ORIGINAL ARTICLE

Culture and Access Issues in Sexual Health Care in Mayan Guatemala

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The 1996 Peace Accords, which officially ended the 36-year conflict between the Guatemalan government and the guerilla forces, affirmed the right of all indigenous people to health care. As part of its reconstruction plan, the Accords provided for health sector reform and highlighted the government commitment to extend health care to previously neglected indigenous areas. Nevertheless, health care standards in Guatemala are lacking in several areas, from vaccinations to sexual health. Contraceptive use and family planning knowledge are two especially sensitive and significant topics in rural areas. To date, the necessary sexual health resources have not reached highly indigenous Mayan areas. Several non-governmental organizations, including APROFAM and USAID, have implemented various intervention strategies to access these Mayan areas. In doing so, they confront socio-cultural barriers that make this work uniquely difficult. This paper explores those barriers, which include religious restrictions, Mayan cultural practices, and general Guatemalan attitudes.

Suffering from insufficient maternal, child, and natal care, infant malnutrition and morbidity, and a rise in HIV/AIDS rates, Guatemala's indigenous Mayan population desperately needs improved medical attention. Throughout Guatemala's recent history, these people have survived in the country's lowest economic quintiles, separated ethnically, socio-economically, and geographically from the wealthier Ladinos. This physical division of the two groups has led to differential access to modern health care. Family planning (FP), family planning knowledge, and basic sexual health care provisions reach very little of the Mayan population; however, due to nongovernmental organization (NGO) efforts, this is changing. But even the NGOs dealing with family planning issues in Guatemala, Asociación Pro Bienestar de La Familia (APROFAM) in particular, struggle with the issue of extending sexual health care to the indigenous Mayan populations in rural areas. The challenge can be divided into two categories: access factors and cultural factors. To succeed in serving Mayan populations, NGOs must address these two issues. Numerous studies have analyzed the difficulty of access. Several others have discovered certain characteristics in Mayan culture that lead to an aversion to family planning. Indeed, to successfully implement sustainable FP programs, organizations must first grapple with indigenous Mayan medical attitudes, while increasing services.

FAMILY PLANNING DISPARITIES

Although Guatemala has had an active private family planning program for over 30 years, it has, as of 2004, the second lowest level of contraceptive use of any Latin American country.[1] A disparity in family planning use is evident between the Westernized and socio-economically dominant Ladino populations and the indigenous Mayan populations. Statistics on contraceptives and fertility rates reveal drastic differences between the Ladinos and Mayans. For example, the total fertility rate from 1983-1987 among Mayan women was 6.8 life-time births, compared with the 5.0 births among Ladino women. Further research shows that contraceptive use among Ladino women has increased considerably from 22% to 34% from 1982-1992 while only from 4% to 6% among married Mayan women.[2] By 1998, these statistics grew to 13% among in Mayans. Among Ladino women, contraceptive use increased to 50%.[3]

Another trend in comparative awareness of birth control is explored in the 1999 Guatemalan Migration and Reproductive Health Survey, which found that Mayan migration to urban areas is "positively associated" with increases in contraceptive knowledge in these peoples. It detailed how "Rural-to-urban migrants eventually achieve a level of modern contraceptive use slightly below that of urban non-migrants, with the level of contraceptive knowledge being an important factor associated with use of modern methods."[4] The nation's fertility rates over the past three decades reveal that:

"Guatemala is lagging behind other Latin American countries on the socio-economic characteristics that have traditionally caused fertility to decline…Ethnic inequality has been recognized to affect the pace of the demographic transition."[7]

Mayan fertility rates have declined, according to national estimates. The total Mayan fertility rate gap decreased from 6.8 to 6.1 between 1987 and 2002. Studies also show that the fertility rate between the Mayans and Ladinos is widening. The total Ladino fertility rate decreased from 5.0 to 3.7 from 1987-2002. Furthermore, "fertility rates differ greatly between rural and urban areas and at the local level."[7]

But, why is the rate of family planning use growing slower among Mayans than among Ladinos? Studies attribute the low use to various access factors: NGO effectiveness and reach, poor governmental care, relative high cost of and accessibility to contraceptives, low promotion of contraceptives, and indigenous beliefs, religious attitudes, institutional allegiances, family traditions, etc. As for the high Mayan fertility rate, significant factors include "an earlier age of marriage, lower educational attainment, and generally lower socioeconomic status."[5]

To synthesize an effective intervention strategy in Guatemala, both cultural and access factors must be considered. Primarily, it is critical to examine the prevailing attitudes towards family planning, as well as which organizations provide services and how effective they are. The following report will analyze the comparative importance of these two factors.

ACCESS FACTORS

The 1996 Peace Accords, which officially ended the 36-year long conflict between the Guatemalan government and the

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guerilla forces, affirmed the right of all indigenous people to health care. As part of its reconstruction plan, the Accords provided for health sector reform and highlighted government commitment to extend health care to previously neglected indigenous areas. The product of this commitment was the Integrated Health Care System (SIAS), which "leveraged existing indigenous NGOs and assigned operational responsibility and funding to them."[6]

The Peace Accords helped ease the way, providing a safe environment for extending family planning services to indigenous areas. APROFAM, the primary provider of these services, is a private Guatemalan NGO. Faced with financial troubles, they have had to implement major cost-reducing strategies over the years. Their major source of funding is USAID. It was not until 2001 that the Guatemalan government made a substantial move to improve family planning services. This came about through the Redproductive Health Programme in January and the Social Development and Population Law in October. These two laws "made reproductive health part of a national policy and instigated several initiatives to improve access to FP services."[7]

The Ministry of Public Health and Social Services (MSPAS) moderates all government-provided health services. The MSPAS covers 25% of the population, while the social security system covers another 15%.[8] MSPAS services include hospitals, health centers, and health posts. Modern family planning methods are available at these locations, though the MSPAS supplies less contraceptives than the private sector does:

"APROFAM…distributes about 36% of the contraceptives used in the country. In contrast, the entire public sector, including the social security system, provides about 25%. Moreover, the public sector distributes most contraceptives from hospitals – less than 5% of contraceptives distributed by the public sector were distributed outside of hospitals. This means that the government provides very few contraceptives outside of major urban areas."[8]

The statistics have clear implications: the government is not a sufficient provider of family planning services for the Mayan population and NGOs are reaching out to the neglected indigenous areas. APROFAM has been proven to be the most used by Mayans. Likewise, the government health centers and health posts are the closest facilities but among the least used. Despite the lack of government aid, studies have found that there is some level of contraceptive knowledge among the Mayans. A study in 2005 in the Ch'orti area reported that: "Nearly all women in the town of Jocotán had heard of FP…around 40% had heard about it through APROFAM or through a doctor, and about 20% had heard about FP…at school or in the pharmacy."[9] Furthermore, a 1995 study in the highland department of El Quiché found that, though men had a low level of contraceptive knowledge, they were interested in learning how to plan their families.[6]

CULTURAL FACTORS

Because of sociocultural barriers, it is difficult to implement a Western model of birth control in rural Guatemala. This structure would have to provide for:

"1. Reducing the birth rate through better spacing of children through the use of birth control, thereby allowing each child greater access to family resources with which to acquire strength and viability, 2. Preventing disease through education regarding the importance of hygiene, vaccination programs, and nutritional supplements (mostly vitamins and minerals), 3. Curing infants of acquired diseases."[10]

Such straightforward techniques ignore the prevailing beliefs of the indigenous Mayans, however. At the heart of the matter is the Mayan attitude towards childbirth. As in other agricultural societies, fertility is a God-given attribute; God creates the pregnancy, and thus it should be carried out. Moreover, God decides how many children a woman should have. The Catholic and Protestant institutions, often strong influences in Mayan communities, are a powerful opponent to family planning movements. One Mayan Catholic explained, "[family planning]…is a sin because the Virgin Mary has put a necklace on each of us and we have to fulfill this obligation [to have children]."[2] This sort of attitude clearly conflicts with efforts to advance birth control use among the Mayans.

Any health organization in Guatemala must consider another significant point: native attitudes towards the concept of appropriate family size. Guatemalans tend to react more positively to the idea of larger families.[2] As one young married Maya-Quiché study participant remarked, "Our fathers say we are weak now because we only have six or eight kids; before it was normal to have 14 or 15 kids."[2] Furthermore, having larger families allows for caretaking of the parents in old age as well as increased economic assistance.[2]

Indigenous attitudes towards chemical means of birth control are much stronger than those towards birth spacing. Indeed, the most suspicion is reserved for the pill. A study of the Nahaulenses revealed that the top five concerns against participating in birth control were: "1. Contraceptive pills/injections cause cancer, 2. Contraceptive pills/injections make a person sick, 3. Contraceptive pills/injections make a person impotent, 4. Contraceptive pills clog up the stomach, 5. Contraceptive injections stop menstruation."[2] A study focused in an area in the northwestern highland area of Guatemala near Santa Cruz del Quiché (the capital of the Department of Quiché) found that "Several adverse health effects were associated with the pill. The belief that it causes both weight gain and loss, and general debilitation, appeared to be widespread; several groups also mentioned that the pill causes cancer. Some participants felt that the pill is 'toxic' and kills children in the womb, and causes illness or death for the mother."[2]

Such beliefs are rooted in the basic Mayan belief in health. In an almost Galenic manner, the Mayans regard sickness as an imbalance in the body, often as a result of excess heat or cold. Another study of the Nahaulenses revealed that "the pill and Depo-Provera injections used in birth control are feared by many people to be so excessively 'hot' that they have the power to cause cancer or severe sickness and stop menstruation permanently. The pill is not only hot, it suppresses the ability to digest corn. Even worse, the pill accumulates in the pam (a word for both the stomach and the womb)."[10] In terms of current users, Mayan women often tend to not to choose the pill because of the cost. One interviewed Mayan woman said, "We don't even have enough money to buy food, much less to buy

those."[2] Another dangerous cultural characteristic of the pill is its weight gain side-effect. Mayan women taking the pill without notifying their husband worry that their sudden weight gain will lead to their unmasking.[10] Abrupt weight changes "are considered proof that a woman is using contraceptives, and this can trigger criticism from the community."[2]

Additionally, the Catholic Church remains a powerful institution in many Mayan communities. With alternative sexual health education unavailable, the Catholic Church has become the sole source for such information:

"Within these Mayan communities, the principal source of family planning information appears to be the Catholic Church, represented primarily by the local lay workers. These individuals offer premarital classes, in which they encourage prospective couples to have all the children God sees fit to send. The participants claim that the catechists preach that family planning is murder, and that one of the principal purposes of these classes is to convince people not to use modern contraceptives…Religion is particularly influential in this culture, since young Mayans receive almost no guidance or information concerning sexuality and family planning in their families."[2]

As a result of this indigenous mentality, Western biomedical arguments may not be valid among Mayan communities. Surely, an effective intervention strategy must harmonize with their traditional thinking. These sociocultural barriers considered, very few birth control options remain. The biochemical method cannot be implemented in rural Guatemala so long as their current conception of health dominates. Which choices, then, are available?

The best option, it seems, is the practice of birth spacing. Birth spacing, does not employ any chemical impositions and is the easiest to adapt to long-held Mayan customs. Population Reports cites a 2002 study by the Demographic and Health Surveys (DHD) "that children born 3 years or more after a previous birth are healthier at birth and more likely to survive at all stages of infancy and childhood through age five."[11] Furthermore, it promotes maternal health, as it reduces chances of anemia, third-trimester bleeding, and increases likeliness of surviving childbirth.[11] The previously mentioned DHS study found that younger women, women with no education, women in rural areas, women with lower status, and unemployed women are more likely to have shorter birth intervals than their respective counterparts.[11]

What are the Mayan objections to birth spacing? Morally, the people's Catholic beliefs lead to the view of family planning as sin, as it goes against God's determined number of children per couple. Furthermore, several interviews with groups in a Quiché community determined that "the term 'family planning' is commonly translated in Maya-Quiché as 'to cut off the children.' Thus, it was specifically associated with having few children: in none of the groups was spacing births considered related to family planning."[2] One of the interviewed women asserted, "Those who plan their families do so because they are lazy." Others believed that family planning would diminish the Mayan population. Population Reports specified common cultural norms that can influence women's birth spacing practices. These include a pressure on a couple to prove fertility, breastfeeding practices, which determine how long women will remain amenorrheic, postpartum abstinence, and the preference for a son after a birth of a daughter.[11]

Regardless of these restrictions, Mayan culture does allow for a level of tolerance for birth spacing. Though the Mayans do not intentionally try to space births, many believe that it is unsafe to quickly have children in succession, as the practice could lead to the first child stopping breastfeeding prematurely. Moreover, "after childbirth, the womb is considerably weak, needing sufficient time to recover between births."[2] Also, raising two young children concurrently requires full attention of the mother. Finally, the method of postpartum abstinence is widely used. Women are often suggested to remain abstinent for 40 days following childbirth, and "men who do not 'hold out' during the postpartum period are though to be irresponsible and inconsiderate of their wives."[2] Indeed, then, birth spacing can be adjusted for assimilation in Mayan practices.

The Population Reports study presented evidence of women with positive birth spacing attitudes who attribute to the practice the benefits of healthy children and having older children help raise younger siblings. A male respondent in Jordan described that birth spacing "gives each child born his rightful level of caring and attention, and they give your wife the time to rest and regain her health."[11] He also cited advantages to the husband, saying, "They give the husband the chance to weigh his financial situation and plan his family's future".[11] Certainly, birth spacing has proven well-received in other countries, and can be successful in Guatemala especially if promoted among young couples provided with prenatal and postpartum care.

Table 1. Family Planning Guideines. Adapted from reference 2.

1. To be credible and understandable to the Mayan population, family planning information should be provided by Mayans. Promotional messages should be carefully worded to indicate that the agencies are suggesting options, not insisting that methods be used.
2. Guatemalan agencies must focus more attention on the individuals and groups that influence family planning decisions and have an impact on women's choice, specifically church leaders, husbands and community leaders.
3. Promoting family planning for birth spacing has more relevance to Mayans than promoting it for limiting births. Family planning messages should focus on the health benefits of longer intervals between births and of postponing childbearing to later ages.
4. The widespread knowledge of periodic abstinence offers some hope for methods of fertility awareness. The image of family planning associations in Mayan areas can be improved by the promotion of more acceptable tradition methods, which could eventually open the way to providing Mayans with information on more effective methods.

How should family planning strategies be promoted? An aforementioned study in Santa Cruz del Quiché established a series of guidelines for maximum effectiveness (Table 1).[2]

Two main family planning strategies are promoted in experimental intervention strategies: birth spacing (having children less frequently for the health of the mother and child) and responsible parenthood (having fewer children in order to provide better for them). A study by APROFAM (which, in Guatemala, delivered 25% of the supply methods and 41% of clinical methods[2]) from 1992 to 1996 called for the Quiché Birthspacing Project to test the effectiveness of the former method by enhancing the following aspects of health care reform:

"Improving access to services by increasing the number of volunteer promoters…improving quality of services through training, supervisory visits and continuous supply of contraceptives…improving the acceptability and image of APROFAM by forging ties to other development agencies that had gained the trust of the community…[and] increasing awareness of the benefits of birth spacing through information, education and communication (IEC) activities".[5]

Over the four years of the project, the proportion of volunteer promoters increased from 24% in 1993 to 49% in 1995. The APROFAM clinic where the project centered offered six different methods of family planning to the Maya-Quiché area: pills, IUDs, injectables, condoms, female sterilization, and vasectomy. The promoters (who could reach remote areas) engaged in the project only offered three of these methods to their constituents: pills, condoms, and spermicides. The Guatemalan Ministry of Health also offered three methods in 1993, but only two (pills and condoms) in 1995. Actual use of these services revealed that the most used was the pill, followed by the condom.[5]

CONCLUSIONS

When facing the access and factor barriers, it seems the most efficient option for NGOs is to synthesize a non-confrontational, and more importantly, adaptable method of intervention. In order to incorporate birth control techniques into the indigenous society, NGOs cannot follow a Western model of intervention. First, as the APROFAM study showed, a variety of techniques must be offered. With injectable contraceptives growing more popular, this possibility should be explored and promoted. Second, the movement towards family planning must be presented to communities by Mayans themselves; a foreigner's influence is not only inherently limited, but often mistrusted. Modes of disseminating birth control information must be structured so that they are promoted by community and religious leaders. Radio broadcasts, informative talks and pamphlets, and visual aids have proven extremely helpful in promoting family planning and health discussions among people. Methods and communication must also be sensitive to the nuanced Mayan belief system. This aspect of intervention ought to be of highest importance. Birth control methods are best integrated by being systematically meshed with sociocultural standards. NGOs must not underestimate the level of Mayan family planning knowledge. They must intervene with a sense that Mayan peoples may already have some understanding of the issue, and must thoroughly understand their attitudes and awareness towards it before implementing any promotion strategies. To meet the needs of the community, more health NGOs should make their documents and information more accessible to the Mayan population, in terms of language and complexity of official forms. There is a need for more Mayan speakers in the national health care as well as the health NGO system.

If met with conflicting attitudes, NGOs may wish to opt to support existing practices of birth spacing and postnatal care. As these practices are strengthened, concepts such as birth spacing may be promoted, and can well lead to an increase in contraceptive use. Indeed, a sufficient health care system must be operating in the remote areas of the Mayan regions before any of these designs can be carried through. Access to resources thus is a priority, and birth control promotion cannot take place without the increased reach of such NGOs as APROFAM, which requires further economic and political support, especially from the Guatemalan government.

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