific social positions. Thus, the notion of social representations comprises sociological and psychological meanings. It is the way in which social subjects understand and interpret everyday life situations and information from the social environment.

In this respect, concepts of historical and ideological context, social interaction and language become crucial for the notion of social representations. They uphold the idea that social reality can only be investigated by looking at the cognitive and symbolic processes in their specific context and social groups and within the particular symbolic environment that is a characteristic of the population. The term social representations also stresses the importance of culturally and socially constituted systems of knowledge for people's thinking and practices.

2.2 Social representations, beliefs and practices

Farr (1991) has described how the study of social representations is highly relevant to the study of widespread beliefs, assigning particular importance to their *content*. Because the object of study of social representations is the information that circulates within the society, the study of beliefs plays an important role in a deeper understanding of any culture in its broad sense. Thus, every idea or belief assumes a large number of others with which it forms a whole representation.

It has also been stated also that social beliefs and representations are an integral part of everyday action and this action is reflected in cognitive, symbolic and iconic terms (Farr, 1987, 1991; Moscovici, 1988). Similarly, some authors have asserted that social groups give relevance to their beliefs if they take place in daily practice; by describing and explaining the objects of their social world, groups give these objects relevance and a place within the group's daily practice, which at the same time allow groups to maintain a sense of social identity (Jovchelovitch, 1996). Besides providing knowledge about the world, these shared beliefs admit certain kinds of actions and exclude others which do not form part of a shared system of reference. Therefore, the conclusion is that, in scientific understanding, beliefs and actions in social and cultural contexts form an inseparable unity.

The relationship between representations and actions has been illustrated extensively by Wagner (1993, 1994). He has established that in daily life people rarely believe and act without the influence of the shared knowledge and belief systems of the group to which they pertain. These beliefs have to correspond to the group's systems of shared knowledge. Thus, what makes cultures and social groups unique is this system of shared beliefs. He also stated that 'irrespective of how specific social practices look and are expressed in everyday life and irrespective of how divergent cultural and social beliefs describe and represent their local worlds, these beliefs have one task to fulfil in any culture: that is, they are beliefs *in local practice* and *for local practice'* (Wagner, 1995: 5, *stress in original*). He concludes that representations, being part of social action, are intimately linked to coordinated practice and interaction. These arguments also maintain that representations can be investigated only when they are held collectively by a group and expressed either discursively or through the actions of their members.

From a different perspective, the notion of paradoxical representations proposed by Abric (1994) brought forward the meaning of social

representations. In this respect, he argues that social representations are both stable and moving, rigid and flexible, and as a result they can mark strong inter-individual differences. He states that social representations have an internal organisation, with core and the peripheral elements, explaining that:

> The central core is linked and determined by historical, sociological and ideological conditions (...) it is strongly marked by the collective memory of the group (...) It is stable, coherent, it resists change (...) Contrasting with the central system, the peripheral system is then far more sensitive and determined by the immediate context characteristics. It constitutes the interface between concrete reality and the central system (1994: 75-76).

The process of transformation of representations and the relationship between representations and practices is explained in terms of paradoxes and contradictions.

Thus, according to social representations theory, social practices are considered to be the expression of beliefs, knowledge, metaphors and symbols (representations) that are shared collectively within a group and constructed in processes of social interaction between its members. A representation can be expressed discursively (through language) or through practical actions which, at the same time, create new kinds of knowledge and construct new practices. Hence, aspects such as social communication and social interaction that social beings construct among society members and towards objects and elements within that society are highly relevant to the study of beliefs. As representations display characteristics of stability and change, the dialectical principle of unification of opposites is fully acknowledged within the theory, breaking with the traditional paradigm of contradictory structure and functions. As a result, when we look at how local knowledge is constructed and expressed in daily practices, interpretation cannot be considered as the positivist analysis in which behavioural outcomes are the focus of inquiry.

2.3 Health and illness as social representations

One of the most influential studies in this field is Herzlich's (1973) now classic study on health and illness. The work was guided by the argument that health, as an idea that individuals hold, is a social representation. Herzlich's findings affirm that people do not think of health and illness as simple opposites. Health, for her respondents, was sometimes an absence of symptoms and sometimes a presence, a combination of positive feelings of well-being or impersonal perceptions. She proposed a way in which social representations of health and illness might be structured. She suggested that by exploring the individual's relationship with society we are able to identify his/her conceptualisation of health and illness; as she states, 'to think of oneself as healthy is to think of oneself in a particular relationship with the society' (1973: 36). Therefore, while health is always related to the individual, it is something that is exercised in the individual's active involvement in society.

Farr (1994), in his analysis of Herzlich's work, argued that she failed to demonstrate that the social representation of health and illness existed at a social level. This was because she sampled individuals rather than communities of individuals. Hence, Farr concluded that if 'naïve informants are invited, in the course of a single interview, to make attributional statements about two oppositely valued states such as health and illness, then they will tend to attribute the positive pole to the self and the negative pole to the non-self (or the environment)' (Farr, 1994: 31).

These findings suggest that people's ideas about health are not a simple unchanging entity. They also established the independence of health as a concept; this suggests that the way people think about their health is not something limited to their own bodies and individual experience. Instead, it is affected by the way in which health is understood as part of the wider representation of society and the individual's place within it.

Alternatively, in a study on representations of the body and its transformation, Jodelet (1984) argued that studying the body's functions would seem to be a privileged subject for research on social representations because it enables the rediscovery of the social deep within the individual. In addition, she stated that the experiences, practices and physical states to which representations are linked depend upon regulations and social aspects.

> The simultaneous 'social' and 'private' nature of the body makes us face up to three current and interrelated questions which are debate on social representations: the relationship between social and individual representations, the relationship between representation and behaviour and the relationship between social representations and individual and social change (1984: 236).

Body functions thus become part of a reality that is both social and subjective (Jodelet, 1984). She also identifies the effect of social changes on the active and mental relationship to a major biological fact (pregnancy). The study concludes that changes in values and knowledge have brought about changes in social practice concerning the freedom of procreation. Thus, change in the norms relating to female and male bodies affects not only lived experience but also knowledge. According to Jodelet, the study showed that changes in conceptions of pregnancy and childbirth are a consequence of the gradual change in beliefs and attitudes. And these experiences have modified the image of childbearing at the cognitive and experiential levels. Through this study the circular nature of the relationship between representations and behaviour is clearly demonstrated.

More recently, Gervais and Jovchelovitch (1998) observed that notions of health and illness are organised within a system of everyday knowledge that is transmitted and reproduced through 'key cultural practices' (1998: 21). This cultural knowledge also provides the framework within which identities are negotiated. Hence, changes in values and knowledge bring gradual changes in social practices and, at the same time, these social practices create new forms of knowledge.

This overview demonstrates how social representations theory can provide a valuable starting point in the study of local knowledge of health and illness and related practices in traditional societies. As the theory asserts, representations of health and illness cannot be studied in isolation as they are part of a whole system of knowledge that is shared among certain community members. This knowledge has been constructed throughout different historical periods and is expressed through key cultural practices. The general assumptions stated above contain significant elements for the analysis of local knowledge.

Furthermore, in the context of this study, I can assert that representations are grounded within a culture where several systems of knowledge conflict with, and confront each other. Hence, social representations theory can provide a fruitful starting point for the interpretation of the conditions of production and transformation of divergent systems of knowledge through the analysis of their content. These systems of knowledge are the expression of diverse cultural and historical realities in which deprived communities construct models of identification in order to gain more control over their own existence and express their sense of identity. Hence, having revealed the relevance of these issues, I shall proceed to analyse the construction of local systems of knowledge and their forms of expression.

3. Local knowledge: an entrance to social life

> Essential to the representational world are the many organised schemata that the individual constructs during the course of his development and that form the background frame of reference to all current processes of perception, imagining, remembering, feeling and thinking. The representational world in all the different aspects of its organisation is constantly being created as new perceptual and conceptual solutions are being found. These schemata form the basis for future attempts at adaptation and problem solving, although they may in turn be modified by experience.
>
> (Joseph Sandler, From Safety to Superego. In Gilman, 1988: 1; Disease and Representation).

The idea of representing the world, its objects and elements reaches back through the ages in the necessity to construct a frame of reference within which human groups are able to make sense of the reality around them. Nevertheless, despite the acknowledgement of the social constructionist ontological assumption of the social nature of human knowledge (Berger and Luckman, 1966), it seems that not all research comprehends this crucial point, as the former quote shows. In fact, some theories of health and illness conceptualisation still regard the representational act as a cognitive schemata derived from psychological processes and constructed with the purpose of *adaptation* to the environment in order to resolve problems of future orientation. Here we come to the very core of two related contentions. The first displays an essential theoretical postulate of structural functionalism: the structure determines behaviour. And the second, a structural determinism: similar structural influences produce similar behavioural responses (Cohen, 1995; Guzman Böckler, 1986). This Cartesian dichotomy between processes and structures has imposed a way of thinking in social sciences in which contradictions and paradox are not accepted, and configuration and functions are seen as antagonistic. A mechanical interpretation of local knowledge under this paradigm has provoked an overemphasis on the expression of that knowledge and an inadequate attention to the substance or meaning.

Nevertheless, against this logic of thought, research and practice have demonstrated that processes and structures can be properly understood only in relation to each other in a context of social interaction (Jodelet, 1991; Blumer, 1986; Habermas, 1992). From this social psychological perspective, a representational act makes reference to the past and present thought and reflects the local knowledge of a social group, its relations and spheres of social participation. It is, therefore, the entrance to a system of symbols and meanings in which everyday actions are taking place.

I want to introduce the analysis of representations as local knowledge with the work of the anthropologist Geertz (1973, 1983). In his concept of culture he states:

> ... a man is an animal suspended in webs of significance he himself has spun, I take culture to be, therefore, not an experimental science in search of law, but an interpretive one in search of meaning (Geertz, 1973: 5)...
>
> ...Culture is not power, something to which social events, behaviours, institutions, or processes can be causally attributed; it is a context, something within which they can be intelligibly — that is, thickly — described (1973: 14).

Hence, Geertz's concept of culture contains several useful principles from which some points of analysis can be drawn. *First,* the significance of contextuality is derived. What is seen of reality, and how it is seen, depends essentially on the social location from which it is viewed (Berger and Luckman, 1966) and on social positions (Davis and Harré 1990), which at the same time, express a sense of ethnic and gender identity (Hall, 1990; Moore, 1994). It clarifies the role of human beings *in* the local world and *within* the world as transforming rather than an adaptive response. *Second,* it states the social nature of human interaction. Individuals and social groups cannot be considered in isolation, they exist and transform themselves through social activities (Vigotsky, 1978). And it is precisely through the process of social interaction that human groups search for meaning (Blumer, 1986) within a social context or field of action (Bourdieu, 1990). And *third,* it states the historical dimension of human local knowledge (Marx, 1969). The dialectical principle of historicism allows us to explore the role of social and historical memory in the construction of representations and identities (Elejabarrieta, 1994), which is the privileged domain of ideology (Martín-Baró, 1985a, 1996; Alonso, 1988).

The former assumptions: social context, social interaction (practices) and historicism, constitute a base from which representations can emerge and

transform and, at the same time, construct local knowledge. Because they are usually considered as given in any research on health and related practices, minor or simplistic attention is paid to their analysis, converting them into a kind of natural phenomenon or unquestioned supposition (Hardon, 1992). This issue is even more constant if research interests are focused on Third World countries, where rapid results are required in order to establish local policies and actions. Due to the complexity of the social reality in which this study is immersed, I shall stress their relevance in integrating them into the very core of my discussion. I shall also assert that those assumptions are intrinsically interconnected: their existence is neither causally attributed nor deterministic, therefore no specific order is required for their analysis. I separate them exclusively for the purposes of my discussion which requires a certain order of ideas.

3.1 Contextuality: meaning of reality

What actually is reality? It would seem quite redundant to repeat an interrogation, which has been the object of analysis since ancient times. Yet, this simple question is often ignored or taken for granted and thus pushed aside as a self-evident definition. To establish the meaning of social reality implies a philosophical position and, therefore, a conceptual view within the social sciences arena. To start with, and from the social constructionist standpoint, social reality can be seen as:

> ...a realisation in a double sense of the word, in the sense of apprehending the objectivated social reality, and in the sense of ongoingly producing this reality (...). The same body of knowledge is transmitted to the next generation. It is learned as objective truth in the course of socialisation and thus internalised as subjective reality (Berger and Luckmann 1967:84).

This notion of social reality implies two contentions: 'objectivated' and 'subjectively internalised' reality. The first denotes the concrete world, or objective facts shared within a 'space of reality', as Freire (1970) would say. It

would include objects, social facts, economic activities, culture, etc. And subjective life would mean the objective world internalised by individuals, the perception that human groups have about their own concrete existence. In other words, social reality is how individuals and social groups create, transform and express their local knowledge and identity. It is a concrete world, inherent to the individual's own cultural, social and historical background, which is internalised through socialisation and communication. In fact, this subjective perception of reality is what makes its content somewhat relative and unique; it is, therefore, a partial reality (Jovchelovitch, 1998). Taking into consideration the relative meaning of a social reality and, in order to apprehend its complexity, one has to look at its historical dimension. Hence, social reality cannot be studied as a static phenomenon analysed just from what we can observe from prevalent facts and actions. It has to be apprehended through specific historical facts, which are kept alive through social memory, aspects which will be analysed in the following section.

3.1.1 Transforming history into present knowledge

History is a central focus in the social arena because the meanings of the past define the knowledge of the present (Fanon, 1963). The seeker of historical truth has always looked at past facts that can provide a sense of orientation for his/her present and future life. Whether written, oral or graphical symbols, the meaning is retained in the social memory of different social groups, which in fact represents a highly valuable resource for keeping alive ideas, values, culture or, alternatively, power domination. And it is precisely through processes of social communication and interaction that this knowledge is transmitted through different historical periods. Therefore, the basic principle is that everyday life, beliefs, norms and values have been created historically through generations which incorporate, ignore or deny the local and actual knowledge existing in a social group (Marx, 1845, in Douglas, 1987). Thus, if we consider those past meanings as finished facts we are denying the dialectical role of social and historical memory and its importance for constructing present

representations and knowledge. In other words, it is not relevant to study historical facts in isolation, what is important is how these facts construct and change representations and how they develop identities (Hall, 1990). To give an example, the work of Alonso (1988) on representations of the past in the construction of official and popular historical discourses in rural Mexico asserts that social memory is an integral creation of social meaning. These past representations are a central element in the symbolic constitution of present social knowledge and identities, which at the same time evolve an ideological meaning. In this regard, we come to three important points for analysis: the meaning of social memory, its ideological constitution and the significance of these two for the construction of social identities.

3.1.2 The meaning of social memory and its symbolic construction

> It is not enough to keep repeating that memory is socially structured. To have come so far invites a further step. The next thing is to discover what qualities of institutional life have distinctive effects on remembering (Douglas, 1987: 80).

The question of social memory, its development, social and cognitive functions have emerged as a fundamental social problem in the study of the social transmission of knowledge. As stated in the previous chapter, social cognition approaches have narrowly concentrated on the cognitive mechanism of memory. Nevertheless, the work from the social constructionist positions gives insight into the study of the role of language and social transmission as the only way to keep social memory alive (Halbwach, 1950; in Echeberría and González, 1998).[1] Evidently, the sites of production of representations are to be found in social groups, which are considered the unit of analysis. And it is precisely through the processes of interaction and practices that dissemination of social knowledge is produced. Therefore, from one generation to another, that

[1] It is not my intention here to give an account of the different approaches to the psychosocial aspects of social memory. For a current review see Echebarría Echabe and Gonzáles Castro (1998).

construction of social memory is negotiated and transmitted in the form of symbols and shared meanings (Gergen, 1982).

At this point we turn to the question of negotiation and discrimination: why do social groups remember some facts and disregard others? According to Ricoeur (1978: 45) 'social groups form images of themselves in relation to a set of founding events and re-enact this shared link to a collective past in public ceremony as well as in everyday life'. In other words, social facts, which have a common and shared meaning, need to find a collective public expression in order to be socially remembered. It is, therefore, necessary for the establishment of social memory to have a social reconstruction of the past about meaningful facts through institutionalised mechanisms of acknowledgement (Middleton and Edwards, 1990). Hence, if we consider this mechanism of creation and remembering, we encounter the fact that social meanings play a crucial role in the reconstruction of social and historical memory. For instance, in Guatemala after a long period of internal war, which was officially denied, one of the recommendations made by The Commission of Historical Clarification for the recovery of the social and historical memory of the victims was:

> ...Designation of a day of commemoration of the victims (...) the construction of monuments in public parks (...) and the assigning of names of victims to educational centres, buildings and public highways (...) [*Those*] commemorations should promote and authorise the raising of monuments (...) in accordance with the forms of Mayan collective memory (1998: 49).

As a mechanism for recovering the social memory of a society, the former example shows that the use of local symbols which have a collective meaning can strengthen the sense of community boundaries (Cohen, 1995). In other words, the sense of distinction or discrimination that a community has in relation to other social groups 'encapsulates the identity of the community' (1995: 12). Cohen also states that people's experience and understanding of their community boundaries resides in their orientation to its symbols.

However, it is stated that the presence of a symbol within a community does not mean that its members will share its meaning. Symbols are socially shared and expressed in the social memory if the community constructs their meanings. On the other hand, Martín-Baró (1985a) states that a symbol that has been imposed on a community and, as a consequence, whose meaning is not shared between its members, can provoke dissonance and contradiction among them. With this argument he states that the ideological connotation of meanings is retained in the social memory of the community. From this perspective the concept of social memory is directly linked to the concept of ideology.

3.1.3 Ideological constitution of social memory

As stated earlier, social memory is directly linked to language and its modes of transmission – communicational activities between members of social groups (Gergen, 1982). Language and thought are, therefore, the domain of public argumentation which is developed through discourse and social communication (Billig, 1992). Hence, any public discourse carries a symbolic meaning and, implicitly, it also contains an underlying ideology.[2] As an example of the ideological meaning of public discourse we can look at health education campaigns on contraceptive use in Guatemala, in which the underlying assumptions express pejorative inclinations towards the poor[3]. A well intentioned educational message can implicitly possess the sentiments of rejection towards certain social groups. And, as a form of ideology, the content of that message remains established in the collective memories of the population it targets, which in turn constructs a perceived sense of discrimination and social exclusion by the users of health services. As was discussed in the previous chapter, this point is highly germane for critically analysing the negative consequences of health promotion activities and the way

[2] Here, I am using 'ideology' in Billig's sense, which implies a set of 'beliefs and practices which assure the reproduction of power relationships' (1992:78).

[3] See Chapter 3 'The underlying ideology'.

in which health services in Guatemala are provided, based on an ideology of ethnic and class distinction. As social services are offered by a system which promotes an ideology of domination and denial of peoples differences, provision of health services has been traditionally built upon this ideology of power supremacy which, in turn, is transmitted through official discourse, formal education and provision of health services. Thus, in seeking a link between ideology and social memory one might ask the question: How is social memory ideologically constituted?

Ideology and power

> Institutions create shadow places in which nothing can be seen and no questions asked. They make other areas show finely discriminated detail, which is closely scrutinised and ordered. History emerges in an unintended shape as a result of practices directed to immediate, practical ends. To watch these practices establish selective principles that highlight some kinds of events and obscure others is to inspect the social order operating on individual minds. Public memory is the storage system for the social order (Douglas, 1987: 69-70).

Billig (1992) has stated that 'ideology would be a form of social memory in so much as it constitutes what is collectively remembered and forgotten' (Billig, 1992: 77). He also asserts that any opinion or argumentation implies an ideological value that people use in order to express their relationship of power. In other words, what is socially transmitted and evoked (social memory) is established within a battle between poles in which competing knowledge is disputed (Alonso, 1988; Jovchelovitch, 1997). Hence, what is collectively remembered and forgotten depends on struggles of power dominance among social groups. Obviously, the ideological valuation of forms of knowledge varies from society to society and from group to group and depends on the social positions in which this knowledge is situated. Regarding this point, Jovchelovitch (1997) stated in her research on the transformation of social representations in peripheral communities that communicative processes need to be understood in connection with the power relationship retained by

different cultural systems. As this relation of power is asymmetrical, not all social knowledge has its power recognised and, therefore, some social groups have to 'defend or renounce their local knowledge' (1997: 24). Ideology, therefore, is an important element in shaping social knowledge and memory within a society. But what brings about domination is not just ideas, but rather power in social relations which is acquired through the appropriation of the most fundamental values in social life, as Ricoeur (1978) points out:

> The negative aspects of ideology become prominent as codes of interpretation are mobilised to legitimate relations of domination, resulting in a phenomenon of political 'over value' through which the excess of the claims of the rulers over the response of the ruled is dissimulated (1978: 48-49).

As has been stressed in the preceding paragraphs, social memory is a product of a relationship between power and knowledge, a dyad that has been extensively analysed by Foucault (1980)[4]. The production of local knowledge is, therefore, influenced by this ideological relationship in which social groups struggle to advance and defend competing claims, values and interests. In this respect, and for the purpose of analysing the local knowledge of Mayan communities, I embrace the study of historicity and social memory in two senses: first, in the sense of the social transmission of knowledge, which enhances and keeps alive the identity of a community. Without the role of social memory, no knowledge could be transmitted from one generation to the next and no identities could be negotiated. And second, in the sense of the ideological meaning of social memory: what is collectively remembered and forgotten depends on asymmetrical power relations in which the dominant ideology determines and imposes its own knowledge and disregards others. It also has to do with the social positions held by a particular group within a society and the sense of identity that this expresses. Here we come to two

[4] In the European tradition of social research Foucault's ideas on power and knowledge conform the foundation of social analysis. With the purposes of providing a meaning of 'contextuality', in this research, issues of power and knowledge will be explored through the work of some Latin American social scientists such as Martín Baró (1985, 1996) and Freire (1972, 1970).

important interrelated points of analysis: social positions and their expression in local identities.

3.2 Social positions and identity

A popular proverb says, 'everything depends on the colour of the crystal that you look at it through', this is precisely the argument that I wish to further. The nature of a social reality lies in the meaning that it has for the person, or group, for whom it is a reality (Blumer, 1986) and the social positions that those individuals or groups have within a social reality (Davis and Harré, 1990; Hall, 1990).

The symbolic interactionism standpoint, presented by Blumer (1986) and founded on the work of G.H Mead, states that the meaning of the object (social reality) establishes the way in which social groups act towards it through communicative processes. In other words,

> Individuals, also groups occupying and living in the same spatial location may have, accordingly, very different environments; as we say, people may be living side by side yet be living in different worlds. Indeed, the term 'world' is more suitable than the word 'environment' to designate the setting, the surroundings and the texture of things that confront them. It is the world of their objects with which people have to deal and toward which they develop their actions. It follows that in order to understand the actions of people it is necessary to identify their world of objects (1986: 11).

This crucial point might be analysed from different perspectives, such as gender, family relations, social grouping or ethnic groups. If we take an example from the previous chapter about the acceptability of health services, the 'perceived needs' of the users of health services might differ from those held by their providers. An objective reality may indicate that it is necessary to engage in certain preventive actions regarding health (for example, contraceptive use). Nevertheless, if that action does not have a meaning for the users, or they do not consider it as a resource for their future wellbeing, it

would be difficult for them to have a positive reaction towards it. Therefore, this example shows that a 'world of objects' or *habitus*, as Bourdieu (1990) puts it, inclines individuals and groups to act towards the reality they encounter. This perceived reality cannot be understood exclusively as the result of prevalent deprivation in which communities are established. It also emerges as a product of the historical exclusion and deprivation with which they continue to correspond (Hall, 1996). This idea also shows that social location determines the contextual reality from which individuals construct their social positions (Davies and Harré, 1990), which allows individuals to build a 'space of reality in which their identity can be expressed' (Elejabarrieta, 1994:246). Hence, it refers not only to a symbolic occupation of a space of identity which needs to be defended, but also to the dynamic through which positioning expresses a sense of identity.

Looking at the case of the gender identities, Moore (1994) argues that individuals occupy very different subject positions in the social arena and it is therefore not possible to consider a single definition of a gender position. She argues that there is a variety of forms of masculine and feminine identity, which are created by contradictory and competing discourses. As she adds:

> Individuals are multiply constituted subjects, and they can, and do, take up multiple subject positions within a range of discourses and social practices. To be positioned is always to be positioned in relation to others and, thus, one's interrelations with other individuals – intersubjectivity – will also determine what positions one takes up. It is for that reason that modes of subjectivity and questions of identity are bound up with issues of power and with the material benefits which may be consequent on the exercise of that power (Moore: 1994: 55-65).

In the light of the above, we can determine that contextuality can neither be analysed in isolation from its historical background, nor be reduced to an amalgam of static social issues. The notion of social position, multiple and contradictory subject positions and the implication of these two for the construction of identities leads us to a highly significant aspect of social reality

that I believe it is important to emphasise: the transformation of identities and its implications for the construction of representations.

3.2.1 Renovation of identities

Given the singularity of this study which states that local identities comprise a central core for the construction of community resources and social networks, I draw on Hall's (1990, 1996) analysis of social identities in post-colonial societies. He claims that social identities are tied to social positions and status that are part of a reality the individual has internalised:

> (...)[Social identity] does *not* signal that stable core of the self, unfolding from the beginning to the end through all the vicissitudes of history without change; the bit of the self which remains always-ready, 'the same', identical to itself across time. Nor (...) is it that 'collective or true self hiding inside the many other, more superficial or artificially imposed 'selves' which a people with shared history and ancestry hold in common' (...). Though they seem to invoke an origin in a historical past with which they continue to correspond, actually identities are about questions of using the resources of history, language and culture in the processes of becoming rather than being (...) Identities are therefore constituted within, not outside representation. (Hall, 1990: 3-4) (*stress in original).*

Therefore, the recognition that social identities are constructed 'within' a specific social reality denotes their sense of boundary as described above. It is precisely because of this sense of discrimination that a social group and communities find the expression of difference. Yet, the reference to a notion of variance does not simply mean a set of binary oppositions, for instance, one ethnic group confronting another. These singular oppositions are in permanent processes of confrontation and renovation from which new identities emerge (Alatas, 1977). Regarding this point, and in relation to the Latin American identity, Martín-Baró (1996) has observed that in a region in which a system of exploitation and discrimination has been reproduced since colonial times, excluded social groups have developed a strong sense of social and ideological resistance. This resistance is manifested in different forms of daily life struggles

against the impositions of a dominant group which, in turn, denotes an expression of a strong sense of identity that has been manifested throughout different historical periods. Therefore, the social construction of a 'spoiled identity' (Goffman, 1963) that has been reconstructed in the course of history, is rejected by a sense of community boundary from the excluded social group. Such a case can be analysed through the 'Lazy Latino' identity which will be explored in the next section.

3.2.2 The 'Lazy Latino' identity: the Guatemalan case

The historical foundations of the Guatemalan context have been set out in the first chapter. Moreover, in order to illustrate the idea of transformation of identities I shall offer a brief synopsis of what constitutes the current Guatemalan identity and how it has been constructed throughout different historical experiences.[5] In an illuminating analysis of the social and ideological effects of the Spanish colonisation of Guatemala, Guzmán Böckler (1986, 1995) noted that current national social identities still reflect the relations of domination that the Spanish imposed more than five centuries ago. Besides forced mechanisms of repression, the colonial social structures applied ideological instruments of control, which aimed to reinforce their power. These instruments included the imposition of an unknown religion, the denigration of native values and the use of pejorative language in describing the indigenous people's way of life. This system of social discrimination, denigration and exclusion was unfortunately reproduced throughout different historical periods by diverse powerful social classes. Thus, since colonial times, two categories of social relations were established: the *dominator* and the *dominated*. To belong to the first category, social actors have to own the power and the economic resources, they have to have a Western physical appearance, to be bright and organised, clean and civilised and, most of all, they should have the

[5] The study of the complexity of Guatemalan identity goes far beyond the scope of this review. My intention is to give an overview of the mixed society of Guatemala in order to give the reader a sense of the context.

ability to decide over the others. Regarding the other category, the dominated, to which the majority of the population belongs, ideas such as 'people are poor because they do not know how to work properly', they are dull, uninteresting, lazy, superstitious, passive, fatalistic and inclined toward a realm of magic, were prevalent. In other words, people 'who deserve be dominated because they do not find their way around by themselves'. A binomial categorisation, distinctive of a Western Cartesian analysis, constructed the basis of what Martín-Baró (1996) designated the 'lazy latino' identity, a label that the social order in Latin America encourages and reinforces in certain strata of the population. As he states:

> (...) members of the subject classes continually 'learn their place' in society as the poor, the unlettered, the campesinos,[6] or the indigenous. [*Therefore*] social colonisation puts down roots only when it is ideologically articulated in the mindset of persons and groups, and is thus justified with the seal of what seems to be natural rather than historical. The myth of the 'lazy native' is an important part of such ideological colonisation (1996: 214).

The former analysis also corresponds with Fanon's (1963) studies of the colonised territories in Africa. He noted that the tendency of the coloniser is to join together in one category entire multifaceted populations, allowing for no acknowledgement of any particular characteristics within the social groups included. Other social categories that are bound within this oppressor and oppressed dichotomy – such as gender and class status – appear to be most powerful when they are regarded as being natural, transparent and taken for granted. According to Moore (1994: 92 *in original*) this point can be most clearly made by examining how 'social identities that are based on ideologies or "naturalised" cultural conventions are implicated in power structures and in the structuring of inequalities'. Naturalisation of unequal social conventions leads to injustice and oppression being taken for granted.

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[6] The Spanish term *campesino* means peasant or rural worker, although it can also mean underdevelopment. The translator of Martín-Baró's essays preferred to keep this terminology in Spanish as its meaning is lost in the English translation.

During post-colonial times the former system of domination remained untouched in respect to the socioeconomic structure of power domination, social deprivation and cultural disregard. As a result, new forms of social identity emerge within a context which reproduces the oppressor/oppressed dichotomy of domination (Freire, 1972). In the case of Guatemala, the *ladino* identity represents the power dominator and the Mayan the dominated.[7] According to Annis (1987), in Guatemala what has distinguished the indigenous and non indigenous over time has not been biological heritage, but a changing system of social classification, based on ideologies of race, class, language and culture, which ideologies have also taken on different meanings over the time. Similarity, Watanabe (1992) observes that the study of ethnic relations in Guatemala has traditionally relied on Barth's (1969) concept of ethnic boundaries, seeing a bipolar ethnic scenario in which rigid structural boundaries separate the categories Maya and *ladino*. Indeed, the dominant ideology in Guatemala reproduces this system of thought in which opposites are considered to be antagonistic and irreconcilable.

One of the most powerful ideological mechanisms of social rejection is the racist nature of the Guatemalan identity. Smith (1984) states that discrimination in Guatemala is a social phenomenon that involves political, socioeconomic, and cultural exemptions, restrictions and preferences, which limit the Indians in the exercise of human rights and fundamental liberties. Similarity, Cojti Cuxil (1996), in analysing the struggle against racism in Guatemala, explains '... it appears that the more educated a person is, the more racist and intolerant he or she becomes towards the Maya...' This racist reality is expressed even in the National Constitution, which recognises the 'groups of Maya descent' as ethnic minorities. It scarcely mentions indigenous rights and does not fully recognise ethnic communities as subjects with rights (Cojti Cuxil, 1996 in Fisher and

[7] I would like to clarify that in Guatemala the categories of Maya and *ladino* are based on strong social class and ideological, rather than ethnic, criteria. Within the 'ladino' category there is strong differentiation and discrimination depending on phenotypic features, educational level and cultural traits.

Brown, 1996: 48). Hence, from the governmental authorities down, Guatemala promotes a system of racism and cultural discrimination, which is manifested in daily life as moral and psychological violence towards the indigenous population. As a concomitant effect of this system of oppression, and as an effect of its prolongation, inequalities are considered to be normal and social injustice and impunity are taken for granted as issues of everyday life. Thus, as was previously stated, this ideological manipulation is interjected in the form of a dogma of conformity, resistance to change and fear of a better future.

In Guatemala, this ideology is widely expressed throughout different levels of social relations: at the macro level (governmental), community and social groups. As a result, social relations have been constructed upon a system of ethnic difference and social class exclusion in which strict boundaries separate one social group from the other. At the level of social services and, more specifically, provision of health services, relationships are based on a top-down intervention, which considers the users of health services as passive receptors of a 'knowledgeable' system of reference. Within this paradigm, users of health services, in this case the Mayan communities, are neglected and almost 'officially' acknowledged as being conformist, lacking initiative and openness for any developmental intervention. An ideological connotation which, as was previously mentioned, has constructed a spoiled identity among them.

The above clearly demonstrates that social identities are not unchanging entities. Through different historical periods they have been transformed and negotiated, struggling, all the while, to keep their distinctiveness or sense of boundary. In Guatemala, as in many Latin American countries, deprived social groups express their sense of community boundary as a part of their resistance against ideological manipulation, social oppression and exclusion. History has demonstrated that dominant social groups have always imposed their systems of knowledge, shared values, beliefs, ideologies and practices on deprived social groups. These excluded social groups have struggled to find an

opportunity to express their own. Over centuries a profound cultural inheritance has been restrained through poverty and exclusion and the vast wealth of these peoples' knowledge is left behind with what 'remains unsaid' and what 'is not worthy to be listened to'. The construction of social identities throughout different historical periods allow us to interpret how diverse social groups establish divergent social positions which, in turn, express conflicted local knowledge. Hence, a common understanding, negotiation and dialogue is needed in order to encounter new alternatives for participation and the development of community resources.

4. A link between local knowledge and health beliefs and related practices

In looking at how representations of reproductive health have been constructed and negotiated, and how they express the local knowledge of a society which, at the same time, is manifested in their practices regarding health services, one has to consider the following factors:

- Historical dimension: the relevance of the study of social memory in a dual sense. First, in the sense of social transmission of cultural inheritance and, second, in the sense of the institutionalisation of an ideological power which historically constructs two opposing poles.
- Contextuality: the meaning of social reality depends on the social positions from which social groups emerge, participate and express their knowledge. As has been noted, social positions allow us to link representation with social identities.
- Renovation of identities: How the stigmatised identity of a social group has been reinforced throughout different historical periods, and how as a part of their resistance, these groups struggle to keep a sense of boundary or distinction from which their voices can be heard.

- Community support: the sense of boundary is constructed through diverse social support and social networks which, in turn, express the local identity of the group.
- Expression in daily practices: beliefs, knowledge, identities and community boundaries are constructed upon, and expressed through daily practices, which at the same time construct new forms of knowledge.

3. Final reflections

What is the relevance of historical memory, ideology and power, renovation of identities and contextuality to the study of health beliefs and related practices? At this point I wish to, once again, embrace the basic principle of the theory of social representations: 'every idea or belief assumes a large number of others with which it forms a whole representation' (Moscovici, 1998: 222). In this respect, a representation cannot be studied in isolation, nor can it be treated as the sole object of investigation. It must always be analysed in relation to the context from which it emerges and that it transforms. As stated in the first chapter, reproductive health problems in Guatemala require the recognition of several conflicting views. As their comprehension integrates several level of analysis, I believe that at the macrosocial level of explanation regarding the origins of cultural beliefs and actions, social representations theory can make a valuable contribution. I would like, therefore, to conclude by highlighting the contribution that social representations theory can bring to the study of health beliefs and related practices, considering the specific context in which this study is immersed:

1. How to construct local practices: the social and historical dimensions of local knowledge are of great importance and it would be impossible to understand them without the analysis of social memory, social identity and social practices. Local knowledge is the result of numerous social practices and, at the same time, these result in more practices.

2. The theory allows the identification of different kinds of competing knowledge: Medical knowledge and lay people's knowledge. These different systems of knowledge express distinct sets of experience and interests.

3. The theory permits an understanding of how this knowledge establishes a dialogue: different systems of knowledge have different ways of communicating. And it is precisely by the recognition of the legitimacy of a cultural system of knowledge that differences can be negotiated and taken into account.

In the second part of the thesis, we will explore how these ideas were put into practice through the application of qualitative methodology.

PART II

METHODS

Chapter 5

Methodology

Part One
1 General background of the setting
1.1 An overview of the visit
2 Land distribution: a starting point for social analysis
2.1 Social and economic consequences of land scarcity
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1 Epistemological assumptions
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2.3.1 Conducting focus groups
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3 Obtaining entrée: being an insider 'outsider'
4 Analysis
4.1 Procedure of analysis
5 Conclusions

This chapter is divided into two parts. In the first part of the chapter I seek to describe the social setting in which fieldwork was conducted. I shall give a general overview of my visit to the sub-geographical region of the western highlands of Guatemala. Given the complexity of the issues involved, I consider it necessary to examine some specific social, economic and cultural characteristics of the communities included in this study. This preliminary description provides the foundations for the subsequent analysis.

Part Two identifies some epistemological assumptions about the application of the conceptual framework of local systems of knowledge in the study of reproductive health beliefs and practices. Here I seek to justify the use of the theoretical framework or conceptual 'toolkit' in order to explain current representations and practices relating to the acceptance of reproductive health services. In the following section, I seek to justify the use of qualitative methods of data collection and analysis. In line with the aims of this research, which looks at the construction, transmission and mediation of local knowledge and its expression in daily practices, I favour open-ended flexible research methods such as semi-structured individual interviews, focus groups and participant observation. Thus, I shall describe each method theoretically, analysing issues of triangulation, procedures of application and conduct. I shall also explain the procedures of data analysis proposed and offer some concluding remarks.

Part One

In this part of the chapter I give an overview of the setting of my study; the CARS (Cuenca Alta del Río Samalá) region in the western highlands of Guatemala. I aim to provide a general and succinct picture, that will situate the reader in the context of the study. I shall first provide some information about the region, giving a summary of my fieldwork visit. Second, I shall give an overview of the communities included in this study, followed by general information about their socioeconomic situation.

1. General background of the setting

The western highlands of Guatemala is a geographical region located in the western part of the country bordering with southern Mexico and the southern coast of Guatemala, centred around the highest peaks of a chain of mountains and volcanoes (between 2,000 and 4,230 metres). Its geographical division does not follow any authorised demarcation, since each territory actually forms part of a different and officially recognised geographical zone. The fact that people acknowledge it as 'the region of the Western Highlands' has more to do with issues of a common identity, shared history and similarities of economic and social situation. There are three important and common aspects shared by all the region: it is the home of the Mayan population of Guatemala (divided into four main linguistic groups: K'iché, Mam, Kakchiquel and Tz'utujil and several other minor ethnic groups), the economy and land division are based on *latifundia* and small peasant farms, and it has the highest levels of population density and poverty in the country (Ordóñez, 1997).

The sub region of the Cuenca Alta del Río Samalá (CARS), in turn, is made up of six municipalities: Totonicapán, San Cristóbal de Totonicapán, San Francisco el Alto, San Andrés Xecul, Salcajá and San Francisco la Union (Schulte, 1998). Its division also follows the same parameters of ethnic, geographic and

socioeconomic boundaries as previously stated. These zones are linked together by the fact that, historically, all have shared the same water supply from the river Samalá. This natural resource has played a crucial role in the people's way of life: it has been a source of water supply that also provides moisture to the land and influences weather changes; two important geographical factors that, moreover, retain cultural and symbolic meanings for the inhabitants.

The fieldwork was carried out in nine villages and two main towns from the 312 villages and communities that belong to the CARS region. The division is presented in the following table:

Municipality	Main town	Communities (villages and towns)
Quetzaltenango	Quetzaltenango, Xela	
Totonicapán	Cantel	
San Cristóbal Totonicapán		La reforma (cuatr caminos)
San Francisco el Alto		Chirenox Pavatok
San Andrés Xecul		Chajabal Nimasaj Palomora Llano los Tuises
Salcajá		
San Francisco la Unión		Chuestancia Tzanjuyup

Table 1. Villages and towns of the CARS included in the fieldwork study.

Regarding the characteristics of the population of the CARS, all the inhabitants belong to the K'iché and Mam linguistic groups. The population is predominately young, with 66 per cent being under 24 years old and 50 per cent (between 15-64 years) being economically active. Their way of life is mainly agricultural (small harvest), traditional cloth-making, incipient trade and care of domestic animals. In relation to health issues, infant mortality rates stand at

78.1 per 1,000 live births, and life expectancy is 59. 8 for both sexes. Fifty-three per cent of the population is illiterate.

The region has an average population density of 683 inhabitants per square kilometre, the highest in the country, with an average of 6.9 children per family (Ordóñez, 1997). According to the National Institute of Statistics and Census (INDE, 1990) the population in the region is set to increase over the years 2000–2010, establishing an increment in rural areas over urban.

1.1 An overview of the visit

The length of my visit was eight weeks, running from 8 January to 4 March 1999. I worked with a local non-governmental organisation (Asociación PIES de Occidente del Movimiento Tzuk Kim-Pop), working on health promotion research and sustainable development for the region of the western highlands of Guatemala. Access to this organisation was possible as I had worked with them on previous research projects on healthcare issues in the Guatemalan highlands. The NGO office was located in Quetzaltenango, one of the main towns of the CARS sub-region, but their activities were based in the villages and towns which were around 30-60 minutes drive from the main town of Quetzaltenango. My fieldwork was in fact delayed, as the whole region was facing a cholera epidemic as one of the consequences of the recent hurricane Mitch in November 1998. At the time of my arrival, all the health personnel working in the NGO to which I was assigned were leading vaccination campaigns within the villages and towns, and were distributing drinking water and whey. To get in contact with any health worker who could take me into the villages was a difficult task. Nevertheless, I was invited to join them in their daily vaccination duties and in all other activities related to the anti-cholera campaign. My presence in the villages was attributed to the vaccination programme itself and so it was not difficult to get inside people's homes and to

hear their first expressions of acceptance or rejection with respect to the effects of such medicines.

After three weeks, the campaign finished and I involved myself in the ordinary activities of the NGO (daily visits to the communities, organisation of women's groups, seminars, etc.). The selection of the communities included within the study was based on the NGO own priorities. These communities are part of the Micro Región I, in which several programmes on reproductive health and development were carried out.

In the following sections I shall go on to describe the main characteristics of the communities studied: their socioeconomic conditions and the consequences for the general wellbeing of the inhabitants. Despite the fact that all the communities included within the CARS region share a common cultural background and similar socioeconomic characteristics, each village and town has its own particularities and experiences which merit special attention. Moreover, in this short description, I aim to give general information that characterises the CARS region as a whole. I do not intend to go deeper into the analysis at this point, as it will be further explored in the chapters that follow.

2. Land distribution: a starting point of social analysis

As stated earlier, the region relies on agricultural activities as its main source of livelihood. Land distribution is characterised by large concentrations of territory in the hands of a few wealthy landowners, providing sources of industry and commerce (mainly coffee). The rest of the territory, a small proportion compared to the needs of its users, belongs to the population settled in the mountains. Here, the produce of the land constitutes the only source of income, for what is fundamentally a self-sufficient economy with a small amount of local interchange and trade. The local economy is based on the production of basic grains (corn and beans) and the limited production of

potatoes and *calabaza* (pumpkin). Peasant-based agricultural activities are also used for medical purposes, since Mayan medicine is based on the use of curative plants. As the region is predominantly agricultural, all aspects of production, distribution, use and consumption of land resources have a positive or negative impact on the way and quality of life of the native population. The relationship between land/peasant goes far beyond the productive activities related to self-sufficiency, it is also associated with a complex system of land/family ownership and inheritance system, a daily concern of every head of family (Pérez, 1977).

The scarcity of land ownership is also aggravated by the population growth. This overpopulation is mainly concentrated in rural areas which, in turn, increases the social pressure on natural resources. Faced with the necessity for agricultural production for their own consumption, and given the scarcity of agricultural property, local peasants in the region overuse the land they have, as they 'cannot let it rest' if agricultural production is required. This situation, of course, provokes serious problems in the ecosystem, causing erosion, deforestation and lack of water supplies. Circumstances are further exacerbated by the use of illegal deforestation on the part of private companies to supply the wood trade. As a result of this agricultural crisis, it is believed that the areas of Salcalá, San Francisco la Unión and San Francisco el Alto have reached the point of being abandoned, as the land is already depleted and cannot be used further for agricultural production (Schulte, 1998a). Given the relevance of agrarian operations for economic sustenance, the generation of a paid labour force and general social wellbeing, the scarcity of this resource exacerbates poverty levels which, in turn, affects daily social and cultural life. For example, one of the consequences is migration to nearby regions and the performance of underpaid jobs, aspects that will be discussed in the following section.

2.1 Social and economic consequences of land scarcity

The scarcity of land ownership, and its overuse, also underpin the concomitant negative social and economic effects in the CARS region. As there is not enough land to satisfy local subsistence needs, people have to find, wherever possible, survival alternatives for their families. One such alternative is to seeek a different source of employment outside the region. A good option would be to get a daily paid job in one of the main towns, in a service area such as transport, construction or light industry. For example, in the case of San Francisco la Union, people have set up small cooperatives for traditional cloth-making and have developed an incipient trade of 'used cloth' between different communities. The owners of these companies usually have connections with groups from the southern part of the country which, in turn, increases the possibility of more widespread commerce.

Nevertheless, since these jobs require a minimum degree of skill and most of the local peasants do not fulfil these criteria, the majority of them have to migrate to nearby regions or abroad in searching of more appropriate options. Migration is one of the most common social problems faced by the CARS region at this time. In a study of migration experiences in the region, it is noted that each family has at least one member (father, brother or son) that has migrated to the southern coast of Guatemala and the capital city during the last five years or, illegally, to Mexico and the United States, (Schulte, 1998). Internal migration implies working in large plantations outside the region (coffee, sugar cane, bananas) or, in the case of women, working as domestics in nearby towns or in the capital city. If men choose to work abroad, they work as agricultural labourers or in road construction, usually in extremely arduous working conditions, receiving very little pay and without basic human rights (health, food, housing, security). If everything goes well, they return to their villages and use the income to improve the standard of living of their families (build a new house, for example). But generally, if they are not deported, their labour

force is overused and they have to stay for years in order to pay back the expenses they owe to the foreign country. Migration also forms the basis of family disruption, loss of identity and the importation of foreign infectious diseases such as AIDS, another health problem now faced by the region. The social effects of these problems are profoundly felt by whole communities, but more specifically by women who do not possess the social and economic tools for survival, an issue that will explored in the next section.

2.2 Women in CARS: the most affected groups

The unequal land distribution, the intensification of poverty and the amplification of the agrarian borders have all contributed to the modification of women's traditional roles. Their participation in domestic and agrarian work has intensified and multiplied. In order to find survival strategies, they also have to search for jobs outside the confines of their homes: in the fields, as sellers, or as small traders of handicrafts and cloth, besides attending to their housework and looking after their children. This work has been characterised by long working hours in the fields, usually caring for their small children under difficult circumstances. Women suffer from social discrimination both within their family boundaries and outside their families. For example, they do not get jobs easily and they are paid less for their labour. Within the private realm, women inherit less land than men, a tendency that is widely acknowledged throughout the western highlands of Guatemala. If women's patrimony is less than men's, their dependence on their husbands increases, a situation that reinforces the patriarchal relationships within the family. The triple labour force, unequal gender opportunities, family violence and high fertility rates have led to a decline in women's physical and psychological wellbeing. The women in CARS can be chracterised as follows:

The group of young women ran from the age of 15 to 28-30. They are mainly dedicated to the learning process in all senses, gaining knowledge about the

house, production activities (grinding corn, washing cloth, selling in the market) and reproduction (bearing and attending to children, education and health), instructed by adult women and the elderly. Their positions as 'learners' gives them the flexibility to find new alternatives regarding their participation in other social activities. For example, they are more willing to be engaged in educational activities, are more receptive and more able to express themselves and to listen to others. This group is also more likely to be bilingual, depending on the village and place of origin.

By contrast, adult women (aged 30-45) dedicate themselves more to commercial activities and their role as active producers is mainly in alternative forms of commerce (making clothes, selling). They are characterised by being more attached to their domestic work and to their children. As a group, they also tend to be less receptive to external activities, and their participation and involvement is less active. They are mainly monolingual and predominantly illiterate.

The last group is represented by the elderly, who enjoy much recognition, both within and outside the boundaries of the family. Their role within the domestic space is more directly linked to the activities of food preparation and organisation of internal activities (distribution of labour, administration). Outside their homes, they are usually engaged in community committees of elderly people, groups of midwives and are the responsible for organising the community's cultural events (festival of *cofradias*). In relation to their participation in any social external activity, they tend to be highly engaged and dynamic, free to express their opinions and to discuss with confidence their culture and traditions. The majority are monolingual.

As we shall see in the next section, there is an incipient development of social organisational activities in which actions to further women's development are integrated.

2.3 Social organisation

The Mayan K'iché communities of the western highlands have their own organisational principles. These Mayan institutions are independent of the administrative organs of the Guatemalan state – which represents the colonial organisational principles acquired since Spanish rule. The Mayanestablishments are divided into 'speaking municipalities' with diverse hierarchies. Whether they are political-legal (*municipalidad indígena*) or religious (*cofradía*), these may be understood as a ladder of public offices, each with a clearly defined area of responsibility for the execution of the political and religious tasks of the community (Ekern, 1997). For the Mayans, the highest political and religious authority in the municipality will lie with a Council of Principals or male elders. This *Consejo de Principales* comprises of a selection of all men who have successfully served their terms in a hierarchy. The council possesses wide powers in interpreting the laws that govern the community –Mayan laws – which are conceived as a divine balance between sanction and approval (Ekern, 1997).

The role of the traditional birth attendants or *comadronas* merits equal respect.[1] This group of women also conform to organisational rules based on a system of hierarchies which determines their duties and rights. In both institutions – *consejo de principales* and *comadronas* –the necessary knowledge is gained only by the coming of age and the successful completion of assigned periods of service to the community. Ideas such as decisions by simply counting votes, or equal rights for everyone regardless of sex, age and service to the society are foreign and potentially disruptive (Watanabe, 1992).

[1] The term 'comadrona' might be translated as 'traditional birth attendant' or 'midwife'. Nevertheless, I prefer to keep the terminology in Spanish as I consider that the English versions do not convey its full meaning. Therefore, in the following sections I will rather use 'comadrona' when referring to Mayan traditional birth attendants.

Independent of the Mayan organisational institutions and the state establishments, there are a number of non-governmental organisations working at the local level. Despite the social conditions of violence and repression left by the civil war, at the beginning of the 1990s, people developed new forms of social organisation in the forms of sociorural groups and self support institutions – few of them work in conjunction with the Mayan organisational principles. Among the most salient groups are: development committees, health, agricultural, handicraft, human rights, cooperatives, Mayan religious groups and women's organisations. They work independently and with no external support, although they manage to survive with a self-supporting status. Contrary to the needs of the region, the less well-developed groups in terms of activities, social support and self-assurance are the health and women's groups, a situation that detracts from the possibilities of local development and any real improvement in the standard of living in the region (CONSOC, 1996).

3. A kind of conclusion

My intention in this first part of the methodology chapter was to transmit some fundamental information about important socioeconomic aspects that characterise the region of CARS, the contextual setting of the fieldwork. This information also lays the foundations for further analysis and, therefore, all aspects covered will be discussed in greater detail in the course of the thesis. To conclude, the CARS region of the western highlands of Guatemala has been characterised by:

1. A high concentration of the Mayan population from the K'iché and Mam linguistic groups. They represent one of the most underprivileged human groups in Guatemala in terms of levels of poverty, illiteracy, high fertility rates and deficient health.

2. The region is characterised by *latifundia* and small peasant landholding used in agricultural production. Unequal land distribution underscores the agricultural activity for auto-consumption, which does not satisfy the requirements of the majority of the population. As a result, people have to find alternative strategies for survival through land overuse, small-scale trade and labour migration.

3. Internal and external migration also carry other concomitant negative effects for the people's wellbeing, including family disruption and the lack of a local labour force, which are detrimental to health conditions. The most affected groups are women and children.

4. There is an outgrowth of local social organisation for the development of self-supporting groups such as cooperative committees for agrarian activities. The development of women's and health groups is still incipient.

Part Two

1. Epistemological assumptions

1.1 Health beliefs and practices as a case study of local systems of knowledge

In the previous chapters I presented a review of the literature on health-related practices and a conceptual framework which examines the role of local knowledge in the construction and expression of health practices. I argued that there is a need for socio-psychological approaches which can lead to an understanding of systems of knowledge that underscore reproductive health beliefs and practices in the developing world. Given the diversity of social contexts and realities and the lack of conceptual frameworks which can make a contribution towards the comprehension of *local* settings, social research has to meet a new demand: the need for 'sensitising concepts' which can be locally applicable within diverse cultural and social backgrounds (Blumer, 1986: 147). Thus, within the context of this work, social representations theory is applied as a sensitising concept, revealing a new perspective in the field of health and illness research. By looking at the content and processes of transmission of local knowledge – through discursive and material practices – health beliefs and practices are not considered as products of individual personal attributes, but rather, as social constructions that form part of an extensive system of reference, in which numerous aspects of social life – including health – are immersed. In this way, social researchers can gather more information about people's acceptance or rejection of health services and give further recommendations on how social services can better meet their needs.

As stated earlier, besides the application of the theory of social representations, the conceptual framework presented in this study also embraces several theoretical constructions, which I believe make a valuable contribution to the

particular reality being studied. It is argued that cultural knowledge and practices cannot be evaluated in isolation, they represent and portray a system of reference which has been constructed historically in order to make sense of the world, shaping, at the same time, local identities. It is also argued that health promotion services may be evaluated as part of a system of values and ideologies, which reflects relations of power and domination between the users and providers of health services, a system which extends to other spheres of participation within the society. As a result, development of community resources and social networks, two highly relevant psychosocial aspects for the implementation of health-enhancing behaviour, can solely be understood within a wider perspective which includes issues of ideology and identity within a context of macro-social relations. Hence, dialogue and discussion may be key elements for the analysis of diverse systems of reference, which portray different forms of knowledge and construct different meanings, needs and expectations regarding health services.

Drawn from this perspective, the general aim of this research is to explore the conditions of production and transmission of representations of reproductive health, and their expression in daily practices. I highlight the relevance of local knowledge for, on the one hand, shaping practices towards reproductive health and official reproductive health programmes. Local practices are studied in terms of the levels of acceptance of health services by the Mayan communities. On the other hand, I explore how local knowledge relates to other systems of knowledge emanating from health institutions, the State and the Church. My intention is not to prove whether or not a theory is correct, but rather to demonstrate that the conceptual framework presented has the power to explain the issue under investigation.

1.2 Local knowledge of reproductive health: a qualitative study

In line with the aims of this research and the corroborating theoretical position, I favour the use of qualitative methodology. The selection is based on the following assumptions:

First, in order to explore the complexity of psychosocial phenomena related to the content, construction and transmission of everyday meanings and representations, it is necessary to include open-ended and in-depth methods of data collection and analysis (Farr, 1991). In this view, shared meanings, subjective viewpoints and social interactions are the starting point for any qualitative research which can be evaluated as a form of discourse (Harré, 1998) a system of symbols (Douglas, 1986) and everyday actions (Jodelet, 1990). These contentions are mutually constituted in the process of the construction and expression of representations, and are truly investigated by participating actively in the field of action, directly immersing oneself in people's experiences, and recorded with flexible research methods which allow the gathering of a wide range of data from different sources (Burgess, 1984). The heterogeneous reality of the Mayan people of Guatemala requires this approach: the inclusion of well suited open-ended methods that are able to depict what people think about their health *'on their own terms'* (Gervais and Jovchelovitch, 1998: 4).

Second, as was previously stated in the review of the literature, research design and intervention on healthcare issues in developing countries is characterised by an over-reliance on quantitative methodologies (MacPhail and Campbell, forthcoming), diminishing the complexity of psycho-social phenomena. In the case of Guatemala, research on health beliefs and practices is strongly associated with large-scale surveys based on 'individual centred' theoretical constructions (Betrand et al, 1979; Ward et al., 1992).[2] Systematic quantitative

[2] See chapter 3. 'Individual Level of Analysis'.

methods generate valuable descriptive data but, if they are applied as the sole referents of data collection and are drawn from inadequate theoretical positions, they cannot provide appropriate results. On the other hand, the available qualitative research on health issues suffers from a lack of scientific rigor and the absence of well-designed methods of data collection and analysis. Exploratory studies based on unsystematic qualitative methodologies and infused with the personal impressions of their authors, might also fail to shed light on the meaning of the social reality under investigation. This situation means that it is difficult to generate reliable information and to direct further research and intervention. Against this paradigm of social research on health enhancing behaviour, I intent to provide a deeper and more systematic analysis of how processes of reproductive health and illness are understood by the Mayan people.

Third, being an *insider researcher* allowed me to explore in more detail ethnographic data which it is only feasible to collect and analyse by using qualitative methods. In addition, by participating actively in the field within the scope of ethnographic research, I was able to make a contribution to the proposed theoretical framework, including the theory of social representations. According to Flick (1999), ethnography starts with a theoretical position of describing and analysing social settings and also 'aims at developing theories and their applications'(1999: 150). As entering the field is of central importance for this qualitative method, participation is highlighted by the inclusion of insiders as researchers, who are able to share similar backgrounds and understand 'historically constituted homemade discourses' (Toren, 1996: 33). According to Toren (1996) being an insider and/or an outsider with regard to the field of research may be analysed in terms of strangeness or familiarity with the field to be investigated by the researcher, although certain activities and discourses will always remain hidden from the view of the researcher as a stranger. In any case, conducting social research as a native brings with it several advantages, as Clifford (1986) highlights:

> Insiders studying their own cultures offer new angles of vision and depths of understanding. Their accounts are empowered and restricted in unique ways (1986: 9-10).

Taking advantage of being a native researcher applying qualitative methodology, I also hope to contribute to the field of healthcare research in Guatemala. As has been mentioned, this has been characterised by the participation of outsiders as researchers the methods of whom have restricted the scope of the investigation (Bertrand et al., 1979; Population Council, 1998). Nevertheless, given the characterisation of the participants involved in this research, in which a diverse cultural identity strongly defines the boundaries between being an insider or an outsider, issues of native involvement are far more complex than can be justified in this way. Therefore, I believe that this point deserves special attention and further clarification will follow.

The themes addressed above allow us to appreciate that, in order to explore the processes of everyday representations and generation of meanings, it is necessary to have a deeper involvement with the field of action by using flexible qualitative research methods. From this perspective, and in order to show how the theoretical framework of local systems of knowledge was applied, I shall go on to outline the diverse sources of data which were combined during the stages of data collection and analysis.

2 Application of the framework

In order to explore the local knowledge of a particular linguistic community of the Mayan population of Guatemala three different sources of data were combined: interviews with lay informants (users of health services) and interviews with key informants (providers of health services, community leaders and *comadronas*); focus groups with lay informants; and ongoing participant observation. The combination of different forms of data collection as well as the application of a specific theoretical framework which I believe appropriate to my data analysis, is justified by the issue of triangulation.

2.1 Triangulation

The principle of triangulation is used to describe the combination of different research methods that used in order to take into account as many different aspects of the problem as possible. Denzin (1989) argues that the combination of triangulation of data, triangulation of methods of data collection and triangulation of analysis is an essential task that the researcher has to undertake in the study of complex phenomena; considering the principle to be the 'the soundest strategy of theory construction' (1989: 236). Triangulation was first conceptualised as a strategy for validating results obtained with one single method (Flick, 1999). However, the focus has shifted to compiling knowledge from several sources of data, using a multi-source and multi-method design which increases the scope, depth and consistency of the methodological procedures.

In this thesis, triangulation of data and triangulation of theory are utilised. Different sources of data, space and time were assessed, establishing the substantive topics of the case being studied. Regarding this point, Lunt and Livingston (1996) argue that diverse contexts of data collection do not validate one another, but rather 'they illustrate the truism that different contexts generate different kinds of data with different meanings' (1996: 91). In this way, the data is approached using multiple theoretical perspectives in order to supply a sound theoretical construction applicable to the *local* reality. This integration allows a deeper interpretation and gives the researcher a general sense of reference and guidance in approaching the problem. It is hoped that the choice of methods used in this thesis will *contextualise* the analysis and provide beneficial answers to the fundamental questions posed by the research.

Methods	Actors
Interviews	• Lay informants (households, peasants) • Key informants (*comadronas*, Mayan priest, healers, health workers, local medical doctors)
Focus groups	• Lay informants (households, peasants)
Participant observation	• The Mayan K'iché communities

Table 2. The study: Methods and actors

2.2 The semi-structured interview: description and justification

The semi-structured interview is recognised as being a method of maintaining and generating conversations with people on a specific topic or range of topics. It allows the researcher to explore in-depth a particular sphere of social life and to become progressively acquainted with it (Flick, 1994). Groeben (1990) suggests that the semi-structured interview is characterised by the reconstruction of subjective theories, stating that the rich stock of knowledge possessed by individuals is expressed spontaneously in answering an open question. The belief is that, through this communicative process, individuals express their points of view, which are constructed and interpreted on the basis of their personal experiences, knowledge and the meanings they relate to the topic. The flexibility of this exploratory procedure does not mean that there is no direction to the enquiry; it means that the focus is originally broad but becomes progressively sharper as the enquiry proceeds (May, 1997). The posing of such questions helps to *sensitise* the respondent to different and new perspectives (Blumer, 1986).

In the field of social psychology of health, the semi-structured interview has not

enjoyed much recognition as a relevant method. There is a preference for more structured methodologies which can yield precise data. The work of Herzlich (1973) on representations of health and illness provides an example of exploratory research using open-ended interviews. However, Farr (1994) argues that data gathered from single interviews was interpreted as an individual construction of the reality, rather than as a social construction. Thus, in the field of social psychology of health, there is a need to apply flexible open-ended interviews, designed to gather meaningful themes as a social constructions. Given the objectives of this research, I would argue that the open-ended interview is a highly suitable method for exploring how representations of reproductive health are portrayed at the individual level (Jodelet 1984). By deepening individual viewpoints, an interview can provide a space for the production and transformation of representations through individual discourses and everyday conversations which are understood to be socially generated.

In this thesis, the semi-structured interview is also used as a method of collecting in-depth information about specific aspects of social life, which calls fora degree of expertise concerning the subject in question (interviews with *comadronas*, local health personnel, healers, medical doctors). Furthermore, it is utilised to delve deeper into some relevant topics garnered from focus groups or through participant observation (Lincon and Guba, 1985). By using open-ended interviews, I was able to gather information on sensitive topics which I perceived the informant wished to remain confidential (Lee, 1993). In this respect, it is argued that interviews also permit the creation of a potential private space where individuals can express, in some depth, their feelings, intentions, beliefs and knowledge which, in other public spaces, would have not been expressed. As Anderson et al. (1990) argue:

> Interviews with women can explore private realms such as reproduction, child rearing and sexuality to tell us what women actually did instead of what experts thought they did or should have done. Interviews can also tell us how women felt about what they

did and can interpret the personal meaning and value of particular activities (Anderson et al., 1990; quoted by May, 1997: 95).

From this perspective, it is important to take account of the personal contexts that people use to frame their accounts (Lunt and Livingstone, 1996) and specific past personal experiences. Therefore, through the semi-structured interview it is possible to explore the reality that mediates between the individual and the social world, a reality that reflects meanings, knowledge and actions.

2.2.1 Conducting the interviews

The majority of the interviews were conducted in the last two weeks of my visit. As stated earlier, I needed almost a month to become somewhat familiar with the surrounding issues and to get in contact with 'key' informants, health personnel or lay people who were willing to participate in an individual interview. The issue of voluntary participation deserves clarification. As was mentioned in Chapter 1, Guatemalan people have suffered from years of political, military and ideological repression, in which instruments of control were introduced in order to command people's actions and instil personal insecurity and fear. It is, of course, reflected in people's behaviour, particularly those living in rural areas or villages, where participation in social activities is undermined by fear and disbelief. Moreover, people are not used to talking about themselves, they do not know how to express an opinion, or personal feelings and disagreements within the public arena. They are also are not used to talking about their culture and traditions. They are regarded as sacred 'secrets', which cannot easily be shared. Thus, to find a voluntary informant required time and great effort. Nevertheless, after being in contact with the health personnel, participating in their daily activities, negotiating and sharing personal experiences, I succeeded in gaining their trust and confidence and got as many participants as I considered necessary.

The criteria for inclusion in the interviews wereas follwos: men and women of different reproductive ages who were willing to participate, who belonged to the linguistic community of K'iché and were living in the geographical area of the western highlands of Guatemala. 'Key' informants were selected for their position within the community (Mayan priest, *comadrona*, community leader), or their knowledge of, and expertise in reproductive health or health issues in the community. Lay informants were selected from focus group participants who showed enthusiasm to participate and initiative, or people encountered in informal meetings during the participant observation. In total, 15 interviews were conducted. The number of interviews was selected on the basis of the new contributions added. Open-ended questions were asked followed by probes, regarding issues of reproduction, childbearing, maternal care, family relations and satisfaction with the provision of health services.[3] Each interview with experts lasted approximately 90-120 minutes; the interviews with lay informants lasted 45-90 minutes. All interviews were tape-recorded, translated when necessary and transcribed verbatim.

	Lay informants	**Key informants**
Women (aged 20-65)	2 households (peasants, cloth-makers)	4 *comadronas* 1 health worker
Men (age 20-65)	3 households (peasants, rural workers)	1 Mayan priest 3 health workers 1 medical doctor

Table 3. Participants in semi-structured interviews

2.3 Focus groups: description and justification

Focus groups are widely used in social sciences where the aim is to explore shared meanings and understandings. Traditionally, the idea of using focus groups was to justify exploratory studies where little is known about the social

[3] See interview guides, Appendix II

phenomena of interest to the researcher (Stewart and Shamdasani, 1990). However, it is also argued that focus groups are being used as a stand-alone method rather than simply a source of ideas and interpretations for future research (Krueger, 1988; Morgan, 1988). In contemporary research practice, which explores the generation and negotiation of meanings through the processes of communication and interaction, focus groups are regarded as the simulation of various aspects of social relations and everyday communication (Lunt and Livingstone, 1996). In this way, the use of focus groups is grounded in a theoretical conception of the relationship between identity and discourses, both of which are present in social representations enquiries. Regarding the use of focus groups for social representations research, Lunt and Livingstone (1996) argue that:

> Moscovici outlines four conditions for the emergence of social representations that parallel features of the focus group: (a) the representation of an issue must emerge through the conversation of ordinary people (the focus group); (b) a vital contribution is provided by 'amateur scholars', who mediate between scientific knowledge and the laity ... (the moderator); (c) the debate is typically held at the time of social concern or crisis (the topicality of the research); and (d) the social representation may emerge through a variety of debate forms ... (qualitative data). Social representations are an ideal field for the application of group techniques(1996: 86).

Taking the point expressed above, in this thesis the focus group is used as a method for exploring to what extent the negotiation of categories of gender, childbearing or sex by lay people are the expression of their representations and local knowledge. Negotiation of meanings is derived from debate and contention (Billig, 1992), which are the bases of focus group discussions. In this way, discourse is one of the most important ways in which people negotiate understandings and accomplish social ends.

Looking at the aims of this research, we see that, in order to promote empowerment and development of local resources, it is first necessary to encourage dialogue and discussion. The expression of systems of knowledge, shared necessities and negotiation of meanings provides a frame of reference

upon which educational activities can be implemented. As Freire (1972: 81) argues, 'without dialogue there is no communication, and without communication there can be no true education'. True education can be reached through focus group discussions, where critical thinking emerges and alternative solutions are expressed by the participants. In this case, participants might also feel encouraged to talk about sensitive topics as they support each other, and do not feel 'evaluated' or disregarded (Lee, 1993). I also believe that group discussions create an environment of common understanding and reciprocity, where people who share a common identity and can find space to express their views on a problematic issue in a way that would not be feasible in other places. Therefore, given the singularity of this method, it is a highly valuable research tool for exploring the local knowledge of the Mayan people.

2.3.1 Conducting focus groups

As in the case of the semi-structured interviews, focus groups were conducted after being in the field for three weeks. Once in the field, it was easier to get access to – and to gain participation from– women rather than men. This was for the following reasons which were, in themselves, significant: to talk about reproduction and childbearing is regarded as an issue of 'concern to women' and it was almost impossible to gain participation from men (just one focus group with six participants). I tried to arrange a mixed sex group (women/men) with no success. And as reproductive health issues (childbearing, contraception, sexually transmitted diseases, family violence and so on) affect women more than men, women were more willing to participate in the hope of encountering 'solutions' to their problems.

Furthermore, the NGO with which I was working also prioritises work with women as part of a whole strategy of maternal/childcare and reproductive health. And finally, at times when it was feasible to go into the communities (from 8am to 4 pm), the majority of men were working in the cornfields or

downtown in the markets. Selection of participants followed the same criteria appliedd in the semi-structured interviews. In this case, a 'thematic universe' or general enquiry about their reproductive lives inaugurated the discussions, followed by probes (Freire, 1972: 86).

Discussions did not follow a particular sequence, affording the opportunity to discover new themes.[4] New generative themes were introduced only when the discussion repeated previous contributions, so I acted as a moderator when it was necessary. During the course of each group discussion a translator was essential, who, at the same time, served as a mediator between the participants and the researcher (translation from the native language K'iché to Spanish). All forms of interaction and participation established were recorded, being themselves significant to a deeper exploration of the issue under investigation. For example, in some groups (mainly among the elder members) they spontaneously chose a moderator who would transmit the information first to the translator and afterwards to me. After several sessions the way was opened to a more direct dialogue.

In total six focus groups were conducted, five with women and one with men. The number of groups was selected on the basis of the new contributions added and when it was noted that discussions were repeating previous statements. Each discussion lasted approximately 60–120 minutes. All were tape-recorded, translated when necessary and transcribed verbatim. The following table presents data about the composition of the focus groups.

[4] See Focus groups guides Appendix III.

	Lay informants	Occupation	Region Village
Women (aged 16-26)	2 groups	Clothing maker Peasants	San Francisco la Union Limasaj
Women (aged 26-64)	1 group 2 groups	Midwives Peasants	San Francisco el Alto Limasaj Palomora
Men (aged 24-45)	1 group	Trade/ Commercial	Pavatok

Table 4. Focus groups participants

2.4 Participant observation: description and justification

> It is ... my belief that any group of persons – prisoners, primitives, pilots or patients – develop a life of their own that becomes meaningful, reasonable and normal once one gets close to it, and that a good way to learn about any of these worlds is to submit oneself in the company of the members to the daily round of petty contingencies to which they are subject (Goffman, 1967, quoted by Lofland, 1971: 1)

Participant observation has been used in social research as a method of garnering information *in situ* regarding human meaning and interaction, which requires a direct involvement in a variety of forms. Its definition and application varies greatly within the fields of anthropological and sociological research, as there is a wide range of research techniques that can be interpreted as participant observation. For example, some advocates of participant observation prefer to gather information by moving overtly among people (May, 1997), others favour being a concealed unknown observer (Jorgensen, 1989); some encourage systematic counting on protocol sheets (Burgess, 1990) and others prioritise gathering all kinds of information derived from day-to-day interaction within the field and recorded in the form of field notes (Toren, 1996). As has been widely described, selection of the type of observation strategy depends on the circumstances of the field of action, the research

questions and the characteristics of the object of investigation (Flick, 1999).

There is a wide range of social situations in which participant observation may be a appropriate research tool. For instance, it is particularly suited to situations in which people are unable to talk or to express themselves due to language barriers or disabilities (Hammersley and Atkinson, 1995) or in other circumstances where people are so familiar with their context that they think there is nothing to comment upon (Lofland, 1971). Both situations are present within the context of this study.

In an attempt to provide a wider definition of participant observation from which a deeper analysis of social phenomena can be drawn, Denzin (1989) suggests that participant observation could be defined as a 'field strategy that simultaneously combines document analysis, interviewing of respondents and informants, direct participation and observation and introspection' (1989: 17-18). Instead of being defined as a single method, it actually refers to a combination of methods that permit a greater and richer interaction with the field of study.

Within the study of the conceptualisation of health and illness and, more precisely, in the analysis of the local knowledge underlying health behaviour, participant observation has enjoyed much recognition as a relevant method (Jodelet, 1984). Conditions of emergence and production of local knowledge are to be found in symbolic practices and shared meanings. And it is precisely through the observation of social interaction and practices that symbolic meanings are better comprehended. Ethnographic observation also promotes a more valid analysis of the narrative material and allows the researcher to link discourse and practice (Toren, 1996). For example, observation reveals aspects of a situation that discourses do not mention or omit from their accounts. Such omissions often suggest underlying assumptions about shared local knowledge (Gervais, 1997). Culture, beliefs and knowledge are grounded in practices

which, in turn, create new practices and knowledge: 'it is a context, something within which they can be intelligibly — that is, thickly-described' (Geertz, 1973: 14). Description and interpretation of cultures requires commitment and observation of practices, an active participation in the research field. Therefore, in order to capture the relevance of these issues, in this research participant observation is applied as MacCall and Simmons (1969) suggest:

> ... it involves some amount of genuinely social interaction in the field with the subject of the study, some direct observation of relevant events, some formal and a great deal of informal interviewing ... some collection of documents and artefacts, and open-endedness in the direction the study takes (1969: 1).

Considering the object of my research, I regard participant observation to be a particularly relevant tool. If my aim is to understand Mayan reproductive health practices, attitudes towards health services, family traditions around childbearing and the meaning that reproduction has for Mayan people, I should immerse myself in their daily life expressions, rejections, adversities and traditions. And, if representations are to be found in the knowledge, practices and symbols of everyday life which, in turn, are the conditions of the latter's production and emergence, one has to opt to be a witness of people's 'daily process of "making culture" rather than "having culture"' (Crossley, 1996: 6). I hope that this choice of methodology is fully justified in accomplishing my research aims.

2.4.1 Procedure

My observational activities started from the moment that I arrived in Quetzaltenango, the main county of the western highlands of Guatemala. As I stated earlier, during the first two weeks of my visit, I participated in the healthcare promotional activities and vaccination campaigns undertaken by a local NGO. I did not have the opportunity to stay overnight in the villages and people's homes as the main bases were set up in the town of Xela. Nevertheless, after some daily visits to the communities I was able to get in contact with local

leaders and key informants. My first impressions were gathered inside the homes of Mayan women – mothers, grandmothers, mothers-in-law, sisters – who were strongly against themselves and their children being vaccinated. I recorded my activities in a fieldwork diary – village, protagonist, reactions, health personnel's responses, etc. – conducted some informal interviews, participated in discussions held by the health personnel and also drew up some preliminary interpretations of these events.

After three weeks, the campaign finished and I involved myself in the ordinary activities of the NGO. I joined a sub-team of health personnel who were appointed to carry out a research project on contraceptive use financed by the Population Council. I participated in their meetings, joined them in their activities inside the villages, cooperated in training sessions with women's and midwives groups, got in contact with health personnel from the Ministry of Health and collected documents pertaining to recent research projects on health, reproduction and development. I was also invited inside people's homes, shared meals, observed the family environment, and the work of midwives and participated in a Mayan ceremony with Mayan healers and priests. My observations were carried out during eight weeks of fieldwork and were recorded in a fieldwork diary. All my notes, documents and observations generated data in their own right or were used as 'background knowledge' supporting the data collected usingother methods (Gervais, 1997: 31).

3. Obtaining entrée: being an insider 'outsider'

The issue of being an insider researcher merits special clarification. Access to the NGO health personnel was possible as I had worked with them on previous research projects. Nevertheless, to gain entry to the Mayan villages and small towns and inside people's homes would not have been feasible without the presence of a health worker or a member of the community centre, who were themselves Mayan. During my stay in the region, I always had to be

accompanied by a native K'iché who could take me inside the life of the community and introduce me to people with whom I could speak. Despite my Guatemalan background – coming from the mixed 'Ladino' background – Mayan people saw me as an outsider since, as has been mentioned before, there are strict boundaries that separate Indians and *Ladinos*. I do not share certain commonalties with them: do not speak the native language, do not wear their native costumes and do not face the same problematic situations – for instance, I was not pregnant myself, not married and did not have seven children. For centuries, they have learnt to defend their cultural traditions with silence and scepticism towards strangers and foreigners. Nevertheless, the mere fact that I was engaged in the problem being studied and showed interest in gathering information about their cultural traditions allowed me, in time, to become well enough accepted by them and integrated in their community. My position as an insider 'outsider' allowed me to gather different information and knowledge that offered new perspectives and depths of understanding on the subject. But, above all, the existence of a mutual intention to learn about each other's thoughts and systems of reference created an environment of reciprocity and understanding. I was not there just to explore and to hear about their lives and experiences as the 'object' of my study. I was there to share with them my experiences and positions as well. It was not until we opened a legitimate and reciprocal dialogue that the real entrée began.

4. Analysis

The data collected from each interview and focus group were analysed for their content. This analysis was supported by the computer software programme Atlas/ti (textinterpretation, textmanagement and theory building) (Muhr, 1997). Prior to the explanation of the procedures undertaken in the data analysis, I shall state some basic general criteria which underlie the analysis of both focus groups and interviews:

First, The analysis was based on a bottom-up strategy, seeking generative themes or meaningful thematics in people's discourses (Freire, 1972). All generative themes and subsequent domains originated – categories and sub categories – emerge from the data and are based on the respondent's own descriptions and concerns. *Second,* the processes of selecting the meaningful thematics are not developed in isolation. Selection of generative themes is made in an attempt to discover the links that these topics have with other themes, order of emergence and a concern for their specific contextual base. It is also supported by data derived from participant observation and fieldwork notes. *Third,* repetitions of discourses, non-verbal communication, abrupt changes, accentuations, style of interactions and the contextual conditions in which discourses are grounded all generate data in their own right, or serve as background knowledge for further interpretation. In the following section I describe the procedure of selection of generative themes and the subsequent coding frameworks.

4.1 Procedure of analysis

What are termed meaningful thematics comprise all the general topics that emerged from the first and most general enquiry of this research (for example, ideas about reproductive health). The general topics were selected by recording a systematic account of common discourses, taking into consideration their sequential structure and occurrence of repetitions. In the first instance, the topics that came forward after this first selection were treated as one entity, regardless of the various themes and links that these universal ideas have between each other. This was done with the purpose of avoiding repetition and reducing the risk of losing focus. From the huge amount of data gathered at the beginning of the analysis, three meaningful themes were selected: i) reproductive health and productive activities; ii) reproductive health and gender relations; and iii) reproductive health and community participation in

health interventions. These three general themes constitute the main topics of each of the chapters presented in the analysis of the thesis.

Having selected the central topics, the second step was the creation of categories, sub-categories and examples – quotations– for each of the central themes. In this sense, ATLAS.ti provides a useful tool for the organisation of textual data –discourses– and for the construction of ground-based theories. ATLAS.ti allows one build a frame of reference based on codes and networks between the data. From the analysis of these coding frames and the links established between them, further categories and sub-categories can be derived.

In this thesis, selection of the main codes was based on two criteria. *First,* the occurrence of quotations –sequential structure – congregated around each code. In this sense, by using ATLAS.ti I was able to count a number of quotations that are related to a given code. For instance, by reviewing the text of one single interview, the code 'family planning' was created. This means that this specific topic was mentioned repeatedly in the text. After a code has been created, ATLAS.ti categorises each code a symbol such as the following{ 3~0}. This is an important nomination since it allows us to explore how relevant a code is within the text. The first number displays the number of quotations already coded for a particular term. The larger this number, the more evidence has already been found for this code in the data. And the number following the dash is the number of other codes linked with this code. For instance, how the code 'family planning' is related to the code 'ethnic identity'. According to Muhr (1997), codes with large numbers can be interpreted as having a high degree of theoretical consistency. But this latter characteristic belongs to the networking and links procedure that will be explained below.

The *second* criteria for coding selection were not based on numeric evidence, but rather on the author's criteria about the significance that a given code has for the data as a whole. This evidence was supported by data gathered during

participant observation, the exploration of non-verbal communication, field notes and contextual meanings. For instance, some codes that were not repeatedly mentioned within the text, were otherwise included within the analysis as they represented valid data of value as background-knowledge, as a linked code, or as a stand alone code.

Having created the thematic universe and made the first selection of codes, the third step corresponded to the construction of links and connections between codes. Since ATLAS.ti makes no restriction on the number of codes assigned to a quotation and vice versa, a code may refer to an arbitrary – and enormous – number of quotations. This means that one has to follow a process of linkage, discrimination and discarding of codes and quotations. The criteria for doing so follows the same parameters as the first selection of codes: the sequential evidence that a given code has in the data and the researcher's theoretical criterion. The principle of 'linkage of codes' was based on conceptual similarities that these codes had between each other and the correspondent quotations.

Having analysed commonalities across discourses, selected the main codes, linkage of codes and networks, the last step in the analysis corresponded to the exploration of variation of data and 'interesting exemptions'. Before discarding the data that had not been included – codes and quotations – I proceeded to select a number of codes that diverged from the general statements chosen previously. By doing so, I also established an appropriate interconnection between each one, and selected the ones that, in my point of view, contributed to a better understanding of the data. These 'interesting exemptions' were also analysed by their fundamental links with the meaningful thematics, taking into consideration their specific contextual base.

Participant observation is also content analysed. The analysis of reports, the fieldwork diary and special documents follows the same criteria described

above. Systematic accounts of observations are included in the analysis of the context, style of interactions and description of the setting. As stated before, all these data support or enrich the information gathered using other methods.

5. Conclusions

The aim of this chapter was to present the methodological issues considered during the process of data collection and analysis. The selection of the methodological principles follows the accomplishment of my research questions and interest. I argue here that health beliefs and related practices of reproductive health are an interesting case study of the conceptual framework of local systems of knowledge. As a result, and given the complexity of the issues involved, I favour the use of qualitative methodology through which I have been able to gather wider information about the local knowledge of the communities being studied. In sum:

1. The conceptual framework of local systems of knowledge was applied through semi-structured interviews, focus groups and participant observation.

2. In total 15 open-ended interviews were conducted (with lay informants and key informants).

3. Six focus groups were conducted with lay informants (one group of men and five of women from different reproductive health ages).

4. Participant observation was used as a form of direct interaction, informal interviewing, observation, collection and revision of documents.

5. Issues of entrée were explored, together with a detailed exploration of the procedures of data analysis.

PART III

ANALYSIS

Chapter 6

An Agrarian Culture: Building Everyday Life Knowledge of Reproductive Health

1	The notion of 'Mother Earth': a link between production and reproduction
1.1	Mother Earth and the concept of territoriality
1.1.1	The domestic space: production and reproduction in a social setting
1.1.2	The Mayan family as a complex unit of social analysis
1.2	The Mayan cosmology: a dyad between nature and reproduction
1.2.1	Choosing day and time through 'Nahuales'
2	Cultural practices
2.1	The placenta language
2.2	*Temascal* baths
2.3	The *comadrona*'s work
3	Variation of data: stability and change in the representational field
4	Conclusions

The findings presented in this chapter result from the analysis of the data gathered from participant observation – direct observation, informal interviewing and revision of some documents – and the general themes that emerged in the interviews and focus groups. Three main points are analysed and discussed: (i) generative representations of reproductive health; (ii) Cultural practices; (iii) variation of data. First, I examine the main generative representations of reproductive health, demonstrating how these representations are directly linked to the concepts of territoriality, agrarian production and family. The main generative theme of 'Mother Earth' is the cornerstone of the Mayan's daily life, giving meaning to their productive and reproductive activities. This main concept is linked to other sub-categories such as the symbolic aspects of the land, material aspects of territoriality and the domestic space. All together represent the scenario from which reproductive practices are fostered and are expressed symbolically through the Mayan calendar system. As a second point, I will go on to analyse the practices of reproductive health. Here I examine the main practices which are linked to the binomial category of reproduction/production, analysing the symbolic meanings of conception, delivery and childbearing. And third, I present a preliminary analysis of variation of data. In this sub-section I show

that changes in productive activities, social position and economic situation produce concomitant changes in these people's reproductive health conceptualisations and practices. This demonstration of preliminary findings and presentation of data forms the basis of further analysis that will be presented in subsequent chapters.

1. The notion of 'Mother Earth': a link between production and reproduction

What is known as 'Mother Earth' comprises all aspects related to the social dynamics that communities construct around their activities of land production and their relations with nature. This narrative of origins includes two main domains: Home Fields and The Mayan Calendar. The domain Home Fields is, in turn, divided into three sub-categories. The first represents all material aspects related to territoriality and land property: its location, extension, productive capacity, potentiality of distribution, commerce and social interchange around agricultural activities. The second sub-category makes reference to the domestic space in which social activities around land production take place: the house, the fields, the social distribution of labour within the family (children, adolescents, adults and the elderly) and systems of land inheritance. And the third represents the Mayan family as a unit of social analysis. The second domain, or the Mayan calendar, represents the symbolic aspects of land activity. It also encompasses the versatile meanings of the productive and reproductive processes according to Mayan cosmology. These two domains are intrinsically interconnected; one is not separated from the other. As we will see, they form the basis of Mayan cultural identity from which all aspects related to their reproductive lives are derived. In what follows, I discuss in more detail each domain and its related sub-spheres. For the purposes of a better understanding of the context, I will include some description of the setting and activities involved.

1.1 Mother Earth and the concept of territoriality

> Indigenous life is directly linked to the agricultural activity in the fields ... nothing else, or it's better to say, everything else depends on this. So, in this sense, the more land they have, the more they would then think about having more children who can participate in the agricultural work. It is as if they are still living 500 years ago, they don't have land anymore!, it's difficult to understand ... but they still hold out hope of having it **(Interview, Expert, man).**

Peasant economies are based on an intensive use of labour force for the production of agricultural activities (Van Der Werf, 1990). The direct and daily contact with nature implies a profound immersion into its dynamic: the maintenance of the fields, the harvest, its production and distribution. Their relationship with the land does not only follow economic principles; it involves a complex system of reference in which territory, family and nature form a single unit. As a collectivist society, land tenancy and property signifies an extension of a cultural patrimony beyond the limits of fences. Activities of land production are socially distributed depending on age and level of expertise, within single families or as a form of combined effort in which the whole community undertakes an action. According to Cabrera (1992), by sharing agricultural production with other community members, social patrimony is expanded with the practice of a system of inheritance through marriage or common union. This action secures the prolongation and distribution of property not just in terms of its production, but as a form of social inheritance of the practice of agriculture.

The case of K'iché families certainly follows the principles of agricultural societies, in which profound boundaries attach families to their lands. The productive use of land involves the institution of several actions that not only ensure a source of income, but also represent a form of cohesion between family and community members. Men, for example, are the producers of land resources, being in charge of their commercialisation. To women falls the duty of administration of resources and decisions about their use; whether they

will be utilised for local consumption or commerce. Children also participate in these actions, as a collectors of the products, transporting the daily food to the father who is working in the fields, or producing the aliments with their mothers. It is a priority in each family to secure the basic requirements of daily consumption before starting the processes of distribution. Their role as enhancers of, rather than takers from, the natural environment defines their spheres of social relations. As one young peasant affirms:

> We work in the fields for eating, we don't eat for working, as other people do. In the fields, we work a lot but we eat this. Although it is just a few things, we make them. Downtown, people don't make anything, they just buy ... I've been doing this for years, my father showed me how to do it ... my children work with me as well. But this land is not just ours, it also belongs to my brother-in-law and his children ...we share it. It's little what we can get with this **(informal interview).**

The social organisation related to land production determines alternative activities in all other aspects of their life. As agrarian duties are key signifiers of their way of living, the productive capacity of the land, or its decline, determines the future stability of a family, a village or an entire community. If family work is not enough to satisfy the requirements of land production, it is then necessary to employ other workers within the village. And if sufficient labour is not available from local workers, employees from outside the local community should be engaged. In this sense, land ownership and its production is associated with the number of family members that are able to make a contribution towards its improvement. This meaning of territoriality is directly manifested in the Mayan's reproductive behaviour. The possibility of having large families represents an economic gain rather than a cost, as children can provide future economic subsistence for their parents and the legacy of land production can be prolonged. It was precisely through the discussion of issues related to their agricultural conditions of living, that the topics about reproduction emerged.

Throughout the course of my field work, I observed that communities that had stronger links with the agricultural activity and promoted internal contracts for its production, at the same time retained several particularities: They were inclined to keep their language (traditional K'iché without the influence of the Spanish language), showed a stronger attachment to their religious practices, tended to maintain their traditional costume and had a positive sense of ethnic affirmation. On the other hand, they were also more resistant to health aid from organisations and had the tendency to have large families. Their representations of reproduction are determined by the links they have with their lands, which are, in turn, a cultural expression of a historically compounded sense of identity.

Their role as 'producers' of a natural resource that, at the same time, is the source of daily food, social interchange and reproductive health, attaches them closely to it. Likewise, the domestic space becomes the social setting in which activities of land production are grounded and within which private reproductive health practices are negotiated.

1.1.1 The domestic space: production and reproduction in a social setting

As stated previously the Mayans construct their representations of reproductive health around key notions of territoriality, land production and family. These notions represent a complex relationship with their natural social setting and establish new forms of social interactions. León y Deere (1986) point out that the domestic space constitutes the social setting for both productive and reproductive activities. It is within the private domain that a number of social, economic and emotional interactions are established and negotiated. These relationships not only determine other spheres of social participation but also construct and reconstruct new meanings and practices.

In the Mayan social setting, the domestic unit is shared by the whole family group and includes the house, patio, corrals, latrine and *temascal* ('sauna room'). The quality of their houses (type of material used for the construction, location, size and space division) obeys socioeconomic principles. They vary between each community depending on their income and access to social services. Usually, within villages and small towns, houses consist of just one single room without sub-divisions. Within it, all productive activities and interactions are established – the fire, food preparation, eating, sleeping, sex, birth and also death. As a result families suffer from lack of private space and overcrowding. This situation also diminishes the quality of living conditions, as resources are not enough to satisfy the physical social and psychological needs of various generations interacting within one single space.

Outside the limits of the Mayan home, there are a number of social settings that correspond to the community's organisation of their domestic space, among the most salient of these is the *temascal* bath. *Temascal* – or *Tuj* in K'iché, which means heat – is an indispensable element within the productive and reproductive boundaries of a Mayan community. It is a kind of sauna that is used for several purposes: hygiene, therapeutic purposes, prevention and curing diseases and it is especially used for all aspects related to the pregnancy and post-delivery processes. Sick children and pregnant women who have to receive systematic therapeutic baths after delivery are given priority.[1] The *temascal* sauna is also utilised for searing maize and other kind of seeds.

Each member of the family has diverse responsibilities in the adequate maintenance of the domestic space, but the main duties for its administration correspond to women: they are the key signifiers in the construction of its productive and reproductive activities. In relation to the productive activities, women are the ones who generate income for the household, in such activities

[1] The practice of *temascal* baths has a symbolic meaning that will be analysed further.

as ambulant commerce (selling vegetables, grains), production of handicrafts (fabrication of traditional cloth, sleeping-mats, textiles, etc.) and the domestic economy (breeding and selling animals, such as hens and pigs). Their reproductive activities comprise all actions related to maintaining the home (doing housework, grinding maize, carrying wood); and the conception, bearing and rearing of their children (socialisation, education and health conservation). These issues place new demands on women's quality of life and situate them as the main focus of social analysis within the boundaries of a family system.

Reviewing the meaning of the domestic space Moore (1986: 71) argues that people live through actions performed in structured space and time. The organisation of the material space that surrounds communities gives meaning to the social distinctions that strengthen their 'social relations, symbolic systems, forms of labour and quotidian intimacies'. As communities are divided into gender specific domains and spaces, and into gender specific tasks, the organisation of space reflects the hierarchical nature of relations between men and women. Looking at the case of the Mayan domestic setting, both women and men undertake a diverse set of tasks within the household, which denotes diverse forms of knowledge of productive and reproductive actions. Men are in charge of the productive activities engaged outside the limits of the community: large scale production and commerce. But within the home fields boundaries, such productive and reproductive actions and knowledge rests mainly on the shoulders of women. The importance of community life lies in this integration of the diverse social, psychological, symbolic and economic relationships engaged in the productive and reproductive activities. And it is precisely through family interactions that these engagements find a form of expression and dissemination. Following this discussion, in the next sections I explore how this system of land production is transmitted over generations and how it is linked to the concept of family and reproduction.

1.1.2 The Mayan family as a complex unit of social analysis

Within the confines of the home, the Ki'ché family follows the model of agricultural societies: that is to say, patriarchal, monogamous and extensive, in which the authority of elders is highly respected (Meillassoux, 1987; Cabrera, 1992). Within the same household several generations interact with one another, establishing closer links and interactions. Within the Mayan families studied, age is a particularly strong determinant of people's position within the family unit, their status improving as they grow older. In fact, control over productive and reproductive resources, including the essential knowledge required for the assured reproduction of Mayan families, is invested in the elderly. As Meillassoux (1987) argues, age and sex are regularly used as organisational principles in social systems, the primary function of this age hierarchy being the social reproduction of society. In this sense, the key institution supporting this reproduction is marriage.

Moore (1986: 62) adds to this discussion, stating that marriage is an extremely important feature of a family in traditional societies, as it links the formal system of social reproduction 'with the means by which command over resources and reproduction is achieved'. It is for this reason that within the Mayan families, unions and marriages follow strict principles of lineage and the choice of future partner is carefully analysed by family members, but particularly by the grandparents. If a grandparent rejects the choice of his grandson, it will be difficult to change his/her mind. The elderly are the ones in charge of the administration of the social patrimony acquired and transmitted through marriage:

> In our families, our grandparents are the past and grandsons are the future. So, we try to combine the way in which the past exchanges with the future. You can see this exchange when someone in the family decides to get married. We have several meetings with the family members and between both families ... it is a process of negotiation until an agreement is reached. But the last word goes to the grandparents. They have the wisdom and knowledge to decide

> what is the best for us ... for the whole family **(informal interview, man).**

In this sense, marriage and its physical location – the household – are not only the site of social reproduction, they are also the focus of interpersonal relations. It is a tradition that when the son of a nuclear family marries, his wife has to come to live with her new family, until the couple inherit a piece of land and become independent. As an informal interviewee expresses it: 'we lose a daughter, but we gain a daughter-in-law'. Often, the detachment from the nuclear family takes longer than desired, as land scarcity is one of the main impediments to their independence. Once a woman gets married she becomes part of the new family, her husband's parents replace hers, and her mother-in-law becomes a central figure in the woman's future life. The mother-in-law is the judge, companion, consultant of the woman's decisions and actions in relation to her productive/reproductive activities. The two of them will interact and negotiate their reproductive and gender spaces (Angin and Shorter, 1998).

Since age and sex are the core principles in the social organisation of a family unit —considering that both affect the prolongation of the reproductive system —age at marriage is an important aspect to be analysed within the family structure. In Mayan communities, men usually marry at the age of 16–18, and women at 14–18. In the case of women it depends on her menarche, as it is considered to be the signal of her reproductive life:

> Men have to start finding a woman around the age of 20, more or less. But women should be married before reaching their twenties (...) I have two daughters and they are ready to find a husband – they are 14 and 16 – but I want to be careful ... I respect their decisions, because once they are married I don't have anything to do with their lives. If, in any case, their husbands become bad men, it is no longer my duty to support them ... I have nothing to say in that conflict. So it's better to be sure before they make that step **(interview, lay informant, man).**

Early marriage is distinctive of agricultural societies (Kunitz, 1990). It enables the continuation of a family boundary and guarantees the system of land inheritance. However, early marriage is also strongly conditioned by the concrete conditions of life. Both men and women gain rights in land and livestock when they marry. It is men who control and have ultimate rights over land, but women also acquire some rights, which they use to improve their positions, to feed the family and to support their children. During the course of this study, it was observed that communities that are more attached to land production – such as Xajabal, Nimasaj, Palomora – also tend to promote earlier marriage and have larger families. In this sense, decisions regarding early marriage are associated with the family's awareness of the impoverished standard of living they experience. The choice of early marriage – and concomitant large families – serves as a response to these objective conditions, which permits families to build strategies of survival. For example, awareness of their short life expectancy might mean an early marriage offers the best chance of seeing their children grow up and to have a large family is seen as the best way of compensating for the high levels infant mortality among Mayan children:

> The earlier the better. I started at the age of 14, and had eight. Three of them died, but I brought them up ... all of them. I was with them all the time... My *comadre* (godmother), just to name someone, she started very late and did not have the time to see them ... to see her grandchildren **(interview, lay informant, woman).**

> I think it is a matter of survival, given the conditions of poverty in which people live. Believe me, I have seen some families close to Santa Clara la Laguna, for example, a family of eight children. Three of them were named after their father, Valeriano. Instead of calling them Pedro, Carlos or Juan, they had the same name ... So I asked the mother, why did you give the same name to three of your boys?, and she answered me, 'because I want the name Valeriano to stay with us'. I think she felt that was better to secure the name in the family as soon as possible ... If you go around, you can see many cases like this **(interview, expert man).**

Given the high tendency towards early marriage, it is not surprising to find grandmothers aged 28 or 30. This tendency increases maternal morbidity,

reducing the life expectancy for the mother and child. In this respect, child morbidity signifies a dual failure for the mother and the whole family. Children represent the possibility of economic support and their mortality erodes parent's expectations. Besides this economic principle, early infant mortality suggests a woman's failure in her maternal function, a social and cultural role for which women in rural areas have been educated. This decline also affects psychological development, as is the case of children and adolescents. These generations have labour obligations to their parents, are prematurely engaged in reproductive activities, and from an early age have to struggle to provide economic sustenance for their young families. They do not have the opportunity to experience full childhood or adolescence, as they jump straight from being a young child to being young adults.

Through the course of the above descriptions we were able to identify that the Mayan's attachment to their lands defines their daily way of life and the quality of social relations. These representations are an important resource to maintain a living Mayan identity, shaping and constructing their everyday life knowledge, not just in relation to their reproductive health reality, but in all other spheres of social participation. These representations also construct the scenario in which all other activities encounter and create a space of social interaction, where family and community members undertake a combined action. The communities studied relate their traditional system of knowledge of reproductive health to their concrete conditions of living. The fact that this population established a strong relationship with their lands not only obeys prevalent economic principles, but it also emerges as a product of the historical social exclusion and deprivation with which they continue to correspond (Hall, 1996). But above all, the meaning of territoriality represents a sense of identity compounded by history, a distinctiveness that is manifested in their links with their land and family and expressed through language, costume, religion and traditions.

The activities of land production, spatial organisation of territory, marriage and ways of interacting, all form a cycle that signifies the perpetuation of life and identity. Clearly, to have children and the expansion of their land possessions are issues of vital importance to the Mayans, not to be understood merely in terms of economic principles. Equally, the meanings of reproduction and land production are to be found in the Mayan's ancient narrative of origin which is represented by the complexity of their calendar system. Thus, the tendency to have large families is not just associated with land production, it has to do with the whole concept of collectivity, life and reciprocal exchange with nature that the Mayans hold. These representative meanings are intrinsically related to their traditional cosmology, which is at the same time, connected to their representations of reproductive health. In order to explore Mayan reproductive cosmology in more detail, I shall go on to examine more closely the main domains that emerged from this analysis: the relationship between the nature and reproduction, and the 'meaningful days' for reproduction. Both domains are crucial to understanding the ways in which the Mayan people construct their meanings of reproductive health, based on their experiences with the natural world and territory.

1.2 The Mayan cosmology: a dyad between nature and reproduction

> Women are like the land, they have humid times and dry times. The humid 'age' means that she is ready to be pregnant, and during the dry times, even if the seed is there, they cannot have family. It is like nature, you cannot sow corn from November to April ... everything is dry ... you have to wait for the rain **(Informal interview, man).**

As was explored earlier, the concept of territoriality and nature is directly linked to the concept of family and reproduction for the Mayan people. Likewise, it is also related to the concept of life, development and death. These three aspects are directly expressed in the Mayan calendar system, which is based on the dialectical fusion between the woman's reproductive cycle and the processes of maize germination (Copmagua, 1999; Watanabe, 1992), a system that is represented through the agricultural activity in the

production of maize, the complement of daily consumption and commerce. The sowing and harvesting of maize possesses a symbolic meaning: it represents the source of daily maintenance, of health and reproduction (Cabrera, 1992). As stated in Chapter 1, one of the Mayan calendar systems consist of 260 days, 9 months and 28 days, and is applied to the control of crops and divination. Its use is better explained by an elderly health worker:

> The Mayan calendar is precisely based on the period of women's gestation that lasts nine months. It is not that our life has to adapt to the calendar, as the Ladino calendar shows (the Gregorian calendar) ... but the real explanation is that the calendar was based on men's and women's life cycle ... It is also based on the period of maize production ... It is very clear, you see, from the moment you sow maize until it is collected in the harvest, it also has a vegetative cycle of nine months ... I mean, at least in this territory of 'cold land', you have to wait nine months to collect the first crops. These two elements are combined, the nine months that a woman needs for childbirth and the life-cycle of maize ... It is also related to the moon-cycles, that is to say, both women and maize are related to this **(interview, expert, man).**

The above description shows that Mayan reproductive health knowledge is objectified in the use of land, as the ancient Mayan narrative of origin shows. Nature and reproduction form a single system in which each interacts with the other. Their life concept represents a continuum that begins at the moment of conception and terminates in death. Both events are natural part of life and are perceived as being unavoidable, since they conform to an intrinsic component of the forces of nature.

Other studies of K'iché beliefs state that this system of reference is prevalent not just in relation to the concept of reproduction, but in relation to health as a whole (Marcos, 1989; Hurtado, 1992; Zur, 1995). Life starts in the moment of procreation and it will continue if people retain an equilibrium with nature. Their bodies have to search for this balance, maintaining healthy eating habits, controlling their body temperature – hot or cold – and through the establishment of good social relations based on mutual understanding and comprehension. Since their bodies and minds are strongly connected to

natural forces, any change or alteration in these forces will affect the general state of their mental and physical health. For example, it is believed that an individual's strong feelings can result not only in harm to the person expressing them but also to the other people in the community in the form of illness, death or some other calamity such as the destruction of a person's corn crops.

This system of belief was prevalent in the data of this study and expressed openly in reference to pregnant women, who are recognised as being the most sensitive recipients of all the positive or negative aspects of their social and natural surroundings:

> We explain to them that the child they carry inside will survive if they take in good food, if they don't go around in the mist or when there is a full moon. If their husbands fight with them, it is better to avoid all the anger ... They also have to run away when a group of women are around, they might give the child the evil eye ... and the child will die full of infection **(interview, *comadrona*, woman).**

As such, the analogy between human beings and nature is best represented in the ancient Mayan millenary account of their ancestors. This calendar links the process of fertility of land with fertility of humans and, therefore, involves women as a central figure. Based on these principles, the whole concept of human reproduction is a key notion for the Mayans and expressed in multivariate forms.[2] One of them, and that most mentioned among the participants, is the concept of *Nahuales* or 'meaningful days' for reproduction.

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[2] The Mayan cosmology is best represented in the ancient Ki'ché book *Pop Wuj* (or the Mayan Bible) which relates the stories of the origin of human civilisation. It is stated that human beings come from the maize (*mazorca*), which grows from the mother land (*Ixquik*) and the grandmother (*Ixmucanek*). The first ancestors made several 'tests' to prove what would be the best origin of the first men and women: they tried with wood, with water and mud, with no success. In the end, they decided that the best option would be the maize, which is able to resist wind, water and fire. (Anonymous, *Pop Wuj. Poema mito-histórico Ki'ché,* translated by Adrian Chávez).

1.2.1 Choosing day and time through 'Nahuales'

The Mayan people are constantly searching for equilibrium with nature and with the world around them. This is reflected in the Mayan calendar, in which each day possesses a meaning or *nahual*, positive or negative. Both qualities are useful to regulate the divergent forces necessary for the construction of a social interaction full of harmony. This qualitative meaning of days helps people to orient themselves in the world, choosing the best time for performing their daily activities. This world includes, sowing, harvesting, visiting the healer, buying their daily food, and so on. On the basis of this system it is also possible to identify the best day and period for conception and delivery, as is noted in the following statement:

> People called me very early in the morning and said she was ready for the delivery. It was rainy and windy ... I didn't want to attend her, she looked so bad, but I didn't want to do anything ... 'the child has to wait', I thought. 'If he waits one day more, he will find his way around ... he will be happy and brave, today is not his *nahual*'... This kind of certainty doesn't come too often. But I was sure ... And she waited ...you just have to see this boy today! **(interview, *comadrona*, woman).**

Likewise, it is believed that the combination of positive and negative aspects will construct the future personality of the child, or will decide his/her future vocation. On the other hand, the avoidance of this principle could lead to the opposite effect:

> Each couple is able to decide how their children will be. If they want to have someone intelligent ... so they have to join two forces ... It was for the wellbeing of the community, for example: if I already have a lazy but intelligent child, so the next one will be active but not a very good learner. They anticipate the positive and negative sides of the child by combining these two forces. If a child is not born within a symbol, families will not know how to educate or control him ... It is not just until they go to school that you decide for them what to study; no ... they already have a *nahual*, they were conceived on a specific day. If you know nothing about your child's *nahual*, it is because you didn't plan his conception .... Why do you see so many angry or sad, silly or aggressive people around?

Because their parents pay no attention to his *nahuales* **(interview, expert man).**

The fact is that for the Mayan people life begins its course in the early period of conception. Any imbalance during this crucial time will affect the future wellbeing of the child. Following the principle of symmetry between human beings and nature, their system of knowledge is based on paradox representations in which contradictions and incongruity are accepted and structures and processes are not seen as irreconcilable (Abric, 1994). This is similar to the findings of a study of Chinese societies, there Gervais and Jovchelovitch (1998: 7) stated that the Chinese culture sees the 'human body, the natural surroundings, the social relations that organise society and the supernatural world as elements linked and regulated by the adequate management of opposites and similarities'. In the case of the Mayan people, their systems of knowledge are grounded on the qualitative meaning of reproduction, within which both natural and supernatural forces are concealed. By considering reproduction as not just the mere aggregate of physical and psychosocial conditions, the Mayan people widen and enrich the dimensions in which human beings are immersed.

The application of the deeper meaning of the Mayan calendar system varies in depth and structure, as knowledge is not always presented in an truly articulated form. Its presentation varies according to the social actors involved and the degree of proximity to the Mayan cosmologies, mainly by the elderly, the *comadronas* and healers. Nevertheless, the whole concept that represents the dyad between nature and reproduction is transmitted and objectified through their daily practices. Regarding this point Gervais and Jovchelovitch (1998: 12) argue that this socially transmitted cultural knowledge 'comprises the objectification of a number of conceptions and rituals that keep the cultural system of the community alive and provide for each of its individual members a clear sense of identity and belonging'. The cultural knowledge of reproduction and maize germination is best objectified

in three key cultural practices: (i) the exercise of keeping the placenta; (ii) the use of *temascal* baths; (iii) the work of the *comadronas* (midwives). In the following sections I shall explore these practices in greater detail.

2 Cultural practices

There are a number of symbolic and cultural practices through which the Mayan cultural knowledge of reproductive health is objectified. In this section I will present those which, according to my observation and the information gathered from the participants, are the most generally implemented.

2.1 The placenta language

Perhaps every participant in the research mentioned the role of the placenta in their lives. The ritual of keeping the placenta certainly possesses great significance for the Mayan people, as they are a way of making sense of the processes of reproduction and child's development. As a young health worker explains:

> I think that is basic to understand people's beliefs. For example, the placenta language, it is so complicated to understand! ... I just know that it is sacred. People call it 'the child's flower', his companion. It means the child's route (development) from the beginning (the conception) until the delivery. People believe that it is a sin to destroy it and to use contraceptives means destruction of the placenta. Everybody keeps it, they sow it back into their fields, or in the courtyard of their houses, or by the river... that's why they don't go to hospitals, because over there, they just throw it away, and maybe some dogs can eat it... Everybody keeps it, even people who don't call themselves Mayans, they don't dare to destroy it. Mine is in the courtyard at home. **(interview, expert, woman).**

The practice of its conservation varies between regions – sowing it under a tree, burning it and mixing the ashes with soil, keeping it by the river – but all coincided that it should be kept within the community boundaries. They believe that by sowing the placenta in the family cornfields, the community

will always have high quality of crops and the child will be a virtuous agricultural labourer. According to midwives and the elderly, by following the 'placenta language' they are also able to discern the future reproductive behaviour of the mother, acknowledging its contraceptive properties:

> S1: ...you have to count the number of bullets that it has ... if the first child has three bullets in his placenta, he will have three more brothers and sisters ...
> S2: Some women ask us to destroy them, you know, they don't want to have more children. And sometimes we do it... if she really has too many ...
> S3: We are allowed to do so ... just us....
> (focus group, *comadronas*).

The fact that Mayan people acknowledge the placenta's contraceptive properties shows the existence of a structured knowledge about contraception and birth control. By objectifying their cultural knowledge in this practice, Mayan people express an implicit willingness to implement fertility control actions 'on their own terms'. This symbolic expression represents the endless cycle of human development enhancing at the same time, a collective awareness and sensitivity to their everyday life necessities of reproduction and survival.

2.2 *Temascal* baths

Within the home fields *temascal* baths enjoy much recognition among the Mayan respondents, being used as a resource to maintain their health and avoid illness. Based on the curative properties of hydrotherapy, it is utilised as a mediator between the external environmental conditions and the body. By keeping an appropriate temperature inside, their bodies can compensate any imbalance caused by weather changes, inappropriate food, psychological status (such as anger or sadness) and physical disorders. Besides, *temascal* is

an indispensable component of men's and women's sexual life and reproduction. According to midwives, it can be utilised as a contraceptive method and as a therapeutic resource for infertility problems:

> The heat and humidity cure everything ... when she cannot have children ... one hour each day is enough ... or when she has too many, she should take some baths with herbs ... After having the child, their bodies are warm and they have to sweat everything for six days **(interview, *comadrona*, woman).**

Besides their use for effective contraception, *temascal* baths are also implemented during pregnancy, at the moment of the delivery and post-partum. Right before the delivery a woman has to follow a process of 'preparation', in which she receives massages with herbs and baths. According to some *comadronas*, this is not only to determine the right position of the baby, but they believe that the combination of humidity and physical contact helps women to relax and be ready for the enormous physical experience that is to follow:

> They find patience inside the *temascal*. If the moment arrives (the delivery) and they are at home, they become desperate and anxious and feel more pain. But if the *temascal* is ready and waiting for them, they relax inside it, their pulse becomes slower and they peacefully await the child ... **(focus groups, *comadrona*, expert).**

The former reproductive health cultural practices are based on a highly structured knowledge that links concepts of production and reproduction. Regarding the value of symbolic practices, Cohen (1995) argues that rituals express millenary cultural knowledge that reaffirms and reinforces the community boundaries and people's sense of social location. By practising their traditional knowledge, communities reassure their continuation and permanence. One of the key figures that guarantees the dissemination of the Mayan traditional knowledge of reproduction is the *comadrona* or traditional birth attendant.

2.3 The *comadrona's* work

Local practices of reproductive heath are best represented in the work of the Mayan traditional birth attendants or *comadronas;* which in K'iche language means *katid* or grandmother. *Comadronas* enjoy a strong and well-established position within the community boundaries and are central figures of technical and psychosocial support in the reproductive lives of entire communities. The *comadrona's* reproductive health practices rely on the combination of traditional knowledge, wisdom, authority, confidence and certainty. And this is precisely what they transmit to each pregnant woman they attend. They have a wide range of responsibilities within the community, duties that assure the reproduction of the society as whole. From the time that a couple decides to marry, the *comadrona* begins to play a key role in their reproductive lives, not just in terms of her medical advice, but in relation to the emotional and psychosocial support she offers. Their vast traditional knowledge includes advice on: sexuality, conception, pregnancy, delivery – place and time for the delivery – contraception, abortion, unwanted pregnancies, maternal health and childcare and psychological advice for women, children and couples. Their work is based on a coherent and well-organised system of knowledge which has been transmitted by the elders of the community or the Mayan priest and healers. All of them belong to a network of health activists that operate in conjunction with the 'committees of principals' – or the Mayan local authorities – and are independent of the national health services. Each *comadrona* has her own 'work sector' from which she is entitled to attend certain number of families within a community. Their physical boundaries reinforce their firmly established authority.

According to a health worker, there are three kinds of *comadronas*:

> ... The elderly, who are the ones that possess the richness of our traditional knowledge. Destiny leads them to choose this profession, which is given by adjudicated forces – dreams, external ideas. They only practice pure Mayan knowledge. Then is the group of middle-

> age *comadronas*, they are more flexible and integrate the knowledge they learn in the hospitals. They become *comadronas* because maybe their grandparents or parents were healers, *comadronas* or Mayan priests. And the last group is made up of the young *comadronas*. They treat it as a profession, to earn a living, but they don't have the wisdom. People don't rely on them that much, because they always try to substitute medical practices for the traditional comadrona's *practices*, and none like this (...) And I think there are some groups in between that combine these three kinds of *comadrona*'s work **(interview, expert, man).**

The practices of *comadronas* are based mainly on traditional Mayan cosmology, but some also include some knowledge of Western medicine, which they 'transform' or reconstruct on their own terms. Since *comadronas* are the key health and social authorities within the Mayan communities, the medical health sector should view them as crucial mediators between the community's cultural life and the medical system. Despite this clear need, the role of these traditional birth attendants is often undervalued, as it is considered to be as magic and supernatural. In many cases, *comadronas* are used as interlocutors for the medicalisation of Mayan reproductive health knowledge.

Reviewing Mayan cultural practices, we can conclude that the meaning of their traditional local knowledge is objectified in actions, places, things and boundaries which help to keep alive their millenary cultural identity. The grassroots of these practices offer a broad and cogent synthesis of the network of factors that are relevant to their health and identity. As Cohen (1995: 50) affirms; rituals are symbolic expressions that increase in importance within the boundaries of a community when they are 'undermined, blurred or otherwise weakened'. All these examples show that whatever practice is undertaken, these symbolise or represent the community's cultural boundaries. In this sense, as outlined in the conceptual framework of this thesis (Chapter 4), the boundaries that are drawn up are the expression and affirmation of their awareness and sensitivity of survival as an ethnic group. By objectifying their cultural knowledge in practice, communities are socially

and culturally oriented. By doing so, social subjects build a space of reality in which their beliefs, feelings and uncertainties find a form of expression. Thus, symbolic practices serve as a 'frame of reference' in which to formulate, express and evaluate the community's identity.

Cultural knowledge and practices of reproductive health are not rigid, they vary according to a number of sociocultural, historical psychological and contextual determinants. Representations, then, do far more than merely stand for one single experience. As I shall explore in the following section, representations and practices of reproductive health are moulded by the social positions and the contextual meanings experienced by social subjects.

3. Variation of data: stability and change in the representational field

Given the importance of agriculture as an income-generating resource, it is precisely through the transformation of productive activities that reproductive representations and practices are modified. Thus, this data confirms the assumption that changes in the socioeconomic context and social positions within a society, produce concomitant changes in representations and practices (Davis and Harré, 1990; Elejabarrieta, 1994).

Faced with the reality of scarce land scarcity and given the impoverished socioeconomic conditions in which communities normally live, some families have to opt to reduce the number of family members as they are unable to leave a piece of heritable land to their children in order to secure their future. As a health worker explains:

> You have to consider that in rural areas people don't have any social insurance or pensions that can secure their future, so their children offer a kind of security to them .... But, I also believe that some people are really worried about it, and try to have less and less children so the land can stay with them, with their children ... A child is like a kernel of maize, they can not survive in dry soil ... you need humid soil **(interview, expert, man).**

It was observed that communities that had turned to the establishment of an open system of external contracts for land production, or given the scarcity of land, had to switch to other economic activities, shared several particularities. They tend to be bilingual, suffer more family disruption and are inclined to have fewer children. Faced with an enduring system of exclusion and deprivation, social actors attempt to make sense of their experiences by constructing new alternatives for survival. Two examples might clarify this issue:

First, the case of San Francisco el Alto. There, production and the economy is no longer based on agriculture, but on cloth-making and its commerce. Men and women collaborate together in incipient trade with cooperatives from the southern coast, which permits a bilateral contact with other regions. Locals have stated that over the last 20 years they have observed a reduction in family size. Before, people tended to have eight children but *"now we can talk about four children per family"* (Informal interview).

Likewise, communities that have experienced a large proportion of external migration towards the USA, as is the case of San Francisco la Union (Chuestancia, Tzanjuyup) display distinctive features. They suffer family disruption, their links with their Mayan identity are not profoundly expressed and their participation in social activities tends to be more independent and individualistic. Yet, they also display a clear decrease in family size:

> Here we have many things to do. Our husbands are in the north, at least my husband sends me some money. With that money I opened a butchery and I'm doing well ... He is still there, maybe will not be back, but I have something to give to my children ... I have three... The other women are not as lucky as me. They are still waiting ... and their children are waiting as well ...**(interview, lay informant, woman).**

The cases above demonstrate that the social position in which communities

are situated in relation to their productive activity shapes people's representations of their everyday life. These representations, in turn, mould the characteristic of social organisation – collectivist or individualist – the quality of social relations and lead to new practices in relation to reproductive health. But in other cases, given the change of traditional setting, their changes in socioeconomic status and the influence of external values, their representations also change and their identity is less clearly expressed or renovated (Hall, 1990).

Throughout the evaluation of the above representations we can determine that they follow the principles of what Abric (1994) terms the central and peripheral system of representations. According to this concept, there are some representations that are characterised by being stable and central, coherent and not highly sensitive to immediate contextual influences. In contrast, he states that the representations situated within the peripheral system permit the integration of contextual influences, as these are flexible and subject to change. The former representations are linked and determined by historical and ideological conditions and are strongly marked by the collective memory of the group. The latter are more situational and linked to the subject's own history.

Looking at the case of the Mayan communities, we can determine that in fact there are some representations that have resisted historical and social adversities and form the basis of the Mayan identity. The stable nature of these representations can be clearly demonstrated in the practice of *temascal* baths, in which contextual modifications do not alter people's practices towards them. As I explored in the preceding section, the use of *temascal* has caused consternation among medical personnel, as they consider these to be dangerous to a woman's health. Some medical personnel claim that women have suffered from dehydration and suggest that their use among pregnant women should be treminated. In response to that, many *comadronas* or health

workers from NGOs have 'transformed' or renovated the practice of *temascal* without impinging on people's beliefs. As a *comadrona* explains:

> ... You can improve it, but you can't change it or make it disappear. If you do so, people won't believe you anymore. I was a health activist in a Christian NGO, and we managed to collect some funding to improve our *temascales*. Now, if you see, they are made of concrete and look more like log cabin ... In the beginning people didn't want to use them, they said they were not the same as the old ones. But with time, they began to accept them, and now we have many people even from other communities who want to try our new *temascales* ...**(interview, expert, woman).**

The core representations related to *temascal* baths are stable, coherent, and are not sensitive to immediate contextual influences. The fact that the health personnel 'improve' or change the material conditions of these baths, did not mean a change in people's implementation of their practices in this area. These representations are marked by a profound local knowledge of reproduction and are conditioned and determined by the social memory of the Mayan people as an ethnic group. Their cultural identity does not seem to be threatened or eroded by renovating these symbolic practices.[3] The relationship between nature-family and reproduction and the qualitative meaning of reproduction display similar attributes. By contrast, there are some representations that are flexible and subject to alteration with the influences of socioeconomic conditions, changes in the subject's system of production and social relations. Socioeconomic adversities have brought about changes in the peripheral system of Mayan's representations, which in turn, permit the integration of new knowledge, producing concomitant changes in their reproductive health practices. The combination of both kinds of representations have moulded Mayan identity, in which historical and contextual factors construct new expressions of this identity.

[3] The issue of the objectification of cultural knowledge in symbolic practices will be addressed in more detail in Chapter 8, when I explore community participation in health interventions.

4. Conclusions

In this chapter I have presented some preliminary findings gathered from the analysis of common themes that emerged from the participant observation, interviews and focus groups. My intention is to demonstrate how people organise and construct their knowledge in relation to one generative theme, highlighting the significance of contextuality, as discussed in the conceptual framework of the thesis. It would seem that people construct their system of meanings regarding reproductive health in relation to their productive activity and their concrete living conditions. From point of departure all other domains and meanings are derived. Based on this assumption, the notion of Mother Earth emerges. This concept comprises all aspects related to the social dynamics that communities construct around their activities of land production and reproductive processes. Included within this notion are the following:

1. The concept of reproductive health is directly linked to the concepts of territoriality, agrarian production and family. Following the principles of nature, the meanings of reproduction are based on a profound relationship with the natural world.

2. The system of production and reproduction is expressed in the domestic spaces, within the family and, specifically, by women who represent the fusion of reproductive and productive activities.

3. Concepts and practices regarding production and reproduction are also represented in the complexity of the calendar system, which gives qualitative meaning to both processes. These representations form a central part of Mayan daily life and have formed the basis of their identity.

4. Diverse socioeconomic conditions determined by historical processes have built new representations which at the same time create new practices with respect to reproductive decisions.

Taking this contextual base into consideration, in the following chapter I shall explore the level of household in greater detail. The analysis will be focused on two interrelated issues: Mayan constructions of reproductive life and family planning.

Chapter 7

Beyond Reproduction and Family Planning

1.	On the naturalisation of reproduction
2.	Setting the limits of reproduction and sexuality
2.1	'Marianismo' in a Mayan community
2.1.1	The privilege of motherhood among the unprivileged
2.1.2	The blessing of the son
2.1.3	The shame of infertility
2.2	Is reproduction a men's concern?
2.2.1	The refuge of virility
2.2.2	We don't know what the word 'valorisation' means
2.3	Finding release through public absolved actions
3.	The threat of family planning
3.1	Defining knowledge on contraception
3.1.1	Pushing artificial contraceptives
3.1.2	'The ladino plot' against the Mayan culture
3.1.3	Contraceptive use: conflicting needs and values
4	Concluding remarks

This chapter explores two broad issues of reproductive health representations and practices: reproduction within the household and the significance of family planning. By exploring Mayan ideas on reproduction, I argue that *first*, society constructs social categories that serve to naturalise all social processes related to women's reproductive functions and social relations. This naturalisation is based on ideologies that institutionalise men's patriarchy, social inequalities and asymmetrical power positions at every level within society – household, community and state. *Second*, both men and women endorse distinct sets of interests and needs in relation to their reproductive roles, positions that also embrace valorisations of their parenthood obligations undermined by an exclusive and discriminatory social environment. *Third*, representations of reproductive health, in turn, shape people's conceptions of identities in relation to their gender and ethnic positions. Mayan's construct their concepts of femininity and virility through the value assigned to motherhood and responsible fatherhood. Values that allow them to be included – or excluded – within the community system of social interactions. *Fourth*, the family planning project comes to represent the

imposition of a world of objects that clashes with the Mayan system of values, an imposition that, in turn, generates conflict between the values and needs of the Mayan people. And finally, I conclude by setting out the way in which representations of reproductive health and related practices embrace issues of positioning, identities power and social memory previously addressed in the conceptual framework of this thesis.

1. On the naturalisation of reproduction

There is no doubt about the natural dimension of human reproduction. Society will always be dependent on the natural reproduction of biological individuals for its continuity. However there is clearly much more to the whole reproductive process. It involves the reproduction of socially constructed individuals able to extend and transform, if necessary, a system of ideas and values; that is, to reproduce and reconstruct ideologies and power. The social category of reproduction has been built upon a socially constructed system of ideas that 'naturalise', take for granted or assume every aspect related to reproduction as being part of a natural and unquestioned process, as normal as the process of life and death, processes that appear to be so obvious, so natural. Perhaps nowhere does this analysis ring more true than in the image of women. Since women are the key receptors and transmitters of life, upbringing and development of their children, family and communities, they are continually defined by the labels of mothers, wives, care-givers, labels that define their relation to work, to social relations, to sexuality and to life. There is no social category that is considered more natural than women and their reproductive function. And in this respect, every social process related to them – motherhood, bearing children, family interaction – appears as natural or transparent as do certain social relations that emerge from a conflictive and unequal social environment – patriarchy, family violence, control and power supremacy. It is in such a conflictive social environment that women play a special role, not in terms of acquisition of

power, but in being the key receptors of all these social ends. Thus, the naturalisation of women and reproduction, in turn, serves to naturalise social inequalities, violence and disruption not just in relation to gender identity but in relation to ethnic identity and the social position of actors within society.

Here we come back again to the issues of positioning, power and ideologies addressed in the conceptual framework of this thesis (Chapter 4). By reviewing the work of Martín Baró (1985a;1996) and Freire (1972) I argued that power supremacy is based on ideologies that serve to institutionalise inequality and reinforce power in distinct spheres in social life. In this case, this assertion is extended and expressed at every level within society – household, community and state – and within different social categories – gender, class and ethnicity. This naturalisation constructs representations of reproduction within a community and shapes the conception of identities. It also comes to organise social practices of members of that community, in such a way as to reproduce those social categories and discourses. Within the household, for example, naturalisation of power supremacy is demonstrated through the social and emotional relationships between family members, that is to say, between husbands and wives, mothers and their children and between women themselves. They vary depending on their gender position, social position and degree of participation within the community. As such, at a macro social level, these power relations are expressed and objectified through the relationships between distinct group members, as occurs in the case of the users and providers of health services. In other words, representations of reproductive health and practices are determined by positioning and power aimed at the satisfaction of distinct set of needs and interests at different levels within society.

This comes to sustain that ideas of reproduction and correspondent healthcare, depend on both definition of needs and positioning (Davis and Harré, 1990; Hall, 1990; Moore, 1994). Some of those definitions interact with,

and complement each other, but others clash and compete with one another, establishing contradictions, demands and conflicts which, in turn, determine the constitution of survival strategies. As stated earlier, it is important to point out that the definition of needs, positioning and the subsequent conflict and contradiction occur at different levels within society. They occur within gender and community interactions, but they are also constructed and expressed between different ethnic groups (Mayans-ladinos) and social organisations (national health services-local institutions). It is on the foundations of both, the definition of needs and positioning within private spaces and between public spheres, that representations of reproductive health are constructed. Aspects which themselves mould Mayan's conception of identities –gender and ethnic – and create new forms of social interactions within the community.

Having made this point, I will go on to analyse the ways in which Mayan communities, depending on their gender, social and ethnic position, construct and express their knowledge of reproductive health. I argue that K'iché representations of reproductive health are organised in relation to their own needs and positions, and express distinct sets of interests and concerns. The asymmetrical nature of gender, ethnic and social relations imply power struggles to establish new positions, satisfy distinct sets of needs and re-establish their own gender and ethnic esteem. All these are constructed upon a macro social system that naturalises and promotes inequality by transmitting an ideology of control and subordination. Representations and practices of reproductive health are engendered from this background which, in turn, shapes conceptions of identities.

Participant's discursive and material practices of reproductive health are organised around two main issues: the meaning of reproduction within the household – having children – and considerations about family planning. By analysing these two broad issues I will explore the social environment in

which they are fostered – household, community – and the social psychological conflicts that emerge – family violence, contradictions between values and practices, gender and ethnic self-esteem. In what follows, I shall begin with the level of household, reviewing the participation of women and men within the boundaries of community life.

2. Setting the limits of reproduction and sexuality

To have children is a shared concern between a couple. For each, women and men, children come to fulfil diverse expectations and needs. The desire to have children conforms to an inner personal concern that implies personal gains and losses, satisfies needs and demands new duties, imposes challenges and represents burden. On a material level, as discussed in the previous chapter, for many Mayans, having a large family is an eminently rational strategy of survival. Children's labour is vital to the family economy, children compensate for the absence of social security for their parents and younger siblings. But moving beyond the material gain and losses, what do children come to represent for their parents?

First of all, there are certain premises that should be stressed when implementing any analysis of deprived communities. In order to understand their local knowledge we need once again to revisit one of the main features of underdeveloped agricultural societies, in which deprived living conditions profoundly shape their representations. To put it simply, systematic social exclusion, lack of access to social benefits and ideological oppression, lay the foundations for the construction and maintenance of unequal and backward social relations based on gender power dominance and patriarchy. As a consequence, several factors related to their social and emotional life are ignored, denied or perceived as unquestioned processes. This is the case with regard to Mayan ideas about reproduction and sexual life.

For both, men and women, whether lay people or expert, reproductive processes – having children – and sexual life forms a single unit. They conceive of no separation between these two processes, and no contradiction either. The purpose of sexual activity is reproduction and to have children means an enhancement of sexual life. In a patriarchal society, it is men who enjoy the primary right, and duty, for all reproductive and sexual decisions. Women are valorised in terms of their reproductive capacity alone, which, in turn, defines their social relations and the perception they have of themselves. In this sense, women and men posses distinct and asymmetrical interests and rights towards reproductive and sexual life, and decisions regarding having children also involve a correspondent concern for the satisfaction of their sexual needs. The analogy between sex and reproduction defines every aspect of their reproductive health and it partially defines their decisions to undertake any reproductive healthcare intervention. As some informants point out:

> ... I would say that to my children (sons) ... that even if they feel tired and feel like making it (having sex), they should first think about their wives, that they may have already too many children and it is difficult to keep having more ... I know that men can't control themselves, they need sex, but we women suffer a lot ... **(interview, lay informant, woman).**

> Men prefer to have more children than to stop sleeping with their wives (having sex). This is a right, so why do we get married?. The Bible says ...'go forth and multiply' ... we didn't invent this **(interview, lay informant, man).**

Among the respondents, the link between the reproductive process and sexual life is an issue that is taken for granted, one inherent to every natural process. This representation forms part of a complex web of psychological and social processes, through which it is maintained and reproduced. But above all, it is strongly supported by a system of social categories that assure the fulfilment of men over women within the community. This idea shapes the roles and social categories of both genders and creates distinct forms of participation. At this point, we turn again to the issue of positioning and power. Women are

seen as the passive natural receptors of men's and children's physical, social and psychological needs. They are the natural key providers of life and satisfaction and, as a consequence, they are expected to deal with, and confront, any painful experience they encounter. Their natural role as wives, mothers and community caregivers demands from them a socially constructed stoicism with which they should correspond. It is on the basis of this stoic role that women find a form of expression.

2.1 'Marianismo' in a Mayan community

Within Latin American religious ideology, women are conditioned from childhood to ignore ill-health, pain, insult and abuse. According to Martín Baró (1990), such charismatic Catholic and medieval evangelical ideas have gradually constructed a highly structured cultural pattern in the image of motherhood. 'Marianismo' or the daughters of the Virgin Mary, is the 'paragon of chastity, meekness and submission' that every women has to fulfil (Shallat, 1994: 160). It glorifies motherhood and denies women's sexuality, as it is so pervasive that women who choose not to bear children are viewed as selfish, frivolous and unnatural. Women are educated to feel shame and guilt when talking about their sexual life and reproduction. Regarding physical injury, every irritating menace related to their reproductive life; for instance, menstruation cramps, pregnancy complaints or delivery pains, are considered to be manageable and even propitious for building a woman's desired strength. Adolescent girls are even trained to look forward to this physical pain. For example, they are told by their mothers not to complain about menstruation cramps as these are signs of fertility:

> I learnt that 'la costumbre' (the period) was something dirty, that I should feel ashamed for having it. Even more, I remember that my mother and grandmother quarreled with me the first time I was bleeding. They told me that I should hide it and stay at home **(interview, lay informant, woman).**

> I didn't know anything about 'el lavado' (the period) when I got it. I was so scared and cried. My mother told me that I was bleeding because I was a bad girl and this was my punishment ... and I had to get accustomed to that if I wanted to have children, it was my destiny **(interview, lay informant, woman).**

> Here many women think that to be pregnant is a sin, because it means they have slept with a man and that is seen vulgar. They don't like to talk about it, even if they are married. They prefer to hide their bellies and to squeeze them up with their lasses, so no one can see they are expecting a baby. People call it 'la enfermedad' (the illness), maybe because they find release after nine months ... If someone has period cramps or complains about any pain while pregnant, people say that she is a wimp, that she is not a real woman **(interview, expert, woman).**

The cultural norm that requires women to tolerate without complaint any pain related to their reproductive functions costs some women their lives:

> She didn't say anything to anyone, even to her mother-in-law. Only when she fell on the ground screaming did the neighbours bring her to me...It was too late, she had a huge infection **(interview, *comadrona*, woman).**

As such, emotional suffering and depression resulted from unsatisfactory marriage, violent environment or even unhappy motherhood are considered as weaknesses which women do not have the right to feel and complain about. The social and ideological category of Marianismo imposes certain roles on women and obliges them to behave in accordance with the expectations that society establishes for them. The husband's 'needs' and enjoyment are seen as paramount. It is a social category that endorses submission and underpins power supremacy.

> Men think that women have to dress up or fix themselves up just for them. They prefer to see us at home with dirty clothes or in a mess, so that other men can't lay their eyes on us. Look at my case, I can't brush my hair that often because he thinks I fancy other men (...) If I want to go out, I am allowed to do so only if I bring a child with me (...) I can't complain, I got married (...) even if he finds another women I'm still his wife **(interview, lay informant, woman).**

The former descriptions exemplify the experiences of the Mayan women participants of this study. The combination of ancient religious beliefs, charismatic Catholicism and evangelical movements have introduced new existential dilemmas to people. As discussed in the previous chapter, within the Mayan cosmology, women maintain a position of respect, their status improving as they grow older. This particular position also imposes new demands and strains on women which are heightened with the intrusion of foreign medieval values (Martín Baró, 1996), values that engender their representations of their own reproductive processes and sexuality. Female respondents, almost without exception, felt ashamed when asked about their menstruation, pregnancies and, more significantly, about their sexual life. Ideas about dirt, untidiness, subordination, dependency and unpleasant experiences form their representations of femininity and guide them towards an acceptance of disagreeable experiences.

Regarding this point, Douglas (1966) argues that to examine what is considered as unclean in any culture is to look into the ordered pattern that a culture strives to establish. Similarly, she suggests that some ideas regarding pollution are used as analogies for expressing a general view of an unpleasant social order. In this case, such discourses and ideas come to institutionalise conceptions of gender identity and practices and locate women in a unequal position. Within Guatemalan society, for example, ideas and discourses regarding pollution, which operate on many levels including the law and education, often carry pejorative connotations towards women. This, of course, portrays a contaminated social system which reproduce certain order of things. Women's 'Marianismo', and its damaging consequences, is not only an attribute of the poor and underprivileged Mayan communities, it also operates within the highest social classes within society; among the wealthiest and most educated people. Girls are educated to feel ashamed about their own reproductive processes and sexual life and are told to tolerate an unsatisfactory marriage, even if this causes profoundly unpleasant

experiences and psychological damage. If the privileged social groups, with better social options, are confined to a system of prejudices and stereotypes and restricted to social categories which reinforce their submission; what might we expect to find among the underprivileged?

2.1.1 The privilege of motherhood among the underprivileged

Women come to have different understandings of themselves with regard to their femininity, and thus they develop forms of 'acceptable behaviour' that allow them to enter the established social order (Goffman, 1969). These standards depend on the social pressures and expectations that society imposes on them. Within Mayan communities, single women are less valorised and ostracised if they do not marry by a certain age. Even for their parents, to have an unmarried girl is considered a shame and a burden. They expect to be provided with grandchildren who can protect their rights to land and other inheritable property. When a couple fails to have a child within the first year of marriage, accusations are directed against the woman. As a result of all these demands, the label of 'mother' denotes a special and highly respectable position. On the one hand, it comes to fulfil social interests. On the other hand, it facilitates the entrance of women into a reputable position that allows them to obtain a powerful status otherwise denied them. Thus, women's children come to represent their best social rewards:

> They are my company (her children) ... it is very hard to have them, but it is worth it. When I am alone I know he will stand up for me and will not leave me as his father **(interview, Lay informant, woman).**

> People marry and immediately start to fill their houses with children, and I think that women get used to carrying them. They get used to carrying a load on their backs, and they believe that is the only thing they are able to do. They go with their children everywhere ... to wash, to clean, to the market ... If you take a child from a woman's back, she would it will do harm to her and to her child, that is something very bad for both (...) I think that for a woman it is very

important to see her children and grandchildren growing ... they hope they will remain close to them **(interview, expert, woman).**

Similarly, children are for women the only source of satisfaction, pride and self-respect:

> I married two years ago and don't know what happened when we couldn't have any children. I felt very bad ... everybody was all over me (...) Whenever I went out to the market, I felt that other women were talking in my back saying nasty things about me, so I prefer to stay at home (...) My husband left me and went to have children with another woman (...) But suddenly one day I was pregnant! ... and now I can go out with my child on my back, so women can see I am a real woman **(interview, lay informant, woman).**

With no other option but the home, many women turn to children as the primary source of power, pride and social-self respect. In Guatemala, as in many developing cultures, the birth of the first child, brings a woman an automatic status that other domestic and social roles do not. A child pleases a woman's husband and her in-laws, the people who control her life. Regarding this point, Hartmann (1995: 48) suggests that the more children a woman has, the stronger her authority. She also argues that social systems whose positive images of a woman are all linked to the reproductive role 'leave woman with the only one way to achieve sense of purpose and accomplishment'. Immediate social pressures, the in-laws, or other external demands – including pressures from other women in a similar position – lead women to construct their femininity based on the positive values of motherhood. Being a 'good woman' gives them a sense of belonging that allows them to be included within the whole system of social interaction and ensures their participation within the community. Women's participation in the social and material life of the community is further improved if the expected child is a male, their greatest source of pride.

2.1.2 The blessing of the son

The son preference is the most common and significant case of patriarchy among developing societies, being the highest manifestation of an oppressive

ideology. It is a natural and taken-for-granted practice that is explicitly reflected at the highest levels within the social structure, including social constitutions and policies.[1] Thus, women have an additional reproductive responsibility: to bear a son. As addressed in the former chapter, son preference is a value that is profoundly manifested among Mayan people. For the sake of having a son a man may repudiate his wife and look for other women who can provide him with a male child. The belief is that a woman's marriage and life is more secure if she bears a son. And, in fact, it is.

Since girls after marriage move away from their parents' home to live with their in-laws, it is the son who stays at home to protect the mother in the case of widowhood, divorce, or abandonment. If he marries, he will bring his wife who can help his mother and take care of the housework. Sons are also the ones who can go out and work, get better paid and, in many cases, can help with the education and maintenance of their siblings. As a result, if a family has some economic possibilities, they would prefer to invest in their boys, sending them to school. Meanwhile girls remain at home. Furthermore, having male children also assures a family's continuance and respectability 'they must be men to carry on the family name'. It is a highly conscious cognitive recognition that means that people can even improve their income out of it. For example, there were some cases of young 'comadronas' that charge more for their services if the new arrival is a boy.

Thus, the system clearly provides several material and emotional incentives for male preference, reinforcing women's segregation and undermining their social valorisation. Women, in turn, are devoted to the wellbeing of their sons and educate their daughters to follow this pattern of predilection:

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[1] The most tangible example is China's devastating 'One son or two-child' population control policy (Jackson, 1994).

> I think my mother loves us equally, but has always treated my brother in a special way. When he comes to the house my mother will always say to my sister and me 'stand up and give your chair to your brother!' He will always eat before us, and get the best portions. We were brought up to know that it is our duty to respect and comfort our brother **(interview, expert, woman).**

In the local villages studied, there were some cases of women who did not bear any son and their husbands died, migrated or abandoned them; they had no other option but to reduce themselves to begging as they did not have the opportunity to earn a living. It is all about needs and survival. Thus, concrete living conditions construct the value of male predilection which is objectified in different forms, one way is through the practices of 'fertility trials':

> Here, people try again and again to be pregnant until they get at least two sons. And if they don't get them? ... they will just keep trying. It's so sad when a woman already has four daughters and they expect to have a male, and suddenly the fifth child is coming ... and it is a girl again. I feel so embarrassed to tell them that the awaited child was a baby girl ... and I just add: 'you have to see, it was very hard isn't it? but you did not make it with your own hands, it was not your fault ... so you have to learn to love her' **(interview, *comadrona*, woman).**

The uncertainty that a patriarchal system imposes on women represents a powerful incentive for high fertility. The best insurance is to bear as many sons as possible. Another form is through the imposition of new demands on their children as well. Children are a woman's possession, the only means to obtain and to communicate power. As a result, children are expected to correspond to their mother's aspirations and wishes. What other source of power does a woman have than in children? If children are the only way to a women's social and emotional satisfaction, the means of expression of her feminine identity, the only conduit to penetrate into the patriarchal social arena, what would occur in their absence? As we shall see in the next section, if a woman is unable to bear any children, she is ostracised and socially repelled from the community boundaries.

2.1.3 The shame of infertility

I would like to cite an example of the way that people's representations of reproduction lead to the construction of an identity of spoiled femininity identity for infertile women. Catalina is a 34 year-old K'iché woman. I met her when she was visiting her parents in Palomora village, in the municipality of San Andrés Xecul. As she told me, she was on holiday as she normally lived in the capital, where she had a job as a domestic worker. She was very kind and showed me the main centres of the community and introduced me to some 'approachable' people with whom I could speak. Since she spoke fluent Spanish – and on that occasion I was not accompanied by a health worker who could translate for me – I asked her if she could help me with the translation of some of my interviews. Despite her friendly and helpful attitude she flatly refused, arguing that she would not know what to answer. I insisted that she would not have to say anything about herself, just to translate what other people said. But she was resolute in her decision. My initial response to her abrupt denial was to interpret that she felt a bit intimidated with the content of such discussions, as had been the case with other women. And perhaps she would prefer to do the translations in a more private place around the village, where we could talk without restraint. After a while, I began to discern that she was more than intimidated, and understood that there was more behind her firm resolution. I then put aside my previous practical interests and concentrated on listening to her story.

She told me that she would not dare to go around asking other women 'such things' as she did not had the right to do so; she had never been married and of course did not have any children. 'Only the ones who are married can talk about those things, otherwise you make yourself foolish'. She told me that before she was 20, she had undergone major surgery in her ovaries and as a result of malpractice she had suffered an infection. After her recovery, the doctor told her she would never be able to get pregnant. In despair, her

parents took her to the local midwife and she confirmed 'such was her fate'. At that time, she was engaged to be married to a man within the community and her parents thought it would be better to be truthful with her future husband and tell him 'the very bad news'. As usually happens in such cases, the man refused to marry her. And she understood that she would stay single for the rest of her life. She could not go around as other women do, she felt ashamed and criticised. Everybody in the community knew about her condition, and 'it was not looked upon very well to go around with this shame'. Her parents supported her and suggested that the best thing she could do was to take up a job opportunity in the capital, so she 'could make something out of her life' (Goffman, 1963: 136). Until the time I met her, she had been working in the city for 12 years and feels happy whenever she comes to visit her relatives and friends. She was able to study a little, and speaks fluent Spanish, so people can say something positive about her.

The story of Catalina is normal for infertile women. They perceive themselves as worthless and without the right to demand social inclusion as they 'have nothing to offer'. These are people who are somehow left out of the pattern of society, which encapsulates them providing no option for those who cannot fulfil the most desirable status. As such, infertile women – and their families – are conscious of those social structures and restrain their actions in accordance with the restrictions and patterns that a society demands. Thus, they will either encapsulate themselves and stay away from the punitive social boundaries, or strive to find a socially acceptable image through which they can achieve a more respectable social position.

As we have seen so far, Mayan representations of reproduction are constructed on a patriarchal system that prioritises and overvalues men's needs and rights, which, in turn, have shaped women's conceptions of femininity. These representations are organised in such a way as to valorise women for her reproductive capacity alone, or shall we say, through the value

of motherhood, thus denying equally important aspects of their feminine life. As such, women have to find new ways to express their needs and find a socially acceptable refuge through their children, mainly their sons, a value that imposes new forms of power and authority on them. The valorisation of children as the most desirable social end, serves to ostracise women unable to accomplish this target. It is for this reason that representations and questions of identity are bound up with issues of power, constructing at the same time new forms of social relations and participation with the community. As reproductive processes concern both women and men, in the following section, I will examine contributions from men regarding their reproductive needs and expectations, and how this powerful position imposes new demands on them.

2.2 Is reproduction a men's concern?

Elsewhere, the reproductive health literature exclusively focuses on women, paying little or no attention to men's needs and concerns regarding reproductive health. This approach leads to negative consequences on two counts. First, it puts an excessive burden and responsibility on women, and places on their shoulders all the demands and expectations related to reproductive decisions. Women become the key receptors of health interventions in both, at the level of health promotion and intervention – from contraceptive distribution to empowerment programmes. And second, it marginalises men in all senses. In the problematic story of reproductive health-enhancing behaviour, women are seen as the passive victims and men are assigned the negative and destructive role. The extension of these arguments go as far as to catalogue men as the 'most to blame' responsible for women's deplorable reproductive health conditions in particular, and their social and emotional wellbeing in general. If men are the 'most responsible' for women's deplorable health conditions, why are their opinions not taken into consideration? If patriarchy is destroying women's wellbeing in Third

World countries, why are men's needs and concerns excluded from any analysis of reproductive health decisions?

The answer of these queries is straightforward and has been examined at the beginning of the chapter. Patriarchy or male dominance is seen as a given, a natural and unquestioned fact. This 'natural' status is reflected even in research on reproductive health. Despite a wealth of feminist analysis on patriarchy, there is little concern for examining the specific conditions of production of this social phenomenon. These conditions vary in distinct cultural systems and with particular consequences for reproductive health matters. Based on a structural deterministic analysis, patriarchy is considered to be an unchangeable social category and subject to the most simplistic generalisations. It is considered almost as a 'demographic variable', on a par with sex and occupational status. The lack of acknowledgment of men's positions and participation means that research takes for granted their opinions and needs, and is not concerned with its deeper significance. By excluding men from reproductive health analysis, the system reinforces their practices regarding reproduction, since it is assumed that no change in their mentalities will occur. If we are to understand the real ambit of reproductive health local knowledge and the concomitant choices, it is necessary to revisit all actors involved in this process, without exclusions and preconceived notions.

As discussed earlier, it is true that patriarchal relations deprive women of their most significant needs and rights. And these relationships reduce women to passive receptors of men's decisions. It is also accurate to say that men are the active instigators of their family's reproductive choices as their positions and needs are prioritised and overestimated. But what are the needs and positions of men in relation to reproduction? Following the discussion of the previous sections, I shall explore men's ideas about reproduction — having children — and family life.

2.2.1 The refuge of virility

Earlier I examined how for the Mayan people reproduction and sexuality form a single unit and, therefore, their reproductive decisions are directly linked to the enhancement or reduction of their sexual life. This idea forms the core of men's representations of reproductive health which, in turn, shape their conception of their masculine identity. For men, children represent a sign of their virility, the social cognitive recognition that shows how 'capable' they are in their sexual life. The greater the number of children, the better their performance. A value of prime recognition within the community:

> I know many families that are so poor but they can't stop bearing children ... If a man knows that his wife can't give him the number of children he wants, he will go to see other women and have children with them ... Even if he is so old, no one can tell him to stop, to tell him that he is not a real man **(interview, expert, man).**
>
> Unfortunately, I could only father four children. I thought she was taking something, but she wasn't. With time I just accepted it ... maybe it was better for us as all our children are doing well, but I would have chosen to have eight. I think I was able to do that **(interview, lay informant, man).**

This representation, in turn, shapes the quality of their social relations as it is directly linked to their social recognition within the household and the community. For many men, the pregnancy of their wives gives them automatic social status and a respectable position within the community. It is a matter of honour, a sign of virility, to have many children. For that reason, infertility represents the biggest threat which they are unable to confront.

> In total ... he has 15, I think. He has children everywhere. If he goes down town, everybody recognises him and calls him the *'effective man'* **(interview, lay informant, man).**

Nevertheless, their conception of virility does not end with the number of children they are able to bear, but more importantly, it includes the number of children they are able to provide with a 'decent' life. For Mayan men, to

provide their families with respectable living conditions – land, house, food and even education – means to fulfil an aspiration of greater value than any other. And this is perhaps the whole meaning of their reproduction duties: to be able to bear as many children as possible, but at the same time to satisfy their most significant needs. This was the most common concern among the respondents. To be a 'real man' is to offer one's family a decent living, a value that signifies their sense of masculinity and self-satisfaction:

> A woman needs to keep herself well ... but for that, there is the man to look after all her needs (...) the man also has to look after his children's needs, if he does that, a man finds happiness (...) Sometimes I can behave badly, being drunk ... but if I have put rice and beans on the table for my family, I feel happy ... and think they are as well **(interview, lay informant, man).**

> I had seven ... and all of them have reached 15. Even more, I sent three to school ... only one finished, but at least they know how to read and write. The two girls are 'well married' ... in that respect I don't have any worries. One of my boys is in the north, he says that he's doing well, I didn't believe that, but he has now begun to send some money to his wife (...) I am very proud of my home ... I have accomplished my duties before God **(interview, lay informant, man).**

Thus, the values of bearing children, and their maintenance, form the basis of their masculine identity. Men who are unable to be 'responsible' fathers, are appraised by the community, and by the social system, as being incapable and worthless. This disapproval reduces their self-esteem and social status. As is understandable, the lack of access to social and economic resources and an underpaid labour force, means the great majority of the families are unable to satisfy their basic needs. As poor men are unable to meet their essential economic obligations and fulfil the needs of their families, they are left in despair and suffer a serious loss of masculine identity and self-esteem. Men who are unable to demonstrate the successful completion of their fatherhood responsibilities, perceive themselves as powerless, inefficient and valueless. This condition is further exacerbated by social discrimination and racism and leads them to reinforce their already undermined powerless status.

2.2.2 We don't know what the word 'valorisation' means

As Moore (1994) argues, gender ideologies and other forms of difference, such as race and class, which draw on social identities, are essential to understanding social reproduction, both at the level of the household and the level of the state. In this respect, the ideologies of discrimination or ethnic difference are to be reflected in constructions of gender identity – masculine of feminine. Taking the case of Mayan men, it is clear that men construct their sense of virility on the basis of their social performance in relation to reproduction. As such, these constructions are in turn determined by the accomplishment of their fatherhood obligations, which are undermined by their deprived conditions of living. Nevertheless, the case of Mayan men goes beyond their accomplishment of, or failure to meet such obligations. They suffer a constant apprehension: their ethnic discrimination and isolation, which leaves them vulnerable and even hostile.

Men are the prime recipients of social intolerance and segregation outside the limits of the household. When interviewing men about their reproduction concerns, all of them made reference ,directly or indirectly, to their perceived sense of discrimination and lack of value. They were aware – to a much higher degree than women – of the depressing social conditions of living and made reference to their perceived ethnic segregation that makes them unable to meet their obligations and needs as fathers and family members. They were sensitive to the lack of opportunities that their children face when searching for jobs or when they attend local health centres or hospitals. This perceived sense of ethnic discrimination gnaws further away at their already beleaguered gender and ethnic esteem and creates a negative background for the constructive representation of reproductive health. Regarding this point, I want to quote a young health worker's participation in a focus group discussion, in which he lucidly analyses their perceived sense of

discrimination and its implications for the construction of harmonious family relations:

> Since we are born, I think ... we've constantly been the object of rejections and accusations. For example, if we search for a job, no one believes that we are able to do this or that. If we go to hospitals, we can't get any treatment ... and if we practice our Mayan medicine, people accuse us as witches. If someone wants to start a project within these communities, we are 'invited' to participate just to do the hard part; working in the fields, carrying materials, washing, cleaning – and on the top of that –we have to be pleased about that treatment (...) Even if some of us have some education we'll never be given administrative duties, as 'we are Indians and we don't know how to work with money', we'll steal it and use it for our own good (...) Wherever we go, we always hear that we are useless, thoughtless and unable to do things by ourselves.
> So, what happened? We don't know what the word 'valorisation' means ... We don't know how to value ourselves, as we've received only rejection and punishment, we have a very low self-esteem – we, as Mayans – we have our self-esteem on the floor (...) For example, I ask Marta, Do you like to speak your language? (...) or I ask myself, do I dare to wear my costume?. Will I get a job if I am wearing my trousers? (...) So, if I am treated badly everywhere, how am I going to treat my family? If I can't value myself positively, am I going to value my children positively? Of course, we would like to protect our family from all this, to give them a decent life, to protect them. We are now trying to get up and discuss this, but it has been a very hard work ... **(focus groups, expert, man).**

This extract points to at least two complex issues. First, it clearly shows the manner in which people perceive their positions in relation to their household, families and to society. As men engage in wider interactions with the social environment outside the community boundaries, they are also the primary receptors of all social abuse. Discrimination is the first thing they face when meeting the outside world, a pattern that reinforces their low self-esteem already undermined by the impossibility of fulfilling their fatherhood 'obligations'. Thus, if we look at the image of men as family members, there are several damaging social and psychological factors that destabilise their role as active constructors of a positive family environment. In this sense, one may state that ideas of reproduction and family interaction are not based on gendered roles alone, they are also linked to ideas about power relationships

within a distinct set of class and ethnic positions. It is for that reason that we cannot isolate the analysis of 'fatherhood' to within the boundaries of a family unit and reduce men's role to that of the 'first to blame' within the deprived household. Men do indeed have an active responsibility in these matters. However, as has been discussed at length, their participation may be seen as a product of a convulsive social and economic system. This extract illustrates the way in which representations of reproductive health not only affect people's conception of their gender identity —masculine and feminine — but also mould their ethnic identity. Likewise, their sense of ethnic identity is manifested in their practices regarding family planning, an issue that will be discussed further below.

The second aspect of the above extract to be analysed is the way in which men express their dissatisfaction with the social order. Men are powerless and vulnerable outside the limits of the household, and in order to re-establish their sense of legitimisation and power, many turn in despair to alcoholism and domestic violence. This sense of self recognition also includes the right and power to have extra-marital relations to assert a sense of masculinity as active and aggressive. Expressions of power and violence over women are both cause and effect of an unconstructive micro-social environment in which reproductive health representations and practices are fostered and reconstructed. Nevertheless, these forms of psychological and physical violence are part of an extensive form of 'socially acceptable' refuge and release of their anxieties. Therefore, society creates forms of socially satisfactory behaviour in which people can express their grief and anger, without feeling guilty or ashamed. As we shall see, these forms of 'innocuous' behaviour are extensive not just among men, but among women as well.

2.3 Finding release through publicly absolved actions

Up to this point, we have explored the ways in which men and women construct their representations of reproduction based on their own necessities and positions. As has been explained, these representations shape both women's and men's conceptions of femininity and virility respectively, and also mould their ethnic identity. These representations, in turn, shape their practices towards reproduction and enable them to be integrated within the community boundaries by giving them a sense of belonging. As we have also seen, Mayan representations are fostered within a confused social environment that imposes restrictions and demands. In response to a need for expression and exteriorisation of these conflicts, needs and concerns; society creates 'culturally condoned opportunities' that allows people to express themselves and find comfort (Zur, 1995: 64).

There are many ways of finding release and demonstrating power, some of them differ between men and women; but others are similar, irrespective of gender. As discussed earlier, family violence —physical and psychological — is the primary way of exteriorising these conflicts and anxieties. This is articulated towards every member within the household, between husband and wife, but it is also manifested from the parents towards their children, a situation that generates child abuse. Beating their children or wives is a culturally accredited social act, considered to be harmless and normal. No one has the right to intervene between husband and wife. Public opinion never reproaches the man who has violently asserted his authority over his wife.

Another form of exteriorisation, which is socially acknowledged for both men and women, is alcoholism. Being drunk provides a culturally condoned form of release, a practice that none would blame, even the law. According to some respondents, in past years 'frowned upon' to see drunk women around, but nowadays, it has been increasing among middle age and elderly women:

> If a woman who is beaten by her husband goes to complain to someone else, her parents, for example, everybody will call her a wimp. But if she is found drunk somewhere in the community, no one will say any word ... **(interview, expert, woman).**

Women may also find release when their husbands or partners have migrated abroad. They are liberated from any social obligations towards their husbands and are somehow 'forgiven' if they marry again, stay alone or live in common union with someone else. This autonomy is collectively conceded only when it is made public that their husbands have been unfaithful and if it is verified that they are not sending any income to their children. Since single women of migrated husbands are in practical terms in charge of all the unfinished economic and social duties left by them – from paying the loans for the trip, to the economic burden of maintaining their families – likewise, they also maintain a degree of freedom and independence when staying alone. Public opinion absolves them for their future actions and gives them status when trying to find a job or search for a better way of living.

Thus, society creates socially acceptable practices that permit people to express themselves in accordance with the socially adequate definitions of what a 'good woman' or a 'real man' should be. These expressions, whether innocuous or destructive, allow people to find refuge in their daily contingencies and give them a hitherto denied opportunity to express their power according to the normative conventions of the social order. Moreover, some of these expressions – such as alcoholism and family violence – jeopardise women and men's positive feelings of communication and impede an open dialogue. As has already been stated, actions themselves can be a type of critical reflection that does not necessarily have to involve conscious or discursive strategising (Martín Baró, 1996). Those actions certainly reflect a convulsive social order unable to satisfy or give priority to people's needs and interests. It is against this background that reproductive health knowledge and practices are constructed, within the household and the community. By

exploring the ways in which people express themselves according to socially acceptable patterns of behaviour, I want to examine the relevance of including different forms of practices – discursive or material – that express ideas about reproduction within the context of family relations. I also want to stress the significance of widening the scope of research on reproductive health to go far beyond the analysis of the social issues intrinsically related to reproductive processes. Thus, reproductive health and related practices are not a single and isolated concept, they are, in fact, the cornerstone from which several complex historical, cultural, social and psychological phenomena emerge.

To conclude this section on reproduction within the household, I shall stress once more that men and women establish different positions and practices, and that those positions reflect different set of needs and interests. This point is crucial to understanding the diverse, and sometimes contradictory, positions that men and women adopt. In this respect, I want to take up a basic premise of post-structuralist thinking on the subject, highlighted by Moore (1994: 55). She argues that individuals are multiply 'constituted subjects', and they adopt numerous subject positions within a range of discourses and social practices. Some of these subject positions will contradict and come into conflict with each other. This issue is clearly demonstrated in the image of woman, as mother, wife, daughter, and as member of a nuclear family and community. Despite their naturalised role as caregivers in relation to reproduction, they also assume different positions and are subject to power, but also express and reproduce power towards their children and other women, for example. Thus, there is no single definition that might describe the role of women in society and even within the social structure of power. And this is certainly the case for men. They adopt different power positions depending on the social role they encounter —as fathers, husbands and labourers. Thus, a unitary definition of the subject would be unrealistic to apply when describing the social role of men and women within the macro

system of social relations. I wish to clarify the relevance of this concept of 'multiple subject positions' as it is crucial to understanding some issues that will be addressed in the following sections. In the remainder of this chapter, I shall explore people's ideas about family planning and how this knowledge enables or impedes them to undertake contraceptive use. This is but one aspect of reproductive health knowledge mentioned by the Mayan respondents.

3. The threat of family planning

Family planning is certainly a term that carries considerable meaning in reproductive health matters. This term has become so popular that it appears to be an automatic practical justification when implementing any research on reproductive health. Within the scope of this research, the issue of family planning was regarded by the participants as being both a cause for concern and a requirement. Directly or indirectly, the matter of family planning was present in any conversation on reproductive processes and family relations. People tried to avoid to mentioning it, or deliberately brought up the issue at the very beginning of the discussions. Arguing that was better to 'get to the point' at once rather than to avoid it. People are used to —and in simple terms, bored with —hearing about it and assume that any health intervention on reproduction is for the purpose of introducing family planning ideas. As a result, family planning has become a rather sensitive issue that provokes the most diverse reactions.

First of all, it is important to point out that the term family planning is a foreign and unknown expression. However, it is a widespread and well known practice among the Mayan communities. In the previous chapter I argued that people objectify their cultural knowledge through certain symbolic practices. These practices, in turn, display a highly structured knowledge about contraception and family planning. As was concluded,

people understand — and act towards — family planning on their own terms. Nevertheless, the language expressions of 'family planning', 'birth control' and 'contraceptive use' do not have any point of reference within their system of knowledge and, more importantly, they have highly pejorative meanings.[2] Western biomedical expressions — and practices — of family planning and contraception are associated with a wide range of negative values and experiences. Whether people agree to use them or not, the mere presence of such ideas within their value system represents a social and emotional threat. In order to identify how these people construct their ideas of family planning, it is first important to explore how they define it in reference to natural and artificial methods. These definitions will be presented in the next section.

3.1 Defining knowledge on contraception

Blumer (1986: 11) states that the meaning of social reality paves the ways in which social groups act towards it. As such, each social group possesses distinct 'world of objects' or system of reference. In order to understand people's actions, it is necessary to identify the world of objects, the concepts and beliefs to which they make reference. Within the communicative practices between users and providers of health services, there is clearly a clash of cultures that expresses dissimilar, and sometimes contradictory, set of beliefs and knowledge. This is certainly the case when referring to their ideas regarding contraceptive methods.

There is a clear divergence between the Mayan system of reference and that of the National Health Service in relation to natural and artificial methods of contraception. According to the Western biomedical model, the term 'natural methods' is used when referring to periodic abstinence, the calendar or rhythm method — which charts the time of ovulation according to the pattern

[2] In the next chapter I will explore in more detail the use of language expressions and neologism as a form of resistance.

of a normal menstrual cycle – and the temperature method – that identifies ovulation by a rise of body temperature (Dixon-Mueller, 1993).

The majority of the Mayan respondents made reference to natural methods when they use *temascal* baths, traditions around the 'placenta language' or when they use indigenous plants and herbs for contraception. Thus, when any researcher or local medical doctor asks people about the use of 'natural methods', their response will always be affirmative, since they are making reference to *their* world of objects in relation to 'natural methods'. This, of course, leads to misunderstanding and misinterpretations:

> Here when doctors come to ask about contraception, people will always say 'yes, we do practice family planning, we use natural methods' but in fact they make reference to their traditional plants. For example, beverages made with avocado seeds, and the use of temascal. I think that very few understand the rhythm method ... and would say that none practice the withdrawal method or any of the others (...) **(interview, expert, woman).**

> People don't know such terms, they are completely foreign to them. Here the majority of people speak K'iché , and since all of such words are in Spanish, they don't have any translation into the K'iché language. And when people translate them into K'iché their version is always a vulgar expression (...) **(interview, expert, man).**

Likewise, the method of periodic abstinence or 'women's dry and humid periods' is a well known practice among Mayan priests and elder *comadronas*, but it is not a popular practice among ordinary lay people. Nevertheless, there are some people who do know about these methods, the ones who are closer to the Mayan traditions or the ones that enjoy a better economic income and some degree of education.

In addition, as reproduction is associated with sexual life, the great majority believe that they have to discontinue their sexual intercourse altogether if they want to reduce their family members. In this respect, the new trend of family planning intervention that introduces the 'birth spacing' strategy instead of

'family planning' is interpreted in different ways. [3] First, it is not understood in terms of widening the intervals between births, but as the 'spacing' of their sexual intercourse. Second, it is also understood as a intromission into their intimate sexual life, a position that anyone would accept:

> I am the owner of my own life, no one can come and tell me how can I 'espaciar' (space) my life with my wife **(focus groups, lay informant, man).**

Similar to these experiences, there are several occurrences in which people's ideas on contraception clash with the ones that the providers of health services hold. The lack of sincere determination to understand the diversity of these sets of knowledge has continuously built a barrier that has denied mutual comprehension. Unfortunately, the common strategy is to keep transmitting information about the variety of contraceptive methods, without taking into consideration the existing knowledge about the matter. There is no real concern to build a space in which people can discuss *their* distinct ways of understanding. Regarding this point, Freire (1985) suggests that any process of education should not be based on *transferring* knowledge but to create the possibilities for the production and the construction of knowledge. He argues that any process of education should be based on the development of critical consciousness, or people's awareness of their own situations. What is important is to generate the conditions for the participants to pose their own problems and question their everyday life experiences, by bringing them into communication, understanding and action. In Guatemala, rather than understanding the diverse ways in which people conceptualise and define their 'own' methods of family planning, research and intervention is directed towards the constant imposition of an unknown system of reference. It is as if everybody is speaking in their own language with no possibility of a point of

[3] In chapter 2, I mentioned that the National Health Services in Guatemala introduced a strategy named 'birth spacing' that came to replace the well-known and stigmatised 'family planning' programme. In theory, this strategy was aimed at implementing longer intervals between births within a family, but it was also aimed at reducing the already negative connotation that the term 'family planning' had among the Mayan people.

congruence. Contrary to the expectations of the health services, the Mayan people continue to construct their own versions of western contraceptive use, full of disbelief and damaging connotations. This point is clearly expressed in their ideas regarding artificial contraception, which is basically the only form of contraception that the medical system promotes.

3.1.1 Pushing artificial contraceptives

Negative reactions are further exacerbated when making reference to the so-called 'artificial methods', which are both totally unknown and considered to be contrary to the principles of the Mayan culture. Hormonal contraceptives (the pill, injections —such as Depo-provera — Norplant) and the IUD are widely associated with sterilisation. There are several reasons for this belief. As discussed in Chapter Two, during the 1970s, many Mayan women suffered massive sterilisations while medical personnel implemented vaccination campaigns to their children. As a local doctor explains:

> I was a witness to such sterilisations in the 1970s. The national army, in its civil action offensives, had the responsibility to take polio vaccinations to Mayan children in some communities. As usual, they just brought the solvent (serum) without the solute (polio vaccine). And of course, they also brought Depo-provera for the mothers, and explained to them that those injections were just vitamins for improving their breast feeding. They vaccinated hundreds of children just with water, and introduced a five-year sterilisation to their mothers, without them even knowing it. So what happened afterwards? There was a huge polio epidemic in the region and women didn't get pregnant. And what are the results? of course people believe ...'It is not worth vaccinating our children since they will get infected anyway', and 'such injected vitamins cause sterilisation'. Two negative consequences that still remain in people's mentalities today **(interview, expert, man).**

Forcing people to have fewer children by using coercion and lies only gave family planning a dreadful name, hurt women and men and reinforced the interplay of authoritarian power structures. Furthermore, the introduction of Depro-provera injections demonstrates yet another abuse of family planning,

as it enjoys the 'injection mystique' in many areas of the Third World (Hartmann, 1995: 201). People associate injections with safe, effective, modern medicine and thus are eager to receive them. This injection mystique reduces the need for motivational effort, the injection is long-acting, effective in preventing pregnancy and can be hidden from women's husbands and their in-laws. It is also easier to administer, without the need to explain its dreadful side effects. For example, heavy bleeding can be particularly serious for undernourished women, who already suffer from anaemia. And since menstrual blood is considered unclean, women who experience intermittent bleeding suffer not only physical inconvenience but social ostracism. But in most of the cases, what difference do such 'minor side effects' make in women's already overburdened life?. Third World women are seen as able to cope with everything.

In this respect, when introducing or promoting family planning, priority is given to those contraceptives that are beyond a woman's control, as is the case with the IUD, injections and transplants. For instance, once a IUD is fitted inside, women cannot remove it themselves. There is the need for a well-trained doctor who can fit it and remove it whenever *he* considers convenient. However, doctors and medical equipment disappear when is time to offer adequate screening, follow up procedures or removal in case of complications. This is one of the main reasons that such contraceptives are regarded as being the most effective methods of preventing pregnancies by local agencies of family planning: fast, long-lasting, effective and low cost. Nevertheless, liberal distribution of other hormonal contraceptives such as the pills is also a common practice among private family planning clinics. They are distributed openly without prescription and, of course, without explaining to people the side effects. As such, people associate those side effects with cancer, sterilisation and infertility; the biggest threat among the community. The combination of all the above mentioned factors and inconveniences has increased people's scepticism and aversion towards artificial methods of

family planning. There is a huge contrast between the traditional agricultural society where the Mayan people are living and the new contraceptive technology that the system imposes. Artificial methods of contraception are perceived as being a threat to Mayan beliefs, values, culture and, as we shall see, are even considered to be yet another wave of repression against the Mayan culture.

3.1.2 'The *ladino* plot' against the Mayan culture

As discussed earlier, the Mayan people have constantly been in peril of persecution, isolation and death from years of military, economic and cultural repression. The destruction of life and community at the time of the conquest through the violent repression of the recent counterinsurgency, have shaped people's strong sense of identity. They perceive themselves as being constantly under threat, as such, they should mobilise and defend themselves against such assaults. Douglas (1966) argues that when a community is constantly attacked from outside, the external danger fosters solidarity within. And this is certainly the case of the Mayan people who have faced persistent aggressions, which, in turn, have encouraged them to be unified against such unveiled attacks. For many Mayan respondents, family planning was described as another form of repression aimed at the destruction of their cultural roots:

> This is not the first time ...we have to keep our eyes open (...) we are attacked from everywhere – taking our land, destroying our crops, killing our people – and now they call it 'birth spacing'. It is all the same ... **(interview, lay informant, man).**
>
> If we don't defend ourselves, no one will do it for us. This new plan of 'birth spacing' is no coincidence. It is a *ladino* plot to exterminate us, to end our culture **(focus group, lay informant, woman).**

In Guatemala, as in other cases, these ideas may have been constructed as a response to colonialism, since indigenous communities sought to reconstitute

themselves after suffering high death rates. Oppressive colonialism and military repression also disrupted traditional methods of birth spacing, causing profound damage that had an adverse effect on Mayan cultural knowledge. As discussed in the conceptual framework of this thesis, society creates an institutionalised mechanism of remembering, if the past symbols have had shared meanings between community members (Ricoeur, 1978; Middleton and Edwards, 1990). Thus, Mayan's traditional knowledge, and their historical resistance, have been kept alive through their collective memory. And those shared meanings embraced in their collective memory are reflected in their existing practices of contraceptive rejection. Therefore, it is important to point out yet again, that social memory and social identity become essential components in the analysis of current reproductive health representations and practices.

In this respect, there have been cases in which Mayan local authorities – Mayan priest for example – openly reject the use of any contraceptive technology as these are recognised as being against the principles of the Mayan cultural identity. Anyone who uses artificial contraceptive technology is seen as a traitor to the Mayan traditions and suffers social ostracism. This situation has several implications. On the one hand, the Mayan people have fostered a sense of solidarity that has helped to maintain their cultural traditions and identity. On the other hand, it has produced a Guatemalan society marked by confrontation and isolation. The system has constantly excluded the Mayan people from their most significant rights and prohibits them from access to any technological, social and economical advances. The only way of approaching them has been through aggression and imposition. Therefore, as a part of their resistance they have developed a strong sense of community identity in which the refusal to use contraceptive technology is but one aspect of the complex system of their expressions of resistance,[4]

[4] Issues of Mayan resistance as a form of obtaining power will be extensively explored in the next chapter.

Nevertheless, despite this open rejection of contraceptive use, and in the face of the well known negative experiences around them, many women turn to use of contraceptives in order to alleviate their daily burden of too frequent pregnancies.

3.1.3 Contraceptive use: conflicting needs and values

So far, we have explored the ways in which people construct their representations of reproductive health in relation to reproduction and family planning. As I have extensively analysed, children are the best social rewards for Mayan women and men, in terms of the economic, social and emotional gains they represent for their parents. Their constructions of feminine and masculine identity are shaped by these ideas of motherhood and fatherhood, which allow people to build a sense of belonging within the community. Since children represent a highly valuable position within the value system of the Mayan culture, ideas of family planning signify a considerable threat.

Mayan ideas on family planning sharply diverge from the ones proposed by the Western medical model, creating disparities and controversies. Such disparities are further exacerbated by the imposition of an unknown system of reference that strongly contradicts the traditional world of objects that the Mayan culture upholds.

Against this background of values, needs, beliefs, positions and gains, there are several women who still want to reduce their pregnancies by using artificial contraceptive methods. These practices demonstrate conflicting needs and values. During the course of my fieldwork I did not manage to meet any woman who openly acknowledged using artificial contraceptives. This is, of course, a taboo topic, which none would recognise. The information was gathered from all other informants, who also refuse to talk about the 'big

issue'. The ones who take contraceptives obviously hide it from their husbands and from other women, as they are afraid of social rejection:

> I am a health promoter and I have some contraceptives with me (...) Some women come and ask for some injections that could help them to reduce their pregnancies. They prefer the injection as it is easier to hide it from their husbands and mother-in-laws. I don't understand why, but injections are the most expensive and women have to take the pill, which is cheaper (...) It is difficult with the pill, women don't follow the instructions (...) and it is more likely to be found by their relatives. Many poor women would like to 'espaciar' (space their babies) but their husbands are so jealous and don't allow them to do so (...) and others feel they are doing something wrong against the Mayan culture. I haven't met anyone who has succeeded in taking contraceptives, they never finish the prescription, they don't have the money to keep buying them, or they simply change their mind **(interview, comadrona, woman).**

There are two points to be considered from this quote. First, women suffering the burden of repeated pregnancies are in need of birth control, but there is little availability of contraceptives. Contrary to what I had previously understood, even women who wish to take contraception are unable to do so as they have to pay for it. And, of course, people would prefer to invest in their daily necessities than to buy a monthly pill supply. And this is not just the case for women, male condoms are also very expensive. Some men who were conscious about the importance of prevention from infectious diseases were not able to afford the high cost of any barrier methods. In contrast, in many family planning posts and health centres, food or clothes were offered to the ones who chose to use contraceptives. These opposite and contradictory interventions – the lack of availability and the use of coercion – also introduces dilemmas to people. There are no coherent modes of intervention, but people are always the 'first to blame' in case of failure.

The second point derived from the quote is related to the conceptions of masculine and feminine identity previously explored. To take contraceptives is associated with infidelity. This was, in fact, the first idea that came into their minds when the issue of contraception was raised. Both men and women have

the widespread belief that contraceptives are used only if someone wants to be unfaithful to his/her partner. Among the male respondents, for example, almost everyone stated that they would prefer to have their wives 'full of children', so that their motherhood obligations do not 'allow them to see other men'. In this respect, to take contraceptives represents a tangible threat to their virility. The case of women is even more complex. On the one hand, they are overburdened by the daily contingencies of their family life. They strive to find a solution by taking contraceptives. On the other hand, this social need may be contradictory to the beliefs and values in which they have been educated and, of course, they also put in danger their social relations and integration within society. This dissonance between needs and values definitely influences their decisions regarding any family planning actions.

This conflict between needs and values is also present in their conceptions of femininity. Women also associate the use of contraceptives with infidelity and reject their use – or change their minds – if this action will threaten their marriage. Many women prefer to have as many children as possible, in order to secure their relationships with their partners:

> ...They envy me, even if I am not his wife, it is with me that he has children. His real wife couldn't have more and he already has three with me. And if he wants he can have more ... **(interview, lay informant, woman).**

As such, women may also feel offended when their partners suggest undertaking any family planning action as it represents an affront to their already destabilised feminine self-esteem. In many cases, women are the ones who refuse to implement family planning even if their partners agree to do so. The following expressions were common among the respondents:

> I felt very bad when he wanted to 'espaciar' (birth spacing) ... I thought he was going with other women and didn't want to have children with me anymore **(interview, lay informant, woman).**

> No one understands women, they are crying to have less and less children, but if their husbands come up with the initiative of using family planning, they reject the idea and become very jealous. Women accuse men, men accuse women ... no one reaches any conclusion **(Interview, expert, man).**

As we have seen, people's representations of reproductive processes and ideas about family planning have been shaped by a wide array of social components. Their participation in health-enhancing activities has been characterised by the expression of conflicting, and sometimes contradictory, needs and values. These ideas are grounded on the diverse social roles and positions that they uphold. In the case of women, for instance, their views and participation may change – and sometimes may be contradictory – depending on their social positions and the roles embraced. These diverse and contradictory subject positions are part of the multiple dimensions of human beings, who do not simply react to social strains from one single perspective. As stated earlier, individuals are versatile complex subjects, and they assume numerous subject positions within a range of discourses and social practices (Moore, 1994). Therefore, conflicting needs and values foster contradictory material and discursive practices. These actions are part of the ongoing system of social relations in which people strive to find a place to express their needs within a convulsive social world.

Contraceptive behaviour is one of the most complex issues in healthcare and related practices. It is a battle between two distinct conflicting poles expressed at every level within the social system. First, it expresses conflicting views between men's and women's values and needs within the household. Second, it also communicates contradictions between two distinct sets of systems of knowledge: the Mayan culture and the Western biomedical system. These antagonisms and clashes are reinforced by the way in which the communicative actions are established at every level: through impositions, coercion, lies and abuse, a paradigm that, in turn, fosters an ideology of oppression and power struggles from the highest level of society to the micro-

social world of gender relations. The family planning programme is built on a philosophy of fear, not understanding.

4. Concluding remarks

In this chapter I discussed K'iché representations of reproductive health in relation to two interrelated and far-reaching processes: reproduction within the household and family planning. Each topic included within the analysis exposes people's primary concerns and interests in relation to their reproductive lives, or ideas about having children. In this respect, it is important to point out that meanings and actions vary from one context to another, as each village and community generates different kinds of experiences. Specific living conditions shape their conceptualisations of reproduction and illustrate the truism of diverse kinds of data. Therefore, in order to do justice to the wide range of concerns and ideas on reproduction, the analysis aimed to explore the diversity of views that are part of the people's definition of reproductive health.

As explored above, representations of reproductive health form the cornerstone from which psychosocial, cultural and historical processes emerge. These processes are expressed at every level within society, from the household to the macro social level. As such they also express ideologies that naturalise reproductive processes and power relations. Naturalisation of reproduction, in turn, serves to naturalise social inequalities in relation to gender and ethnic identity. It is upon the naturalisation of reproduction that Mayan representations of reproductive health and practices are constructed:

1. Patriarchal ideology constructs representations of reproduction which prioritise men's needs and rights over women's, reducing the latter to their reproductive role alone.

2. Women construct their representations of reproduction through the value of motherhood. The valorisation of children as women's ultimate social end ostracises women unable to accomplish this target. In the case of men, their representations of reproduction also shape their conceptions of virility, which are further invested with the valorisations of their parental obligations undermined by an exclusive and discriminatory social environment, a position that also serves to exercise power over women and children.

3. It is for that reason that representations of reproductive health shape conceptions of gender and ethnic identity. It also shapes the quality of people's social interactions and provide a space for expressing socially condoned actions.

4. Within this adverse social context, family planning represents a threat that imposes foreign Western values and generates conflicting views between values and needs. Mayan ideas regarding family planning sharply diverge from the ones proposed by Western medical knowledge, creating disparities and controversies.

Following the logic of unequal positioning and satisfaction of needs, in the next chapter I will explore the ways in which Mayan people express themselves through actions in resistance to impositions. Resistance is analysed as a form of obtaining power and as a way to re-establish their undermined gender and ethnic esteem, within the context of reproductive health representations and practices.

Chapter 8

Shaping Participation and Social Agency

1 A closer look at participation
2 Reproductive health authorities: the establishment of a contradictory discourse
2.1 The national health services: rhetoric and reality
2.2 The illusion of empowerment programmes
2.3 Through the glass of the local church
3 Is participation a definitive concept?
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3.2 Participation and its symbolic and daily expressions
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3.3.1 The birth of a culture of control and violence
3.3.2 Controlling and being under control
3.3.3 APROFAN: the byword for restriction
3.3.4 'To keep the secret with us'
4 Return to the local: natural methods and empowerment
5 Conclusions

This chapter explores community participation in reproductive health enhancing activities, by exploring the link between participation and resistance. In doing so, it addresses three broad and inclusive issues. First, I explore the context in which participatory actions are directed. In doing so, I analyse the mainstream providers of health promotion services, that is, the state's national health institutions, international health agencies and the Church. I analyse how the macro-social level of intervention implements contradictory methodologies, which introduce dissonance between the values they promote and the actions that are implemented. In the second section, I explore the Mayan people's participatory practices regarding these services, looking at their actions of resistance as a form of participation. I argue that community participation is an extensive concept, which can be defined in different ways. One way is through the construction of meanings, discursive and non-discursive practical ends. I will then go on to explore, first, the implementation of Mayan symbolic practices as a means for expression of their

power and thus resistance. And second, I will look at the creation of special linguistic codes – neologisms and stigmatised utterances – related to the Mayan reproductive cosmology. In this section, I argue that by constructing special codes, people implement their participation and edify a space of reality in which their identity can be expressed. In this sense, resistance is valued as a resource for living, which allows people to re-establish their previously undermined social position and power and enables them to sustain their cultural boundaries. In the last part of the chapter, I explore how these dissimilar systems of knowledge can engage in a dialogue. This will be done by exploring the benefits of the concept of empowerment and the links it has with the promotion of natural methods of contraception. Finally, some conclusions will be drawn.

1. A closer look at participation

Community participation in health promotion is not an isolated concept. It goes hand in hand with other areas of social and community development and sociopolitical organisation. Within the framework of participatory health promotion processes, there are a number of different approaches that have developed both the theory and practice of health promotion.[1] As discussed in review of the literature (Chapter 3), there is no doubt that these new frameworks of participatory research have overcome some of the weaknesses evident in the initial proposal of the 'victim blaming ideology'. Nevertheless, one of the fundamental problems that remains is the interpretation of participation and health promotion using a top-down framework analysis, rather than health promoters being seen as 'knowledgeable partners' in the educational relationship. Whichever way you look at it, participation seems to provide the vital foundations on which to achieve health, at the same time

[1] See Chapter 3: Prevalent Approaches to Health-Related Practices. 4.1.2: Community Participation.

giving intervention programmes a 'unique sense of appropriateness' (Ramella and De la Cruz, 2000).

In order to obtain this sense of appropriateness in participatory intervention, it is necessary to promote a deeper involvement of the diverse social actors engaged in the educational relationship. That is to say, that both users and providers of health services make a symmetric contribution in the construction of health interventions. Considering our existing health promotion reality, this argument would seem to be quite illusory. And this illusion is not just grounded on the practice of health promotion itself, but more importantly, on the ways in which health intervention programmes, and the correspondent community participation, are conceptualised. In order to introduce a new dimension to the analysis of participatory actions in health promotion, conceptualisation of community participation should include the study of the social psychological processes that underpin health-enhancing practices. These psychosocial processes are part of the vast and diverse system of local knowledge within a specific cultural reality.

At this point, we come back to the issues of the conditions of production and transmission of Mayan representations and their expression in daily practices. In this sense, community participation is seen as a form of daily practice, an expression of their cultural beliefs and values. If we consider community participation as the expression of cultural and social knowledge in practice, we enter into a complex framework through which participation should be understood. On these terms, I have already explored diverse forms of participation in reproductive health-enhancing activities throughout the course of this thesis. For example, the ways in which Mayan cultural knowledge is objectified through key cultural and symbolic practices should be viewed as a form of participation. Or looking at the case of the multiple gender and subject positions (for example, the value of motherhood) I have also investigated people's participation as a form of social interaction in the public arena. As

discussed earlier, by acting within the social environment, the subject's knowledge is recreated, at the same time fostering new practices. This interplay between knowledge and practices permits people to build strategies of survival when there is an overwhelming scarcity of social resources. These actions and knowledge create a space for agency and change within a violent and tumultuous social system. As I have concluded thus far, people develop their participation towards reproductive health activities on the basis of their reproductive health knowledge and practices.

On the basis of this understanding of community participation in health intervention, in this chapter I shall explore another angle from which participation can be comprehended: the examination of people's participatory actions by looking at their diverse forms of resistance and social agency. Faced with an enduring oppressive system, people organise their continued resistance and build forms of participation that allow them to express their interests, knowledge and power. Thus, participation in reproductive health issues not only refers to the ways in which people implement or reject health services by their use of family planning services. Likewise, it cannot be reduced to the community's strategies and abilities to identify 'their own health needs and assume responsibility for their own development' (Stone, 1992: 409). Participation implies diverse modes of resistance in form of silence and the construction of special linguistic codes that permit outsiders to enter into — or to be excluded from —the Mayan's world of objects. It also entails people's abilities to express themselves and openly participate, when the possibilities of dialogue and communication allow them to do so. In this sense, it must be stressed that it is only because of their creativity and energy that people manage to survive their pervasive poverty and maintain their identity. The poor show signs of vitality that are astonishing, considering the objective conditions they face. By objectifying their cultural knowledge in practice — discursive and non-discursive — the people resist and build new forms of participation in health interventions.

In order to explain the former argument, it is first important to revisit the contextual conditions from which participatory actions are originated and engaged. If one's aim is to understand a community's participatory actions in health intervention, one has to explore the context in which these actions are directed. In this respect, I shall begin by exploring the mainstream health services that are available to the Mayan communities, that is, the role of the national health services, international organisations and the Church. These dissimilar establishments sustain and implement distinct sets of systems of knowledge, that compete and clash with the Mayan's world of objects. The asymmetrical relationship between users and providers of health services is an expression of these conflictive systems of knowledge that often provokes contradictions and undermines active community participation. It is on the basis of these competing systems of knowledge that participatory actions are fostered.

In order to accomplish this initial aim, I will explore the people's perception of, and satisfaction with, the local reproductive health services. This analysis will be complemented with some case studies. Second, against this background, I will explore how communities respond to, and intervene in, the health services provided. I will look at the people's actions of resistance, through the construction of both cultural practices and the creation of linguistic codes – neologisms and stigmatised utterances. I argue that by implementing communicative actions, the Mayan people seek to obtain power and to re-establish their undermined sense of self-esteem. Actions of resistance may be seen as a form of community participation and agency, which creates a space of reality in which issues of identity and power can be expressed. Finally, I will investigate how this conflict between two different systems of knowledge can take the form of a dialogue and lead to a community's empowerment. This will be done by describing the significance of natural methods of contraception.

2 Reproductive health authorities: the establishment of a contradictory discourse

As stated in Chapter 2, Guatemalan health promotion activities – either participatory or information based – are virtually non-existent at the level of macro-social public intervention. The scarce national budget for health is mainly allocated to curative actions. Thus, health promotion activities are likely to be implemented at the non-governmental level or by private institutions only. However, as such establishments come from a wide range of political and ideological backgrounds (Ekern, 1997), there is no coherent way of implementing reliable participatory methodology to specific social realities. The situation is even more limited when it comes to health education on reproductive topics. Since these issues are regarded as taboo areas, whatever form of health promotion – participatory or non-participatory – is entirely left to the individual families. As such, people have no other option but to recur to the Church in order to find answers to their questions on reproductive and sexual matters.

The situation becomes even more deplorable in the case of reproductive health promotion among the Mayan communities. In the highland villages, for example, people are 'approached' only when there is the need to distribute contraceptives, and of course, without their being informed about the characteristics of such devices. As stated in Chapter 6, based on their traditional practices of sexuality and healthcare, people obtain knowledge through their grandparents, committees of principals and *comadronas*. However, such knowledge is not transmitted until they marry or they start to bear children. As such, sexual health promotion focused on the younger and more accessible ages is almost non existent. Coupled with this problematic level of health services, intervention programmes often implement contradictory methodologies in which their theoretical frameworks contradict what they actually put into service.

Therefore, the wide range of limitations in developing effective participatory community-based projects is linked to the way in which health institutions approach the people. Why is it that there is such a wide gap between the health proposals and concrete practice in the field of health education? What are their real proposals? In what follows I shall explore people's perceptions and ideas about reproductive health institutions.

2.1 The national health services: rhetoric and reality

When gathering information on how people seek medical care during pregnancy and related reproductive stages, there was a common answer among the respondents:

> We try to avoid the medical care coming from the health centre. And in any case where we do use it, we practice it in our own ways **(focus groups, woman, lay informant).**

The fact that people wish to introduce changes or to implement a mediation between their knowledge and the ones that the Western medical services provide, indicates levels of dissatisfaction with such services. There are several reasons behind this dissatisfaction, and these are reflected in the content of such health services, as well as in the quality of the delivery. Regarding the content of the national health services, it is clear that official reproductive health systems prefer modern Western-style medicine, undervaluing traditional forms. In the case of family planning, this means that birth control methods in use for generations, whether they be herbal beverages, withdrawal, abstinence or prolonged breast-feeding, are passed over in favour of modern contraceptives. These devices are often less culturally acceptable and more disruptive of traditional practices. As one local doctor explains:

> People come here and ask about how to reduce their pregnancies. The first thing I do is to ask 'what do you know about birth spacing', and they start to tell me a few things about their traditional methods. Unfortunately, with respect to contraceptive

> use, I can't suggest any better alternative than to use these technical devices. But my experience has told me that I would do better to try to combine their beliefs with what I try to give ... Very few medical doctors understand this. They believe that there is nothing that people can tell you and it is just waste of time. But I think that to interfere with local beliefs and constraints can only serve to increase fertility levels ... **(interview, expert, man).**

The fact that Mayan people seek medical care determines a need for health actions, and in most of the cases, there is no possibility for them to find satisfaction of those needs. Since the medical system of knowledge interferes with the Mayan one, the usual reaction from the Mayan people is to avoid it, or to utilise it with reticence and scepticism. Given the fact that the official health institutions do not acknowledge traditional Mayan medicine as a resource for living, there is no real concern to conduct research into these traditional methods. There is even less interest in providing the practical mechanisms for improving and understanding such practices. Yet, as a health worker explains:

> The Mayan culture is full of traditional practices in relation to reproduction. Some of them are extremely positive for the people, as they feel good when practising them. But others are not very effective and need improvement. And here we comes again to the question: how can we make people understand that some practices should be improved? If you talk about that, people would react as they think you want to change or 'make their practices disappear. And we understand this, because this is what medical doctors come to do **(interview, expert, man).**

These arguments uphold what was explored earlier in Chapter 6: Mayan representations and practices of reproductive health are intrinsically linked to the survival of the community as an ethnic group and express the crucial link between representations and identity. Medical health institutions impose a restricted system, paying little or no attention to the existing cultural knowledge. In response, people may stick to their traditions, or given their lack of sufficient medical knowledge, may make inadequate use of such treatments, as occurs in the case of using the hormonal pill or the application of other medications:

> I don't ask anyone what I should do. I have my own knowledge. When I go to the hospital I just ask for injections for my wife ... that's it **(interview, lay informant, man).**

> I always ask the *comadrona* what to do. If she sends me to the doctor, I obey her, but she already knows what I have. I can't use such treatments that the doctors gave me. Once I used them and became very sick, if it hadn't been for the *comadrona* I would be dead **(interview, lay informant, woman).**

The lack of acknowledgement and investment in the Mayan's traditional knowledge by the official health authorities may jeopardise the community's real interest and initiatives in implementing better health options for their survival. And in the most severe cases, may even put people's health in danger. Within the highland villages, it seems that the national health services do not view health as a human right and as a resource for everyday living.

Regarding the quality of delivery of the reproductive health services, there are several impediments to people's participation. According to the medical health personnel of the NGO I was working with, medical health promotion programmes are characterised by being inappropriate for the local communities. Transmission of western ideals, lack of knowledge of the Ki'ché language, absence of positive attitude towards the people and an aggressive doctor-patient relationship are among the problems mentioned:

> Doctors tell us all things what we have to do, that we have to eat fruit, meat, vegetables to improve our health and our baby's health. But here, we don't have all these things ... At the entrance of the health post, there is a big poster which shows a lot of fruit, milk and meat. I always look at it. Here we can't afford to buy these things ... **(focus groups, lay informant, woman).**

> I think that one of the main problems is communication. The majority of our women can't speak Spanish and Doctors can't speak K'iché ... so women are afraid to go to see them, as they can't follow their instructions. Another thing is that they would prefer to have a female doctor to feel more confidence, but I haven't seen any female doctor around here **(interview, lay informant, man).**

> Many doctors don't have patience with their patients, and as we are Mayans they are aggressive and racist. I know that many people do not want to visit the doctor, even though they have some economic possibilities, they don't want to be carelessly treated **(interview, expert, man).**

These factors are further complicated by other material and economic impediments, which are among the major restraints. In the majority of the cases, clinics are far away and are mainly attended by auxiliary nurses, with people being unable to pay the cost of their services and medicines. In sum, the medical institutions impose the authoritarian model of 'or you are in or out', which does not invite people to participate in any health intervention. Against this backdrop, people make no effort to use medical services and their scepticism is reinforced with repeated negative experiences. Thus, besides the conflict between diverse systems of knowledge regarding reproductive practices, there are a number of material obstacles that hinder the community's participatory actions. As stated earlier (Chapters 4 and 7), reproductive health representations and practices have been shaped by a system of social exclusion that promotes an ideology of domination and the denial of people's differences. As a result, health interventions may be evaluated as a part of this scheme of values and ideologies, which reinforces the segregation of a stigmatised social group. In this way, health intervention is but one aspect to be considered within the more generic system of social exclusion promoted by the state. It is for this reason that participation in health-enhancing activities should be evaluated within the context of the existing political structure, local health policies and the quality of the delivery systems. As the healthcare system is not built in isolation, in the next section I will explore the role of foreign aid agencies in the promotion of reproductive health. This will be done by analysing the contradictory messages emitted when empowerment programmes are undertaken.

2.2 The illusion of empowerment programmes

When reviewing the reproductive health literature on the application of empowerment programmes, and when contrasting it with the local reality in which those programmes are applied, I found a profound contradiction. This contradiction is not to be found in the conceptualisation of 'empowerment' per se, but in my view, it is reflected in the conceptualisation of health as a resource for living (WHO, 1986). This contradiction is fundamentally established in the mere fact of, on the one hand, encouraging empowerment programmes – and concomitant community participation – and on the other hand, implementing the use of contraceptives which are beyond women's agency and control. This opposition sums up the list of impediments to participatory interventions from the community. In order to express this point, I will first review the concept of empowerment and its applications with regard to local realities.

Following the International Conference on Population and Development (ICPD) in Cairo, 1994, the population agenda broadened to incorporate empowerment concerns (Jackson, 1994). As discussed earlier, empowerment is a particularly complex concept because it is multidimensional and takes place in multiple domains: home, community, organisations, political realm, and so on. As such, its analysis requires a profound immersion in each of the social arenas that it covers. It is acknowledged that well-empowered individuals and communities can provide supportive status to communities (Rissel, 1999). As such, it is argued that empowerment programmes go hand in hand with educational practices. All of this is acknowledged within the population and family planning establishment today. But going a bit further with the analysis of such projects, and observing the reality of local people, it is interesting to see that these paradigms are in contradiction with the practices they foster.

As I explored in the previous chapter, looking at the case of contraceptive use, the local family planning agencies in the Third World prefer the application of

the so-called hormonal injected methods and IUD devices. This preference is towards long-acting methods that require little initiative by the user, minimal control and minimal interaction between the user and provider. People are not advised about the side effects of such devices, and when they do suffer them, there is no well-trained doctor who can implement check up procedures or removal. Women, then, have to adapt themselves to situations that impede their participation and inhibit their decisions. Coincidentally, the case of industrialised societies is quite the opposite. Hormonal pills and barrier methods are the most widely used and distributed methods and hormonal implants are almost unknown (Bracht, 1999). In the industrialised nations contraceptive methods are implemented in ways under the complete control of women and their partners, in which their decisions are respected and considered. Is it a coincidence that Third World women have to accept methods beyond their control, while their counterparts in developed nations enjoy the options that remain strictly under their control? Whatever reason the population establishment gives for this contrast, imposition is imposition. As Hartmann (1995: 173 *in original*) points out, 'technological innovations are not "neutral"; instead, they embody the values of their creators'. In this respect, the demographic objective is obvious in the design of such drugs and devices, which impose not only contraceptives that are beyond control but their concomitant negative values.

By implementing the 'hidden alternative' of using implants or injections, which 'help' poor women to implement family planning without the consent of their in-laws, contraceptive technology is also encouraging several negative principles. Lack of communication between couples, defamation, lies, insecurity and distrust are just some of the damaging values which are implicitly promoted when implementing the use of 'Third World' contraceptives. By designing a 'hidden alternative', they are obstructing people from implementing communicative actions within the family and community.

There is also an implicit ideology of oppression which patronises women's and men's decisions, values and rights. As a health worker explains:

> Very few would agree to use the injection or implant, and if they do so, it is out of pure need. Women would prefer to be at peace with their husbands and not to be punished for being controlling (practising contraception) ... And as I told you before, many women change their minds in the middle of the treatment and it is impossible to take it (the implant) off once it is fitted ... Many women come here being angry with me as they can't take it off ... and some even blame me for their husbands abandoning them **(interview, expert, woman).**

By creating and imposing such actions, it is clear that coercion, silence and control are the principles to be transmitted. In this sense, we come back to the issues addressed in previous sections (Chapters 2 and 7); Why does the macro social system of intervention – population agencies– utilise these institutionalised practices of silence and control in implementing their health interventions? Why are these values, which are widely acknowledged to be negative ones, the ones which are reinforced within the communities?

The definition of community empowerment states that social action should be promoted to encourage people's participation in gaining control over their lives. These ideas are based on the World Health Organisation's (WHO) conceptualisation of health promotion – which conceives it 'as a process of enabling people to increase control over and improve their health' (in Webb and Write, 2000: 88). But taking a closer look to both conceptualisations, are these ideas inconsistent with the practices of contraception they promote?[2] In order to encourage a complete state of physical and mental wellbeing and promote community participation, health interventions should not introduce dissonance between values and practices within the communities.

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[2] This contradiction is even clearer when one notes that the UNPFA (United Nations Fund for Population Activities), is one of the largest donors for implementing birth control in the Third World and one of the main suppliers of the injected contraceptive Depo-Provera (Fathalla, 1994).

By doing so, people have to carry with them another existential dilemma. On the one hand, social agency and control over their lives is promoted. On the other hand, a five-year injection is given, leaving women without the possibility of using the 'empowerment' they have already 'learnt'. In this sense, promotion of their 'complete mental wellbeing' is overlooked or forgotten.

Thus, contradictory methodology that advocates underlying negative values serves to introduce conflicts in decision-making among social subjects, when implementing their reproductive health practices. These ideas come to reinforce the conflict now prevalent among the Mayan people between values and needs with respect to contraception (Chapter 7). And above all such methodology comes to undermine people's active and spontaneous participatory actions. In order to meet their need for advice on sexual reproductive health, people have no other option but to recur to the local church, which only adds to their existential dilemma. In the next section I will explore the role of the Church in promoting community participation in health-enhancing behaviour.

2.3 Through the glass of the local church

Any analysis of the reproductive health experience in developing countries would be incomplete without mentioning the role of the Church, or of religious movements. As pointed out in Chapter 2, the dynamic of religion in any culture is a very complex matter, and it is ambitious to analyse it within one single review. But what I would like to outline here is the role of Pentecostal movements – evangelical or Catholic charismatic – [3] in the promotion of reproductive health behaviour among the Mayan communities. As was widely acknowledged among the health experts participating in this study, religion is perhaps the greatest impediment to encouraging people's participation in

[3] See Chapter 2 for a review of the origins of the religious Pentecostal movements in Guatemala. 3.2.2 Religion as an Instrument of Ideological Control.

health-enhancing activities. This assertion does not only imply participation in reproductive health matters. It has to do with the obstruction of people's participation in any kind of social engagement. Such radical movements aim to influence people by introducing an ideology of insecurity and a lack of perspective: everyday life is seen as simply the preparation for a much better one, which will come soon if people allow themselves to be converted to Pentecostal ideas. In order to make people insecure, these religions attempt to penetrate their primary frame of reference, their basic beliefs, their most precious values and their common sense. It is here that religion begins to play an important role, since it forms part of the world view of any population.[4] In this respect, many health interventions are blocked by practitioners of such religious sects that neglect first, the value of traditional Mayan religious practices accusing them of 'paganism' and, second, these movements impede people's participation in health-enhancing practices:

> In our region, the worst impediments are these evangelical pastors. There are many experiences I can recount, but I will just tell you one. In one of our vaccination campaigns around the villages, we succeeded in implementing the use of vaccines and drinking serum among pregnant women. People attended our discussions and tended to participate actively and were courageous in asking questions. The week after our visit, we went back to the village to distribute the second dose of these vaccinations. What did we find? No one opened their doors, people were very aggressive and some people even threw boiling water at us. We wondered what had gone wrong. After a while a local *comadrona* told me that the (evangelical) pastor got so angry with them and told everybody that God would not allow them to use such things, as it was against his will. If they have to die, they will die anyway, with or without injections. And we health promoters, were satanic and were sent by the devil ... **(focus groups, expert, woman).**

[4] In this respect, it is important to point out again that when I mention religion, I refer to radical religious sects — Pentecostalism, charismatic Catholicism. I do not include a variety of religious movements — Catholic and non-Catholic priests, pastoral workers and catechists — that promote social change and better health conditions through the creation of Christian-based communities and NGOs. Unfortunately, the radicalist movement is predominant throughout the rural areas of Guatemala.

This example is an ordinary occurrence among Mayan villages. As is the case of many *comadronas* that are directly approached by evangelical pastors who strive hard to 'convert' them to the Pentecostalism. Some of them renounce their knowledge, but others are forced to opt for a hidden practice, a case that reinforces the culture of control and repression:

> I learnt all these customs from my grandmother, but I stopped practising them. My son is an evangelical pastor and quarrelled with me each time I attended a pregnant woman. Never mind, for me it's the same ... Now, they (women) still visit me when my son is not at home, or I meet them somewhere downtown. But to give all our treatments, I can't. I am now evangelical and God may punish me if I keep giving such things to women **(interview, *comadrona*, woman).**

Regarding the role of religious Pentecostal movements, Cohen (1995) argues that such groups act as a society with closed boundaries, which penetrates ideologically in opposition to the symbolisms possessed by an outside community. Their constructed stigma is used 'as a symbolic means of asserting and embellishing its own boundaries, and as a means of constructing an alternative community' (1995: 62). Their 'alternative community' seeks to eradicate Mayan activism by destroying the cultural values that ensure cohesion and collective action. They also strive to instil insecurity about 'ones own beliefs, judgements and feelings, about right and wrong and about what should and should not be done' (Martín Baró, 1996: 139). In order to prevent people from acting against their oppressive reality and promoting their own development – from participation in health movements to insurgency groups – radical religious movements seek to win the 'hearts and minds' of the people, by introducing a deep existential dilemma, a psychosocial conflict that threatens their collective action. By mentioning the role of radical religious ideas in the construction of community participatory actions, I aim to with the paradigm of condemning 'local religious beliefs' as the main impediments to the introduction of health promotion. Health research usually states that strong religious beliefs undermine people's acceptance of health services, a statement that omits a deeper critique of the conditions of production of people's

religious ideas and their influence in building up negative reactions towards health services.

To conclude this section on the mainstream providers of reproductive health services, we can take into consideration several points of analysis. *First*, all of these models are designed and implemented as an ideology that neglects people's needs and real interests. Each organisation or movement – directly or indirectly – approaches the people with a deliberate interest, which does not necessarily mean a real concern for improving the community's reproductive health status. *Second*, by concentrating their efforts on birth control actions – be they in favour or against these – other reproductive needs are ignored. And by doing so, they also neglect the underlying causes of people's deplorable reproductive health conditions. *Third*, these institutions do not have a coherent and joint strategy from which the problem of community participation in reproductive health intervention might be understood and approached. As a result they tackle the same problem in many different, and sometimes contradictory, ways. *Fourth*, by promoting deliberate actions of imposition and control, and by transmitting contradictory messages, such institutions introduce conflicts in people's decision-making, dilemmas that undermine their active participation and create a context of uncertainty and insecurity. Taking into consideration the former analysis of the contextual environment in which participatory actions are fostered, in the second part of the chapter I will explore diverse forms of community involvement in these reproductive health interventions. This will be achieved by looking at the link between participation and resistance.

3. Is participation a definitive concept?

Mayan people have experienced decades of diverse endemic violence and repression. This violence is not only marked by physical confrontation and deprivation but by the denial of the expression of their most significant cultural

and social knowledge, needs and rights. As in the case of power relations, there is an interplay of diverse forms of domination which are constructed and expressed in diverse social settings within the social structure, from the household to the macro-social levels. The multiple nature of subjectivity is experienced physically and discursively, through practices that may simultaneously impose coercion, prohibition and silence. People live and act within a system that has constantly nurtured a web of unresolved conflicts: land disputes, unrecognised leadership, illegitimacy, impunity and denial. Without a doubt, whatever the form of aggression — within the family or the state — people experience themselves as being under constant intimidation and threat. And this is the permanent backdrop against which the Mayans live: a social system that constructs and promotes a culture of violence.

Violence and domination do not imply an undemanding acceptance and adaptation. On the contrary, they entail struggle, resistance and action. As was discussed in the conceptual framework, the ideological construct of the 'lazy Latino' imposes certain categories that assure that the dominated 'learn their place' in society as the poor and the troublesome people (Martín Baró, 1996: 214). As such, they have the duty to accept the established order which provides the social opportunities they 'deserve' and 'passively' accept. Against these ideological assertions, it has been demonstrated that people construct their participation in social activities based on their actions of resistance. At the social level, for example, resistance is part of a resource for living that allows people to maintain their cultural and social boundaries. It is precisely through this sense of active resistance that social groups and communities find an expression of difference (Hall, 1990). Nevertheless, resistance need not be only discursive, coherent or conscious. A great number of actions are not deliberately organised or clear. They are apprehended only when they find a concrete expression or after their effects are known. In this case, actions themselves can be seen as a part of critical reflection (Freire, 1985). Whether conscious or not, actions of resistance denote an attempt to express rejection,

unconformity and to allow people to create spaces to express their power. In this sense, resistance is a form of power, a means to re-establish an undermined social position and sense of self-esteem (Martín Baró, 1996; Fals Borda, 1988; Freire, 1985).

It is important to make clear the diverse and multiple nature of representations and practices as this is crucial to identifying the dissimilar forms of resistance that involve people's participation in health interventions. Modes of resistance operate in different ways, as a form of non-discursive —physical — and discursive — language —practice. Both forms are interrelated and cannot be conceived in separation from one another. As such, these forms of participation are part of a coherent and a conscious alternative, but they also involve the ability to construct meanings from seemingly trivial events. Having said that, in the next section I will explore how people construct distinct modes of participatory activities by implementing actions of resistance.

3.1 Resistance as a form of participation

People construct different forms of participation in health-enhancing activities, which are characterised by being multifaceted and heterogeneous. This heterogeneous nature of participation corresponds with the versatile disposition that human beings possess in different circumstances, expressing a wide range of interests. As has been discussed at length, social subjects may act according to a variety of subject positions within the social system and between diverse social groups. Thus, they constantly have to deal with a diverse set of roles, which require them to act differently. In this respect, people construct their practices in terms of competing sets of interest, needs, positions and expectations. This reality is fully reflected in the ways in which people act towards health services. As a response to cohesion, for instance, an individual may agree to use contraceptives, while in other circumstances they would not do so. The complex nature of human intersubjectivity makes us understand

that there is no coherent and linear way of acting. For this reason, any ill-health behaviour should be considered in relation to a wide range of issues that shape such discursive and material practices. In order to analyse this argument in more detail, I will go on to explore participatory actions in health intervention by looking at the actions of resistance at both the level of material – non discursive – and discursive practices.

3.2.1 Participation and its symbolic and daily expressions

As I have already addressed in detail (Chapter 6), socially transmitted cultural knowledge comprises the objectification of a number of rituals and cultural practices that keep the cultural system of the community alive. At the same time, it provides the community with a clear sense of identity and belonging. That is to say, cultural practices regarding reproductive health are deeply related to the survival of the community as an ethnic group, expressing the crucial link between representations and identity. Among those symbolic practices related to reproduction I have explored the use of *temascal* baths, the placenta language and the work of traditional birth attendants or 'comadronas'. In this respect, I argued that by implementing these practices people reaffirm and reinforce their community boundaries and sense of location. And by keeping a sense of boundaries, Mayan communities find an expression of difference.

In the same way, in Chapter 7, I explored a number of practices within the household. I argued that representations of reproduction shape conceptions of feminine and masculine identity through the value assigned to motherhood and responsible fatherhood. The threat and uncertainty that a patriarchal system imposes on people serves to institutionalise a number of practices in relation to their reproductive behaviour. By overvaluing the meaning of motherhood, women find a socially acceptable refuge in their children, their greatest social rewards. This value represents a powerful incentive for high

fertility. It also undermines the possibilities of acceptance of family planning services, since their practice represents an attack on their already undermined gender and ethnic esteem. In this sense, the ways in which people act towards, and participate in, social services, including health services, is linked to their conceptions of identity, asymmetrical power relations and the social positions that the different members of household possess.

As we have seen, social practices have been analysed from several perspectives, as a way of objectifying cultural knowledge and as a form of social interaction within the household. These practical ends are particularly important when considering the ways in which people interact towards social and health services. Since both material practices imply a reaffirmation of community boundaries and identity – gender and ethnic – they are intrinsically related to the expression of power and, thus, resistance.

The picture that has emerged from this analysis is very complex and points out to an idea brought up by Bourdieu (1990), who emphasises the practical nature of social knowledge. He argues that praxis is not simply about learning cultural rules by rote and the application of such rules. It is about coming to an understanding of social distinctions through the body, spaces and social roles. Thus, it is not necessary for social subjects to be analytically or discursively aware of their values and knowledge to invoke them or use them strategically in order to gain power. What is necessary is that such social knowledge should be expressed in the practices 'of how to proceed, of how to participate in social situations and of how to manipulate such situations' (Bourdieu, 1990, in Moore, 1986: 190). In this sense, Bourdieu argues that members of the household possess diverse sets of knowledge and experiences, and by putting them into daily practice they also express their power. A good example of this interplay between knowledge/practices and power is represented in the image of *comadronas*. By practising their traditional knowledge of reproduction, they also exercise their power over other members of the household and over the

providers of health services. Through the practice of their cultural knowledge, 'comadronas' maintain a sense of distinctiveness, which serves not only to empower their ethnic and gender identity, but also to resist against impositions and aggressions. At this point, I am able to turn to the issue of resistance as a form of participation in health interventions. In the next sub-section, I will explore how the implementation of people's material practices may serve as a form of resistance to, and participation in, health-enhancing activities.

3.2.1 Standing up for their boundaries

When reviewing the data on Mayan perceptions of family planning (Chapter 7), I argued that people consider such services as a threat to their gender – feminine and masculine – and ethnic identity. As such, they seek to mobilise and to defend themselves against confrontations. This reality sustains the idea that when a community is constantly attacked from outside, the external danger fosters solidarity within (Douglas, 1966). Cohen (1995) transcends this argument by adding that rituals are symbolic practices that increase in importance within the boundaries of a community when they are undermined and destabilised. People build special practices, or strengthen the old ones, when their boundaries are threatened or omitted. The practice of a ritual, therefore, provides an occasion to reconstitute the community.

What emerges from this discussion is that by implementing material practices regarding reproduction – as a form of ritual or everyday interaction within the household – Mayan people resist and express their power. And this resistance is expressed in a set of practices that seeks to reconstitute the community's identity. Practices that are, in turn, articulated in diverse forms of participatory actions in health interventions. As a local doctor expresses:

> ... To interfere with local beliefs and constraints can only serve to increase fertility levels. If I come to a community and tell the people not to use the *temascal* anymore, they will not want to attend our

> discussion groups anymore and it will be difficult to make them to follow useful recommendations ... But if I gently convince them that the heat shouldn't be that high ... they might pay attention to me and become more flexible towards accepting further advice **(interview, health expert, man).**

Being in isolation and under constant attack leads people to strengthen their practices. And by expressing those practices, people become more aware of their own knowledge and stand up for their boundaries. As Moore (1994: 82 *in original*) argues, 'behaviours can be used to "read against the grain" of dominant discourses'. From this perspective we can determine that resistance is not just reflected in the ways in which communities defend their traditional practices, it also takes place in each doctor-patient relationship and in the ways in which people interpret, and make use of, medical knowledge. As it has been extensively addressed, a community's interactions and participation in health services cannot be reduced to the ways in which people implement or reject such services. It has to do with the whole system of social interactions that people undertake in order to preserve their positions, power and sense of identity. By practising their cultural knowledge, people resist and build their participation in health services. Since the expression of cultural knowledge can be both practical and discursive, in the following sections I will look at actions of resistance by focusing on the level of language, within the context of participatory actions.

3.3 Safety passwords: entry to a world of meanings

Since participation is established at the very beginning of any social interaction and communication, I will initiate this discussion by recounting my own experience when trying to encourage people to participate in the reproductive health initiatives implemented by the local health NGO I was working with. During the initial stages of my observational activities and while conducting the preliminary interviews, I realised that people reacted positively — or negatively — when certain words or phrases were mentioned. The expression

in their faces indicated that I was saying something 'wrong' or illicit and thus something that they were 'not allowed' to comment upon. My use of specific words would turn people away from me, as I was not able to get access to their opinions or to incite their involvement in the health activities we were implementing. Alternatively, by bringing up certain 'key' words I was able to gain their confidence and openness. It took me a while to understand the meaning of such reactions and to realise that by mentioning certain expressions, or avoiding them, I was somehow integrated within – or excluded from – the community's world of objects and interactions. After several encounters I was able to figure out that people construct special meanings –neologisms –which allow them to make sense of the unfamiliar events of health promotion. At a certain point, one health worker brightly suggested to me:

> People are like computers, when you talk to them you have to enter certain 'passwords'. Without those passwords it would be impossible to get access to their 'data; If you don't know certain key words that belong to their code of communication, it will be very difficult to take information away from them. On the other hand, if you mention some phrases or words that have a negative connotation, like, for example 'family planning' or 'birth control', they will be afraid of you, they will not trust you and will just ignore you. ... and God only knows how difficult is to make them to move on! **(informal interview, expert, man).**

As Cohen (1995) suggests, local symbols which have collective meaning can strengthen a sense of community boundaries. And these shared meanings will always find a symbolic expression through language or other modes of communication (Bourdieu, 1991). In this sense, it was clear that people became more open when I made reference to familiar expressions from their language or when I mentioned their widely-shared positive terms. For example, to call the traditional birth attendants, *comadrona* or *katid* – which in K'iché language means grandmother – made our conversations more comfortable. Similar

reactions were noted when mentioning the traditional practices of *temascal* use (the heat) or placenta language (named the child's flower).[5]

In contrast, since a great amount of the terminology linked to reproductive health has connotations of stigma and pollution meanings, people create a 'meta-vocabulary' which can substitute their previous uncomfortable meaning. Hence, words lose their original meaning through the construction of new expressions, which in turn, strengthen people's confidence and allow them to uphold a position of power when mentioning them. This is the case of widely used family planning terminology. For instance, no one would dare to mention the word *planificar* (to practice family planning); instead people would say *espaciar* (to space). The fluidity of such definitions extends to the vocabulary of reproductive functions; such as *el lavado* (the wash) or *la costumbre* (the custom) when making reference to menstruation. Similarly, expressions such as *la enfermedad* (the illness) or *comprar un niño* (to buy a child) suggest processes related to pregnancy. And in the case of the delivery, *componerse* (to get well) or *alumbramiento* (lightening) are the most commonly used expressions. These terms are not exclusive to Mayan vocabulary, as they are also widespread among the other Guatemalan social groups.

As was discussed earlier, processes of reproduction are considered taboo events and the source of pollution. Douglas (1966) in her now classic study of conceptualisations of dirtiness, suggests that things that cannot be categorised are often considered to be unclean, polluted and thus subject to taboo. In this manner, it is easier – and safer – to use ambiguous words when referring to taboo events, as such words exclude individuals from responsibility and open involvement. There is no confusion about words, everybody knows what they mean. The significance of such symbolic meanings endorses profound cultural

[5] It is important to note that when I am referring to these special K'iché words I make allusion to the symbolic meanings embedded in them, not to their syntaxes and morphemes. As my knowledge of K'iché language is limited, I mentioned the Spanish version of such words, which, unexpectedly, was very welcome.

knowledge that cannot be understood from one single analysis. But what is important to note is that the processes of construction and reconstruction of meanings are not only objectified in words, but in the practices of resistance that these words suggest. Cultures create 'shadow places' (Douglas: 1987: 69) which allow social beings, on the one hand, to be protected against incursions and impositions and, on the other hand, to anchor their cultural knowledge by making the unfamiliar, familiar. By implementing this basic principle of the theory of social representations (Moscovici, 1984) it is possible to recognise the value of lay people's knowledge which actually reflect a position within a convulsive social arena. On the basis of this reconstruction of meanings people establish strategies of participation.

The meanings, like the acts to which they refer, are not only designated to name reproductive health matters. Some of them also make allusion to the convulsive social order in which they are grounded. Zur (1995) in her analysis of the discourse of denial in Guatemala, argues that people construct 'languages of denial' in order to make sense of the violent and senseless events of the civil war. People construct neologisms which refer only to certain period of the violent conflict. Many of these 'quickly acquired' expressions were 'attributed with extra layers of meanings', which might include other connotations or take the form of diverse viewpoints (Zur, 1995: 67). As an example of such constructed meanings that are directly involved in the Mayan's construction of their reproductive health representations; in the next section I will explore some stigmatised terms such as the word 'control'.

3.3.1 The birth of a culture of control and violence

In the reproductive health literature, the expression 'birth control' is used to denote the implementation of family planning programmes. As such, health promotional initiatives usually note the value of 'responsible parenthood' by pointing to the necessity to implement control of family size. In our

contemporary culture, which is based such values as independence, competition and self-efficacy, the meaning of self and social control seems to be the paragon of personal success. People strive to reach the minimum of self-control that is compatible with the normative conventions of the social order and the expectations that society determines. As such, the social system develops measures of social control and management that allow it to be in command of people's behaviour by promoting the judgement of oneself and others. This legacy, unfortunately, persists in many family planning programmes today. Taking the analysis of birth control programmes a step further, Hartmann (1995: 101) quotes a family planning poster that symbolises our contemporary culture of control:

> MODERN LIFE IS BASED ON CONTROL AND SCIENCE
> We control the speed of our automobile. We control machines. We endeavour to control disease and death. Let us control the size of our family to ensure health and happiness.

The birth of a culture of control that promotes the management of physical and social mechanisms as well as people's decisions, establishes a paradigm of supervision and antimony within society. Certainly, this seemly innocuous expression comes to represent an amalgam of social and psychological processes that imposes restrictions, surveillance and judgements. Even happiness seems to be a product of effective social restrictions. But how does this seemly inoffensive system operate within society? In the following section I shall explore how the stigmatised meaning of control establishes forms of social interactions and constructs diverse new practices of reproductive health.

3.3.2 Controlling and being under control

The meaning of control embodies a pattern of interaction that operates at every level within society. In Guatemala, for example, social structures rest on strict determinations of control. At every level, social interactions are built on these measures of surveillance: the state controls the people, a married woman is

under the control of her husband, parents control their children, older children control their younger siblings, and so on. Each social institution and sex approaches the other with deliberate evaluation and restraint. It is widely acknowledged that without such measures of social control society simply could not operate. As a complement to this system, reproductive health initiatives also implement measures of control by promoting and imposing irrational birth regulations and reducing people's autonomy, power and consciousness:

> Here people have the children that God sends. If he decides that I am made for having 10, so I will have 10. Then, my husband is the one who decides ... in fact, he decides everything. If he doesn't allow me to go out, I can't go out on my own. People will tell him that I was walking around the streets and that's very bad ... I just have my children, and I tell my little women that they can't decide for themselves. Perhaps when they are grown up and they have their children they can do so ... I think that women whose husbands are in the north are the lucky ones. They don't have anyone watching over them, they can go around and see other women, go to the market and attend meetings like this. I was allowed because the health worker spoke with my husband, but I shall be home by 1:00 O'clock ... and I can't stay longer because my mother-in-law is here as well to keep an eye on me. No, she is a very nice midwife and she allowed to be here, but I know that she is watching me ... **(interview, lay informant, woman).**

> We know many different ways of attending to a pregnant woman, she can give birth in many different positions and she can take a lot of beverages ... But when the doctors come to teach us how to improve our practices, they teach us a lot of things we don't understand, or things that we forget once they leave. They evaluate how we are doing but never ask about our 'ways of going about things' (...) We prefer to keep our secrets with us because once you start to talk, you can be caught out ...They like to make lists and control if we are real *comadronas* or if we are just a fake. So we get afraid of those meetings because maybe they will decide that we can't go on anymore **(focus Groups, *comadrona*, woman).**

Control is always associated with violent repression and punishment. In fact, control and violence form a single unit; one is the product of the other. The systematic application of violent repression makes people unable to discriminate sufficiently between actions related to family planning and other

forms of repression. As a result, whatever form of violence that people may experience, they perceive themselves as being under constant intimidation:

> Here, Catholic and evangelical churches have a political component, many of these people have links with the army and the only thing they do is control people. When they go to visit people in their houses, one way or other they are controlling. They always ask how many children people have, what is their dedication and so on. They want to know all about people's life. It is in the Church that people learn to control their children, and that so-called control has affected people. Parents become the guards of their children, people say 'we always have to know what our children are doing' **(interview, expert, man).**

Being observed and being under constant evaluation creates a permanent feeling of insecurity. This constructs the foundations of their social constructions of reality based on fear and disbelief, a paradigm that is deeply internalised in people's representations. As Martín Baró (1996: 161) argues, violence and control assume different forms and expressions, and in some cases people have no way of distinguishing 'which behaviour is being punished, as the stimulus all look the same'. That is, if people fear the army, the government, the national health services or whatever perceived repressive force, the result of this violence is that it will inhibit people's behaviour and will hinder their participation in health interventions. In relation to reproductive health practices, I will revisit one particularly stigmatised term that communicates both the idea of control and violence.

3.3.3 APROFAN: the byword for restriction

As explored earlier, violence and control represent a generic term in the Mayan's construction of reality, in general, and in their reproductive health experience, in particular. As such, on the basis of these socially constituted meanings, people build their participation towards reproductive health interventions. This system of meanings and symbols is not reduced solely to representations of gender identity and reproductive functions, it embraces

interconnections between diverse institutions of social reality. As such, the meaning of control and repression is objectified through different forms, but whatever dimension these take, such symbols will always have adverse meanings and, thus, will produce negative reactions in people. This argument is better understood by exploring the interconnection that people make between family planning agencies and repressive groups.

The national family planning agency, APROFAN (Asociación Pro-Bienestar de la Familia) or Association for the Family's Welfare hasa dreadful reputation among the villagers. APROFAN was the first private family planning agency in charge of birth control in Guatemala and is still the official and most effective channel for implementing health promotion and contraceptive distribution. It was created in the 1970s as part of the 'sustainable development strategy' sponsored by USAID, the largest donor in the population control establishment today (USAID, 1993). As pointed out in Chapter 7, in order to implement birth control, such organisations were empowered to undertake aggressive actions of contraceptive distribution among the people. As such, APROFAN has played a highly negative role, using tactics of coercion and manipulation:

> I am a health promoter and I work for APROFAN as well; here I have all these products they gave me, which I sometimes distribute among some women who ask for them. But I would never dare to place an APROFAN poster up in the main wall of this clinic. If I do so, the next day I will be lynched by the villagers. Believe me, even though I know that people like me, they would not hesitate to lynch me. Here, among us, you can't mention the word APROFAN. It has told too many lies to people, so they feel cheated **(interview, *comadrona*, woman)**.

Returning briefly to the issue of language and the construction of meanings, it is clear that those constructed meanings of violence and control are objectified through certain stigmatised expressions, such as APROFAN. The 'extra layers of meanings' (Zur, 1995: 67) contained in these expressions might include other connotations or take the form of diverse viewpoints. In addition, these impress on individuals specific attitudes and positions, as it is reflected in the case of

the slogan of 'APROFAN' and the word 'control'. Meanings, like the acts to which they make reference, are crucial to understanding the role which language plays in the construction of social identity (Bourdieu, 1990; Davis and Harré, 1990). In this case, language is defined not just as a social discourse, but as a system of social signification. Thus, the process of making sense of a multifaceted reality is bound up with the construction of a world of images and representations through language and other modes of communication. Among these other forms of interaction, in the following section, I will explore how non-verbal forms of communication reveal strategic positions through which people express their power.

3.3.4 'To keep the secret with us'

Earlier, I explored the different ways in which the Mayans build their system of signification that permits them to interpret social reality and to foster their participation towards reproductive health actions. I looked at the construction of specific linguistic codes and their symbolic constitution. By doing so, it was argued that through this socially created language, people implement their participation and edify a space of reality in which their identity can be expressed. Language was not interpreted as a discursive practice only, it encompasses diverse forms of communication and interactions. In this sense, non-verbal communication, omission of meanings and silence are all part of this system of resistance and action.

Silence is perhaps the most common strategy that people use in order to resist, build their participation and obtain power. Guatemala, in fact, has been living not just within a culture of violence and control, but also within a culture of silence. Silence means protection, security and survival. It envelopes both sacred traditions and fear. It signifies resistance and abstention and expresses a certain kind of involvement. However, the practice of silence has also been institutionalised (Giddens, 1979). The social system has benefited from this

abstinence by imposing restrictions to quieten the population. This institutionalised silence, constructed within the country as a result of control and coercion, is directly related to the construction of reproductive health practices at every level. For example, at the level of the household, one such practice is the hidden alternative of contraceptive use. As discussed in the previous chapter, some women – and men – may prefer to 'keep the secret' of using contraceptives, or may not inform one of the number of children they bear. Similarly, they would prefer not to share the knowledge and practices related to their traditional methods of birth attendance with outsiders:

> Very little is known compared to what remains unsaid. People feel judged when they say something, so they prefer to stay quiet if they are asked about their practices ... And I think that's fair enough ... it is better to keep the secret with us **(interview, expert, woman).**

There are many ways in which people build their participation and demonstrate power by implementing silence and reticence. One way is reflected in the style of interaction that was implemented during focus group. Before starting any discussion, a common strategy practiced among the participants was to spontaneously designate a moderator who could translate and, more importantly, transmit the information, first to the moderator and afterwards to me. Following the proposal of a topic of conversation, the people began to discuss it among themselves in their native K'iché language. And only after having reached a mutual agreement, the group 'mediator' was charged with transmitting the information to us. The content of this information would be based on a mutual group consensus and was transmitted by making reference to the group's agreement. My initial response to that style of interaction was to believe that I was not clear enough when transmitting the procedure of a group discussion. However, after several meetings, I understood the real meaning of their innovative style of interaction.

To select a moderator in our discussions indicated the need to intercede between their knowledge and my enquiries. A form of mediation was necessary to maintain power over their knowledge, since they could not 'let it go that easily'. Silence and mediation imply a collectively granted complicity. Therefore, I came to see their resistance as the reaffirmation of our relationship, an assertion of the control they know is theirs and, finally, as an attempt to shift the balance from my management of the situation. Making this decision, that is, to reach a group consensus on the information to be imparted, represented a concrete affirmation of their power.

After quite a few similar experiences, I understood that people are not only aware of their power, they make use of it. Turning off the tape recorder, using the time of the interview to ask questions about myself and deciding what experiences to include when telling a story, indicates their power. By choosing the route of participatory and collaborative research, I entered in a process of negotiation with participants that revealed and challenged unexamined assumptions of power and control within the context of participatory health actions (Freire, 1972).

This argument serves to strengthen the assumptions explored earlier regarding the meaning of language and systems of signification for the constitution of identities and social participation. Thus, it is important to point out once again that despite living within a system that exercises control and violence, people create systems of meanings that reaffirms their values and builds actions of resistance. As outlined in the introduction of this chapter, resistance as a health enhancing practice, is part of a resource for living. It allows people to re-establish their undermined social position, esteem and power, to create a space of reality in which their identity can be expressed and, finally, to maintain and prolong their cultural and social boundaries. And it is precisely through the implementation of symbolic practices – material, non discursive and discursive – that people build a special system of signification and express

their resistance. It is on the basis of this struggle that participation in health interventions should be understood.

These conclusions serve to break the paradigm of the 'lazy Latino' ideology in which people become subject to labels – learned helplessness – or the objects of negative stereotypes – fatalistic, conformist. It also questions the 'top-down' paradigm in which participation in health-enhancing practices is only understood as the community's ability to define their own needs and assume responsibility for their own development. The understanding of 'historically constituted home made discourses' (Toren, 1996: 33) and symbolic practices is vital for apprehending the ways in which people make sense of their social reality and the ways in which they participate towards it.

Taking into consideration the two broad topics analysed above, the contextual base of health promotion institutions in Guatemala and people's participatory actions, in the remainder of the chapter I will explore how these diverse systems of knowledge might engage in a dialogue. In order to do so, I will look at the benefits of the concept of empowerment and how it could be better implemented by promoting natural methods of family planning.

4. Return to the local: natural methods and empowerment

In order to explain my argument on the construction of 'empowerment' through the promotion of natural methods of family planning, and how these actions might stimulate a dialogue between diverse systems of knowledge, I would like to recall my experience when undertaking focus group discussions. As explored in the methodology chapter, interactions within focus groups vary greatly among the Mayan participants of this study. Sometimes the younger women – or men – were the most openly participative or quiet and on other occasions, the elderly or middle aged participants interacted more overtly. The diverse nature of the social interaction that was established, did not permit me

to draw out a specific pattern of focus group interactions based on age and social position. Perhaps, I should say that the social interactions established relied more on the social context. Nevertheless, I can recount the existence of a group of people – women and men –who interacted and communicated openly during our discussions. In some groups, there were certain participants who tended to be enthusiastic, without reticence in expressing their opinions and were more open to listen to discrepancies. Likewise, it was interesting to realise that when discussing issues of family planning, these 'approachable' individuals not only agreed with its implementation, but they were more open to sharing their experiences about it.

I would call this group of people, 'the users of natural methods'. These individuals practiced diverse forms of natural methods; mainly abstinence and some reinforced this with their traditional methods. By definition, knowledge about women's 'humid and dry periods' implies the identification of women's fertile and infertile periods in her monthly cycle. Using biomedical terminology, by employing the calendar or 'rhythm' method, people are able not just to learn about their body functions, but it encourages men and women to reach an agreement when undertaking intercourse. Combining both traditional and biomedical knowledge, the participants who referred to using the rhythm methodor periodic abstinence; seemed to be able to negotiate and discuss with their partners by establishing a fairly symmetrical communication. The same was the case when using barrier methods, such as condoms, although such methods were scarcely mentioned and almost unknown. Some of the users explained:

> Yes, I do practice. I follow my own calendar, without pills or injections. I do it through my menstruation and I know when I am able to get pregnant. I discussed it with my husband and he understands that we can have sex in certain periods **(focus Groups, lay informant, woman).**

> Everything depends on your husband. If he is a good husband, you can talk to him and come to an agreement. I was lucky to have a

husband who understood this ... I learnt how to space my children in some courses that one NGO organised long ago. And we sat down and talked about it. We don't feel bad as it is in the natural way **(focus Groups, lay informant, woman).**

And in the case of health workers:

> I think there are a few couples that practice abstinence or the rhythm method, as you know how men are. But I feel that even if it is few people who do that, there is at least, a small understanding within the couple **(Interview, Expert, woman).**

Practising abstinence increases the man's respect for his wife, and may help to create a dialogue between the two. It also involves women in fertility decisions. By doing so, both the woman and man are the participants of a common agreement which requires them to reach at least a 'small understanding', helping to strengthen their confidence and self-respect. In this way, the psychosocial foundations for further empowerment are laid. It is also interesting to realise that the 'the users of natural methods' were neither accused by the community of being 'against the principles' of the Mayan traditions, nor blamed for being unfaithful. Their sense of masculinity, femininity and ethnic identity does not seem to be threatened by practising the natural methods. As discussed elsewhere, it is true that men play a crucial role when implementing a dialogue between the couple and participation. But it is also true that if empowerment programmes would focus on the positive values of communication and mutual understanding, people would be willing to implement a more open participation and dialogue.[6]

Encouraging communication as a social value could increase the possibilities for better understanding, not just in relation to family planning matters, but regarding discrepancies between divergent systems of knowledge. This case is

[6] Although we are talking about very different social realities and cultural backgrounds, it is interesting to note that barrier methods – condoms – and abstinence are especially used in Scandinavian countries, where women enjoy egalitarian positions and their opinions are equally considered (Bracht, 1999).

fully reflected in the ways in which 'the users of natural methods' interacted during our group discussions. By promoting communication, people may increase their possibilities of expressing themselves at home and within the community. As such, by building a mutual dialogue, people become more aware of their own needs and may feel more confident in expressing them.

This situation enables people to be the constructors of their own empowerment. Implementing dialogue and negotiation between diverse systems of knowledge can always serve to improve people's quality of health services:

> ...You can improve it, but you can't change it or do away with it. If you do so, people won't believe you anymore. I was a health activist in a Christian NGO, and we manage to collect some funding to improve our *temascales*. Now, you can see, they are made of concrete and look more like a log cabin ... In the beginning people didn't want to use them, they said they were not the same as to the old ones. But with time, they began to accept them and now we have many people even from other communities who want to try our new *temascales* ... **(Interview, expert, man).**

Therefore, participation in health promotional interventions is a very broad and inclusive issue. Its analysis has to be embedded within the particularities and contradictions of each society. It may be implemented as a mediator between the conflictive relationships among diverse social sectors. In this sense, health interventions should neither be grounded on the harmful values which certain oppressive systems impose, nor patronise people's interests and feelings. In contrast, health-enhancing initiatives should take advantage of people's positive feelings about childbearing, family planning and social relations and work with local practices. By doing so, interventions would avoid transplanting foreign medical knowledge and focus on how to improve local skills. In order to promote reproductive health and concomitant community participation, the value of communication and dialogue should be apprehended at every level, starting from the macro-social level of intervention in local realities. These values are not only relevant to reproductive health

rights, but to the rights and needs of diverse social groups and minorities. As a local health worker pointed out:

> By perceiving that one's values and costumes are respected and considered, people feel happy and become more open ... We feel at peace with our own culture and with that of others **(Interview, expert,man).**

By implementing participatory programmes in reproductive health activities, I learned that ordinary people, in one way or other, are aware of their own situation. Differences and disagreements are no longer seen as dangerous phenomena, but rather as natural occurrences. And it is precisely through the recognition of such divergences that participation might be negotiated.

5. Conclusions

In the last part of this discussion I am in position to discern whether participation is a definitive concept. The wide range of topics discussed in this chapter would lead one to believe that in fact, it is not. Participation in health promotion – as action, behaviour, activities and practices – is an all-inclusive psychosocial process, incapable of being defined within a clear description of meanings. Instead, by analysing the conditions of production and transmission of the process of participation, health promoters may have a general sense of reference and guidance in approaching specific empirical issues. In other words, using Blumer's argument (1986: 148), participation in health promotion should be seen as a sensitising concept which 'merely suggests the direction in which to look'. Taking the case of Mayan participation in reproductive health promotion activities, I can suggest several points that provide a general sense of reference to approach the empirical issue of community participation and social agency. Such guidelines constitute the conclusion of this discussion:

1. In order to analyse participation in health promotional activities, concrete conditions of living should first be considered, including an

analysis of mainstream providers of health services. It is important to explore how their underlying systems of knowledge compete with the representations of the user's of health services, through the implementation of aggressive and contradictory methodology.

2. Against this backdrop, community participatory actions can be defined in different ways. One of them is through actions of resistance. In the case of the Mayan communities studied here, people construct special meanings, discursive and non-discursive practical ends, which are the concrete expression of their actions of struggle against impositions.

3. People implement through symbolic practices, language neologisms and stigmatised utterances, an active form of participation in health services and construct a space of reality in which their identity can be expressed. In this sense, resistance is valued as a resource for living, that allows people to re-establish their undermined social position and power and allows people to maintain their cultural boundaries.

4. Communicative practices should be promoted in order to promote a dialogue between several competing systems of knowledge and encourage empowerment. And in the case of reproductive health knowledge and practices, this improvement in communication may be reached by promoting the use of natural methods. By doing so, people would benefit not only by planning the intervals between births but by improving the quality of family interactions through the implementation of a mutual dialogue.

Chapter 9

Conclusions

Throughout the course of this collaborative research on representations of, and practices related to, reproductive health, I gained a broad and cogent knowledge on the web of factors that are relevant to the Mayan's reproductive lives. This exploration began with an overview of the pertinent issues that characterise the problem of reproductive health in the context of Latin America. In this way, in Chapter 2, I presented an introductory analysis of the main socioeconomic, historical and political aspects that underpin the construction of representations of reproductive health. I argued that research and intervention has been characterised by a reductionist analysis, which prioritises the implementation of birth control actions, with the negation of other highly relevant aspects of people's reproductive lives. I also argued that there is an underlying theoretical inconsistency and inadequacy in approaching the problem of reproductive health within the context of developing countries.

In order to explore in more detail this theoretical insufficiency, in Chapter 3 I offered a critical analysis of the prevalent approaches on the factors associated with healthcare behaviour that have been used as a theoretical foundation for health promotion activities in Latin American countries. By looking at diverse levels of analysis, I argued that there is a wide gap between the theoretical underpinnings of these models and their applications in Third World realities. There is also a tendency to promote and impose Western cultural values in health interventions, values and interests that may be not shared by the population concerned.

Against this background, and faced the need for sensitising theoretical models to understand our local realities, in Chapter 4, I presented a theoretical framework named 'local systems of knowledge'. Within this framework, representations were explored as local systems of knowledge, viewed as an

expression of the community's lay knowledge, identity and cultural practices. This theoretical 'toolkit' was introduced by the theory of social representations which provided a key starting point for a compressive analysis of the health reality, and served as a 'bridge' in paradigm from the former reductionist approaches on healthcare behaviour. The conceptual framework also draws on the ideas of liberation psychology (Martín-Baró, 1996; 1985a), education for critical consciousness (Freire, 1972) and the analysis of positioning and identities (Hall, 1990; Moore, 1994), among others.

Methodological enquiries were explored Chapter 5, in which I justified the selection of ongoing participant observation, open-ended interviews and focus group discussions for the analysis of health beliefs and practices as a case study of local systems of knowledge. These diverse sources of data were woven together to increase the scope, depth and consistency of the analysis of the Mayan's discursive and material practices.

The data analysis section began with Chapter 6, in which I explored the main generative theme, namely 'Mother Earth'. I argued that this notion represents a link between the Mayan's productive and reproductive activities. By establishing this concept, I argued that Mayan representations of reproductive health are grounded on their productive activities and are shaped by their conditions of living. I also claimed that their representations of reproduction are deeply related to the survival of the community as an ethnic group and express the crucial link between representations and identity.

Chapter 7 corresponds to a more detailed analysis of the issues of reproduction and family planning, viewed from a gender and ethnic perspective. In this chapter, I stated that patriarchal ideologies construct representations of reproduction within the Mayan household. People construct their conceptions of femininity and virility through the value assigned to motherhood and responsible fatherhood. In this way, it is claimed that representations of

reproduction shape conceptions of gender and ethnic identity. This knowledge forms the basis of Mayan ideas about family planning, which represents a threat to their system of knowledge, values and identity.

Following the two previous analytical chapters, in Chapter 8, I explored how the Mayan's local knowledge of reproduction shapes their participation towards reproductive health services. I argued that community participation is a broadly-inclusive concept which can be understood in different ways. One of them is through the construction of meanings, discursive and non-discursive practical ends. By constructing special meanings, people implement their participation and edify a space of reality in which their identity can be expressed. In this sense, resistance is valued as a resource for living, that allows people to re-establish their undermined social position and power and enables people to prolong their cultural boundaries.

Based on the previous detailed exploration of Mayan stories and daily interactions, and following the review of the related literature, I deduced one plausible assertion: the universal nature of representations of reproductive health and related practices. I must confess that I was amazed to realise that the reproductive health reality of Mayan women and men is analogous to their far distant counterparts from India, Ghana, Egypt, Kenya, Sierra Leone, China and so on. By stating this point, I am not only making reference to the socioeconomic similarities that underpin our so-called Third World contextual realities. I am also including the wide range of factors that construct the dynamics of people's representations of reproductive health and concomitant practices. This assertion begs the question: Is local knowledge of reproductive health local or universal?

After analysing the material included in this thesis, I would say that it is both. Its particularity relies precisely on the cultural attributes of unique cosmologies, in this case, Mayan cultural knowledge. Local representations of reproductive

health correspond to exclusive cultural backgrounds that provide a distinctive sense of social location which helps to build special discourses, practices and create identity boundaries. But the universality of local knowledge actually resides in the general assumptions that underscore such conceptualisations and practices. Founded on these generalisations, one is able to determine a common view upon which interventional reproductive health programmes may be broadly implemented. In this sense, this analysis favours not just the analogous reproductive health realities of Central America, but it may additionally benefit other dissimilar cultural realities in the developing world.

But, which are these general hypotheses that can be drawn from the exploration of local reproductive health conceptualisations and practices? On the basis of a deductive analysis, I shall begin with the general statements that underlie the study of such representations. This will be followed by a number of specific concepts inherently related to the social psychology of health. In the following subsections, I will focus on three universal assumptions described in the conceptual framework of the thesis: the meaning of contextuality, historicism and ideologies. These notions are gathered from the analysis of liberation psychology proposed by Martín Baró (1996).

Contextuality

Contextuality is all-encompassing. It forms the foundations of every representation, and serves to construct and reconstruct social practices. In this case, it is present in the productive and reproductive binomial category that fosters the Mayan's reproductive health knowledge. It is expressed in the domestic spaces of the household, in the style of interaction established between diverse generations (Chapter 6) and in the economic and social rewards received as a product of male preference (Chapter 7). Likewise, contextuality means the concrete conditions of living that underpin the deplorable reproductive health situation of the Mayan people and their counterparts in other developing countries. It is the context of unequal income

and land distribution, of the low national budget allocated to health, inaccessible healthcare and education, the concomitant high maternal and infant mortality and the deprived position of women (Chapter 2). All of these contextual circumstances shape representations of reproductive health and base them on needs of security and survival. This contextual reality defines gender, class and ethnic positions within society.

Historicism

The second aspect, historicism, goes hand in hand with contextuality. In the production of local knowledge of reproductive health, I embrace the study of historicity in a dual sense. First, in the social transmission of cultural knowledge through the social memory of communities (Chapter 4). This is exemplified in the ways in which Mayans practice the rituals of their ancient calendar system and the in the work of the *comadrona* (Chapter 6). In this sense, it was argued that past events are a vital ingredient of current representations and practices, which facilitate the enhancement of local identity and community boundaries. The second point in the analysis of historicism rests on the need to approach the contextual reality within an historical dimension. To be aware of the historical conditions of our 'colonised' cultures is a vital element towards a deeper understanding of our contemporary representations and identities (Chapter 7). An important argument here – which can contribute to a better comprehension of the health-enhancing practices debate – is the irrelevance of studying historical facts in isolation. What is important is how these facts construct and change representations of health and how they develop identities. Thus, the interpretation of historical knowledge helps to give meaning to the present day social situation in all matters related to social life, including reproductive health.

Ideological meaning

The ideological meaning of local knowledge lies at the root of the two previous assumptions. Ideology, as a combination of ideas and practices that assures the reproduction of power, constructs diverse forms of local knowledge regarding reproductive health. This is upheld from the level of the household to the macro social spheres within society. Directly related to reproductive health services, the ideological meaning is reflected in a number of firmly-established institutions and practices. It is reflected in the state's discriminatory provision of health services and in the social categorisation that promotes the isolation of a stigmatised social group – the 'lazy Latino' ideology (chapters 7 and 8). It is also represented in the use of religion as an instrument of control (chapters 2 and 8); and in the construction of the ideological categories of Marianismo and patriarchy that oppresses women (Chapter 7). These categories are similarly constructed among diverse social realities outside the boundaries of the Mayan culture. And finally, ideology is at the roots of the widely disseminated information-based individualistic theories of health-enhancing practices (Chapter 3). The victim blaming ideology places on the shoulders of individuals the burden of their deprived reproductive health conditions. All these ideological meanings form the foundations of representations of reproductive health.

Within the scope of this work, the former general statements were salient to understanding the complexity of the Mayan community's lay knowledge, identity and cultural practices. One of the fundamental arguments of this thesis was precisely that contextuality, historicism and ideology are universal concepts which shape the reproductive health conditions of a given population and people's appreciation of such conditions. Unfortunately, these assumptions are usually considered as given in any health research, and so their exploration is simplistic, inadequate or completely ignored. In order to avoid such a one-

dimensional analysis, I also claimed that the value of local knowledge can only be fully appreciated by utilising qualitative methodology (Chapter 5).

It was actually in the process of immersing myself in the community's everyday experiences and in searching for the appropriate information that I became sensitive to the deficient conditions of our reproductive health research in Guatemala and in the developing world. An over-reliance on quantitative methodologies based on large-scale surveys form the cornerstone of these investigations (Chapter 3). Success in health intervention has typically been evaluated solely in terms of uptake and targets met, not in terms of people's satisfaction with the services delivered. And clearly, the community's perception of its own reproductive life, beliefs, knowledge and cultural practices are either entirely omitted or forgotten.

Against this backdrop, and following the previous discussion on the universality of local knowledge, I shall give a review of a number of particular concepts derived from the qualitative analysis of the Mayan's representations of reproductive health. Such concepts are inherently related to the social psychology of health and, according to my explorations, might be extended to other reproductive health realities. Among the most prominent concepts, I shall revisit the notion of social practices (Jodelet, 1990; Bourdieu, 1990), identity (Hall, 1990; Moore, 1994), self-esteem (Bandura, 1997), and participation through resistance (Martín Baró, 1996; Freire, 1972). Prior to any description, it is important to note that all these concepts are deeply interconnected. I separate them exclusively for the purposes of my discussion, which requires a certain order of ideas.

Social Practices

As in the case of the previous notions of contextuality, historicity and ideologies, social practices are established in any situation. Following the main

ideas of the theory of social representations (Jodelet, 1990), it was argued that local knowledge is created through several social practices and, at the same time, it is objectified through such practices. Objectification is represented in the number of symbolic actions, such as the therapeutic use of *temascal* baths (Chapter 6). In this case, practices are not seen as the cognitive expression of people's knowledge in behaviour, as the traditional models of healthcare behaviour claim (Chapter 3). They are evaluated as the community's day-to-day interactions with their objective reality and as the communicative performance between social subjects. Likewise, social practices are present in the social organisation of space within the household (Bourdieu, 1990), in the exercise of rituals, in the social interactions of women and men interwoven in their parenthood obligations (Chapter 7) and in their actions of resistance (Chapter 8). By observing and identifying all of these practical ends, we are able to identify a crucial point in the reproductive health knowledge.

Identity

The analysis of social practices would be incomplete without considering the role of social identities. This is a familiar concept within the field of social psychology of health. Within this vein, it is considered that affiliation to a group – which share a common identity – may serve as a resource for a group's self-efficacy towards the practice of healthy lifestyles (Bandura, 1986; Berkman, 1995). The results drawn from this analysis showed that social identities do form a crucial component in health-enhancing practices. Nevertheless, this analysis also demonstrated that the relationship runs much deeper than that. Local systems of knowledge of reproductive health, as the representation of a group worldview, engage in an interplay with the group's historically constructed sense of ethnic identity (Hall, 1990). In this sense, throughout the course of the research, it was extensively argued that by expressing their cultural knowledge of reproductive health in practice, people enhance their sense of location and identity boundaries.

This point is clearly manifested in Mayan lay ideas on family planning. Horrendous past experiences between Mayans and Ladinos serve to construct current representations of identity survival. These representations are objectified in different forms. One of them is in the ways in which Mayans conceptualise, and act towards, family planning services – regarding them as the '*ladino* plot' against their identity boundaries (Chapter 7). Another form is through the implementation of symbolic practices – the 'placenta language', for example (Chapter 6). It is also demonstrated in the ways in which representations of reproductive health shape conceptions of gender identity, through the value assigned to motherhood and responsible fatherhood (Chapter 7). In this case, reproductive health is strongly associated with people's representations of their feminine and masculine identity. Thus, Mayan representations of reproductive health are profoundly related to the survival of the community as an ethnic group and as an expression of gender distinctiveness, marking the crucial link between representations and identity.

Self-Esteem

Within the field of social psychology of health, the concept of self-esteem also enjoys much recognition. It is acknowledged that a strong sense of self-efficacy and self-esteem may help to create positive healthy choices (Bandura, 1997). In this research, the concept of self-esteem was directly related to social identities. Thus, it would be more accurate to name it 'perceived group esteem' instead. My results show that a strong sense of ethnic esteem or 'perceived sense of social valorisation' may indeed reinforce or empower positive healthy practices.

This argument is better represented in the ways in which some groups, and individuals, with a strong sense of ethnic esteem were more eager to practice their traditional knowledge by using natural methods of contraception (Chapter 8). For example, *comadronas* who tend to boast more greater

empowerment, expressing themselves with a pronounced air of self-confidence and esteem, were also able to practice their traditional knowledge of birth attendance more successfully (Chapter 6). In this sense, well-empowered groups, as the group of the 'users of natural methods', tend to opt for more healthy choices for the simple fact that they enjoy greater social recognition and opportunities for discussion. Their perceived sense of social valorisation is conformed at every level. In the household – establishing symmetrical gender interactions – (Chapter 7) and at the macro-social levels of health intervention – being conscious of the recognition and valorisation of their traditional knowledge (Chapter 8). These psychosocial processes related to health-enhancing practices should always be understood with relation to the contextual, historical and ideological realities that foster them. Therefore, by establishing a link between 'perceived sense of social valorisation' and health-enhancing practices, we turn to a very important concept in the construction of health representations and practices: the issue of community participation.

Participation through resistance

The question of reproductive health-enhancing practices goes far beyond the simple question of contraceptive acceptance, to encompass actions of resistance at almost every level, from the family on up to the national health services. By reviewing the work of Martín Baró (1996) and Freire (1972) on power and communication, I claimed that power supremacy is based on ideologies that serve to institutionalise inequalities and asymmetrical interactions. This assertion is extended to every level within society – household, community, state – and within social categories – gender, ethnic groups, users and providers of health services (chapters 7 and 8).

In this way, resistance is evaluated as a way of obtaining power and as means to build strategies of survival. Resistance and counter agency are analysed as forms of participation in health interventions. At the macro-social level of

intervention, it was argued that the Mayan's local knowledge of reproductive health competes and clashes with other systems of knowledge coming from health institutions, the state, and the Church (Chapter 8). As this relation of power is not symmetrical, not all social knowledge is recognised. These conditions form the foundation of conflicts and actions of resistance by the Mayans aimed at defending their cultural knowledge and identity. The use of 'passwords' and neologisms in health-related vocabulary is an expression of this defiance (Chapter 8). At the family-group level of analysis, it was also argued that asymmetrical power relations based on male preference serve to undermine women's health-enhancing practices (Chapter 7). Women and men, however, strive to resist and exercise their power over other family members and through publicly absolved actions. Therefore, the question of power implies direct links with the ideological meanings, identity and social practices as discussed above. All form the background to the construction of community participation in health interventions through their actions of resistance and counter agency.

The above general and specific theoretical constructions were explored in detail throughout the course of the thesis. All these notions are directly related to the construction of Mayan representations of reproductive health, and in their decisions to engage in health-enhancing practices. The diversity, complexity and the interconnections that these concepts have between each other helps us to understand how multifaceted and profound the reproductive health situation is. By exploring the case of the Mayan communities, I have showed how the problem of reproductive health beliefs should be approached from a social psychological perspective which locates intra-individual and group processes within broader community and social dimensions. By doing so, we are able to provide well-grounded theoretical constructions that may be equally relevant in the analysis of other realities within the developing world.

I also want to emphasise the importance of exploring any health reality from different levels of analysis. Theoretical and methodological choices should be based on adequate epistemological assumptions, which allow researchers to gain wider knowledge on the issue under investigation. By doing so, it is important to integrate several notions that may contribute to the construction of culturally sensitive health promotion programmes in tune with a specific local reality. This is the reason why I brought together psychosocial concepts that, in my view, should be part of a social psychology of health. This is the case of the concepts of identity, social practices and participation through resistance and power. I also want to highlight the role of firmly-established concepts, such as self-esteem, in the construction of health-enhancing practices. Given the inadequate theoretical premises on which these individual-centred notions are grounded, which considers them as isolated models, little or no attention is paid to them in any health research which focuses on the social level of analysis. As long as we recognise that individual processes – and their underlying dynamics – are socially constructed, there is no impediment to including them in research on local systems of knowledge.

By choosing the route of participatory research, I understood that reproductive health is at the centre of current theoretical debates that go beyond the limits of health questions per se. Population and environmental activists have focused on 'uncontrolled reproduction' as one of the main causes of environmental degradation and poverty. For the sake of securing the natural resources for future generations, our current generations are suffering from devastating policies that control their pregnancies. But this suffering is not equally distributed. While the Western world is irrationally consuming the planet's energy and keeps polluting the remainder of our environment, their developing counterparts have to pay the high price of irrational policies on reproduction control. In order to promote development and keep our earth and resources for future generations, the focus should be switched to improvements in living standards and the position of women and men through more equitable social

and economic development. The problem is not one of absolute scarcity, but one of distribution and irrational consumption of resources. Therefore, as stated in the introduction of the chapter, with this work I also aim to provide a reference work which may serve to contribute to the long journey towards health and development. Much needs to be done in this field, and in the field of reproductive health and community acceptance of health services, and social psychology has plenty to contribute to this endeavour.

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APENDIX I

GLOSSARY OF TERMS

Alumbramiento: Literally, this term means 'lightening', an expression that is used to describe the process of giving birth or delivery.

Comadrona: Formally, this is a term referring to the traditional birth attendant or midwife. A *comadrona* may be defined as a woman who applies the traditional knowledge based on the Mayan cosmology to attend pregnant women and to give advice on any aspect related to their reproductive health lives.

Componerse: 'To get well'. This is a term used to describe the process of giving birth or delivery.

Comprar un niño: 'To buy a child'. This expression points to the moment that the comadrona receives the child during the delivery.

El lavado: 'The wash'. This expression refers to the menstruation or period.

Espaciar: A term used to denote the practice of family planning either by using contraceptives or natural methods.

Katid: Literally this K'iché term means moon, but it also makes reference to grandmother or the community's *comadrona.*

K'iché: One of the four largest Mayan speaking linguistic communities of Guatemala.

La costumbre: 'The custom'. This term refers to the menstruation or period.

Ladinos: A Guatemalan term that defines the Spanish-speaking *mestizo* population. Within the social category *Ladino* there are strong differentiations depending on the educational level, phenotypic features and degree of closeness to the Mayan culture.

La enfermedad: 'The illness'. Term used to describe the nine months of pregnancy.

La flor del niño: 'The child's flower'. This term refers to the child's placenta.

Mayas: Descendants of the ancient Mayan civilisation that emerged 3,000 years B.C. This population is currently settled in the western highlands of Guatemala, Southern Mexico and Belize.

Temascal: This term points to a traditional Mayan bath or sauna which is used for therapeutic purposes in all processes related to reproductive health.

Tuj: A K'iché term that means heat. It is also used to define the practice of *temascal.*

APENDIX II

INTERVIEW-GUIDES

A. Interview Guide-Lay Informants

1. What are the main concerns of women/ men in this community?

   -think about yourself and your family

2. What comes to your mind when you think about having children/ or when your hear that someone has had children?

   -what does this mean?

3. What concerns you about having children/ being a mother?

4. Do you do anything to keep yourself healthy before and after the delivery?

   -What kind of things?
   -Could you please give me an example?

5. How do you inform yourself about treatments and medical care during pregnancy and after the delivery?

7. What does 'birth-spacing' mean to you? Do you feel that is necessary to think about it?

   -Why do you think so?

8. What kind of reproductive healthcare intervention would you wish for?

   -Could you give me an example?
   -How could you participate in it?

B. Interview Guide-Expert Informants

1. What is your role as a health worker in this community?

2. What comes to mind when you think about reproductive health?

3. What do you think are the main concerns about reproductive health within the community?

    -Do you think that people have heard of it or think about it?

4. What do people usually do to seek healthcare before and after the delivery?

5. What do you think about 'birth-spacing'?

    -Why do you think so
    -Do you think that people know about it?

6. As a health worker, how do you perceive the reproductive health services in the community?

7. What about women? How do you perceive their situation within the community?

8. How do you think that reproductive health services can better meet the needs of the people in the communities?

    -Could you please give me an example?

APENDIX III

FOCUS GROUP-GUIDES

A. Focus Group Guide-Lay Informants Women

We will discuss an issue that relates to all of you, that is, women's health. We will exchange opinions about your main concerns, worries and expectations as a woman, mother and as a family member.

1. What do you think are your main concerns/worries as women in this community?

   -Why do you think so?

2. And within the family, what are your main concerns as women?

3. When you think about motherhood what kind of things comes to mind?

4. About your children, how is life for you and your children in the community?

   -How do you feel about it?

5. What concerns you about having children?

6. How do you do to keep yourself healthy before and after the delivery?

   -Tell us a bit about it

7. What kind of healthcare do you usually seek?

8. What kind of reproductive healthcare intervention would you wish for?

   -Could you give me an example?
   -How could you participate in it?

B. Focus Group Guide-Lay Informants Men

We will discuss an issue that relates all of you, that is, your family's health. We will exchange opinions about your main concerns, worries and expectations as men, fathers and as family members.

1. What do you think are your main concerns/worries as men in this community?

   -Why do you think so?

2. And within the family, what are your main concerns as men?

3. When you think about motherhood what kind of things comes to mind?

4. About your children, how is life for you and your children in the community?

-How do you feel about it?

5. What concerns you about having children?

6. What kind of healthcare do you usually seek?

7. What kind of reproductive health-care intervention would you wish for?

   -Could you give me an example?
   -How could you participate in it?

APENDIX IV

CODING FRAMES

The following list corresponds to the final selection of codes drawn from the data analysis, which indicates a systematic account of the main ideas addressed in chapters 6, 7 and 8. Such definitions were supported by data gathered from participant observation.

CHAPTER 6

Primary documents

A. Lay informants - Women and Men

B. Experts

1. Generative Theme - Mother Earth

1.1 Reproduction - land -territory

- **Lack of land**

Absence of economic sustenance. Land represents the basic source of income. Central premise that defines quality of life and living standards.

- **Lack of land - larger families**

Establish a relationship between lack of land production and the need for agricultural labourers.

- **Children - economic gain**

Central premise that improves land production and family cohesion. Children main labour force. Helping parents.

- **Beyond land property**

Land more than source of daily income. People associate land with culture, daily interactions.

1.2 Material aspects of territoriality

Observation of the social and cultural setting (village, location in reference to main town, socioeconomic conditions, social services, health centres, health post, nearby hospitals, schools, cooperatives, organisational, sports centres, housing, recreational centres, transportation, forms of communication, community leadership).

1.3 Domestic Space

- **Women - the core**

Women are the main suppliers of economic, social and emotional wellbeing for the couple, children, family and communities.

- **Elderly - power**

Represent cohesion within the family, respect. All decisions have to meet the approval of the elderly.

- **Elderly - marriage**

The elderly have a decisive influence in the future reproductive life of the couple.

- **Marriage**

Marriage was defined as an important institution that assures the continuity of family life, agriculture and traditions.

- **Sex and age - basic factors**

Social positions within the family and community are determined by sex and age, people's status improving as they grow older.

1.4 Symbolic aspects of the Land

- **Mayan Calendar**

Time counting. Associated with women's reproductive cycle. The Mayan calendar determines special days for reproduction. History of *nahuales*.

- **Health - state of happiness**

Health is defined as state of happiness – Emotional processes are directly associated with changes in the environment and nature.

- **Man and woman: a combined function**

According to the Mayan calendar both men and woman form a conjunction with nature. There is no separation between natural processes and human beings.

- **Sacred womb**

People make reference to the 'sacred womb' as a point of conjunction where nature and traditions meet.

- **Ancestors knowledge**

Important referent that works for the propagation of knowledge throughout generations.

2. Practices related to Reproduction

- ***Comadronas* - key figures in women's reproduction**

They are considered as one more member of the family unit. They have the right to give opinions and make decisions in all aspects related to the reproductive lives of families.

- ***Comadronas* - the community's grandmother**

Make reference to *Katid* 'or grandmother'.

- ***Comadronas* - a necessity**

Many *comadronas* learn the practice as way of earning a living.

- ***Comadrona's* aim: a child's survival**

Ultimate aim for *comadronas* is the survival of the child. They follow up the child's development until they become 'independent human beings'. A child's death is considered a failure to their role within the community.

- **Placenta language**

A complete and well-structured explanation of the child's development.

- **Placenta's meaning within the family**

The practice of keeping the placenta within the family boundaries is the most basic determinant that prevents people from using medical services.

- ***Temascal*: a preferred practice**

The practice of *temascal* baths enjoys great recognition within the communities.

- ***Temascal*: a questioned practice**

Some villagers spoke of their scepticism regarding the practice of *temascal* as it could damage people's health.

3. Variation of Data

- **My life has improved**

Making reference to the productive activities beyond the limits of the agrarian duties.

- **Better options than children**

When people improve their living standards they tend to reduce their family size for the simple fact that they have other social options to look forward to.

- **Education - improved life**

Most educated people tend to reduce the family size.

CHAPTER 7

Primary Documents

A. Lay Informants-Women and Men

B. Experts

1. Generative Theme- Reproduction within the Household

1.1 Women's codes in relation to reproduction

- **Being a good woman**

To be able to meet demands as mothers and caregivers.

- **Women's roles within the family**

To attend to children and husbands as ultimate social end.

- **Men greater value than women**
- **Pregnancy - a source of shame**

Pregnancy is something to be hidden and not commented upon.

- **Pregnancy - a source of happiness**

Being pregnant brings 'good promises' for the future wellbeing of the family.

- **Infertile - ostracism**

Infertile women are unable to accomplish the most valuable social aim.

- **Menstruation - taboo - dirtiness**

Related to general ideas about menstruation.

- **Children - an ultimate social and emotional aim**

Children regarded as the most precious asset within the family

- **Children - come to reduce their stigma**

Children represent the best social reward that any woman can have. Brings automatic position that nothing else can bring.

- **Mothers blamed for having girls/son preference**

Prevalence of male preference. Patriarchy.

1.2 Men's codes in relation to reproduction

- **Awareness of the family's suffering**

Men make reference to the deprived social conditions of their families when they face the outside world.

- **Family's wellbeing- men's self-realisation**

Men feel self-realisation if they are able to satisfy the social needs of their families

- **Having children - masculinity**

To see their wives pregnant gives men automatic status within the community.

- **Having children - self-esteem**

Children enhance men's sense of masculinity.

2. Generative Theme - Family Planning

2.1 Women's codes in relation to family planning

- **A need**

Family planning relieves the burden of too close pregnancies.

- **A sin**

It is considered to be against the principles of religious beliefs.

- **Forbidden action**

The 'community' — social arena — denies the practice of family planning.

- **Contradiction between values and needs**

The need to avoid too close pregnancies leads some people to practice family planning, although they feel 'guilty' as it is regarded as being against the community's cultural values.

- **Infidelity**

Family planning is associated with infidelity, since once women start to use contraceptives they can be unfaithful to their partners.

- **Destruction of culture**

Family planning is implemented with the purpose of destroying the Mayan cultural identity.

- **Natural methods accepted**

The use of natural methods is not associated with infidelity and is not regarded as being against the Mayan cultural values and religious beliefs.

2.2 Men's codes in relation to family planning

- **To hide women's infidelity**

Family planning is associated with infidelity, since once women start to use contraceptives they can be unfaithful to their partners.

- **Unnecessary action**

Some men do not perceive family planning as necessary for the family's wellbeing.

- **A need**

Some others consider it as a need that serves to reduce the burden of too close pregnancies.

- **Men's possession of women**

Men can control their wives if they do not practice family planning. They prefer to see their wives with many children so that their wives will not have the time and energy to see other men.

- **Expensive alternative**

Although many families want to undertake family planning actions, they have to pay for these at very high prices.

- **Destruction of our culture**

Family planning is implemented with the purpose of destroying the Mayan cultural identity.

- **Natural methods accepted**

The use of natural methods is not associated with infidelity and it is not regarded as being against Mayan cultural values and religious beliefs.

3. Men and women's main concerns/ family - community

- **Poverty**

The most basic concern

- **Family violence**

Expressed against women and children.

- **Migration/community's detriment**

It causes family disruption, economic costs for the remaining family.

- **Migration/women's relief**

Some women feel a 'relief' if their husbands have migrated. Release from physical and emotional burden.

- **Migration - wellbeing for the community**

If men succeed, they may help their families economically.

- **Single mothers**

Many women suffer from abandonment

- **Alcoholism**
- **Lack of communication between men and women**

CHAPTER 8

Chapter 8 integrates several points of analysis already explored in the previous chapters. This analysis is complemented with data gathered from participant observation.

Primary Documents
A. Lay Informants - Women and Men
B. Experts

1. Generative Theme - Community Participation

1.1 Men and women's conceptualisation of health services

The following list corresponds to people's perception of the quality of the reproductive health services delivered.

- Cultural discrimination-stigmatisation
- Lack of respect for traditions
- Mayan culture is not included
- Lack of privacy
- Doctors transmit idealised advice
- Afraid of asking for advice
- Health promotion led by foreigners
- Foreign aid/ contraceptive distribution
- The role of the Church
- Health promotion controlled by the Church
- Intromission of ideas - ideological control
- Lack of communication between doctors and patients
- Rejection of foreign values
- Trust in local people

1.2 Diverse forms of participation

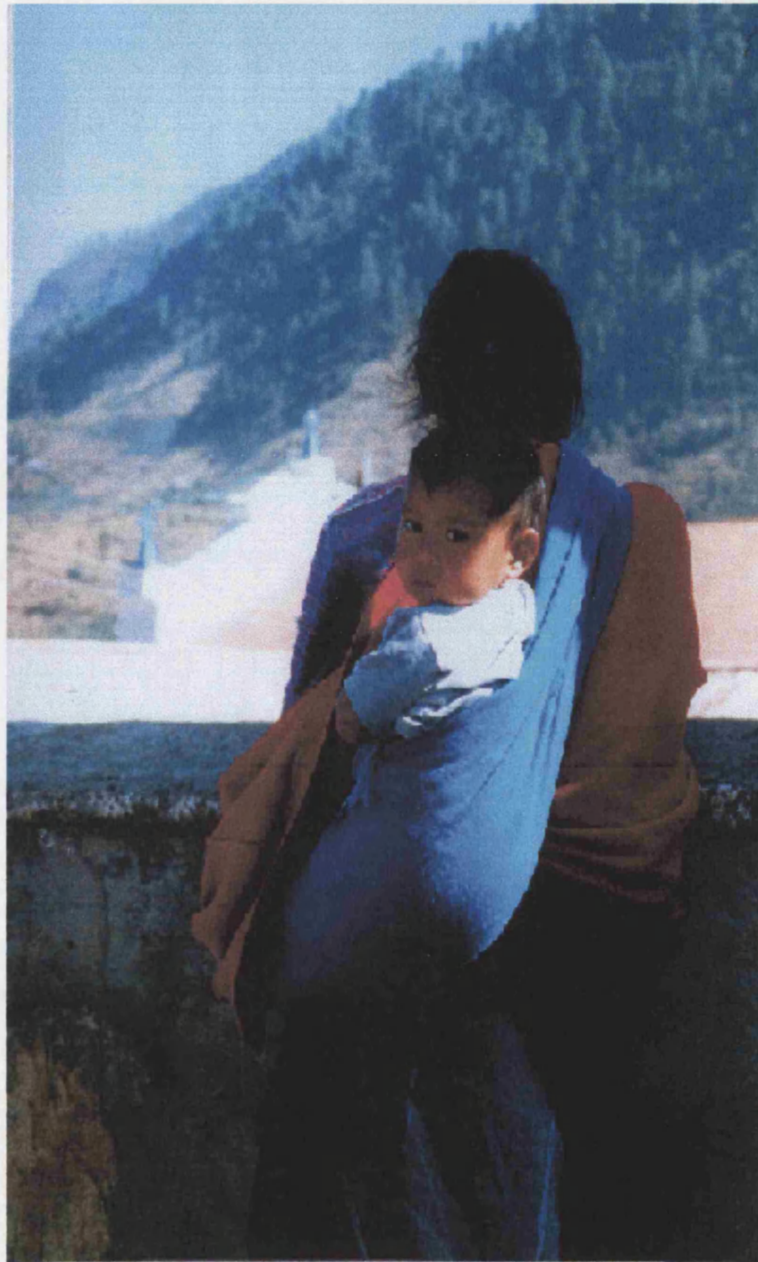
- Use of passwords
- Perception of control
- The use of symbolic meanings
- Culture of silence

1.3 Promoting participation

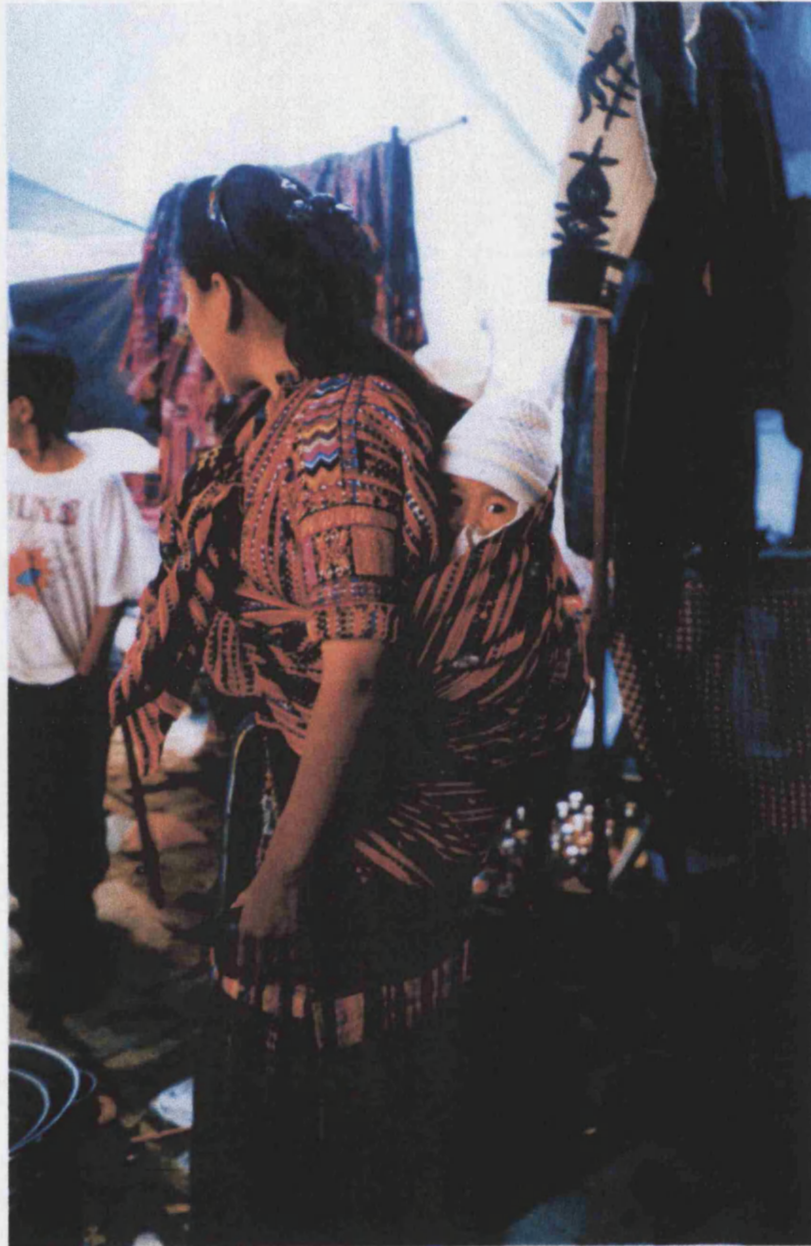
- Respect of identity - increases people confidence
- Natural methods and identity
- Natural methods and empowerment

APPENDIX V

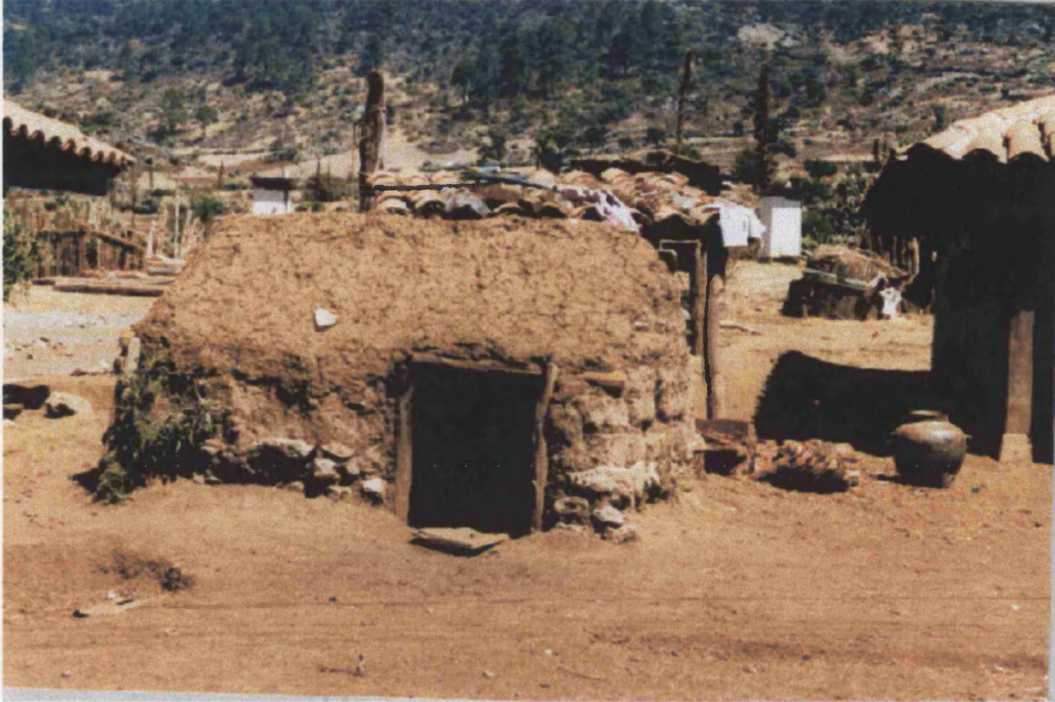
PHOTOGRAPHS
PARTICIPANT OBSERVATION



Mother and child



Mother and child at the local
market



Temascal bath

Focus group with comadronas

Women health workers