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**Unmet Need for Family Planning in
a
Peri-Urban
Community of Guatemala City**

by

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I. Introduction

The Concept of Unmet Need

Around the world, there are millions of women who say they would prefer to avoid a pregnancy, yet are at risk of conceiving because of the obstacles they face in practicing family planning successfully (Robey, Ross and Bhusan, 1996). These women are said to have unmet need for family planning, a concept that has been identified in recent years as a woman-centered way to define one of the key populations in need of improved family planning services (Sinding, Ross and Rosenfield, 1994). Currently, the most common measure of unmet need, developed by the Demographic and Health Surveys (DHS) Project, includes in-union, fecund women who say they would prefer not to have any more children or to postpone their next birth for at least two years but who are not using any method of contraception. It also includes pregnant and amenorrheic women whose current or just completed pregnancy was unintended and who were not using any method of family planning when they became pregnant (Westoff and Bankole, 1995).

Yet the concept of unmet need has been criticized – it is a definitional construct calculated from large-scale surveys, not a direct measure of women's self-defined need for family planning services. In addition, it leaves out women who may also be exposed to the risk of unintended pregnancies – the unmarried who are sexually active, women using ineffective methods or effective methods ineffectively, and those who are dissatisfied with their current methods (Dixon-Mueller and Germain, 1992). It is also possible that the current definition captures women who do not belong in the category – sub-fecund women, for example, or married women whose husbands are not living at home or who are sexually inactive.

An improved measure of unmet need would not only accurately indicate the proportion of women who fall into the category according to their own definition of need but would also contribute to a greater understanding of its underlying causes – the barriers women face in successfully regulating their fertility (Casterline, Perez and Biddlecom, 1995; Bongaarts and Bruce, 1995). It has never been more important to know how to focus efforts to better meet women's self-defined needs for fertility regulation in order to understand how to allocate scarce resources more effectively. To evaluate the current definition and measurement of unmet need and to investigate the economic, socio-cultural, and service-related barriers women face in using reproductive health services and regulating their fertility, ICRW has conducted a collaborative, in-depth, community-level research program in three countries.¹ This report presents the findings from the study conducted in Guatemala in 1995-1996.

¹This research program is funded by USAID, the Offices of Population and Women in Development. In addition to Guatemala, studies were conducted in India and Zambia.

Demographic Background

The population of Guatemala was estimated to be 9.9 million in 1996. It is growing at a rate of 2.9 percent per year, higher than the average rate for Central America (2.3 percent per year) and South America (1.8 percent per year). The population is projected to reach 17 million by the year 2025 (Haub and Yanagashita, 1996). Thirty-nine percent of the population lives in urban areas, mainly Guatemala City, which had an estimated population of 823,000 in 1994.

Yet, data show that fertility rates in Guatemala are steadily decreasing. According to the 1995 Demographic and Health Survey, the total fertility rate was 5.1 children per woman, compared to 5.6 children in 1987, nearly a 10 percent decline in nine years (Instituto Nacional de Estadística, et al., 1996 and Ministerio de Salud Pública y Asistencia Social, et al., 1989).² The total fertility rate for rural women was 6.2, significantly more than the 3.8 level for urban women.

Concurrent with the decline in fertility is an increasing use of contraceptives. In 1995, the DHS found that 31.4 percent of women in-union used some method of family planning, up from 23.2 percent in 1987. The metropolitan area of Guatemala City, with contraceptive prevalence of 50 percent, had the highest rate in the country.

Despite these changes in fertility and contraceptive prevalence, women are still having more children than they consider ideal and are facing difficulties achieving their fertility preferences. Overall, 24 percent of married women in Guatemala were classified as having unmet need for family planning.³ The rate was lower in Guatemala City, where DHS found 16.9 percent of women could be classified as having unmet need.

The Study Site: La Esperanza

Another demographic reality in Guatemala is a high rate of internal migration due to lack of land and low wages in the countryside, the 1976 earthquake, and the civil conflict. Many of the internal migrants have left the countryside for urban areas. This has led to a proliferation of peri-urban communities, particularly surrounding Guatemala City. Living conditions in these communities are often poor, and there is little or no infrastructure or health service delivery, especially for reproductive health needs. Given Guatemala's changing demographic conditions and people's desire to exercise more control over their fertility, the researchers felt it was important to understand the reproductive dynamics in these communities in order to improve people's access to and use of reproductive health services. The community chosen for this study -- La Esperanza -- was selected after reviewing conditions in several peri-urban areas of

²The total fertility rate (TFR) is the number of children a woman would have at the end of her reproductive years if she bore her children at today's age specific fertility rates.

³This was calculated by DHS using their conventional definition.

Guatemala City. The following factors were assessed: the extent of infrastructure and access to health services, the willingness of local women's grassroots organizations to participate in the study, and the personal safety of the research team. The size of the settlements was also taken into account for purposes of sampling. La Esperanza is part of the community of El Mezquital, settled by squatters more than a decade ago and located in the southern part of Guatemala City (see Chapter II for more details).

Design and Methodology

This study had two objectives:

- to investigate the economic, socio-cultural, and service-related barriers women from a peri-urban community of Guatemala City face in using reproductive health services and regulating their fertility; and
- to evaluate the current definition and measurement of unmet need from the perspective of women themselves.

The ultimate goals are to make policy and programmatic recommendations aimed at reducing Guatemalan women's and men's barriers to the use of reproductive health services (and thus to reduce unmet need), and to propose suggestions for the concept of unmet need and its measurement that would better reflect women's self-defined need for family planning (see Chapter VIII).

The study took place in three phases and used a combination of quantitative and qualitative methods for the collection and analysis of data.

Table 1.1. Samples used in the research, by methodology.

METHODOLOGY	SAMPLE
Survey	n= 275 women, randomly selected
In-depth interviews with women	n ₁ = 68 women
In-depth interview with men	n ₂ = 10 male partners purposively selected from partners of women in n ₁
Comparison between survey and interview classifications of unmet need	n ₃ = 60 women in-union, 30 with unmet need and 30 with met need according to the conventional definition

Phase 1. The first phase involved collecting survey data from a random sample of 275 women of reproductive age (15 to 44), both to identify women for in-depth interviews and to estimate the prevalence of the unmet need for family planning according to three definitions. These include the conventional definition used by the Demographic and Health Surveys; a modified definition that adds other variables included in DHS and hypothesized by the researchers to be important; and an improved definition that includes new variables, suggested by the critical literature

(Dixon-Mueller and Germain, 1992). Table 7.1 provides details on each of these definitions.

For this phase, data were collected using a pre-coded questionnaire, based on DHS, to obtain the variables needed for measuring unmet need for family planning. The same sequence of the questions was kept in each section. At the end of some sections, new questions were added to obtain data on other variables not included in DHS. These variables refer to the women's reproductive/contraceptive intentions for the immediate future.

Before preparing these additional questions, a focus group was held with women from el Mezquital. The purpose was to explore the issues and local terminology regarding sexuality, reproduction, the spacing of children, and the use of contraceptives. The focus group included midwives and volunteer health promoters, as well as community-based family planning workers and their clients. The focus group also shed light on issues that would be systematically addressed during the in-depth interviews in the next phase of the study, such as the perception that younger women are more knowledgeable and sophisticated than older women about sexual issues.

The questionnaire used to measure the prevalence of the unmet need for family planning was reviewed several times before being pretested on a small sample of women not included in the final study sample. Finally, with the 1995 Guatemala DHS questionnaire in hand, a last review and question-by-question comparison was made, so as to maintain the same order and flow of questions.⁴ The interviewers all received a handout with instructions for how to conduct and code the survey.

All the interviewers were young women who had graduated, or were close to graduating, in cultural anthropology. These women received theoretical and practical training in administering the questionnaire, including lectures, discussions about the basic concepts, and a review of modern, natural, and folk methods of family planning. The field director supervised the field activities and developed a data quality control system, to reduce the number of questionnaires with insufficient information, internal inconsistencies, or lack of clarity.

The survey was conducted with a random sample of 275 women between the ages of 15 and 44. The size of the sample was determined by the probability of detecting in the survey at least 50 women whose need for family planning services was met, and another 50 with unmet need. To select the sample, the community was studied and maps were developed for each sector to establish the path to be followed. A portable calculator with a program specifically tailored to select -- at random and *in situ* -- houses in locations where a sampling frame does not exist (Matute and Boy, 1991). Once a house was selected, the first household (group of persons living under the

⁴A copy of this questionnaire is available on request: in English from ICRW and in Spanish from Estudio 1360 S.A.

same roof and sharing food) was chosen in the event that there was more than one. If there was more than one woman of reproductive age in that household, the interviewee was randomly selected. Chapter II summarizes information about the women who participated in the survey.

Phase 2. The second phase was the qualitative study of the cultural, social, economic, and gender factors that influence the reproductive intentions and family planning behavior of 68 women (a sub-sample of the 275 women interviewed in phase one) and 10 of their partners. After using the survey data to classify the women according to their met/unmet need status, a random selection was made of 30 women whose need for services was met, and another 30 whose need was unmet. The age range of the women in the sub-sample was similar to that of all the women in the survey. In addition, all seven of the sexually active, not-in-union women identified in the initial sample of 275 were interviewed to try to better understand the reproductive intentions of unmarried women. The analysis and classification of the women's met/unmet need status, and the selection of the random sub-sample were done by a team member who was not involved in the in-depth interviews, so as to prevent any bias in the collection of qualitative data.

A life-history ethnographic approach was used to explore women's and men's experiences during different stages of their reproductive lives: from puberty to sexual relationships, unions, pregnancies, and contraception. Part of this qualitative analysis was a thorough examination of women's self-defined needs for family planning and the barriers they face in achieving their reproductive intentions.

The guide for the in-depth interviews was prepared with two objectives in mind: to explore the factors that influence the wishes and reproductive/contraceptive decisions of the women and their sex partners, including the availability and accessibility of reproductive health services, and to establish their degree of satisfaction with family planning methods. The preparation of these guides was based on the literature, similar studies in other cultures, and the focus groups and key informant interviews in the community. The guides were revised several times and pre-tested at least once. The questions were open-ended, and their order was flexible, although some questions had an internal structure and logical sequencing.

The interviews with men were conducted with the partners of 10 of the women interviewed in-depth. The men were purposively selected to include some whose wives had an unmet need for family planning, and some whose partners were already using contraceptive methods. No man was interviewed without his partner's approval. The men's interviews were carried out by an experienced male interviewer.

The analysis of the in-depth interviews was qualitative in content, in order to understand the reproductive lives of men and women in the community, and particularly the factors that influence their family planning decisions, from a socio-cultural perspective. In

conducting the analysis, a previously established plan was followed to determine first the need for family planning, from the point of view of the women themselves. Then another analysis plan was used to systematically identify various cultural, social and material/economic factors that shape the reproductive/contraceptive decisions made by the women and their partners. These analyses are presented in chapters III, IV, and V.

Finally the in-depth interviews linked the women's unmet need status to their reproductive histories. The researchers developed a communication and knowledge scale that considered seven equally weighted criteria: information about menstruation at menarche, information about sexual relationships at first sexual encounter, information about pregnancy at first delivery, information on contraceptive methods, type of family planning services used, communication with partner on family planning, and the kind of sexual education preferred for children. Women's scores on this scale were then paired with their unmet need status. This is presented in Chapter VI.

Phase 3. The third phase of the study examined how well each of the three survey definitions was able to identify women with unmet need as categorized by the analysis of the in-depth interviews. This comparison was done for a sub-sample of 60 women. The qualitative perceptions of the women regarding their reproductive and contraceptive intentions, as well as their use of contraceptive methods at the time of the study, and their degree of satisfaction with such methods were considered to be the best definition of each woman's need for family planning. For the purpose of the qualitative analysis, the definition of unmet need included all sexually active women, whether or not they were in union. The interview definition of unmet need is presented in Chapter VI.

The researchers hypothesized that not only would the prevalence of unmet need increase over the conventional, the modified, and the improved definitions, but also that the improved definition would more accurately reflect the unmet need classifications derived from the in-depth interviews. The comparative analysis was done to assess if the questions added by the reviewers to the survey could in fact be used in the future to obtain a more woman-centered measure of unmet need. This analysis is presented in Chapter VII.

II. The Community and the Study Population

The Origins of El Mezquital, A Peri-Urban Community

Because of the growth of peri-urban communities in and around Guatemala City and the difficult socio-economic and health circumstances faced by many of the residents in these communities, the researchers decided to focus this study on a peri-urban population. One of the study's goals was to develop policy recommendations that address how to enhance people's use of reproductive health services and thus their health status. The researchers identified El Mezquital as an appropriate site for the study. It is a densely populated, peri-urban community located in the southern part of Guatemala City and is formed by several settlements (El Éxodo, Tres Banderas, Monte de los Olivos, El Esfuerzo, La Esperanza, Lomas de Villalobos and 8 de Marzo), as well as by a low income housing project called Colonia El Mezquital. To the north and west, it is adjacent to other low income housing projects and to the west and south, it is surrounded by deep ravines. Throughout El Mezquital, the residences located near the ravines are at risk of being undermined, especially during the rainy season when landslides are common. In addition, El Mezquital is located in an earthquake-prone area.

In fact, settlement of El Mezquital began after a massive earthquake in 1976, when the destruction of housing forced many poor families to become squatters in fields on the fringes of Guatemala City. (That original settlement is the section now referred to as Colonia El Mezquital. A few years later, in mid-March 1984, approximately 800 families settled the land across from Colonia El Mezquital and built makeshift dwellings with discarded materials. The early settlers recall the distressing lack of public services. Shortly afterwards, electric power lines were installed, and drinking water became available as public drinking fountains were installed in various sectors. This second "invasion of squatters" resulted in five settlements: El Éxodo, Monte de los Olivos, Tres Banderas, El Esfuerzo and La Esperanza. The settlers came from other parts of Guatemala City, largely because they saw an opportunity to own a plot on which they could build a makeshift home, an important consideration since rents had risen considerably after the earthquake. Other families joined them little by little. Around June of the same year, there were approximately 9,000 families in the area. The parcels of land were fairly apportioned from the start.

The desire to obtain legal ownership of land and at least minimal housing conditions sparked efforts to organize the community, activities that were strengthened by NGO support. NGOs assisted the community to obtain basic services, and, in 1989, the purchase of the land was legalized with a loan from the World Bank.

In 1995, when this study was initiated, El Mezquital was already a densely populated area. A local census conducted by the *Dios Con Nosotros* parish reported more than

65,000 inhabitants. Although there have been improvements in public services -- water, electric power, transportation, schools, and health posts, among others -- the area is still depressed. It is considered a violent area because neighborhood gangs ("*maras*"), formed by youths of both sexes, are involved in delinquent activities including theft, armed robbery, rape, murder, consumption and trafficking of drugs, and disputes between gangs.

La Esperanza

Description of the community. The specific community chosen for the study was La Esperanza, one of the five settlements mentioned above that were established over 10 years ago by squatters. The settlement is classified as very precarious (SEGEPLAN/UNICEF, 1991) and consists of four sectors, known as A, B, C and D, that are located on narrow areas of flat terrain and slopes surrounded by steep, deforested ravines. Two roads connect the four sectors, and narrow alleys separate the blocks of houses. The researchers' first visit to this community, in March 1995, offered a disheartening view. There were sewer lines draining above ground, multiple garbage dumps, and rutted and muddy dirt roads that made for difficult access on foot and in vehicles; the wooden shanty houses had, for the most part, sheet-metal roofs and dirt floors; latrines and drains emptied into the surrounding ravines; and there were many dogs whose feces contaminated the alleys where children played. There was little vegetation left in the area, partly due to people's attempts to settle every available space, but also due to lack of foresight on the part of the settlement's planners.

According to the survey of 275 women conducted for this study in mid-1995, most families surveyed in La Esperanza had ownership rights to the land they occupied, which does not exceed 72 square meters, and the National Reconstruction Committee was about to issue formal land titles. The housing units were, for the most part, makeshift quarters built of wood and sheet metal, although a fair number were constructed with cement blocks. Sixty-one percent of the units had dirt floors, and 34 percent had cement flooring.

The settlement has drinking water provided by the municipal water company and a local cooperative. Sixty-four percent of the homes have potable water. The rest use public fountains or buy water from families whose homes had drinking water. Ninety-four percent of the homes have electricity. It is common for a house with its own power meter to share electric power with other houses for a monthly charge.

There are several bus lines linking La Esperanza with other parts of Guatemala City. Very few families have their own means of transportation: only 16 percent have a bicycle, 3 percent a motorcycle, and 6 percent a car.

The community has two public schools, one private school and a nursery. All three schools offer elementary education, and one of the public schools plus the private

school also offer three additional years at the secondary level. The neighboring settlements and communities also have educational centers which are attended by the school-age population of La Esperanza.

The predominant religion of the population of La Esperanza, like the rest of the country, is Catholic. Half of the people said they practiced Catholicism, a third said they were Protestant, and the rest said they did not practice any religion.

A common topic of conversation among the community members is the consumption of alcohol and drugs (glue and marihuana) by adolescents and adults, particularly the unemployed. Another frequent topic of conversation is the violent behavior of gangs, who fight among themselves at night or mug neighbors as they return home late at night. Furtive sales of liquor were observed during fieldwork, as were small groups of adolescents drinking or sniffing glue down in the ravines. The study personnel also learned about the violent deaths of at least eight young men, in two cases as retaliation for raping young women.

Despite the grim conditions, progress is being made in the area. The settlement is experiencing rapid change, particularly infrastructure development, according to observations the researchers made at the end of 1995 and the beginning of 1996. In sector A, the installation of sewers, running water, individual power meters, and telephone lines was completed, and the main road and alleys were paved. Other sectors were still without sewers, but progress was being made towards installing electrical power and telephones, as well as paving the alleys. COVIVES, the local housing and water cooperative, is offering loans to neighboring settlements for house construction and the committee in charge of assigning the land in El Mezquital has been reassigning some of the housing plots.

Characteristics of the Women

During the first phase of this study, a survey on reproductive health was administered to 275 women between the ages of 15 and 44. Only one woman per home was interviewed. The number of eligible women per home depended in part on the life cycle of each family group. In 175 of the homes (64 percent), there was only one woman in the eligible age range. In the other homes, the woman to be interviewed was selected at random. The number of eligible women in these homes ranged between 2 (25 percent) and 5 (0.7 percent).

Of the women interviewed, 70 percent were joint heads of the household, 5 percent were household heads in single-parent homes, 18 percent were daughters, and 7 percent daughters-in-law, mothers or sisters of the household head.

Table 2.1 shows the distribution of women by age, ethnicity, and marital status. Eighty-nine percent of the women belong to the community's predominant ethnic group,

Ladinos, a non-indigenous, Spanish-speaking people who practice a variation of Latin American culture. Eleven percent of the women are indigenous, and their mother tongues are among the 21 Mayan languages spoken in Guatemala. The women's marital status is distributed across three categories: married (a civil or religious marriage), cohabiting (this kind of relationship is recognized by the law as a marital union after the couple has been together for at least three years), and not-in-union (single, widowed, or divorced). In the rest of this report married and cohabiting women are considered as a single category: women-in-union.

Table 2.1. Distribution of the women, by age, ethnicity, and marital status (n=275).

AGE	INDIGENOUS			LADINO			TOTAL	
	Married	Cohabiting	Not-in-union	Married	Cohabiting	Not-in-union	n	%
15-20	1	2	2	7	17	32	61	22.2
21-30	2	6	1	35	39	7	90	32.7
31-40	3	9	1	42	34	8	97	35.3
41-44	1	2	0	7	16	1	27	9.8
Total	7	19	4	91	106	48	275	100.0

Most of the women interviewed came to El Mezquital from other parts of Guatemala City. However, 70 percent of them were born elsewhere and moved first to other sectors of the city before coming to El Mezquital. Many came to Guatemala City as adolescents looking for work. Two-thirds of the residents were born in urban areas (the nation's capital, provincial capitals, or municipal seats), and about one-third in rural areas.⁵

The educational level of the interviewed women is low. Nearly a quarter (24%) had no schooling at all. Of the 209 women who attended school, 81 percent left school before completing the elementary grades. Seventeen percent reached secondary school, and only 2 percent of the women completed high school and obtained a diploma or degree.

Forty-three percent of the women surveyed contribute income to the maintenance of their families. Most work in the community and carry out such activities as selling tortillas, food or other popular items; doing laundry and ironing; loading and transporting goods; running errands, such as shopping for the owners of small commercial establishments; managing their own small businesses, such as shops, sewing services, market stalls; and taking care of children. Those women who work outside the community are employed in factories, retail businesses and restaurants, or work in private homes as maids.

Eighty-seven percent of the women reported having had at least one child born alive. The average number of children, among those who had ever had a child, was 3.7,

⁵A small percentage, 1.5 percent, were foreign born.

ranging between 1 and 14. It was not uncommon for these women to have experienced a child death, and the average number of living children at the time of the survey was 3.4. The major causes of infant/child death are respiratory ailments and diarrhea. One fifth of these women reported having had at least one child who was born alive but died shortly afterwards.

Of the 275 women, 28 (10 percent) were pregnant at the time of the survey. Among the 247 women who were not pregnant, 111 women (45 percent) were practicing family planning. Of these, 92 percent were using modern methods (tubal ligation-47 percent, the pill-18 percent, injectables-11 percent, condoms-8 percent, IUDs-5 percent, vasectomy-2 percent, and vaginal tablets-1 percent); 6 percent were using natural methods (periodic abstinence-5 percent and withdrawal-1 percent); and 2 percent were using other methods.

Reproductive Health Services in the Area

Table 2.2 shows the grassroots reproductive health services available to the study population. The table shows that La Esperanza has nearly half (48 percent) of the reproductive health resources, including most of the breastfeeding advocates.

Table 2.2. Grassroots reproductive health services available to the women of the La Esperanza

Providers	La Esperanza	Other El Mezquital settlements	Colonia El Mezquital	Villalobos	Total
Midwives	4	6	3	2	15
APROFAM* Promoters	2	1	2		5
Breastfeeding Advocates	16			2	18
<i>Reproinsas</i>	8	8		8	24
Total	30	15	5	12	62

*Asociación Pro Bienestar de la Familia/Association for the Well-being of the Family

As shown on the table, the area has a significant number of grassroots reproductive health providers (62 women). *Reproinsas* (i.e., volunteers who work through the Integrated Health Program) constitute the largest group -- 24 active representatives and 83 inactive. These women are volunteers who have been trained by the Guatemalan Ministry of Health with the assistance of Doctors Without Borders. They serve micro-sectors, making house-to-house visits and keeping a registry of births and infant/child morbidity and mortality, as well as providing advice on preventive measures to promote health and improve sanitary conditions. These women also help conduct vaccination and anti-parasite program, and are engaged in other preventive health tasks. The *reproinsa* program periodically trains new volunteers. Current *reproinsas* assist with the training, which covers five module including one on reproductive health.

While the field study was being conducted, 47 women were attending this course. The women who complete *reproinsa* training have the option of becoming members of FUNDAESPRO (*Fundación Esfuerzo y Prosperidad*/Effort and Prosperity Foundation). This is a grassroots organization of *reproinsas* from different areas of Guatemala City that has received technical and financial support from UNICEF. FUNDAESPRO members enjoy benefits, such as housing loans, support for small shops or child care centers, or additional training to work in the Foundation's comprehensive assistance centers.

This study was endorsed by FUNDAESPRO, and our request for the assistance from *reproinsas* was submitted to the organization's Council, which left the final decision up to the coordinating offices in each area. The *reproinsas* in El Mezquital welcomed the study and decided to participate by providing support personnel. (See Annex 1 for a more detailed description of the role of the *reproinsas* in this study.)

In addition to the *reproinsas*, the researchers identified midwives, APROFAM promoters and breastfeeding advocates working in the area. The midwives monitor pregnancies, provide assistance in home births, or births taking place in authorized health houses, and treat various childhood diseases. These women charge for their services. When the midwives detect a high risk pregnancy or birth, the patient is referred to a health center or hospital. The midwives have been trained or re-trained by personnel from the Guatemalan Ministry of Health, which also exerts some control over their services. The APROFAM promoters are volunteers who sell contraceptive methods -- mainly pills, vaginal tablets, and condoms -- and refer patients to APROFAM clinics for clinical methods such as IUDs, injectables, and sterilizations. These women get a percentage of their sales. Their training and supervision is provided by APROFAM. The breastfeeding advocates are also volunteers who promote and educate mothers on the benefits of exclusively breastfeeding their babies up to the age of six months, both to improve the children's health and to space pregnancies using a natural method.

Table 2.3 shows other health services available to the study population. There are a significant number of pharmacies in the area. FUNDAESPRO's pharmacy fills prescriptions of various types but does not supply contraceptives. However, the pharmacies located in Colonia El Mezquital do sell contraceptives. The highest demand is for various brands of condoms. Because vaginal tablets require a lot of instructions, pharmacies have decided not to carry them. Therefore, they can only be obtained through APROFAM promoters.

The settlements have also benefited from several medical clinics supported by NGOs that provide health services either at very low cost or free of charge. The clinic located in the UPAVIM building provides a wide range of preventive and curative reproductive health services to the settlement of La Esperanza. However, if a woman wants to be sterilized, she is referred to APROFAM. Other settlements have clinics such as that of the *Asociación de Mujeres* (Women's Association), and the clinic of the Parish of *Dios*

con Nosotros. Both clinics offer lectures on reproductive health and family planning. The Parish clinic teaches natural family planning methods.

There is a Health Post, located in the Tres Banderas settlement that provides medical services eight hours a day, Monday through Friday. This Post is staffed by a nurse's aid, who has helped with difficult births, and whose assistance is sought by midwives. The Post is supposed to provide pills and condoms free of charge, upon request; however, it is frequently unable to satisfy the demand.

Because of the level of community organization and management within the settlements, it was possible to construct, with the support of international development agencies, a Type A Health Center to provide assistance for the most frequent illnesses. This Center has a team of health professionals and technicians. Although the Center has an in-patient section for childbirth, this area was not in operation at the time the survey was conducted. The Center provides pre- and post-natal care, as well as family planning services and referrals for patients who wish to be sterilized. The Center is located in Colonia Villalobos. Several of the women participating in the survey said they had attended lectures on sexuality and family planning given by the Center as well as by other organizations and churches in the area.

Table 2.3. Reproductive health services available to the women of La Esperanza.

Providers	La Esperanza	Other El Mezquital settlements	Colonia El Mezquital	Villalobos	Total
Pharmacies		1	7	1	9
Health Posts		1			1
Health Centers				1	1
Private Clinics		1	3		4
NGO Clinics	1	1			2
Total	1	4	10	2	17

III. The Reproductive Life Cycle in a Socio-Cultural Context

This chapter addresses the socio-cultural context of reproduction and the experiences of women and men at various phases of their sexual and reproductive life cycle. The socio-cultural context is analyzed according to two key components: 1) ideological and social norms concerning family life, reproduction, and family planning, and 2) intra-family, conjugal, and sexual violence. The ideological and normative component is presented as an analytical continuum, in which the end-points or poles are called the paradigms of silence and speech. The experiences studied include puberty, first sexual encounter, first union, and first child. Each of these phases is presented in terms of the kind of information (biomedical, ethno-physiological) that the person had before facing the experience.

The results presented in this chapter are derived from qualitative analysis of the in-depth interviews conducted with 68 women and 10 men from La Esperanza. The 68 women are of reproductive age (15 to 44) (see Table 3.1), and they are all sexually active. Sixty-one of the women are in a relationship, and seven are not. Most are *Ladino* (90 percent), and a minority (10 percent) *Mayan*; this reflects the ethnic distribution in the community, not the country as a whole, which is about half *Mayan* and half *Ladino*. The men interviewed are partners of 10 of the 68 women.

Table 3.1. Age distribution of the women interviewed in-depth (n=68).

Age Range	Percent Distribution
15-20	15%
21-30	50%
31-40	28%
41-44	7%

The Silence-Speech Continuum

In La Esperanza, people's reproductive lives are oriented by two far-reaching, conceptual paradigms that the researchers named the paradigms of silence and speech, due to their norms regarding communication about reproduction and sexuality. These paradigms can be viewed as poles on a continuum, since individuals are differentially influenced by them. The silence paradigm emphasizes large families: children are a source of wealth and support for elderly parents. This paradigm is rooted in traditional rural and urban cultures, both *Ladino* and indigenous, and is transmitted along gender and generation lines: from grandmothers and mothers to daughters, and grandfathers and fathers to sons. It is reinforced by couples' extended families and their circles of friends and neighbors as well as some social institutions.

The speech paradigm favors smaller families and responsible parenthood. It has been disseminated throughout the country by a range of institutions since the 1960s. One of its principal promoters is APROFAM, which has made its message known through mass media -- radio and television -- and community-based family planning programs. Women's organizations, following a gender approach, have also contributed to the emergence of this paradigm by redefining motherhood as a right rather than an inescapable duty and by promoting fatherhood as responsible fatherhood. Other advocates for the speech paradigm include health services, schools, NGOs and even churches -- according to their own religious convictions.

Table 3.2. The conceptual poles of the silence-speech continuum.

CONCEPT	PARADIGM OF SILENCE	PARADIGM OF SPEECH
The family	An expression of God's will. A large number of children as an symbol of virility and femininity A source of material and social wealth.	An expression of the will of the couple or the woman. A planned family A source of satisfaction, and emotional or future security.
Family size	Large: As many children as God grants.	Small, to ensure a high quality of life.
Ideal number of children	It is not discussed by the couple.	2 to 4 and is discussed by the couple.
Ideal sex of children	A preference for the first child to be male, and for male descendants.	A boy and a girl, or without preference for either sex.
Communication between generations on sexuality and reproduction	Silence as a strategy to restrain young people's sexual impulses, pre-marital relations, and unplanned pregnancies.	Sex education at home, school, and health institutions. Information on sex, pregnancy, and sexually transmitted diseases.
Beginning of life as a couple	At an early age and with parental consent. For the woman, it represents the beginning of her sex life; for the man, it provides companionship and ensures his procreation.	At a later age. By mutual agreement.
Concept of marriage	Long lasting, and with tolerance for male behavior (which may be violent).	Long lasting, with reciprocal accountability for behavior
Women's control over their own bodies	None. Women's sexuality is subordinated to men's demand. Women are not expected to enjoy sex.	Women control their bodies and are expected to enjoy sex. There is negotiation between the couple.
Reproductive intentions	Couples do nothing to prevent pregnancies. Abortion is condemned.	Couples are free to space or limit pregnancies.

Table 3.2 continued

Regulation of fertility	Breastfeeding for a longer time, abstinence after birth and during "fertile days." Women may refuse sex if they are feeling tired or sick.	Couples choose from a variety of contraceptive methods to suit their needs. Consensus on which method to use
Family planning services	They are not taken into account.	Family planning services, information, and counseling are sought by the couple.

These two paradigms offer conceptually opposite positions on a series of issues, such as the concept of the family and life as a couple; the roles of men, women and children; family size; ideal number of children by gender; information on reproductive health and sexuality; and family planning. In the paradigm of silence, the family is an expression of the will of God for humankind. A large number of children is considered an expression of virility and femininity, and a source of material and social wealth. The following quotes illustrates this: "A couple should have as many children as God sends;" " Men and women exist for the purpose of childbearing;" and "Children exist to help their parents, keep them company, and support them in their old age." As a result, the number of pregnancies is not controlled. A couple does not discuss the ideal number of children ("we didn't even think to talk about that"). There is a preference that the first child be a boy, and for a predominance of male children. Women believe this guarantees their support in old age, since girls leave home and cannot help their parents, once they are marry and are subsequently maintained by their husbands.

The paradigm of silence receives its name because of the lack of communication. If reproductive issues are discussed at all they are only mentioned in a veiled way, to protect girls from their sexual impulses, i.e. from pre-marital sex and unintended pregnancies. Girls hear nothing about menarche, sex, or pregnancy. A girl is only told about menstruation at menarche, and she is warned at that time about relations with men. The information she receives about sex and pregnancy is unclear or ambiguous, and often induces fear. Girls learn about these issues, particularly the last two, through experience, rather than prior information and advice.

In the paradigm of silence, life as a couple is expected to begin at an early age, and to mark the beginning of sexual relations for women. It is expected that the first child will be born within a year. When these ideals break down, people are expected to find ways to conform; for instance, if a woman becomes pregnant due to premarital sex, she is expected to form a couple with the father of the child.

Life as a couple is considered a life-long commitment, and women are expected to tolerate their husbands' behavior, even if they are womanizers, drunkards, irresponsible, or violent. It is not ideal for women to have children by different men, or to have several sequential monogamous relationships, although both things do happen.

In the paradigm of silence, there is very little room for family planning, except for that provided by long-term breastfeeding. Abstinence after the birth of a child, during "fertile days" or because the woman is tired or sick is also acceptable. Culturally defined fertile days do not coincide with biomedically defined fertile days.

In the speech paradigm, family size is considered to be the result of informed and responsible decisions made by a couple. Family size is relatively small to ensure a better quality of life, including satisfaction of basic needs. Children are spaced to have more time between pregnancies to protect a woman's health and ease her childcare burdens. Daughters and sons are both welcome.

In this paradigm, sex education -- provided by parents at home and complemented by instruction at school, NGOs and health institutions -- is intended to inform boys and girls about the physiological and psycho-sexual changes that take place with the onset of puberty, as well as about sex, pregnancy, and the prevention of sexually transmitted diseases. The parents who adopt this paradigm for their children emphasize educating them in their youth and helping them postpone their first sexual relationships and pregnancies. This paradigm stresses that children should be planned and wanted. To achieve these family planning goals, use of contraceptive methods is advocated. The Catholic Church advocates natural methods based on periodic abstinence, while APROFAM and other institutions favor modern methods.

People find themselves caught up in an interplay between the two paradigms, the clash of which may result in acceptance, conflict, or ambivalence. Most people can be placed in intermediate or transitional positions between the silence and speech poles. People who came from rural areas were generally socialized within the paradigm of silence, but their stay in the capital city has exposed them to the paradigm of speech. Community members who came from more urbanized areas were more likely to have been exposed to the paradigm of speech at home and in their workplaces.

The following quote illustrates how a Mayan woman, originally socialized in the silence paradigm in a rural community, moved to an intermediate position in the silence-speech continuum. She had her first child at 18, and by the age of 23 was the mother of four. She then decided to seek a sterilization. However, because she was very young, the family planning service she visited would not authorize the surgery. So she warned her husband to either get a vasectomy or leave the house, and her husband agreed to be sterilized.

I [thought] that we would have as many children as He [God] would send us. But now I ask God to help us care for the children we already have, as well as for everything to turn out well, and for Him to give me the strength I need to continue working.

At the beginning, I didn't even think about how many children we would have. I didn't realize how easy it is to be loaded with children. I did not react until I already had three. Then, I realized that my husband was not treating me well, and decided that I did not want another child. That is when I told him to do something about it.

Table 3.3. Key indicators along the silence-speech continuum.

	SILENCE PARADIGM	INTERMEDIATE POSITION	SPEECH PARADIGM
INFORMATION ON REPRODUCTION	none or folk	combination of folk and biomedical	biomedical
INFORMATION ON CONTRACEPTIVE METHODS	none or folk	combination of folk and biomedical	biomedical
COMMUNICATION WITH PARTNER ON FAMILY PLANNING	none	husband decides or lets the woman decide on female methods	good communication and joint decisions
REPRODUCTIVE HEALTH PROVIDERS USED	folk (midwife, others)	folk and modern	modern (nurse, doctor, community-based distributor)
ATTITUDE TOWARD CHILDREN'S SEXUAL EDUCATION	socialization in silence paradigm	socialization with a combination of silence and speech features	socialization in speech paradigm

Table 3.3 shows key indicators along the silence-speech continuum. Information on reproduction and contraception ranges from no knowledge or folk knowledge to a combination of folk and biomedical knowledge to biomedical knowledge. An example of combined folk and biomedical information is that the amenorrhea that may be caused by injectable contraceptives (biomedical) can provoke death by eliminating the monthly cleaning of the body brought about by menstruation (folk). Communication within the couple about family planning goes from silence to consensus with a communication style dominated by the husband in an intermediate position. Use of reproductive health services moves from relying only on midwives and other folk providers to using a combination of folk and modern service providers to a reliance on modern services. Attitudes toward children's sexual education also vary: women who have moved from a silence to an intermediate position may envision better sexual education for their children. While the data collected in the interviews reveal that movement along the continuum is generally from the silence end toward the speech end, it is interesting to note that in one case the direction was reversed.

Intra-Family, Conjugal, and Sexual Violence

Intra-family, conjugal, and sexual violence are part of the socio-cultural context. The first refers to the verbal or physical abuse that takes place among family members, for instance, between parents or stepparents and their children. The second is verbal or physical violence within the couple. The third type of violence is generally experienced by women who are forced to have sex against their will or are violently prevented from using contraceptive methods. Of the 68 women interviewed, 59 percent reported having suffered at least one of these forms of violence. In some cases, these types of violence converged; for example, one woman was raped by her father under a death threat, and she left home. Three of the women, while still living at home, were subjected to attempted sexual abuse by their fathers or stepfathers, and when they reported this to their mothers, there was family conflict. In these three cases, the women decided to get pregnant, as a "legitimate" way of getting thrown out of their homes.

Of the 68 women, 21 percent reported having experienced violence from their current partners, and some of the women reported a history of marital violence with more than one partner. Occasionally, women living with in-laws (mother, sisters or brothers) reported that these relatives lied to their husbands about their behavior, and this led to verbal or physical abuse.

Several types of violence linked to sexual activity were identified: rape, verbal abuse or emotional blackmail by a man when his partner refuses to have sex, and physical or verbal abuse if a man opposes the use of contraceptives. For 12 of the 68 women, rape was their first sexual experience; for example, one woman was raped by her stepfather who threatened to kill her. More than a fifth (22 percent) of the women have been verbally abused by their husbands, who, for example, accuse them of having a lover if they refuse to have sex. The women may also be emotionally blackmailed: husbands tell their wives that they will find someone else if they refuse to have sex. In order to show their husbands that they are mistaken, or to prevent their partners' infidelity, these women agree to have sex, even if they do not feel like it. In other cases, however, the women refuse to have sex despite increased verbal, or even physical, abuse from their husbands.

He wants to swing me as if I were a rattle, you know what I mean? He is very aggressive. He is always fuming, and I cannot stand it. He is very demanding. He tells me, "You have another lover". But that is not true.

Sometimes a woman gets lucky and finds an understanding man who realizes that one is not always in a mood for it [sex]. If he gets angry, the woman has to give in, but it is not as pleasurable, because it is not what you want.

Women's Experience Regarding the Reproductive Cycle

Menstruation. In traditional rural and urban cultures, among both Ladino and Mayan people, menarche is a sign that a woman is ready to conceive. It marks the passage from childhood -- when a girl is not yet physically attractive to men and is allowed to play with boys -- to youth, at which time a girl's body acquires the shape that men find attractive. At this point, the young woman must distance herself from boys and men and provide more help with household chores. Delayed menarche is a source of concern because it is interpreted to be an impediment to a woman's reproductive functions. Lack of menstruation, for reasons other than pregnancy or post-partum amenorrhea, is associated with illness, because of the ethno-physiological belief that menstruation is to "clean the body."

According to traditional Guatemalan cultures, menstruation is viewed as a "hot" state, during which the woman's health is vulnerable if exposed to "cold" elements. As a result, she must avoid eating what are considered "cold" foods and must not touch cold water. For this reason many women do not bathe during their periods. Infringing on these rules may leave women susceptible to future sicknesses, such as getting a "cold uterus" that might affect her reproductive function.

Menarche and menstruation are generally not discussed in the cultural paradigm of silence. They are only mentioned on rare occasions, and it is common for a young woman to have little or no information before she gets her first period. She may even be misinformed, told, for example, that the blood comes from a wound or a blow. Sometimes, if the girl asks questions, she is silenced and asked not to talk about those things. This silence or misinformation means that girls experience shock, fear, and distress when they have their first periods. Frightened and in fear of punishment, many girls hide the onset of menstruation from their mothers and other family members. When they finally confide, they may be told that menstruation is a periodical condition experienced by women, and instructed how to behave and care for themselves during their periods, as well as be advised about their capacity to become pregnant. In this last regard, girls may be warned not to have contact with men.

In the paradigm of speech, however, the idea is to prepare girls to expect menarche without fear, to be happy about it, and to consider it a symbol of femininity -- the transition from childhood to youth -- and the capacity to procreate. There is no silence regarding menstruation, and girls are not separated from their male friends. The subject of sexual relations and their link to pregnancy is explicitly addressed. Girls are trusted to be responsible for their own bodies and to avoid sexual relations and unwanted or untimely pregnancies, since it is believed that they are still emotionally and physically unprepared for motherhood. This approach to menstruation was introduced in Guatemala in the mid-20th century by educational and health institutions

and distributors of sanitary napkins. Schools also play a role, although this receives a mixed review from parents.

The 68 women interviewed reported having had their first periods between the ages of 10 and 18. Depending on the degree of information they received before menarche and their perception of the changes they experienced, the women are classified in three categories: little or no information, somewhat informed, or informed. These categories correspond to three points in the silence-speech continuum: silence or near silence, transition, and speech.

Fifty-two percent of the women received no information from their families, friends or schools. In some cases, when the women asked why their older sisters or mothers were washing bloody garments, they were denied information or misinformed. These women reacted to menarche with distress, fear, embarrassment, or tears. Many thought that they had received a blow, that they had done "something wrong" related to the injunction against touching their genitals, or that they were sick. Some decided to spend the day in the river, feign sickness, or stay at home. In one extreme case, a woman wanted to kill herself because she feared being punished by her father for having done "something wrong" (sexual connotation). Other women kept their menstruation a secret for some time, until a family member (mother or sister, for example) realized what was going on and offered an explanation and advice. The following narrative by a Ladino woman from the Eastern part of the country, who had her first period at 12, is illustrative:

I went for water to one of the fountains. I was just walking when I felt a warm gush on my cool skin. When I saw that red, warm gush, I began to scream. Really scream. I thought that I had died or was about to die. I was screaming like that, and I was alone in the bushes I was not about to tell my father [her mother had left home] because men get angry. What I did was to get into the water up to my waist. I was in the water and saw the water getting redder and redder. "Jesus what should I do, and without anything to put on."

When the women finally confided in someone, they were told that menstruation is something experienced by all women and given advice on hygiene and the foods they should eat. They were told to use napkins and to wash them or to dispose of them in private. They were also told not to touch water, especially cold water, to prevent future damage to their reproductive systems. And girls were told to be wary of men and to avoid contact with men, without any explanation about what "contact" meant. Thus, some girls believed that they could become pregnant by holding a man's hand; others were told that men could hurt them, by getting them pregnant and abandoning them. They were also told not to trust men if they asked for "proof of love or affection" (sex).

Thirty-two percent of the women received some information about menarche, generally from friends who had already gone through the experience, or in the form of veiled comments like these: "Have you already been frightened by the little old man?" or "Have you already had a visit from John?". Menstruation was commonly referred to as "the thing." When girls informed their mothers or sisters that menstruation had started, they were given messages similar to those described above.

A Ladino woman from a ranch in a western province had her first period at 16, after undergoing medical treatment. She was employed at the time as a maid for a school teacher in the provincial capital:

I was about 14 years old, when the teacher asked me if I already had it. I told her that I didn't, and she said to me: "Have you done something, are you expecting?" I told her I was not. I had already heard something about the period from an old woman I took care of, so I could answer what the teacher asked. But I had no idea what she meant by whether I had done something, and I never asked her. When I was around 16 years old, the teacher asked me again, and my answer was the same. Then, she told me: "Get ready, I am taking you to the doctor, so that he can examine you, to see if you have done something." She took me to a doctor in San Marcos. He said that I was all right, and that all I needed was some vitamins. I was given some injections and then my period came.

Only 16 percent of the women received advanced and sufficient information about menarche, within the paradigm of speech. This knowledge was provided by their families and schools. In the family, it was generally the mother who explained what menstruation was and the hygienic practices and behavioral rules to be followed.

When I got my first period I was happy, because my mother had already explained everything to me. After that, I tried to behave differently, not as a child, but as a young lady. My mother used to say that my life would change from then on; that I would be vulnerable in different ways; that things could happen to me, but that it would all depend on whether I was careful. From that day on, I became a different person because of all that my mother said. I began thinking about other things, and taking a little better care of myself. My mother told me: "Look, when you are around 11, you are going to go through puberty, which means that you are going to menstruate, and you are going to lose blood. Don't let that scare you, because it is normal for all women, some have it earlier and some later. After that, you must take care of yourself, because you can become a mother. "Your body is going to change, your breasts, your hips, your legs, your face are going to look different; that is, you are truly going to become a young woman. Your period will last three or four days. Do not get frightened if you become pale." I couldn't wait to see how it would be, and when it happened I felt happy. We are fairly open with my

mother and father. My parents trust us and tell us things as they are. After I got my period, my parents continued to let me go out, and trusted me. They were there to help me, and there was nothing I was forbidden to do.

Of the 68 women, all the indigenous women (7) and about half of the Ladino women arrived at menarche with little or no information. A third of the Ladino women were somewhat informed, and only about a fifth were well informed. Women from Guatemala City tended to be better informed. However, the predominant pattern regardless of ethnic or geographical origin was insufficient information. Education seems to have made more of a difference: 73 percent of the illiterate women, 58 percent of those who completed between one and three years of elementary school, and 33 percent of the women who completed more than four elementary school years arrived at menarche with little or no information.

First sexual relationship. The age of first sexual contact for the 68 women interviewed ranged between 13 and 24 years old, and half the women had sexual relations before age 16.5. Two-thirds of the women had their first sexual encounter before they were 18, that is before they were considered adults under both Guatemalan law and UNICEF guidelines. Despite the proscription to avoid sexual contact before marriage, more than half of the women -- not counting those who were raped -- began their sex lives outside of a union or marriage. The average number of years between menarche and first sexual relationship was 3.7 years.

The women interviewed were also classified according to the amount and kind of information they said they had before their first sexual encounter: little or no information, somewhat informed, or informed. Those women who received information generally received it at menarche.

Fifty-two percent of the women either had no information before their first sexual encounter, or had received only a veiled warning to avoid contact with men before marriage, because they could become pregnant. The most common expression they heard was: "It is necessary to be careful with men." The women did not ask what that meant. They accepted these warnings in silence, even if they did not understand them consequently, some women thought that they could become pregnant simply by holding hands with or kissing a man. They feared the treachery of men, and their irresponsibility in making women pregnant and abandoning them. Some women were left with the idea that if they had a premarital sexual relationship with a man, other men would not love them. The messages they received led them to fear and avoid something which, although they did not clearly understand it, they knew was socially scorned.

Twenty-six percent of the women had obtained some information about sex through observation and communication. Some of them saw their parents or other couples having sex, but did not understand exactly how it was done and did not dare ask.

Others found out from comments by friends or neighbors, who told them, for instance, that if a man asked them for "proof of love," they should not give it, and should not trust the man. Some women knew that sex meant to lie with a man, but they did not understand the specifics of sexual contact.

Twenty-two percent of the women experienced their first sexual encounter somewhat better informed. These women received information on heterosexual sex at home or from friends or neighbors. Some were curious to know if what they were told was true, and this led them to agree to sexual contact during courtship. Some were told that the first sexual relationship was painful, that it was embarrassing or unpleasant and that bleeding was evidence of their virginity -- comments based on socio-cultural lore rather than biomedical knowledge. Few women expected sex to be pleasurable.

About half of the women arrived at their first sexual relationship with little or no information. Again, education makes a difference: two-thirds of the illiterate women had little or no information at the time of their first sexual contact.

Women experience their first sexual encounter in one of three ways: rape, premarital sex, or post-union sex. Eighteen percent of the women began their sexual lives through rape. Rape was classified as stranger rape, incest, and forced intercourse (or date rape). Three women were raped under violent conditions. Two of them lived on a ranch and knew the men who raped them; one lives with her rapist. Both of them have had a life of marital violence and abandonment. A third woman was assaulted by two men wearing masks, one of whom raped her. This woman maintained that she knew who the rapist was, and after some time had passed, and under the influence of alcohol, she summoned up the courage to threaten the man with a knife and make him confess. She was ready to kill him, but a religious conviction stopped her:

I was raped at 19, and it was a traumatic experience. I was walking one night, when two men wearing masks got in my way and grabbed me. And they did it to me. I was an evangelist at the time, and withdrew from religion....I was full of hate. All I could think of was revenge. I was full of hate. It was one of my boyfriends who did it, I realized that afterwards. He did it out of spite.

Eight women were forced to have sex by their boyfriends or someone they knew through physical force or coercion. Among this group, six of them were little informed, and two were somewhat informed about sex. The situations were similar and took place in the city. A man invited a woman to go out for a meal, a movie, or a walk. She accepted with pleasure. Then, the man, manipulating the situation and deceiving the woman, took her to a motel, or to some other place, where he forced her to have sex; this generally took place late at night, when the woman normally would have already been home. The most common threat was to keep her until the act was consummated. The following case is illustrative of this type of situation:

We went to the movies. I was an ignorant child [from an eastern municipal capital], and it was the first time I was going out with him. But as he was from here [Guatemala City], he already knew about all of this. I said: "A person born here is more knowledgeable; one who comes from the country, like me,...doesn't know anything." One is completely ignorant when one first arrives. It was the first time I went out with him, and I trusted him completely; and this is what happened to me for trusting him. He raped me. I did not feel a thing, because I am not an animal.

Fifty percent of the women initiated their sex lives in pre-marital relationships with their boyfriends. In most cases, men took the initiative; women consented to have sex out of affection for the men. In a few cases, it was the woman who initiated sexual contact, because she was curious. The women's reactions during their first experience with sex varied from feelings of embarrassment to pleasure. Afterwards their reactions were different: ranging from concern that other people might know that they were no longer virgins because of the way they walked, to fear that their parents may learn about it, and anxiety over the possibility that they might be pregnant. They also lost self esteem over losing their virginity and betraying their parents, who had warned them not to have pre-marital sex. Some of these women told their friends about their experiences, but generally kept it a secret, unless they became pregnant.

The case of a Ladino woman from Guatemala City is illustrative of the internal struggle between the desire to experience sex and fear over the consequences. It also provides an example of how family conflicts lead women to engage in sexual relations in order to get pregnant deliberately and thus be "forced" by circumstances to leave their parental home and form a couple:

I will speak truthfully. I heard my parents talking about sex when I was growing up, and I was curious to know what it was. When I got older and I met the man who is now my husband, I told him that I wanted to have sex and to know how it felt. That was how I made my mistake. I was not thinking of doing it until we got married, but there were so many problems at home [her stepfather mistreated her], and I made the mistake. It was a mistake for me, because I wanted to leave my home dressed in white [a wedding gown].

Many women expressed ambivalent feelings toward sexual contact as the following example illustrates: "Her first sexual relations took place when she was in love, and with the father of her children. It was something wonderful that happens once in a life time. The sex took place before they became a couple. She was 18 years old. It was embarrassing but beautiful, because one is not used to showing one's body, especially when so many people are telling you that it is a bad thing to do." (Fieldwork notes)

The women who began their sex lives either with their boyfriends or through rape transgressed, willingly or unwillingly, against the ideal that sex is something that must take place within marriage, preferably one sanctioned by the Church and the law. These women represent two-thirds of the women interviewed. Only one-third of the women initiated their sex lives after having joined as a couple. Fifty-nine percent entered into their marriage or union with little information about sexual relationships. Analysis showed that 14 percent had insufficient information and 27 percent said they had adequate information. In most cases, their partners had already had sexual relations with other women, but there were cases in which both the man and the woman were virgins. The following narratives highlight a range of circumstances:

I knew nothing about intimate relations. The first one I had was with my husband. We were going out together, and he told me: "Come to live with me." So I went to live in his parents' house, and then had sex with him. I felt embarrassed after it happened. I thought he would leave me, and I felt embarrassed to face his parents, but I figured that they must have done the same thing.

I was 13 years old. When you are a kid, you don't know what you are getting into. I told myself: 'I will not leave my home and stop suffering, unless I form a couple with a man.' I didn't like being reprimanded, so I told myself: 'As soon as he asks for my hand, I will go with him and leave this house.' So we got together, and had sex as a couple.

First union. The women interviewed began their married lives by one of four means, all of which are common in both La Esperanza and the country as a whole. The first is called "getting together" (*juntarse*); it takes place when a man and a woman simply decide to begin their life together without any legal, religious or cultural contract or sanction. The second is a union formed through a cultural ritual in which the man and his parents ask for the bride's hand, and vows are exchanged by the couple. The third is a civil marriage, which takes place before a recognized legal authority. And the fourth is a religious marriage, which, according to Guatemalan law, must be preceded by civil marriage. For the purpose of defending the rights of the couple and their offspring, Guatemalan law officially recognizes "a union" after a couple has lived together for three years.

Women's attitudes towards these forms of union vary. Some women want to get married (a civil marriage, or both a civil and religious wedding), since they believe it would ensure that the relationship would last, that the father would stay involved in the children's education, and that he would take his role as breadwinner more seriously. Marriage enhances a woman's status, since she becomes the "wife," regardless of any lovers or mistresses her husband might have. Most of the women also see marriage as more in accordance with religious morals. One woman, whose partner had proposed marriage, did not want to get married because she thought that she "did not deserve

to," because she had been raped. Although marriage is considered the ideal, the poor economic conditions of the settlement are an obstacle: "A wedding is very expensive. That is why some couples don't do it." For other women, marriage represents an unbreakable bond that may not be desirable, because it may "tie" them down to a womanizer, drunkard, or irresponsible man. They believe that a union without marriage gives them greater freedom to leave such a man.

Of the 68 women interviewed, 66 are, or have been, in a relationship. Such relationships took place for the first time when they were between 13 and 29 years old; there was, on average, one year between the age of their first sexual contact (16.9 years old) and the age at which they first joined a couple (17.9 years old). Before the age of 18, half of the women were already in a union.

The main reasons why these women began their respective relationships include pregnancy or the birth of a child, pressure from their parents, fear of being kidnapped by their boyfriends, eloping (stolen bride), desire to leave home, expectations about being supported and not having to work, or the couple's desire to live together. A third of the women (22) began their unions as a result of a pre-marital pregnancy, and got married while pregnant or shortly after the birth of the child. Of those women, 17 became pregnant as a result of sexual relationship of their own free will, three were forced to have sex, and two were raped. All of them formed unions with the fathers of their children. Several of the women admitted getting pregnant on purpose, so that their parents would throw them out of the house; this was the only way they saw to escape the violence within their families and the sexual harassment to which they were subjected in their homes. The following narrative shows the case of a woman who had pre-marital sex with her boyfriend, became pregnant, and got married.

The first time I had sex was with him on December 25th. I became pregnant on January 15, when we had sex for the second time. I did not tell my parents that I was pregnant until I was married, but I did tell my mother-in-law before the wedding. My mother did not learn it from me until I had been married for 15 days. She told me, "Yes, that is what I figured!" She said this because she was already angry with me when I got married. She summoned me 15 days later, but since I had gotten married I did not go to see her. I felt sad and sulky. When she called me again and I went to see her, I was already showing a little. I told her that there was something I wanted to say, but that I did not want her to reprimand me.

In some cases, parents either influenced or determined the women's first relationships. Four women began living with their partners because of pressure from their parents. One young woman began going out with a boy at a young age, and her father pressured her to get married as a way of avoiding pre-marital sex. In another case, the young woman was pregnant, and her father gave her 15 days to formalize the relationship.

Bride kidnapping continues to take place in rural areas in Guatemala. A woman's suitor kidnaps her to force her to become his spouse. Two of the women interviewed decided to begin living as a couple with their suitors when they were still living in their villages, because they were afraid of being kidnapped. They preferred to leave their homes of their own will, rather than being subjected to a violent act.

Eloping, known locally as "stolen brides", is different from being kidnapped in that there is discussion and mutual agreement between the man and woman to begin their life as a couple without their parents' consent. It is a culturally accepted, though not preferred, way to begin life as a couple, especially when the parents of the woman reject the man or think that she is too young to get married. In Mayan culture, there are rites associated with eloping that include asking forgiveness from the parents of the bride and giving the bride an opportunity to change her mind in front of her parents. This serves to reconcile the family of the groom and the family of the bride and to legitimize the couple's marriage. However, in the Ladino culture, if the woman is under-age and she is "stolen," her family may file charges with the police to have the man arrested and return the young woman to her home. Four Ladino women began their respective lives as a couple after eloping.

Conflict within the family and paternal strictness led seven women to form unions as a way of getting away from home. Six of these women were born in hamlets or municipal capitals, and one in Guatemala City. Three were forced by their boyfriends to have sex for the first time, and three agreed to have pre-marital sex. One woman waited to have sex until she was married. One Ladino woman describes her first pre-marital sexual relationship as "traumatic and something dirty," because she did not want it. She went away with the young man because she "couldn't stand living at home any longer." Later, when she lived with him, she drank to help her tolerate sexual relations. She says that her parents influenced her decision to get together with the man because "they saw that he had money." Her parents never told her that it was a mistake to get involved with an older man who was already married. Another Ladino woman was forced by her boyfriend to have sex and became pregnant. The woman's mother spoke with the young man and asked him to take responsibility for his actions. The man lied about his marital status so that he would not be forced to form a union with the pregnant woman. A month after the child was born, the woman did move in with the young man, because "she was very badly treated at home." Her stepfather, who had sexually harassed her, became angry when she got pregnant and told her to leave the house. She first lived with a woman she knew, and, when the time came to decide between returning home or moving in with the father of her child, now at his request, she opted for the latter.

It is sometimes said that women only want to get married so they won't have to work for a living. However, only one of the women who had pre-marital sex said she sought her first union because she wanted to stop working.

He asks me, "Why did you marry me?" And I say, "So that I don't have to work." I was working for a family, taking care of their children; and I was tired of it. I told myself, "I will only be able to stop working if I marry." I will have money and all I need, and I won't have to get up early, do this and that, and put up with these children. Oh no! I will get married."

Finally, 26 of the 66 women who, at the time of the study were in a relationship or had lived at some point as a couple, said that the first time they did so was a result of a decision with their partner, without regard for any family pressure or pre-marital pregnancy. The vast majority of these women had sex for the first time within the context of their first union.

I have only been married once, and I have lived with my husband for 10 years. We were attracted to each other, and liked each other. I met him when I was 14 years old. He was my first boyfriend, and we began going out steady from the start. We were not allowed to see each other outside the house. He came to my home to see me, and he made the decision that we should get married after we had been seeing each other for two-and-a-half years. I believe that we got married because we wanted to be together, to share our lives, and because we loved each other so much.

I have only been married once. I got married when I was 24 years old, and he was 21; and I have been married for almost two years. We decided to get married on our own. My mother-in-law asked my husband whether he felt competent to support a family, because he drinks too much, and he was already drinking when I met him. But he did not back off. My mother-in-law and his aunt spoke to my husband clearly. They asked him whether he was sure of what he was going to do.

First pregnancy. In both the silence and speech paradigms, it is expected that if a woman becomes pregnant she will carry the baby to term. Abortion is not acceptable. Some women described it as sinful and objectionable. They said that, from time to time, aborted fetuses or abandoned newborn children are found in the ravines or alleys of the community, and that there is a rumor that one or two women perform abortions. An APROFAM promoter said that a young woman asked for her help to abort but that she advised the woman to have the child. The APROFAM promoter assumes that the woman got what she wanted, because some time later she was no longer pregnant.

In this socio-cultural context, the women who undergo abortions or kill their offspring are socially condemned regardless of the situation in which they become pregnant. They are called "unnatural mothers;" are alienated; and may be imprisoned, according to the laws of the country. Some midwives and women said that having an abortion

would bring on a run of bad luck. Of all the women interviewed, only two admitted to having had an abortion. These two women said that they were forced into it, in one case by her mother-in-law, and in the other by her husband. Three other women had been pressured by their partners to abort, but did not give in. In one case, the woman's partner gave her the money, but she and her mother used it to buy clothes for the child.

It is expected that if a man gets a woman pregnant, he will recognize the child and assume his paternal responsibility. At the time of menarche, young women are told that they are capable of producing a child, and that they must avoid premarital sex. If a woman has pre-marital relations and becomes pregnant, one of the tactics employed by men to deny paternity is to say that the woman has had sex with other men, or that he is already involved with another woman. Frequently young women who become pregnant outside a relationship suffer violence at the hand of their parents. But even in those situations, the women do not see abortion as a solution, rather they and their families accept the responsibility for the child.

Of the 68 women interviewed, 66 have been pregnant at least once. The women first became pregnant between 14 and 29 years of age. Half of the women were pregnant for the first time before they turned 18, and three-quarters before they turned 20. The Guatemalan Ministry of Health considers that pregnancies are risky if the woman is under 18 years old, and the DHS if the woman is under 20. A comparison of the average age at the first sexual relations (16.9 years old), first union (17.9 years old), and the first pregnancy (18.1 years old) shows how closely these three events follow each other. Only nine of the 66 women (14 percent) were adequately informed about the physiology of pregnancy when they became pregnant for the first time. Most of them arrived at such a momentous event with little or no information. Some did not even know that they could become pregnant after having sex, and they did not associate the absence of their menstrual periods with a possible pregnancy. Other women did not even know where a child comes out of the body.

The interviews covered the nature of the first pregnancy to determine whether it was unexpected and unwanted, unexpected but welcomed, expected, planned, or desired as a way to "escape" the parental home. The researchers classified these data using the following definitions: If a woman did not know that she could become pregnant after her first sexual encounter, or as a result of sporadic sexual activity her pregnancy was classified as unexpected. An unavowed pregnancy occurred when a woman or her partner, conscious that pregnancy was possible, took no measures to prevent it. An expected pregnancy occurred when a woman or couple wanted it. A planned pregnancy occurred when a woman or her partner stopped using a method of family planning in order to get pregnant. An "escape" pregnancy occurred when a woman, not knowing what else to do to avoid her problems at home, got pregnant intentionally, so that her parents would throw her out of the house.

Of the 66 women who have been pregnant at least once, only one, in her early twenties, planned her first pregnancy. The rest described their first pregnancies as follows: Twelve women (18 percent) wanted to become pregnant; 19 (29 percent) did nothing to prevent the pregnancy; 3 (4.5 percent) got pregnant to escape their homes, and 31 (47 percent) were pleasantly or distressingly surprised that they were pregnant. Thus, 76 percent of the women did not make a decision regarding their first pregnancy.

Information was obtained from 47 women regarding their degree of knowledge of the physiology of pregnancy. Among those with little or no information, 54 percent had an unexpected first pregnancy; among the somewhat informed, the percentage was 42; and among the informed, 33 percent. This seems to indicate that the better informed the women are, the lower the proportion of unwanted first pregnancies.

Men's Reproductive Cycle

In this section we discuss some of the results of the analysis of the in-depth interviews conducted with 10 men: puberty, first sexual relationship, and first union. Paternity will be discussed in Chapter Four.

The men were the partners of 10 of the 68 women interviewed in the course of this study. Most of them are immigrants from other urban areas, and they are either illiterate or have limited elementary schooling. Seven are Ladinos and three Mayans. They work in construction, transportation, and sales. Half are wage earners, and half work for themselves. They range in age from 25 to 40 years old.

Puberty. Puberty represents the transition between childhood and reproductive maturity. It is marked by the appearance of the secondary sex characteristics -- such as voice change. The men reported they began experiencing these changes between the ages of 14 and 17. Except for one, none of the men were prepared by their families for the onset of puberty. Like many women, they were socialized in the paradigm of silence. However, unlike the women, before the onset of puberty their friends had told them what physical changes to expect, and what behavior and values they should adopt.

While the paradigm of silence emphasizes the importance of virginity for women before marriage, men's socialization reinforces the masculine identity through pre-marital sexual experience. It takes place among friends, who talk about the sex drive that is awakened at this stage in life and that must be released to avoid physical ailments, homosexuality, or trauma. Hence, men need to learn about and have sexual relations with women. Men are encouraged to engage in sex with prostitutes, girl-friends, and older women:

In the countryside, it is your chums who tell you. You go to the field and kid around with your friends, and they tell you that it is about time you have a woman, so that you won't go crazy or get sick.

Puberty is great. It is the best time of life. I was told that I could go crazy; that if I didn't control myself during that time, I could go crazy. What people mean is that the emotions can make you crazy. I remember that I had lots of doubts about that. Then, after many experiences, you calm down and the doubts go away; but until you live through it, you are not at ease.

For instance, if the man did not have sexual relations he was told he would die. So, he had to do it; that is what was said.

They told me to go in (to have sex), that it was for my own good. They said that if I didn't go in, I would get sick; they scared me. They told me: "if you don't go it, you are going to turn into a fag. That is how I decided to take the plunge [begin to have sex]."

Adolescent men, especially in urban areas, face a significant risk of contracting sexually transmitted diseases. One of the men interviewed took that risk seriously and turned to exercise to relieve sexual tension:

Most of them told me "I am going to take you to the girls [prostitutes]". But I was rather afraid, because there was talk about many diseases. So I would say "No, better not. I will exercise more". My concern was that I would catch the diseases I heard about, AIDS and all of that, or venereal disease. That was my fear, since one doesn't know about the other person.

First sexual relationship. The men had their first sexual relationship between the ages of 12 and 20. Four of them were initiated into sex by older women; two by prostitutes; three began their sex lives with a girlfriend or fiancée; and one with his wife:

I was 17 years old when I had my first sexual experience. She was older. I was a bit afraid, but she convinced me. I thought that this was the only way I could find out; I needed to know what being with a woman was all about. It was desire rather than love. I was happy, because it felt good, and who doesn't like that? It was not very difficult for me, because she was experienced and helped me. She had been doing it for some time. She did it with me, and had done it with many other boys I knew. She was a young woman who lived near by, and liked to do it with boys. Maybe she liked it because she was older and we were young. That's what she liked!

First union. The men in the study began their first union between the ages of 17 and 28. Following the same categories used for the women, six of them got together as a result of a decision reached with their partners, one because of pregnancy, another under pressure from the girl's parents, and one eloped with his bride. Those who established a union without external pressure did so out of loneliness, because they wanted a companion, and to establish their own homes with a wife who would take over the domestic chores (a desirable gender division of labor from their perspective).

I chose her as my partner because there comes a time when one feels very lonely and needs someone by his side. It is essential to have a woman; and not only because of the sex drive; she is also important in the home. There are lots of things that men cannot do, but can be done by women: cooking, the laundry, and taking care of the children. I also decided that she should be my partner because we had been going together for some time, and, of course, I was not about to leave her after all that time.

We talked about wanting to live together, wanting to form a couple, because I needed her; I needed her with me. I needed someone who understood me. I worked, and I needed someone to take care of my things, my home; to share with me what I earned, my wages, the money I had. I wanted to share with someone what I achieved; and I didn't have that. I spent my time walking around, and squandering money. And I didn't want that. I wanted to have company, someone with whom I could share my problems.

In comparing the reproductive lives of the women and men interviewed, there are similarities and differences. The most relevant similarity is that most of the men and women interviewed were socialized according to the paradigm of silence. They received little or no information from their families to prepare them for puberty, sexual relations and pregnancy. For the women, menarche and the first sexual experience were in many cases painful and surrounded by fear, anxiety and even violence. However, the men had a circle of friends who were their primary source of information about sex and their reproductive behavior. While women were warned against pre-marital sex, men were pressed to seek it with prostitutes, older women or fiancés.

Although the paradigm of silence deprives both men and women of accurate information, gender differences in the way the men and women are socialized about reproductive issues place women in a vulnerable position. While the men have socialization groups parallel to the family, the women can seldom escape the silence within their families and society as a whole.

IV. Roles Affecting Reproductive Decisionmaking

Gender roles affect reproductive decisionmaking. In the silence paradigm, a woman is fulfilled by becoming a wife and mother to a large number of children. Similarly, a man's identity is established when he becomes a husband and father to a large family, particularly one in which the first child is a son. The speech paradigm, by emphasizing women's and men's control over their bodies, as well as responsible parenthood allows for more flexibility among the definitions of women's and men's roles. This chapter presents the data on gender roles from the perspective of the 68 women and 10 men interviewed for this study. The analysis will present how role definitions fall along the silence-speech continuum.

Woman, Partner, and Mother

The women interviewed see their roles as women, partners and mothers as complementary. They "are born women," but their womanhood is fulfilled by becoming mothers and partners. For most of the women interviewed, being a woman is intrinsically linked with being a mother. This means that having children is a source of happiness and companionship, as well as economic and emotional support in old age. Becoming a mother bestows on a woman a respectful status, which is expressed by the title "señora" (lady). A woman without children is pitied. Being a man's partner is considered desirable, especially if that partner "turns out to be a good man," if he is responsible, treats the woman and their children well, and helps support the family. The ideal is that a man and woman are seen as a couple with complementary rights and duties in the home. However, after experiencing, or observing other women's experiences with infidelity, abandonment, mistreatment, lack of financial support, alcoholism, and drug addiction, some women have come to believe that they do not need a husband to feel fulfilled.

In the silence paradigm, motherhood is associated with having many children, while in the speech paradigm, a small number is associated with a high quality of life. Within the silence paradigm, the three roles -- woman, partner, mother -- are complementary; in the speech paradigm, they are more independent. The following comments highlight different views on the three roles:

The role of children in a woman's life:

The way I think about it is that a woman wants to have children of her own, to know how it feels loving them, and all of that. That is, a woman wants to experience what is like being a woman. I enjoy it. I have her [a small girl], and I keep her in clean clothes, I dress her up, and make her pig tails. Other mothers feel tied down because, once the children arrive, their life changes. They are so tied down that they cannot go out. It is not the same, they don't have the same freedom; and some women prefer

being by alone. [How would you feel without children?] I would feel very sad. The doctor told me that I could not have more children; and that is sad. I have always wanted kids; I guess I look forward to growing old, and seeing my own children as grown ups.

I think that a woman must have children to feel that she is a woman. Maybe not a lot; just one or two. My mother used to tell me: You will pay your dues when you become a mother. And I guess she was right, because my daughters, especially my eldest, is a bit disrespectful to me. The way I see it, being a mother is not just having children; there are many things to think about. It is not just a question of having them. You have to decide what to do when they get sick, and how to make them study. I think that a woman who hasn't had children cannot really feel like a woman. Or maybe she feels that she is a woman, but has not experienced what it is to have a child. A single woman, who hasn't had a husband, cannot feel like a woman. To feel like a woman it is necessary to have a husband and children. A woman who has children, but doesn't have a husband, is even more of a woman, because she is both father and mother at the same time. A woman who has only a husband and no children cannot feel like a woman, because what makes a woman is having children.

Imagine that you get sick, who will take care of you? [It is good to have] at least one, or even two or three children, so that one of them can bring you a glass of water [when you need it].

There are some people who say that "Even if you cannot have children, you are still a woman."

A woman is a woman from the time God sends her into this world. Many women don't see themselves as being better or greater simply by the fact of having children; they are just women.

The importance of having a partner:

One gets respect and support [from one's partner], because your parents do not help you after you are 18; you are no longer their responsibility. Your parents tell you to make a life for yourself; so I have made my own life, by myself [without my parents].

Because I feel that a woman, even if she cannot have children, needs someone to keep her company. She needs to have a man, because we are not made of stone, we have feelings. I believe that a woman needs a companion, even if she cannot have children. I have two friends who are

sterile. They cannot have children, and they get sad. But they need someone to keep them company; they need a boyfriend with whom to be intimate, even if they don't have children. They need to speak about what bothers them inside, to get it out of their systems; that helps a little.

A woman needs a partner if she is in love; but doesn't need one, if she is not.

One shares with them [partners] happy moments and sad moments. It is nice. When a woman is alone, she may think that she has freedom. But if a woman is with a man, she has to prepare his meals and iron his clothes. When one is alone, there are no worries.

It is essential to have a partner, because as the saying goes: "A single log is not enough to have a flaming fire."

No. [Having a partner] is like killing yourself. You tell yourself: Things will go well with this one. But it is not necessary to have a husband in order to get ahead. A woman can always work. And if there are children, the woman must care for them. There are mothers who seem to have lost their love for their children, and leave them without care when they go to work, so it is difficult to know whether they have eaten or not. I was about to begin working at a private home; but I thought: "Who is going to take care of my children?"

A woman can live without a partner. If she knows how to work, it makes no difference whether she is with or without a husband. A woman is more daring than a man. A woman is braver. That is my feeling.

Of the 68 women interviewed, 70 percent have had one union, 18 percent two, and 9 percent three or more. Only two women (3 percent) had not ever been in a union. These data show that while the women are essentially monogamous, the incidence of serial monogamy increases with age. Among women 15 to 30 years old, 11 percent reported having had two unions. However, among those 31 to 44 years old, 54 percent are in either their second (7 women) or third (6 women) unions.

Ninety-six percent of the 68 women in the study have had at least one child. The women ages 15 to 30 have an average of 2.3 living children, ranging from 1 to 6. Among the women in this age group who have had only one union the average is 2.7 children, compared to 2.2 for those who have had two unions. In the 31-to-44 age group, the women have an average of 4.7 living children, ranging between 1 and 8. In this age group, the women who have had only one union average 4.3 living children, while those who have had two or three unions, average 5. According to the Ministry of Health, women over the age of 35 and those who have had four or more children are at

a higher risk of health problems if they get pregnant. In the 15 to 30 age group, 10 women (24 percent) are in this higher risk category because of the number of children they have had, and in the 31 to 44 age group, there are 18 women (75 percent) in the highest risk category.

Despite the socio-cultural emphasis on motherhood, which includes carrying all pregnancies to term, raising the children, and maintaining good mother-child relations, at least seven of the women reported abandoning, or losing contact with one or more of their children. One left a boy with a former partner, who had abandoned her, and gave a girl to another woman who had no children. Another left her home and her four children because of the violent treatment she was getting from her husband. Yet another said that her husband had taken their two children away from her because she was unfaithful to him. When these women spoke about their situations to the interviewers, they tried to justify themselves because they felt guilty. In their environment, women who behave this way are considered "bad mothers."

Man, Partner, and Father

In general, the interviewed men were also socialized according to the gender roles and family values of the paradigm of silence. They view the roles of man, partner and father as complementary. Although the role of man is somewhat independent from the other two, because of its biological nature -- one is "born a man"-- men find fulfillment by becoming partners and fathers. In the early stages of their lives, the interviewees were pressured, particularly by their fathers, into having sex to prove their manhood. Later, they searched for partners to satisfied their need for company, affection, and someone to take care of domestic chores and ensure their comfort by preparing their food, taking care of their clothing, etc.

For a man, being a father is proof of his virility, especially if his first child is a boy and he fathers several sons. Sons "belong to the father," just like daughters "belong to the mother." Boys help the man in his work and keep him company. Men are sometimes mocked when they have only daughters; their manhood is questioned, and they are at the mercy of what other men might do to those daughters. Yet, daughters ensure that a father will have "more love and attention."

Social pressure on men reinforces their roles as breadwinners: "A good man covers the expenses needed to support his children and wife, so that they do not go wanting" and "so that his wife won't have to look for work and neglect the house and the children." Social pressure also reinforces men's role as progenitors, hence it is considered important to have many children. Due to their precarious living conditions, the men interviewed face a dilemma. On the one hand, they cannot provide sufficiently for a large number of children. On the other hand, if they decide to practice family planning and have only a few children, their manhood may be questioned. Their male

identity may also be threatened if their partners choose to use contraceptive methods, particular those that men do not have control over (such as pills or IUDs). Because of the difficult economic conditions and social pressures the roles of man, partner and father within the paradigm of silence may be a source of conflict for a man.

Deciding the Number of Children

Many of the 68 women had thought about their ideal number of children at various times in their lives: before their first unions, at the beginning of those relationships, throughout their reproductive lives, upon starting new unions, in retrospect, and upon concluding their reproductive lives. Some had thought about this subject since they were young. Others did not begin to think about it until after they already had several children. Some had discussed the issue with their husbands or partners; others had not.

The two of us have made the decision together. We spoke about it when we were going out. I want to have only two or three children. If he wants more, I do not. But he also says that there is no need for more.

One 35-year-old woman, who has been pregnant nine times and has five living children, thought about the number of children she should have had. She followed her doctor's advice to undergo sterilization, disregarding what she was told by a midwife. The midwife, after counting the nodes on the umbilical cord from the birth of one of her children, said she would be having four more.

Nobody, not even him, told me: let's stop having children. We just had one after another, until I got seriously ill with the last. That is when I decided to have an operation. I did not want to die, because I had more children to take care of.

The women's thoughts about the ideal number of children range from non-numeric responses such as: "As many as God sends me; that is what a woman is for," to a particular number of children, specifying how many of each sex, for instance "two boys and a girl." The women's gender preferences also vary from a distinct preference to no preference at all. These variations can be placed along the silence-speech continuum.

He tells me: "You are very young. Have as many children as you want. After one becomes old and sick, one doesn't have the strength to have children." But I tell him, "What is the point of having a lot of children." He says, "It is beautiful. They all grow up at once, and you are done; there is no raising involved." This is partially true. The children grow up and some go to work with their father, and help him.

I only want to have two children, a boy and a girl. Raising many children is hard. There is not enough money. There may be money to buy something for some of the children, but not for all. When my mother goes through hard times, she tells me, "I shouldn't have had any more children after you."

Women give a range of reasons, related to their perceptions of gender roles, to justify their preferences for boys or girls. Boys are wanted because they help their fathers and keep them company, and because they can assume the role of man of the house in the father's absence. They also "suffer less" (in reference to pregnancy and childbirth) and "require less care," in the sense that there is no need to worry about sexual harassment and pregnancy at an early age. Girls are wanted because they keep their mothers company, and help with household chores. In addition, it is nice to "dress up girls." Two children -- a boy and a girl -- are seen as highly desirable, since there will be one for each parent. However, there may be disagreements, even fights, within the couple regarding the ideal number of children, and their distribution by sex.

I told him that three were enough and that I wanted to have an operation. But he told me that we should have at least another, because he wanted one more. He wants a girl, so that we have two boys and two girls. He says that we should have four, because there is no way of knowing what the future will hold for us. I may have another one, but I don't know when. If I do, it will be a long time from now. I don't have a preference for either sex. If God sends us another boy, what can we do about it. If it is your child, you accept it.

My parents say that I should not have any more children, because I have been very sick during my pregnancies. As they tell me: I already have a boy and a girl. One to help him, and the other to help me. What else do I need!

Women also justify their ideal number of children in terms of the family's economic situation, their expectations for the children's quality of life, their health, number of unions, productive and reproductive work, family tradition, spacing of children, and loneliness if children leave home at young ages. It is also clear that a woman's view of the ideal number of children may change during her life, depending on her age and experiences. Having a new partner or losing a child influences or redefines a woman's ideal number of children.

When I was single, I wanted to have two or three children. That is enough. It is possible to have more children, but you cannot feed them well, and you cannot give them what they want. It is not a good idea to have just one child, because he/she becomes spoiled by being the only one. Now, I am satisfied with just two children. If my second girl were alive, I probably wouldn't have had any more. But I wanted to have a third child. I had two girls with my first partner. Later, with my second partner, if my second girl had been alive, I

wouldn't have had another child; although he might have opposed me on this, because he wanted a girl. I might have had a third child; but I would have waited until my second girl, the one that died, was 10 years old, to avoid having two children in diapers and taking the bottle. I would have not have liked that. When I got together with my second partner, I wanted to have another child right away, because my girl had died; and he wanted a girl, because he already had two boys from another woman.

Maybe one has children to get help from at least one of them in one's old age -- if they turn out to be good children. If you are sick or bedridden, nobody visits you except for your children.

I want to have two children, to give them as much as I can. It is best to have a boy and a girl, so that they both get the same attention. We are five children in my home, and my parents cannot give us all what we want. Having two children is easier. If the husband works, it is easy to give the children what they want.

One of my sisters has three children, and now regrets it, because her daughter is already 17 years old. She is 45, and she regrets that her children have formed their own relationships, and she has been left alone. She now says, "It would have been better if I hadn't had an operation, so that I could have another baby; they are so nice. But what is the use now? There is nothing I can do about it now." I tell my sisters, "Learn from me. I have lots of children." They laugh at me and say, "We are not strong enough to have many children."

V. Perceptions and Use of Family Planning Methods

The options for spacing or limiting pregnancies include a variety of folk, natural and modern methods. The way people think about and/or use these methods can be analyzed in the context of the values and beliefs described by silence-speech paradigms. At the silence pole, the options are close to none. A woman has a mission: to be a devoted mother and wife. A woman whose behavior is oriented by the silence paradigm does not use family planning methods even if she knows about them. At the other end -- the speech pole -- a woman's mission changes. She is expected to have as many children as she wants and is able to provide for economically and emotionally. She is also expected to space her pregnancies, to protect her health and that of her children. Apart from her roles as woman and wife, she has the right to control her own body and to make decisions about her relationship with her partner, as well as the right to informed use of contraceptive methods -- especially modern methods -- and the right to discuss continued use of an appropriate method with her partner.

As will be shown in the next chapter, the 68 women interviewed are distributed along the silence-speech continuum rather than grouped at the poles. Thus their knowledge and perceptions of family planning methods vary. Generally speaking, they rely less on ethno-physiological information and more on biomedical information as they move from the silence to the speech pole. In the middle part of the continuum, it is common for people to have knowledge and ideas characterized by a mix of ethno-physiological and biomedical understanding. Biomedical information is often reinterpreted within a cultural matrix containing ethno-anatomical and ethno-physiological information, a reinterpretation that may provoke fear of methods and constitute a barrier to family planning.

In this chapter the varying perceptions of methods are presented in terms of the silence-speech continuum. Thirty-five (52 percent) of the women interviewed use contraceptive methods. Of this group, 66 percent use modern methods (pills, injectables, condoms, sterilization, IUDs), 17 percent use a combination of methods (rhythm and pills, or condom and vaginal tablets), 11 percent use natural methods (rhythm, withdrawal), and 6 percent use folk methods (brews).

Folk and Natural Methods in the Silence-Speech Context

Post-partum abstinence and breast feeding. The "diet" is a period of about 40 days right after the birth of a child, during which a woman is expected to rest, follow a diet prescribed by tradition, and abstain from having sex. In some cases this period can be lengthened to four or more months. If, after a birth, a woman decides to space or limit her future pregnancies, she will generally choose a method after the diet period is over. Being in the diet period is a key reason women gave for not using any

contraceptive method at the time of the study. However, there are cases of women who had sex before the diet period expired, when pressed by their husbands. These women were at a risk of becoming pregnant.

It is similar to what happens after giving birth, you know? The couple does not have sex. But my husband is not like that. I had not completed my 40 days, and he wanted to have sex. That scared me, because I have heard that it is very easy to get pregnant at that time; and that it is easier to get pregnant if you have had a curettage, because you are not well.

After only fifteen days, he already wants to have sex. He knows that he must wait until the 40th day, but he told me: Aren't you my woman? That is the first thing he says; or he gets angry. In truth, and I'll be frank [...]. I was supposed to get my period on September 21; or, failing that, at the end of the month, around the 30th. But I got nothing; imagine all the time that has gone by without my menstruation. Before this, being irregular had not happened to me. I was told at the hospital that I could go back to using the copper T after the 40 days. But I had sex with my husband before the 40 days were over.

Both midwives, who generally follow the paradigm of silence, and modern-sector health providers who follow the speech paradigm, recommend a rest period after birth, even though the activities, beliefs, and values associated with this period may be different. It is similar with breastfeeding: both paradigms consider it important, but from different perspectives. In the silence paradigm, breastfeeding is assumed to be part of the maternal role, and a woman may breastfeed a child until a new baby is born. Women have observed that breastfeeding is a natural way to space pregnancies, and some believe that as long as they are breastfeeding they cannot get pregnant. Within the speech paradigm, breastfeeding is perceived to be a natural contraceptive method that works only if practiced in a specific way. In the community, volunteer promoters for the Breastfeeding League are trying to teach this approach. However, very few of the interviewed women understood that to receive the contraceptive benefits of breastfeeding they must breastfeed the baby on demand and avoid giving any supplementary food or beverages (including water).

My mother did not get pregnant until she stopped breastfeeding. I think that breastfeeding feeding is a form of birth control, but it does not work for all women. I am confident that it is what is keeping me from getting pregnant. I have not gotten an injection since March, and the effect wore off in June. Three months have gone by, and I have not gotten pregnant. I am thinking of going back [to the health center], because I am concerned that I will get pregnant, and my child is still very small [11 months old]. My mother has told me that breastfeeding prevents pregnancies. She was against giving my child the bottle. Right after the birth, I went back to the

hospital, to the IGSS; and they gave me formula for the child. My mother did not want to feed the child formula, and my sister breastfed him, so that he wouldn't get used to the bottle. Now I breastfeed him when he wants it, even at night.

"Breastfeeding did not work for me. I got pregnant." She is not using any birth control now because she is breastfeeding. [Her child is 15 days old]. She thinks that is not a risk because she is in post-partum. After the 40th day, she will go to for a check up, and she is thinking of using whatever method is recommended to her. (Paraphrased)

The false confidence that postpartum amenorrhea gives women is also a cause of unwanted pregnancies. Many women associate breastfeeding with a delay in menstruation; and, since menstruation is a symbol of fecundity, many women associate the absence of menstruation with a safe period, in which they are sure, or relatively sure, that they will not become pregnant.

Breastfeeding delays menstruation after childbirth. She became pregnant immediately after she stopped breastfeeding. (Paraphrased)

Abstinence during "pregnancy" days vs. rhythm. In the silence paradigm, the ethno-physiology of pregnancy explains that women, during their menstrual cycle, have fertile and infertile days. However, these do not coincide with the fertile days determined biomedically. Thirty percent of the women interviewed said that they avoid having sex before, during and after menstruation. They believe that the time of greatest fecundity is 8 days before and 8 days after menstruation. A woman referred to this time period as "pregnancy days" and said, "We avoid having sex during those days, because one must be careful."

Abstinence during "pregnancy days" is culturally different from the rhythm method, a natural method based on biomedical knowledge. However, both methods are alike in avoiding sex during so-called fertile days. In the minds of most women interviewed, the analytical difference established here by the researchers does not exist. To them, abstinence or rhythm is avoiding sex during fertile days, which are understood by them as the 16 days with menstruation in the middle. Very few women know that the fertile days in the biomedically defined cycle are close to 14 days after menstruation.

The following case gives an example of the use of periodic abstinence, according to ethno-physiological knowledge rather than biomedical. The woman is a 29-year-old Mayan, who has had six children and is currently pregnant. In the course of her reproductive life she has tried using contraceptive pills and injectables, but stopped them because of health problems. Before she became pregnant the last time, she was using periodic abstinence, which she describes as follows:

He would ask me when I was expecting my period, and when it ended. So, about eight days after my period had dried out – sometimes it did it little by little – when I was dry, he would ask me, “You don’t have anything?” And I would tell him that I didn’t. He would say, “Are you sure because you will get pregnant otherwise? How many days have there been?” Eight days. And we would have sex. When I forgot how many days passed, that is when I ended up pregnant. It is a nice method, if you know how to use it, and don’t make mistakes. It works, if you know how to use it.

Women see two major advantages to periodic abstinence: 1) it does not have unwanted side effects for their health or that of their partners, and 2) it requires the involvement, knowledge, and consent of both parties. However, the women also realize that it is a risky method; hence, some women combine it with other methods, such as pills or condoms.

One day a woman told me that it was eight days before and eight days after menstruation. She said that this method was harmless, because it did not involve a condom, a pill or anything; and she considered it healthy, because she was not doing harm to herself or her husband. That is what she said.

Frequency of sex. There is also an ethno-physiological connection between the frequency of sex and the probability of conceiving. Several women who became pregnant premarital and who had been socialized within the paradigm of silence expressed this idea. They thought that they would not get pregnant if they only had sex every once in a while. The following case illustrated this idea. A 22-year-old Ladino woman, with four children has decided, along with her partner, not to have any more children, because of their precarious economic situation. They tried modern methods (condoms and vaginal tablets), but stopped after the woman had vaginal irritation. She has not had a period since her last child was born, over a year ago, and she is still breastfeeding him. She believes that she will not get pregnant as quickly if she breastfeeds the child and has sex only occasionally. She would feel more secure if she or her partner were using a modern method but she has been told that she must wait for her period to resume, before she can take the pill or get an injection.

We have come to an agreement not to have sex very often. He has agreed that we will only do it every once in a while. I have enough with our children, and I am convinced that if we have sex often, I will get pregnant again. We have sex every fifteen days, because we don’t want to get me pregnant, because my child is very young. . I have noticed that, if I have sex often, in a month’s time I begin getting symptoms that I am pregnant. I am concerned now, because I am not using any birth control, and I could get pregnant. In the past, I did not worry because I knew that he was using condoms.

Brews. The use of brews to prevent pregnancies is primarily recommended by midwives, who are respected for their great knowledge of the medicinal properties of plants and compounds. The plants that are believed to have contraceptive properties include parsley, *apazote*, coconut, avocado seeds, and plantains.

Of the 35 women who said they were using a method, one indicated that she uses "parsley water" to space her pregnancies. She is a 28-year-old Ladino woman, who has four sons. She and her partner had decided to have only three children, but she got pregnant again because they wanted a girl. They had another boy. She thought of getting sterilized but decided against it, because she still wants a girl. Instead, she chose to use a method to space her pregnancies. She has been drinking "parsley water" for three years, following the advice of her sister. Although she tried using condoms and the rhythm method, she believes that "parsley water" is a better and more effective method, and that it may even have sterilizing properties. She takes three glasses of parsley water eight days before she menstruates, and another three glasses the first three days of her period. Notice that this practice is consistent with the "pregnancy" days.

I use a bunch [approximately 30 twigs of parsley] for three days. I blend it and brew it. I have a sister who drinks it, and it has never failed her. I was told that with time one becomes mannish [loses the capacity to have children]. During the time I have tried this method, it has worked well for me, because I haven't had any pain at all; nothing, nothing at all. I have been taking it for three years, and it hasn't failed me.

However, most women think that brews are less effective in preventing pregnancies than modern contraceptive methods.

I have heard midwives saying that women should take "apazote water" to stop having children; but that is false. One of my sisters took it, and she has already had 12 children. She began taking the water 40 days after giving birth. And she always got pregnant; the apazote water did nothing for her.

Withdrawal. In order to get pregnant, a woman needs a man's semen. This proposition is true for ethno-physiological as well as for biomedical understanding of reproduction. However, there is difference in the perceptions of withdrawal as a method. From an ethno-physiological viewpoint, the interruption of coitus can be harmful to a man and is not sexually pleasing. From the biomedical side, neither of these two propositions is true. Since withdrawal demands male willingness and control to prevent a pregnancy, the decision to use it can be taken unilaterally by him or together by the couple.

When he wanted to have sex, we did it, but he finished outside me. I wasn't happy with that, because I thought that, if he couldn't hold it, I would end up pregnant again. It doesn't feel the same. He told me that it felt better inside than outside. I didn't like the idea, and I decided to tell him to use that [a condom].

Yes, I use that when I am not using anything else. We use it when I am not using anything else, because it is truly effective, only that the man must get used to it. Not every man is willing to do it; I have heard people talking about it. But I tell him, there must be understanding between the couple, and he is understanding. I tell him: Look, I am not taking anything, and I am worried about getting pregnant. Is this O.K. with you? Because, otherwise we'll just have to stop having sex. What happens, you know, is that, in their desire to be with a woman, men sometimes forget. Men forget getting out; and there you have it.

Three of the women interviewed (9 percent) reported having used withdrawal as a method. One of them uses this method exclusively and the other two combine it with other methods -- the pill or vaginal tables. Other women had used withdrawal as a form of birth control in the past, but did not volunteer much information about it, probably due to modesty associated with the intimacy of coitus. Several women said that they only used it while they were looking for a more satisfactory method. Others pointed out that this method was ineffective in preventing pregnancies:

Between my first child and my second child I did not use any contraceptives. He tried to avoid getting me pregnant, by not leaving anything inside me. He told me that I was not going to get pregnant; but it did not work. My girl was a year and three months old when I got pregnant again. He has never wanted me to use anything else, because he believes that it is harmful. What we used to do is that he would get out before leaving everything inside me.

Withdrawal does not seem to be one of the most popular methods. However, it is seen as an option when there is concern about the side effects of modern methods, when the husband objects to their use, or when the couple does not have sex frequently.

I don't like using it [withdrawal], and he doesn't like either, because it doesn't feel the same to him; we don't always use it. There are times when he cannot pull out. The reason we use it is because I have problems with condoms, injections and vaginal tablets.

Modern Methods within the Silence-Speech Continuum

Condoms. The use of condoms for contraception and for prevention of sexually transmitted diseases (STDs) has increased in recent years as a result of the attention given to them by the mass media, and because they are easy to obtain and affordable. From a biomedical point of view, a properly used condom is safe and effective, however, in reality condoms do have a fairly high contraceptive failure rate. From an ethno-physiological standpoint, condoms can be "dangerous and less satisfying" for both men and women. The most detrimental effects are suffered by women. Condoms are considered "hot" for women's reproductive organs (they "burn the ovaries"), and a source of urinary tract and vaginal irritation. The most dangerous effect of condoms reported by the women is that they may explode during sex, and a woman may get small pieces of the condom inside her uterus. Condoms are also seen as depriving women of the nutritional benefits of the semen deposited inside their wombs.

I get a swelling when we use condoms; that is why I only used them once. I had a burning sensation and had problems urinating. I felt as if my ovaries were burning up.

It is not the same having sex that way. It didn't feel the same to me when we had sex using condoms, because the semen of men provides nourishment for the woman. I have heard that it is not the same because semen provides nourishment for women.

Although there is a high rate of condom sales in the community, only 23 percent of the women interviewed reported using them. In half of the cases, condoms were used in conjunction with another method (vaginal tablets or periodic abstinence, for the most part). Many women associate the use of condoms with changes in the sexual behavior of the community's young men, who seem to have agreed to use them to prevent unwanted pregnancies.

...nowadays you see condoms littering the place. Young people stay up talking until the wee hours of the morning. We go to sleep and turn off the lights, and they stay up doing their thing. That is why you see such litter in the morning. And they are adolescents, still living with their parents. That is why I think that there are women who need this method. Otherwise they will have a child, and then the child suffers; first of all because there is no father, and then because the child doesn't get what he needs.

The following comment is from a woman who is cohabiting and whose partner uses condoms. She is 29 years old and has two daughters, the younger of whom is five. Fifty days after giving birth, this woman went to APROFAM, where she was given a

contraceptive injection effective for three months. After that, she started taking pills, because the injection was contraindicated by blood circulation problems in her legs. Approximately nine months ago, she stopped the pills as well. She and her partner decided to use condoms, because of the health problems she had with other modern methods.

We now use condoms because the pill left me very edgy. I was told that the only option I had was to use condoms. I went by myself, and then told him about it. He agreed. I am happy with this method, because the pill was something I had to take everyday, and condoms are used only when you are about to have sex. In reality, I don't even touch them.... He doesn't like them because he has to put them on and take them off. Maybe because I haven't used condoms before, I can feel the latex. Condoms have worked for me.

Injectables. Injectables are used by six of the interviewed women, 17 percent of the 35 users. Most women consider their long-lasting effect to be an advantage. Injectables are known by most women. However, in a third of the cases, their knowledge is a mix of biomedical and ethno-physiological. From the biomedical side, they know that injectables may cause amenorrhea, headaches and face pigmentation, and are contraindicated for women with varicose veins. From the ethno-physiological side, they think that lack of menstruation may bring about health problems, even death. This type of combined knowledge is typical of intermediate positions along the silence-speech continuum. A 19-year-old woman described it this way:

When my husband found out [about the injection] he got a bit angry, and then told me not to get many of them, because they are harmful; but I asked a doctor, and he told me that they were not harmful. My husband said that I was going to die if I stopped having my period, because a woman gets cleansed by her period; otherwise [she] may die.

I also got an injection. That was in July of last year, and I was concerned because I didn't have my period. I waited for it the first month, and it didn't come. I also missed it the second month; but it did come on the third month. I still have one injection left, but I am afraid to use it.

The injections are not healthy. They harm you, and make your stomach swell. One of my sisters uses them, and she has not gotten pregnant. She says they made her fat. They did not harm her; but she got fat.

Injectations were not for me. I had much discomfort. I got headaches and stomach aches, and was very angry.

Contraceptive Pills. The pill is well known in the community. It is employed by nine (26 percent) of the 35 users in the interview sample. Two women combine it with another method: withdrawal in one case, and periodic abstinence in the other. Knowledge about this method varies along the silence-speech continuum. About a sixth of the 68 women interviewed have ethno-physiological ideas about it; two-fifths express combined ethno-physiological and biomedical information, and slightly more than two-fifths have biomedical knowledge. Biomedical concepts include the following: the pill makes some women "very nervous," and some get patches [of pigmentation] on their faces, or gain weight." Interviewers heard the following ethno-physiological notions: prolonged use of the pill poses a health risk for women; the pills do not dissolve or are not absorbed by the body, instead they accumulate in the uterus, or along the sides of the uterus, and cause cancer.

With pills, you have to take them every day; and they stay in your body. Many people say that pills don't dissolve right away. That is how my first husband's aunt died. She was taking pills, and because the pills didn't dissolve, she got a tumor a year later and died. She had an autopsy and a large number of pills were found inside her. That is what the doctors said.

My husband says that the pill gets stuck to the woman's uterus, and you get a whole bunch of them stuck up there. And then, you can get cancer because the pills don't dissolve; they form a mass. That is what he says. I don't know.

Pills also give you cancer. The part around your ovaries gets filled with something like stones. That is why they are also a health risk, aren't they? After using them for a while, they are harmful to the woman. They affect her uterus. They create stones in the uterus.

Despite these concerns about the pill, many women consider it one of the most effective methods for preventing pregnancies, and they are aware that in order for it to be effective they need to be disciplined and take the pill strictly as prescribed. The women associate the failure of this method with improper use.

After I had my boy, we decided that we would only have two children. I told myself, "Here is where I stop." And he said, "Yes, we already have a boy and a girl, and that is it." So I began doing family planning. I took the pill for six years. Perhaps I got bored with it; I don't know, but I began taking them wrong. When I got pregnant, he was sad, and so was I, because we were not ready for that pregnancy and did not want it. He told me, "Now you must have the child; what else can we do?" When I got

pregnant for the third time, I told him," Oh my God, I am pregnant." He was not sad, only thoughtful. He probably was thinking of what he was going to do, having another child. At that time, he did not have a steady job. I began to cry and to insult him. He said," Let's be patient. This is the last one we are having. I promise you that this is the last one." I asked him to remind me to take the pill; that was his responsibility. I used to tell him, "I do my share, and you do yours; you have to remind me to take the pill." It was his fault for not reminding me. If I take the pills, there is no problem; we can have sex every day. He has to help me to take the pills, because I forget everything. Now, he is always reminding me.

The pill is a fool-proof method, but it makes me tense. The best method for me is the pill. You take them and you can relax, without having to worry about whether they will work or not. It has affected my nerves, and I have patches of pigmentation on my face. I am told that this is because of the pill. I really haven't stopped to think about it. I really don't want to get pregnant, so I try not to think about it.

I chose the pill because I consider it the most effective method. I hadn't used anything previously, and I trusted the pill from the start. I am glad to be taking it. I realize that my pregnancy with my third daughter was due to forgetfulness on my part. It was not the pill which failed. It is an easy method, because you take them and you don't need to use any creams, or anything like that. You take a pill and you are protected for 24 hours. The pill makes me irritable, but I feel at ease because I know I won't get pregnant. I feel good; relaxed.

After my boy [second child] I took pills for almost three years; but I got very thin, and I stopped taking them. That is when I got pregnant with a girl. After that, I had injections.

The Intrauterine Device: The Copper T. The copper T, a kind of intrauterine device, is used by two of the 35 users in the interview sample. These two cases illustrate why women use this method, as well as their different behavior regarding checkups. While the first woman has been careful to have her medical checkups, the second has been negligent about them.

In the first case, a 20-year-old woman began a union three years ago. She has a two-year-old girl. After the girl was born, she and her partner decided to prevent another pregnancy, because of their precarious economic situation. When the girl was one year old, the mother went to have a copper T inserted. The mother underwent medical checkups every three months, and at the time the interview was conducted, she had been using the IUD for approximately two years.

I got it mainly because my sisters had the copper T, and I saw that it did not harm them, so I went with them. This is the most effective method for me. I think that many people don't trust the pill, because many women have become pregnant, and the same goes for injections. Plus the pill is not good for many women, because it makes them very tense. A friend of mine was injected, but the injections made her uncomfortable. She was getting very tense. She told me, "Oh, don't use the injections; they make you feel bad."

But with the T one has to be very careful. You have to get a checkup, because in many women it has become embedded in their flesh. This happened to one young woman; but I believe that it is because of negligence, because people don't go for their checkups. One has to go and be checked; that is a must. There are women who are afraid of having a copper T inserted; they say it hurts. It didn't hurt me. About three days after the insertion, you feel an ache around the ovaries -- and they give you pills for that -- but then it goes away.

I like the fact that ,when I was not using anything, my period was very long; it lasted about eight days. And now, it is becoming more normal, only three or four days at most. The T doesn't hurt me or anything. It doesn't bother me at all.

If I got pregnant, I wouldn't have the child, because I would be worrying about whether the T got embedded into the child and hurt the child. I wouldn't want to have a child sick like that.

The second case is that of a 27-year-old Ladino woman. She is married and has two daughters. She got her copper T one year after she had her second girl. This is what she thinks:

The best method for me is the copper T, because it helps you not to get pregnant. People say that the copper T can become embedded in the flesh, and then one has to have surgery. They say that one has to have a checkup every year. I am going to get scolded because I haven't gone to be checked. The only method I have used is the copper T; and the only problem that the T has given me is that I find it very painful. Every time I have my period I feel as if I were giving birth. I have been told that there is something wrong with one of my ovaries. When I went to APROFAM, the lady who helped me told me that I could only use injections or the copper T. I decided to try the copper T. When I had it inserted, I was afraid, because I didn't know how it would feel. My mother warned me

that one could have problems if one failed to be checked; but I decided to use the copper T anyway.

One of the most frequent concerns about the copper T is women's fear that should they become pregnant the T would harm the child. Several of the women interviewed spoke about children who had been born with a T stuck to their bodies.

I have heard about children at the IGSS who are born with half of the device on their little heads, and the doctors cannot find the other half. The women themselves have told me that the children have to be x-rayed, to locate the rest of the T.

The copper T is also associated with several diseases, including infections and even cancer, as shown below:

The copper T causes cancer because, as long as the device is in the uterus, it is leaving a kind of rust there, which is harmful to women.

I got the copper T for two months, after giving birth to my girl; but my ovaries hurt, and my body rejected it. It didn't work for me. I went to APROFAM and was told that my uterus was rejecting the T and that I had an infection; so they cured it. Then, I got pregnant with my youngest, who died.

Vaginal Tablets. Approximately 25 percent of the women said that vaginal tablets were not very effective and could not be relied on. They blame their low effectiveness both on incorrect use and on the method itself. None of the women interviewed were using vaginal tablets exclusively. Three women of the 35 users were using them in conjunction with condoms.

Vaginal tablets are viewed negatively within the context of both ethno-physiological knowledge and a mix of ethno-physiological and biomedical knowledge. They are considered to be "too hot." Just as with the condom, vaginal tables are thought to cause vaginal irritation and urinary tract infections. Some women also believe that vaginal tablets cause cancer. Regarding effectiveness, some women think that vaginal tablets work when properly used. Others do not trust them because they think that vaginal tables are "weak" and therefore ineffective against "strong" semen. "Hot-cold" and "weak-strong" classifications are found among popular cultures in Guatemala. This research shows how cultural classification schemes have been applied to modern contraceptive methods such as condoms and vaginal tablets:

All methods are good, but it is necessary to know how to use them. I used vaginal tablets, because I did not want another baby. I would have

liked an injection, because the tablets are a nuisance, but it was denied me.

Between my third and fourth child, I used vaginal tablets; but the method did not work for me, because I forgot to use them and got pregnant. Between my fourth and my fifth child, I used NeoSampon vaginal tablets; but I think that they are very weak for my husband's strong semen, and I got pregnant again. Between my fifth and my sixth child, I continued using vaginal tablets, but they had no effect. These last two children are two years apart.

Sterilization. Women or couples may decide to stop childbearing altogether. Women in the community reported at least three reasons to justify fertility limitation decisions, the most important being the economic situation of the family. A large family implies more expenses for food, clothing, shoes, and education. Therefore, a precarious economic situation is one of the major reasons for wanting to limit family size. For men, a decision to limit implies a dilemma between the traditional values of virility and the need to provide adequate support. For women, many of whom have only a part of their partner's wages to pay for their family's needs, limiting family size represents a survival strategy. Other motivations for limiting include women's health risks and the problems of dealing with instability in the relationship such as alcoholism, infidelity, or economic irresponsibility:

Many times men don't want to understand the woman's point of view, or to allow women to use contraceptive methods. Men are hard-headed and want to believe that they can support a dozen children; but the truth is they can't.

When I had this girl, I got seriously ill in the hospital, and that is why I made my decision to be operated on. When he arrived to see me, a doctor and a nurse had already spoken with him, and told him that they had been able to save my life this time, but that they could not promise anything if I were to give birth again. I left the hospital three days later. We talked about what the doctor said, and about all the complications I had during the delivery. And my partner told me that he agreed. He said that I should write the letter, and we would sign it. On the one hand, I feel at ease and well, but sometimes I still feel discomfort from the surgery; also, I am not so sure that I will not get pregnant again, because I have seen sterilized women who have become pregnant. I know one woman whose daughter was three years old when she got pregnant again, and the woman was convinced that she would never have another child, because her tubes were tied. [The doctors] showed me something they removed from my body. I think that it was part of my tubes. I felt

reassured when I saw that they had taken something out of my body. I heard the scissors cutting through it. That I heard loud and clear.

Although women or couples may decide to limit pregnancies by using temporary methods, female sterilization is perceived in the community to be the best limiting method. However, as with other methods, women hold ideas derived from a re-interpretation of biomedical information. For example, while biomedical literature has reported a low failure rate for female sterilization, some women think that sterilization works only for a specific number of years, e.g., 3, 5, 8, after which the Fallopian tubes are "untied." Other women do not even know that sterilization deals with the Fallopian tubes; rather they think that the uterus is burned during surgery. Few people know about male sterilization, which has not been promoted by reproductive health services. The prevailing gender ideology of *machismo* may also contribute to the low regard for vasectomy.

Out of the 35 users in the interview sample of 68, four women reported having been sterilized. Of the four sterilized women, only one took the decision on a consensual basis with her partner as a strategy to achieve their reproductive goals. The rest were women who had a large number of children and who therefore faced the dilemma of being sterilized or risking death in the next pregnancy. The following two cases are illustrative:

The woman who chose sterilization as a way of achieving her reproductive goals is 26 years old. She got married at 18, used pills for a few days and then abandoned them. A year later she gave birth to her first son. During the following four years, she had a miscarriage and later her second son was born. While breastfeeding him, she got pregnant again seven months later. The baby was a girl, so she and her husband had achieved their desired number of children and their ideal number of boys and girls. They decided to cease childbearing, so she went to APROFAM, where she was advised to use injections until her daughter was one year old. She abandoned the injections because she had medical problems and was sterilized. (Paraphrased)

A woman who faced the risk-of-death dilemma is 33 years old. She married at age 16 for the first time. She had a child and then got divorced. She married a second partner and had seven more children. She had problems during her last delivery, and her doctors advised her to have a sterilization. She and her partner accepted it. Thus she arrived at the operating theater without ever having practiced family planning. She had thought about using methods but never did so because she was afraid of side effects and of being disrespectful to God's wishes.

I feel calm and also somewhat safe because of the operation. But God is first, and I asked first of all for his forgiveness, because children are his providence. I first asked to be forgiven, and said to Him that I was having

the operation because the situation was such that I couldn't have so many children, my situation was very difficult as it was.

VI. Unmet Need For Family Planning

Unmet need for family planning, as it is usually presented, is a definitional construct calculated from large-scale surveys, primarily the Demographic and Health Surveys (DHS). It is not a direct measure of women's self-defined need for family planning. It focuses on family planning behavior, rather than on the need to avoid unintended pregnancies (i.e. the results of family planning behavior or non-behavior). The conventional definition excludes key groups of women who may be using a method of family planning but still have unmet need to prevent unintended pregnancies: those who have experienced a method failure and are pregnant or amenorrheic, those using effective methods ineffectively or highly ineffective methods, those whose methods are contraindicated, and those who are dissatisfied with their current methods. Unmarried women have also been excluded for the most part from the conventional definition because many large-scale surveys have not collected data from the unmarried. In this study, women's own determination of their needs, as analyzed from the in-depth interviews, was used as the "bottom line" to determine unmet need.

In this chapter, the in-depth interviews are analyzed to assess the extent of and reasons for unmet need in the study population. First, the definition of unmet need according to the interviews is introduced. Second, six patterns of family planning use are presented. Third, unmet need among several categories of users is described -- these women are at significant risk of unintended pregnancy, yet have not been included in the conventional definition of unmet need. Fourth, unmet need among women not currently practicing family planning is explained in terms of the barriers they face in getting the services they need to meet their reproductive intentions (spacing or limiting future births). Fifth, unmet need is linked to the silence-speech continuum and patterns of family planning.

The Definition of Unmet Need from the In-Depth Interviews

Analysis of the in-depth interviews yields the following definition of unmet need, which the researchers consider to be the best reflection of women's self-defined need for family planning:

A fecund, sexually active woman,⁶ whether in union or not, who wants to space⁷ or limit her pregnancies, has unmet need for family planning if:

- she is not using **any** method of family planning, including modern, natural or folk methods,⁸ and is not pregnant or experiencing post-partum amenorrhea (up to 6 months after giving birth), or

⁶A woman who has had sex at least once in the six months preceding the interview.

⁷She wants to have a child two or more years from the date of the interview.

- she is pregnant or experiencing post-partum amenorrhea⁹ and her intention before her current or most recent pregnancy was to space or limit her pregnancies and her present intention is to space or limit future pregnancies.

A sexually active, fecund woman, whether in union or not, who wants to space or limit her pregnancies and is using a modern, natural or folk contraceptive method (including use by her partner) has unmet need for family planning if:

- she and/or her partner are dissatisfied with the method they are using, or
- she and/or her partner use the method incorrectly, or
- she is not breastfeeding in the correct manner to prevent pregnancies¹⁰, or
- she is using a folk method even though she has “proof” that it has failed, or
- she is using a contraindicated method.

A sexually active, fecund woman, whether in union or not, who is not pregnant, has met need for family planning if she and/or her partner are correctly using a modern, natural or folk method (including exclusive breastfeeding), and are satisfied with that method. All cases of female sterilization are classified as met need, even if the woman or her partner are dissatisfied, since she cannot discontinue use, and is therefore not at risk of an unintended pregnancy. A sterilized woman may have, however, unmet need for other reproductive health services.

A woman can be classified as having no need of family planning if she:

- is fecund and wishes to have a child within the next two years,¹¹ or
- is pregnant or experiencing post-partum amenorrhea as a result of stopping the use of method in order to become pregnant, or
- is infecund due to menopause, hysterectomy or any other reason.

⁸Exclusive breastfeeding for the first six months after birth if done for family planning reasons would be included as a traditional method.

⁹This includes pregnancies following a method failure.

¹⁰For the lactational amenorrhea method to be effective, the baby must be less than 6 months old, must not take any supplementary foods or liquids, including water, and must be fed on demand, approximately 12 times a day.

¹¹One special case was also considered as no need: A woman whose husband has had a vasectomy, and she is dissatisfied with the situation.

Table 6.1. Distribution of women, by marital status, age, and family planning need status according to the in-depth interview definition (n=68)

Age	USERS					NON-USERS				Total
	In-union			Not in-union		In-union		Not in-union		
	UN	MN	NN	UN	NN	UN	NN	UN	NN	
15-20	1	2		1		2	1	1	2	10
21-30	5	11	1			15	1	1		34
31-40	2	8				7	1	1		19
41-44		3			1	1				5
Total	8	24	1	1	1	25	3	3	2	68

UN = unmet need, MN = met need, NN = no need

Table 6.1 shows the distribution of the 68 women interviewed, by age, use/non-use of contraceptive methods, union/non-union status, and need for family planning according to the interview definition. Among the 35 users there are 9 with unmet need: 8 in-union and 1 not in-union. There are 33 non-users, out of which 28 have unmet need (25 in-union and 3 not in-union).

Patterns of Family Planning

Table 6.1 shows women's status as users or non-users as of the second half of 1995, i.e. the time of the interviews. However, their unmet need status may have changed throughout their reproductive lives. In order to analyze this variation and better understand unmet need, six family planning patterns were identified:

Successful family planners: This category includes women who have consistently achieved their reproductive goals to space or limit pregnancies, including discontinuing the use of family planning to become pregnant when they wanted to.

Failed planners: This category includes women who became pregnant as a result of incorrect or inconsistent use of contraceptives; or who continue using an ineffective method (usually a folk method), despite being aware of its limitations.

Erratic planners: This category includes women who have changed contraceptive methods two or more times, for fear of their side effects, without consulting a health provider. These women might have had unwanted pregnancies during the periods they have been users.

Discontinuers: This category includes women who used at least one method in the past but who are not currently using any method.

Non-planners: The women in this category have never used any birth control method.

Other: This is a residual category for women who are using a contraceptive method, but did not fit into any of the above categories.

Users with Unmet Need According to the Interview Definition

Of the 35 users, 33 are in-union (16 married, and 17 cohabiting), and two are single (see table 6.1). Twenty-four (73 percent) of the users have met need according to the interview definition; that is, they are correctly using a birth control method to space or limit pregnancies; the method in question is not contraindicated for them, and the couple is satisfied with it. Three of the 24 have been sterilized, while 21 use temporary methods. The 24 women whose needs are met are in the 21-44 age range. Twenty-three are Ladino, and one is Mayan; the former represent 37.7 percent of the 61 Ladino women, and the latter, 14.3 percent of the 7 Mayan women.

Nine of the users (25.7 percent) have unmet need. They are using a contraceptive method incorrectly; they or their partners are dissatisfied with their current method; or they are using a method that is contraindicated. As a result of incorrect use, the women are at risk of becoming pregnant. Dissatisfaction increases the risk that a couple will give up their current method. With contraindicated methods, the women's health is at risk. The family planning patterns of these nine women show that they have tried to achieve their reproductive goals, but have not been able to do it successfully. Five are erratic planners, two are failed planners and two are in the "other" or residual category. Here are some examples:

One 26-year-old woman is an erratic planner. During her first union, she used rhythm incorrectly and became pregnant. Then she and her husband decided to switch to condoms. They did not use them consistently, and she became pregnant for the second time. Her second husband also used condoms inconsistently, and she got pregnant again. Her third child is only a few months old. She and her husband have switched among withdrawal, the copper T, and condoms over a very short time period because they either do not trust the method, are afraid of perceived side effects, or find it unpleasant. They have not had adequate counseling on family planning. She has also thought about sterilization, but her husband opposes this definitive method.

One 27-year-old is a failed planner. She started taking pills as soon as she began her first union. She discontinued them because she was afraid of becoming infecund. In fact, she thought that the effect of the pills was lasting, and thus her pregnancy was a surprise to her. After her first

child was born, she and her partner used withdrawal. Her husband had guaranteed that she would not get pregnant, but the method failed.

Nonusers with Unmet Need According to the Interview Definition, and the Barriers They Face Meeting their Reproductive Intentions

Thirty-three of the women interviewed were not using any method of family planning; of that group, 27 are Ladino and six are Mayan. Five of them have no need for family planning services. The remaining 28 have unmet need. These women represent 41 percent of the women interviewed. Twenty-five of the 28 are in union. Sixty-one percent of the 28 women with unmet need are pregnant or amenorrheic, post-partum, their current or recent pregnancies being unintended.

Table 6.2. Distribution of non-users by marital status, need for family planning services, reproductive status, and age.

Age	In-Union					Not in union			Total
	Unmet need			No need		Unmet need		No need	
	P	NP	Amen	P	Amen	DN	Amen	NP	
15-20		1	1	1			1	2	6
21-30	6	3	6		1	1			17
31-40	2	2	3		1	1			9
41-44			1						1
Total	8	6	11	1	2	2	1	2	33

P = pregnant; NP = not pregnant; Amen = experiencing post-partum amenorrhea; DN = doesn't know whether she is pregnant or not

Out of the 28 non-users with unmet need, nine (32 percent) have never used contraceptive methods. The rest have used them at some point in the past. Seven are failed planners, seven are discontinuers, and five are erratic planners. These data show that most of the current non-users include women who have had unsuccessful family planning histories.

The non-users gave a range of reasons to explain why they were not using any method of family planning at the time of the interviews. Almost all of the women gave multiple reasons -- between two and five reasons for not using contraceptives.¹² These reasons are presented in table 6.3, in rank order. At least three of them -- fear of side effects, infrequent sexual relationships, and procrastination -- are related to lack of information, insufficient information or misinformation resulting from an ethno-physiological re-interpretation of biomedical knowledge.

¹²One woman gave only one reason.

Table 6.3 Barriers reported by non-users with unmet need for family planning (n=28)

RANK	BARRIER	DESCRIPTION	# OF WOMEN MENTIONING THE BARRIER
1	Fear of methods' side effects for the woman or her future child	This results from misinformation, little or no information, or women's prior experience with methods.	13
2	Waiting for change in reproductive cycle	Pregnant women are waiting for child's birth. Amenorrheic women are waiting for the diet period to be over or for return of menstruation.	12
3	Gender subordination	A partner is against use of a method, or a woman is waiting for her partner's permission to use a method or his choice of method.	11
4	Dissatisfaction with methods	Dissatisfaction with one or more methods used in the past, that, in a woman's perception, failed.	10
5	Infrequent sexual relations	Infrequent sex due to temporary absence of husband, husband's infidelity, or a recent break-up of the relationship.	6
6	Procrastination	A woman continuously postpones her decision on using a method.	4
7	Religious beliefs	A woman or couple believes that birth control is against religious beliefs.	2
9	Contraindication	There are contraindications against the use of certain (preferred) methods.	1
9	Lack of time	Lack of time to go to health services.	1
9	Lack of money	Lack of money for buying methods.	1

Fear of side effects. The women's fears about side effects are related to lack of information and re-interpretation of what information they do have through more traditional lenses. The following case illustrates the fear about injectables. A 31-year-old Ladino woman has already reached her ideal number of children (3), but her husband wants to have more. She wants to limit future pregnancies because of the couple's poor economic situation. She has asked her husband to use a male contraceptive method, but he has resisted. This woman used injectables, but gave them up for fear of severe hemorrhaging that, according to her cultural views, could result from discharging the blood that accumulated in her body during the months she did not menstruate.

This woman did not use contraceptives after the birth of her first girl. When she got pregnant with her second girl, her employer told her that she should have said something. The woman's employer scolded her, and told her that she had some pills she could have given her. After the second girl was born, both a friend and her employer told the woman that

she should go to APROFAM. Her period came back a year and eight months after the girl was born. She was breastfeeding and at APROFAM she got an injection. Her period stopped on the second month. She used the injection for four months and then gave it up, because she hadn't had her period. She was afraid that she would experience a severe hemorrhage when her period finally came. (Paraphrased)

The next case is a 29-year-old Ladino woman, mother of five, who has never used contraceptive methods and distrusts them all. Her sources of information include television, lectures by non-governmental organizations working in the community, her neighbors, and her observations of the side effects other women had experienced. This woman has biomedical and folk information. On the one hand, she knows that condoms are used by men to prevent pregnancies. On the other, she believes that condoms can explode in the vagina during sex and that pieces of latex can enter the uterus and harm a child during pregnancy. Her statements illustrate the re-interpretation people make of correct information, such as that provided in APROFAM advertisements, or through lectures by trained personnel.

I do not know even one, all I know about contraceptive methods is what I have heard in television – channels 3 and 7. I have never used pills, injections or the copper T. The method that I really do not trust, and would not like to use, is that which looks like a balloon, the one which I think the man wears.....The husband of a woman who lived here as a tenant wore that thing and had sex with his wife; but the balloon exploded inside her, and she was worried. She went to the doctor, who said that he found nothing wrong; however, eight days later the woman urinated a piece of latex. She urinated that, and got pregnant anyhow, and her child was born with a piece of latex in his eye. The balloon exploded inside her. [Which method would you trust?]: Oh God! I don't think that I could trust any. Not even surgery. There are women who become pregnant after having their tubes tied. I would only trust in God! That is why I have never used any birth control. The pill leaves stains on your face; injections make you nervous; that other thing [the copper T] becomes embedded in your flesh and makes your period heavier.

In the hospital I was given a piece of paper which listed several things; and I read that paper over and over for a week. I am not using any method, because nobody had told me which one I should use, and because I am afraid of them. But, after giving birth at the Roosevelt Hospital, I was told that I should go to APROFAM when the 40 days were over, to see if I want to be operated on or use any other method to prevent pregnancies.

Waiting for a change in the reproductive cycle. Quite a few women mentioned waiting for a child to be born, for the post-partum period of sexual abstinence (the "diet") to end, or for the post-partum amenorrhea to conclude as reasons for not using birth control at the time of the interview. These kinds of delays place women at risk for an unwanted pregnancy, particularly because of the ethno-physiological understanding of the role of amenorrhea. For most of the women interviewed -- both users and non-users -- post-partum amenorrhea is an indication that they are temporarily "safe" from pregnancy. Because breastfeeding is a common practice among the women in the study, post-partum amenorrhea may last for over a year; feeling safe in this condition, women wait for their periods to resume before looking for a contraceptive method. However, women often become pregnant while they wait because they do not exclusively breastfeed their babies. Before the age of six months, mothers give their babies water from boiling rice or aniseed, as well as gruel, or other kinds of milk. This situation is illustrated by the following quote from a 26-year-old woman, who is waiting for her period before going to APROFAM.

I have noticed that as long as I breastfeed, I don't get pregnant. My mother had her children every two to three years. My sister and I are five years apart, and there was another child right between us -- three years apart -- who died. My mother became pregnant when she stopped breastfeeding. I think that breastfeeding is a method, although it doesn't work for all women. I trust that it is working for me.

A 24-year-old woman became pregnant twice, while relying on postpartum amenorrhea and breastfeeding. She is once again experiencing post-partum amenorrhea, and waiting for her period before considering a modern contraceptive method.

My husband wanted me to use birth control, but I was not taking or using anything. I had been told that one doesn't get pregnant while breastfeeding; but I did. I got pregnant with my second child when my first child was nine months old; and pregnant with my third child as I was breastfeeding my second child.

Gender subordination. Gender subordination includes several reasons related to decisions or attitudes on the part of husbands or partners. Some husbands express explicit opposition to family planning, which may even take a violent turn. For instance, one woman used the pill without telling her husband. He found out and accused her of infidelity. She was even battered, and had to give up the pill:

I was more aware, so I went to get pills from the health center, without his knowledge. He knew nothing, but found where I had hidden the pills, and burnt them. He said that I was taking them because I had a lover. But I was doing it to prevent suffering. I could not continue taking the pills because he beat me. He beat me more because he said I had a lover.

In other cases, a woman is not using a method because her husband has not decided whether she should use it, or has not selected the particular she should use. A 36-year-old Mayan woman has been pregnant eleven times, including two miscarriages. She has six living children. Both she and her husband want to space future pregnancies, but she is waiting for him to take the initiative and decide which method they will use. This gender subordination has been a pattern in this couple's life. When the man asked for the woman's hand in marriage, he literally asked her whether she "wanted to be under his power." She thinks that if her husband did not want her to use a method, she would just have as many children as would come, because she would feel embarrassed about doing something behind his back. She has never done anything without his knowledge. He has to know everything. (Paraphrased)

Dissatisfaction. A woman's or couple's dissatisfaction with a method may lead them to abandon it. Such dissatisfaction may be due to the method's mode of use, incorrect use, or fear of side effects. If no attempt is made to look for a substitute method, a woman may discontinue use and thus risk an unwanted pregnancy. The following example from a 33-year-old woman illustrates this situation. She had a copper T for four years, but did not go for her checkups. She felt sick and believed that it was due to the copper T. The IUD was removed, and the bad experience she associated with this method kept her from using other contraceptive methods. She later had two unplanned pregnancies.

I felt all right when I was using the T. But one is supposed to have a checkup every year, and I waited four years. I went to be checked because I was getting very thin. I hadn't gone before, because I thought that it was going to hurt a lot. My neighbor told me that the T could become embedded in my flesh, and I should have it checked. I went for the checkup, but the T had become embedded in my flesh, and they pulled down on my uterus. My head was pounding. I was dizzy and with nausea, and stayed sick for eight days. At APROFAM they told me that I should go back, to see what I wanted to do - - whether to get injections or take pills. But, just thinking of all that pain kept me from going back; I preferred to have another child. We did nothing, and I had another two children.

Infrequent sexual relationships. Infrequent sex was also reported as another reason for not using methods. This reason must be understood within the context of the ethno-physiological knowledge held by the community. Frequent sex is associated with a higher risk of becoming pregnant. People believed that if a woman only has sex every once in a while, there is little chance she will become pregnant. In addition, if a woman's husband works away from home for several weeks or months at a time, this idea is reinforced by the cultural expectation that the woman should be faithful. A

woman who uses a method under such circumstances would be viewed with suspicion by her husband. A 30-year-old Ladino woman illustrates this situation:

She was taking pills, but after two-and-a-half years she had a problem. She went to see a doctor who advised her to continue taking the pills, and that is what she did. She wanted to have a copper T inserted without her husband's knowledge, because he didn't want her to use any birth control; but this method requires sexual abstinence for a month and she could not refuse him sex; so she did not get the T. At the time of the interview, the woman was not taking pills: "I have been without anything for two months, because my husband is not here. As I see it, a woman uses birth control because she is having sex. When her husband is away, she shouldn't be using anything, because she is not having sex at all." (Paraphrased)

Procrastination, lack of money, and lack of time. Several women said, "I have let time go by" as an explanation for why they were not using a family planning method. These are women who want to space or limit future pregnancies, but have not moved from intention to action. Some of them planned to use a contraceptive method after giving birth, or after their periods resumed, but have let time go by without taking action. The following case illustrates procrastination, combined with lack of money and time. The woman is 22 years old with two children, one of whom is a year and a half old.

We haven't bought anything, and I haven't gone to be treated, because it is an expense, and we don't have the money. I thought of going to a health center nearby, but I don't have the time. He wants me to go; but the health center only sees patients in the morning, so I cannot go in the afternoon. I have to take the little boy. I haven't yet set a day aside to do it; maybe I will go a week from now.

Religious beliefs. Two women mentioned religious beliefs. A 31-year-old woman, who is in her third union and has seven living children, has tried pills and injectable, but she abandoned both methods: the pill because it affected "her nerves," and injectables because her second husband was against them. Her current reproductive intention is to limit future pregnancies, while her husband wants to space them. She would like to have an operation but she has not done it for fear of God and her husband. This woman believes that being sterilized may bring the wrath of God upon her, and she may be punished with a disease or the loss of a child.

One shouldn't have just a few children, because God may take one away, and then one can only regret not having had more. Some women lose their only child and they could not have more because they have

had their operation. I have not been operated, first of all for fear of God, but also to avoid problems with my husband.

It is important to indicate that other women expressed fear of, or respect for, God, but not as a reason for not using a method. Also, some women acknowledged that their churches or religious leaders were against the use of certain methods, but they did not take such advice into account when making their decision.

I have not let religion influence me, although the Bible says that no one has the right to prevent pregnancies, and that one should accept as many children as God sends us. But I don't agree, not the way things are in this time and age. Can you imagine how many children we would have by now. My partner was not influenced by religion in his decision, but by the fact that he cannot stand a noisy house; it drives him crazy. He says, why should I have so many children, when I am going to be spanking them.

Multiple barriers: an example. As mentioned above, almost all of the 28 non-users gave more than two reasons why they were not using birth control. It is often the combination of reasons that throws up an insurmountable barrier to women achieving their reproductive intentions. One case, a 26-year-old woman who had been experiencing post-partum amenorrhea for 10 months, provides a dramatic example of this.¹³ She had an unplanned child and received her first injection 40 days after the child's birth. However, when the second injection was due, she decided not to get it, because she got pigmentation stains on her face. She was influenced by her family not to use a modern method. This child is one year old, and she wants to believe that breastfeeding will keep her from becoming pregnant; but she is not sure.

I have made the decision of using a method. Last Monday, I spoke with my partner about going together to find out if there were any methods he could use; but he did not want to go. I asked him whether he wanted me to do something to prevent another pregnancy. He said yes; and I asked him: "Which method should I use?" He said that he didn't know, and that I should get whatever agrees with me. We both agreed that we must use birth control, but he left the decision of what to use up to me. Birth control is against religious teachings. My mother does not want me to use contraceptives. I don't think God will punish me, but I first asked him for his forgiveness. I think that there is no reason I should bring more children into this world, since they will only suffer.

My mother did not get pregnant until she stopped breastfeeding. I think that breast feeding is a form of birth control, but it doesn't work for all women. I am hoping that it is working for me. I haven't gotten an

¹³Note: Her case was also quoted above under individual barriers.

injection since March, and the effect of the last one was up in June. There have been three months, and I haven't got pregnant. If I had the chance, I would use a method. I asked my husband to go with me, but he didn't want to. I am planning on going by myself, because I am concerned that I will get pregnant, and my child is still very young.

Unmet Need in the Silence-Speech Continuum

In order to relate the women's positions on the silence/speech continuum to their need for family planning, the researchers developed a "communication and knowledge scale." Based on the interview guide, this scale considered seven equally weighted criteria: information about menstruation at menarche, information about sexual relationships at first sexual encounter, information about pregnancy at first delivery, information on contraceptive methods, type of family planning services used, communication with partner on family planning, and the kind of sexual education preferred for children. Each criterion was graded from one to four points: a grade of one represented the silence pole, two and three intermediate positions, and four the speech pole. Points for each of the seven criteria were then summed to obtain the total score ranging from 4-28. The scores were then converted to an equivalent 100 point scale. Women with scores up to 25 were assigned to the silence pole, those with 26 to 50 to intermediate one position, those with 51 to 75 to intermediate two position, and those with scores between 76 and 100 to the speech pole. Annex 2 shows partial and total scores as well as position in the silence-speech scale for each of the 68 women interviewed.

Table 6.5 organizes the 68 women according to their score on the silence/speech scale, need for family planning, pattern of family planning use and age. Sixty-three of the 68 women are placed at intermediate positions on the continuum. Only one is at the silence pole, and four are at the speech end. Out of the 23 women at intermediate-one position, 17 (74 percent) have unmet need for family planning, 4 (17 percent) have met need, and 2 (9 percent) have no need. Forty women scored at intermediate-two position: 20 (50 percent) with unmet need, 16 (40 percent) with met need, and 4 (10 percent) with no need. Although few women score at the ends of the continuum, the data seem to highlight a trend: as women approach the speech pole of the continuum, unmet need decreases and met need increases. Thus, in a large sample one would expect the highest percent of unmet need among those with the lowest scores and the lowest unmet need in those with the highest scores.

Table 6.5. Distribution of women according to their need for family planning position on the silence-speech scale, pattern of family planning use and age (n=68).

POSITION		SILENCE			INTERMED 1			INTERMED 2			SPEECH		
FP pattern	Age	UN	MN	ND	UN	MN	ND	UN	MN	ND	UN	MN	ND
Successful = 20 (29.4%)	15-20								1			1	
	21-30					1			6	2		3	
	31-40								4				
	41-45					2							
Failed = 10 (14.7%)	15-20							1					
	21-30				2			3					
	31-40			1				3					
	41-44												
Erratic = 16 (23.5%)	15-20				2								
	21-30				2			4	2				
	31-40							2	2				
	41-44					1				1			
Discontinued = 7 (10.3%)	15-20												
	21-30				2			1					
	31-40				3				1				
	41-44												
Never used = 11 (16.2%)	15-20						2	1					
	21-30				3			2					
	31-40				1			1					
	41-44				1								
Other = 4 (5.9%)	15-20				1						1		
	21-30							1					
	31-40							1					
	41-44												

Table 6.5 continued

Total by family planning need	0	1 ¹⁴	0	17	4	2	20	16	4	0	4	0
Total by position on continuum	1			23			40			4		
% with no need by position				8.7%			10%					
% with unmet need by position				73.9%			50%					
% with met need by position	100%			17.4%			40%			100%		

un = unmet need; mn = met need; nn = no need;

Based on table 6.5, 37 women have unmet need of family planning. According to their pattern of family planning, 9 (24 percent) are failed planners, 10 (27 percent) are erratic planners, 6 (16 percent) are discontinuers, 3 (8 percent) are “other” planners, and 9 (24 percent) have never used a contraceptive method. Thus unmet need is found among women who have not attained success in family planning as well as among those who have never used contraceptive methods. While failed, erratic, discontinued, and “other” planners with current unmet need are placed within the silence, intermediate-one, and intermediate-two positions of the continuum, successful planners with met need or no need tend to be located at the intermediate-two and speech positions. Out of 20 successful planners with met need or no need, 3 (15%) are at intermediate-one position, 13 (65%) at intermediate-two, and 4 (20%) at the speech position.

Age does not seem to provide a neat clue to understanding unmet need for family planning: Fifty percent of the women in the 15-20 category, 59 percent of those 21-30, 58 percent of those 31-40, and 20 percent of those 41-45. Education seems to be a better indicator. A chi-square test was run by using interviewed women’s data on schooling and need of family planning. Schooling was coded as no schooling, 1-3 years of elementary school, 4-6 years of elementary school, 1-3 years of secondary school, and 4-6 years of secondary school. Need of family planning was coded as unmet need, met need, and no need. Chi-square test value was 18.32467, df=8, and .01892 significance.

¹⁴This woman was sterilized after having had nine children for health reasons and based on her doctor’s recommendation, not because she wanted to stop bearing children for demographic reasons.

VII. Defining and Measuring Unmet Need for Family Planning

This chapter provides a quantitative analysis of unmet need. The first section presents estimates of unmet need for family planning using three different definitions. The definitions include the conventional DHS definition and two others that address issues raised in the critical literature. These estimates were calculated for the 275 women interviewed in sample survey. The second section compares the three survey-derived estimates with the estimate derived using the in-depth interview definition of unmet need presented in Chapter VI.

Unmet Need According to Three Definitions: Survey Results

In this report, the researchers use the following labels for the three definitions to estimate unmet need among the 275 women interviewed in the survey: 1) the conventional definition used by DHS; 2) a modified definition that includes other questions routinely asked in DHS; and 3) an improved definition that includes new variables added by the researchers based on the literature. The details of these three definitions are presented in table 7.1.¹⁵

Table 7.1. Three operational definitions used to estimate unmet need for family planning.

DEFINITION	CONVENTIONAL DHS	MODIFIED DHS	IMPROVED
Unmet need	An in-union, fecund woman of reproductive age ¹⁶ who is not currently using any method of family planning and who wishes to limit or space her pregnancies, and:	Same as for conventional DHS and:	Sexually active, fecund woman of reproductive age, who is not currently using any method of family planning and who wishes to limit or space her pregnancies, or A woman who is using a method of family planning but she and/or her partner are dissatisfied with that method, and:
Union status or sexual activity	The woman says she is in union (formal or informal)	The woman says she is in union and currently living with her husband or sex partner	The woman says that she has had at least one heterosexual relationship in the last 6 months.

¹⁵Anyone interested in the specific questions can request copies of the questionnaires from ICRW (in English) or Estudio 1360 S.A. (in Spanish).

¹⁶Reproductive age is defined as 15 to 44.

<p>Fecundity: The woman is deemed to be fecund =====></p>	<p>If she is pregnant/amenorrheic¹⁷ or Does not meet the following conditions: She says she doesn't want any more children, or that she is not using family planning methods because she <u>cannot become pregnant</u> or has had a hysterectomy or is in menopause or her last pregnancy took place over 5 years ago and she has not been using any form of family planning.</p>	<p>Same as for Conventional DHS</p>	<p>Same as for conventional DHS or The woman is sub-fecund, when she meets the following conditions: does not use a family planning method, hasn't menstruated for over six weeks, and says that her period is irregular and last pregnancy was over five years ago.</p>
<p>Family planning status, including degree of satisfaction if using a method:</p> <p>not pregnant/amenorrheic</p> <p>pregnant/amenorrheic</p>	<p>Neither she nor her spouse use any modern or natural family planning method</p> <p>Neither she nor her spouse were using any family planning method at the time of conception</p>	<p>Same as for conventional DHS, or does not use breastfeeding as a family planning method</p> <p>Same as for conventional DHS</p>	<p>Same as for modified DHS and did not use a method during last intercourse or is using a method but she and/or her partner are dissatisfied</p> <p>Same content as for conventional DHS but different style of question or experienced a method failure</p>

¹⁷ Amenorrheic throughout this table refers to post-partum amenorrhea.

According to the conventional DHS definition, there were 62 women with unmet need for family planning out of the total of 214 women in-union for whom there was sufficient information (223 women in union - 9 with insufficient information = 214). This proportion (62/214) represents an unmet need prevalence of 29 percent.

The unmet need estimate using the modified definition included, among other changes, all women whose partners or husbands were co-resident – a condition that lowered the denominator – and all women who reported that they and/or their partners were dissatisfied with the method they were using at the time of the survey. This condition increases the absolute number of women with unmet need for family planning services. The combination of both changes resulted in a slightly higher prevalence of unmet need (31 percent).

The improved definition is based on the premise that every sexually active woman may have an unmet need for family planning, whether or not she is in union. The use of this criterion changed the denominator, both by adding 8 sexually active women who were not in union, and by subtracting 18 women who were in union at the time of the survey but had not had sex in the previous six months. Moreover, personal dissatisfaction was measured using two questions, a standard DHS question and the one formulated by the research team. By adding this second question more women were classified as having unmet need. The final result was an unmet need prevalence of 39 percent. Thus, the estimate of unmet need by means of the improved definition is 10 percentage points greater than the estimate obtained with the conventional definition, and 8 percentage points above that obtained with the modified definition.

Table 7.2. Estimate of the unmet need for family planning services in a peri-urban community in Guatemala City, by definition of unmet need: survey results.

Conventional definition	Modified definition	Improved definition
29%	31%	39%

Source: Survey in La Esperanza 1995

The analysis of unmet need according to the three definitions showed, not surprisingly, that the percentage of women with unmet need varies according to the definition. This was one of the first attempts to quantify how much unmet need would increase if new categories suggested by the critical literature were added to the definition.

A Comparison Between the Survey and Interview Definitions of Unmet Need

The definition of unmet need developed after analysis of the in-depth interviews combines elements of all three of the survey definitions outlined above (see Table 7.1). Conceptually, it is based on the improved definition, in that the denominator includes all

Conceptually, it is based on the improved definition, in that the denominator includes all sexually active women, not just those in union, and the numerator includes women who are using family planning but they and/or their partners are dissatisfied as well as women who are using methods ineffectively or contraindicated methods (these were not included in the improved definition). But it goes back to the conventional DHS definition of wanting to space births by at least two years.

Using the interview definition as the basis of comparison, the researchers analyzed how well each of the three survey definitions was able to identify women with unmet need. Women's need for family planning (unmet, met, or no need) was classified for a sub-sample of 60 women in union according to the interview definition. Very few women were classified as having no need for family planning because one of the criteria for selecting the sub-sample was that the women have either met or unmet need, according to the conventional definition. For the purpose of the comparative analysis, it was decided to group the women with met need and no need in a single category (absence of unmet need). Thus the comparison was between the classifications obtained through the interview (unmet need and met need plus no need), and the corresponding classifications obtained using each of the three survey definitions. Tables 7.3, 7.4, and 7.5 show the data.

Table 7.3. The interview definition compared to the conventional DHS definition.

Survey:	Interview		
	Presence of unmet need	Absence of unmet need	Total
Conventional			
Presence of unmet need	17	5	22
Absence of unmet need	16	22	38
Total	33	27	60

Table 7.4. The interview definition of compared to the modified DHS definition.

Survey:	Interview		
	Presence of unmet need	Absence of unmet need	Total
Modified			
Presence of unmet need	18	8	26
Absence of unmet need	15	18	33
Total	33	26	59

Table 7.5. The interview definition compared to the improved definition.

Survey: Improved	Interview		Total
	Presence of unmet need	Absence of unmet need	
Presence of unmet need	19	8	27
Absence of unmet need	14	18	32
Total	33	26	59

A comparison of the interview definition with the conventional DHS definition shows that the interview definition classified 55 percent of the women as having unmet need whereas the conventional definition classified only 37 percent that way (see Table 7.6). Thus classification according to the conventional definition matched the interview classification of unmet need 67 percent of the time.

In comparing the interview definition with the modified DHS definition, the former classified 56 percent as having unmet need (a slight change because one case dropped out due to missing data) and the latter classified 44 percent. Unmet need classifications matched 79 percent of the time.

Finally, comparing the interview definition with the improved definition, the interview definition again classified 56 percent and improved classified 46 percent as having unmet need, for a match of 82 percent.

There was an increase over the DHS conventional, modified, and improved definitions in the percent of women correctly identified as having unmet need among the three survey definitions, as hypothesized. At the same time, these results indicate that none of the survey definitions did a good job overall in matching the definition derived from the in-depth interviews because overall there was no increase in the total proportion of correct classifications (unmet and no unmet need). The percent of correct classifications is as follows: 65 percent for the conventional, 61 percent for the modified, and 63 percent for the improved. Concurrent with the correct classification of unmet need is an increase in the incorrect classification of no unmet need.¹⁸ Additional research is needed on how to design questionnaires to capture classification of need to avoid unintended pregnancy -- met and unmet -- as defined by the women themselves.

¹⁸The researchers believe that the lack of agreement in part results from having to collect the survey data before having the benefit of the interviews. The study was designed under inevitable funding constraints, and there was not sufficient funding to do both a screening survey to identify women for the in-depth interviews and a follow-up survey to examine quantitatively the various definitions.

Table 7.6: A Comparison of Four Different Definitions of Unmet Need for Family Planning.(n=60)¹⁹

Definition of Unmet Need	Percent of Women with Unmet Need	Percent of women with unmet need, according to the interview definition, who were correctly classified as having unmet need by each survey definition	Percent of all women whose classification as unmet or no unmet need, according to the interview definition, was correctly matched by each survey definition
Interview	55%		
DHS conventional	37%	67%	65%
Modified	44%	79%	61%
Improved	46%	82%	63%

¹⁹The unmet need percentages in Tables 7.2 and 7.6 are not the same because Table 7.2 is based on the representative community sample of 275 women and Table 7.6 on the purposively drawn sample of 60 married women interviewed in-depth. Those women were selected based on their unmet need status. The comparison in Table 7.6 is to highlight not the unmet need percentages per se, but rather to show the extent to which they agree or disagree.

VIII. Conclusions And Recommendations

This report provides the results of qualitative and quantitative analysis of unmet need for family planning in a peri-urban area of Guatemala City. Based on these analyses, this chapter presents conclusions and policy recommendations concerning reproductive health and family planning services. The findings of this research highlight the importance of policies that will expand people's access to services and enhance service quality. The recommendations are based on the premise that reproductive health and family planning must be part of the process of political change that is taking place in Guatemala. Although the researchers believe that family planning is part of the wider concept of reproductive health, it is mentioned separately in this study for emphasis.

Conclusions

This study analyzed the factors that affect the reproductive behavior and use of contraceptives among a group of sexually active women of reproductive age living in a peri-urban area of Guatemala City. These women, who for the most part moved to the city from the countryside, belong to a low socio-economic class and have little schooling. Their reproductive behavior, which was reconstructed using a reproductive life cycle approach, highlights differences among the women in their family values; the knowledge they brought to significant reproductive health experiences throughout their lives; their views about the roles of woman, mother, and wife; and their attitudes and practices regarding family planning. These differences can be understood as part of a continuum that has as its end points the socio-cultural paradigms of "silence" and "speech." The paradigm of silence favors a large family, considering it to be the will of God. Male descendants are valued more highly than female ones. Silence is used as an inter-generational "communication" strategy to protect women's chastity: Women are generally excluded from the reproductive and sexual decisions that concern them. Within this paradigm, control over fertility is not encouraged nor is the use of family planning services.

The paradigm of speech encourages small families and the practice of family planning as an expression of the will of the couple and a means to achieve a higher quality of life. Neither sons nor daughters are favored. Within the paradigm of speech, discussion of reproductive and family planning issues at home, school, health services and other contexts is encouraged. This paradigm supports women's self-respect as well as their right to practice family planning, which implies adopting a contraceptive method based on a woman's or couple's informed choice.

Most of the 68 women interviewed can be placed at intermediate positions on silence-speech continuum. Their positions on the continuum are correlated with their

schooling, so that women with less education are closer to the paradigm of silence, and those with more education closer to the paradigm of speech.

According to the definition derived from the in-depth interviews, unmet need for family planning does not result from a single factor, but from a combination of factors that may reinforce each other. These factors, in order of importance, are fear of side effects, based on ethno-physiological and/or biomedical or popular beliefs; the women's decision to wait for the resumption of their periods after giving birth; the women's submission to their husbands or partners; their dissatisfaction with the contraceptive methods they have used in the past; infrequent sexual relations; procrastination in choosing a method; religious beliefs; medical contraindications; lack of time to visit reproductive health services; and lack of money to pay for the contraceptive methods. These factors are, for the most part, based on ethno-physiological beliefs, of the information available on contraceptive methods, and the behavior associated with the paradigm of silence. These limiting factors or barriers often take place in a context of family, marital, and sexual violence, which erodes the women's decision-making power over their own reproductive lives.

Six family planning patterns were identified in this investigation that describe recurrent behaviors throughout the women's reproductive lives. Most of the women interviewed (68 percent) have used family planning methods at some point in their lives, but few of them have been successful in reaching their reproductive goals. Most of the women have either given up on family planning, engaged in erratic family planning behavior, or experienced repeated method failures. While successful family planners generally have met need or no need for family planning (because they are currently planning to have a child), unmet need predominates among the erratic planners, the discontinuers, the failed planners, and those who have never used family planning methods.

Although this study included only a small sample of men, the results indicate that men's reproductive lives are also influenced by the paradigms of silence and speech. Yet, the analysis revealed both similarities and differences in women's and men's socialization. The most relevant similarity is that the majority of the men and women interviewed were socialized at home according to the silence paradigm. They received little or no information from their families to prepare them for puberty, sexual relations and parenthood. However, the men had a circle of friends who provided information (or misinformation) about sex and puberty. While the women were warned to avoid pre-marital sex, the men were often expected to seek sex with prostitutes, older women, and girl friends. The paradigm of silence limits access to accurate reproductive information for both men and women, yet gender differences in the way the men and women are socialized place women in a vulnerable position. While the men have socialization groups parallel to the family, the women can seldom escape the silence within their families.

The quantitative analysis of unmet need according to the three survey definitions showed, not surprisingly, that the percentage of women with unmet need varies according to the definition. This analysis was one of the first attempts to quantify how unmet need would change if new categories suggested by the critical literature were added to the definition. The study also compared the survey definitions with the definition of unmet need derived from the in-depth interviews, considered to be the best reflection of women's self defined need for family planning. There was an increase over the DHS conventional, modified and improved definitions in the percent of women correctly identified as having unmet need among the three survey definitions, as hypothesized. At the same time, these results indicate that none of the survey definitions did a good job overall in matching the definition derived from the in-depth interviews because overall there was no increase in the total proportion of correct classifications.

Recommendations

This study identified a set of factors or barriers that make it difficult for women to achieve their reproductive health objectives. These barriers provide useful guidance for identifying policy and programmatic changes that would help women and couples prevent unwanted pregnancies and receive comprehensive reproductive health care. The study results also highlight changes to the concept of unmet need itself that would make it a better reflection of women's self-defined need for family planning services, and the study suggests a research approach to keep women's self-defined needs at the forefront of research and policy processes.

Policies and programs. This study shows clearly that people need more and better information about every aspect of reproductive health. The far-reaching policy and programmatic recommendations below address that issue in the context of social and political change.

The government of Guatemala should develop a national reproductive health and family planning policy -- formulated with the participation of women from all of the country's ethnic groups, and disseminated and explained to both women and men. The implementation of this policy must be done with sufficient resources, in terms of personnel, materials and procedures, to provide individuals and couples with the necessary information and services. The objective is to guarantee these individuals and couples their reproductive rights, to support, in the strongest possible terms, responsible parenting, and to allow women and couples to decide freely the number of children they wish to have and when they want to have them.^{20,21}

²⁰Articles 47 and 48 of the Guatemalan Constitution (1985) refer to the protection of the family and of motherhood, respectively. Article 93 recognizes the right to health as an essential right, and Article 95 declares health to be a "public good." Article 47 is particularly relevant to family planning:

- The Ministry of Health and other institutions that provide reproductive health services -- IGSS, APROFAM, NGOs and others -- must develop, promote and implement institutional policies for expanding services and improving their quality.
- The quantity and quality of information, education and communication programs on reproductive health and family planning at various levels and within all sectors in Guatemalan society should be improved:
 - i. Institutions that train health personnel, such as universities, Ministry of Health, and others, must include policies to promote the concept of quality health care in their curriculums. Traditional midwives and health care volunteers -- both men and women -- must also be trained in this new approach to reproductive health.
 - ii. Reproductive health and family planning providers must adopt policies that promote quality health care in the refresher and training courses for their regular and newly hired personnel.

The State guarantees the social, economic and legal protection of the family. It will promote [social] organization on the legal basis of marriage, equal rights between the partners, and responsible parenthood, a well as the right of men and women to freely decide the number of children they will have and the space between them.

²¹Two important initiatives are now taking place in Guatemala regarding reproductive health and family planning. The first has been put forward by the Technical Secretariat of the Social Policy Office (*Gabinete Social*), by means of a project entitled "In Search of a Consensus in Reproductive Health Matters" (*Búsqueda de Consensos en Materia de Salud Reproductiva*). This Project is aimed at "establishing some agreements among the various sectors of society, for the purpose of formulating public policy proposals in this regard." Several workshops -- with participants of different sex and age from various ethnic groups, as well as health service providers and representatives from the major religious groups in the country-- have analyzed the points of "agreement and dispute" in this regard. The workshops have also served to gather proposals for establishing guidelines.

The second initiative is a bill for the Comprehensive Advancement of Women. In referring to the reasons why it was drafted, the bill mentions that "reproductive health" and "reproductive rights" imply access to information and services and improved the quality of such services, as well as fostering the decisionmaking power of women regarding their reproductive and sexual lives, and the women's freedom of choice; it also refers to abortion as a social problem,-which must be addressed, rather than promoted as a family planning method, and the prevention of disease, and the reduction of teenage pregnancy,- which requires sex education and reproductive health services. This bill is now being analyzed and debated in the print media. As of now, comments are supportive of most of the contents of the bill, except for a few of its articles, such as Article 14, which refers to reproductive rights and has been interpreted as including "abortion rights"; Article 10, regarding the teaching --in elementary and higher education-- of the gender concept, which in its "truest sense includes up to five genders, based on nature and sexual orientation"; and Article 8, which introduces a new concept of the family that is contrary to the "traditional and true concept of the family" --i.e. mother, father and children.

- iii. NGOs must also be encouraged to adopt a quality approach to health care when educating and training volunteer personnel, as well as when providing reproductive health and family planning services to users.
 - iv. The government and NGOs need to provide more forums for educating the population on the full range of reproductive health and family planning issues, including sexuality, reproductive rights and duties, and family planning – with emphasis on the side effects associated with the various family planning methods, whether they are natural, modern or folk.
 - v. Institutions that provide educational reproductive health programs and use mass media communication strategies should promote approaches that favor consultation, question-and-answer forums, and face-to-face dialogues, as well as discussions about stereotypes, prejudice, gossip, and fears. The programs should be appropriate for a wide range of geographic areas and audiences, taking approaches tailored to each kind of audience. Innovative activities, such as reaching men and women at their places of work, are crucial. Including men, both adolescents and adults, should be considered strategically important.
 - vi. Schools, particularly rural schools, need to expand their reproductive health curriculums both in terms of content and in terms of the grades covered. Educational programs need to be introduced to younger students, given the high drop-out rates.
 - vii. Fourth to sixth grade elementary and secondary schools should teach sexuality and reproductive health, with a focusing on love and a healthy attitude towards sex, as well as on the development of associated values.
- Public health services need to explore new locally based reproductive health services that integrate and collaborate with institutions, such as schools and churches, that focus on values regarding reproductive health and family planning. These new health care approaches could include activities such as the following:
 - i. Providing door-to-door services (diagnosis, information, materials, etc.)
 - ii. Creating discussion groups on subjects of interest.
 - iii. Producing, adapting, or copying supporting educational materials.
 - iv. Giving special attention to male and female pre-adolescent and adolescent groups.
 - The government and NGOs must provide opportunities for women’s participation in community development organizations that promote comprehensive

approaches, such as organizations that engage in productive, income generating activities, provide gender training, and offer reproductive health and family planning services. The objective is for women to have their own incomes, be less economically dependent, improve their self-esteem, and be better able to negotiate with their partners.

- Government and NGOs need to promote opportunities for couples to receive counseling -- both couples who are engaged and those already living together. Counseling can be provided either at home or in an institutional context; and could, in the latter case, it can be offered to couples separately or to groups of couples.

The concept of unmet need. This set of recommendations suggests changes to the definition of unmet need that would better reflects women's self-defined needs; it should focus on the need to avoid unintended pregnancies, not to practice family planning per se; and provide a better guide for developing policies and programs that are more responsive to women's need, directly address the barriers they face in accessing services, and enhance service quality.

- The definition of unmet need for family planning must be expanded to include all sexually active women of reproductive age, i.e., all women who have had a heterosexual relationship within the last six months. The current definition of unmet need used by DHS excludes sexually active women who are not in union and includes in union women who are not sexually active.
- The definition of unmet need must be expanded to include dissatisfied users, who are likely to discontinue use in the near future, as well as those who are using a contraindicated method, or an effective method incorrectly. Method failure, among pregnant and amenorrheic women, should be considered as unmet need.
- In classifying women who are using traditional or folk methods, the criterion of the women's own satisfaction with the method must prevail over "scientific" evidence of the method's effectiveness, as long as there is no evidence that the method has failed for that particular woman.
- In defining the status of unmet need for pregnant women, or amenorrheic women within their first six months post-partum, the deciding factor should be the women's plans for the future, in terms of new pregnancies and the use of contraceptives, rather than the wantedness of the current or just completed pregnancy.

The changes suggested above will help ensure that the concept and measurement of unmet need better reflects the heterogeneity in the group of women who are risk of an

unintended pregnancy, something that the current definition does not do. That the conventional DHS definition leaves out several significant groups of women was highlighted by both the qualitative and quantitative analyses presented in this report. As long as these women remain invisible, they will not be targeted by new service delivery strategies and will thus be at continuing risk of unintended pregnancies.

Measuring unmet need. The methodological recommendations have three objectives: (1) to expand the participation of women's grassroots organizations in research on reproductive health and family planning; (2) to obtain qualitative information on a periodic basis regarding the reproductive behavior of men and women; and (3) to validate new questions for use in surveys to better measure unmet need.

- Grassroots organizations, particularly women's organizations, should be involved at all stages of the research, including analysis. Their assistance at this stage will make it more likely that the programmatic recommendations are appropriate to the community and could be carried out, by the NGOs themselves. Including grassroots organizations will not only facilitate the research, by improving access to the community and grounding the analysis in socio-economic and cultural reality, but will also benefit women by making it easier for them to participate in the study and more likely the results will be used.
- In addition to population-based surveys, qualitative studies of small samples should be conducted on a regular basis to obtain deeper understanding of the human and social experience of reproduction in changing conditions:
 - i. In-depth, qualitative studies are essential for identifying men's and women's reproductive health knowledge, attitudes and practices. Reproductive behavior is shaped by fears, prejudices, stereotypes, gender subordination, misinformation and other factors that are often difficult to measure in sample surveys.
 - ii. Well designed, qualitative studies begin by obtaining the community's view on how local people approach and talk about reproductive health and family planning issues. This again serves to ground the research in the socio-economic and cultural realities of the communities under study.
 - iii. Qualitative studies can suggest possible questions and ways of studying sexual activity in large surveys. This study makes clear that sexual behavior needs to be addressed more explicitly in studies of unmet need. Qualitative approaches may also be more appropriate than surveys for studying issues such as the correct use of contraceptive methods that require significant tact, flexibility and probing on the part of the interviewers.

- iv. Qualitative studies should be conducted on a regular basis to reflect changes in women's and men's understanding of their own reproductive health needs and how to satisfy them.
- Future surveys that collect the data to calculate unmet need should incorporate additional questions from the regular qualitative studies mentioned above that have proven to be effective in reflecting local realities and deepening our understanding of the barriers women face in obtaining reproductive health services.

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Annex 1: Partial and total scores on silence-speech scale by woman's code, age, family planning pattern and family planning need.

code	age	FP need	FP pattern	info. mens- truation	info. sex relations	info. pregnancy	info. methods	FP servi- ces used	FP communica- tion with partner	sexual education for children	Score in in 0-28 scale	Score in 0-100 scale	Position
4	26	un	erratic	2	1	2	1.4	2	3	3	14.4	51	Int 2
10	21	un	never	1	1	1	3	1	1	3	11	39	Int 1
14	33	un	failed	1	2	1	2	4	4	3	17	61	Int 2
21	33	un	never	3	3	3	2	4	3	3	21	75	Int 2
22	27	un	failed	2	2	1	2	4	3	3	17	61	Int 2
23	26	un	given up	2	3	4	2.5	4	1	3	19.5	70	Int 2
30	29	un	never	1	1	1	1	1	2	3	10	36	Int 1
36	36	un	never	1	1	1	1	1	1	3	9	32	Int 1
37	41	un	never	1	1	1	1	1	1	3	9	32	Int 1
50	30	un	failed	1	1	1	3	4	2	3	15	54	Int 2
51	31	un	failed	1	1	1	1.7	4	2	4	14.7	53	Int 2
52	23	un	failed	1	1	1	2.2	2	2	4	13.2	47	Int 1
53	25	nd	successful	2	3	3	1	4	3	4	20	71	Int 2
54	28	mn	successful	2	4	4	2.5	4	4	4	24.5	88	Sp
68	33	mn	given up	3	1	1	1.5	4	1	3	14.5	52	Int 2
72	30	un	failed	2	2	1	1.7	4	2	3	15.7	56	Int 2
75	36	mn	erratic	1	2	2	1.5	4	2	3	15.5	55	Int 2
79	42	nd	erratic	2	3	3	2	1	2	2	15	54	Int 2
83	21	un	erratic	1	2	1	2	3	1	4	14	50	Int 1
88	33	un	other	4	2	2	1	1	1	4	15	54	Int 2
89	18	mn	successful	4	3	2	2.3	4	2	4	21.3	76	Sp
93	38	mn	successful	1	2	1	2.7	4	3	3	16.7	60	Int 2
95	22	un	erratic	2	3	2	2.3	4	3	3	19.3	69	Int 2
97	16	nd	never	2	3	2	1	1	1	3	13	46	Int 1
99	17	nd	never	1	1	1	4	1	1	3	12	43	Int 1
102	45	mn	successful	1	1	1	2	4	2	2	13	46	Int 1
107	34	un	given up	1	1	1	1.7	4	1	4	13.7	49	Int 1
109	44	mn	erratic	1	1	1	1	2	2	3	11	39	Int 1
110	23	un	other	1	2	1	2.5	4	2	3	15.5	55	Int 2
112	19	nd	other	2	2	3	3	3	2	3	18	64	Int 2
113	29	un	erratic	1	3	2	2	4	3	3	18	64	Int 2

120	41	mn	successful	2	1	1	2	1	3	3	13	46	Int 1
122	27	un	never	2	3	2	3	1	2	2	15	54	Int 2
124	30	mn	erratic	2	1	2	2	4	4	3	18	64	Int 2
128	34	nd	failed	1	1	1	1	1	1	1	7	25	Si
131	18	un	never	2	2	2	3.5	1	2	3	15.5	55	Int 2
136	26	un	never	1	1	1	1	1	2	3	10	36	Int 1
142	31	un	erratic	2	2	1	2.5	4	1	4	16.5	59	Int 2
146	27	un	given up	1	1	1	2.3	1	3	3	12.3	44	Int 1
168	18	un	failed	4	3	2	2	1	3	4	19	68	Int 2
169	27	mn	successful	3	3	1	2.25	4	2	3	18.25	65	Int 2
170	25	mn	erratic	1	1	1	2.75	4	2	3	14.75	53	Int 2
176	26	mn	successful	3	4	4	1	4	3	3	22	79	Sp
177	22	un	given up	1	2	1	2.5	1	2	3	12.5	45	Int 1
178	35	mn	successful	1	1	1	2.7	4	2	4	15.7	56	Int 2
180	21	nd	successful	3	1	1	3	4	3	3	18	64	Int 2
185	29	mn	successful	1	2	1	4	4	3	3	18	64	Int 2
186	29	mn	successful	2	1	1	2.2	4	3	4	17.2	61	Int 2
201	20	mn	successful	2	2	2	3.75	4	3	4	20.75	74	Int 2
206	27	un	failed	1	2	1	2	1	2	3	12	43	Int 1
207	35	mn	successful	1	1	1	3.3	4	2	3	15.3	55	Int 2
211	22	un	erratic	2	1	1	2	4	3	1	14	50	Int 1
216	26	mn	successful	1	1	1	1.5	4	3	3	14.5	52	Int 2
218	38	mn	erratic	1	1	1	2.25	3	2	4	14.25	51	Int 2
219	20	un	erratic	2	1	1	1.8	2	2	2	11.8	42	Int 1
224	24	un	never	2	1	2	2	4	2	3	16	57	Int 2
226	20	un	other	3	1	2	1.7	1	2	3	13.7	49	Int 1
237	21	un	erratic	2	1	2	3	3	3	3	17	61	Int 2
239	25	mn	successful	3	3	3	3.8	4	3	4	23.8	85	Sp
247	21	mn	successful	3	2	3	3	4	2	3	20	71	Int 2
248	28	mn	successful	1	1	1	1	4	2	3	13	46	Int 1
252	18	un	erratic	1	2	2	1.75	1	1	1	9.75	35	Int 1
253	32	un	failed	2	1	1	2	4	2	4	16	57	Int 2
261	32	mn	successful	1	1	1	2	4	4	3	16	57	Int 2
264	32	un	given up	1	1	1	1	1	1	3	9	32	Int 1

267	34	un	erratic	1	2	1	1.5	4	2	4	15.5	55	Int 2
268	28	mn	successful	1	3	3	3	4	4	3	21	75	Int 2
275	33	un	given up	2	1	1	2	1	3	4	14	50	Int 1

Annex 2: The Role Of The *Reproinsas* In The Research Process

Reproinsas played a fundamental role as facilitators of the fieldwork, since they have deep knowledge of the community and have earned respect as devoted voluntary health workers. They assisted the research in a variety of ways. They

- accompanied the researchers at all times for personal safety (due to the high crime rate in the community);
- introduced the researchers to households selected for the survey;
- took care of children during interviews;
- made special appointments with women who were not at home during the first visit of the survey researchers;
- informed neighbors about the research;
- made appointments with women and men for in-depth interviews;
- looked for private places to conduct the in-depth interviews when women to talk outside of their homes;
- insured privacy during the interviews in private homes by playing with children or talking with other household members; and
- collected information on local reproductive health services and providers.

The researchers and *reproinsas* both benefited from the interaction. By participating in the research, *reproinsas* improved their knowledge of the community, not only its physical conditions but also the reproductive health needs people identified. At the same time, the research process informed women in the community about the *reproinsas*' role as voluntary health workers. After the field work was completed, some of the *reproinsas* were visited by women, men, and couples who were looking for advise on reproductive health matters. Three *reproinsas* decided to support family planning programs by becoming APROFAM community promoters.

The researchers invited all FUNDESPRO members to attend a presentation of the research results. About 20 *reproinsas* from El Mezquital attended the presentation. Their main comments on the finding were as follows:

- They reinforced the fact that women's lack of knowledge about their reproductive cycle is a negative factor in their lives.
- They reflected on core problems that should be overcome through educational programs. These problems include women's lack of self esteem; lack of negotiating power vis-à-vis their partners on sexual and family planning matters; economic dependency on husband's income; and sexual, reproductive and domestic violence.
- *Reproinsas* emphasized the need for women to have support groups to discuss their problems and ways of overcoming gender asymmetries, especially at home.

- Since youth are now more exposed to sexually transmitted diseases, early pregnancies, and unintended pregnancies, *reproinsas* indicated that both young women and men need educational programs on sexuality and family planning.

At the beginning of 1997, the researchers visited the *reproinsas's* new building in El Mezquital. They had been able to get enough institutional financial support to build a three-level building. At this facility they are offering a variety of reproductive health services: psychological counseling, contraceptive methods including sterilization, Pap smears and other laboratory tests, prenatal care, and educational programs.