Negotiating Contraceptive Choice: Case Studies in Rural Mexican Villages

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For many years, Mexico adhered to an expansionist ideology. Its pronatalist outlook was reflected in the General Law of Population of 1947. At that time, the sale of contraception was illegal in Mexico and there was a desire to encourage growth of the population though natural increase and immigration. Measures to foment marriage and the increase of fertility were encouraged. In fact, a national contest was held every year to find the most prolific mother in the country (IMSS 2001b, p. 14). Demographic changes over the next several decades however, and the economic ups and downs that the country would experience would eventually cause concern among Mexican government elites.

In the 1940s, Latin America experienced rapid declines in mortality. Slight declines had begun at the start of the century, but mortality began to fall more rapidly at in the 1930s and these declines were especially sharp in the 1940s (Arriaga 1970). Similar declines in fertility did not occur at that time. As a result, Mexico's population increased rapidly in the decades that followed. The population grew 157% in the 30 years following 1940. The growth was in marked contrast to the 30 years prior, when growth of the population was only 30%. Concern regarding the detrimental effects of population growth would reflect the international debate on the issue and would eventually lead to population policy that would change the picture of contraceptive use in the country.

International Discussion on the Effects of Population Growth

International interest and concern regarding the effects of rapid population growth began its evolution around the mid-1950s, largely led by the US and USAID (Donaldson 1990). By the 1960s there was increasing attention paid to the scientific study of population

around the world and the effect that rapid population growth could have on development. This was reflected in and further influenced by the works of Coale and Hoover (1958). The 1960s was designated as the Decade of Development by the United Nations (UN 2003), and greater attention was placed on the neo-Malthusian concern with the detrimental effect of overpopulation.

Although consensus about the directions of the relationship between population and development had not been reached by all nations,[i] by the 1970s a general concern existed among many countries with regard to the issue of rapid population growth. There was increasing discussion of the necessity of developing and adopting population policies to deal with such growth. Conferences prior to the 1970s had largely focused on scientific debate rather than policy, but the World Population Conference held in Bucharest, reflecting the state of the evolving international discussion, focused on policy issues (UN 2003).

Policy Formulation and its Evolution in Mexico and the International Context

The development of Mexican national policy regarding family planning somewhat mirrored the international experience since the early-1970s. Prior to the mid-1970s the right to family planning was not explicitly mentioned in Mexican policy and methods of family planning were not easily accessible. The percentage of women using contraception in Mexico prior to the 1970s was low and most obtained their method in the private sector. Some very limited provision of maternal and child health care and family

planning services were offered through the public sector before the 1970s, but it was only in the urban areas and it was not widely available (IMSS 2001b, p.13).

The economic problems associated with a rapidly growing population ultimately resulted in a change in official government policy in the early 1970s. Echoing the terminology used in the United Nations International Conference on Human Rights in Tehran in 1968 and the World Population Plan of Action in Bucharest in 1974, and in preparation for the International Year of the Woman to be held in Mexico in 1975, the new General Population Law of 1974 proclaimed that Mexican has the right to choose, "… in a free, informed and responsible manner the size of their family" (CONAPO 1999; Perez-Duarte y Noreña 1999; UN 2003). This law had been preceded in 1973 by a change in the Health Code that made the sale of contraception legal. Moreover, and most significant for the future expansion of contraceptive services, was the General Population Law's declaration of the obligation of the State to provide free family planning services at public health institutions (CONAPO 1999 p. 203).

These changes were followed by a significant expansion of services by the Mexican government. After 1977 the government substantially increased active efforts to promote family planning especially in the rural areas, creating the Rural Health Program and constructing clinics in rural areas as well as making services available to people who had not before been covered by the Mexican Institute for Social Security (Alba and Potter 1986; IMSS 2001a; Potter 1999).

In the years that followed, adoption of contraceptive methods from public sources, increased substantially. The active nature of seeking and promoting family planning to women, thereby creating (or perhaps awakening) demand, has played a large part in the dominance of public services as a source, as well as the patterns of use observed. Doctors and medical personnel especially those at the Mexican Institute for Social Security (IMSS) rural clinics were strongly encouraged the recruit new acceptors through the use of targets (Potter 1999).

Changes in the Use of Contraception after Policy Modifications

The marked increase in the adoption of contraception in the years that followed was dramatic. Overall, use of contraception among women of reproductive age who are married or in union increased from 30.2 % in 1976 to 47.7% six years later and continued to increase to 68.5 % in 1997; total fertility rates fell largely as a result of the increased adoption of contraception (CONAPO 1999, table 3).

With increased use, came a change in the source where contraceptive users obtained their method that reflected an increased use of the public sector over the years. In 1979 only 51.1% if contraceptive users obtained their method in the public sector. By 1987, this percentage had increased to 61.9% and by 1997 it had increased to 72.5% (CONAPO 1999, table 5)

The distribution of the types of contraceptive methods used changed over the years as well. In the initial stages of rising use in the country, the distribution could be

characterized as one of greater pill use. But as the years went on, use of both the IUD and female sterilization increased such that the pill no longer dominated. In 1976 the distribution of users was such that 35.9% were using the pill**,** 18.7% the IUD, and only 8.9% female sterilization. By 1987, the numbers from those same categories had changed to 18.2%, 19.4%, and 36.2%, and by 1997 it had changed to 10.2%, 20.8% and 44.7% (CONAPO 1999, table 4).

One explanation for the bi-modal distribution (IUD and female sterilization) in Mexico, as previously mentioned, identifies the history of the expansion of services in Mexico and the role that doctors and other medical personnel as important factors in the resultant patterns of use[ii]. Early in the implementation of the program, when government institutions were expanding to the rural areas, strong method-specific targets were used to motivate medical personnel to recruit new users. Although the Ministry of Health issued normative guidelines in 1993 stressing the importance of informed choice, and dissuading the promoting of any method over other[iii]**,** the style of delivery, is it argued, had become entrenched. Medical personnel were and continue to be characterized as "interventionist"; this was the case in the early 80s and, based on a 1996 survey by CONAPO, likely to still be the case in the mid-90s (see Potter 1999).

A person's right to informed decision-making with respect to childbearing has, by now, long been in the language of both international and Mexican documents on population policy.[iv] Mexican public institutions have run into problems with informed consent in the past (see Dixon-Mueller 1993, p. 19). Even today, targets set by some of the family

planning programs run by public institutions may be argued to run counter to the idea of free and informed choice (as a possible negative consequence of the desire to meet these targets). At present, the IMSS still uses method-specific targets at the clinic level.[v]

This begs the obvious questions of how informed (or not) women are when they are told of their options, whether or not constraints are placed upon their choice of methods, and ultimately whether or not women are given the method that best suits them. All of these issued are concerns addressed in the 1994 ICPD Conference in Cairo, whose final document was signed by Mexico.

Though language in the spirit of the 1994 ICPD is present in official Mexican government documentation and rhetoric,[vi] I consider its existence in the discourse of the people providing care to women. My intention is to explore here the interpretations that medical personnel put to the official rhetoric and contrast it with the realities they see in the context of their day-to-day implementation of their programs and what this means in terms of provision of care.

Methods

The study looks at 4 areas in rural Michoacán, Mexico with populations of less than 2,500 inhabitants. I selected these locations using census information from 2000 collected by and provided to me by the Mexican Institute for Social Security (IMSS) Oportunidades (formerly Solidaridad)[vii]. I chose these four rural areas according to the differences in the use of contraceptive methods that predominate in each: in one the IUD

and sterilization predominates, in another the pill predominates, another the calendar method predominates, and the last is characterized by a more even distribution of use.[viii] All are locations where there is an IMSS medical clinic that provides services to the community, however all communities have varied access to alternative locations to obtain medical care in cities outside of their community.

At each of the 4 locations I interviewed a sample of village women and the medical personnel that the women named as having provided them services. Each of these two groups is described further below.

Women

In each community, around 20-33 women were interviewed. In each of these locations this amounted to roughly 20% of the women who were married or in union at the time of the 2000 census. The method of obtaining respondents was simply to go up and knock on doors and ask for their participation, making sure to cover all areas of the community. Surprisingly few women asked for their participation, declined (roughly 3 or 4 in each village). Those who declined gave as their reason for declining either the fact that they did not want to be recorded or that their husband would not allow it. The women were between the ages of 15-49 and married.

The interviews were anywhere from 15 minutes to 1 hour and 30 minutes in duration and focused on having them provide me with a history of their pregnancies and their use of methods of contraception, the providers they went to for obtaining their methods, their

view on why they chose whatever method they chose to use or why they stopped using a method, probing further on any stories about interactions and experiences they have had with providers, as well as other relevant questions.

Medical Personnel

The doctors I chose to interview were selected based on their being frequently named by women during their interview (either for pre-natal care or delivery or specifically for obtaining the methods they used). If they were in the area, I went and found them and interviewed them. However if they were in another state, had provided services in the very distant past, or were difficult to find, they were not interviewed.

The interviews with the medical personnel include: asking them about their training, the challenges they face in providing care for the community, personal and institutional strategies they use to meet goals (if any), their opinions on when to recommend certain contraceptive types and so on. Some questions varied with the role of the provider occupied (nurse, supervisor, rural assistant, etc).

There are a total of 135 interviews. Of these, this paper focuses mainly on those with 31 providers and makes use of the interviews with women only marignally.

Participant Observation and field notes

In addition to the interviews, I did participant observation in various settings, had informal talks with medical personnel, as well as obtained information from various

informants including rural assistants and other women in the community in an effort to get a better understanding of the community.

Participant observation also plays a part in learning about the communities and the institutions that serve them. In particular, I was invited to 2 "sterilization clinics" and was able to see the routine in which women in the communities who have chosen to be sterilized are sterilized through a program offered by the Mexican Institute of Social Security. During these clinics I was allowed to see the entire process as it proceeded in the day. Beginning with waiting for and picking up patients, driving to the hospital, processing the patient for surgery and the surgery itself.

I also had many informal talks with women and medical personnel who I either never formally interviewed or was not formally interviewing at the time. These talks provided me with more information than I could gain from simply interviewing and on more than one occasion were very insightful about some activities were not easily observable and of which I would never have known otherwise.

Follow up to interview questions

For any given interview, transcription often reveals further questions needing to be asked or responses needing clarification. Also, after chatting with people in the community or after conducting a given interview or seeing something during participant observation, I might find new questions to which people already interviewed might have answers. In such cases I conducted follow-up interviews in which specific questions are asked.

Depending on the length of the questions involved, these interviews may or may not be recorded. (I have found that these questions asked in the course of conversation are more naturally answered, which also tends toward a less formal approach)

Willingness to talk/ Openness of respondents

Overall, women were very receptive to being interviewed. Once we began the interview, the women got comfortable. I did encounter some situations, particularly in the discussion of coitus interruptus, in which some women experienced a little uneasiness about talking about it, but in the few cases where this happened we would agree on an adequate euphemism and continue the discussion.

Gaining trust with the medical personnel was a greater concern to me. Although I arrived with the permission of the supervisors, the nurses and the clinic doctors had some suspicion about the reason for my presence there. There was a general wariness, among some of these personnel that I was an investigative reporter for a magazine or newspaper. Still others, it seemed, interpreted my investigation with promotion of use and thus responses at times seemed to be of this nature… a chance to boast about the programs. I found this to be the case especially with superiors. Further, some seemed to alternate between the two possibilities at different points in time. My response to this was to clarify that the research was for my doctoral dissertation and to explain to them, in general, the questions I would ask. In addition, I maintained as neutral a stance as I could in response to their boasts about their successes or lamentations about, for example, the

difficulties dealing with certain types of people. When pressed, I simply told them that I was there to understand the community and not to promote the use of contraception, nor was I an investigative reporter.

Even so, it was clear that some of the medical personnel were somewhat guarded in providing me with responses. Some clearly provided me answers strictly in line with the institutions policy. I do not believe that there was any way around this problem other than entering subversively into the situations and interviewing them without obtaining informed consent and clearly this was not an option. However, despite this, some respondents, after having established a rapport with me, opened up a bit more. In my discussion, I indicate, where I feel necessary, the rapport and the sense I felt when talking to any given respondent whom I quote, or in a given situation that I observed.

Had I only interviewed medical personnel, this would have been of greater concern. Since I interviewed women as well, however, I was further able to fill out some parts of the picture as far as provision of care. I refer to them as they come up throughout my discussion.

Official Rhetoric on Family Planning Services in Mexico

In 1993 Mexico's Ministry of Health produced the document I mentioned above. This document serves as the normative guideline for family planning services in Mexico. It addresses some of the same concerns regarding the provision of family planning as does the Program of Action of the 1994 ICPD, and was produced with the assistance of

several international organizations such as the World Health Organization, the International Planned Parenthood Foundation and the Population Council among others.

The document contains information on indications and contraindications for all methods of contraception, including natural methods. It begins with a section on topics that concern the provision of family planning in general**.** The 6 sub-sections under it include: 5.1 family planning services, 5.2 promotion and diffusion, 5.3 information and education, 5.4 counseling, 5.5 prescription and application of contraceptive methods and 5.6, diagnosis and management of cases of infertility and sterility (SSA, 1993).

It describes family planning services as constituting a group of actions "…to contribute to the attainment of complete physical, mental, and social well being, and not just the absence of infirmity…" (SSA 1993), wording identical to the Program of Action of the ICPD 1994 as regards reproductive health (Chapter VII, 7.2).

Section 5.4.2.3 states that "[c]ounseling should take into consideration at all times that the decisions and informed and responsible consent of users should be completely respected…" and Section 5.4.2.2 that "…emphasis should be made on the considering the attributes and limitations of the… methods, with the needs and characteristics of the individual or couples" (SSA 1993). Section 5.4.2.3 also states that users should not be persuaded into "…. the acceptance of specific contraceptive methods…" (SSA 1993).

These three particular elements related to informed choice I refer to hereafter as: 1) informed consent, 2) treatment of each individual case, 3) providing a full range of methods (not persuading people to use specific methods). A concern for potential violations of these three elements of choice emerge when you consider numerical targets. Though the Normative Guidelines do not mention targets per se, it can be argued that numerical targets can create potential problems with regard to counseling (see Donaldson 2002, p. 99)

The three groups of providers I interviewed can be broken down as 1) not having any numerical targets (private doctors); 2) having targets that are general and not method-specific (Ministry of Health); and 3) having targets that are method-specific (IMSS Solidaridad).

Private doctors, do not have goals[ix] they have to meet with regard to recruits unless those goals are personal ones they have set for themselves. I asked the question of all providers interviewed, however, if they followed certain goals. Private doctors almost always responded something like this:

> Well… at first I think we all have them don't we… to have more and more patients, but I don't anymore. Now my goals are that give the best care to the patients I have… dedicate more time to them… even if I have fewer patients… and goals of educating them a bit more…. So they can know when they come to the doctor about… pregnancy and contraception…. (Private doctor)

That is, "goals" to them were conceived more broadly and were generally about providing quality care and education to the women who were their patients. This is hardly

surprising given the two vastly different contexts in which these private and public doctors find themselves. Private doctors began their interviews in a different mindset. Whereas public doctors began it with the big picture, talking about the benefits of particular health campaigns to groups of people, private doctors began with a more individualized perspective.

Goals set for the Ministry of Health's Centro de Salud hospitals are percentages of active users of the population of reproductive age. Their goals are not method-specific[x] and there is no pressure to meet them. Rural assistants, people who are from the villages themselves and who can dispense condoms and hormonal methods to women who have a prescription, do not have to meet goals. The targets applied to the IMSS Solidaridad rural clinics, on the other hand, are the most specific goals of all. They are method-specific and favor the IUD. I was told by the administrative supervisors that these figures, indicating the number of new recruits per month for each method, are calculated based on reports of population counts obtained from the clinics.

In the past, IMSS Solidaridad would reward auxiliary nurses who topped the charts in insertions by giving them vacation days, currently however, these "prizes" are no longer rewarded. Not meeting goals was frowned upon but the repercussions were not severe. One *pasante* [xi]described it as "…a way of pressuring you". But even though punishment does not follow, the insistence of meeting the goals is there:

> They made an emphasis on family planning [at the last meeting]… that we have to meet our family planning goals 100%. We need to insert IUDs, we need to find patients for female sterilizations and patients for vasectomies (IMSS Solidaridad *pasante*).

As mentioned earlier, a survey conducted in 1996 indicated that doctors were not entirely familiar with the Normative Guidelines, while most of them could easily talk about the targets for new contraceptive recruited they either they or their institutions employed (Potter 1999).

Although the line of questioning in my interviews did not directly ask about the 1993 Normative Guidelines, the subject nevertheless emerged with a few of the public doctors with whom I spoke.

A Ministry of Health doctor/director of the Centro de Salud hospital, in the larger town where a lot of the women from one of my locations went to give birth, mentioned it as did the nurse in charge of family planning at the same location. She said she "bases her decisions upon the Norm" (SSA Nurse) and if she has any doubts she asks for the help of a doctor. Of course, since it is a document published by the Ministry of Health, this comes as no surprise.

The nurse in this example was referring to it in the context of how she trains herself mostly on the job, using documents and the assistance of doctors. Ministry of Health personnel do not receive the same amount of training as the IMSS Solidaridad personnel do and this difference in training becomes clear when comparing the two. Because of this training, IMSS Solidaridad personnel tend to offer much more uniform responses to questions regarding the provision of contraception which I take up later.

Several higher-level supervisory IMSS Solidaridad doctors explicitly mentioned the Normative Guidelines. In particular, they mentioned that is was used in the training of new *pasantes*[xii] as well as in other training sessions. None of the IMSS Solidaridad clinic personnel (those personnel in the villages on a day-to-day basis) mentioned the document.

Not explicitly mentioning the guidelines however, does not mean that the personnel are not familiar with the information contained within it, in particular the 3 elements I mentioned above. Informed consent, treatment of the patient as and individual, and the choice of a full range of methods, the contexts in which they arise, and the extent to which they are specifically addressed are considered below.

Informed Consent

The IMSS Solidaridad personnel repeatedly mentioned the term informed consent. When mentioned by the clinic personnel, it seemed to me that it was mentioned less so as a general concept regarding the right for a person to know what is being done to them, and more often as the procedure for obtaining it. This is not surprising given that procedure is a big part of the IMSS and that it is brought up at every training session[xiii]:

> They gave us [a course] on the topic of counseling. Everything that we have to know... informed consent... which is really important that the patient who is going to accept a method sign for us... and explaining to them all the points in the informed consent [form]. (IMSS Solidaridad *pasante*)

> …counseling… and informed consent… shared and informed consent. That's so that you can inform the patient and they reiterate the information and accept… regarding some method. (IMSS Solidaridad Nurse)

> ...it has like some what... maybe some three... four years that we use that sheet... for informed consent. You inform them of the methods... that are going to be used and their risks and advantages and disadvantages (IMSS Solidaridad Nurse)

Though the emphasis seems to be on procedure the reasoning for it is generally understood.

> Because well… you should tell the patient what you are going to do…. We had a time here at the clinic there… there was a doctor that he… he wanted to insert them [post-partum IUD insertions] without telling them. And what happened? Well the women didn't want him to attend their births because of that… because he would put in IUDs without telling them so. (IMSS Solidaridad Nurse)

IUD insertions

The IMSS in general, has had problems in the past with doctors performing post-partum IUD insertions without consent especially in the larger hospitals. In fact, the nurse just mentioned above had given birth 5 years before at the hospital in the large city of Morelia and found out days later while she showered, that they had inserted an IUD without her permission.

The supervisory doctors, as one would expect, argue that it is a thing of the past, or a problem of the large cities where it is more difficult to supervise. Of the women I interviewed, none claimed to have had an IUD inserted without permission in the last 5 years.

In fact, several factors work against post-partum IUD insertions at the rural clinic level. The first is that relatively few births actually take place there in a year; women are more apt to go to the Ministry of Health hospital or a private doctor[xiv]. Furthermore, the relative anonymity of doctors that exists at the hospitals in larger cities, where this has been known to be a problem, does not exist at the clinic. IUD insertions at the clinic level, without consent, are likely very few. This does not mean that the problem does not exist somewhere else. The women who did have this happen to them in the more distant past, had it happen in hospital in a large city.

Sterilizations

Female and male sterilizations are performed about once a month as part of a program to reach the clients in which the Ministry of Health's Centro de Salud Hospitals provide the operating room and the IMSS Solidaridad provides the personnel. Clinics from surrounding communities travel to the larger city where the hospital is located and several men and women from different communities are sterilized on the same day. Unless there are more than 12 surgeries to perform, a single surgeon performs all of the sterilizations. At the clinics I attended there were only 4 women at one, and 3 women and 2 men at the other.

When I attended a sterilization clinic, the procedure for obtaining informed consent seemed somewhat suspect. Though, in theory, it is possible to get consent from the women prior to the date of the actual surgery some *pasantes*, for whatever reason did not.

The day of the surgery, supervisory doctors rushed to get the consent forms signed. It all seemed so hurried to me but I was told that the women had received the counseling but has just not signed a form prior to the day of the surgery.

Part of the reason for this last minute rush to get informed consent has to do with the criteria for obtaining consent and the sometimes-secretive nature of the women undergoing the procedure. The informed consent form contains a list of all the risks of undergoing the operation and must be signed both by the patient and by a witness. The witness must not have an affiliation with the IMSS nor can it be a family member of the person undergoing the surgery. For some women the local rural IMSS Solidaridad clinic is located miles away off the highway and to coordinate with a friend to go with you and sign the form is not practical. Other women simply want to keep the entire event to themselves. As a result, they often wait until they day they are being sterilized and have one of the other patients sign as the witness.

Counseling continues until right before the woman goes in for surgery, even after signing the consent form. The woman is taken into a room with a social worker who explains again what is going to happen during the surgery and that she will no longer be able to have children.

At one clinic, I witnessed a woman decide at the very last minute that her understanding of the procedure was incorrect and decide to leave; she did so after her the counseling session with the social worker finally clarified the procedure for her. Apparently, she

believed that she would have her fallopian tubes tied and that she could reverse it when she felt like having more children. It did make me wonder about the effectiveness of the prior counseling she was given. One of the supervising doctors told me that it was precisely for this reason that they repeat the explanation many times. In fact right before the surgery the surgeon would repeat again, "Do you understand that you will no longer have any more children after this operation?" or a variant of that.

In speaking with the women back at the villages, almost everyone who was sterilized had planned to do so; those who underwent the surgery post-partum had decided weeks or months before delivery that they wanted to have the procedure. One woman told me that she had been sterilized by a private doctor after a particularly difficult labor, without the consent of her or her husband.

Women in the community, it appears, have encountered few problems with informed consent and post-partum IUD insertions or sterilizations. The issue of choice or a potential lack of it, however, concerns more than just these types of blatant violations. It is also concerns the treatment of women as individual people with different needs who are offered a range of method from which to choose.

Needs as an individual or couple

Language describing women as individuals with individual needs arose more with private doctors than with public personnel.

> Each patient is different…. You have to check the patients and according to the clinical characteristics that you find… you ask them their family history…. if they don't suffer from any important diseases… degenerative diseases… like diabetes… hypertension… breast cancer…. (Private doctor)

"It depends on the person, because not everyone can use the same method"(IMSS *pasante*)

The *pasante's* statement is short and to the point when compared to that of the private doctor. Reality is that she lacks the ability to perform extensive tests on her patients that private doctors may perform on theirs. Rather than use extensive histories and tests to find if a woman is contraindicated then, the IMSS providers follow more general guidelines based for example, on age, weight, parity as well as more specific signs of disease such as hypertension (those easily diagnosable with the equipment on hand).

It seems that sometimes, as a result of this, the IMSS Solidaridad personnel are more apt to "disqualify" someone from a method where a private doctor or even, the Ministry of Health would not. For example, a woman who is slightly overweight and has given birth at least once before may still be able to use hormonal methods if she were to go to a private doctor, whereas if this same woman were to go to an IMSS clinic, the clinic personnel may tell her that because of her weight, she should use the IUD rather than hormonal methods.

Offering a full range of methods

Everyone agreed that women should be explained all the methods. For example, when I asked a Ministry of Health nurse what method she would recommend for a woman who

wants to space her births, her response was: "Well I give freedom to the patient to decide which of the 3 methods she wants to use[xv]" (SSA Nurse).

As mentioned above, suggestions as to the best method for particular women, is where the main contrasts occur. Whereas, the Ministry of Health nurse for example says she would give them a choice, her first preference are the injectable hormonal methods and will recommend them unless a woman is contraindicated for them. This was different than, for example, on of her colleagues in another hospital who tended away from hormonal methods. Private doctors ranged from liking the pill best, even if for reasons other than contraception, to one who preferred the calendar method as he was a devout Catholic. IMSS personnel, who repeatedly attend training sessions during the year, on the other hand almost uniformly prefer the IUD and sterilization above other methods.

The difference is reflected in the approach they have when they counsel the woman on the method[xvi]. A private doctor, for example, may choose to begin with the pill and move forward eliminating the woman if she is found to be contraindicated for hormonal methods. IMSS personnel on the other hand, begin with the IUD and then move forward eliminating the IUD and moving to other methods only as alternatives.

The crude breakdown for IMSS is that if a woman has not had any children, then she can use the pill if she has no other contraindication for it. For all subsequent spacing, the IUD is recommended. Sterilization is recommended for stopping.

When asked if there was a method or methods which they were more inclined to promote, an IMSS Solidaridad nurse told me, "… long-term methods, that is, [one] that they will not stop using…."

Discontinuation, in fact, is a big concern when considering the methods prescribed:

> You can have 10 women and you have 10 on the IUD and from here to the next year, maybe you will have 9 or 8 still using it. In contrast, if you have 10 women with hormonal methods, oral or injectable, at the end of a year maybe you only have 3 (IMSS Solidaridad supervisor)

Although I was told that the method suggested depends on each patient, a preference for the IUD was clear. The IUD is best for a certain kind of patient since it is a long-term method, and alternative methods are just too troublesome.

> Depending on… depending on each patient. Those patients who normally already have…had a baby and who are not contraindicated for the IUD… that would be the method of first choice [for them]. Why? Because it's a long-term method and the patient doesn't have to be worrying about having to take something, or having to put on something, or having to interrupt [sexual] relations. (IMSS Solidaridad doctor)

One of the main selling points of long-term methods is that a person does not have to be worrying about it from day-to-day. This borders on the paternalistic. The following is an argument that a person with a sex life that is not very stable does not need to use the pill because of the fact that sex does not occur very frequently.

> Hormonal methods are also not recommended for women… who don't have sexual relations more than 1 or 2 times a week, because the pill is taken daily, whether you have or don't have relations, and the injection is once a month, whether you have or don't have relations. So also, these little women that have these sexual lives that are so spaced out. Why are they going to take the little pill on the daily basis? (IMSS Solidaridad *pasante*)

Yet another doctor indicated to me that the women in the villages are so busy in their daily lives that they simply forget to take the pill and that this is why the IUD is best for them.

This said, I was informed by all of the IMSS Solidaridad personnel that if I woman was, for whatever reason, told she could not use hormonal methods and the woman still demanded a hormonal method, they will provide her the method after explaining the risks involved.

According to the women with whom I spoke, however, this was not always the case. Though I did meet a handful of women at one location who said they had been informed of the risks involved in using hormonal methods and that they nevertheless preferred it, several women from 2 other locations mentioned being turned away at the IMSS clinics if they wanted injections. Some even said that the nurse had told them that if they used injections, they would go insane.

Whether or not this is true, and why these women were told this, I cannot be sure. Whether they were contraindicated for them or not, or whether they wanted to scare them into using the IUD I do not know. Whatever the reason, this type of response seems severe.

Reaching Targets

Most clinic personnel complained about the targets. I heard frequently from nurses and *pasantes* about not being able to meet these goals. Because of the changing demographics of the population, and the fact that the targets did not account for this change, they were impossible to meet. Seasonal migration, as well as permanent emigration, limited the pool of women that they could target.

The extent to which the nurses let not reaching their targets affect them varied. One nurse, although she favored the IUD just like the others, was mainly concerned with making sure that the woman be informed. She has a more relaxed style and was not too concerned about not meeting her targets. In this location, the predominant method in use was the calendar method.

In contrast, another nurse whom I accompanied to a sterilization clinic was a bit more concerned when she did not meet her monthly targets. The morning of the sterilization clinic, one of the two women they had recruited decided against it at the last minute. Both the nurse and the *pasante* were very upset about the fact that the woman had changed her mind. They were anticipating having a relaxed subsequent month since they would have been ahead of their quota by one woman. Now, it seemed, they would have to work to find a new recruit for the following month. Seeking recruits to make their monthly quota goes as far as having them search other villages for a woman, any woman, who might want the surgery since they have such a hard time finding new recruits.

Even though the nurse seemed visibly upset and annoyed in front of the *pasante* about the fact that the woman had dropped out at the last minute. I found out later that it was the nurse herself that had gone to the woman's house the day before to tell her that if she was unsure, she should not do it. The woman in question was only 20 years old and this concerned the nurse. This illustrates the subtleties that exist, especially with the nurses and their communities. The p*asante* who is only in the community for a year can risk her relationship with the community. The nurse, on the other hand, has to deal with the community for years. She had more of an interest in making sure that the women are served well. The stress for her it seemed, was balancing the demands of the targets with the service to the women in her community.

I inquired with a few of the superiors about the potential conflict between having numerical targets and providing a range of methods. Particularly, I asked them if they thought that having targets like these created personnel who would push these targets specifically. The responses varied from outright, "No", proof of which he said was the locations I was in to begin with, which used the pill and the calendar methods in greater frequency. I did not tell him how these villages were deviant cases compared to most villages that have an IMSS clinic in it. The second maintained that the IUD was the best method for the population whom they served and that those numbers were based on calculations that justified the IUD as the method of choice. "The IMSS promotes based on the documented medical literature" (IMSS Solidaridad doctor).

The last, said that perhaps it did and immediately followed with the fact that maternal mortality in his region had fallen substantially.

> Well, let me tell you, on one hand yes, it could be that it looks like that. But on the other hand um... we've seen that with regard to maternal morbidity that is has declined as well.... And rather than look poorly upon it I look at it positively... because if I have to promote to the sky, the sea, and the earth, that a woman use family planning and with that I would prevent that a child or a woman die, I would do it a thousand times... I would try to reach all of the targets there were if that meant that I would prevent [these deaths].... In [the zone I supervise] up to now, and knock on wood because I don't want it to happen, we haven't had one [of these] deaths. (IMSS Solidaridad doctor)

Conclusion

My interviews with the personnel discussed here are far from representative. Additionally, since some of the locations I went to were "deviant" cases as far as contraceptive use goes, it is even less representative of Mexico as a whole. I do believe however, that as concerns the IMSS Solidaridad personnel it seems the issue is not a lack of familiarization with the general content of the Normative Guidelines. Knowing something does not necessarily translate into practicing it. This is more so the case when it is taught to you at the same time you are told to meet numerical goals. A conflict is inherent in the two.

It seems however that what is most important here is the method by which women are selected out or in for a particular method type. With the IMSS Solidaridad personnel, long-term methods are preferred and the IUD is seen as the method of "first choice" for anyone who has had at least one child. This means, this method will be presented to the woman as the best choice for her even though all other methods will be mentioned.

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ENDNOTES

[i] Several countries, led by Algeria and Argentina, still argued that underdevelopment was a consequence and not a cause of underdevelopment. (UN 2003)

[ii] The changing distribution among the different method types could also be explained in theory, by alternative ideas. For example, it could mean that women themselves have popularized these two methods themselves.

[iii] See Norma Oficial Mexicana, NOM-005-SSA2-1993, De los Servicios de Planificación Familiar Section 5.4.2.3.

[iv] The language "... the right to decide the number and spacing of children in a free and responsible manner..." has existed since December of 1974 (CONAPO 1999).

[v] The Ministry of Health....

[vi] Although the Program of Actino of the 1994 ICPD does mention that. "[d]emographic goals, while legitimately the subject of of government development strategies, should not be imposed on family-planning providers in the form of targets or quotas for the recruitment of clients (1995), the Ministry of Health's Normative Guidelines however, do not explicitly mention numerical targets.

[vii] Once I had the locations chosen, my access to the communities was facilitated through the cooperation of the National Population Council (CONAPO), the Mexican Institute for Social Security (IMSS), and the Ministry of Health (SSA). The National Population Council (CONAPO) helped by introducing me to the other 2 organizations. As I arrived in each of the communities, I was introduced first to the clinic doctor and nurses who assisted me in finding a place to live in the community.

[viii] The original study is a comparative investigation of communities that deviated from the norm found in México (high IUD and high sterilization), however, I do not go into the details of these differences in this paper.

[ix] The terms "targets" and "goals" are used interchagebly. In the interview, I used the Spanish word "meta" which means "goal" but which is also the word that is used to talk about numerical targets. Because of this, its interpretation depended on who was being asked the question.

[x] The actual village locations I studied did not have a Minstry of Health clinic in it. The personnel from the Minsitry of Health that I discuss here are from the Centro de Salud hospitals in cities outside the villages, where many women told me they had gone to give birth to their children and to obtain contraceptive methods.

[xi] A *pasante* is a medical student who is doing his/her year of social service at one of the rural clinics.

[xii] How this actually manifests itself I do now know. I was not able to attend a training session and the bulk of the Normative Guidelines are the medical indications and contraindications of methods; the advice on counseling is brief.

[xiii] Regional training sessions where reproductive health issues are covered, occur every 2 to 3 months.

[xiv] Private doctor's clinics are better equipped. Ministry of Health hospitals, which offer free services, do not have the equipment private clinics have but, if complications were to arise during delivery, a woman at the Ministry of Health can be quickly referred to a private doctor.

[xv] The three methods she refers to are the three she considers to be for spacing purposes and that are available by them at the Ministry of Health Centro de Salud Hospital: the pill, the hormonal, and the IUD.

[xvi] Women generally do want to be given advice about which method the doctor or nurse thinks is better for them. Though some taboos and doubts exist about some methods, women nevertheless see the doctors and nurses has having more authority than they do on the subject.