‘Uno tiene que cuidar también de sí mismo’: Guatemalan Family Planning Decisions in the Context of Social Cognitive Theory and a Political Economy Approach

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
Dalla Lana School of Public Health
University of Toronto

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Abstract

Understanding the persistent inequalities in family planning rates between indigenous and non-indigenous women in Guatemala requires localized explorations of the specific barriers faced by indigenous women. This thesis presents, across three papers, a novel framework for simultaneously considering proximal, intermediate and distal factors affecting family planning.

Based on Social Cognitive Theory, elicitation interviews were carried out with 16 young women, aged 20 to 24, married or in union, from rural districts of Patzún, Chimaltenango in Guatemala. Content analysis was carried out using the constant-comparison method to identify the major themes raised by participants in terms of barriers to accessing and using family planning. Barriers not directly mentioned by participants were distinguished through the application of a political economy approach. The first paper presents this augmented elicitation interview methodology and the resulting family planning self-efficacy scale.
In the second paper, a political economy approach contextualizes structural issues that affect current family planning decisions, including: social exclusion and repression of indigenous people dating back to colonial times and exacerbated by the recent civil war; gender inequity; the influence of the Catholic Church at the state level, and on individual beliefs; and the evolution of population politics at the global and national levels.

The third, methodological, paper draws on this inter-cultural research to highlight recommendations for: early involvement of a local team in preparing research instruments, recruitment and conducting interviews; multilingual interviewing, transcription and team analysis; and inclusive reporting and dissemination.

The combination of theoretical approaches extends the application of either perspective in isolation: Social Cognitive Theory incorporates more structural influences on individual decisions about family planning and the political economy perspective links impacts and interactions at the individual level. This approach may be useful for a more complete understanding of health issues both within and outside the realm of reproductive health.
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Chapter 1 - Introduction

1.1 Problem Statement

Access to contraception is a fundamental human right, as confirmed at the International Conference on Population and Development (ICPD) in 1994, where 179 countries committed to improving reproductive health (Greene, Joshi, & Robles, 2012). The accompanying Plan of Action specified that people should have the “capability to reproduce and the freedom to decide if, when and how often to do so” (United Nations, 1994). There have been dramatic increases in the use of contraception overall, with birth rates declining by half in developing countries since 1960 (Gakidou & Vayena, 2007). However, considerable challenges remain in ensuring equitable access to family planning services, information and supplies, in order to allow people to exercise their preferences for fewer children (Cleland et al., 2006; Gakidou & Vayena, 2007; Greene et al., 2012). Approximately 222 million women worldwide lack this access to family planning services, leading to 76 million women in developing countries experiencing unintended pregnancies each year (Kols, 2008).

Unmet need for family planning is defined as “the proportion of currently married women [or women in union] who do not want any more children but are not using any form of family planning (unmet need for contraception for limiting) or currently married women who want to postpone their next birth for two years but are not using any form of family planning (unmet need for contraception for spacing)” (Mills, Bos, & Suzuki, 2010; Westoff, 2006). Currently, one in six married women has an unmet need for family planning, with significant ramifications for maternal health, as well as social and economic development in general (Kols, 2008).

Meeting the unmet need for family planning would help to reduce the mortality and morbidity from unwanted pregnancies, particularly from the 19 million unsafe abortions that women resort to each year to terminate these pregnancies (Kols, 2008). Overall, satisfying unmet need for family planning would prevent 29% of maternal deaths (Ahmed, Li, Liu, & Tsui, 2012). Assuring that people are able to act on their reproductive preferences also promotes social and economic development, as smaller families are better able to feed, provide health care and schooling for each child, ultimately contributing to a more productive workforce (S. Singh, Darroch, Vlassof, & Nadeau, 2003). Increasing access to family planning is a cost-effective
intervention that would reduce maternal and newborn health related costs by US$11.3 billion annually (Greene et al., 2012; Prata, Sreenivas, Vahidnia, & Potts, 2009).

Increasing recognition of the pivotal role of reducing unmet need for family planning, both for reducing maternal mortality and for improving development prospects in general, led to the addition, in 2006, of unmet need for family planning to the Millennium Development Goal (MDG) Five to improve maternal health. Canada signed on to the MDGs in 2000, along with 188 other countries, as a commitment to ambitious objectives for development and poverty alleviation (Travis et al., 2004). Thus, research which furthers an understanding of unmet need for family planning is relevant for furthering Canadian commitments to international development.

From an equity perspective, furthering understanding of unmet need for family planning is also of paramount importance. Gakidou & Vayena (2007) show that, despite the trend in increased use of contraception overall, the poor are falling farther behind in their access to family planning. They found that Latin America was the region with the greatest inequalities in use of contraception, as compared to sub-Saharan Africa and South and South-East Asia. Countries in Latin America were divided by Westoff (2006) into two sub-groups: those with high contraceptive prevalence and low levels of unmet need, such as in Brazil, Colombia, the Dominican Republic and Peru; and those with high levels of unmet need, such as in Bolivia, Haiti and Guatemala. Guatemala also stands out from a demographic perspective as being the “only country showing a potential stall in fertility decline after fertility transition had apparently already begun” (Bongaarts, 2008). The situation in Guatemala is compounded from an equity perspective because inequality in unmet need for family planning, along with other maternal health indicators, is so stark along rural/urban, indigenous/non-indigenous lines (Guttmacher Institute, 2006). For example, there are 153 maternal deaths per 100,000 live births and this rate is three times worse for indigenous versus non-indigenous women (211 versus 70) (ibid.). The total fertility rate for indigenous women is 4.5, compared to 3.1 for Ladina women (Ministerio de Salud Publica y Asistencia Social, 2009). Contraceptive use by indigenous women in Guatemala is significantly lower than that of their Ladina counterparts: 28% compared to 54% (ibid.). This difference persists even for indigenous women who have immigrated to the city or who co-reside with Ladinos in rural towns, although contraceptive knowledge is positively associated with number of years lived in an urban setting, and immigrants from rural areas eventually have
modern contraceptive adoption rates only slightly below their urban non-migrant counterparts (De Broe, Hinde, Matthews, & Padmadas, 2005; Lindstrom & Hernández, 2006). Latin America is a region characterized by inequality, and social and economic inequality in Guatemala is among the highest in the Americas, with the highest income quintile of the population holding 58 percent of total income, compared to the bottom quintile, which holds only three percent (Haub & Gribble, 2011). Limited information is available on abortions in Guatemala, which are illegal except to save a pregnant woman’s life, however “27,000 women are hospitalized each year for treatment of post-abortion complications” (Guttmacher Institute, 2006).

The first step in addressing unmet need for family planning is “to determine whether and why unmet need is high,” particularly when unmet need persists among marginalized groups, such as indigenous peoples (Kols, 2008). Indeed, Gakidou and Vayena (2007), who carried out a macro-level analysis showing the poor’s decreasing relative access to contraceptives, concede that “much could be learned by a more in-depth study of individual level determinants.” Casterline and Sinding (2000) similarly argue that local social science research “is a prerequisite for developing effective programs to reduce [unmet need for family planning].” Shiffman & Valle (2006) examine structural context and history to explain disparities in safe motherhood between Guatemala and Honduras, and concluded that exploring whether the same factors might influence other reproductive health outcomes would be “an interesting issue for future research.”

This thesis aims to further understand social, cultural, economic and political as well as other types of individual barriers, to family planning for young, indigenous women from rural Guatemala. In order to be consistent with the definition of unmet need for family planning, this research focuses on the experience of women who are married or in union. While unmet need for contraception certainly exists among unmarried women, the recommendation of my research partner organization in Guatemala, Abriendo Oportunidades, was that respondents would be much more likely to discuss their reproductive health decisions if they were married or in union. Because I am interested in a life-course approach, I focus on this issue in young women aged 20 to 24, who are still relatively early in their reproductive lives. It is also important to specify that my research is about unmet need for family planning, which by definition is among women who want to delay pregnancy. Determinants of the demand for contraception, or the desire to delay pregnancy, are separate issues, although the factors influencing low demand and unmet need for family planning may overlap. This research was conducted in collaboration with a local research
team, and using community based participatory research (CBPR) principles, to ensure the priorities and practices of the Mayan people influence the research, methods, interpretation and translation of study findings (Horowitz, Robinson, & Seifer, 2009; Wallerstein & Duran, 2010).

From a health behavior perspective, unmet need for family planning can be understood as the gap between women’s reproductive intentions and their contraceptive behavior (Loaiza & Biddlecom, 2012). This concept thus lends itself to exploration under the lens of health behavior theory, which strives to understand the constructs that determine behaviour and explain discrepancies between intentions and behaviour.

Social Cognitive Theory, from the family of health behaviour theories\(^1\), recognizes the triadic influence between behavourial, cognitive and environmental influences,” which is appropriate in Guatemala where environmental and structural issues are so salient (Bandura, 1978a; Glanz & Rimer, 2005). The political economy approach complements self-efficacy theory because it helps to contextualize the historical and political factors underlying the more proximal explanations for unmet need for family planning. While political, economic, social and structural issues have been used to examine family planning in Guatemala (Santiso-Galvez & Bertrand, 2004), these have not been employed in conjunction with psychosocial models.

1.2 Research Questions

- What are the experiences of young indigenous women in rural Guatemala who want to delay pregnancy in terms of accessing and using family planning?

- What do Social Cognitive Theory and a political economy perspective contribute to interpreting these experiences?

1.2.1 Research Sub-Questions

- What specific barriers contribute to unmet need for family planning in this context?

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\(^1\) The Theory of Planned Behaviour (TPB) and the Theory of Reasoned Action (TRA) are two other frameworks that also investigate the link between intentions and behaviour, but they “assume all factors (e.g. culture, the environment) operate through the model’s constructs.” In contrast, SCT is premised on reciprocal determinism, whereby “psychological functioning involves a continuous reciprocal interaction between behavioral, cognitive and environmental influences” (Bandura, 1978a; Glanz & Rimer, 2005).
• How does a political economy perspective help to understand the relationships between these barriers to family planning as well as their historical and political roots?

1.3 Significance of Research

This research is significant in several ways. First, it offers a localized exploration of the specific barriers to accessing contraception in indigenous women from rural Guatemala. It is the first comprehensive contraceptive self-efficacy scale consistent with Bandura’s Social Cognitive Theory, augmented by a political economy approach, and developed specifically with young adult indigenous women in rural Guatemala as opposed to non-indigenous adolescents in North America (Bilodeau, Forget, & Tétreault, 1994; Levinson, 1995a; Levinson, 1986). This is also the first time a self-efficacy scale appears to have been developed in relation to contraception anywhere in Latin America.

Bringing a political economy perspective to research on contraceptive self-efficacy does not appear to have been done before and this approach helps to differentiate the aspects and origins of unmet need for family planning that are more individual, social and societal in nature. The synergy of this approach allows the connecting of women’s individual responses about barriers they face in using family planning with the structural forces that frame their experiences. By taking a longer historical view, barriers that are not specifically mentioned by women in elicitation interviews are still considered, past struggles are honoured, and an overly biomedical and simplistic view of family planning choices is avoided. Casting a wider political, economic, historical, social and cultural net facilitates an understanding of current family planning choices and helps to explain the persistent gap in family planning prevalence rates between indigenous and Ladina women in Guatemala.

Methodological reflections about this inter-cultural research discuss the alternative consequences of different research designs and implementation strategies. Decision points and rationales are analyzed using concrete examples from this global health research study conducted by an international team within the constraints of relatively limited financial resources. Practical and ethical implications are highlighted for those conducting, funding and reviewing inter-cultural research, in order to ensure that research is not reduced to being merely the latest extractive industry. These findings were generated through global health research with young indigenous
women in Guatemala about family planning, but the reflections are relevant across disciplines, to anyone participating in health research in a culture other than one’s own.

A novel framework is thus presented for simultaneously considering proximal, intermediate and distal factors affecting family planning. Understanding the nature of these individual and social barriers highlights ways to focalize policy and programming to better ensure contraceptive access by this marginalized group, with implications both in Guatemala and for reducing unmet need for contraception in similarly marginalized groups worldwide.

This research creates a situation specific set of self-efficacy measures relevant to this context and health issue, thus extending the use and application of Social Cognitive Theory. The combination of health behavior theory with a political economy perspective represents a novel methodological approach that could be useful for a more complete and pragmatic understanding of health issues both within and outside the realm of reproductive health.

1.4 Organization of Thesis

This manuscript-based thesis is put into context with a literature review in Chapter 2, which highlights major findings and gaps in both quantitative and qualitative extant literature. Chapter 3 introduces the theoretical perspectives that guide the research, and presents the theoretical framework. Chapter 4 discusses methods and the research setting. Chapters 5 through 7 are the individual manuscripts: “Barriers to accessing and using contraception in Highland Guatemala: A family planning self-efficacy scale,” “‘Uno tiene que cuidar también de sí mismo’: Putting Guatemalan family planning decisions in context using Social Cognitive Theory and a political economy approach” and “‘Taking Care’ in inter-cultural research: lessons from a Guatemalan family planning study.” All research reported on in the three papers was led by Emma Richardson with the support of her committee as part of her doctoral programme in Social and Behavioural Health Sciences. An extended version of the second paper, “‘Uno tiene que cuidar también de sí mismo’: Putting Guatemalan family planning decisions in context using Social Cognitive Theory and a political economy approach” is included in Appendix 1. This version of the manuscript provides the complete analysis that informed the shorter version for publication, which had to be reduced in length to meet restrictions of the peer-reviewed journal. In Chapter 8, research findings are summarized, additional links between the individual manuscripts are
made, policy implications are reviewed, strengths and limitations are discussed, and potential areas for future research are indicated.
Chapter 2 - Literature Review

2.1 Critical Review of Related Research

The concept of unmet need for family planning emerged during the 1960s and has become “an important organizing concept in international population” (Casterline & Sinding, 2000). With rising amounts of research to confirm and understand unmet need for family planning, this concept has also come under significant scrutiny (for a full history of this evolution, please see Casterline & Sinding, 2000). The entire body of knowledge about unmet need for family planning is too large to review in full here, so I focused on three areas that are most salient to this research, and reviewed both primary research and secondary critiques of this literature. First, I reviewed recent international qualitative research about unmet need for family planning in married women from rural areas in developing countries. The themes identified in this literature were considered for inclusion as topics and probes in the elicitation interviews. I then reviewed quantitative literature about unmet need for family planning that incorporates self-efficacy theory. Finally, I briefly reviewed research about family planning in general from Guatemala, in order to provide geographical and cultural context. Across these three areas of research, I identified significant findings as well as methodological and substantive gaps, which are reviewed in section 2.5 at the end of this chapter.

2.2 Qualitative Research about Unmet Need for Family Planning

Critics have charged that this concept of unmet need for family planning may not correspond “with the expressed experiences of individuals,” since it is calculated indirectly by data analysts who refer to different components of Demographic and Health surveys (Casterline & Sinding, 2000). Qualitative research has been essential for showing empirically that unmet need for family planning is more than a mathematical sleight of hand, and in fact represents a real frustration on the part of individuals to regulate their fertility (ibid).

2.2.1 Method of Qualitative Literature Review

My initial search strategy involved searching PubMed, Scopus and Google Scholar databases using combinations of the following search terms: “qualitative,” and “unmet need for contraception” or “unmet need for family planning” or “barriers to contraception” or “barriers to
birth control.” I sorted through the results of these searches, selecting for further consideration empirical studies of unmet need for family planning using qualitative methodologies (for at least part of the study), with participants including those aged 20 to 24, in rural settings of developing countries. I also hand searched the references of chosen articles. This process led to identifying 16 articles for inclusion, including one systematic review, but a paucity of studies about unmet need for family planning from Latin America. Adding “Latin America” as a search term to the original searches above produced no additional results, so I also searched Scielo, a database with articles in Spanish and Portuguese. This led to the identification of three further articles from Brazil, Colombia and Mexico, although I had to relax the criteria of being from rural contexts in order to include these studies. Hand-searching grey literature about contraception in Guatemala also led to identifying three more relevant studies which included qualitative research from Guatemala and Latin America.

The resulting 22 papers were reviewed to extract all possible themes that could represent barriers to contraception in rural, developing country contexts. The aim of this review was to identify all possible themes, so even if a factor was mentioned in only one study it was considered.

2.2.2 Results of Qualitative Literature Review

The twenty-two reviewed studies were about unmet need for family planning in rural settings in Iran, Pakistan, India (Gujarat and Patiala), Nepal, Cambodia (two studies), Philippines, Albania, Nigeria, Rwanda, Ghana, Ethiopia, Bolivia, Ecuador and Guatemala (3 studies; Adeyemi, Ijadunola, Orji, Kuti, & Alabi, 2005; Aryeetey, Kotoh, & Hindin, 2011; Asturias de Barrios, Mejia de Rodas, Nieves, Matute, & Yinger, 1997; G. W. Bogale, Boer, & Seydel, 2011; Bremner, Bilsborrow, Feldacker, & Holt, 2009; Casterline, Perez, & Biddlecom, 1997; Dieudonne, Broekhuis, & Hooimeijer, 2009; Kragelund Nielsen, Nielsen, Butler, & Lazarus, 2012; McNamee, 2009; Metz, 2001; Peyman & Oakley, 2011; Samandari, Speizer, & O’Connell, 2010; Samandari & O’Connell, 2011b; Shelton et al., 1999; N. Singh, Kaur, & Singh, 2009; Stash, 1999; Visaria, 1997; Ward, Bertrand, & Puac, 1992). Three studies from urban settings in Colombia, Brazil and Mexico helped to add themes from Latin America, which may be pertinent in Guatemala also (Agudelo, 2009; Gomez-Sanchez & Pardo, 2010; Marques Ferreira, Maria de Lourdes, da Silva, Goncalves, & Temer Jamas, 2010). The qualitative methodologies employed include individual and focus group interviews as well as participant observation. Some studies
were investigations into the general reasons for unmet need for contraception, while others tested hypotheses about particular barriers, often using mixed-methods approaches. What follows is a brief summary of the barriers to contraception that were identified in the reviewed studies. In some cases original quotes from participants in individual studies are included to provide greater detail about particular themes.

Lack of knowledge about contraceptive options is often assumed to contribute significantly to unmet need for family planning; however, most women are able to identify at least one method of modern contraception. There are several types of knowledge gaps that can contribute to unmet need for family planning, including the incorrect perception that one is not at risk of becoming pregnant because one is post-partum, generally prefers abstinence, or one’s husband is absent for long periods due to migration. Access to contraception can often be limited, whether contraception is entirely unavailable in one’s community, only very few methods are available, or access is inhibited due to the way methods are obtained. Stash (1999) documents how in Nepal, sterilization was historically the only contraceptive method available, causing women to conflate contraception with sterilization, even though other temporary methods had become available more recently. In this same context, interactions with family planning clinic staff were described as stressful and discriminatory: “Doctors, even when they are talking to women about women’s problems, really yell at us. Some doctors only treat people who understand things well” (Stash, 1999). A Mexican study highlighted how some women do not approach service providers because they lack the identification documents necessary for accessing services (Agudelo, 2009). This type of barrier may also be important in Guatemala where many rural, indigenous women lack identity documents (González et al., 2009).

Fear of side effects accounts for a considerable portion of unmet need for family planning, particularly when amplified in the social context of poverty. Women fear side effects such as headaches, irregular menstrual bleeding and cycles, weakness, weight loss or gain and even death\(^2\). Furthermore, there are fears that using temporary contraception can result in infertility. By comparing responses between users and non-users of contraception in the Philippines, 

\(^2\)The study of Casterline et al. (1997) from the Philippines documented one woman’s fear of death related to the use of contraceptives: “I also heard [that] someone who was ligated had an ectopic pregnancy. The woman had 50-50 percent chance of surviving because she lost so much blood.”
Casterline et al. (1997) show that women who use contraception are just as likely to fear side effects as women who do not, but these “may well serve as decisive obstacles for some subgroups of women who, for whatever reasons, are more sensitive to these views.” Authors have explored how these fears of side effects can be exacerbated in the context of poverty, where there is a higher premium on staying healthy in order to protect one’s livelihood. For example, in Cambodia one non-user of contraception summarizes: “I’m not sick and if I get injection and lose weight I’ll have to look after myself and lose time [from working]. It’s even more difficult and my family situation is even worse” (Samandari & O’Connell, 2011a). In Nepal, Stash (1999) found that these considerations led to seasonal variation in the adoption of family planning methods, with more sterilizations and first use of temporary methods clustered around the coldest months of the year when agricultural work is less intense.

Costs associated with family planning, both direct and indirect financial ones, as well as social costs, contribute to the balance of unmet need for family planning. In Bogotá, Colombia, focus groups found that women’s contraceptive choices depend on affordability and ease of purchase, although there was a parallel, seemingly contradictory, perspective expressed by some women that “lo barrato sale caro,” similar to the idiom, ‘you get what you pay for’ in English (Gomez-Sanchez & Pardo, 2010). As discussed above, the potential opportunity costs of illness and time away from work can also be definitive for women, particularly in very poor settings. In both Patiala, India and Nepal, some women expressed that the long travel and wait times in public clinics, and the potential side effects of temporary contraceptives influenced them to avoid these altogether in favor of eventually opting for sterilization (N. Singh et al., 2009; Stash, 1999). This leads to large proportions of unmet need for spacing (as opposed to limiting). Due to the expansion of publicly funded family planning programs, contraceptives are often available free through public clinics, and can be subsidized in pharmacies. Women may nevertheless experience that obtaining contraceptives is too socially costly if their confidentiality is compromised while obtaining contraceptives in communities where they are ill-regarded.

Certainly the opinions of one’s friends and relatives directly influence, and can be sufficient to override, women’s own opinions of contraception. In a Guatemalan study based on focus groups in Maya-Quiché communities, it was found that “community leaders, religious leaders and husbands exert considerable influence on family planning decisions and usually oppose the use of contraceptives” (Ward et al., 1992). Wider social norms around women’s reproductive
capacity can also be key, as many women feel a pressure to prove their fertility while early in their marriages, particularly from their husbands and in-laws (Williamson, Parkes, Wight, Petticrew, & Hart, 2009). Furthermore, in Guatemala men have expressed dissent about their wives’ using contraception based on a belief that women use contraception to hide their infidelity (Metz, 2001; Ward et al., 1992). In Guatemala, women sometimes opt to use family planning without telling their husbands (Ward et al., 1992). Using case studies, Stash (1999) shows how in rural Nepal three communities had different patterns of acceptance of contraceptives that could be traced directly to the spread of opinion and experience through social networks. In Guatemala, Lindstrom et al. (2005) used network analysis to show that “social ties to urban or international migrants are associated with a greater likelihood of modern contraceptive use among married women.”

Religion often plays a pivotal role in influencing the cultural and social acceptability (or non-acceptability) of contraceptives. This was underlined in the Brazilian study, and appears to be potentially salient in Guatemala, where many women report their ideal family size is “God’s will” (Asturias de Barrios et al., 1997; Da Silva, Gonçalvez, & Temer, 2010; Metz, 2001). Ward (1992) found that in Guatemala “distrust of family planning on religious grounds” was voiced by both Evangelical Protestants and Catholics.

The nature of a woman’s relationship with her husband, his opinions of contraception, and her feelings about gender equity can all be decisive for contributing to unmet need for family planning. These issues emerge as salient in several of the reviewed qualitative studies, and the influence of married women’s decision making power on modern contraceptive use was the specific subject of study in the paper from Ethiopia (B. Bogale, Wondafrash, Tilahun, & Girma, 2011). In this mixed-methods study, women from rural and urban Ethiopian were found to have greater power over contraceptive decisions if their knowledge of modern contraceptives was greater, their attitudes about gender more equitable, and their involvement more significant in decisions about child and economic affairs (ibid.). Across studies, and particularly in cultures characterized by greater gender inequity, the opinion of the husband takes precedence over that of his wife. In the Philippines, for example, one woman commented, “Personally, I want to have two. I wanted to be ligated, but he said “not yet.” And since he is my husband, his decision prevails… Tell him what you like, but in the end, of course, his decision dominates” (Casterline et al., 1997). Married Maya-Quiché women in focus groups expressed, “We can’t make a
decision on that [family planning] because the custom here is that the man decides (Ward et al., 1992). In Honduras, a quantitative study found “women who had ever used or were currently using modern methods were significantly less likely to hold attitudes supporting male-centered decision-making than those who relied on traditional methods and those who had never used a modern method” (Speizer, Whittle, & Carter, 2005).

Interestingly, the impact of gender inequity was interpreted differently in the Brazilian study, where the responsibility for contraception was viewed as unfairly placed on the woman in the relationship, as the man would never consider limiting his capacity for reproduction (Da Silva et al., 2010). For example, one Brazilian woman comments that “[her] husband says [she] is the one who has to take care of herself” (ibid.). In many study settings, issues of sexual and reproductive health are so taboo that partners avoid discussing them altogether. This can lead to misperceptions of partner’s attitudes, such as where the woman mistakenly assumes her husband is anti-contraception. Gender inequity can also lead to unmet need for family planning in environments where male children are heavily favoured over females. In Nepal, for example, women described having many more children than they had wanted in order to give birth to one or more sons (Stash, 1999).

Only two of the qualitative studies explicitly use the concept of self-efficacy, those from Iran and Cambodia. In the Iranian study the concept of self-efficacy is described consistently with Bandura’s definition, but is operationalized in a very general sense, interpreting contraceptive self-efficacy as “a sense of having the ability and resources to use [oral contraceptives],” without reference to specific barriers (Peyman & Oakley, 2011). The Cambodian study operationalized the concept of self-efficacy in a way that was more consistent with Bandura’s definition, referring to women’s confidence “in their ability to dismiss rumors of contraceptives and find a method that was “appropriate” for them (Samandari & O’Connell, 2011b).

2.3 Literature Review of Quantitative Research

This section highlights the findings from quantitative research incorporating self-efficacy theory and relating to unmet need for contraception.
2.3.1 Method of Quantitative Literature Review

This literature was identified by searching in PubMed, Scopus, PsycINFO and Google Scholar search engines for combinations of the search terms: self-efficacy, contraception, family planning and birth control. Because my interest is in how these issues have been studied in women aged 20 to 24, and much of the literature from the initial search was about adolescents, I added search terms so studies that focused exclusively on teenagers were excluded. I decided to use this approach since the issues that adolescents face in deciding to use contraception are distinct from those of young married women between the ages of 20 and 24\(^3\). Restrictions were not made based on the year of publication. The papers identified through these searches were imported into RefWorks (reference management software) and duplicates were eliminated. This process resulted in 199 unique references for further consideration. The titles and abstracts were considered based on the inclusion criteria of being papers about use of contraception that in some way employ the concept of self-efficacy, in whole or in part, and that are published in English language peer-reviewed journals\(^4\). In order to be included, the research had to include as part of its sample women between the ages of 20 and 24 who are married (although the sample could include other women as well). The context could be developed or developing country, urban or rural, but articles about specific populations such as sex-workers were excluded. Studies focusing on self-efficacy for condom use in HIV prevention were excluded because they deal with issues that are distinct from those related to family planning. Ultimately nine articles met the inclusion criteria, the results of which are summarized and critiqued below.

\(^3\) One general reason these decisions by adolescents may be qualitatively different is because they may be more likely to use contraception for primary purposes other than prevention of pregnancy, such as using condoms to prevent sexually transmitted infections. In Guatemala the high rates of adolescent pregnancy indicate that negotiating contraceptive use for unmarried women may be difficult. The number of births to adolescent mothers in Guatemala has risen to be the highest in the Latin American region, with one out of five Guatemalan mothers being aged between 10 and 19 (PLAN, 2011; Valladares, 2012). Another complicating factor is that health service providers in Guatemala often discriminate against unmarried adolescents and young women, refusing to provide them with contraceptives (Center for Reproductive Rights, 2003).

\(^4\) The qualitative literature review searched for articles in Spanish, but the quantitative literature review originally focused on only English-language publications. An update to the quantitative literature review was carried out in April, 2014 by searching the Scielo database for Spanish articles. However, no Spanish-language articles were found that met the search criteria (“auto-eficacia” y “planificación familiar” o “anti-conceptivo”).
2.3.2 Results of Quantitative Literature Review

Quantitative research about self-efficacy and contraception use for adult women includes three intervention studies from Taiwan, Tanzania and the United States, and six analytical studies from Pakistan, Hong Kong, Vietnam, Iran (two papers about the same study) and the United States (Agha, 2010; Bui et al., 2012; Chung-Park, 2008a; Ip, Sin, & Chan, 2009; Lee, Tsai, Tsou, & Chen, 2011; Peyman & Oakley, 2009a; Peyman & Oakley, 2009b; Peyman & Oakley, 2011; Rogers et al., 1999; Williams et al., 1997a). Self-efficacy is defined in relation to different theories including Social Cognitive Theory and the Transtheoretical Theory of Change, and with differing degrees of precision and consistency, precluding the possibility of aggregating results. One paper from Iran compares the utility of the Theory of Planned Behaviour and that of self-efficacy theory as defined by Bandura, finding that variables capturing constructs from the latter were more powerful in predicting contraceptive behavior, as detailed below (Peyman & Oakley, 2009b).

Taken together, the six analytical papers find the construct of self-efficacy to be helpful for explaining and predicting contraceptive behavior. Women attending a maternity clinic in the United States who had unintended pregnancies were found to have lower sexual self-efficacy their counterparts with intended pregnancies (Group mean of 15.1 compared to 16.9; p<0.01; Williams et al., 1997b). In Pakistan, women’s “self-efficacy for discussing family planning” with their husbands was found to correlate significantly with intention to use a family planning method (Odds ratio from a logistic regression for “I am not able to discuss family planning with spouse or convince spouse to use family planning” of 0.81 (0.67-0.98); p<0.01; Agha, 2010). Similarly, in Vietnam, women’s “sexual communication self-efficacy” was significantly associated with actual contraceptive use in a logistic regression (e^β=1.13; p=0.039; Bui et al., 2012). In Hong Kong, a descriptive study found that contraceptive self-efficacy was not related to contraceptive knowledge, but that it increased for women who were married and who were older^5 (Ip et al., 2009). In Iran, family planning self-efficacy was found to predict intention to

^5 This paper reported very little detail (and no table) about quantitative results, stating that no significant relationship was found between contraceptive self-efficacy and knowledge (p>0.05). Regarding age and marital status, Ip et al. (2009) state, “In regard of the relationships between C-CSE and socio-demographic variables, the only significant findings were noted on age (r=0.25, p<0.05) and marital status. The participants who were single...
use contraception and contraceptive behavior (using multiple regression analysis, family planning self-efficacy had significant and the highest correlation coefficients compared to all other independent variables for intention to use contraceptives (0.70; p<0.01) and for practice of using contraceptives (0.37; p<0.01; Peyman et al., 2009; Peyman & Oakley, 2011).

One of the advantages of self-efficacy as a construct is that it is amenable to change through intervention in the short term (Bandura, 1977). Two of the three intervention studies found that contraceptive self-efficacy increased in women exposed to an intervention as compared to control groups, as detailed below. In Taiwan, a program for post-partum women based on the Transtheoretical Theory of Change was found to increase contraceptive self-efficacy (CSE), compared to control groups (mean CSE of 633 compared to 558; p<0.01 in least significant difference test; Lee et al., 2011). In the United States, an educational intervention designed for young women in the army, also based on the Transtheoretical Theory of Change, was found ineffective in increasing contraceptive self-efficacy, although the intervention was based on just two class sessions spaced over two months (mean CSE of 2.49 for experimental group compared to 2.39 for control group; p<0.074; Chung-Park, 2008b). In Tanzania, a radio soap opera with storylines based on messaging about family planning was found to increase self-efficacy for family planning (In a multi-variate model, belief that determining family size is possible, “a measure of self-efficacy,” was significantly and positively influenced by being in the treatment compared to the comparison area: β=0.38; p<0.01; Rogers et al., 1999). Being in the treatment area was also significantly and positively associated with use of contraception (β=0.52; p<0.01; Rogers et al., 1999).

The reviewed quantitative studies varied widely in terms of the detail they provided about the way self-efficacy was defined and measured. The studies from Tanzania and Pakistan defined self-efficacy in a very general sense and provided little detail about the scales or questions used to assess this construct (Agha, 2010; Rogers et al., 1999). The intervention studies from the United States and Taiwan both used scales that were described in other papers, but upon follow-
up only the referenced paper in the United States’ study provided the questions in the scale and no detail about how these were developed (Chung-Park, 2008a; Galavotti et al., 1995; Lee & Yen, 2007; Lee et al., 2011). The study from Vietnam effectively adapts questions from the “instrument bank established by the Centre for HIV Identification, Prevention and Treatment Services of the University of California at Los Angeles” and includes the list of five questions used to measure sexual communication self-efficacy (Bui et al., 2012). The study with adult women from Hong Kong translated a contraceptive self-efficacy scale developed by Levinson (1986), but curiously made no adaptations despite this scale having been developed for use with adolescent populations in the United States (Ip et al., 2009). The analytical study from the United States provides the list of questions used to derive its sexual self-efficacy scale, but the questions ask for yes or no responses, and thus do not employ the Likert-type methodology called for in self-efficacy scales (Bandura, 2006; Williams et al., 1997b). The Iranian study is the only one to describe self-efficacy scales derived from initial context-specific research. Focus groups were conducted to ground the content of their self-efficacy for family planning scale. Unfortunately the resulting questions were largely vague in terms of specific barriers, for example: “If I try enough I can meet my well-planned family health needs” and “If I try enough I can meet my well-planned family health information” (Peyman et al., 2009).

Although not included directly in this literature review, it is worth emphasizing Levinson’s work in creating and validating a contraceptive self-efficacy scale for use with adolescents (1986 & 1998). Studies using this scale have proven the utility of the self-efficacy construct in predicting contraceptive behaviour and highlighting areas that can be impacted through intervention⁶

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⁶ A literature review completed for my qualifying exam about self-efficacy and adolescent pregnancy summarized findings from 14 observational and four intervention studies. Two observational studies measured and found a significant relationship between self-efficacy and a sexual health outcome (as opposed to behaviour): contraceptive self-efficacy was found to be negatively associated with adolescent pregnancy (R. H. Wang, Wang, & Hsu, 2003) and lower “personal efficacy” was associated with a greater likelihood of adolescent pregnancy (Young, Martin, Young, & Ting, 2001). Nine studies found relationships between types of self-efficacy and related behaviours. For example, four studies found contraceptive self-efficacy to be associated with greater contraceptive use (Chewning et al., 2001; Ryan, Franzetta, & Manlove, 2007; R.; Wang, Wang, Cheng, Hsu, & Lin, 2007; R. P. Wang, 2008). Self-efficacy for sexual negotiation and higher sexual stigma were found to be positively associated with abstaining from sex (Kaljee et al., 2007; Pearson, 2006). Four studies confirmed hypotheses about various influences on different types of self-efficacy, such as that of: sexual stigma on contraceptive self-efficacy, communication with parents on self-efficacy for sexual communication and religiosity scores on self-efficacy for refusing unsafe sexual encounters (DiClemente et al., 2001; Kaljee et al., 2007; McCree, Wingood, DiClemente, Davies, & Harrington, 2003). Taken together, these observational studies support the idea that various self-efficacies are related to the behaviours of abstaining from sex, refusing unprotected sex and using contraceptives, and even with the sexual health outcome of
(Fisher, 2011; Bilodeau et al., 1994; Levinson, Wan, & Beamer, 1998a; Levinson, 1986). A robust contraceptive efficacy scale has not yet been developed for use with young women, such as those between ages of 20 and 24 in my study. The quantitative literature review in fact revealed the common fallacy of self-efficacy research where there is an attempt to “do too much with too little,” particularly by using scales that are too general or incorporate very few questions (Maibach & Murphy, 1995a).

2.4 Review of Further Research from Guatemala

In order to understand unmet need for family planning in Guatemala, it is important to review major research that has been carried out about family planning in general in this country. Early studies of family planning in Guatemala showed persistent gaps between Ladinas and indigenous women in terms of contraceptive knowledge and behavior, particularly in rural areas (Bertrand, Pineda, & Santiso, 1979). These trends have been monitored over time, showing increasing gaps along ethnic lines. The hypothesis that this gap was due to differential access (i.e. distance to health facilities providing contraceptive services) between indigenous and Ladino populations was originally supported when access to services was found to be a significant correlate with contraceptive use for the Mayan population, once socio-demographic variables were controlled for (Bertrand et al., 2001a). However, this hypothesis was later refuted when a study linking household to facility-level data showed that physical distance to family

lower adolescent pregnancy. Furthermore, many of the characteristics found to be associated with higher and lower self-efficacies are amenable to change through interventions, such as communication with parents about sex. Two interventions were found to increase self-efficacy for condom use: a school-based “Safer Choices” program based on Social Cognitive Theory (Coyle et al., 1999) and a low-technology computer based, interactive sex education programme (Rijsdijk, Bos, Ruiter, Leerlooijer, & De Haas, 2011). One intervention study about a peer-education model to promote safer sex and contraception use found contraceptive self-efficacy was higher for intervention than comparison youth (p=0.001), but only for the intervention arm reaching in-school adolescents (Brieger, Delano, Lane, Oladepe, & Oyediran, 2001). Of five randomized control trials of social marketing campaigns reviewed by Wakhisi et al. (2011), one reported increased self-efficacy for refusing unsafe sex as a significant effect in female participants.

Relative differential contraception use rates between indigenous and non-indigenous women have been dropping over time, but the absolute difference has maintained between 1978 and 2009 (Bertrand, Seiber, & Escudero, 2001a; Ministerio de Salud Publica y Asistencia Social, 2010). Research has been conducted to understand the reasons behind the gap in contraception use rates between indigenous and non-indigenous women in Guatemala, as summarized here, but not specifically to understand the reasons behind the trends in how this gap is changing.
planning providers was not significantly different between Ladinos and Mayans (E. Seiber & Bertrand, 2002). An alternative hypothesis emerged that the quality of services may be driving differentials, with Mayans being offered discriminatory services in inferior facilities by health professionals who mostly do not speak their native language (E. Seiber & Bertrand, 2002; USAID, 2008). The most recent study of ethnic inequality in Guatemala lends support to this hypothesis, finding that “not speaking Spanish accounts for the largest portion of ethnic differentials” in met need for modern contraceptives, calculated to be 49% in indigenous compared to 72% of Ladina women (Ishida, Stupp, Turcios-Ruiz, William, & Espinoza, 2012).

Based on analysis of the nationally representative Survey of Maternal and Infant Health from 2008-2009, this study used predicted probabilities to show that the language barrier was more important than poor education and rural residence in explaining ethnic differentials in contraceptive use (ibid.). There was nevertheless a residual difference in modern contraceptive use between Mayan and Ladina women which could not be explained by any of the quantitative factors included, and probably relates to social and cultural influences which are not possible to capture in quantitative proxy measures.

Several studies have attempted to further understand these socio-cultural factors that influence the low demand of Guatemalan women for contraceptives. Many of the key themes were summarized in the qualitative literature review above and will not be repeated here. One further finding that could help explain Mayan women’s lower demand for contraception was that many Mayans perceive family planning as a “Ladino plot to do away with the Mayan population” or a “U.S. plot to diminish the strength of Guatemala” (Metz, 2001; Ward et al., 1992). A mixed methods study of a peri-urban community found that unmet need for contraception was associated with a “paradigm of silence” that discourages discussion between spouses about reproductive decisions and “favors large families, which are considered the will of God” (Asturias de Barrios et al., 1997). The only paper about contraception in Guatemala to exclusively examine political and historical factors was that of Santiso-Galvez & Bertrand (2004). They outlined how “the convergence of four factors in a single country explains why Guatemala lags far behind its Latin American neighbors in the acceptance of family planning…: the anti-imperialist leftist movements of the 1960’s and 1970’s; the large percentage of the population that is indigenous; the civil unrest that peaked in the 1980s and paralyzed social
programs, especially in the western highlands; and the powerful alliance between the government and the Catholic Church” (ibid.).

2.5 Substantive and Methodological Gaps from the Literature Review

The reviews of qualitative and quantitative research both highlight gaps in the literature relating to self-efficacy and unmet need for family planning. Two qualitative studies incorporate the concept of self-efficacy, but only the Cambodian study operationalizes the concept in a way that is consistent with Bandura’s definition. There are nine quantitative studies examining the relationship between self-efficacy and contraceptive behaviour but most use overly simplistic scales for measuring self-efficacy, as discussed in the results section of the quantitative literature review (section 2.3.2). Of these quantitative studies, only the one from Iran explicitly uses self-efficacy scales that are developed through research into localized barriers to access of contraceptives, but unfortunately creates scales that are too general (Peyman et al., 2009). It is also worth noting that the vast majority of quantitative research about self-efficacy and contraception relates to the experience of adolescents. Levinson’s contraceptive self-efficacy scale is an important addition to this literature, but this was developed specifically for use with adolescents (1986). My research led to the development of a contraceptive self-efficacy scale for use with adult women aged 20 to 24 who are not adolescents but are still early in their reproductive lives. This research thus makes a unique contribution to the literature.

My literature review found no papers from Latin America that brought self-efficacy theory to bear on the issue of unmet need for contraception. As Casterline & Sinding (2000) argue, local social science research “is a prerequisite for developing effective programs to reduce [unmet need for family planning].” In her study of unmet need for family planning in Guatemala, Asturios de Barrios (1997) similarly concludes, “Qualitative studies of small samples should be conducted on a regular basis to obtain a deeper understanding of the socio-cultural experience of reproduction in changing conditions.” Up to date, theory-based research on the current reasons behind unmet need for family planning in Guatemala will be helpful for tackling this issue in this particular context. Indeed, as Bandura (2006) writes, “multifaceted efficacy scales not only have predictive utility but provide insights into the dynamics of self-management of behavior.”
Bringing a political economy perspective to research on contraceptive self-efficacy has not been done before, and this approach will help to differentiate the aspects and origins of unmet need for family planning that are more individual, social and societal in nature. Freedman (1975) inspired this kind of analysis in the examination of fertility patterns, likening immediate variables such as contraceptive use to being at the narrow end of a funnel. He encouraged researchers to “work backward from the narrow neck of the funnel to the broadening opening, where we are likely to find that we cannot deal simultaneously with all the important variables in the foreseeable future. But, an inventory of the number and complexity of the variables puts our work in perspective” (Freedman, 1975 as quoted in Shiffman, 2006).
Chapter 3 – Theoretical Approaches

The theoretical approaches employed in this research are discussed in detail in the first two individual manuscripts. The first paper focuses on self-efficacy theory, the second on the political economy approach, and the overlap of these two theoretical perspectives is discussed in both papers. This chapter will thus provide an overview of these main approaches and then present the theoretical framework designed and used in this research.

3.1 Self-efficacy Theory

Self-efficacy theory, anchored in Bandura’s Social Cognitive Theory (SCT), guides this research and is complemented by a political economy approach. SCT is “one of the most frequently used and robust health behavior theories (Glanz & Rimer, 2005). Bandura introduces the central construct to his behavioural theory in his article, “Self-efficacy: Toward a Unifying Theory of Behavioural Change” (1977). Perceived self-efficacy not only helps to determine if a person will initiate coping behaviour, but also “how much effort will be expended and how long it will be sustained in the face of obstacles and aversive experiences” (ibid.). If people’s initial objections were based on erroneous estimations of difficulty, repeated behaviour can lead to self-correction of efficacy beliefs, making the behaviour progressively easier (ibid.). As defined in Bandura’s SCT, learning from the outcomes of one’s own actions is more powerful than observational learning from the actions of others, as there is less question about what is observed. Bandura’s concept of self-efficacy is particularly useful for thinking about contraceptive use in Guatemala, and health behaviour change in general, because it designates pathways through which the central construct of self-efficacy might be enhanced.

In SCT, “expectations of personal efficacy are derived from four principal sources of information: performance accomplishments, vicarious experience, verbal persuasion, and physiological states” (ibid.). As discussed above, personal performance accomplishments can enhance efficacy expectations as people see evidence of their ability to carry out the behaviour. Furthermore, general coping skills can be developed that help deal with any number of stressful situations (Bandura, 2004a). Through vicarious experience people observe others carrying out behaviours, which can have effects on self-efficacy in the same two ways described for performance accomplishments. Using the example of people overcoming phobic behaviour,
Bandura shows that personal experience is more powerful than observing others or imagining oneself carrying out the preferred behaviour (Bandura, 1977). One way to enhance vicarious learning is to have participants model the behaviour they see. This social learning is also more powerful if models are more similar to the observer in other characteristics (ibid). Verbal persuasion, being convinced by the arguments of influential others, also benefits from persuaders being perceived as prestigious, trustworthy, expert and assured (ibid.). Under SCT the informational effects of physiological arousal are believed to be more important than the motivational ones: “People rely partly on their state of physiological arousal in judging their anxiety and vulnerability to stress” (ibid). Anticipatory self-arousal can create a vicious circle where fear creates an expectation of more fear. Anxiety arousal can be reduced through performance accomplishments and modeling, “diminishing proneness to aversive arousal…[and] teach[ing] effective coping skills by demonstrating proficient ways of handling threatening situations” (ibid.). This last source of information for increasing self-efficacy is probably the one that least applies to understanding contraceptive use in Guatemala, which depends on longer-term behaviour patterns that span a greater time duration than a heightened physiological state. Nevertheless, the three other sources of efficacy expectations are highly relevant to considering the issue of family planning in Guatemala: performance accomplishments, vicarious experience and verbal persuasion.

Bandura lectured in 2002 about the centrality of self-efficacy within the constellation of constructs making up SCT. He confirmed that “belief in one’s efficacy to exercise control is a common pathway through which psychosocial influences affect health functioning” (Bandura, 2004b). Personal efficacy “is the foundation of human motivation and action” but is accompanied by other core determinants in the SCT: “knowledge of health risks and benefits of different health practices…, outcome expectations about the expected costs and benefits for different health habits, the health goals people set for themselves and the concrete plans and strategies for realizing them, and the perceived facilitators and social and structural impediments to the changes they seek” (ibid). Self-efficacy is the central construct because it not only affects behaviour directly, but also through its impact on the other constructs. For example, someone with higher self-efficacy is more likely to: have more ambitious goals to which they are more firmly committed, expect better outcomes and overcome greater obstacles.
It is important to emphasize that “the efficacy belief system is not a global trait but a
differentiated set of beliefs linked to distinct realms of functioning” (Bandura, 2006). Self-
efficacy scales “must be tailored to activity domains and assess the multifaceted ways in which
efficacy beliefs operate within the selected activity domain,” which “relies on a good conceptual
analysis of the relevant domains of functioning” (ibid). In the case of my research in Guatemala,
the qualitative literature review provides background about the barriers that have been identified
in extant literature that are salient to the domain of accessing and using family planning methods
to avoid unwanted pregnancy. The elicitation interviews with individual women garner
information about the actual barriers faced by young, indigenous married women (aged 20 to 24)
in Chimaltenango, Guatemala.

SCT is also advantageous for considering contraceptive behaviour in rural Guatemala because of
how it situates environmental factors. While the Theory of Planned Behaviour (TPB) and the
Theory of Reasoned Action (TRA) “assume all factors (e.g. culture, the environment) operate
through the model’s constructs,” SCT is premised on reciprocal determinism, whereby
“psychological functioning involves a continuous reciprocal interaction between behavioral,
cognitive and environmental influences” (Bandura, 1978a; Glanz & Rimer, 2005). In this
conceptualization, environment is elevated to have an independent influence, which is fitting for
the Guatemalan context where the structural and environmental elements of oppression have
been and continue to be so significant.

SCT, nevertheless, may underestimate these structural aspects, since its conception of
environment appears to be very much malleable and in the present. For example, Bandura
explains that “most environmental influences affect behaviour through intermediary cognitive
processes” and that “sociostructural factors operate through psychological mechanisms of the
self system to produce behavioral effects” (1978, 2001). If people are primarily influenced by
the environment and sociostructural factors through the effects they have on cognition and
psychological mechanisms, then ‘environment’ is very much conceived as being temporally
located in the present, and does not sufficiently take into account the structural discrimination
that has accumulated, been compounded and affected the situation of Guatemalan indigenous
women over centuries.
Health behaviour theory has sometimes been critiqued as being inapplicable in non-Western cultures due to its development in the West where notions of individualism prevail (Airhihenbuwa & Obregon, 2000). Bandura himself (2002) goes into great detail about how this critique is itself short-sighted, as mixes of proxy, individual and collective agency are present in all societies, and even communities that emphasize more collective and communitarian pursuits still value and benefit from individual self-efficacy. Furthermore, “the elicitation process is exactly what makes the model applicable to all cultures… Failure to elicit these beliefs from the population, with investigators often measuring beliefs that they think should be relevant, is the reason that some investigators have concluded the model is Western and not appropriate cross-culturally” (Montaño & Kasprzyk, 2008).

3.2 Political Economy Approach

In order to address the relative limitation of Social Cognitive Theory to fully take into account social, economic, environmental and political factors, it is helpful to consider the contributions of a political economy perspective. Political economists generally view the lens of analysis that behavioural scientists use as overly focused on proximal causes. The “political economy approach to understanding health and illness considers the political, social, cultural and economic contexts in which disease and illness arise, and examines the ways in which societal structures (i.e. political and economic practices and institutions, and class interrelations) interact with the particular conditions that lead to good or ill health” (Birn, 2009). This focus somewhat overlaps with that of behavioural scientists, but adds political and historical factors to explanations for differentials in health outcomes (ibid.). In contrast to SCT, which “recognizes how environments shape behavior, [but] focuses on people’s potential abilities to alter and construct environments to suit purposes they devise for themselves,” the political economy approach puts more weight on the macro influences on health and well-being (Birn, 2009; McAlister, Perry, & Parcel, 2008).

Political economy aspects of family planning are framed by the larger debates arising from applying a political economy approach to fertility. Two dominant schools of thought must be considered at this macro level: demographic transition theory and the conclusions from the “Princeton Fertility Studies” in the 1970s (Coale, A. & Watkins, S., 1986).
In broad terms demographic transition theory describes three stages: the first when both fertility and mortality are high and approximately equal; the second when mortality begins to fall and fertility stays the same, creating a situation of population growth; and a final stage when fertility falls to the levels of mortality, and population growth levels off (Thompson, 1930; Watkins, 1987). This stylized description of demographic transition represents the received wisdom since 1930 and hinges on the logic that individual couples would decide to have fewer children since they could count on more of their children to live. In reaching this conclusion Thompson (1930) describes “differential birth rates” between rich and poor and rural and urban populations and attempts to explain these differences because of the relative costs associated with having children, with rich urban couples having the most to lose by having large families. This interpretation also fit well with the data that more highly urbanized countries had greater declines in fertility (ibid). Although Thompson admits he has “no doubt that many country people who do not now restrict the size of their family will do so once they learn how,” he regards contraceptive technology as “the means used to accomplish an end,” not as a possible explanatory variable for lower birth rates in and of itself (ibid.). Applying this logic to developing countries where the demographic transition has yet to fully occur, there would be no motivation to promote contraception, since these changes would come about naturally, but only after mortality starts coming down and people begin to make decisions based on this declining fertility. Following Thompson’s narrative, this would be especially so in contemporary rural Guatemala where having children is relatively less costly than in the city.

In their book, The Decline of Fertility in Europe (1987), Watkins and Coale find general support for demographic transition theory at the country level, but they provide alternate explanations for its underlying mechanisms based on a meticulous decade-by-decade examination of fertility transitions in Europe at the provincial level. They find that “fertility declines took place under a wide variety of social, economic, and demographic conditions” and that calculation by individuals could not account for the sudden and widespread declines in fertility (Knodel & Walle, 1986; Watkins, 1987). In fact, “family limitation emerges among some groups of the population much earlier than among others and long before any urban-industrial transformation is evident” (Knodel & Walle, 1986). In England, for example, urbanization and industrialization preceded a drop in fertility, while during the same period in Hungary fertility declines occurred even though the country was considerably less well-developed (ibid.). On a micro level, the
Princeton studies suggest the causality might be reversed in the standard explanation that families had many children prior to declines in child mortality because they were trying to achieve their desired (large) family size. Rather, they cite qualitative evidence that many infant deaths may have been intentional as a way to limit family size in the absence of knowing and having access to family planning methods (ibid.). Furthermore, the fact that fertility declines were found to be uni-directional and very fast once initiated at the country level, even in communities where economic development and lower mortality had yet to be achieved, also favoured the explanation that diffusion and social network effects were critical for explaining fertility declines (ibid.). In other words, couples who would have been expected under demographic transition theory to have preferred many children appeared to emulate the behaviour of early family planning adopters much sooner than anticipated (ibid.). Culture and context appeared to matter beyond their association with socioeconomic status, as evidenced by the Belgian example where matched Flemish and French speaking towns only 10 kilometres away from each other followed fertility decline trends in their language group much more closely than those of their neighbouring towns (ibid.).

Applying the framework of Princeton Fertility Studies, family planning programs in countries such as Guatemala could have impacts even before a high level of social and economic development is reached. I believe this second interpretation of fertility declines is superior both for Guatemala and in general due to the knowledge we now have of unmet demand for contraception. In Guatemala, for example, total unmet need for family planning is 20.8% and 19.4% of births are unwanted (MSPAS, 2009). This suggests that, all else being equal, if contraceptives were available, accessible and endorsed by the peers in their networks, Guatemalan women might take advantage to space and limit the total number of their children.

Greenhalgh (1990) summarizes these debates and their critiques, along with more recent research that fits this label of research about “the political economy of fertility, as it draws key insights and methodologies from research in political economy, an area of inquiry that cross-cuts traditional disciplinary boundaries.” For example, she describes the work of Kertzer and Hogan (1989), which shows that in Northern Italy, “political developments, such as the adoption of laws making school attendance compulsory and restricting child labor in factories, were crucial instigators of fertility change, underscoring the importance of political and legal forces that lie outside the purview of conventional theory” (Greenhalgh, 1990). Greenhalgh distinguishes
between strands of political economy of fertility research that are top-down versus bottom-up\(^8\), but emphasizes how “these isolated intellectual endeavors share common features, and that they add up to something - a new analytic perspective (not a theory, but a framework that may embrace diverse theories), with a new research agenda - that has the potential for appreciably enhancing our understanding of the sources of fertility decline” (ibid). This approach embraces the political, economic, social and cultural, de-emphasizing the idea of a single demographic transition in favour of particular transitions, “each driven by a combination of forces that are, to some unknown extent, institutionally, culturally, and temporally specific” (ibid).

The political economy approach is particularly salient when considering the case of indigenous women from rural Guatemala, since the overlapping ethnic and gender discrimination they face is the result of oppressive distal and proximal historical events, including colonization and a 36-year bloody civil war that ended only in 1996. During this war, silence was a learned protection strategy used by indigenous people, who were the targets of violence from rebels and especially the state. Indigenous families would not identify their own relatives killed in counter-insurgency operations, for fear of being killed themselves (Lovell, 2010). The violence affected “particularly Maya people, whose women were considered to be the spoils of war and who bore the full brunt of the institutionalized violence” (ibid.). This environment of mistrust, violence and oppression towards indigenous people in Guatemala may have lasting impacts on indigenous women’s current decisions about family planning, which depend on trusting the state health system for provision of family planning information and methods.

Monteforte, a Guatemalan intellectual and politician who served in the 1940’s and 50’s, links his country’s inequity to the issue of land:

> Land is the root cause of national backwardness, of elite economic clout, of social imbalance, of the survival of pre-capitalist structures, of the over-population of our cities, of criminality, of the absence of internal markets, of menacing unrest in

\(^8\) Greenhalgh (1990) describes this distinction between those working “from the bottom up, first outlining the cognitive environment of individual demographic decisions, then sketching in local institutional and cultural configurations, and finally coloring in the larger forces shaping institutional change. A political economic demographer is more likely to work from the top down, beginning with an understanding of the historically developed global forces-the world market, the international state system, and so on-that shape local demographic regimes, next identifying the ways these impinge on regional, national, and local institutional environments, and finally tracing their effects on individual fertility behavior.”
rural areas, of ignorance, of illiteracy, of the nostalgia that was this country five centuries ago. (Monteforte, 1999 as cited in Lovell, 2010)

Indeed, inequity in landholdings reflects the situation in Guatemala: “Ninety percent of the total number of farms account for 16 percent of total farm area, while 2 percent of the total number of farms account for 65 percent of total farm area” (Lovell, 2010). Unequal access to education is another symptom of this inequity in Guatemala, which correlates to contraceptive rates (MSPAS, 2009). Across Latin America, indigenous peoples are typically less educated than non-indigenous peoples. Guatemala exhibits the greatest difference where indigenous adults have less than half the level of schooling of non-indigenous adults: 2.5 versus 5.7 years (G. Hall & Patrinos, 2006). In Guatemala, whether or not a girl goes to school is largely determined by her ethnicity and her area of residence (Guttmacher Institute, 2006). Primary school completion has been found to be “five times as high among non-indigenous as among indigenous young women (51% vs. 11%), and 2.5 times as high among urban as among rural adolescents (62% vs. 24%)” (ibid.). Mayan females “are by far the most disadvantaged group in Guatemala – only 39 percent of 15-64-year-old Mayan women are literate (versus 68, 77 and 87 percent of Mayan males, Ladina females, and Ladino males, respectively) (Hallman, Peracca, Catino, & Ruiz, 2006).

Across the world, women are more likely to use family planning if they, for example, are less poor and attain higher educational levels (Cleland, 2006). The overlapping sources of exclusion for indigenous women in Guatemala, such as lack of land ownership, poverty and poor educational attainment, are therefore likely to contribute to their lower uptake of family planning methods.

A political economy approach to fertility and reproductive health has been used by progressive anthropologists, sociologists and historians who have encouraged a wider view of fertility choices and patterns; (Freedman, 1975; Greenhalgh, 1995; McNicoll, 1980; Phillips & Ross, 1992; Ramírez de Arellano, 1983; Richey, 2008; Ross & Maudlin, 1996; Shiffman & Valle, 2006a; Warwick, 1982; Watkins, 1987). In Central America, Shiffman & Valle (2006) use structural context and history to explain disparities in safe motherhood between Guatemala and Honduras. They conclude, “the more general issue raised by comparing these two countries is the influence of history and social structure on modern health outcomes, and the need for public health inquiries to supplement the dominant practice of quantitative analyses of survey-based data on health service availability and use with inquiries into social structure.” The only paper
about contraception in Guatemala to exclusively examine political and historical factors is that of Santiso-Gálvez & Bertrand (2004). They outline how “the convergence of four factors in a single country explains why Guatemala lags far behind its Latin American neighbors in the acceptance of family planning…: the anti-imperialist leftist movements of the 1960’s and 1970’s; the large percentage of the population that is indigenous; the civil unrest that peaked in the 1980s and paralyzed social programs, especially in the western highlands; and the powerful alliance between the government and the Catholic Church” (ibid.). Where the analysis of Santiso-Galvez & Bertrand falls short, however, is in their compartmentalized, historically frozen and de-politicized consideration of these factors. For example, they describe “a resumption of normalcy in the western highlands” after a long period of civil unrest, which is “no longer problematic,” without identifying the state as the perpetrator of the vast majority of this violence, and with insufficient attention to lasting impacts and overlapping influences of the four factors they consider (Santiso-Galvez & Bertrand, 2004). This research examines some of the same political economy factors, but does not de-link these factors from their current impacts, recognizing, for example, the ongoing influence of the civil war on warranted mistrust of the state by indigenous populations. In keeping with this fluid interpretation of history, a novel framework will be developed for simultaneously considering proximal, intermediate and distal factors affecting family planning. The weaving back and forth between micro and macro examinations of barriers to family planning in Guatemala thus brings together bottom-up and top-down perspectives used by researchers of political economy of fertility in the past (Greenhalgh, 1990).

3.3 Conceptual Model

My research is based on the following conceptual model (Figure 1), which highlights how constructs from Social Cognitive Theory can be considered concurrently with a political economy perspective. This model hypothesizes where self-efficacy is situated in relation to other individual, social and societal determinants of contraceptive use. Self-efficacy is the primary construct of interest, with a focus on understanding how self-efficacy for contraception might be comprised and enhanced in Guatemalan women (through mastery and vicarious experience as well as verbal persuasion). Social outcome expectations include ideas about how one’s behaviour might be sanctioned or condoned by influential others.
Health outcome: Avoiding unwanted pregnancy

Behaviour: Using contraception.

Self-efficacy: “The conviction that one can successfully execute the behavior required to produce the outcomes” (Bandura, 1977).

Outcome expectations: “The expected costs and benefits for different health habits” (Bandura, 2004). These include three types: physical (“the pleasurable and aversive effects of the behavior and the accompanying material losses and benefits”), social (“the social approval and disapproval the behavior produces in one’s interpersonal relationships”) and self-evaluative expectations (“the positive and negative self-evaluative reactions to one’s health behavior and health status”) (Bandura, 2004b; Bandura, 1986).

Mastery experience, vicarious experience and verbal persuasion: These are three of the four sources of self-efficacy as defined above and by Bandura (1977). The fourth, physiological states, is not as relevant for contraceptive use, which depends on longer term behaviour patterns that span a greater time duration than a heightened physiological state.

Social and societal determinants of health: In this model history separates the more proximal social determinants of health from their more distal antecedents, the societal determinants of health. Social determinants of health are “the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness” (WHO, 2014). Whereas social determinants can be considered the “causes of the causes,” the societal determinants of health are “the causes of the causes” of health and disease (Birn & López, 2011). Societal determinants thus highlight the political, “such as political-economic systems that prioritise highly concentrated accumulation of private wealth.
over redistribution of power, property and privilege within and across countries” (Krieger et al., 2010). These social and societal determinants of health are conceived in the model to structure a range of probable scenarios regarding self-efficacies, outcome expectations, behaviour and outcomes that relate to contraceptive use. These determinants are thus not completely prescriptive, but they do shape considerably the likely range for individual determinants and outcomes.

This model embraces the concept of reciprocal determinism that underpins Bandura’s SCT, and also emphasizes the historical and political nature of the environmental influences on behaviour. As Freire (2000) implores, “reflection and action become imperative when one does not erroneously attempt to dichotomize the content of humanity from its historical forms.” The perils of “de-politicising and de-historicising health inequities” are well-documented (Anne-Emanuelle Birn, 2009; Krieger, 2001; Krieger et al., 2010). This model gives place not only to the social but also the societal determinants of health. While some authors have begun using the term societal determinants of health instead of social determinants of health in order to emphasize the political (Birn & López, 2011), I believe it is helpful to include both these concepts in the model, separating them temporally. Social determinants are somewhat captured in proximal attributes such as gender, ethnicity, religiosity, perceptions of gender equity and educational level, whereas societal determinants refer to the political, economic and social structures that, over time, have created the conditions for the social determinants to be relevant.

These social and societal determinants of health are conceived in the model to structure a range of probable scenarios regarding self-efficacies, outcome expectations, behaviour and outcomes that relate to family planning. These determinants are thus not completely prescriptive, but they do shape considerably the likely range for individual determinants and outcomes. As a critical mass of women adopt contraception, this can influence outcome expectations and also begin to alter the social determinants of health, which represent the more proximal concept of environment in Bandura’s reciprocal determinism.

This research focuses on the link between contraceptive self-efficacy and contraceptive behaviour. Elicitation research helps to identify the specific barriers that are relevant for understanding contraceptive self-efficacy in this Guatemalan, rural, indigenous context. These identified barriers are used to develop a contraceptive self-efficacy scale for this population and context. Further analysis using a political economy approach deciphers which barriers are more individual, social or societal in nature and contextualizes the historical and political reasons behind the more proximal reasons for unmet need for family planning.
Chapter 4 – Methods

4.1 Research Design

Elicitation interviews were carried out with indigenous women from rural districts of Patzún, Chimaltenango in the Highlands of Guatemala, in order to understand the particular barriers to contraception in this context and inform the development of a family planning self-efficacy scale.

This chapter provides a general overview of the research design, community and community partners, sample, data collection and analysis procedures, timeframe, ethics and reflexivity used for this dissertation. More detailed and specific methods about the elicitation interview methodology are included in the first manuscript, “Barriers to accessing and using contraception in Highland Guatemala: A family planning self-efficacy scale.” More detailed and specific methods on the application of a political economy approach are included in the second manuscript, “‘Uno tiene que cuidar también de sí mismo’: Putting Guatemalan family planning decisions in context using Social Cognitive Theory and a political economy approach.” A detailed description specifically of methodological issues in inter-cultural research is included the third manuscript, “‘Taking Care’ in inter-cultural research: lessons from a Guatemalan family planning study.”

4.2 The Community and Community Partners

Patzún is located on the Western edge of the Department of Chimaltenango, in the centre of the Kaqchikel region and Guatemala (SEGEPLAN, 2010). The department has varied and abundant agricultural production due to its high quality soil, with cultivation of corn, beans, coffee, sugar cane, ginger, wheat, oats, fruit and vegetables, fine lumber, medicinal plants and dyes (Rouanet, 1996).

In the most recent national census of 2002, the municipality of Patzún had 42,326 inhabitants; 17,346 who live in the municipal centre, and 24,980 in the surrounding rural areas (Instituto Nacional de Estadística, 2002). The majority (40,241 people), identify themselves as indigenous, and 2,085 as not indigenous (Instituto Nacional de Estadística, 2002). Patzún is somewhat unique compared to some nearby municipalities for the high percentage of indigenous
people and especially for the rate of Kaqchikel use. In Patzún, 84.3% of people are literate and primary net enrollment rates (equivalent to 1st to 6th grade) have risen to 94.4% in 2009, although basic education enrollment rates (equivalent to 7th to 9th grade) remain lower at 39.7% (UNDP, 2011). Income inequality in the Department of Chimaltenango is reflective of national inequality between indigenous and non-indigenous people: 46% of indigenous people in this Department live in poverty compared to 26% of non-indigenous people and 23% of indigenous people in Chimaltenango live in extreme poverty compared to 10% of non-indigenous people (UNDP, 2011). Total poverty rates for the Department (61%) are higher than the national average (51%; ibid). On average, women 20 to 24 years of age in Chimaltenango wish to have 3 children, which is equal to the national average (Ministerio de Salud Publica y Asistencia Social, 2009). Sixty-nine percent of women in Chimaltenango have used a contraceptive method to prevent pregnancy in their lifetime, which makes the department among the lowest in terms of contraceptive use (Ministerio de Salud Publica y Asistencia Social, 2009). According to the National Survey on Maternal and Child Health, 25.3% of women in Chimaltenango have an unmet need for family planning (11.9% unmet need for spacing and 13.4% unmet need for limiting; Ministerio de Salud Publica y Asistencia Social, 2009).

This study was led by a non-Mayan researcher from Canada, in collaboration with a local research team, and using community based participatory research (CBPR) principles, to ensure the priorities and practices of the Mayan people influence the research, methods, interpretation and translation of study findings (Horowitz, Robinson, & Seifer, 2009; Wallerstein & Duran, 2010). The Creating Opportunities Program is a Population Council initiative, which works with indigenous adolescent and young women from rural Guatemala, and one of my Guatemalan partners for this work. The Creating Opportunities program provided my initial introduction to the community, Patzún, and local partner organization, Renacimiento. Renacimiento is a non-governmental organization that provides extension health services in the rural districts of Patzún, as part of the national health system. They have a clinic and office in the municipal centre of Patzún and several local clinics in rural districts staffed by part-time nurses, a doctor that visits

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9 The total poverty rate is equal to the sum of the rates of poverty and extreme poverty.

10 For more information about the Creating Opportunities Program, please see http://www.popcouncil.org/research/abriendo-opportunidades-opening-opportunities
about once per month and local community facilitators and volunteers who work part-time in their own communities.

4.3 Research Sample and Recruitment

Applying Bandura’s Social Cognitive Theory to contraceptive behaviour, young women’s contraceptive behavior is understood to depend pivotally on self-efficacy for contraception in all contexts. Self-efficacy is “the conviction that one can successfully execute the behavior required to produce the outcome” and is measured by understanding people’s confidence in overcoming progressively difficult barriers to the successful achievement of a particular behavior (McAlister, Perry, & Parcel, 2008; Bandura, 1977). Self-efficacy is behavior and situation-specific, and “self-efficacy scales developed and validated with one population may not be applicable to other populations” (Maibach & Murphy, 1995a). In order to understand contraceptive behavior in young indigenous women from rural Guatemala, it is therefore critical to first understand what the particular barriers to contraception are in this context.

Elicitation, in-depth interviews were carried out with 16 women, married or in union and aged 20 to 24, who are both users and non-users of contraception. The decision to interview women who are aged 20 to 24 results from two factors. I am interested in taking into account a life course approach, as decisions made while women are younger in their reproductive lives can help set the trajectory for later decisions and outcomes. The country director of the Creating Opportunities Program nevertheless cautioned against focusing on data collection with adolescents as she thought they would be unlikely to share information about their sexual experiences with an outsider who has not lived in their community for over a year, since adolescent sexuality is an extremely taboo topic in Guatemala. By focusing on contraceptive practices of women aged 20 to 24 who are married in union, I am still analyzing barriers to contraception for a group who are relatively early in their reproductive lives, but who are more willing to share about their experiences, leading to more fruitful research.

Women were purposively sampled, attempting to maximize variation along the key domain of contraceptive use or non-use. According to general guidelines on elicitation research, about 15 interviews should be carried out, until there is saturation from each target group (Montaño & Kasprzyk, 2008). Participants should be identified such that “about half have performed or intend to perform the behavior under investigation and half have not performed the behavior
The research assistant worked with local facilitators of the Renacimiento NGO to identify women in the rural districts of Mercedes and El Llano who fit the age-criteria for recruitment. As interviews progressed, the research assistant then continued recruitment in order to complete the categories relating to unmet need for family planning, as designated in Table 1 below, simultaneously ensuring that half of participants (n=8) were users and non-users (n=8) of contraception.

<table>
<thead>
<tr>
<th>Wanted next birth within 2 years</th>
<th>Wanted to delay next birth by 2 years or more</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using modern method of contraception</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Not using modern method of contraception</td>
<td>4</td>
<td>4*</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6</strong></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>

*These participants have an “unmet need for family planning”

Potential participants were approached in their homes during the day when they were less likely to be in the company of their partners. The research assistant explained the nature of the study and read the contents of the information letter. Once participants agreed to participate an appointment was made for me to return with the research assistant to conduct the interview. In the first rural district where we conducted recruitment, El Llano, all women aged 20 to 24 were approached about the study, with the exception of one who could not be found at home after repeated attempts. Of 14 women approached, 13 agreed to participate in the study. In the second rural district where we conducted recruitment, there were only three interviews which still had to be conducted. These three participants were recruited in collaboration with the community health worker from the Renacimiento NGO, who accompanied the research assistant to the houses of potential participants in Las Mercedes until recruitment was complete.
4.4 Data Collection

I developed the interview guide (Appendix 2) based primarily on suggested questions for elicitation research from the literature (Middlestadt, Bhattacharyya, Rosenbaum, Fishbein, & Shepherd, 1996; Montaño & Kasprzyk, 2008). The interview also asks about women’s contraceptive knowledge and behaviour, primarily using questions adapted from previous instruments such as the Demographic and Health survey (ICF International, 2011). Women completed informed consent forms (Appendix 3) prior to starting the interview. Participants were generally interviewed only once and they were not compensated for their participation, following the advice and practice of my Guatemalan partner organizations. As described in detail in the third manuscript, titled, “‘Taking Care’ in inter-cultural research: lessons from a Guatemalan family planning study,” (Section 5.3) the interview guide and consent form were translated into Spanish by the author, and shared with local research staff for their comments to improve language and make questions more accessible for participants. Interviews took place in women’s homes, with one exception where a participant preferred to be interviewed in the local health clinic.

This elicitation process is critical for ensuring that the language and barriers included in the self-efficacy scale are culturally relevant and situation-behaviour specific to this population. Interviews were carried out until there was saturation in terms of the themes relating to accessing and using contraception, “when no new responses are elicited” (Montaño & Kasprzyk, 2008).

4.5 Data Analysis Procedures

The elicitation interviews were audio-recorded, transcribed and analyzed in order to inform the creation of a ‘self-efficacy for family planning’ scale that is appropriate in this context. As pointed out by Middlestadt et al. (1996), these elicitation interviews, with their “open ended responses, [also] provide a rich source of information about terminology, language, and word choice” used by the population of interest about the particular health behaviour. Content analysis using the constant comparison method allowed the investigator and the local research team to identify the major themes raised by participants in terms of barriers to accessing and using family planning. Themes were identified both deductively and inductively (Table 2). Analysis of data from participants resulted in the inductive themes, which were a function of the interviews themselves, whereas deductive themes were generated from a consideration of extant
literature about self-efficacy for family planning and of contextual issues. NVIVO 9 software was used to manage the analytic process. Analysis of the elicitation interviews should also help to “limit the number of domains required for a thorough assessment by identifying the most important task and challenges,” thus reducing the total number of questions in the self-efficacy scale (Maibach & Murphy, 1995b). The resulting family planning efficacy scale therefore included the most condensed version of possible of questions about obstacles to accessing and using family planning, reflecting language used by participants themselves.

4.5.1 Political Economy Analysis

In keeping with a political economy approach, further analysis of the interviews and structural context was carried out to understand the historical and political factors underlying the more proximal barriers to contraceptive use. A focused and critical literature review was used to support emerging structural themes and to generate deductive themes for consideration in the analysis of the elicitation interviews (Tables 2 & 3). Information about the political, economic and cultural structures affecting family planning decisions was obtained from various sources in grey and academic literature, including: historical and political documents, government surveys, United Nations and donor reports and published research (Table 3). This analysis took into account previous work that analyzes the reasons behind “the delayed contraceptive revolution in Guatemala,” such as that of Santiso-Galvez and Bertrand (2004).

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Inductive</th>
<th>Deductive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Cognitive Theory*</td>
<td>• To identify themes raised by participants in elicitation interview data</td>
<td>• Themes identified from extant literature about self-efficacy for family planning</td>
</tr>
<tr>
<td>Political economy approach*</td>
<td>• To support emerging themes from interview data</td>
<td>• Structural-level themes identified for consideration</td>
</tr>
</tbody>
</table>

*This table divides analytical processes into those used primarily in the application of Social Cognitive Theory versus the political economy approach. In reality these parallel analytical processes were ongoing and simultaneous, serving to extend the application of either perspective in isolation.
Table 3: Categories of Political Economy References

<table>
<thead>
<tr>
<th>Type of document</th>
<th># referenced in manuscript</th>
</tr>
</thead>
<tbody>
<tr>
<td>Historical documents</td>
<td>5</td>
</tr>
<tr>
<td>Government documents</td>
<td>1</td>
</tr>
<tr>
<td>Government surveys</td>
<td>3</td>
</tr>
<tr>
<td>United Nations reports/presentations</td>
<td>4</td>
</tr>
<tr>
<td>Donor reports</td>
<td>2</td>
</tr>
<tr>
<td>NGO report</td>
<td>5</td>
</tr>
<tr>
<td>Published research</td>
<td>19</td>
</tr>
<tr>
<td>Newspaper article</td>
<td>3</td>
</tr>
</tbody>
</table>

4.6 Knowledge Dissemination

The plans for knowledge dissemination are mostly in the academic realm, but also include activities with participants and community partners. The three manuscripts have been submitted to peer-reviewed academic journals in North America and Guatemala. Results from this research have been presented at the Canadian Global Health Conference, the Guatemalan Scholars Network and the Latin American Studies Association. Once published, the manuscripts will also be shared with academics and community organizations who expressed interest in the results at the Guatemalan Scholars Network conference. Results were also discussed with my host academic supervisor at the Universidad del Valle in Guatemala, who is a co-author on the second manuscript. Further opportunities to present findings at the Universidad del Valle may also ensue. Through an opportunity provided by my primary supervisor, I presented in the Grand Rounds of Public Health Ontario, which included a webinar component. An easy to read initial summary of results was prepared and shared with study participants as well as community
partners: the Renacimiento and Abriendo Oportunidades NGOs in Guatemala. It should be noted that the strategy to involve local community organizations in the research from early in the process has also enabled knowledge dissemination with partners who are in a good position to implement programming and policy changes based on the research findings.

4.7 Timeframe

Interview participants were recruited and data was collected between May 1st and July 31st, 2013. Interview transcription and analysis was ongoing during this period through April 2014.

4.8 Ethics Review and Ethical Considerations

Ethics approval was obtained for this research from the University of Toronto Research Ethics Board. Ethics approval was also sought and obtained from the Research Ethics Committee of the University del Valle in Guatemala. Ethics approval was not specifically sought from the community of the research, because I adopted a community-based participatory research approach and involved community partners in the research from the early stages.

Beyond completing university research ethics protocols, I also benefitted from discussing ethical considerations, as they arose on the ground, with my community partners in Guatemala. This included conversations with Alejandra Colom, the country director of the Creating Opportunities Program and Professor Andrés Castañeda, Dean of the Faculty of Social Sciences at the Universidad del Valle de Guatemala, who acted as my host supervisor while I was a visiting scholar in his department in 2013.

4.9 Reflexivity

It should be noted that there are inherent issues with conducting research in this indigenous, rural context as a Caucasian, Canadian female from Toronto. Some of these concerns are potentially compounded since I am fluent in Spanish and play the dual role of researcher and interpreter in some cases. The third manuscript (Section 5.3), titled, “‘Taking Care’ in inter-cultural research: lessons from a Guatemalan family planning study,” reflects on these methodological and ethical issues in the context of inter-cultural research. Further ramifications of my outsider status are explored in the discussion chapter (Section 6.2.2), including how this impacted the way I framed the research, as well as collected, analyzed and interpreted data. Ultimately, this study was led
by a non-Mayan researcher from Canada, in collaboration with a local research team, and using community based participatory research (CBPR) principles, to ensure the priorities and practices of the Mayan people influence the research, methods, interpretation and translation of study findings. I designed the study and study instruments, with the support of my doctoral committee, participated in recruitment and led: data collection, coding, interpretation and writing of the three manuscripts. The specific roles of each co-author are outlined at the end of each manuscript.
Chapter 5 – Results

5.1 Barriers to accessing and using contraception in Highland Guatemala: A family planning self-efficacy scale (Manuscript #1)

**Title:** Barriers to accessing and using contraception in Highland Guatemala: A family planning self-efficacy scale

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**Conflict of interest:** None

**Running title:** Family planning self-efficacy scale
Abstract:

Understanding the persistent inequalities in prevalence rates of family planning and unmet need for family planning between indigenous and non-indigenous women in Guatemala requires localized explorations of the specific barriers faced by indigenous women. Based on Social Cognitive Theory, elicitation interviews were carried out with 16 young women, aged 20 to 24, married or in union, from rural districts of Patzún, Chimaltenango in Guatemala. Content analysis was carried out using the constant-comparison method to identify the major themes. The following barriers are incorporated into the self-efficacy scale: lack of knowledge about and availability of methods, fear of side effects and infertility, husbands being against family planning (and related fears of marital problems and abandonment), pressure from in-laws and the community, and the belief that using contraception is a sin. This is the first comprehensive self-efficacy scale developed with young adult, indigenous women that addresses the issue of family planning in Latin America.

Key words: Social Cognitive Theory; Family planning; Indigenous; Marginalized populations; Elicitation interviews

Introduction

Access to contraception was confirmed as a fundamental human right at the International Conference on Population and Development (ICPD) in 1994, where 179 countries committed to improving reproductive health (Greene et al., 2012). The accompanying Plan of Action specified that people should have the “capability to reproduce and the freedom to decide if, when and how often to do so” (United Nations, 1994). Despite dramatic increases in the use of contraception overall, with fertility declining by half in developing countries since 1960, considerable challenges remain in ensuring equitable access to family planning services, information and supplies (Cleland et al., 2006; Gakidou & Vayena, 2007; Greene et al., 2012). Approximately 222 million women worldwide lack access to family planning services, leading to 76 million women in developing countries experiencing unintended pregnancies each year (Kols, 2008).

Unmet need for family planning is defined as “the proportion of currently married women [or women in union] who do not want any more children but are not using any form of family planning (unmet need for contraception for limiting) or currently married women who
want to postpone their next birth for two years but are not using any form of family planning (unmet need for contraception for spacing)” (Mills et al., 2010; Westoff, 2006). Currently, on a global scale, one in six married women has an unmet need for family planning, with significant ramifications for maternal health, as well as social and economic development in general (Kols, 2008). Meeting the unmet need for family planning would help to reduce the mortality and morbidity from unwanted pregnancies, particularly from the 19 million unsafe abortions that women resort to each year to terminate these pregnancies (Kols, 2008).

From an equity perspective, further understanding of unmet need for family planning is also of paramount importance. Gakidou & Vayena (2007) show that, despite the trend in increased use of contraception overall, the poor are falling farther behind in their access to family planning. They found that Latin America was the region with the greatest inequalities in use of contraception, as compared to sub-Saharan Africa and South and South-East Asia. Latin America is a region characterized by inequality, and social and economic inequality in Guatemala is among the highest in the Americas, with the wealthiest quintile of the population holding 58 percent of total income, compared to the bottom quintile which holds only three percent (Haub & Gribble, 2011). The situation in Guatemala is compounded from an equity perspective because inequality in unmet need for family planning, along with other maternal health indicators, is very stark along rural/urban, indigenous/non-indigenous lines (Figueroa, Lopez, Remez, Prada, & Dresher, 2006). In Guatemala, there are 153 maternal deaths per 100,000 live births and this rate is three times worse for indigenous versus non-indigenous women (211 versus 70; Kols, 2008). The total fertility rate for indigenous women is 4.5, compared to 3.1 for ladina women (Ministerio de Salud Publica y Asistencia Social, 2009). Contraceptive use by indigenous women in Guatemala is significantly lower than that of their Ladina counterparts: 28% compared to 54% (Ministerio de Salud Publica y Asistencia Social, 2009). This difference persists even for indigenous women who have immigrated to the city or who co-reside with ladinos in rural towns, although contraceptive knowledge is positively associated with number of years lived in an urban setting, and immigrants from rural areas eventually have modern contraceptive adoption rates only slightly below their urban non-migrant counterparts (De Broe, 2005; De Broe & Hinde, 2006; Lindstrom & Muñoz Franco, 2005; Lindstrom & Hernández, 2006).
Unmet need for family planning can be understood from a health behavior perspective as the gap between women’s reproductive intentions and their contraceptive behavior (Loaiza & Biddlecom, 2012). This concept thus lends itself to exploration under the lens of health behavior theory, which strives to understand the constructs that determine behavior and explain discrepancies between intentions and behavior. Social Cognitive Theory, from this family of health behavior theories, recognizes “the triadic influence between behavioral, cognitive and environmental influences,” which is appropriate in Guatemala where environmental and structural issues are salient (Bandura, 1978a; Glanz & Rimer, 2005).

Applying Bandura’s Social Cognitive Theory to contraceptive behavior, young women’s contraceptive behavior is understood to depend pivotally on self-efficacy for contraception. Self-efficacy is “the conviction that one can successfully execute the behavior required to produce the outcome” and is measured by understanding people’s confidence in overcoming progressively difficult barriers to the successful achievement of a particular behavior. Self-efficacy is behavior and situation-specific, and “self-efficacy scales developed and validated with one population may not be applicable to other populations” (Maibach & Murphy, 1995a). In order to understand contraceptive behavior in young indigenous women from rural Guatemala, it is therefore critical to first understand what the particular barriers to contraception are in this context.

This is the first time a situation-specific self-efficacy scale has been developed in relation to contraception in Latin America. Levinson’s adolescent self-efficacy scale has been informative and used in North American research regarding self-efficacy for contraception in the United States in adolescent girls (Levinson, 1995b; Levinson, Wan, & Beamer, 1998b; Levinson, 1986), in college age females (Heinrich, 1993), in male and female black college students (Wright, 1992), and in male and female adolescents in Quebec, Canada (Bilodeau et al., 1994). These studies have demonstrated the utility of the self-efficacy construct in predicting contraceptive behavior and highlighting areas that can be impacted through intervention (Bilodeau et al., 1994; Levinson, 1986; Levinson, Wan, & Beamer, 1998c). This same scale has also been used in Hong Kong to examine contraceptive self-efficacy in adult women (Ip et al., 2009), although no adaptations were made despite Levinson’s scale having been developed for use with adolescent populations in the United States (Fisher, 2011; Levinson, 1995c; Levinson, 1986).
The barriers facing young, indigenous women in highland Guatemala who are married or in union are nevertheless very different from those of adolescents or unmarried women attending college in the United States, and therefore Levinson’s scale is not directly applicable in this rural Guatemalan context. Peyman et al. (2009) developed a self-efficacy scale based on focus groups with married Iranian women; however their scale lacks clarity in terms of specific barriers and may not be appropriate for an indigenous context. The family planning self-efficacy scale described in this paper was developed with a population consistent with those surveyed in large national demographic and health surveys\(^\text{11}\) used globally to determine rates of unmet need for family planning (women who are married or in union).

The purpose of this paper is to present results from the elicitation interviews, the resulting Guatemalan family planning self-efficacy scale and discuss benefits and drawbacks of this method and its amplification using the political economy framework. This is the first comprehensive contraceptive self-efficacy scale consistent with Bandura’s Social Cognitive Theory and developed specifically with adult indigenous women in rural Guatemala as opposed to non-indigenous adolescents in North America (Bilodeau et al., 1994; Levinson, 1995a; Levinson, 1986; Monteño & Kasprzyk, 2008).

**Materials and Methods**

Elicitation interviews were carried out with 16 young women, aged 20 to 24, married or in union, from two rural districts of Patzún, Chimaltenango in Guatemala: El Llano and Las Mercedes. According to general guidelines on elicitation research, about 15 interviews should be carried out, until there is saturation from each target group, “when no new responses are elicited,” with about half of the participants having performed the behavior under investigation (Montaño & Kasprzyk, 2008). Women were purposively sampled such that users (n=8) and non-users of contraception (n=8) were equally represented, and among the non-users of contraception, half (n=4) wanted to delay childbearing for more than two years, consistent with the definition of unmet need for family planning.

\(^\text{11}\) Demographic and Health Surveys (DHS) “are nationally-representative household surveys that provide data for a wide range of monitoring and impact evaluation indicators in the areas of population, health, and nutrition” (MEASURE DHS, 2014).
The semi-structured interview guide was based on suggested questions for elicitation research from the literature (Middlestadt et al., 1996; Montaño & Kasprzyk, 2008). Women were also asked about their contraceptive knowledge, behavior and sociodemographic variables, primarily using questions adapted from previous instruments such as the Demographic and Health Survey (ICF International, 2011). The interview guide was translated from English to Spanish by the primary researcher, and the research team, including both a local research assistant and a research coordinator, helped to simplify language in the research guide to ensure it would be better understood by participants. For those participants requiring it, the research assistant translated the interview guide into Kaqchikel (the native Mayan language), and the research coordinator back-translated this into Spanish, in order to confirm the accuracy of the translation.

Recruitment was carried out by a young, female, Kaqchikel research assistant, in collaboration with local facilitators from the Renacimiento NGO, which provides health extension services in the rural districts where research was conducted. Within rural districts, women in the age range of 20 to 24 (inclusive) were pre-identified and then approached in their homes to explain the nature of the study. In the rural district of El Llano where the majority of interviews were carried out, every woman in this age-range was approached, resulting in the successful recruitment of 13 out of 15 potential participants (one was never found at home, despite several repeat visits, and the other refused to participate on the grounds that she was too busy). In the second rural district of Mercedes, potential participants were approached in their homes on a random basis and asked initial screening questions in order to ensure the various categories of users and non-users of contraception were recruited. Informed consent was sought prior to beginning the interviews, consistent with research ethics approval obtained from both the University of Toronto and the University del Valle in Guatemala. The interviews occurred mostly in women’s homes during the day when their husbands were absent, and when privacy was a concern, in the local health centers. The Kaqchikel research assistant was present during all interviews to introduce the concepts of the research to participants, and translate between Kaqchikel and Spanish when necessary.

The elicitation interviews were audio-recorded, transcribed verbatim, with original comments recorded both in Kaqchikel and Spanish, and analyzed in both languages. Interviews were carried out between May and July, 2013, and continued until saturation was reached in
terms of the themes raised relating to accessing and using contraception. Content analysis was carried out by the investigator and research team using the constant-comparison method, which “is concerned with generating and plausibly suggesting (but not provisionally testing) many categories, properties, and hypotheses about general problems” (Glaser, 2008). Codes were developed and revised by the research team, to ensure accuracy and validity, then organized into themes relating to the barriers for accessing and using family planning. NVIVO 9 software was used to manage the analytic process.

Historical and political documents, government surveys, United Nations and donor reports as well as published research were consulted to provide information on structural elements that might also affect women’s access to and use of family planning. The political economy perspective was applied only as far as it directly influenced the development of the self-efficacy scale.

Results

Participants

Sixteen indigenous women, who identified themselves as Kaqchikel, participated in the elicitation interviews (Table 1). The mean age of participants was 22.4 years old, with a range of 20 to 24 (Table 2). Women of this age-range were specifically recruited because we were interested in examining decisions of women early in their reproductive lives, but were advised by community partners that interviewing adolescents had particular ethical challenges. Also, since indigenous people in Guatemala have life expectancies that are 13 years shorter than their ladina counterparts, and pregnancy during adolescence is common, these women are already approaching the middle of their reproductive lives (Elías, 2013). Participants were from two rural districts of Patzún, Chimaltenango in Guatemala: Las Mercedes (3) and El Llano (13).

Table 1: Participant characteristics related to definition of unmet need for family planning (n=16)

Table 2: Descriptive characteristics of participants (n=16)

Inter-related barriers
Three interrelated barriers were identified: concern about social chastisement for using family planning; husband being against family planning; and fear or experience of side effects. Many women described the fear of others finding out about their use of family planning:

Sometimes one is scared, scared that someone will find out, because they start to talk about and make fun of them… For example, they say, ‘look, see, she is taking care of herself because she does not want to give children to her husband; she’s looking for others, and they start to say a lot… it’s hard if someone knows.

Having one source of support (or the absence of a barrier) can act as a buffer against the effects of other barriers. For example, a husband’s support is helpful for withstanding social pressure and chastisement:

I’ve been told that, ‘one marries to have children, and when you can’t have children, you are not women.’ That is what I’ve been told, but I don’t give that importance. It’s good to be in agreement in the couple. My husband helps and encourages me. People say what they say but they don’t see what I lived with my family and I want to have something, and provide education to my daughters. That’s my… good that my partnership is like that.

On the contrary, if a woman does not have the support of her husband, critiques from others can cause problems in the relationship:

It’s good to make the decision as a couple, because if only a woman and not him, and that comes: they all start to talk… Then it starts, you start having problems in the couple.

Fear of side effects and infertility was common among participants. For example, one woman described:

Some say you can’t have children later, yes, that’s what they say (laughter), we haven’t proven this… According to what they say, if you use that [contraception], it can give you cancer.

Often side effects were described based on having heard about another woman’s experience:

A sister of my sister in law said that she used the copper T. She said she got bacteria in the place where the method was. It got infected and they operated on that part. So, yes, it causes illness.

Others dismiss the side effects they have heard others speak of as rumor:
Well, many say that the planning that some use, that it harms them; their stomachs hurt or it gives them cancer in their stomach. So they don’t want to use those methods and they keep giving birth each year, because of hearing those rumors or gossip that others tell them, but I think it’s not like that.

Family planning is used to prevent or achieve pregnancy. Social pressures to have children may cause some women to hide their use of family planning, sometimes even from their husbands. Hiding the use of family planning to prevent pregnancy, combined with limited contraceptive options, may push some women to use and remain using contraceptive methods despite experiencing side-effects or other adverse reactions. For example, one participant who used Depo-Provera (three month injection) chose this method because it is more discreet and she could do so without her husband knowing. She would have been reticent to switch methods even if she experienced side effects. A husband being a barrier to using contraceptives amplifies the effect of limited options for family planning (currently extension services in the community offer only natural methods, condoms and the Depo-Provera injection). Stories of these side effects, which reach women contemplating using family planning, no doubt have an amplified effect to negatively influence the uptake of a family planning method for preventing pregnancy.

**Multiple reasons behind barriers**

Participants discussed several reasons why they think husbands are against family planning, all with different implications for potential programing and policy (Table 3).

**Table 3: Perceived reasons for husband’s objection to family planning**

One participant whose husband had previously been against even discussing family planning explained that he was convinced of the merits of spacing children, and using modern contraception to achieve this, through special sessions directed at men at his work. The participant attributed these sessions with his willingness to begin broaching the topic with her, and ultimately with their joint decision to start using a modern form of contraception.

Another common barrier was the belief that family planning is a sin (Table 4). Religion often plays a pivotal role in influencing the cultural and social acceptability (or non-acceptability) of contraceptives. In previous studies from Guatemala, many women report their ideal family size to be “God’s will” (Asturias de Barrios et al., 1997; Da Silva et al., 2010; Metz, 2001). Ward (1992) found that in Guatemala, “distrust of family planning on religious grounds”
was voiced by both Evangelical Protestants and Catholics. Eleven of 16 participants in this study talked about the understanding that using contraception is a sin as a barrier to family planning, despite only 5 reporting attending church (4 Catholic and 1 Evangelical). However, for various reasons several participants countered this discourse, or felt themselves to be exempt.

**Table 4: Resistance of belief that contraception is a sin**

*Applicability of self-efficacy in the indigenous Guatemalan context*

Participants showed varying levels of confidence in overcoming particular barriers during elicitation interviews (Table 5).

**Table 5: Degree of confidence in overcoming barriers**

*Development of self-efficacy scale*

In order to develop the family planning self-efficacy scale, the codes developed both deductively and inductively using the constant-comparison method were re-visited. Codes relating to specific barriers faced by participants were identified, grouped and their content examined. The barriers discussed by participants in accessing and using family planning were distilled as much as possible into one-phrase obstacles and then integrated in the following family planning self-efficacy scale (Figure 1). The barriers relate to the following issues: lack of knowledge, availability, or communication about family planning methods, availability of contraceptive methods, fear of side effects and infertility, husbands being against family planning (and related fears of marital problems and abandonment), pressure from in-laws and the community, and the belief that using contraception is a sin. Conceptually, the 19-item scale may be understood to group around four elements or sub-scales of self-efficacy for family planning. These four sub-scales are comprised of items relating to: Access (questions 1, 3 and 4), communication (questions 2, 5, 6, 7 and 17), social support (questions 8, 9, 10, 11, 12, 13 and 19) and assertiveness for family planning (questions 14, 15, 16 and 18). These conceptual groupings suggest the scale may be multi-dimensional, but they would have to be pilot tested and validated. Exploratory and confirmatory factor analysis could be performed to see how the items load onto these four factors suggested by conceptual groupings (McDowell, 2006; Streiner, 2013).
Figure 1: Family planning self-efficacy scale

Experience of obstacles in scale is more nuanced

The barriers in the scale represent summaries of the types of issues faced by individual women, and are not nuanced enough to represent the full experience of participants. For example, the statement asking of one’s confidence to “Use a family planning method even if my partner does not want me to” probes only generally at the influence of the husband’s opinion. Another important dimension to consider is the reason behind the husband’s opposition to family planning, which are diverse, as presented in the results section, all with different implications for potential programming and policy.

Importance of local context

Individual elicitation interviews are critical to successfully develop self-efficacy scales that are relevant to the local context. The barriers found to be important in this context are suggestive of potential barriers in other contexts, but are not exhaustive. For example, a draft scale developed for this study based on a review of the literature included questions to capture whether the direct cost of obtaining family planning methods was prohibitive. Another series of potential questions asked about language barriers if reproductive services were offered only in Spanish, which is not the native language of participants, and feeling discriminated against by the health service provider, potential barriers that are suggested by the quantitative research of Ishida et al. (2012) in Guatemala, as described above. Due to relatively new expansions of national health strategies in this municipality of Guatemala, and the provision of Kaqchikel services by doctors and nurses in the communities where interviews were carried out, these potential barriers were not found to be important, and were dropped from the scale. These barriers may, however, still be important even in neighbouring municipalities of the same Department, where service provision may not be as available in Kaqchikel or costs of family planning methods may be prohibitive, especially if the primary supply chain breaks down and an alternate supplier must be secured.

Another type of barrier that was explored was the possibility that administrative requirements for obtaining family planning methods might serve as a barrier for individual women. Women have to sign a sheet at the rural health post to confirm they are receiving a
method, and if they cannot sign their name, they provide their fingerprint. At the Health Centre in Patzún, women receive a “Carnet de Planificación Familiar” (A family planning booklet) when they begin using Depo-Provera, and in this calendar their tri-monthly appointments for future injections are included. They must bring this booklet each time they come for their appointments. Such administrative requirements might serve as impediments to access for women who are using family planning without the knowledge of their husbands, or who are worried about their family planning status becoming known in the larger community. Probes about these potential kinds of administrative barriers were included in elicitation interviews, and this type of obstacle was not articulated as important by participants, hence it was not included in the final family planning self-efficacy scale. However, it is important to consider that the husbands of women in the study knew whether their wives were using family planning or not. We were transparent in our recruitment about the potential risk of inadvertently revealing a woman’s family planning status to her husband. Therefore, women hiding their use of family planning from their husbands were likely to self-select out of the study. In one rural district the local nurse preferred for us not to approach women in the community because she knew this situation to be prevalent. We therefore proceeded with recruitment in a different rural district. It is therefore difficult to estimate the proportion of women who are using family planning without the knowledge of their husbands. Only one participant had previously used family planning without her husband knowing, although this was no longer the case at the time of the interview. Reports from local nurses who have tended to victims of domestic violence and stories told in the interviews suggest that a woman using family planning without her husband knowing is a fairly common practice, with real risks of violent reactions from her husband if he finds out. For this particular group, where privacy and confidentiality are even more critical, having to sign for contraceptives could present a barrier.

**Self-efficacy scale enhanced by political economy approach**

Social Cognitive Theory (SCT) is advantageous over other behavioral health theories because of the way it incorporates the influence of the environment, conceptualizing behavior to reciprocally affect and be affected by cognitive and environment influences (Bandura, 1978a; Glanz & Rimer, 2005). However, the way that this is operationalized into research on self-efficacy mostly leaves out considerations of environmental influences, unless they act directly on and are expressed also as proximal barriers to particular behaviors. The self-efficacy scale
presented in this paper builds on the self-efficacy approach by incorporating a political economy perspective, and including considerations that may serve as barriers but were not directly mentioned by participants in elicitation interviews. For example, the question about the limited number of methods available becomes salient when one considers the larger supply environment. Women themselves did not mention few method options as a barrier, probably because they are not aware that other methods exist. However, the Ministry of Health does occasionally face stock disruptions, which also affect service delivery at the local level by public clinics and non-governmental organizations that are part of health extension services (USAID, 2013). Thus the question about a woman’s confidence in using family planning “even if only 2 or 3 methods are available” was included in the scale.

Discussion

The development of this self-efficacy scale represents a first step in the application of localized self-efficacy for family planning research in rural Guatemala. This research provides insights as to how localized elicitation interviews can influence understanding of particular obstacles to carrying out a particular behavior in a given context (Bandura, 2006; Maibach & Murphy, 1995a).

Results of the study show how the presence or absence of one barrier may have a reinforcing or weakening effect on the influence of other obstacles. Self-efficacy scales list obstacles as if they were free-standing and independent, but this research suggests the possible presence of interaction effects that are not captured by asking about confidence in overcoming individual barriers and would have to be empirically tested. This phenomenon is evidenced by the overlap of three kinds of barriers found in this study: concern about social chastisement for using family planning, the husband being against family planning and fear or experience of side-effects. The inter-relatedness of individual barriers has implications for policy. For example, the resolution of barriers relating to fear and experience of side effects is multi-faceted: more options of methods and information about side effects and their likelihoods should be made more accessible (such that women know about and can switch between methods more easily if they experience side effects), but women will not increase their self-efficacy for family planning and take advantage of the array of choices if they are limited to the options that can be used in secret. Thus, work to educate young husbands, influential others (mothers in law, etc.) and to help
young women develop the skills to convince their husbands if they want to use family planning, are key.

The integration of a political economy perspective provides a more holistic basis through which to understand potential barriers that may not be mentioned by participants themselves. Consideration of this more macro perspective resulted in the inclusion in the self-efficacy scale of the question about availability of methods, even though this was not identified directly by participants. This combination of the political economy and self-efficacy approach represents an enhancement of how Social Cognitive Theory is applied to family planning.

Early research on family planning in Guatemala showed persistent gaps between Ladinas and indigenous women in terms of contraceptive knowledge and behavior, particularly in rural areas (Bertrand et al., 1979). These trends have been monitored over time, showing increasing gaps along ethnic lines (Bertrand et al., 2001a). The hypothesis that this was due to differential access (i.e. distance to health facilities providing contraceptive services) between indigenous and ladino populations was originally supported when access to services was found to be a significant correlate with contraceptive use for the Mayan population, once socio-demographic variables were controlled for (Bertrand et al., 2001a). However, this was later refuted when a study linking household to facility-level data showed that physical distance to family planning providers was not significantly different between Ladinas and Mayans (E. Seiber & Bertrand, 2002). An alternative hypothesis emerged suggesting that the quality of services may be driving differential access, with Mayans being offered discriminatory services in inferior facilities by health professionals who, for the most part, do not speak their native language (E. Seiber & Bertrand, 2002; USAID, 2008). The most recent study of ethnic inequality in Guatemala lends support to this hypothesis, finding that “not speaking Spanish accounts for the largest portion of ethnic differentials” in met need for modern contraceptives (Ishida et al., 2012). There was nevertheless a residual difference in modern contraceptive use between Mayan and ladina women which could not be explained by any of the quantitative factors included, and probably relates to social and cultural influences which are not possible to capture in quantitative proxy measures (Ishida et al., 2012).

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12 Ladinas are “Spanish-speaking women of mixed Spanish and indigenous heritage” (Ishida et al., 2012).
Due to the obstacles mentioned, and not mentioned, by the indigenous women in the study presented here, there is evidence that distance to health services is not prohibitive for them, nor do they find service provision to be discriminatory. However, the barriers included in the self-efficacy scale probably relate to “unexplained” ethnic differentials in previous quantitative studies which are primarily due to social and cultural factors. Since extant qualitative literature about the barriers to family planning for ladino populations in Guatemala is sparse, it is hard to make a direct comparison to those found as important for the indigenous population in this study. In her mixed methods study of a predominantly ladino peri-urban community of Guatemala City, Asturios de Barrios (1997) found that unmet need for contraception was associated with a “paradigm of silence” that discourages discussion between spouses about reproductive decisions and “favors large families, which are considered the will of God.” Lindstrom et al. (2005) used network analysis to show that in Guatemala “social ties to urban or international migrants are associated with a greater likelihood of modern contraceptive use among married women.” These potential barriers and facilitators were also found as important for the indigenous women interviewed in this study, suggesting that the same factors may influence contraceptive adoption by both Ladinans and Mayans in Guatemala, although the barriers may be more strongly felt by Mayans.

The scale’s reliability and validity need to be tested empirically. For example, predictive validity of the scale could be examined by assessing if women’s confidence in overcoming these barriers correlates with contraceptive behavior, as would be predicted by Social Cognitive Theory. The scale intentionally employs simple, repetitive language for use in poor, rural areas where women are unlikely to have much formal education. An important question remains about how much the concept of confidence will be salient to indigenous women in this context, and whether they will be able to express their confidence numerically, particularly given typically low numeracy and literacy levels. Critics have charged that behavioral theories in general are anchored in individualistic societies, and thus not appropriate in more collective communities such as the site of this research (Montaño & Kasprzyk, 2008; Smith, 2012a). Bandura strongly disagrees with the contention that any psychological model with the word “self” in it necessarily promotes individualism, and he defends why self-efficacy is just as valid a concept in more collective societies (2002). He points out that “group pursuits are no less demanding in personal efficacy than individual pursuits” (Bandura, 2002). A promising outcome of this research is that
varying degrees of confidence in overcoming particular barriers are discernible from participants’ responses.

If using numbered scales to express confidence proves too challenging for participants, alternatives exist such as using visual representations of different levels of confidence, for example circles of progressively larger size (Bandura, 2006). Alternatively, the application of self-efficacy scales might have to involve a higher degree of interpretation than is customary on the part of the researcher, in order to assign numerical equivalents of confidence expressed through verbal responses.

The primary limitation of this research arises from the sampling strategy. The elicitation interviews formed the basis for developing the self-efficacy scale, which is appropriate to the local context of rural districts from this medium-sized rural community in Guatemala. However, because a convenience sample was used, the results are not generalizable. Caution is therefore advised before using this scale directly in another developing country context, although the barriers discussed here should certainly be considered as possibilities for family planning research with other marginalized populations in developing countries, as this is the first comprehensive self-efficacy scale that is consistent with Bandura’s Social Cognitive Theory and developed specifically with young adult women. Furthermore, these rural districts are ideal for researching certain aspects of unmet need for family planning, precisely because culturally appropriate, confidential services appear to be available, so it is possible to probe more specifically the cultural and social reasons behind unmet need for family planning.

A further limitation relates to how social desirability bias has been found to be a pervasive problem in research about family planning (Stuart & Grimes, 2009b). In order to mitigate this concern, participants were assured that there are no right or wrong answers, and that their anonymity is guaranteed (Maibach & Murphy, 1995a; Stuart & Grimes, 2009b). Since family planning is likely a behavior that is not socially sanctioned in Guatemala, the interview guide incorporated advice about how to “load” questions in order to maximize the likelihood of frank responses (Stuart & Grimes, 2009b).
Conclusion and policy implications

Despite most participants (10 out of 16) expressing the desire to wait two years or more before the birth of their next child, many barriers exist in this rural, Guatemalan context which inhibit young women from using family planning. These barriers sometimes overlap in ways that amplify individual effects and complicate programming and policy solutions.

Important strides have been made with the provision of culturally appropriate extension services through the national health system, which women find convenient and have made family planning more convenient and accessible. The fact that language and discrimination were not mentioned by participants reflects this. However, this study highlights several policy options for improving reproductive health services, including: providing a greater array of methods, ensuring privacy and confidentiality, and emphasizing that women can switch between methods in the case of complications. This study finds popular notions and rumors about exaggerated side effects to be prevalent, indicating that the provision of timely information about real side effects could be helpful.

The barrier of husbands’ opposition is so salient for many of the women with unmet need for family planning that prioritizing this is important in order to enhance family planning self-efficacy. There are two potential approaches which could be taken: in the longer term, programs and policies that improve gender equity, and women’s confidence in their own power within the relationship, would be critical. But even in the shorter term, with inequitable gender relations as they are, important strides could be made through improving the family planning knowledge of young husbands. Programs that invite men to special sessions in their own small communities are unlikely to be successful, due to the tabooed nature of the topic, and existing social pressure against family planning. Men might fear attending due to potential chastisement. However, programs and information that reach men in their more habitual environments, such as their places of work, could prove highly effective.

Indigenous women in Guatemala, who experience higher levels of unmet need for family planning, will need more than improved availability of family planning services in order to close the gap in contraceptive prevalence levels with Ladinas. Programs that target inequitable gender relations, and educate young husbands about the merits and mechanics of family planning, may
be particularly fruitful, in addition to the continued expansion of high quality and confidential reproductive health services.

**Authors’ Contributions**

ER was principal investigator of the study and led writing of this manuscript.

KA helped conceive of and plan the study, supported the analysis and helped write drafts of the manuscript.

AB helped conceive of and plan the study, supported the analysis and helped write drafts of the manuscript.

DG helped conceive of and plan the study, supported the analysis and helped write drafts of the manuscript.

All authors have read and approved the final manuscript.

**Tables and Figures**

**Table 1: Participant characteristics related to definition of unmet need for family planning (n=16)**

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<td>8</td>
</tr>
<tr>
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<td>4</td>
<td>4*</td>
<td>8</td>
</tr>
<tr>
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<td>10</td>
<td>16</td>
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*These participants have an “unmet need for family planning”*
Table 2: Descriptive characteristics of participants (n=16)

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<th>Characteristic</th>
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<th>%</th>
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</tr>
<tr>
<td>Pregnant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>No</td>
<td>12</td>
<td>75</td>
</tr>
<tr>
<td>Knowledge of family planning (# of methods spontaneously named)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>3</td>
<td>6</td>
<td>38</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Current family planning method</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depo-Provera (3 month injection)</td>
<td>7</td>
<td>44</td>
</tr>
<tr>
<td>Condoms</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>None</td>
<td>8</td>
<td>50</td>
</tr>
</tbody>
</table>

*One participant had one child who had died
### Table 3: Perceived reasons for husband’s objection to family planning

<table>
<thead>
<tr>
<th>Basis of husband’s objection</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wants more children</td>
<td>“They don’t use family planning because their husbands forbid it, or because their husbands want to have children.”</td>
</tr>
<tr>
<td>Worried about infidelity by the wife</td>
<td>“Some women don’t because their husbands are very jealous. They can’t because their husband sometimes thinks that because the woman is using a method, she can go with any man.”</td>
</tr>
<tr>
<td>Feels uncomfortable with the method</td>
<td>“He didn’t want to because he said he didn’t like it. So, like, the first day we used a condom and he felt uncomfortable. And I told him to get used to it, and it was like that until he got used to it.”</td>
</tr>
<tr>
<td>Concern about infertility</td>
<td>“Because he’s scared that maybe one day he is going to want another child and all of a sudden it won’t be possible” “He started to tell me ‘oh no, because that would be injections, but with that you can’t have any children, and I would like to have five children.’”</td>
</tr>
<tr>
<td>Fear of God</td>
<td>“We have thought about using methods, but at the same time it makes us feel bad and scared, for fear of God… Have you talked about this fear of God with other women?* No, with no one, only with my husband… And what does your husband think? He pretty much disagrees… So, do you think you could still use methods, or maybe not? Maybe not. Uh, because your husband is against it because of this fear of God? Uh, yes, that’s how it is.”</td>
</tr>
</tbody>
</table>

*Text in italics refers to the voice of the interviewer*
Table 4: Resistance of belief that contraception is a sin

<table>
<thead>
<tr>
<th>Grounds for resistance of idea that contraception as a sin</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having more children than one can care for is also a sin</td>
<td>“As my father in law says, one part is that planning is a sin, but as my husband was saying, a greater sin is having children that we don’t have… we don’t have enough to give them the things that children should be given, so we decided to plan, yes.”</td>
</tr>
<tr>
<td></td>
<td>“According to what I’ve heard all methods are a sin, because they say that what God sends, one has to receive, but, but at time one does not have the possibility to provide for all of them.”</td>
</tr>
<tr>
<td></td>
<td>“Well the Bible says it is good, but thinking about it, living it, well one can’t, because one is of scarce resources and can’t manage with so many children.”</td>
</tr>
<tr>
<td></td>
<td>“They say you can’t do anything because in their mind it’s a sin and the Bible says that God created man and woman to have a family. Well yes, but it also says in the Bible that you’re not going to give your child a stone if he asks for bread, so there it talks about the family. But as they don’t understand, they are closed-minded that it’s not good, so for this reason they don’t use a method.”</td>
</tr>
<tr>
<td>Using contraception is not a sin compared to abortion</td>
<td>“According to what they say, they’ve told me that it’s a sin, but I say it’s a sin when you’re pregnant and you think about aborting; there yes, because you have a human in your belly, but not if you take care of yourself from the beginning. I say this is not a sin; that’s what I’ve understood.”</td>
</tr>
<tr>
<td>Contraception is not a sin if you know you are not pregnant when you start using it</td>
<td>“With natural methods one can’t, can’t abort. And with contraceptives one can cause an abortion. Or someone who has not used contraceptives, and without realizing it, is expecting, and then they plan or use methods. This is the risk of using contraceptive methods. With natural methods you can’t abort. But if one knows she isn’t pregnant she can use contraceptive methods, uhum, to not become pregnant.”</td>
</tr>
<tr>
<td>Cannot plan family naturally because her cycle is inconsistent</td>
<td>“The priest says one has to plan naturally, take care of oneself, but sometimes this doesn’t work. Because, for example, I can’t because my period is not consistent.”</td>
</tr>
<tr>
<td>Otherwise gets pregnant annually; Pastor’s wife approves of using a contraceptive method</td>
<td>“You’re a ‘year-er’ [añera] people said, since I would get pregnant very quickly… [In Church] They told us that it’s a sin to use… abort or anything else is a sin… but one time the pastor’s wife asked me, ‘are you taking care of...”</td>
</tr>
</tbody>
</table>
yourself?’ Yes, I told her, yes because my daughter is still very little and another one will be so hard. ‘Yes,’ she said, ‘better that way so when she’s bigger you can have another one. There’s no problem,’ she said. That’s why I was using it.’
## Table 5: Degree of confidence in overcoming barriers

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Degree of confidence in overcoming barrier (Participants)</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husband against family planning (10)</td>
<td>High (3)</td>
<td>“Yes, I had confidence in myself because my baby was really small when I had the next one. So, yes, as he did not want to, I said to my mother and she said ‘if you are ok with it, go,’ she said, and I went.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Well, as a couple it’s the decision of both of you, but if the husband is not… no, does not approve, right? Well you have the right to decide for yourself, because it’s your life. It’s your body and not his.”</td>
</tr>
<tr>
<td></td>
<td>Medium (2)</td>
<td>“It would be hard for me. Well maybe with care, but I do say I would have problems, and always… but it’s difficult because it’s good to make the decision as a couple. Because if alone, and you go and he doesn’t, then there’s a lot of problems. You can even despair sometimes, and like that. But in my case, see, see, talking, talking and if he doesn’t understand then it’s him, and he’ll see the consequence with the kids…”</td>
</tr>
<tr>
<td></td>
<td>Low (5)</td>
<td>“Yes, I think that he disagrees and I can’t command him or decide by myself…Yes, as I said I would like to plan, but as I said my family doesn’t want me to, nor does my husband. They’re in disagreement and that’s how it is.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“In any case it’s good. But yes, both have to be in agreement, with the husband and the wife, then you can. If only the woman, almost no. For my part, I wouldn’t do that because, if one day he found out it’s a problem.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I’d say I wouldn’t. Because he would realize… There would be a fight because we don’t have the same opinion.”</td>
</tr>
</tbody>
</table>
| Fear of side effects (12)                         | High (7)                                                 | “Yes, I still plan to use it for another two years. Despite the pains it could give you? Yes, because with my first baby I didn’t use, then after, just like that we were taking care of ourselves, and with one inattention one can become pregnant. When one is
planning, not anymore; I mean one is not scared of becoming pregnant again.”

Low (5)  
“No, I wouldn’t like to use [methods]. No, because if I’m going to use, suddenly I’ll get sick. Since sometimes it makes people ill after, like this harms them. I’m not sure what it does to your stomach with an injection, right? So that causes another illness, so for that reason I think I won’t use it.”

“Because some women say that, that it gives them a headache or the menstruation comes and goes, comes and goes, and for others that it goes away right away. This is what they say. That’s why I’m scared to use it.”
**Figure 1: Family planning self-efficacy scale**

There are different kinds of family planning. When we say family planning we want you to think of modern methods of family planning, such as the pill, injectables, implants, condoms, spermicide, IUD and male or female sterilization.

How confident do you feel in your ability, as of now, to do each of the following activities? (Indicate your confidence with a number between 1 and 5 (1 = Not at all confident, 2 = not very confident, 3 = moderately confident, 4 = very confident, 5 = completely confident)

<table>
<thead>
<tr>
<th>Confidence Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Obtain information about different kinds of family planning methods.</td>
</tr>
<tr>
<td>2. Talk about different family planning methods.</td>
</tr>
<tr>
<td>3. Obtain a family planning method even if I have to wait in long lines.</td>
</tr>
<tr>
<td>4. Use family planning even if only 2 or 3 methods are available</td>
</tr>
<tr>
<td>5. Find a family planning method from another source if not available at primary source.</td>
</tr>
<tr>
<td>6. Discuss how many children I want to have with my partner.</td>
</tr>
<tr>
<td>7. Discuss family planning methods with my partner.</td>
</tr>
<tr>
<td>8. Discuss family planning methods with my friends.</td>
</tr>
<tr>
<td>9. Know other people who use family planning methods.</td>
</tr>
<tr>
<td>10. Use a family planning method even if I don’t discuss it with my partner.</td>
</tr>
<tr>
<td>11. Use a family planning method even if my partner does not want me to.</td>
</tr>
<tr>
<td>12. Use a family planning method without my husband knowing.</td>
</tr>
<tr>
<td>13. Use a family planning method even if my mother-in law does not want me to.</td>
</tr>
<tr>
<td>14. Use a family planning method even if my parents do not want me to.</td>
</tr>
<tr>
<td>15. Use a family planning method even if I am afraid of side effects.</td>
</tr>
<tr>
<td>16. Use a family planning method even if I experience side effects.</td>
</tr>
<tr>
<td>17. Use family planning even if I believe that family planning is a sin.</td>
</tr>
<tr>
<td>18. Convince my partner that we should use family planning.</td>
</tr>
<tr>
<td>19. Continue to use family planning even if people in my community find out.</td>
</tr>
<tr>
<td>20. Use a family planning method even if my neighbors criticize me.</td>
</tr>
</tbody>
</table>
5.2 ‘Uno tiene que cuidar también de sí mismo’: Guatemalan family planning decisions in the context of Social Cognitive Theory and a political economy approach (Manuscript #2)

*Title:* “Uno tiene que cuidar también de sí mismo”: Guatemalan family planning decisions in the context of Social Cognitive Theory and a political economy approach

*Authors:* Emma Richardson\(^a\), Kenneth R. Allison\(^a,b\), Albert Berry\(^c\), Dionne Gesink\(^a\) & Andrés Castañeda\(^d\)

\(^a\)Dalla Lana School of Public Health, University of Toronto
\(^b\)Public Health Ontario
\(^c\)Department of Economics and Munk Centre for International Studies, University of Toronto
\(^d\)Faculty of Social Sciences, University del Valle

*Abstract:*

*Objective:* A political economy approach was used to contextualize indigenous women’s stated (and unstated) barriers to accessing and using family planning in rural districts of Patzún, Chimaltenango.

*Methods and results:* Elicitation interviews were carried out with married, indigenous women, aged 20 to 24, from rural districts of Patzún, Chimaltenango in Guatemala in order to understand the barriers faced in accessing and using family planning. Coded data from these interviews were analyzed in light of context provided by historical and political documents. Critical structural issues affecting current family planning decisions include: gender inequity; the influence of the Catholic Church at the state level, and on individual beliefs, along with that of other Churches; social exclusion and repression of indigenous people dating back to colonial times and exacerbated by the recent civil war and the evolution of population politics at the global and national levels.

*Relevance and impact:* Casting a wider political, economic, historical, social and cultural net facilitates an understanding of current family planning choices and helps to explain the persistent gap in family planning prevalence rates between indigenous and ladina women in Guatemala.
novel framework is presented for simultaneously considering proximal, intermediate and distal factors affecting family planning. This analysis also highlights the need to expand high quality, culturally and linguistically appropriate services, with mechanisms to ensure participation, trust and confidentiality, for indigenous populations who have historically been oppressed and marginalized.

*Key words:* Family planning, political economy, Social Cognitive Theory, indigenous
**Introduction:**

Several studies have documented unequal contraceptive prevalence rates in Guatemala along ethnic lines (Bertrand et al., 1979; Bertrand et al., 2001a; Bertrand, Seiber, & Escudero, 2001b; Chen, Santiso, & Morris, 1983; De Broe, 2005; Ishida et al., 2012; Lindstrom & Muñoz-Franco, 2005; Lindstrom, 2006; USAID, 2008). Indeed, 54% of Ladinas  use family planning, compared to 28% of indigenous women and unmet need for family planning in indigenous women (29.6%) is almost double that of ladina women (15.1%) (Ministerio de Salud Publica y Asistencia Social, 2009). Unmet need for family planning is defined as “the proportion of currently married women [or women in union] who do not want any more children but are not using any form of family planning (unmet need for contraception for limiting) or currently married women who want to postpone their next birth for two years but are not using any form of family planning (unmet need for contraception for spacing)” (Mills et al., 2010; Westoff, 2006). Of added concern from a human rights perspective is that these differential rates have maintained over time in absolute terms (Bertrand et al., 2001a). Ethnic differences are partially explained by proximal and sometimes intermediate factors such as socio-economic and demographic characteristics, knowledge and attitudes, physical distance or travel time to contraceptive services, migration status, social networks and quality of services (Bertrand et al., 1979; Bertrand & Anhang, 2006; Chen et al., 1983; Ishida et al., 2012; Lindstrom & Muñoz-Franco, 2005; Lindstrom, 2006; Seiber & Bertrand, 2002; USAID, 2008).

Chirix (2010) makes a forceful critique of extant literature about family planning in Guatemala. She charges that most studies have implicitly incorporated an uneven application of the neo-Malthusian perspective, whereby the poor, indigenous people of Guatemala must limit their procreation to avoid catastrophic mismatches between resources available and numbers of mouths to feed, but this logic is not applied to other sectors of society and does not take into

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13 Ladinas are “Spanish-speaking women of mixed Spanish and indigenous heritage” (Ishida et al., 2012).

14 Relative differential contraception use rates between indigenous and non-indigenous women have been dropping over time, but the absolute difference has maintained between 1978 and 2009 (Bertrand et al., 2001a; Ministerio de Salud Publica y Asistencia Social, 2010).

account unjust social structures. She further points out that most studies are quantitative\textsuperscript{16}, positivist\textsuperscript{17} and superficial in terms of behavioural factors they consider, and often have undertones of paternalism and racism, without taking into account “the deeper meaning in social conduct, historical tendencies and symbolic codes from Mayan culture” (Chirix García, 2010, translation by the author). The current study stems from an understanding of fertility decisions in relation to human rights, whereby people have the right to “a satisfying and safe sex life” and should have the “capability to reproduce and the freedom to decide if, when and how often to do so” (United Nations, 1994). This paper responds to Chirix’s affirmation that “sexuality should be a historical-social concept, dynamic, intimately linked with politics and economics” (Chirix García, 2010, translation by the author) by utilizing a political economy framework. This study was led by a non-Mayan researcher from Canada, in collaboration with a local research team, and using community based participatory research principles, to ensure the priorities and practices of the Mayan people drive the research, methods, and interpretation and translation of study findings.

Theoretical Framework: Health behaviour theories are helpful for organizing, analyzing and contextualizing data from interviews with individual women. These models present and examine relationships between constructs that are postulated to influence individuals’ behaviour at the intrapersonal, interpersonal, community and policy levels. One such model that holds particular promise for understanding decisions about family planning is Social Cognitive Theory (SCT) with its fundamental construct of self-efficacy. Perceived self-efficacy not only influences whether a person will initiate a behaviour, but also “how much effort will be expended and how long it will be sustained in the face of obstacles and aversive experiences” (Bandura 1977). SCT designates pathways through which the central construct of self-efficacy might be enhanced: performance accomplishments, vicarious experience, verbal persuasion, and physiological states,” (Bandura, 1977; Bandura, Barbaranelli, Caprara, & Pastorelli, 2001). Personal performance or mastery accomplishments can enhance efficacy expectations as people see

\textsuperscript{16} Epistemologically, within quantitative research, “the investigator and investigated are [considered] independent entities” and research “value-free,” assertions contested in the qualitative paradigm (Sale, Lohfeld, & Brazil, 2002).

\textsuperscript{17} Positivists “assume a common objective reality across individuals” (Newman, 1998). Many “critical theorists, for instance, deny the existence of a reality logically and causally independent of mind, or reject the possibility that we could ever know the truth about such a reality. These are strong forms of anti-positivism” (Dessler, 1999).
evidence of their ability to carry out the behaviour. Furthermore, general coping skills can be developed that help deal with any number of stressful situations (Bandura, 2004b). Through vicarious experience people observe others carrying out behaviours, which can have effects on self-efficacy in the same two ways described for performance accomplishments. Verbal persuasion consists of being convinced by the arguments of influential others (Bandura, 1977).

The fourth, physiological states, is not as relevant for contraceptive use, which depends on longer term behaviour patterns that span a greater time duration than a heightened physiological state.

SCT is also advantageous for considering contraceptive behaviour in rural Guatemala because of how it situates environmental factors. SCT is premised on reciprocal determinism, whereby “psychological functioning involves a continuous reciprocal interaction between behavioral, cognitive and environmental influences” (Bandura, 1978b; Glanz & Rimer, 2005). In this conceptualization environment is elevated to have an independent influence, which is fitting for the Guatemalan context where the structural elements of oppression have been and continue to be so significant. SCT, nevertheless, may underestimate these structural aspects. Bandura explains that “most environmental influences affect behaviour through intermediary cognitive processes” (Bandura et al., 2001). If individuals are primarily influenced by the environment and sociostructural factors through the effects they have on cognition then ‘environment’ is very much conceived as being temporally located in the present, and does not sufficiently take into account the structural discrimination that has accumulated, been compounded and affected the situation of Guatemalan indigenous women over centuries.

Political economy approach: In order to address this limitation of Social Cognitive Theory, it is helpful to consider the contributions of a political economy perspective. Political economists generally view the lens of analysis that behavioural scientists use as overly focused on proximal causes. The “political economy approach to understanding health and illness considers the political, social, cultural and economic contexts in which disease and illness arise, and examines the ways in which societal structures interact with the particular conditions that lead to good or ill health” (Birn, 2009).

The conceptual model developed for this research (Figure 1) thus embraces the concept of reciprocal determinism that underpins Bandura’s SCT, and also emphasizes the historical and
political nature of the environmental influences on behaviour and outcomes. This approach builds on stances of progressive anthropologists, sociologists and historians who have encouraged a wider view of fertility choices and patterns (Freedman, 1975; Greenhalgh, 1990; McNicoll, 1980; Ness, 1984; Phillips & Ross, 1992; Ramírez de Arellano, 1983; Richey, 2008; Ross & Mauldin, 1996; Shiffman & Valle, 2006b; Warwick, 1982; Watkins, 1987).

Figure 1: Conceptual model that combines behavioural theory with a political economy approach.

Materials and methods

Study Setting: Patzún is located on the Western edge of the Department of Chimaltenango, in the centre of the Kaqchikel region and of Guatemala (SEGEPLAN, 2010). In the last national census of 2002, Patzún was described as having 42,326 inhabitants, with the majority, 40,241 people, identifying themselves as indigenous, and 2,085 as not indigenous (Instituto Nacional de Estadística, 2002). On average, women aged 20 to 24 in Chimaltenango wish to have 3 children, which is equal to the national average (Ministerio de Salud Publica y Asistencia Social, 2010). However, 69% of women in Chimaltenango have used a contraceptive method in their lifetimes, which makes the department among the lowest in terms of contraceptive use (Ministerio de Salud Publica y Asistencia Social, 2010). According to the National Survey on Maternal and Child Health, 25.3% of women in Chimaltenango have an unmet need for family planning (11.9% unmet need for spacing and 13.4% unmet need for limiting; Ministerio de Salud Publica y Asistencia Social, 2010).

Elicitation Interviews: Individual interviews were carried out in rural districts (El Llano and Las Mercedes) of Patzún, Chimaltenango, Guatemala with indigenous women, aged 20 to 24, married or in union. The interview guide closely followed advice for elicitation interviews for self-efficacy research (Middlestadt et al., 1996; Montaño & Kasprzyk, 2008), including general questions about participants’ age, ethnicity, education and families then moving to specific inquiry about their knowledge and opinions about family planning methods. Probes were included about barriers to accessing and using family planning which had been identified in extant literature. Ethics approval was obtained from the University of Toronto and the University del Valle in Guatemala. Participants (16) were purposively sampled such that half (8) were using contraception and half (8) were not, and half of those not using contraception (4) met
the definition of unmet need for family planning. The mean age of participants was 22.4 years old, with a range of 20 to 24 (Table 1). Interviews were recorded and transcribed verbatim, then analyzed according to the constant comparison method (Glaser, 2008). Themes were identified both deductively and inductively. Analysis of data from participants resulted in the inductive themes, which were a function of the interviews themselves, whereas deductive themes were generated from a consideration of extant literature about self-efficacy for family planning and of contextual issues. The coding scheme was checked for validity and accuracy by the first author and the local research team, including a research assistant from the community, a linguist who carried out bilingual (Kaqchikel and Spanish) transcriptions, and a local research coordinator. All quotes were translated from Spanish to English by the first author (for further information about the elicitation interview process and results, please see Richardson et al, submitted).

Table 1: Descriptive characteristics of participants (n=16):

Political Economy Sources: In keeping with a political economy approach, further analysis of the interviews and structural context was carried out to understand the historical and political factors underlying the more proximal barriers to contraceptive use. Information about the political, economic and cultural structures affecting family planning decisions was obtained from various sources in grey and academic literature: historical and political documents, government surveys, United Nations and donor reports and published research. This focused and critical literature review was used to support emerging structural themes and to generate deductive themes for consideration in the analysis of the elicitation interviews.

Results

Critical structural issues affecting current family planning decisions include: gender inequity; the influence of the Catholic Church at the state level, and on individual beliefs, along with that of other Churches; social exclusion and repression of indigenous people dating back to colonial times and exacerbated by the recent civil war and the evolution of population politics at the global and national levels. These influences will be discussed in turn, drawing on political and historical documents and direct quotes from elicitation interviews which allude to these factors, whenever possible, in order to interweave political economy and behavioural perspectives.
Gender equity: Mayan culture is patrilocal, in that women live with their husband’s families, and patriarchal (Chirix García, 2010). Patriarchy “refers to historical power imbalances and cultural practices and systems that accord men on aggregate more power in society and offer men material benefits, such as higher incomes and informal benefits, including care and domestic service from women and girls in the family” (World Health Organization, 2007). Gender inequity was never labelled as such by participants, however, imposing a gendered lens on the interpretation of interview data indicates several examples of patriarchy, touching on issues of unequal educational opportunities, the meaning of being a woman in this context, potential dangers of gender-based violence and power differentials in decision-making about family planning.

Education: When discussing the merits of spacing her children, one participant mentioned she would like to have fewer children so she can educate her daughters. She described that during her own childhood:

“Well, in my case I wanted to study, but I didn’t have the support of my father. He said men are worth more because women get married… My brother had the opportunity but he didn’t know how to take advantage of it. Well, he didn’t want to, and, well, I wanted to, but nothing could be done because I’m the eldest and I have to cook; I have to go the fields and get my sisters ready. They don’t go to school. And lots of things that truly, sometimes I feel very alone and really sad… I want to have something and give studies to my daughters.”

Conceptualizations of gender certainly influence access to education in Guatemala. The population who are 15 years or older have on average 4.5 years of education, with non-indigenous, urban men having the highest average years of schooling (8.9 years), and indigenous women from rural areas the lowest (1.2 years) (Dary, Asturias de Barrios, & Vargas, 2004; UNICEF, 2007).

Ser mujer – Being a Woman: Participants commonly described women’s identities in their community being tied closely to having children. Even women who do have children risk the criticism of not being a woman (‘¿No sos mujer?’) if they do not provide many children for their husbands (6 of 16 participants described this in detail). This expression of womanhood is an
interesting variant of the common stereotype of Latin American men as machista\textsuperscript{18} and their feeling that having many children is an important signal of their manhood (Zelaya et al., 1996). Participants describe criticism for not being a woman by neighbours, husbands, mothers in law and women themselves (Table 2).

**Table 2: Critique of not being a woman if one does not have many children**

The slow passing of laws against gender-based violence exemplifies the conceptualization of women as merely mothers and wives. For example, rather than condemning all violence against women, and despite efforts by women’s groups to make the law more comprehensive, the 1996 Law to Prevent, Sanction and Eradicate Violence within the Family, as its title suggests, limited its scope to violence ‘in the family.’

*Culture of violence against women:* The most extreme expression of violence against women in Guatemala is the staggering number of women being murdered, labelled *feminicidios* (femicides), with 8.38 women murdered annually per 100,000 people in Guatemala. Between 2005, 2006 and 2007, 1,986 women were murdered in Guatemala, two thirds of who were killed by men with whom they are close (partners, husbands, fathers, etc.). Perhaps still more shocking is the impunity with which these murders are committed, with only 2% of perpetrators being successfully convicted (43 convictions between 2005 and 2007). This represents a legacy of violence against women connected to the civil war (Berry, 2010), and lends credence to the concerns of individual women who fear violence from their husbands if they use family planning without their knowledge or consent.

Despite these high levels of violence against women, this topic is very much shrouded in silence, such that women are less likely to share openly about experiences or fear of violence. During the civil war silence was a learned protection strategy used by indigenous people, who were the targets of violence from rebels and especially the state. Indigenous families would not identify their own relatives killed in counter-insurgency operations, for fear of being killed themselves (Lovell, 2010). The violence affected “particularly Mayan people, whose women were considered to be the spoils of war and who bore the full brunt of the institutionalized violence.”

\textsuperscript{18} Machismo “typically involves the domination of women, who are viewed as responsible for raising children and serving men” (Arciniega, Anderson, Tovar-Blank, & Tracey, 2008).
violence” (Lovell, 2010). Indigenous women were used as pawns during \textit{la violencia} and considered the enemy’s property (Consorcio Actores de Cambio, in García Chirix, 2009).

Recognizing the hesitancy to come forward about instances of violence is important for understanding nuances in interviews with individual women. For example, many women refer to ‘problems’ in their marital relations which could transpire if they used family planning without their husband’s knowledge and he subsequently found out, and fear of even bringing up the topic of family planning. Due to evidence from some women who were more explicit, and nurse practitioners in the municipality, it is highly likely that the term “problems” is often employed as a euphemism for violence (Table 5).

\textbf{Table 3: Women’s discussion of “problems” and violence}

Special care was taken not to inadvertently expose women’s family planning status when they were recruited for this study. Thus, participants were less likely (than the average indigenous women in this age category) to currently use family planning without their husbands knowing. The nurse who provides extension health services in El Llano, the rural district where most of the elicitation interviews were carried out, described having had to attend to a situation of domestic violence in an adjacent community, where a woman sought medical services after being beaten by her husband when he found out she was using family planning. In Chuinimachicaj, another rural district where interviews might have been carried out, the nurse did not feel comfortable collaborating with recruitment, as she knew many potential participants were using family planning without their husbands knowing, and had already tended to several cases of intra-family violence relating to husbands finding out about their wives using family planning. Taken together, participants’ implicit and explicit comments about fear of violence, the experience of nurses in the area and national statistics and policies about gender-based violence, all point to persistent gender inequity underpinning women’s limited sphere of decision-making regarding family planning.

\textit{Whose decision is it?:} When asked who is responsible for decisions about the number of children to have or family planning, on the surface, participants’ responses mostly embody a more equitable view about this decision-making process between her and her husband. However, often later towards the end of interviews, or if one cross-references with other responses, a pattern can be seen whereby husbands essentially have veto power over the decision to use
family planning. The decision is only a ‘shared’ one, as many women describe, once the husband has already expressed his approval.

One participant revealed her husband’s opposition to using family planning only slowly through the course of the interview. When initially asked, “What does your husband think about that [family planning]? She responds, “He agrees.” Later, when discussing fear of God in relation to using family planning the participant admits, “He’s pretty much not in agreement [about using family planning]” (‘El casi no está de acuerdo’). Finally, when discussing her confidence in using family planning according to various scenarios, the participant confirms, “He’s not going to be in agreement.” She goes on to elaborate that she would not feel comfortable using family planning without her husband’s support, because she fears being abandoned and losing her husband’s help in the case of her becoming ill.

When asked directly, most participants say they believe that using family planning is a joint decision of both the husband and wife; however, many of their elaborations show that the husband effectively holds the definitive decision-making power in this realm:

“Whose decision do you think it is to use family planning, more the woman’s, the man’s or both of them?”

“Both of them, in my opinion, of both of them, because between the two of them they have to be in agreement. No, one won’t come, one doesn’t have problems, let’s say. And if only one is in agreement and the other one not, there, there are problems.”

Another participant is more forthright that the husband has to be in agreement about family planning:

“At any rate it [family planning] is good, but yes, both have to agree, with the wife and the husband, then you can. If just the woman, pretty much no. For my part, I wouldn’t do that because, if one day he found out it would be a problem… Yes, for me, we’d have to both talk to use those methods.”

One woman is explicit about not being able to dictate to her husband:

“I can’t just dictate to him. I can’t decide all by my little self (‘solita’), so we have to be in agreement both of us. Yes, that’s how it is.”

Catholic and other Church’s Influence: The most proximal influence of the Church on family planning is through the way Guatemalans’ religious affiliations influence their understanding and
opinions about using contraception. Eleven participants out of 16 discussed how the conceptualization of family planning as a sin could be a barrier to use and access. Of these, five participants actively attend Church (4 Catholic and 1 Evangelical) and two have a strong ‘fear of God’ that is definitive in dissuading them from using family planning. Even if women did not themselves attend Church, they are often influenced indirectly by what they understand to be the Church’s teachings, and by family or community members who hold strong beliefs about contraception being a sin:

“Sometimes we prescribe that God’s law well, it does not, not, and more the religious communities don’t permit that… So not that [family planning]. Let’s say it’s a sin, because while we seek a husband it’s to have children, because God himself said so, that’s what I think…”

“And why do you think your mother would not be in agreement?”

“Like I told you before, she, in the first place it’s a sin, to do that, to use all those methods, that’s what I think.”

Another participant discusses the repercussions of using family planning in relation to God:

“It’s a sin in front of God. Yes, because maybe he has plans to send the children here to earth, but we don’t want them, hmmmm… Well, what I think is that God sends blessings through children. Yes, for each child that is born He gives us all that parents need. Because of the children, the parents eat. And if one, I think that if one uses methods it’s because, because one wants to, and there won’t be as many blessings… We’ve thought of using methods, but at the same time we feel remorse, due to a fear of God, who knows? (¿saber?)”

In Guatemala the Catholic Church’s influence in governance dates back to colonial times, when it was arguably as significant as that of the secular bureaucracy (Bendaña, 2010; Calder, 1970b; Few, 1995). Few (1995) documents how the Holy Office of the Inquisition of Santiago de Guatemala exerted power and social control over both elite and colonial subjects. In general, “Women's sexuality [was] constituted by the church and civil authorities as dangerous to the social order in a broad sense” (Few, 1995). The Church systematically attacked the healthier and open sexuality of indigenous people, attempting to replace it with more oppressed and “decent” sexual customs (Grupo de Mujeres Mayas Kaqla, 2004).

The Catholic Church’s influence on Guatemalan population policy has largely served to limit access to and use of contraception. When Guatemala’s private family planning
organization, APROFAM, was founded in 1962, many leaders were discouraged from starting or continuing as board members due to constant pressure from the Church that opposed family planning (Santiso-Galvez & Bertrand, 2007). After some gains were made in improving family planning services, the Ministry of Health succumbed, in 1979, to pressure from the Catholic Church, which claimed intra-uterine devices were abortifacient, suspending its family planning program and ordering all intra-uterine devices to be removed (Santiso-Galvez & Bertrand, 2004; Santiso-Galvez & Bertrand, 2007). Berger (2006) documents the Catholic Church’s powerful lobby against any provisions about family planning and sex education in the 2001 Social Development Law.

Another important caveat is that Catholicism, in and of itself, is not enough to explain the lack of contraceptive prevalence in Guatemala, as these same influences were present in other Latin American countries too, such as in Chile and Colombia where contraception rates are higher (Robinson & Ross, 2007). Rather, it is a confluence of factors in Guatemala, and the “close ties between the Catholic Church and the ruling elite on the issue of family planning” as pointed out by Santiso-Gálvez and Bertrand, that contribute to the “delayed contraceptive revolution” in this country (Santiso-Galvez & Bertrand, 2004).

Women’s Sexuality shrouded in silence: Overlapping ethnic and gender based inequity, colonial history as well as the influence of the Church, have all contributed to a situation where women’s sexuality is a taboo topic in Guatemala across all social classes, and even more so for Mayan women (Chirix García, 2010; Pick et al., 2008). Emma Chirix, a Kaqchikel academic from Comalapa, Chimaltenango, writes compellingly about the ways Mayan women’s sexuality has been repressed. She describes how pre-Hispanic clay depictions of Mayan women show the human figure including erotic images, without a negative connotation. Her historical analysis of the Mayan body politic traces how Western conceptions of beauty and chastity have led to a ‘colonization of the body,” furthering and embodying exploitation, guilt and a double morality (Pineda, 2000 in García Chirix, 2009). Thus, according to Chirix, Mayan women’s conceptualizations of nudity and sexuality have been transplanted through the imposition of another “vision of value and ways of dressing, and sexuality has come to be understood as impure, dirty, private, embarrassing and sinful,” with the “human body unworthy of pleasure” (García Chirix, 2009, translation by the author).
As expected, repression of women’s sexuality was not mentioned directly by participants, but it can be observed through several lines of interpretation. Five participants spoke about sex on a total of seven occasions, though never using the term directly. Participants referred to ‘having relations’ in four instances and to “taking care” in three others. Across the interviews, the term “take care” takes on many meanings, most often to describe using family planning, both natural and modern methods. In two of the three instances in this context, women referred to “taking care” as avoiding sex with their husbands during the fertile period of their cycle, when they were using the rhythm method: “If one does not take care of the days that one cannot be with him, but, if one could not take care, then one gets pregnant.” Never was sex mentioned in regards to women’s enjoyment or pleasure. On the contrary, two women talked about being fearful of having ‘relations’ with their husbands when they were not using a modern method of family planning, because they did not want to get pregnant: “One feels fear, feels fear when having relations because what if I get pregnant again and I don’t want to, and like that… One can even feel badly for this. Due to this there can also be problems, because the husbands find out that one, well, does not, not, let’s say, one does not, not feel good with him.” In these instances women had trouble experiencing pleasure in sex because they were so concerned about the reproductive implications. For women with unmet need for family planning, who prefer to wait to have children but are not using a modern method, the fear of becoming pregnant appears to overshadow any possibility of pleasure, and may create new sources of anxiety.

The topic of reproduction in general goes relatively unspoken, with lines of communication about having children typically delayed, even among mothers, daughters and siblings, until after the first pregnancy has begun:

“Well, we talked about it [having a family] sometimes, but it’s not, it’s not the same as when you are living it, then they orient you more than, than when you’re still not, just a comment that simply passes. When one is living it already, it’s, it’s more, more significant the comment they give you”

“And is having children something you plan, or something that simply happens?”

“Well in my case I think it’s, something that, that happened to me and, like that, it happened.”
Discussion of contraception with one’s family is even less common, with many participants finding out about family planning through health service providers once they already suspect being pregnant or have given birth to their first child.

Husbands employ several delay and avoidance tactics to discussing family planning. For example, one woman describes how her husband preferred to talk about family planning after having their first child, then confirmed he was against it: “Yes, we talked about it [family planning] but after he said that ‘There, let’s talk about this after, when we already have our first child,’ he said, ‘to define things well.’ Aha, but yes, we talked a bit [after the first child] but he’s pretty much not in agreement.” Discussions that do occur between young spouses when the husband does not want to use family planning seem to be largely one-sided, with the husband not revealing his reasons for disagreement:

“Mmhh, he’s not in agreement, no”

“And why does he say, why do you think he’s in disagreement?”

“About that, yes I don’t, he tells me he’s in disagreement”

“He simply said he was in disagreement and that’s where the conversation ended?”

“Yes.”

Another participant described being so fearful of bringing up the topic of family planning that initially she felt comfortable doing so only in jest:

“Yes, the first day I spoke to him about this [family planning] I was scared of how to start to telling him so I started to say it with jokes. Jokes, I told him, and jokes and jokes and like that, and until one day I did speak to him seriously… The joke that I told him is that I said, ‘What do you say if one day we use a method?’ I told him like that, then he started to laugh and he said ‘No, no I don’t want that,’ and we started to laugh. Like that, with jokes.”

Humour can facilitate “expressions of thought and acts which are not normally permitted” and jokes are sometimes used to try out “certain views only half seriously” (Wellings, 2000). Expressing herself initially through jokes, this participant was able to broach the sensitive topic of family planning. Examining the interviews for patterns of laughter shows that participants laughed most frequently when discussing if they had been pregnant, how many children they want to have, and whether the timing of their last birth was ideal for them or not. This laughter
is another indication that conversations about reproductive decisions are likely uncommon and somewhat uncomfortable for participants in the study (Wellings, 2000). Chirix (2009) documents how in Comalapa, Chimaltenango, the topic of sexuality provokes laughter, with many women expressing their feelings, emotions and sexual experiences through jokes. Often using metaphors, women refer indirectly to intimate parts of the body, showing resistance to the dominant patterns of sexual repression.

*Ethnic social exclusion through history, culminating in the Civil War:* The introduction of the Commission on Historical Clarification (1999), which attempts to document and understand the roots of the violent and protracted civil war in Guatemala, explains “the unavoidable finding: This society is profoundly heterogeneous and polarized in economic, social and cultural terms, without a shared national project that recognizes equal opportunities for all of its citizens.” The Truth Commission, as this Commission is commonly referred to, goes on to document the highly unequal social relations that preceded and were root causes of the Civil War, which lasted thirty-six years until the Peace Accords were signed in 1996. The concentration of economic and political power and a racist and discriminatory society, have served to exclude large segments of the population from effective political participation, particularly Mayans (Comisión para el Esclarecimiento Histórico, 1999). The lack of institutional channels through which these repressed groups in society could register their concerns and proposals, eventually led to their taking up arms (Comisión para el Esclarecimiento Histórico, 1999). During the war the Guatemalan state was found to be guilty of killings, torture, forced disappearances, massacres, sexual violence, scorched earth operations¹⁹ and ultimately genocide. The Truth Commission meticulously documented organized violence mandated from the highest levels and destroying the country’s social fabric. In total, 200,000 civilians were killed, 93% of whom were killed by government forces (Comisión para el Esclarecimiento Histórico, 1999). Chimaltenango is among the three departments which experienced the greatest numbers of forced disappearances and massacres (70) (Comisión para el Esclarecimiento Histórico, 1999). Even though participants in the elicitation interviews did not directly refer to this lasting and persistent discrimination, it is still important to recognize this oppression as a back-drop for understanding

¹⁹ Scorched earth was an army policy, “where if they found any evidence of guerrilla support in a town or village, they would simply rape, pillage, and murder to destroy the town” (Berry, 2010).
differential access to family planning methods between indigenous and non-indigenous women in Guatemala.

Beyond its obvious health and welfare effects, the bloody and protracted civil war severely contracted health and social services and contributed to a lasting environment of mistrust. This general state of mistrust may also help to explain why indigenous women continue to view public health services with apprehension, including for accessing family planning methods. During the civil war transportation was disrupted, health units were no longer built or maintained, and “few health personnel were willing to relocate to areas of armed conflict…” contributing to “chronic shortages of nurses and doctors” (Santiso-Galvez & Bertrand, 2004).

Berry (2010) has explored institutional racism as a determinant for worse maternal health outcomes for indigenous women in Guatemala, and to help explain their apparently contradictory rejection of “modern” emergency obstetric care. Through anthropological participant observation research and “recognizing the influence of wider historical and social context,” Berry shows how culturally inappropriate and discriminatory services, particularly in hospitals, serve to make indigenous women distrustful and families reluctant to bring women to the hospital, even in clear cases of obstetric emergency (Berry, 2008; Berry, 2010). She shows how efforts by the Ministry of Health to make maternal services more modern have indirectly encouraged doctors and nurses to seek out and praise patients they understand to represent this ‘modernity’ and criticize, chastise and reject patients who for them, fit the stereotype of the “Indio bruto” (brute Indian), undeserving of care and easily dismissed due to being “illiterate, backward, dirty, simple, poor, lazy and stupid” (Berry, 2010). She further shows how the general environment of every day violence, and legacy of mistrust of government from the Civil War, reinforce reluctance to use medical services during pregnancy and labour: “Given the palpable context of violence that makes even the unthinkable plausible, we can now understand why villagers are reasonably reluctant to fully embrace a [maternal health] policy that results in them ceding any tiny bit of control over their bodies that they maintain” (Berry, 2010).

Population politics: International:

It was not until later in the Cold War that the United States began to see population concerns as extensions of their foreign policy, drawing associations between population, development and
anti-communist efforts (Bashford, 2008). The Alliance for Progress, established in 1961, articulated United States’ intentions to help fight poverty, show the benefits of the capitalist system, and control the spread of communism (Comisión para el Esclarecimiento Histórico, 1999). In the same year the United States established its Agency for International Development, with population a major pillar (Chirix García, 2010). Specific birth control methods were heavily subsidized by the United States (Raúl, 2008). Latin American governments were under pressure and funded to enact policies of population control, ostensibly as a measure to discourage instability and the ensuing threat of communism (Birn & López, 2011; Raúl, 2008). A critical view of this motivation was perhaps most eloquently captured by Eduardo Galeano: “In Latin America it is more hygienic and effective to kill guerrilleros in the womb than in the mountains or the streets” (Galeano, 2009).

National population politics: Previous qualitative research on family planning in Guatemala has quoted individual men and women from Mayan Quiché communities to be against family planning because they believe it part a “Ladino plot to do away with the Mayan population” or a “U.S. plot to diminish the strength of Guatemala” ((Metz, 2001; Ward et al., 1992). Especially in light of the recent civil war, this may not have been completely untrue in the past. In her critique of family planning as an imperialist strategy, Chirix (2010) documents how the state of Guatemala was accused in a 1976 newspaper article of massive sterilization campaigns in the Western Highlands. Guatemala’s leading academic institution, the University of San Carlos was a bastion of leftist sentiment, where “family planning was seen as part of an imperialistic plot by the United States to control the masses of its developing-country neighbors” (Santiso-Galvez & Bertrand, 2004). This vocal opposition reinforced governments who were neutral or against family planning, and contributed to a vacuum in service provision, as doctors and nurses who graduated from the San Carlos were not trained in providing contraceptive services (Santiso-Galvez & Bertrand, 2004).

This national version of the imperialist critique is echoed in the ethnographic findings of Nelson (1999), who found Mayan women were criticized for undermining the indigenous movement if their activities strayed too far from childbearing: “Discussion of the genocide suffered by the Maya and emphasis on the role of women in passing on the culture to their children have resulted in a marked pronatalist stance among the Mayan rights movement.” Nelson describes the contradictions some Mayan feminists have faced, and a pattern of glossing
over gender inequity in an effort to stay united in the Mayan movement, invisibilizing the oppression of Mayan women by the already oppressed Mayan men (Nelson, 1999). While this rationale for rejecting family planning was not raised directly by participants in this study, it could be an underlying reason why older generations are in some cases staunchly against family planning and pressure their daughters and daughters in law to have many children.

While the sample for interviews is not statistically representative, it is still noteworthy that seven of the eight women using contraception chose Depo-Provera as their method of choice, with one participant opting for condoms. The predominance of this choice warrants further exploration at both the individual and political economy levels. Depo-Provera is a family planning method that is injected every three months, and six women in the study mentioned they thought this was the best method to use because it was less easy to forget. For example, one woman comments, “The injection is the easiest; it’s the one you can remember easiest because the other ones you forget.” Another woman explains, “Yes, I first tried with those (birth control pills) but no, that was when I became pregnant again with my daughter. I don’t know why that would have been; I don’t know if it was because I wasn’t controlling [‘llevando el control’ or managing] the pills.”

The reason why so many women opt for injection is no doubt determined by individual preferences, due to its convenience, non-permanence and subtlety, but a deeper exploration shows that policy and the supply environment are also important. A 1978 study of family planning use in Highland Guatemala, commissioned by the United States Agency for International Development (USAID), concluded that injections would be the preferred contraceptive method of indigenous people, were it not so expensive\(^\text{20}\), due to their familiarity with injections as cures for common illnesses (Annis, 1978). More recently, Maupin (2011) confirmed that in “Guatemala, injections are a powerful symbol of efficacy, knowledge and power, and for many promoters constitute their primary source of revenue” (Maupin, 2011). In the rural districts where interviews were carried out, Depo-Provera is now provided free by the Ministry of Health, which, perhaps in part due to preferences of external donors such as the United States, and findings such as those in Annis’ (1978) report, seems to have overwhelmingly

\(^{20}\) In the Department of Quiché where the study took place, private pharmacies charged about $5 per injection, and the Ministry had discontinued injections (Annis, 1978).
thrown its weight behind this method. The Ministry of Health sets targets for the number of new users of family planning by department and municipality. For example, in the municipality of Patzún, the Ministry is expected to meet the target of 1596 new contraceptive users in 2013. What is more, the targets for contraceptive users are designated by type of method, with Depo-Provera occupying the large majority of the overall target (1244 out of 1596 new users).

Table 4: 2013 Municipal targets for new contraceptive users in Patzún, Chimaltenango

It cannot be determined from this study whether the supply environment is encouraging individual women to opt for the injection method, or vice versa, however, it is clear that a re-enforcing loop exists which promotes the three month injection over other types of family planning methods.

The lack of availability of a wide array of family planning methods\textsuperscript{21} was one of the concerns raised in 2013 by an indigenous leader from civil society, Noemí Racanjoj, who worries about the centralized way laws relating to reproductive health are enacted and implemented (Orozco & Morales, 2013). Ms. Racancoj criticized planning in reproductive health for taking place in the capital without sufficient consultation in rural areas, leading to the imposition of certain methods without adequate counseling and insufficient consideration of local culture. Given that Mayans represent the majority of the country’s population, one might wonder why they do not have more clout in the government, with a representation of just 11.4% in the current national congress (National Democratic Institute, 2013). Many have pointed to the scant support for Rigoberta Menchú, who received only three percent of votes as the first Mayan woman to run for president in 2007\textsuperscript{22}, as evidence of disunion and incoherence in Mayan civil society (Tally, 2008; Tally, 2008). A further drawback relating to the prompt and adequate drafting of reproductive health legislation has been the weak representation of women in Congress, with only 21 of 158 (13.3%) members of the current congress being women, and just three of these (1.9%) indigenous women (National Democratic Institute, 2013; Vásquez V.,

\textsuperscript{21} The Family Planning Law calls for 16 family planning methods to be available (Morales, 2013).

\textsuperscript{22} Rigoberta Menchú ran again for the presidency in 2011, once again winning less than three percent of votes (Bevan, 2013).
Galicia Nuñez, & Monzón, 2013). This participation by women in Guatemala’s national congress is low by regional standards

The passing of the Law for the Universal and Equitable Access to Family Planning in 2005 shows promise about the Guatemalan state taking ownership of family planning. This law establishes sex education for all school children and a National Commission for the Procurement of Contraception, meant to ensure universal access to a wide array of family planning methods (Reynolds, 2009). The passing and implementation of this law was vigorously fought by representatives from the Catholic and Protestant Churches, who claim parents should be solely responsible for children’s sex education (Reynolds, 2009). Despite this powerful lobby, which did delay the required regulations from passing until 2009, the eventual passing of this law is a testament to relentless efforts by reproductive health advocates and does signify a step by Guatemala towards ensuring “the right of people to freely decide the number and spacing of their children,” as is spelled out in the law and consistent with international reproductive rights frameworks (Ministerio de Salud Publica y Asistencia Social, 2009). However, the relatively few family planning methods available to women interviewed in this study shows that this law is still far from being fully implemented.

**Discussion of results and conclusion**

As has been traced through the above analysis of political, economic, social and cultural factors, individual decisions about family planning are shaped by larger social and societal forces. In Guatemala, the combination of historical and recent ethnic-based discrimination and violence, gender inequity, powerful and influential Churches, and international, national and local population policy, make overlapping contributions to increasing inequities in family planning access and use. The blend of these factors helps explain why Guatemala’s family planning trajectory is so different even from that of other Central American countries, many of which share some of these structural issues, but not all to the same extent and with the same compounding effects. Socio-political factors, including the Catholic Church and education

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23 Guatemala is grouped with Uruguay and Brazil for having low representation of women in national legislatures of Latin America (12% or less) compared to “Nicaragua, Costa Rica, Argentina and Ecuador, where women hold more than 30 per cent of lower house/unicameral legislature seats” (Idea International, 2012).
system, affect the reduced availability of family planning methods. A gender-inequitable society and weak legal system perpetuate institutionalized violence against women and create a culture of fear and intimidation around family planning.

This analysis shares some of the factors previously explored by Santiso-Gálvez & Bertrand (2004) in their examination of macro level influences on family planning in Guatemala, such as the long civil war and the influence of the Catholic Church, however, the factors are examined in a more critical way, implicating guilt on the part of the state when appropriate, and recognizing the ongoing proximal impacts of past societal determinants of family planning, such as the ongoing influence of the civil war on warranted mistrust of the state by indigenous populations.

These findings suggest that reducing the gap between indigenous and non-indigenous rates of unmet need for family planning in a lasting and meaningful way will require a significant re-ordering of social relations in Guatemala. While the influence of the Catholic Church and gender inequity is significant for both indigenous and ladina women, factors such as the legacy of violence, poverty and racism have a concentrated influence on reduced access to family planning for indigenous women in Guatemala. Poverty alleviation and redistributive efforts, such as the cash transfer program that has survived from the last government of Alejandro Colom to Otto Perez’s current presidency, if sustained, will likely continue to improve the political participation of indigenous people in Guatemala. The new initiative for bilingual intercultural schools, which grew out of the Peace Accords, will likely help to remedy the cultural barriers to education, and girls’ education in particular, through the provision of high-quality, culturally appropriate education by bilingual teachers in adequate and dignified facilities (UNICEF, 2007). Programs and policies that contribute to gender equity may help to reach children and adolescents before inequitable gender relations become engrained. Policies across sectors, such as through implementing the right of women to own land and participate politically, would help to improve equality between sexes. Reproductive health policy and planning that is more inclusive and participatory may help to move beyond the provision of basic services and take into account local culture and religion. Given the historical legacy of mistrust that must be overcome for indigenous women to accept family planning services, service providers would be well-served in ensuring all staff, whether community-based or not, understand the importance of, and take all steps to protect, confidentiality. Family planning and reproductive health advocates
may be able to build on past successes and lessons learned, such as with the passing of the Social Development Law, where discreet and timely lobbying with Catholic bishops helped to pre-empt the Catholic Church’s inevitable opposition.

This deeper examination of individual family planning decisions increases understanding of the complexity of these issues, but findings suggest that deep political change may be needed. Bringing a political economy perspective to research on contraceptive self-efficacy has not been done before, and this approach helps to differentiate the aspects and origins of unmet need for family planning that are more individual, social and societal in nature. Through this novel framework, barriers to accessing family planning mentioned by women in individual interviews are considered in a simultaneous and reciprocal way with larger structural influences that frame their experiences. By taking a longer historical view, barriers that are not specifically mentioned by women in elicitation interviews are still considered, past struggles are honoured, and an overly biomedical and simplistic view of family planning choices is avoided. This combination of health behaviour theory with a political economy perspective represents a methodological approach that is useful for a holistic and pragmatic understanding of health issues both within and outside the realm of reproductive health.

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Authors’ Contributions

ER was principal investigator of the study and led writing of this manuscript.

KA helped conceive of and plan the study, supported the analysis and helped write drafts of the manuscript.

AB helped conceive of and plan the study, supported the analysis and helped write drafts of the manuscript.

DG helped conceive of and plan the study, supported the analysis and helped write drafts of the manuscript.
AC provided advice for fieldwork, supported the analysis and helped write drafts of the manuscript.

All authors have read and approved the final manuscript.
Figures and Tables:

**Figure 1: Individual, Social and Societal Determinants of Contraceptive Behaviour**

**Health outcome:** Avoiding unwanted pregnancy

**Behaviour:** Using contraception

**Self-efficacy:** “The conviction that one can successfully execute the behavior required to produce [desired] outcomes” (Bandura, 1977).

**Outcome expectations:** “The expected costs and benefits for different health habits” (Bandura, 2004). These include three types: physical (“the pleasurable and aversive effects of the behavior and the accompanying material losses and benefits”), social (“the social approval and disapproval the behavior produces in one’s interpersonal relationships”) and self-evaluative expectations (“the positive and negative self-evaluative reactions to one's health behavior and health status”) (Bandura, 2004b).

**Mastery experience, vicarious experience and verbal persuasion:** These are three of the four sources of self-efficacy as defined above and by Bandura (1977).

**Social and societal determinants of health:** In our conceptual model (Figure 1), history separates the more proximal social determinants of health from their more distal antecedents, the
societal determinants of health. Social determinants of health are “the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness” (WHO, 2014). Whereas social determinants can be considered the “causes of the causes,” the societal determinants of health are “the causes of the causes of the causes” of health and disease (Birn & López, 2011). These social and societal determinants of health are conceived in the model to structure a range of probable scenarios regarding self-efficacies, outcome expectations, behaviour and outcomes that relate to contraceptive use. These determinants are thus not completely prescriptive, but they do shape considerably the likely range for individual determinants and outcomes.
Table 1: Descriptive characteristics of participants (n=16)

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<th>Characteristic</th>
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<td>6th grade or less</td>
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<td>At least some middle school (equivalent of 7th to 9th grade)</td>
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</tr>
<tr>
<td>Yes</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>No</td>
<td>12</td>
<td>75</td>
</tr>
<tr>
<td>Current family planning method</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depo-Provera (3 month injection)</td>
<td>7</td>
<td>44</td>
</tr>
<tr>
<td>Condoms</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>None</td>
<td>8</td>
<td>50</td>
</tr>
</tbody>
</table>

*One participant had one child who had died
Table 2: Critique of *not being a woman* if one does not have many children

<table>
<thead>
<tr>
<th>Source of critique</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neighbours</td>
<td>“People say that you’re not a woman, that’s why you can’t, you can’t take care of yourself, that you can’t have children, and like that… Someone passes and they say, ‘she’s not a woman; she can’t have a lot of children or like that. It bothers me.”</td>
</tr>
<tr>
<td>Husband</td>
<td>“Well before he didn’t want to hear about methods. With the papers [about family planning] there, I start to talk to him, and he no, he tells me ‘No, for what? So you’re not a woman then?’”</td>
</tr>
<tr>
<td>Mother-in law</td>
<td>My neighbour says that her husband scolds her: ‘If you don’t want children why did you come then? For that, you’re not a woman.’</td>
</tr>
<tr>
<td>Woman herself</td>
<td>“My sister in-law, she has babies every year, and as she says, ‘Since I married my husband, I, as a woman, have to give all the children, all the children that he wants’ she says.”</td>
</tr>
</tbody>
</table>
Table 3: Women’s discussion of “problems” and violence

<table>
<thead>
<tr>
<th>Situation</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced “problems” when used family planning and husband was not in agreement</td>
<td>“If your husband does not agree with planning, if one wants to plan and the other no, it’s not possible to plan because problems arise… The first time [I used family planning] yes, I had problems because he was not in agreement that I plan, and since I decided, well, because, because, because my first baby almost died, and it was already like that, and I said to him that I don’t want anymore, I’m going to plan. He didn’t want to and since I wanted to, I went to ask and they gave [a family planning method to] me. But then he started to suspect; we started to have problems [‘problemas entre pareja’]”</td>
</tr>
<tr>
<td>Potential marital “problems” referring to violence</td>
<td>“I would say no [I would not use family planning if my husband were against it], because he would find out anyways…There would be a fight, because we don’t have the same opinion”… And do you think in these cases there is danger of violence, that a wife might get hit because of this?* “I say yes, yes because maybe the husband forbids her and she, because she wants to help herself, she takes care of herself, maybe there would be problems”</td>
</tr>
<tr>
<td>Problems and violence when husband gets drunk</td>
<td>“Sometimes they say that the husbands don’t want to [use family planning], so he threatens his woman, or because of this he hits her… If the husband does not agree sometimes there are problems because one takes care of herself… For example, when he’s healthy maybe he can’t say anything to you, or, or until he gets drunk, and then he starts to hit you in the house”</td>
</tr>
<tr>
<td>Would have used family planning without husband’s consent, but in fear of problems, including violence</td>
<td>“Maybe he would get really angry, and start to scold me, I say… Yes, also afraid that he would have hit me…”</td>
</tr>
</tbody>
</table>

*Text in italics denotes the voice of the interviewer
Table 4: 2013 Municipal targets for new contraceptive users in Patzún, Chimaltenango

<table>
<thead>
<tr>
<th>Method</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depo-Provera</td>
<td>1244</td>
</tr>
<tr>
<td>Pills (Lo Femenal)</td>
<td>80</td>
</tr>
<tr>
<td>Copper T (Intra-uterine device)</td>
<td>22</td>
</tr>
<tr>
<td>Condoms</td>
<td>57</td>
</tr>
<tr>
<td>LAM (Lactational amenorrhea method)</td>
<td>174</td>
</tr>
<tr>
<td>Cycle beads</td>
<td>19</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1596</strong></td>
</tr>
</tbody>
</table>
5.3 ‘Taking Care’ in inter-cultural research: lessons from a Guatemalan family planning study (Manuscript #3)

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ER was principal investigator of the study and led writing of this manuscript.

KA helped conceive of and plan the study, supported the analysis and helped write drafts of the manuscript.

HR conducted fieldwork and analysis for this manuscript.

WC transcribed and supported analysis for this manuscript.

ST supported fieldwork and analysis for this manuscript.

DG helped conceive of and plan the study, supported the analysis and helped write drafts of the manuscript.

AB helped conceive of and plan the study, supported the analysis and helped write drafts of the manuscript.

All authors have read and approved the final manuscript.
Abstract:
Methodological and ethical aspects of inter-cultural research are discussed in the literature, however, rarely are detailed examples given or practical suggestions offered, particularly in relation to qualitative enquiry. Drawing on global health research by an international team with indigenous women in Guatemala about access to family planning, this article highlights alternative consequences of different research designs and implementation strategies. We used the constant comparison method for analysis and developed a code for portions of interviews or content which might have been omitted had the research been conducted differently. These applied examples are used to illustrate the potential counter-factuals associated with: early involvement of a local team in preparing research instruments, recruitment and conducting interviews; multilingual interviewing, transcription and team analysis; and inclusive reporting and dissemination. Practical and ethical implications are highlighted for those conducting, funding and reviewing inter-cultural research, to ensure that research does not become the latest extractive industry.

Keywords: America, Central; contraception; language / linguistics; qualitative analysis; research, cross-cultural; research, cross-language
Introduction

With the recent increase in global health research (Glanz, Rimer, & Viswanath, 2008; Glanz et al., 2008; Glickman et al., 2009), it is common for researchers to investigate topics in inter-cultural settings, both in their home countries and abroad. Although findings from this research abound, there is a relative paucity of literature which provides concrete and detailed descriptions of culturally specific methods. This article discusses the methodological and ethical implications associated with various research designs and methods, particularly in international, inter-cultural and inter-linguistic settings.

Although the terms inter-cultural and cross-cultural are often used interchangeably, their meanings are slightly different: “Cross-cultural research involves comparing behavior in two or more cultures… Inter-cultural research involves examining behavior when members of two or more cultures interact” (Gudykunst, 2003). These different cultures may be represented in members of the same society, or from different nations, although most discussion and theorizing has been about the former (Shah, 2004). This article focuses on issues particular to inter-cultural research, initiated by a Canadian researcher in Guatemala, but draws on and makes observations relevant to both cross-cultural and inter-cultural research in a single multi-ethnic society.

Other research paradigms such as Community Based Participatory Research (CBPR) have made significant contributions to understanding how local participation in research from inception to application is critical, particularly with marginalized populations (Horowitz, Robinson, & Seifer, 2009; Wallerstein & Duran, 2010). The learnings referred to in this article are applicable to those carrying out CBPR, but they are even more relevant if the stringent criteria for CBPR are not met. Although this research was influenced by CBPR, and we worked with marginalized populations to define and carry out the study, the methodological and ethical reflections are relevant to all inter-cultural research, whether or not the principles of CBPR are followed.

Extant literature in both quantitative and qualitative research provides lessons and advice about conducting inter-cultural research. On the quantitative side, for example, the burgeoning field of cross-cultural psychology grapples largely with how to test and validate universal psychological constructs and theories (Berry & Dasen, 1974, as quoted in Marshall, Walter, & John, 1998). Cross-cultural psychologists typically use culture as “an overarching label for a set of contextual variables (political, social, historical, ecological, etc.) that are thought by the
researcher to be theoretically linked to the development and display of a particular behavior” (Marshall et al., 1998). The Handbook of Cross-Cultural Psychology (2001) describes how this field has developed its own specific methodological innovations (Marshall et al., 1998; Vijver, 2001). Language and interpretation are featured mainly as possible sources of bias, with little practical advice about how to reduce these biases beyond using the committee approach and adapting current instruments (Vijver, 2001). The approaches suggested by cross-cultural psychology to reduce bias have merit in all inter-cultural research, with most direct application in quantitative research using instruments which attempt to decipher cultural differences in the experience of psychological constructs and progress on movement toward “universal truths” about human behavior. However, a detailed discussion of how to achieve accuracy in communication, translation and interpretation is generally lacking.

The Handbook of Culture and Psychology is meant to provide an overview, so it is understandable that not much detail on methods is provided. In addition, a more serious critique of its approach to methods in inter-cultural and inter-linguistic research is needed. Within this more positivist framing of inter-cultural research, which ultimately seeks to uncover “universal truths,” the role of the interpreter and translator is reduced to relative invisibility. The interpreter or translator is understood to help achieve equivalence, but their potential role in later analysis and interpretation of data is omitted entirely. Despite ample literature about interviewing, specific discussion of data collection, translation and interpretation in cross-cultural research is generally lacking (Shah, 2004; Wong & Poon, 2010). Several, mostly qualitative, researchers have attempted to address this gap, show the crucial interpretive role that translators play and highlight special considerations in inter-cultural research (Björk Brämberg & Dahlberg, 2013; Easterby-Smith & Malina, 1999; Esposito, 2001; Gesink, Rink, Montgomery-Andersen, Mulvad, & Koch, 2010; Otten et al., 2009; Quynh Lê, 2008; Shah, 2004; Temple, 2002; Wong & Poon, 2010). They assert that translation is not a neutral technical process, rather, it involves meaning-making and is influenced by power. However, the qualitative literature about inter-cultural research and translation focuses mainly on problems encountered rather than strategies for mitigating these complicating issues (Björk Brämberg & Dahlberg, 2013; Esposito, 2001; For a few notable exceptions that do contribute practical advice, please see Gesink et al., 2010; Wong & Poon, 2010).

In line with the conceptualization of interpreters as valued members of the research team with considerable influence, this article discusses ways that inter-cultural, local research teams
might be formed and employed to elevate the role of the translator and improve reliability, validity and accuracy. Whereas we acknowledge the sources of bias and misinterpretation of concern to cultural psychologists and more interpretivist qualitative researchers alike, we provide more practical advice about how to approach inter-cultural research and minimize communication problems, improving effectiveness and validity even when three languages are involved. The crucial role of the interpreter is acknowledged and operationalized across the research process. The findings presented here were generated through global health research with indigenous women in Guatemala about family planning, but the reflections are relevant across disciplines, to those participating in health research in a culture other than their own.

**Methods:**

This article draws on qualitative family planning research with indigenous women in Guatemala to show alternative consequences of different decisions in the practice of inter-cultural research at various stages. Methodological and ethical implications are the focus, as the substantive findings of this research are discussed elsewhere (Richardson et al., submitted). Ethics approval was obtained for this research at the University of Toronto in Canada and the University del Valle in Guatemala.

Elicitation interviews were conducted with 16 indigenous married women, aged 20 to 24, from rural districts of Patzún, Chimaltenango in Highland Guatemala, to better understand the particular barriers to accessing and using family planning in this context (for greater detail about the elicitation interview process, please see Richardson et al., submitted). Indigenous women in Guatemala use family planning far less than their ladina peers, 28% compared to 54% (Ministerio de Salud Publica y Asistencia Social, 2009), and this research attempts to better understand the reasons behind these differences in this particular context. Family planning is a taboo topic in Guatemala, making elements of cultural sensitivity even more important. Written informed consent was obtained from participants prior to beginning interviews. Care was taken to not inadvertently disclose a woman’s family planning status to her peers or family in the course of the recruitment or interviewing.

During development and implementation of the research study, careful notes were recorded by the first author about key methodological decisions and their possible advantages

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24 Ladinas are “Spanish-speaking women of mixed Spanish and indigenous heritage” (Ishida et al., 2012).
and disadvantages, including practical and ethical implications. The first author attempts to be reflective about her own possibilities and constraints as a Canadian researcher who is bilingual in Spanish with experience working and living in Guatemala, but whose first language is English. Language considerations were especially important because the first language of participants is also not Spanish, but rather the local Mayan language, Kaqchikel. This article also draws on consultations of the first author with her Canadian-based doctoral committee, Guatemalan host supervisor and other local and international scholars of Guatemala.

The constant comparison method (Glaser, 2008) was used during analysis, and a code was developed for portions of interviews or content which might have been omitted had different decisions been taken regarding how the research was conducted. Thus, this article uses these applied examples as much as possible to illustrate the potential counter-factuals associated with decisions relating to: early involvement of a local team in preparing research instruments, recruitment and conducting interviews; multilingual interviewing, transcription and team analysis; and inclusive as well as ethical reporting and dissemination.

Results:

Aspects of data collection - Local research team incorporated early
Because of the sensitive nature of family planning in rural, indigenous Guatemala, it was not at all clear at the outset of this research that young, married, indigenous women (aged 20 to 24) would be interested in sharing their impressions about the taboo topic of family planning in interviews with a Western (Canadian) researcher who is clearly not from their own community. Several factors helped to mitigate this divide, including working with the support of local non-governmental organizations and hiring a local research team.

Recruitment & trust: ‘getting in’
When hiring a local research assistant there are of course many considerations. One might aspire to find someone with research experience or higher education. However, depending on the target group for the interviews themselves, particularly if marginalized, there are many reasons to hire a research assistant who is as similar as possible to participants. For this study the local research assistant was 23 years old and had graduated from tercero básico, equivalent to ninth grade. This level of education was above the norm in her community, but did not socially distance her unduly from her peers. Because she is from Patzún, Chimaltenango, where the study was planned, she wears the typical traje (long Mayan skirt) of this region, and speaks the local Mayan language, Kaqchikel. Her lack of previous research experience made it all the more
important to carefully explain the aims and methods of the study, and to include the research assistant as much as possible in data collection and analysis, to build local research capacity. One important decision was whether to hire a research assistant directly from the rural district where interviews were to be carried out, versus a neighboring rural district. When the research assistant is from the exact community where interviews are planned, ease of recruiting must be weighed against concerns of confidentiality. In this case emphasis was placed on confidentiality and anonymity during the training of the research assistant, such that even though she would hear responses of women from her own community, she would understand the serious implications of sharing any of their responses outside of the research analysis process. Thirteen out of fifteen potential participants from the research assistant’s rural district, El Llano, agreed to participate. At certain points in the interviews, the research assistant was able to put participants at ease by setting up a private channel of communication between them. For example, when one woman broke into laughter in the middle of her response about the advantages of family planning, Hermelinda then said in Kaqchikel “sina’ij pa qach’ab’älja re’ k’omodo” (you can also respond in our language). In this case the woman responded with laughter, “we manäqchqa pa qach’ab’äl” (I don’t have the answer in our language either), showing that lack of being able to express herself in Spanish was not the issue in this case. She went on to eventually answer the question in Spanish. Because the topic of family planning is taboo in these indigenous communities, and conversation about sexual relations even less common, it is notable that among only four cases of “having relations” (sexual relations) being mentioned across interviews, one participant switches into Kaqchikel to do so.

Interview guide and ‘getting on’

The interview guide for this research was translated from English to Spanish by the first-author, who is fluent in Spanish and has previous work experience living and working in rural Guatemala. However, an important step was to review the Spanish-version of the interview guide with the local research team, in this case the research assistant and a research coordinator. Both these local team members are Kaqchikel women in their twenties from Patzún, Chimaltenango, the municipality where the study was carried out. The biographical profile of the research assistant was described earlier in this article, while the research coordinator is a

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25 This relatively high recruitment success allowed us to be more confident we were capturing the diversity of potential participants from this community.
consultant in her final year of an undergraduate degree in Social Work, with prior experience working with adolescents and young women from rural Guatemala in sexual and reproductive health programming, research and evaluation. Together, the research assistant and research coordinator reviewed the Spanish interview guide, with particular attention to making the questions as simple as possible, and incorporating local parlance.

An important decision relevant in many multilingual research settings relates to how to proceed with the interviews themselves. Had the first author exclusively carried out the interviews, some participants who were not always comfortable expressing themselves in Spanish would have been inhibited. The opposite option of translating the interview guide to Kaqchikel and having the research assistant conduct interviews in this native language, would have the advantage of linguistic and cultural closeness, but the disadvantage that the first author would have been excluded from the interview, including crafting follow-up questions to the semi-structured guide. Even though the research assistant received some training about conducting research, she could not be expected to take the lead on asking follow-up questions, particularly in the initial interviews when she was new to the whole endeavor. The first author solicited advice from a Guatemalan academic (Alburez, personal communication, May 10, 2013) with experience conducting research across Mayan languages, who warned against pursuing the alternative of the local research assistant simultaneously translating all Kaqchikel interview responses to Spanish, as this might cut the flow of the interview too much. A compromise was struck and the interview guide was translated into Kaqchikel, but the initial language of interviews was Spanish, with the research assistant translating into Kaqchikel or back into Spanish when necessary. The translations of responses from Kaqchikel to Spanish were brief summaries, to facilitate formulation of appropriate follow-up questions without overly sacrificing the flow of the interview, but the richness of original responses in Kaqchikel would be captured through detailed transcription, as discussed below.

A corollary enterprise related to this was the translation of the interview guide into Kaqchikel. The research team considered the merits of hiring a professional translator, but the local research coordinator explained that the Kaqchikel spoken in research communities was actually a hybrid using many local expressions and a mix of Spanish words: participants might not understand a translation into pure formal Kaqchikel. Therefore, the local research assistant produced a Kaqchikel version of the interview guide based on how the language was spoken in
her community, which was adapted after back-translation into Spanish by the research coordinator, to ensure original meanings were captured (Vijver, 2001).

Beyond “getting in” to the interview, which is concerned more with “gaining access” to begin the interview, there are tacit elements necessary for “getting on” or achieving “social access” in the interview, only some of which can be prepared for in advance (Shah, 2004). The social closeness of the research assistant helped to “get on” in interviews, not only translating between languages, but also helping to interpret responses in a fluid way to keep the interview on track and not miss important concepts (Shah, 2004). For example, the first time a participant mentioned the concept of “being a woman,” the first author took this statement too literally. The research assistant was able to provide a more accurate interpretation which facilitated understanding of this important concept of ‘being a woman’ as related to having and maintaining many children, an important theme across interviews:

Participant: “My sister in law well… she plans [uses family planning]; she knows how this is done and because she starts to tell others, people say that she is not a woman, because she can’t, she can’t take care, that she can’t have children, and like that.”
First author: “And she’s not a woman?”
Research assistant: “Let’s say, she’s not a woman because she doesn’t know how to maintain many children.”

The research assistant’s presence was also critical for building trust throughout the interview, which proved essential as many women did not initially reveal the full situation they were facing. For example, one woman revealed only slowly that her husband was in fact not in favor of using family planning. When first asked if her husband supported family planning, she said “el está de acuerdo, está de acuerdo” (He agrees, he agrees). Later, she reveals that her husband “casi no está de acuerdo” (almost isn’t in agreement) [about using family planning]. Finally, toward the end of the interview, the woman acknowledges, “no va a estar de acuerdo” (He won’t agree) [to using family planning]. An outsider might cut or end the interview at the wrong time, not allowing enough time for trust to be developed and for women to slowly reveal the true obstacles they face in accessing and using family planning. Or, without the presence of a local peer in the interview, sufficient trust might never be established for women to share their true situations.
One participant specifically commented at the end of the interview about how she appreciated the research assistant’s presence, and contrasted this with a previous interview experience:

“Because you [the research assistant] are here, if we don’t understand in Spanish, you can tell us in Kaqchikel. In contrast, [in the case when she was previously interviewed by two Canadian researchers], one could not understand their Spanish and didn’t understand what they said. Maybe they felt upset because one only looked at them. One does not understand nor do they understand. It’s hard.”

This example shows not only the utility of having interviewers fluent in Spanish and Kaqchikel, but also highlights ethical concerns with a less linguistically proficient team, whereby participants might be left feeling frustrated or inadequate. In our research we therefore experienced clear advantages from: working with local organizations; hiring a research assistant from the exact community where the majority of the study was conducted; having locals review final versions of the interview guide to ensure simplicity of questions using local parlance; and conducting interviews in the language most comfortable for participants, allowing for but minimizing interruptions for simultaneous translation.

Aspects of analysis – multilingual transcription

Many participants availed themselves of the opportunity to respond in Kaqchikel, so it was important to handle analysis of the data in a way that respected the richness of their responses, whether in Spanish or in their native Mayan language. An important consequence of this related to transcription. Often in multilingual research, interviews are transcribed by professional transcribers directly from the native language of participants to a language familiar to the researcher, and the roles of the translator and transcriber are kept in the background (Temple, 2002). In this case this would have meant transcription by a professional who understands Kaqchikel and is able to translate into Spanish, and he or she listening to audio of interviews in Spanish and Kaqchikel, but transcribing only in Spanish. However, such a process precludes effectively looking for patterns in Kaqchikel, which might be lost in translation (Alburez, personal communication, May 10, 2013). Although more involved, transcription for this research was carried out by a professional linguist who is fluent in Kaqchikel and Spanish. He transcribed the interviews verbatim, including all parties’ comments in their original languages, then provided his detailed translation into Spanish of any original responses in Kaqchikel and advice about language patterns to consider during analysis.
**Team analysis**

Because the first author is fluent in Spanish but does not speak Kaqchikel, a team analysis methodology was developed to help with interpretation of the interviews, with emphasis on segments in Kaqchikel, the native Mayan language. This approach was also consistent with the philosophy of research, including involving all members of the research team as extensively and interactively as possible in the analysis process. Team analysis meetings involved the first author, research coordinator, research assistant and transcription specialist. As discussed above, all three members of the local research team were bilingual in Kaqchikel and Spanish, and each brought a unique perspective to the analysis process. For example, the transcriber’s professional background as a linguist, with considerable experience in social science research, helped with the identification of important language patterns in participants’ responses. The research coordinator was able to look for particular themes in the data, representative of accumulated knowledge from working in issues of sexual and reproductive health with young, indigenous Guatemalan women over several years. The research assistant, being from the rural district where research was carried out, was able to confirm the local meaning of specific words, and felt a responsibility to capture the experience of participants conveyed through the interviews where she had been present. The first author framed areas of exploration based on knowledge of extant literature and theoretical frameworks, as well as previous experience in social science research.

The team analysis workshops emphasized interpreting Kaqchikel segments of interviews as well as creating, reviewing and adjusting coding schemes, all in the most participatory and varied way possible. For example, team members listened to portions of audio and read transcribed text from Kaqchikel portions of interviews, then independently recorded their translation/interpretation of participants’ comments in Spanish. Each team member then shared their translations and similarities and differences between interpretations were discussed. At the first workshop the team organized Kaqchikel quotes into groups of similar potential codes, then named and defined them. This served as an exercise to confirm codes identified by the first author and create new lines of inquiry, such as tracking cases of laughter and interpreting these in light of local cultural context. Moreover, it helped to introduce the methodology of coding to members of the team who had not previously been involved in this aspect of qualitative research. In the second workshop, the team grouped codes into larger themes, in some cases confirming previous groupings envisioned by the first author, and in other cases creating new ways to look at the data in terms of interpreting access and barriers to family planning (Richardson et al.,
These team analysis processes led to new insights about data provided in individual interviews which enhanced, validated and improved reliability of the initial analysis conducted by the first author, and are described in select examples below.

Multiple versus singular meanings – ‘Taking care’ to interpret appropriately

The word “cuidar” or “take care” came up often in the interviews with various meanings, including using natural family planning, using a modern form of family planning, and in reference to looking after oneself and one’s children. During team analysis of one of these latter cases, we examined the comment of a participant in Kaqchikel about the disadvantages of having many young children: “man yajosq’ij ta, man naya’ ta ri atención chke rije’ y na’an chqa disfrutar rat ke re’ at te’ej…” This had been translated by the transcriber into Spanish: “No los mantiene limpios, no les pone atención y disfrutas ser madre,” meaning, in English “You don’t keep them clean, you don’t pay them attention or enjoy being a mother.” However, when we discussed the translations and interpretations of the members of the analysis team, it was explained that Kaqchikel term “yajosq’ij ta” has many meanings in Spanish. The closest meaning in English is “take care of,” but the word in fact has multiple meanings in Spanish including: cuidar, limpiar, atender, haciar, proteger, dar de comer y bañar (take care of, clean, attend to, wash, protect, feed and bathe). Therefore, when participants comment in Kaqchikel that having many children close together means they cannot “care” for their children, this should be understood as cannot “care/clean/attend to/wash/protect/feed/bathe their children.”

Team analysis revealed another participant’s Kaqchikel comment to also have several meanings. In this case the participant referred to her mother being supportive of her using family planning, and expressing that previously these kinds of methods were not available to her: “As my mother says… ‘I wanted to take care of myself but before there weren’t those things… there was no way to help yourself.’” The translations and interpretations of each team member revealed that the Kaqchikel term “manaq modo nato’ awi” means more than “helping” oneself; in fact this term simultaneously means helping, taking care of and protecting oneself. The inter-cultural team analysis process thus helped to unpack language used by participants.

In contrast to the above cases where team analysis highlighted multiple meanings in Kaqchikel, at other times it was important for confirming the singular meaning of participants’ comments. For example, one participant spoke about a breach in her privacy which occurred when she sought family planning from the local extension health services. The English translation of what she said in Kaqchikel is: “I planned with my daughter, but my sister-in-law
saw me one time when I was being injected. She started to talk about me.” When probed later in the interview the participant said her sister-in-law had not in fact seen her directly while she was being injected, but the community health worker who carried out the injection told her sister-in-law. It was therefore critical to return to the transcripts and audio from the interview with the research team to confirm she initially said she had been ‘seen’ by her sister-in-law. All members of the team confirmed that “xirutz’ët” unequivocally means “me vió” or “saw me,” a phrase she repeated four times. Although this team analysis was useful for confirming the literal meaning of the participant reporting being seen receiving her injection, it is not possible to be sure whether she had simply misspoken, or did not want to impugn the health worker. Both interpretations had to be considered so we needed to go down two analytical paths with these distinct possibilities always in mind. If she had literally been seen by her sister-in-law the breach in privacy was more direct. However, even if her sister in law was later informed about her using family planning by the community health worker, the participant’s wording and revelation shows the extent of the breach: so directly was this woman’s privacy violated that she expressed being seen by others who were informed of her family planning status. Either way, we were able to draw conclusions about the importance of guarding indigenous women’s privacy and confidentiality in community-level service provision of family planning methods.

Over the course of the two team analysis workshops, each lasting about five hours, there were ten discrepancies in interpretation that arose when examining the transcripts in Kaqchikel and Spanish. In eight out of ten of these cases, initial discrepancies in translation and interpretation were resolved through group discussion. This above example was one of two cases where team analysis could not fully resolve discrepancies in interpretation that were related to language and meaning. The second case came from the next passage in the same interview, where the participant described how others knowing about her family planning status brought on more criticism. The team could not resolve from reading the transcripts if she described this as a reflection she made to herself, or one her husband made to her. We decided to re-visit the same passage in the second workshop by listening to the audio transcripts. The pauses in the participant’s comments made it possible for the team to come to a consensus that she was most likely making this reflection to herself. This process shows it is beneficial to conduct analysis in inter-cultural teams of both multilingual written transcripts and audio recordings of interviews, especially in cases where discrepancies in analysis are not easily resolved.
More accurate meanings in cultural context

Even though transcription was carried out in Kaqchikel and Spanish by a bilingual, professional linguist, the participation of the local research coordinator and research assistant helped to validate his translations into Spanish, and in some cases make important adjustments, based on their age, gender, cultural and geographical proximity to participants (the transcriber was also Kaqchikel but from a more distant part of Chimaltenango). For example, the transcription of one participant’s Kaqchikel comment was: “Ri ruventaja k’a ri’, xe ri ta’ij che ri, manlo nk’oje’ chik jun abebé, ja ri’ ri ruventaja ri nuk’äm pe . . . ,” which translated into English means, “Well the advantage [of using family planning] is not having another child; this is the advantage of it brings.” The research coordinator had a different interpretation, which hinged on the Kaqchikel word “manlo.” She explained the woman was likely to have instead said “malon,” which means “delays.” The research assistant was able to confirm through her knowledge of idioms local to her rural district, and her participation in the interview itself, that the participant meant, “The advantage is that the child is delayed.” This enhanced interpretation is critical, particularly because the distinction between unmet need for contraception for spacing and for limiting depends on this difference between wanting to wait before having more children or not wanting to have any more children at all.

The research assistant provided a subtle yet important alternative translation of another participant’s comment about critiques in the community of women who use family planning. The transcriber’s initial translation from Kaqchikel was: “What I’ve heard is that those who use that [family planning] are not willing to have children.” The research assistant corrected this translation to read: “… are not willing to receive children.” This subtle difference has important connotations in this context where people often feel children are blessings that are received from God. The transcriber’s initial translation made having children seem more of a neutral decision by the individual couple; the interpretation provided by the local research assistant reflects the perception of many participants that children are “received,” and to deny this is to deny God’s blessing. In another case the research assistant corrected the transcriber’s translation of a

26 Unmet need for family planning is defined as “the proportion of currently married women [or women in union] who do not want any more children but are not using any form of family planning (unmet need for contraception for limiting) or currently married women who want to postpone their next birth for two years but are not using any form of family planning (unmet need for contraception for spacing)” (Mills et al., 2010; Westoff, 2006).
participant’s comment about her aunt who was a bit “fat” because of injections rather than a bit “deaf.”

New lines of analysis

Joint analysis of transcriptions and audio from interviews helped to identify unusual interactions that might not have been noticed by the first author who comes from outside this cultural context. For example, one participant commented that her mother had been instrumental in speaking with her husband and convincing him about the merits of family planning. During the first team analysis workshop, the transcriber, a man in his forties from the same Kaqchikel cultural group, noted how this interaction was exceptional in a culture where most direct communication is along gendered and family lines. The fact that a mother-in-law spoke with someone of opposite gender, who was not a blood relative, caught his attention. This observation led the first author to pursue a new line of analysis, where the patterns of communication about family planning were tracked across interviews, ultimately confirming the exceptionality of this case where the participant’s mother spoke to her son-in-law about family planning.

Worldview of interpreter affects analysis

It is important to note that although the research assistant, research coordinator and the professional linguist and transcriber share the Kaqchikel culture, their interpretations were still colored by other aspects of their background, beliefs and epistemological positioning. During the second analysis workshop, an illuminating discussion transpired about a participant’s comment in relation to the “wantedness” of her child. The participant had said in Kaqchikel that her baby had come “choj k’ate,” meaning “de repente” in Spanish or “all of a sudden” in English. We discussed how according to definitions in national surveys, this response might trigger the participant to be included in the group with an “unmet need for family planning,” as her child could be construed as unwanted or wanted later. However, the professional linguist and transcriber believed these are Western categories that do not organically exist in his Kaqchikel culture and that all children are in fact “wanted,” probably reflecting a view widely held by middle-aged Kaqchikel men. The research coordinator then contested the implications of his reasoning: that all children are “wanted.” She maintained that if all children are “wanted” in the Kaqchikel community, then there is no such thing as an “unwanted” child. However, she felt she had seen cases where children of Kaqchikel families were clearly “unwanted.” This example highlights where this dichotomous framework of “wanted” or “unwanted” children is
problematic. In fact there are many shades of grey between and the inclusion of an intermediary category might help to reduce an exaggerated assessment of “unwantedness.” One might know one should “want” children because this is what the culture dictates, but struggling against this are aspects of the personal or family situation.

Our experiences with inter-cultural team analysis therefore lend themselves to the following recommendations: transcribing and looking for language patterns in the original languages of interviews; having inter-cultural team members independently review transcripts and audio recordings from interviews, then discuss multiple and single meanings of words in key passages; and encouraging suggestions for new lines of analysis in cultural context, while remaining mindful that the worldview of team members affects interpretation.

**Timing of translation to English**

Because of the many layers of language involved in this research, it was not obvious at which point the first author should translate into her native language of English. This was necessary to receive feedback from some co-authors who do not speak Spanish. However, translating to English too early would take the analysis farther away from Spanish, the language in which the majority of most interviews was conducted, and could preclude the identification of language patterns visible only in Spanish. A balance was struck where initial codes were developed in Spanish and validated with the Guatemalan team. The coding scheme was translated to English for the purpose of sharing with co-authors, along with key illustrative quotes. Original quotes in Spanish were referenced in initial article drafts such that bilingual English-Spanish speaking co-authors could suggest further improvements in translation and/or interpretation in both languages. Advantages were therefore garnered by working and analyzing in the original language of the interviews for as long as possible.

**Ethical aspects of reporting and dissemination**

Following through on responsible and inclusive cultural and language considerations has implications for reporting and dissemination of research results. While attending the Guatemalan Scholars Network Conference in July 2013, the first author heard concerns by many ‘Guatemalanists,’ both Guatemalan and international, about academia becoming the latest extractive industry. This analogy to mining alludes to the propensity, for international scholars in particular, to conduct research in Guatemala, extract knowledge, then publish only in English, without adequately considering the resulting inaccessibility of findings to participants and colleagues who could most benefit from the research in the country of origin. After this
reflection, the first author’s resolve was cemented to ensure at least one of the publications resulting from this research was in the Spanish language, and thus more accessible to Guatemalan scholars and policy makers.

Authorship of articles is a related concern. To recognize the contributions of the local research team and partners, it is important to integrate co-authors as much as possible. Although community research assistants might not have academic affiliations, this should not serve as an impediment. This article, for example, names the research assistant, research coordinator and transcription professional as co-authors, recognizing and making more visible their significant contribution to the data collection and analysis processes.

A further question of ethical salience is how to ensure participants of research with marginalized populations are sufficiently informed of research results, particularly when they would not normally have access to academic publications. A short, accessibly written summary of results was prepared for interview participants and these reports were personally delivered by the research assistant.

**Discussion:**

This article contributes to a small but growing literature that probes critical issues in inter-cultural research across several languages. Several authors point out deficiencies in the standard practice of inter-cultural research, such as treating interpreters as mere translators between languages, kept in relative invisibility, and not critically examining the role and implications of the “outside researcher” (Björk Brämberg & Dahlberg, 2013; Quynh Lê, 2008; Shah, 2004; Temple, 2002; Wong & Poon, 2010). The findings in this article confirm the importance of creating inter-cultural teams in international health research and providing space for the co-construction of interpretation, but it goes one step further. By drawing on concrete examples from research about the taboo topic of family planning with rural indigenous women in Guatemala, this article adds empirical evidence about the importance of active roles by diverse team members in setting up, conducting and analyzing qualitative research, but also how this same philosophy of inclusive and responsible research has implications for reporting and dissemination.

Adequate translation of interview guides is especially important when particular psychosocial constructs are being probed in inter-cultural settings (Vijver, 2001). Word-for-word translation and back-translation techniques have been deficient when formal translations neglect to employ local idioms and syntax (Esposito, 2001; Vijver, 2001). Using local informants and
“the committee approach” are two strategies suggested for improving comprehensibility of interview guides (Esposito, 2001; Vijver, 2001). For example, Gesink et al. (2010) employed four trilingual Greenlandic translators to translate and back-translate their sexual health survey iteratively and in teams. The spirit of this “committee approach” was achieved in this Guatemalan research, despite a more limited budget, through early involvement of a local research coordinator and research assistant, who made suggestions on how to make words and meanings in the interview guide more appropriate and accessible for women in their culture.

The essential participation of the local research assistant in recruitment, establishing rapport and “getting on” in interviews cannot be overstated, and important decisions were made about how to manage translation during the interview. Aligning gender, ethnicity, age and background between interpreter and participant has been shown to have significant influence on the research process, not only for gaining access to participants, but also for establishing trust and maneuvering during the interview (Björk Brämberg & Dahlberg, 2013; Shah, 2004; Temple, 2002). In a study of Vietnamese participants in Australia, L. (2008) shows how “trust is difficult to build when the cultural gap between researchers and participants is wide.” By having the local research assistant take the lead in recruitment, and participate in all interviews, the cultural divide between the first author and participants was effectively bridged. Recognized as being advantageous (Easterby-Smith & Malina, 1999; Shah, 2004), the research assistant’s personal contacts no doubt helped to improve recruitment in her own community, where out of 15 eligible participants who were married women between the ages of 20 and 24, 13 agreed to participate. These women might have felt more comfortable participating in the study because they knew one of the team members apriori. The way the local research assistant put participants at ease and established a privileged line of communication in their Mayan language created another avenue for establishing trust and expressing themselves about uncomfortable topics. Even during Spanish parts of the interviews, a language in which the first author is fluent and most participants are comfortable speaking, the research assistant was able to periodically provide critical interpretations, because of her cultural closeness with participants. For example, the research assistant helped to interpret and draw attention to the important concept of ‘being a woman,’ assuring we did not miss conceptualizing and asking follow up questions about how the identities of these indigenous women are so often tied closely with having many children.

In regards to how to organize translation from Kaqchikel during interviews, we were faced with the trade-off between real-time complete translation, whereby the first author is “no
longer trapped in the past tense… [and] can hear the dialogue as it occurs and intervene to clarify or explain a different area of interest,” and the challenge this can pose to immediacy and the flow of the interview (Alburez, personal communication, May 10, 2013; Björk Brämb erg & Dahlberg, 2013; Esposito, 2001). We adopted one suggestion for mitigating this loss of openness and immediacy by sitting with the interviewer and informant facing each other, and with the interpreter sitting to one side, “which strengthens the interpreter’s role as a conduit” (Björk Brämb erg & Dahlberg, 2013). Furthermore we settled on a compromise, whereby the interpreter provided summaries of women’s responses in Kaqchikel, guarding fluidity more than if she had provided a complete translation, but allowing the more experienced researcher to take the lead in crafting follow-up questions and probes.

Our transcription and analysis process helped to address the concern that “interviews are rarely transcribed in the original language, and possible differences in the meanings of words or concepts across languages vanish into the space between spoken otherness and written sameness” (Temple, 2002). A professional Spanish-Kaqchikel linguist transcribed all interviews verbatim, including original comments in Kaqchikel, accompanied by his translation into Spanish. Potential pitfalls relating to “monopolies” on interpretation, when one person alone translates and interprets data, were mitigated through team analysis processes, including the “articulation of all ideas and subtle meanings that might cause misunderstandings” (Shklarov, 2007). By sharing the analysis and interpretation process both with the local research team in Guatemala, and the doctoral committee in Toronto, Canada, “cultural and contextual interpretation” were sought, “subtle differences in meaning” debated (Quynh Lê, 2008; Shklarov, 2007) and misunderstandings arising from “lack of sharing a frame of reference” (Adelman in Shah, 2004) were mitigated.

Active involvement of the research assistant and research coordinator in interpretation and analysis, with each reading transcriptions of women’s original accounts in Kaqchikel, helped identify several cases where initial translations by the professional linguist did not completely reflect the meaning conveyed by participants, illustrating how their even greater “familiarity [because of gender and age] with social structures and behavioural patterns improves an understanding of responses” (Grafinkel, 1959; Coulon, 1995 in Shah, 2003, p. 561). This process allowed for detailed analysis by the research team of all aspects of the interview, and respected the richness of data provided in the native language of participants. Furthermore, when discrepancies in interpretation arose, the research assistant and translator could be
consulted about her interpretation based on being present in the interview itself. This allowed her to help transmit what women said in the interviews, a desire she herself expressed during a team analysis workshop. Because of an awareness of the potential negative implications of power differences in the research team (Easterby-Smith & Malina, 1999), the team analysis meetings were organized to be the least hierarchical possible, emphasizing that each member of the team brought a unique perspective as a function of their relationship to the research question, the participants and their epistemological and cultural backgrounds.

The inexact correspondence of expressions between languages complicates translation in inter-cultural research (Quynh Lê, 2008). Team analysis in this research evidenced that Kaqchikel expressions used by participants sometimes had several simultaneous meanings in Spanish and English. Furthermore, discerning each team member’s “position in relation to the research” or “intellectual biographies” (Temple, 2002) aided in understanding how divergent interpretations of women’s accounts were reached. For example, worldviews of research team members affect whether or not they think the concept of unmet need for family planning is valid, their interpretation of interview data and the conclusions they draw. The linguist and transcriber, based on his understanding of his own Mayan culture, and as a middle-aged man, gave his opinion that the concepts of unmet need for family planning do not apply in his culture. The research coordinator, a younger professional woman from the same Kaqchikel culture, challenged this opinion based on her own experience. Without an approach that elevates the role and “intellectual biographies” (Temple, 2002) of team members, these multiple meanings would have been lost, interpretation too narrow, and cognizance of multiple interpretations negligible.

Most critical literature about inter-cultural research, while extending from methodological to analytical considerations, falls short on following the implications through to dissemination and reporting. Researchers are often therefore complicit in the ethically questionable practice where “there is often no end product in any other language than English and so no visible sign of the interpreter’s presence” (Temple, 2002). This article suggests a basic minimum for how this omission could be overcome, through providing an accessible summary of results for participants and publishing at least one article in the national language where research is conducted. Results would thus be more available to researchers and practitioners in the country from which the research originated, and complete participation would be avoided in academia as the latest extractive industry.
Based on our findings, we propose several recommendations for conducting inter-cultural health research. Regarding setting up the research, we suggest: working with local organizations; hiring a research assistant from the exact community where the majority of the study will be conducted; having locals review final versions of the interview guide to ensure simplicity of questions using local parlance; and conducting interviews in the language most comfortable for participants, allowing for but minimizing interruptions for simultaneous translation. At the analysis stage we recommend: transcribing and looking for patterns in the original languages of interviews; having inter-cultural team members independently review transcripts and audio recordings from interviews, then discuss multiple and single meanings of words in key passages; and encouraging suggestions for new lines of analysis in cultural context, while remaining mindful that the worldview of team members affects interpretation. As part of research dissemination, we believe it is important to: publish at least one article in the local language of the country where research was conducted; include community researchers as co-authors; and to provide research participants with a simple, accessible summary of results.

The main limitation of this study is that advantages and disadvantages of the research design and methodological decisions are discussed based on hypothesized as opposed to actual counter-factuals. Mixed with issues of inter-cultural and inter-linguistic research is the inevitable over-simplicity of some questions and the possibility that some respondents might want to cover some things up. In single culture studies, many of these same issues arise, and might be resolved through re-interviewing, however, these standard issues interact with inter-cultural ones in complicated ways. Whereas this article represents an empirical advancement compared to commentaries about problems in inter-cultural research which do not discuss potential solutions (Temple, 2002), there is room for more systematic inquiry into these issues of inter-cultural research. Future research could contrast, for example, results from the same study using different approaches, with various levels of integration and participation of inter-cultural team members in preparing, conducting, analyzing and disseminating results. Furthermore, inter-cultural research with larger budgets could extend the findings presented here and present new suggestions for inter-cultural analysis, such as employing a local research analyst to participate in coding in the local language, thus allowing for measurement of inter-rater (and to some extent inter-cultural) reliability.

Despite the limited financial resources available for this research, important findings have been confirmed and generated with implications for researchers, ethics boards, funding bodies
and publishers. Translators and interpreters are important members of inter-cultural research teams. Recognizing, funding and crediting their role in recruitment, interviewing and analysis will strengthen the quality of inter-cultural research. Careful and pragmatic multilingual translation, transcription and team analysis improved the reliability and validity of research results. Thus, funders, ethics boards and publishers should take into account and require important details concerning translation (Esposito, 2001) and inter-cultural interpretation. The impact of research will be strengthened if all parties consider the ethical implications of not publishing at least in the national language of the country where research is conducted. Taking-care in inter-cultural research therefore has multi-dimensional implications across the research process and for multiple stakeholders.
Chapter 6 – Discussion

6.1 Summary of Research Findings

6.1.1 Social Cognitive Theory

Understanding the persistent inequalities in prevalence rates of family planning and unmet need for family planning between indigenous and non-indigenous women in Guatemala requires localized explorations of the specific barriers faced by indigenous women. The first manuscript, “Barriers to accessing and using contraception in Highland Guatemala: A family planning self-efficacy scale,” presents the findings from elicitation interviews with 16 young women, aged 20 to 24, married or in union, from rural districts of Patzún, Chimaltenango in Guatemala. The self-efficacy scale is based on the central construct and methods suggested by Social Cognitive Theory (SCT) and amplified using a political economy approach, which helps to identify barriers not directly mentioned by participants themselves. This is the first context-specific self-efficacy scale developed in relation to family planning for young, married indigenous women in Guatemala and the first such scale developed in Latin America.

I found that extension services in this context have made access to family planning more convenient and accessible. However, women who want to delay their next birth still face several, sometimes overlapping, barriers to accessing and using family planning methods. The following barriers persist and are incorporated into the self-efficacy scale: lack of knowledge about and availability of contraceptive methods, fear of side effects and infertility, husbands being against family planning (and related fears of marital problems and abandonment), pressure from in-laws and the community, and the belief that using contraception is a sin. Conceptually, the 19-item scale may be understood to group around four elements or sub-scales of self-efficacy for family planning. These four sub-scales are comprised of items relating to: access, communication, social support and assertiveness for family planning.

6.1.1.1 Sources of support for enhanced self-efficacy

While the self-efficacy scale focuses on the obstacles that young women face in accessing and using family planning, SCT specifies vicarious experience and verbal persuasion as two potential
sources of self-efficacy, in addition to performance accomplishments and physiological states\textsuperscript{27} (Bandura, 1977). Understanding how these sources of self-efficacy, vicarious experience and verbal persuasion, are present for indigenous women in rural Guatemala, extends the explanatory power of SCT to this issue and context. Despite family planning generally being a taboo topic in these communities, which would often be avoided, particularly by young husbands, several participants mentioned influential people who were supportive of their using family planning, or who were already using family planning and acted as models for social learning about its benefits.

\textsuperscript{27} For definitions of these sources of self-efficacy, please see section 3.1 (Theoretical Approaches; Self-efficacy Theory)
Table 4: Influential others who are supportive

<table>
<thead>
<tr>
<th>Relationship to participant</th>
<th>Number of cases mentioned by participants*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husband 28</td>
<td>12</td>
</tr>
<tr>
<td>Sister</td>
<td>3</td>
</tr>
<tr>
<td>Brother</td>
<td>1</td>
</tr>
<tr>
<td>Mother</td>
<td>5</td>
</tr>
<tr>
<td>Aunt</td>
<td>1</td>
</tr>
<tr>
<td>Sister in-law</td>
<td>3</td>
</tr>
<tr>
<td>Friend</td>
<td>1</td>
</tr>
<tr>
<td>Father in law’s boss</td>
<td>1</td>
</tr>
<tr>
<td>Pastor’s wife</td>
<td>1</td>
</tr>
<tr>
<td>No supporters/models</td>
<td>4</td>
</tr>
</tbody>
</table>

*Ten women mentioned 2, 3 or 4 sources of support. In total, 12 out of 16 participants named at least 1 supportive person.

As notable as the sources of support for family planning is the total absence of support for one quarter of participants (4 out of 16), none of whom are currently using contraception. One possible interpretation is that having support persons and sources of social learning about contraception is critical for developing family planning self-efficacy and for adopting contraception. However, this cannot be concluded from these data alone, as other confounding variables may influence both the presence of support, self-efficacy for family planning and contraceptive behaviour.

Previous research in Guatemala has shown that social networks developed through migration, both nationally and internationally, particularly between rural and urban settings, are associated with a higher likelihood of using modern contraception (Lindstrom et al., 2005). Our data support this, with three women mentioning critical influences that are related to migration.

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28 This number of supportive husbands, 12 out of 16, may seem high given that family planning is generally a taboo topic that is often avoided by young husbands. However, the recruitment strategy for this research biased in favour of interviewing participants whose husbands were in favour of family planning. Firstly, recruitment was conducted such that half the participants (8) were using a family planning method, and care was taken to not inadvertently reveal the family planning status of participants, so women using family planning without the knowledge (or support) of their husbands were less likely to participate in the study. Secondly, recruitment was conducted such that half of those participants not currently using a family planning method (4) wanted to have children within the next 2 years, meaning they may have used a family planning method in the past, which in this context appears to most often happen in conjunction with husbands either being supportive, or not knowing, about their wife’s family planning status. Therefore, it is unlikely that in the general population such a high proportion of husbands are supportive of family planning.
### Table 5: Influences related to migration

<table>
<thead>
<tr>
<th>Migration-related influence</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice from father in law’s boss in the municipal capital of Patzún</td>
<td>“Since my father in-law works there, we met her six years ago. And yes, since her daughter in-law is also.. she was taking care of herself [using a family planning method] because she was also like that, every year, one, one, like that [giving birth every year]. That’s why she told her ‘better to take care of yourself and when the other one is bigger you can have another one. Yes, yearly, yearly, you’ll give [birth], each year they start to walk and the next one is crawling too (laughter). It’s hard like that.’ ‘So that’s why,’ she told me.”</td>
</tr>
<tr>
<td>Learned about methods from Ladina sister-in-law, who emigrated from the Mazate coast</td>
<td>“My sister in law is... What’s that called? Ladina, and she told me that it’s possible to... since she uses methods to plan, uses the pill, so she told me how, what you do to use, or if one wants to, say the injection, she told me and I said, ‘Where? Where can one find this?’ She said ‘In the health centre they give it for free,’ she said. So someone like her, she’s the one who buys the pills to use, but yes, she told me which things you can use to plan. Where is she from? She comes from the coast. As her husband is from here, she came to live here.”</td>
</tr>
<tr>
<td>Experience from living in Guatemala City</td>
<td>“So there I saw everything: how a couple is there. I worked in many places so it was there that I got the idea, experience... I learned a lot because there they had money. Girls my age had studied because they were the only ones; they were one [only child] and her father says he can give the possibility of studies; she has her things. It’s really nice, I learned lots of things and what I didn’t have, they’re doing it. Why? Because they are taking care of themselves with that method. The daughter had the opportunity to keep studying and have her things. So that helps a lot.”</td>
</tr>
</tbody>
</table>

#### 6.1.1.2 Applicability of self-efficacy in the indigenous Guatemalan context

The self-efficacy construct has been critiqued as too individually anchored to be salient in more collective societies (Montaño & Kasprzyk, 2008; Smith, 2012b). If founded, this appraisal could be highly relevant in indigenous rural Guatemalan communities where the collective is more

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29 Voice of interviewer represented in italics
highly revered than in Western individualistic societies (Smith, 2012a). In his paper, “Social Cognitive Theory in Cultural Context,” Bandura acknowledges that “the determinants and agentic blends of individual, proxy and collective instrumentality vary cross-culturally,” but he vehemently disagrees with the notion that any psychological model with the word “self” in it necessarily promotes individualism and he defends why self-efficacy is just as valid a concept in more collective societies (2002). Proxy agency is when “people secure desired outcomes by influencing others to act on their behalf” while collective agency is when “people act in concert to shape their future” (ibid). Mirroring self-efficacy, collective efficacy encompasses “the shared beliefs in the power to produce desired effects by collective action” (ibid.). No matter where they live, every person requires all three types of efficacy on a daily basis. The individual contributions of group members are still valued and “group pursuits are no less demanding in personal efficacy than individual pursuits” (ibid.). Dividing societies dichotomously into collective and individual is unhelpful, particularly when intra-cultural and intra-person diversity across domains of behaviour can be more significant than between different cultures. Furthermore, even in the context of a society that emphasizes collective decision making, such as in the indigenous Guatemalan context, this communal emphasis is more likely to be directly important for decisions about land distribution, for example, compared to decisions about family planning. A promising outcome of this research is that varying degrees of confidence in overcoming particular barriers to family planning are discernible from participants’ responses. In individuals, social support has been found to “enhance psychosocial functioning, ... however, to different degrees across the life-cycle and only indirectly to the extent that it raises perceived self-efficacy” (ibid.). As discussed in the previous section (6.1.1.1), there is evidence that social support, in the form of vicarious experience and verbal persuasion, is indeed an important source of enhanced self-efficacy for family planning for indigenous women in this context.

This study suggests that significant obstacles persist for indigenous women who want to delay childbearing in this context, likely contributing to lower individual-level self-efficacy for family planning. Certain interventions may be helpful for raising individual self-efficacy for family planning, such as: making family planning methods, and information about them, more available and completely confidential; ensuring information about the merits of family planning reaches influential others, such as mother’s in law and husbands; and improving self-efficacy for communication about family planning through role-playing with women the difficult
conversations about family planning that might occur with husbands. However, the political economy approach shows there are probably limits to how effective these increases in individual-level self-efficacy would be without changes in structural influences at the social and societal level. For example, improving women’s self-efficacy for communication about family planning will be limited in its effect if the decision-making power and influence that women have over family planning decisions continues to be so low due to structures of gender inequity. Enlarging the space for choice that women, as a group, can exercise in the realm of reproductive health requires a slow and more community-level process of improving gender equity. Changes at this level may be understood as related to collective general self-efficacy, and depend on group empowerment through larger-scale initiatives such as ensuring property rights and education for Guatemalan indigenous women. The advocacy for and implementation of such policies would, in the longer-term, influence the societal determinants of health, such as gender equity. These more macro level and general changes would in turn have feedback loops to improve the possibilities of effective increases in family planning self-efficacy at the individual level.

6.1.2 Political Economy

As represented eloquently by indigenous Guatemalan poet Saq Ch’umil Blanca Estela Alvarado (re-printed in Chirix García, 2010), family planning and sterilization are considered by some indigenous people in Guatemala to be part and parcel with the exploitation and segregation they have endured over centuries:

HISTORIA

… Lo que guarda la memoria es invasión
Imposición de normas para la segregación
Reino implacable de la explotación
Dominion, ultrajes y marginación
Esclavitud, racismo y discriminación
Los planes de asimilación
Políticas de alienación
Estrategias de aniquilación
Programas de integración
Acciones de interculturación
Y eje transversal de esterilización
Understanding decisions about family planning in Guatemala cannot be achieved in isolation from the repression indigenous Guatemalans have endured over centuries. Casting a wider political, economic, historical, social and cultural net facilitates an understanding of current family planning choices and helps to explain the persistent gap in family planning prevalence rates between indigenous and Ladina women in Guatemala.

This approach builds on the work of progressive anthropologists, sociologists and historians who have encouraged a wider view of fertility choices and patterns (Freedman, 1975; Greenhalgh, 1995; McNicoll, 1980; Phillips & Ross, 1992; Ramírez de Arellano, 1983; Richey, 2008; Ross & Mauldin, 1996; Shiffman & Valle, 2006b; Warwick, 1982; Watkins, 1987). Shiffman & Valle (2006), who use structural context and history to explain disparities in safe motherhood between Guatemala and Honduras, specify how “effective intervention strategies require an understanding not just of changeable features of the environment but also of those that are relatively immutable. Moreover, if our goals… include both intervention and explanation, we must consider both factors that can be manipulated and those deeper in the causal chain that are not easily altered by human agency.”

The only paper about contraception in Guatemala to exclusively examine political and historical factors is that of Santiso-Gálvez & Bertrand (2004). They outline how “the convergence of four factors in a single country explains why Guatemala lags far behind its Latin American neighbors in the acceptance of family planning…: the anti-imperialist leftist movements of the 1960’s and 1970’s; the large percentage of the population that is indigenous; the civil unrest that peaked in the 1980s and paralyzed social programs, especially in the western highlands; and the powerful
alliance between the government and the Catholic Church” (ibid.). Where the analysis of Santiso-Galvez & Bertrand falls short, however, is in their compartmentalized, historically frozen and de-politicized consideration of these factors. For example, they describe “a resumption of normalcy in the western highlands” after a long period of civil unrest, which is “no longer problematic,” without identifying the state as the perpetrator of the vast majority of this violence, and with insufficient attention to lasting impacts and overlapping influences of the four factors they consider (Santiso-Galvez & Bertrand, 2004). This analysis shares some of the factors previously explored by Santiso-Gálvez & Bertrand (2004), such as the long civil war and the influence of the Catholic Church, however, the factors are examined in a more critical way, implicating guilt on the part of the state when appropriate, and recognizing the current proximal impacts of past societal determinants of family planning, such as the ongoing influence of the civil war on warranted mistrust of the state by indigenous populations.

Critical structural issues found to affect current family planning decisions include: social exclusion and repression of indigenous people dating back to colonial times and exacerbated by the recent civil war; gender inequity; the influence of the Catholic Church at the state level, and on individual beliefs, along with that of other Churches; and the evolution of population politics at the global, national and local levels. Individual decisions about family planning are thus shown to be shaped by larger social and societal forces that make overlapping contributions to increasing inequities in family planning access and use. The blend of these factors helps to explain why Guatemala’s family planning trajectory is so different even from that of other Central American countries, many of which share some of these structural issues, but not all to the same extent and with the same compounding effects.

6.1.3 Issues in Inter-cultural Research

As Esposito (2001) points out, “Misinterpretation of meaning is a potential problem in any research, but the risk grows tremendously when language is a barrier. Ideally, increasing the number of competent bilingual researchers will help to minimize this problem.” As a bilingual researcher in Spanish and English, I was able to minimize some potential problems in interpretation, notwithstanding the fact that “One of the greatest responsibilities attached to the double role of the researcher and translator is an obligation to convey adequately the voice of those studied, with the understanding that this commitment pertains to the principles of
respecting the participants’ dignity” (Shklarov, 2007). This responsibility to represent the voice of those studied was complicated in this research due to the multilingual nature of the setting, with participants speaking Spanish only in addition to their native Mayan language, Kaqchikel. Regarding inter-cultural issues in cross-cultural management research, Easterby-Smith and Malina (1999) “consider the insider-outsider dilemma in cross-cultural research and propose that it can be resolved through adopting a reflexive methodology.” It was this reflexive reflection about my own limitations in honouring the voice of local Kaqchikel participants that led me to carefully integrate the contributions of a local research and transcription team as thoroughly as possible in setting up, conducting, analyzing and interpreting this research.

Shah (2003) suggests three options for addressing the limitations of inter-cultural researchers: “training and educating researchers in cultural awareness and against stereotypes; matching the researchers to participants from a cultural perspective; and cross-cultural research teams.” With regards to the first suggestion, my prior professional work for five years with the United Nations in Central America, including one year in Guatemala, has heightened my cultural awareness and sensitivity to specific issues and stereotypes in this context. As detailed in the third manuscript (Section 5.3), titled, “‘Taking Care’ in inter-cultural research: lessons from a Guatemalan family planning study,” I worked with a cross-cultural team and matched the cultural proximity of my research assistant as closely as possible to the backgrounds of participants in the study. For example, the research assistant and participants all self-identified as being from the Kaqchikel indigenous group. These decisions about how to carry out this inter-cultural research are reflective of CBPR principles and recognize my status as an “outsider” in this Guatemalan, rural, indigenous context.

Drawing on my research with indigenous women in Guatemala about barriers to access and use of family planning, the third paper (Section 5.3), titled “‘Taking Care’ in inter-cultural research: lessons from a Guatemalan family planning study,” explores methodological and ethical implications of alternative research designs and implementation strategies in inter-cultural research. In line with the conceptualization of interpreters as valued members of the research team with considerable influence, this analysis shows the importance of: early involvement of a local team in preparing research instruments, recruitment, conducting interviews and analysis; multilingual interviewing, transcription and team analysis; and inclusive reporting and dissemination. The worldview of research team members is also shown to be important for how
we interpret results, beyond the influence of cultural, geographical, gender and age proximity to participants. Without an approach that elevates the role and “intellectual biographies” (Temple, 2002) of team members, these multiple meanings would have been lost, interpretation too narrow, and cognizance of multiple interpretations negligible.

This paper contributes to a small but growing literature that probes critical issues in inter-cultural research across several languages. Several authors point out deficiencies in the standard practice of inter-cultural research, such as treating interpreters as mere translators between languages, kept in relative invisibility, and not critically examining the role and implications of the “outside researcher” (Bramberg & Dahlberg, 2013; Quynh Lê, 2008; Shah, 2004; Temple, 2002; Wong & Poon, 2010). The findings in this paper confirm the importance of creating inter-cultural teams in international health research and providing space for the co-construction of interpretation, but it goes one step further. By drawing on concrete examples from research about the taboo topic of family planning with rural indigenous women in Guatemala, this paper adds empirical evidence about the importance of active roles by diverse team members in setting up, conducting and analyzing qualitative research, but also how this same philosophy of inclusive and responsible research has implications for reporting and dissemination.

Most critical literature about inter-cultural research, while extending from methodological to analytical considerations, falls short on following the implications through to aspects of dissemination and reporting. Researchers are often therefore complicit in the ethically questionable practice where “there is often no end product in any other language than English and so no visible sign of the interpreter’s presence” (Temple, 2002). This reflection suggests a basic minimum for how this omission can be overcome, by providing an accessible summary of results for participants and publishing at least one paper in the national language where research is conducted. Results would thus be more available to researchers and practitioners in the country from which the research originated, and complete participation would be avoided in academia as the latest extractive industry. Taking-care in inter-cultural research therefore has multi-dimensional implications across the research process and for multiple stakeholders.
6.2 Additional Links between Individual Manuscripts

6.2.1 Social Cognitive Theory and Political Economy

The combination of Social Cognitive Theory and a political economy approach allows for a more comprehensive understanding of individual decisions regarding family planning by indigenous women in rural, Guatemala. The combination of theoretical approaches provides synergies that augment and extend the application of either perspective in isolation: Social Cognitive Theory thus incorporates more structural influences on individual decisions about family planning and the political economy approach becomes more pragmatic by linking with impacts and interactions at the individual level. In essence, a political economy perspective reminds us that barriers women face in accessing family planning can go far beyond the obstacles they individually may name, and include environmental and structural factors that are further beyond their sphere of control.

For example, using a political economy approach in gathering data for the self-efficacy scale allows moving beyond barriers to access and use of family planning that are explicitly mentioned by individual women. Through considering grey and published literature about the service-provision environment, a barrier was identified that was not mentioned by participants themselves: the relative unavailability of diverse family planning methods. Hence, the question about women’s confidence to “use family planning even if only 2 or 3 methods are available” was included in the scale. This type of barrier is relevant because it could indirectly discourage women from using family planning methods, even if they are not aware of there being few methods available until this issue is presented to them in the form of a question. Thus, the typical approach to self-efficacy scale construction, which considers only what individuals voice as barriers, is enhanced. This allows the final scale to be more consistent with the full extent of Social Cognitive Theory, which is meant to consider environmental as well as individual factors (Bandura, 1978a; Glanz & Rimer, 2005).

Such a political economy approach allowed the exploration of several system-type barriers, even if they are not ultimately found to be salient, and therefore not included in the final ‘self-efficacy for family planning’ scale. For example, a type of barrier that was explored was the possibility that administrative requirements for obtaining family planning methods might serve as a barrier for individual women. Probes about these potential kinds of administrative barriers were
included in elicitation interviews, and this type of obstacle was not articulated as important by participants, hence it was not included in the final family planning self-efficacy scale.

Inversely, the use of quotes from elicitation interviews grounded in self-efficacy theory shows the relevancy of themes raised through the political economy approach. Identifying of influences at the political, economic, social and cultural levels therefore becomes more than an exercise in macro-level analysis, since impacts and interactions at the individual level are simultaneously located and explained. Since the political economy analysis was anchored in its application to a health behaviour theory, I was forced to consider the practical implications of social and societal determinants of health on the experiences of individual women and be pragmatic about consequential recommendations for structural-level changes. This iterative methodology was employed in the second manuscript, allowing the simultaneous consideration of historical, social, political, cultural and economic factors and their impact on individual experiences. Such a careful approach is important, for example, for highlighting how ingrained gender-inequitable customs in Guatemala have multi-faceted influences to limit women’s choices relating to family planning. Segall (1998) refers to his hope for the contribution of cross-cultural psychology, that “a form of behavior that is so unforgivably common in many societies – spouse battering, rape and male bullying of females – might be reduced were we better able to articulate the relationship of such behaviors to culturally based “common wisdom” concerning how men ought to behave towards women.” By simultaneously considering how Social Cognitive Theory and a political economy perspective help to interpret the experiences of indigenous women in accessing and using family planning in rural, Guatemala, I show, for example, how women’s individual experiences of violence are not isolated. Rather, a gender-inequitable society and weak legal system perpetuate institutionalized violence against women and create a culture of fear and intimidation around family planning.

Bringing a political economy perspective to research on contraceptive self-efficacy has not been done before, and this approach helps to differentiate the aspects and origins of unmet need for family planning that are more individual, social and societal in nature. The synergy of this approach allows the connecting of women’s individual responses about barriers they face in using family planning with the structural forces that frame their experiences. By taking a longer historical view, barriers that are not specifically mentioned by women in elicitation interviews...
are still considered, past struggles are honoured, and an overly biomedical and simplistic view of family planning choices is avoided.

6.2.2 Political Economy and Issues of Inter-cultural Research

Inter-cultural interactions during the research process itself must also be subject to the political economy lens, leading to reflections of a reflexive nature. As Shah (2003) indicates, “The problem in cross-cultural interviewing is that the ‘psychological posture’ becomes ‘inter-group’ rather than ‘inter-personal’, which encourages the participants ‘to perceive each other as a group representative rather than as a unique person (Kim, 1991).” Furthermore, power differences may be felt more strongly if participants come from a historically subjugated group (ibid). Given that the participants for this study are from the historically marginalized group of Mayan women in Guatemala, potential ramifications of these power imbalances must be considered, particularly as I am a white, Canadian researcher. The intercultural interaction, which my research represents, may have been influenced by threads of “otherness” (Shah, 2004). Despite not being a member of the dominant Ladina ethnicity in Guatemala, I nevertheless represent for participants a member of Western society in a neo-colonial world. In such situations participants may be “reluctant to share information” (Adler, 2001).

Being a cultural outsider also impacted my approach, assumptions, interpretations and expectations for this research. As a Caucasian foreigner, certain aspects of setting up the research were probably enabled due to deference in Guatemala, especially at the rural community level, towards foreigners in general. This no doubt facilitated my being able to set up initial meetings with local partners, my connection to the Universidad del Valle, and my entry into the research setting. Being a Western researcher also influences the types of research questions I ask as well as the theoretical frameworks and definitions I bring to the research. For example, I am potentially different from a Mayan researcher in that I am interested and focused on cases of women who meet the international definition of unmet need for family planning. This is a somewhat Western concept, at least in origin, which a Mayan researcher may or may not want to emphasize or take as a starting point. However, I did not assume that all women want to delay or should want to delay their pregnancies, but since I was interested in obstacles faced in accessing and using family planning by women who exhibit an unmet need for family planning, I conducted recruitment such that 10 out of 16 participants wanted to delay their next...
pregnancy. Nevertheless, I did not take unmet need for family planning, or the category of “unwanted” children as givens, and part of my aim with this research was to probe whether these concepts need to be problematized in the case of Mayan women. Ultimately my research did evidence that Demographic Health Surveys may make errors in estimations of unmet need for family planning due to trust and communication issues related to the way questions are asked and how responses are translated, as discussed in the third paper (Section 5.3).

On a more basic level, a Mayan researcher would be more easily able to interpret tacit cultural language and communication during interviews, whereas I had to rely for this on the assistance of the local research team. Even the questions I developed for the semi-structured interview probed only indirectly at issues of culture, an area that could have been explored in a more nuanced way by a Kaqchikel researcher. On the other hand, my outsider status may have allowed me to make observations and connections that could seem too obvious or be overlooked by a cultural insider.

Being aware of my “otherness” as a researcher led me to contemplate how to effectively integrate a local research team. There is some evidence that some of the potential barriers related to my outsider status were overcome, since recruitment in selected communities went so well. In the rural district that was the primary research site, the research assistant successfully recruited 13 out of 15 potential participants, and all these 13 participants completed full elicitation interviews. As highlighted in the third manuscript about inter-cultural research, the active leadership of the research assistant in recruitment and conducting interviews no doubt contributed to establishing trust, with some participants waiting until latter portions of interviews to share what appear to be more complete accounts of the actual barriers they face in accessing and using family planning. It is likely that the presence of the research assistant was critical for overcoming the “otherness” of my presence as a Canadian, non-Mayan researcher.

6.2.3 Issues of Inter-cultural Research and Social Cognitive Theory

Placing a focus on issues of inter-cultural research helped to identify strengths and weaknesses in this application of Social Cognitive and Self-efficacy Theory to the issue of access to family planning for indigenous women from rural Guatemala. Many of these findings are applicable to research about self-efficacy or unmet need for family planning in general.
From a methodological standpoint, Vijver (2001) identifies the potential disadvantage of back translation of “emphasis on literal translations, thereby possibly neglecting other issues, such as ease of comprehensibility of the source text and applicability of the item contents in the target culture.” As Temple (2002) maintains, “the method of back translation can be used with the assumption that there is one agreed-on end product and a translation is therefore right or wrong. The assumption that there is one true version of an account is strongly contested in research generally but left unchallenged and unexamined when translators are involved.” This Guatemalan research attempted to address this first problem through early involvement of “key informants [who] can be asked to judge the accuracy of an instrument” (Vijver, 2001). The local research coordinator and research assistant thus made suggestions on how to make vocabulary in the interview guide more appropriate for women in their culture. The second potential problem Vijver (2001) mentions, about the applicability of the concept of self-efficacy to this context is indeed one of the central substantive questions of this research. As discussed in detail in the first manuscript, there is considerable evidence that the concept of self-efficacy, or confidence in overcoming barriers to accessing and using family planning, does have salience for participants in this context.

This research focused on gathering data to inform the development of self-efficacy scales about family planning for indigenous women in rural Guatemala. While the reliability and validity of these scales still need to be tested, the careful examination of issues in inter-cultural research helped to highlight some potential pitfalls to be aware of in future self-efficacy research. Typically self-efficacy scales are applied by asking participants to comment on their confidence in overcoming a series of progressively more challenging barriers to achieving a particular behaviour (Bandura, 2006). There is often little introduction beyond a small paragraph contextualizing the questions about barriers. Evidence from the elicitation interview process suggests that such a relatively surface application of a self-efficacy scale about this taboo topic with this marginalized population may lead to responses that are superficial and not necessarily reflective of the ‘full’ story. Especially if a cultural outsider alone were to conduct the self-efficacy survey, there is a danger that insufficient rapport would be developed with participants. Furthermore, an outsider might cut the survey off too early; even with the presence of a local research assistant in these elicitation interviews, time was often needed to establish trust and create the space for participants to tell a more complete story. These findings also raise
questions for the application of Demographic Health Surveys, the international surveys through which most information about unmet need for family planning are gathered. Depending on the placement of questions about unmet need for family planning, and the cultural familiarity of the person asking the questions, there is some uncertainty about the accuracy of obstacles to family planning that women may report. Shah (2004) raises the potential perils associated with insiders conducting research, where interviewers may not ask enough about a phenomenon because they assume to know responses due to cultural familiarity. This research highlights how a similar problem may occur when an outsider conducts self-efficacy research, particularly about a taboo topic with a marginalized population: a short self-efficacy survey may not allow enough time to establish rapport and trust such as to elicit complete and accurate responses from participants.

Even though transcription was carried out in Kaqchikel and Spanish by a bilingual, professional linguist, the participation of the local research coordinator and research assistant helped to validate his translations into Spanish, and in some cases make important adjustments, based on their age, gender and cultural/geographical proximity to participants (the transcriber was also Kaqchikel but from a more distant part of the Department of Chimaltenango). In one case an adjustment confirmed a participant expressed that an advantage of family planning is to delay, rather than not have, another child. This enhanced interpretation is critical, particularly since the distinction between unmet need for contraception for spacing and for limiting depends on this difference between wanting to wait before having more children or not wanting to have any more children at all. This finding would also have ramifications for how International Demographic Surveys translate questions and women’s responses in international data collection about unmet need for family planning. Careful translation is necessary in order to correctly categorize women’s responses between unmet need for limiting and for spacing children.

A finding of methodological relevance to self-efficacy research is therefore that great care must be taken in interpretation, and protagonism in the analysis by a local research team may help to improve validity of results. In their survey of sexual health in Greenland, Gesink et al. (2010) found particular attention to wording was needed in translating survey questions and responses between Greenlandic and Danish, as responses to questions involving double negatives need to be interpreted carefully to not completely misunderstand the meaning of participants. The example from this research where the woman’s description of her husband being ok with family planning, then partially ok, then not at all in agreement supports this finding that even simple yes
or no type responses need to be interpreted carefully and triangulated within interviews once greater trust has been gained.

6.3 Policy Implications

Results from the self-efficacy paper show how the presence or absence of one barrier may have a reinforcing or weakening effect on the influence of other obstacles. The inter-relatedness of individual barriers has implications for policy. For example, the resolution of barriers relating to fear and experience of side effects is multi-faceted: more options of methods and information about side effects and their likelihoods should be made more accessible (such that women know about and can switch between methods more easily if they experience side effects), but women will not take advantage of the array of choices if they are limited to the options that can be used in secret. Thus, work to educate young husbands, influential others (mothers in law, etc.) and to help young women develop the skills to convince their husbands if they want to use family planning methods, are key.

Important strides have been made in Patzún with the provision of culturally appropriate extension services through the national health system, which women find convenient and have made family planning more accessible. However, this study highlights several policy options for improving reproductive health services, including providing a greater array of methods, and ensuring privacy and confidentiality. This study finds popular notions and rumours about exaggerated side effects to be prevalent, indicating that the provision of timely information about real side effects could be helpful.

Policy makers in Guatemala may have to balance the desire to increase the reach of family planning services to rural, indigenous Guatemala, with assuring the high quality of these services. Task shifting may allow nominal increases in efficiency, but can erode other dimensions of equity, such as quality of care, if not carried out with the same assurances of privacy and professional service provision assured to users of family planning in urban areas.

The barrier of husbands’ opposition is so salient for many of the women with unmet need for family planning that prioritizing this would be important in order to enhance family planning self-efficacy. There are two potential approaches which could be taken: in the longer term, programs and policies that improve gender equity, and women’s confidence in their own power
within the relationship, would be critical. But even in the shorter term, with inequitable gender relations as they are, important strides could be made through improving the family planning knowledge of young husbands. Programs that invite men to special sessions in their own small communities are unlikely to be successful, due to the tabooed nature of the topic, and existing social pressure against family planning. Men might fear attending due to potential chastisement. However, programs and information that reach men in their more habitual environments, such as their places of work, could prove highly effective.

The deeper examination of individual family planning decisions provided through the political economy approach increases understanding of the complexity of these issues, but also suggests that deep political change may be needed. Whereas an examination limited to more proximal barriers could lead to suggested solutions that relate directly to immediate obstacles, such as the expansion of the number of days that reproductive health services are available, a political economy analysis points to policy solutions that are more complex, slow and realistic. This analysis also highlights the important need to expand high quality, culturally and linguistically appropriate services, with mechanisms to ensure participation, trust and confidentiality, for indigenous populations who have historically been oppressed and marginalized.

Reducing the gap between indigenous and non-indigenous rates of unmet need for family planning in a lasting and meaningful way may also require a significant re-ordering of social relations in Guatemala. Poverty alleviation and redistributive efforts, such as the cash transfer program that has survived from the last government of Alejandro Colom to Otto Perez’s current presidency, if sustained, will likely continue to improve the political participation of indigenous people in Guatemala. The new initiative for bilingual intercultural schools, which grew out of the Peace Accords, will likely help to remedy the cultural barriers to education, and girls’ education in particular, through the provision of high-quality, culturally appropriate education by bilingual teachers in adequate and dignified facilities (UNICEF, 2007). Programs and policies that contribute to gender equity may help to reach children and adolescents before inequitable gender relations become engrained. Policies across sectors, such as through implementing the right of women to own land and participate politically, would help to improve equality between men and women. Reproductive health policy and planning that is more inclusive and participatory may help to go beyond the provision of basic services and take into account local culture and religion. Given the historical legacy of mistrust that must be overcome for
indigenous women to accept family planning services, service providers should be encouraged to ensure that all staff, whether community-based or not, understand the importance of, and take all steps to protect, confidentiality. Family planning and reproductive health advocates may be able to build on past successes and lessons learned, such as with the passing of the Social Development Law, where discreet and timely lobbying with Catholic bishops helped to pre-empt the Catholic Church’s inevitable opposition.

The third paper, ‘Taking Care’ in inter-cultural research: lessons from a Guatemalan family planning study” highlights important findings with implications for researchers, ethics boards, funding bodies and publishers. Translators and interpreters are important members of inter-cultural research teams. Recognizing, funding and crediting their role in recruitment, interviewing and analysis will strengthen the quality of inter-cultural research. Careful and pragmatic multilingual translation, transcription and team analysis improve the reliability and validity of research results. Thus, funders, ethics boards and publishers need to take into account and require important details concerning translation (Esposito, 2001) and inter-cultural interpretation. The impact of research will be strengthened if all parties consider the ethical implications of not publishing at least in the national language of the country where research is conducted. These findings are equally applicable in a Canadian context where a high percentage of immigrants and aboriginal populations with special needs and situations may necessitate multilingual and inter-cultural research. Researchers need to reflect on and take into account the costs and importance of translation in order to ensure inclusion of non-dominant language speakers, who may have specific needs related to research questions (ibid). Taking-care in inter-cultural research therefore has multi-dimensional implications across the research process and for multiple stakeholders.

6.4 Strengths, Limitations and Areas for Future Research

The primary limitation of this research arises from the sampling strategy. The elicitation interviews formed the basis for developing the self-efficacy scale, which is appropriate to the local context of rural districts from this medium-sized rural community in Guatemala. However, because a convenience, relatively small sample was used, the results are not statistically generalizable. This is also why it was important to strive for saturation in terms of themes or barriers raised by participants in the elicitation interviews. Caution is advised before using this
scale directly in another developing country context, although the barriers discussed here should
certainly be considered as possibilities for family planning research with other marginalized
populations, as this is the first comprehensive self-efficacy scale that is consistent with
Bandura’s Social Cognitive Theory, augmented by a political economy approach and developed
specifically with young adult women. Furthermore, these rural districts are ideal for conducting
research on certain aspects of unmet need for family planning, precisely because culturally
appropriate, confidential services appear to be available, so it is possible to probe more
specifically the cultural and social reasons behind unmet need for family planning. This scale is
therefore likely to be highly useful for use in fairly similar cultures.

Another limitation relates to the recruitment strategy employed. Because we coordinated with
the local NGO, Renacimiento, for the recruitment of participants, it is possible that potential
participants were overlooked because they are not on the lists of this NGO. However, the risk of
this type of bias is small, since the rural districts are relatively small (typically with fewer than
1000 inhabitants) and the community health workers, with whom we collaborated for
recruitment, are likely to know all the potential participants aged 20 to 24 in their communities.
A second bias that might have been introduced due to our recruitment strategy relates to how we
approached potential participants during the day, when their partners were less likely to be at
home. This may have indirectly discouraged participants who work outside of the home, who
may have systematic differences in the way they experience or do not experience barriers to
accessing and using family planning. For example, if they earn their own income they may be in
a more empowered decision-making position vis a vis their husbands in all realms including
family planning. The risk of this bias having a large effect is also small, since recruitment in the
first community was relatively successful, with 13 of 15 potential participants agreeing to be part
of the study. One potential participant could not be found at home, even after repeated attempts,
and one other refused to participate because she did not have time. Another relevant piece of
information is that many of our participants did work on Tuesdays and Thursdays to harvest
green beans, so we scheduled interviews on alternate days.

A further limitation relates to how social desirability bias has been found to be a pervasive
problem in research about family planning (Stuart & Grimes, 2009a). In order to mitigate this
concern, participants were assured that there are no right or wrong answers, and that their
anonymity was guaranteed (Maibach & Murphy, 1995b; Stuart & Grimes, 2009a). Since family
planning is likely a behaviour that is not socially sanctioned in Guatemala, the interview guide incorporated advice about how to “load” questions in order to maximize the likelihood of frank responses (Stuart & Grimes, 2009a).

The self-efficacy scale’s reliability and validity need to be tested empirically. For example, predictive validity of the scale could be examined by assessing whether young women’s confidence in overcoming these barriers correlates with contraceptive behaviour, as would be predicted by Social Cognitive Theory. The scale intentionally employs simple, repetitive language for use in poor, rural areas where women are unlikely to have much formal education. An important question remains about how much the concept of confidence will be salient to indigenous women in this context, and whether they will be able to express their confidence numerically, particularly given typically low numeracy and literacy levels. A promising outcome of this research is that varying degrees of confidence in overcoming particular barriers are discernible from participants’ responses. If using numbered scales to express confidence proves too challenging for participants, alternatives exist such as using visual representations of different levels of confidence, for example circles of progressively larger size (Bandura, 2006). Alternatively, the application of self-efficacy scales might have to involve a higher degree of interpretation than is customary on the part of the researcher, in order to assign numerical equivalents of confidence expressed through verbal responses.

The focus on young indigenous women aged 20 to 24, while representing my preference for understanding family planning behaviour in women who are relatively young in their reproductive lives, does point to areas for further research. It would be helpful to interview older women in this context to see if the same types of barriers apply, and the generalizability of the scale may be extended, or if different barriers are important. As reflected in international research on family planning, older women may be in a qualitatively different position relating to negotiating family planning compared to their younger counterparts. In his review of international literature about men’s influences on women’s reproductive health, Dudgeon (2004) shows how women are often better able to assert their preferences for fewer children only later in their reproductive lives once they have proven their “reproductive success” by bearing several children “for their husbands and husbands’ lineages.” Whether or not this phenomenon bears true in the rural indigenous Guatemalan context would have to be probed in elicitation interviews with older women. Older indigenous women in rural Guatemala may also be more directly
impacted by some of themes emerging from the political economy approach, such as distrust of the state due to the lasting legacy of the Civil War, which they themselves would have lived through. These themes could also be probed in individual interviews with older women.

The application of the political economy framework would also be deepened through follow-up and future interviews with participants that probe their understandings of the services provided by the Renacimiento non-governmental organization (as an independent entity providing health services compared to part of the national health system), Mayan female identity, and what meaning they ascribe to the Civil War violence and how this impacts their view of the state or family planning. Interviews with influential others, such as mothers-in laws, touching on these same topics, would also be illuminative. Interviews with a wider array of service-providers would extend the understanding of the local context and the sources of family planning services that women may have access to. In this vein, interviews could be conducted with: community health workers in communities, private clinics, Aprofam (Guatemala’s private family planning organization), the Ministry Health Centre, and other non-governmental organizations.

The main limitation of the third methodological paper about inter-cultural research is that advantages and disadvantages of the research design and decisions are discussed based on hypothesized as opposed to actual counter-factuals. While this paper represents an empirical advance compared to commentaries about problems in inter-cultural research which do not discuss potential solutions, there is scope for more systematic inquiry into these issues of inter-cultural research. Future research could contrast, for example, results from the same study using different approaches, with various levels of integration and participation of inter-cultural team members in preparing, conducting, analyzing and disseminating results. Studies that explore the pathways towards establishing trust and better communication with participants would also be useful, including probing how long this may take, turning points in the process and how much this differs across interviewees. Furthermore, inter-cultural research with greater financial resources could extend the findings presented here and present new suggestions for inter-cultural analysis, such as employing a local research analyst to participate in coding in the local language, thus allowing for measurement of inter-rater (and to some extent inter-cultural) reliability.
6.5 Conclusions

This is the first comprehensive self-efficacy scale developed specifically with young adult indigenous women that addresses the issue of family planning in Latin America. The findings incorporated into the development of this self-efficacy scale aid in understanding the reasons for different family planning rates in Guatemala across ethnic lines, and contribute to a clearer understanding of the barriers to using and accessing family planning methods with relevance to similarly marginalized populations elsewhere. The integration of a political economy perspective provides a more holistic basis through which to understand potential barriers that may not be mentioned by participants themselves. This combination of the political economy and self-efficacy approach represents an enhancement of how Social Cognitive Theory is applied to family planning.

Bringing a political economy perspective to research on contraceptive self-efficacy has not been done before, and this approach helped to differentiate the aspects and origins of unmet need for family planning that are more individual, social and societal, respectively. The synergy of this approach allows the connecting of women’s individual responses about barriers they face in using family planning with the structural forces that frame their experiences. By taking a longer historical view, barriers that are not specifically mentioned by women in elicitation interviews are still considered, past struggles are honoured, and an overly biomedical and simplistic view of family planning choices is avoided. This combination of health behaviour theory with a political economy perspective represents a methodological approach that is useful for a holistic and pragmatic understanding of health issues both within and outside the realm of reproductive health.
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Appendices – Appendix 1 – Long version of manuscript #2: “Uno tiene que cuidar también de sí mismo”: Guatemalan family planning decisions in the context of Social Cognitive Theory and a political economy approach

Title: “Uno tiene que cuidar también de sí mismo”: Guatemalan family planning decisions in the context of Social Cognitive Theory and a political economy approach

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Abstract:

Objective: A political economy approach was used to contextualize indigenous women’s stated (and unstated) barriers to accessing and using family planning in rural districts of Patzún, Chimaltenango.

Methods and results: Elicitation interviews were carried out with married, indigenous women, aged 20 to 24, from rural districts of Patzún, Chimaltenango in Guatemala in order to understand the barriers faced in accessing and using family planning. Coded data from these interviews were analyzed in light of context provided by historical and political documents. Critical structural issues affecting current family planning decisions include: social exclusion and repression of indigenous people dating back to colonial times and exacerbated by the recent civil war; gender inequity; the influence of the Catholic Church at the state level, and on individual beliefs, along with that of other Churches; and the evolution of population politics at the global, national and local levels.
Relevance and impact: Casting a wider political, economic, historical, social and cultural lens facilitates an understanding of current family planning choices and helps to explain the persistent gap in family planning prevalence rates between indigenous and Ladina women in Guatemala. A novel framework is presented for simultaneously considering proximal, intermediate and distal factors affecting family planning. This analysis also highlights the need to expand high quality, culturally and linguistically appropriate services, with mechanisms to ensure participation, trust and confidentiality, for indigenous populations who have historically been oppressed and marginalized.

Key words

Family planning, political economy, Social Cognitive Theory, indigenous

Introduction:

Several studies have documented unequal contraceptive prevalence rates in Guatemala along ethnic lines (Bertrand et al., 1979; Bertrand et al., 2001a; Bertrand et al., 2001b; Chen et al., 1983; De Broe, 2005; Ishida et al., 2012; Lindstrom & Muñoz-Franco, 2005; Lindstrom, 2006; USAID, 2008). Indeed, 54% of Ladinas\textsuperscript{30} use family planning, compared to 28% of indigenous women and unmet need for family planning in indigenous women (29.6%) is almost double that of Ladina women (15.1%) (Ministerio de Salud Publica y Asistencia Social, 2009). Unmet need for family planning is defined as “the proportion of currently married women [or women in union] who do not want any more children but are not using any form of family planning (unmet need for contraception for limiting) or currently married women who want to postpone their next birth for two years but are not using any form of family planning (unmet need for contraception for spacing)” (Mills et al., 2010; Westoff, 2006). Of added concern from a human rights perspective is that these differential rates are maintaining over time in absolute terms\textsuperscript{31} (Bertrand et al., 2001a). Ethnic differences are partially explained by proximal and sometimes intermediate factors such as socio-economic and demographic characteristics, knowledge and

\textsuperscript{30} Ladinas are “Spanish-speaking women of mixed Spanish and indigenous heritage” (Ishida et al., 2012).

\textsuperscript{31} Relative differential contraception use rates between indigenous and non-indigenous women have been dropping over time, but the absolute difference has maintained between 1978 and 2009 (Bertrand et al., 2001a; Ministerio de Salud Publica y Asistencia Social, 2010).
attitudes, physical distance or travel time to contraceptive services, migration status, social networks and quality of services (Bertrand et al., 1979; Bertrand & Anhang, 2006; Chen et al., 1983; Ishida et al., 2012; Lindstrom & Muñoz-Franco, 2005; Lindstrom, 2006; E. E. Seiber & Bertrand, 2002; USAID, 2008).

Chirix (2010) makes a forceful critique of extant literature about family planning in Guatemala. She charges that most studies have implicitly incorporated an uneven application of the neo-Malthusian perspective32, whereby the poor, indigenous people of Guatemala must limit their procreation to avoid catastrophic mismatches between resources available and numbers of mouths to feed, but this logic is not applied to other sectors of society and does not take into account unjust social structures. She further points out that most studies are quantitative33, positivist34 and superficial in terms of behavioural factors they consider, and often have undertones of paternalism and racism, without taking into account “the deeper meaning in social conduct, historical tendencies and symbolic codes from Mayan culture” (Chirix García, 2010, translation by the author). The current study stems from an understanding of fertility decisions in relation to human rights, whereby people have the right to “a satisfying and safe sex life” and should have the “capability to reproduce and the freedom to decide if, when and how often to do so” (United Nations, 1994). This paper responds to Chirix’s affirmation that “sexuality should be a historical-social concept, dynamic, intimately linked with politics and economics” (Chirix García, 2010, translation by the author) by utilizing a political economy framework. This study was led by a non-Mayan researcher from Canada, in collaboration with a local research team, and using community based participatory research principles, to ensure the priorities and practices of the Mayan people drive the research, methods, and interpretation and translation of study findings.

33 Critical theorists critique quantitative research for neglecting to take into account social context and nuances ascertained only through more detailed qualitative exploration. Epistemologically, within quantitative research, “the investigator and investigated are [considered] independent entities” and research “value-free,” assertions contested in the qualitative paradigm (Sale et al., 2002).
34 Positivists “assume a common objective reality across individuals” (Newman, 1998). “Some social theorists, of course, repudiate this epistemology. Many postmodernists and critical theorists, for instance, deny the existence of a reality logically and causally independent of mind, or reject the possibility that we could ever know the truth about such a reality. These are strong forms of anti-positivism” (Dessler, 1999).
**Theoretical Framework**

Health behaviour theories are helpful for organizing, analyzing and contextualizing data from interviews with individual women. These models present and examine relationships between constructs that are postulated to influence individuals’ behaviour at the intrapersonal, interpersonal, community and policy levels. One such model that holds particular promise for understanding decisions about family planning is Social Cognitive Theory (SCT) with its fundamental construct of self-efficacy. Perceived self-efficacy not only influences whether a person will initiate a behaviour, but also “how much effort will be expended and how long it will be sustained in the face of obstacles and aversive experiences” (Bandura 1977). SCT designates pathways through which the central construct of self-efficacy might be enhanced: performance accomplishments, vicarious experience, verbal persuasion, and physiological states,” (Bandura, 1977; Bandura et al., 2001). Personal performance or mastery accomplishments can enhance efficacy expectations as people see evidence of their ability to carry out the behaviour. Furthermore, general coping skills can be developed that help deal with any number of stressful situations (Bandura, 2004b). Through vicarious experience people observe others carrying out behaviours, which can have effects on self-efficacy in the same two ways described for performance accomplishments, although in a less dependable way, “relying as it does on inferences from social comparison” (Bandura, 1977). Verbal persuasion consists of being convinced by the arguments of influential others (Bandura, 1977). The fourth, physiological states, is not as relevant for contraceptive use, which depends on longer term behaviour patterns that span a greater time duration than a heightened physiological state.

SCT is also advantageous for considering contraceptive behaviour in rural Guatemala because of how it situates environmental factors. SCT is premised on reciprocal determinism, whereby “psychological functioning involves a continuous reciprocal interaction between behavioral, cognitive and environmental influences” (Bandura, 1978b; Glanz & Rimer, 2005). In this conceptualization environment is elevated to have an independent influence, which is fitting for the Guatemalan context where the structural elements of oppression have been and continue to be so significant.
SCT, nevertheless, may underestimate these structural aspects, since its conception of environment appears to be very much malleable and in the present. For example, Bandura explains that “most environmental influences affect behaviour through intermediary cognitive processes” and that “sociostructural factors operate through psychological mechanisms of the self system to produce behavioral effects” (Bandura, 1978b; Bandura et al., 2001). If individuals are primarily influenced by the environment and sociostructural factors through the effects they have on cognition and psychological mechanisms, then ‘environment’ is very much conceived as being temporally located in the present, and does not sufficiently take into account the structural discrimination that has accumulated, been compounded and affected the situation of Guatemalan indigenous women over centuries.

**Political economy approach**

In order to address this limitation of Social Cognitive Theory, that is, the relative neglect of social, economic, environmental and political factors, it is helpful to consider the contributions of a political economy perspective. Political economists generally view the lens of analysis that behavioural scientists use as overly focused on proximal causes. The “political economy approach to understanding health and illness considers the political, social, cultural and economic contexts in which disease and illness arise, and examines the ways in which societal structures (i.e. political and economic practices and institutions, and class interrelations) interact with the particular conditions that lead to good or ill health” (Birn, 2009). This focus somewhat overlaps with that of behavioural scientists, but adds political and historical factors to explanations for differentials in health outcomes (Birn, 2009). In contrast to SCT, which emphasizes the ability of individuals to alter their environments, the political economy approach puts more weight on the macro influences on health and well-being (Birn, 2009; McAlister et al., 2008).

The conceptual model developed for this research (Figure 1) thus embraces the concept of reciprocal determinism that underpins Bandura’s SCT, and also emphasizes the historical and political nature of the environmental influences on behaviour and outcomes. This approach builds on the work of progressive anthropologists, sociologists and historians who have encouraged a wider view of fertility choices and patterns (Freedman, 1975; Greenhalgh, 1990; McNicoll, 1980; Ness, 1984; Phillips & Ross, 1992; Ramírez de Arellano, 1983; Richey, 2008;
Ross & Mauldin, 1996; Shiffman & Valle, 2006b; Warwick, 1982; Watkins, 1987). Freedman (1975) used the analogy of a funnel when envisioning the levels of variables affecting fertility:

“We can visualize this as working backward from the narrow neck of a funnel to the broadening opening, where we are likely to find that we cannot deal simultaneously with all the important variables in the foreseeable future. But, an inventory of the number and complexity of the variables puts our work in perspective and helps to explain why current studies account for only a small part of the total variance in fertility” (Freedman, 1975, as cited in Shiffman & Valle, 2006b).

![Figure 1: Conceptual model for this research that combines behavioural theory with a political economy approach](image)

**Health outcome:** Avoiding unwanted pregnancy

**Behaviour:** Using contraception

**Self-efficacy:** “The conviction that one can successfully execute the behavior required to produce [desired] outcomes” (Bandura, 1977).

**Outcome expectations:** “The expected costs and benefits for different health habits” (Bandura, 2004). These include three types: physical (“the pleasurable and aversive effects of the behavior and the accompanying material losses and benefits”), social (“the social approval and disapproval the behavior produces in one’s interpersonal relationships”) and self-evaluative
expectations (“the positive and negative self-evaluative reactions to one’s health behavior and health status”) (Bandura, 2004b).

**Mastery experience, vicarious experience and verbal persuasion:** These are three of the four sources of self-efficacy as defined above and by Bandura (1977).

**Social and societal determinants of health:** In our conceptual model (Figure 1), history separates the more proximal social determinants of health from their more distal antecedents, the societal determinants of health. Social determinants of health are “the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness” (WHO, 2014). Whereas social determinants can be considered the “causes of the causes,” the societal determinants of health are “the causes of the causes of the causes” of health and disease (Birn & López, 2011). Societal determinants thus highlight the political, “such as political-economic systems that prioritise highly concentrated accumulation of private wealth over redistribution of power, property and privilege within and across countries” (Krieger et al., 2010). These social and societal determinants of health are conceived in the model to structure a range of probable scenarios regarding self-efficacies, outcome expectations, behaviour and outcomes that relate to contraceptive use. These determinants are thus not completely prescriptive, but they do shape considerably the likely range for individual determinants and outcomes.

**Materials and methods**

**Study Setting**

Patzún is located on the Western edge of the Department35 of Chimaltenango, in the centre of the Kaqchikel region and of Guatemala (SEGEPLAN, 2010). The department has a varied and abundant agricultural production due to its high quality soil, with cultivation of corn, beans, coffee, sugar cane, ginger, wheat, oats, fruit and vegetables, fine lumber, medicinal plants and dyes (Rouanet, 1996). The area was populated by the Kaqchikel prior to the Spanish conquest, although it was named Patzún only after the Spaniards arrived, probably based on the Kaqchikel word for sunflower, which still grow in the area (Gall, 1978).

In the last national census of 2002, Patzún was described as having 42,326 inhabitants, 17,346 who live in the municipal centre, and 24,980 in the surrounding rural areas (Instituto Nacional de Estadística, 2002). The majority, 40,241 people, identify themselves as indigenous, and 2,085 as not indigenous (Instituto Nacional de Estadística, 2002). On average, women aged

35 Guatemala is divided into 22 Departments.
20 to 24 in Chimaltenango wish to have 3 children, which is equal to the national average\textsuperscript{36} (Ministerio de Salud Publica y Asistencia Social, 2010). However, 69% of women in Chimaltenango have used a contraceptive method in their lifetimes, which makes the department among the lowest in terms of contraceptive use (Ministerio de Salud Publica y Asistencia Social, 2010). According to the National Survey on Maternal and Child Health, 25.3% of women in Chimaltenango have an unmet need for family planning (11.9% unmet need for spacing and 13.4% unmet need for limiting; Ministerio de Salud Publica y Asistencia Social, 2010).

**Elicitation Interviews**

Individual interviews were carried out in rural districts (El Llano and Las Mercedes) of Patzún, Chimaltenango, Guatemala with indigenous women, aged 20 to 24, married or in union. The interview guide closely followed advice for elicitation interviews for self-efficacy research (Middlestadt et al., 1996; Montaño & Kasprzyk, 2008), including general questions about participants’ age, ethnicity, education and families then moving to specific inquiry about their knowledge and opinions of family planning methods. Probes were included about barriers to accessing and using family planning which had been identified in extant literature. Ethics approval was obtained from the University of Toronto and the University del Valle in Guatemala. Participants (16) were purposively sampled such that half (8) were using contraception and half (8) were not, and half of those not using contraception (4) met the definition of unmet need for family planning. The mean age of participants was 22.4 years old, with a range of 20 to 24 (Table 1). Interviews were recorded and transcribed verbatim, then analyzed according to the constant comparison method (Glaser, 2008). Themes were identified both deductively and inductively. Analysis of data from participants resulted in the inductive themes, which were a function of the interviews themselves, whereas deductive themes were generated from a consideration of extant literature about self-efficacy for family planning and of contextual issues. The coding scheme was checked for validity and accuracy by the first author and the local research team, including a research assistant from the community, a linguist who

\textsuperscript{36} The final report of the National Survey for Maternal and Child Health does not break down the total fertility rate (the number of children women actually have) by Department simultaneously with age-group. However, the global fertility rate for all women aged 15 to 49 in Chimaltenango is 3.6, higher than the average number of children women of fertile age (15 to 49) desire for this Department of 3.4 (Ministerio de Salud Publica y Asistencia Social, 2010).
carried out bilingual (Kaqchikel and Spanish) transcriptions, and a local research coordinator. Interviews were carried out until saturation in themes was reached. All quotes were translated from Spanish to English by the first author (for further information about the elicitation interview process and results, please see Richardson et al, submitted).

Table 1: Descriptive characteristics of participants (n=16)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest level of education completed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6th grade or less</td>
<td>10</td>
<td>63</td>
</tr>
<tr>
<td>At least some middle school (equivalent of 7th to 9th grade)</td>
<td>5</td>
<td>31</td>
</tr>
<tr>
<td>Completed high school</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Number of living children*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>1</td>
<td>7</td>
<td>44</td>
</tr>
<tr>
<td>2</td>
<td>7</td>
<td>44</td>
</tr>
<tr>
<td>Pregnant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>No</td>
<td>12</td>
<td>75</td>
</tr>
<tr>
<td>Current family planning method</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depo-Provera (3 month injection)</td>
<td>7</td>
<td>44</td>
</tr>
<tr>
<td>Condoms</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>None</td>
<td>8</td>
<td>50</td>
</tr>
</tbody>
</table>

*One participant had one child who had died

Political Economy Sources

In keeping with a political economy approach, further analysis was carried out to understand the historical and political factors underlying the more proximal barriers to contraceptive use. This analysis took into account previous work that analyzes the reasons behind “the delayed contraceptive revolution in Guatemala,” such as that of Santiso-Gálvez and Bertrand (2004). Information about the political, economic and cultural structures affecting family planning decisions was obtained from various sources in grey and academic literature: historical and political documents, government surveys, United Nations and donor reports and published research. This focused and critical literature review was used to support emerging structural themes and to generate deductive themes for consideration in the analysis of the elicitation interviews.
Results

Critical structural issues affecting current family planning decisions include: social exclusion and repression of indigenous people dating back to colonial times and exacerbated by the recent civil war; gender inequity; the influence of the Catholic Church at the state level, and on individual beliefs, along with that of other Churches; and the evolution of population politics at the global, national and local levels. These influences will be discussed in turn, drawing on political and historical documents and direct quotes from elicitation interviews which allude to these factors, whenever possible, in order to interweave political economy and behavioural perspectives.

Ethnic social exclusion through history, culminating in the Civil War

The introduction of the Commission on Historical Clarification (1999), which attempts to document and understand the roots of the violent and protracted civil war in Guatemala, explains “the unavoidable finding: This society is profoundly heterogeneous and polarized in economic, social and cultural terms, without a shared national project that recognizes equal opportunities for all of its citizens.” The Truth Commission, as this Commission is commonly referred to, goes on to document the highly unequal social relations that preceded and were root causes of the Civil War, which lasted thirty-six years until the Peace Accords were signed in 1996. The concentration of economic and political power and a racist and discriminatory society, have served to exclude large segments of the population from effective political participation, particularly Mayans (Comisión para el Esclarecimiento Histórico, 1999). The lack of institutional channels through which these repressed groups in society could register their concerns and proposals, eventually led to their taking up arms (Comisión para el Esclarecimiento Histórico, 1999). Even though participants in the elicitation interviews did not directly refer to this lasting and persistent discrimination, it is still important to recognize this oppression as a back-drop for understanding differential access to family planning methods between indigenous and non-indigenous women in Guatemala.

Prior to the arrival of the Spaniards, the Mayans had developed into a sophisticated society with “sizeable, well-organized populations” (Lovell, 2010). Only 12 kilometres from the communities of Patzún where this study’s interviews were carried out, the Kaqchikel capital of Iximche was founded in 1478. This Mayan city of over 170 buildings was later occupied by
Pedro de Alvarado during the conquest, when he entered into an alliance with the Kaqchikel to subjugate the K’iche’s, Tz’utujiles and Pipiles (Viceministerio de Patrimonio Cultural y Natural, 2013). Declared in 1524 Guatemala’s first colonial capital, Iximche was fled by Kaqchikeles later that same year, who were frustrated by excessive demands for gold by the conquistadors (Lovell, 2010). In the course of the ensuing four years of rebellion, Iximche was burned (Lovell, 2010; Viceministerio de Patrimonio Cultural y Natural, 2013). As was the case in much of Latin America, the arrival of colonizers represented not only violent conflict, loss of homes, slavery and forced labour, but also severe illness and death from many diseases of European origin (Anne-Emanuelle Birn, 2009; Lovell, 2010). Colonial powers perpetuated social and geographical separation and subjugation, with Indians and criollos forced to live separately, and Indians providing forced labour and heavy tributes (Comisión para el Esclarecimiento Histórico, 1999; Grupo de Mujeres Mayas Kaqla, 2004; Muñoz, 2010). The Spaniards “created a system of repartimiento, where subjects were granted rights not only to the few tracts of arable land, but also dominion over indigenous communities, including the right to tax and the right to the labor of Indians” (Berry, 2010). The legacy of racism as a justification for oppression lived on beyond the colonial period, as the “inferiority of Indians” justified their subordination and exploitation (Comisión para el Esclarecimiento Histórico, 1999; Grupo de Mujeres Mayas Kaqla, 2004).

Independence from Spain in 1821 did little to improve the lot of indigenous people in Guatemala, with the mestizo elite continuing to exert their dominance and control of an exclusionary political and economic system. While the new republic’s constitution recognized all to be equal under the law, it also did away with Indian social protective rights, such as their right to communal lands, paving the way for the expansion of large agricultural estates (Comisión para el Esclarecimiento Histórico, 1999). The growth of the coffee industry in the 19th century benefitted directly from a highly unequal distribution of land and resources, and the inexpensive and often forced labour offered by this system, such as with an 1876 decree forcing Indians to provide between 100 and 150 days of work annually to estate owners (Muñoz, 2010). Predominantly authoritarian governments throughout the 19th and 20th centuries served to uphold this status quo and preclude expression and participation, with Guatemala among Latin American countries with the greatest number of military and dictatorial governments since becoming a republic (Comisión para el Esclarecimiento Histórico, 1999). A lack of social investment was observed even between 1960 and 1980 when economic growth was greatest and
“a brief civilian interlude from 1966 to 1970” was observed, with Guatemala showing the lowest social spending compared to its Central American neighbours, including in the health sector where, for example, public spending in 1997 continued to represent only 0.9% of gross domestic product (Comisión para el Esclarecimiento Histórico, 1999; Shiffman & Valle, 2006a).

The revolution of 1944 initiated a decade of fundamental changes that, if they had not been thwarted in 1954, might have brought lasting improvements to the situation of indigenous people in Guatemala and set the country on a more pluralistic development trajectory. The new constitution of 1945 abolished forced indigenous labour in the estates and re-instated the right to communal lands (Muñoz, 2010). Labour movements flourished and were supported in the new labour code of 1947. The agrarian reform of 1952 aimed to modernize and diversify the farming sector, further integrate the rural sector into the national economy and promote industrial development (Comisión para el Esclarecimiento Histórico, 1999). These reforms unfortunately polarized Guatemalan society and in the context of the Cold War, served as justification for characterizing Arbenz’s government in Guatemala as a communist threat. Due in part to heavy lobbying by the United Fruit Company, an American corporation that sought to maintain its vast tracts of land in Guatemala, anti-communist rhetoric won over Eisenhower, whose United States government ultimately supported a military coup to install Castillo Armas as the new President of Guatemala in 1954. Later that year the agrarian reform was cancelled and national lands were re-appropriated. This led to many violent clashes, with Chimaltenango among the Departments most affected (Comisión para el Esclarecimiento Histórico, 1999). The ensuing repression and efforts to combat the “internal enemy” and communism in Guatemala led to a state of silence and terror, where citizens had no recourse but insurrection to express their discontent (Comisión para el Esclarecimiento Histórico, 1999). By 1960, the Civil war had begun, leading to 36 years of violent strife and repression.

During this war the Guatemalan state was found to be guilty of killings, torture, forced disappearances, massacres, sexual violence, scorched earth operations37 and ultimately genocide. The Truth Commission meticulously documented organized violence mandated from the highest

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37 Scorched earth was an army policy, “where if they found any evidence of guerrilla support in a town or village, they would simply rape, pillage, and murder to destroy the town” (Berry, 2010).
levels and destroying the country’s social fabric. In total, 200,000 civilians were killed, 93% of whom were killed by government forces (Comisión para el Esclarecimiento Histórico, 1999). Chimaltenango is among the three departments which experienced the greatest numbers of forced disappearances and massacres (70) (Comisión para el Esclarecimiento Histórico, 1999). The Peace Accords of 1996 characterize Guatemala as a multi-ethnic, pluricultural and multilingual society, but this goal of a more equitable society has yet to be fully realized in Guatemala. Understanding family planning, and differences along ethnic lines, cannot be accomplished without taking this history into account. The unequal access and use of family planning by indigenous women in Guatemala, compared to their non-indigenous counterparts, cannot be understood in isolation from the general ethnic social exclusion they have experienced over centuries, culminating in the civil war.

*Lasting legacy of the protracted and violent civil war*

Beyond its obvious health and welfare effects, the bloody and protracted civil war severely contracted health and social services and contributed to a lasting environment of mistrust. This general state of mistrust may also help to explain why indigenous women continue to view public health services with apprehension, including for accessing family planning methods. During the civil war transportation was disrupted, health units were no longer built or maintained, and “few health personnel were willing to relocate to areas of armed conflict…” contributing to “chronic shortages of nurses and doctors” (Santiso-Galvez & Bertrand, 2004). Ethnographic reports show the duress that women were under:

“There was also intimidation of women from within the community, in the form of threats to their lives, and sexual harassment by the local men who had killed their relatives. Women were threatened with further rape, and with death; and they knew that the threats were not idle. Any woman who joined a human rights organisation… or even 'neutral' NGOs (non-governmental organisations), were threatened with kidnapping or death, for themselves or their children” (Zur, 1993).

The climate of intimidation thus eroded trust even between members of the same community. Civil patrols were set up after 1982, where men were often recruited to spy on their own neighbours. These patrols “served as the army's eyes and ears, though ostensibly they were set up to eradicate 'subversives' and 'bandits' in the local area. After carrying out a massacre they silenced villagers by threatening them that if they spoke about what had happened they would
suffer further violence. Their activities effectively destroyed all social relationships, networks, and solidarity among civilian populations” (Zur, 1993).

During the war, people’s strong reluctance to use health services, including reproductive services, is understandable, since “Whatever person showed up in the communities, they could be from the military or the guerrilla… Both did bad things to the people if they didn’t collaborate” (Director of Health Center in Chimaltenango, quoted in Maupin, 2009). According to health officials, it took time to “gain communities’ trust by working through local committees.” Renacimiento’s strategy of employing local health facilitators and incorporating ‘guide mothers’ as volunteers appears to be helping gain the trust and patronage of local women in our study, as only one of sixteen participants reported being concerned about privacy and confidentiality, although her concerns are serious and discussed in detail below. The women interviewed in this study would have been born after 1988, and grown up when the worst of la violencia (the violence) was over, so it is understandable that they do not refer to this climate of mistrust directly. However, the legacy of mistrust helps to interpret the comment of one participant who reported having her privacy breached while receiving family planning services in her community: “I planned with my daughter, but my sister-in-law saw me one time when I was being injected. She started to talk about me.” Further conversation about this incident revealed that the sister-in-law did not in fact see her get her injection, but the person working with Renacimiento who did the injection later told her sister-in-law. Regardless of how this breach in privacy came about, two points are important. Firstly, she reports being seen by her sister-in-law, drawing equivalency between her confidentiality being compromised and her exposure to the whole community. Even though it was a series of events, separated temporally, which led to the exposure of her family planning status to the community (i.e. the service provider telling her family member, then her family member talking badly about her to others), the fact that she summarizes this as having “been seen” shows the fragility of her privacy and the extent of the breach. A second important point is that using community members to gain others’ trust can actually be a double-edged sword. There are dangers with task shifting and the community level provision of services if privacy and professional service provision cannot be assured.
Exclusion seen through Social Statistics

In terms of land tenancy, Guatemala is the most unequal country in Latin America, a region characterized by its inequality, and almost half the country’s income is concentrated in the hands of just 10% of Guatemalans (Comisión para el Esclarecimiento Histórico, 1999). Monteforte, a Guatemalan intellectual who served as a politician in the 1940’s and 50’s, links his country’s inequity to the issue of land:

Land is the root cause of national backwardness, of elite economic clout, of social imbalance, of the survival of pre-capitalist structures, of the over-population of our cities, of criminality, of the absence of internal markets, of menacing unrest in rural areas, of ignorance, of illiteracy, of the nostalgia that was this country five centuries ago. (Monteforte, 1999 as cited in Lovell, 2010)

In Guatemala, “Ninety percent of the total number of farms account for 16% of total farm area, while two percent of the total number of farms account for 65% of total farm area” and only 6.5% of land is owned by women (Comisión para el Esclarecimiento Histórico, 1999; Lovell, 2010; United Nations, 2002). Unequal access to education is another symptom of this inequity in Guatemala, which correlates with contraceptive rates (Ministerio de Salud Publica y Asistencia Social, 2009). Across Latin America, indigenous peoples are typically less educated and use family planning less than non-indigenous peoples (Terborgh et al., 1995). Guatemala exhibits the greatest educational differences where indigenous adults have less than half the level of schooling of non-indigenous adults: 2.5 versus 5.7 years (Hall & Patrinos, 2006). In Guatemala, whether or not a girl goes to school is largely determined by her ethnicity and her area of residence (Guttmacher Institute, 2006). Primary school completion has been found to be “five times as high among non-indigenous as among indigenous young women (51% vs. 11%), and 2.5 times as high among urban as among rural adolescents (62% vs. 24%)” (Guttmacher Institute, 2006). Mayan females “are by far the most disadvantaged group in Guatemala – only 39 percent of 15-64-year-old Mayan women are literate (versus 68, 77 and 87 percent of Mayan males, Ladina females, and Ladino males, respectively) (Hallman et al., 2006). Poverty rates also point to the exclusion of the indigenous population, as 74% of the indigenous population are poor, compared to 38% of non-indigenous people (Hall & Patrinos, 2006). In rural areas, this comparison is even more glaring, with 30% of the indigenous population very poor compared to 13% of the non-indigenous (Hall & Patrinos, 2006). Furthermore, these differences are
becoming greater over time, with poverty rates falling more slowly for indigenous than non-indigenous populations (Hall & Patrinos, 2006). The United Nations Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia and related intolerance highlighted different types of racism that are still salient in Guatemala: legal, interpersonal, institutional and structural (UNICEF, 2007).

Berry (2010) has explored institutional racism as a determinant for worse maternal health outcomes for indigenous women in Guatemala, and to help explain their apparently contradictory rejection of “modern” emergency obstetric care. Through anthropological participant observation research and “recognizing the influence of wider historical and social context,” Berry shows how culturally inappropriate and discriminatory services, particularly in hospitals, serve to make indigenous women distrustful and families reluctant to bring women to the hospital, even in clear cases of obstetric emergency (Berry, 2008; Berry, 2010). She shows how efforts by the Ministry of Health to make maternal services more modern have indirectly encouraged doctors and nurses to seek out and praise patients they understand to represent this ‘modernity’ and criticize, chastise and reject patients who for them, fit the stereotype of the “Indio bruto” (brute Indian), undeserving of care and easily dismissed due to being “illiterate, backward, dirty, simple, poor, lazy and stupid” (Berry, 2010). She further shows how the general environment of every day violence, and legacy of mistrust of government from the Civil War, reinforce reluctance to use medical services during pregnancy and labour: “Given the palpable context of violence that makes even the unthinkable plausible, we can now understand why villagers are reasonably reluctant to fully embrace a [maternal health] policy that results in them ceding any tiny bit of control over their bodies that they maintain” (Berry, 2010).

A further expression of the social inequity and structural discrimination is evidenced by considering child malnutrition rates. Guatemala exhibits the highest rates of malnutrition in the continent, and fourth highest in the world. In total, 49.3% of children in Guatemala suffer from malnutrition, but this rises to 69.5% of indigenous compared to 35.7% of non-indigenous children (González et al., 2009; UNICEF, 2007). Chimaltenango, the Department where interviews were carried out for this research, is among those classified as having high nutritional vulnerability, with 60% of children exhibiting chronic malnutrition (González et al., 2009). Child malnutrition is a principal cause of illness and infant mortality, but also affects children’s ability to concentrate in school, and ultimately their educational attainment (UNICEF, 2007).
Due to gender inequity, women and girls suffer a greater proportion of malnutrition since they are often the last to eat, frequently consuming less food of lower quality (González et al., 2009). During interviews, concern for being able to feed their children was the most common advantage of spacing children mentioned by women. For example, one participant comments, “Even the baby suffers in your belly because it doesn’t have any sustenance.” It was notable that in interviews this concern was much more common than providing for children’s education, however, given the context of child malnutrition in Guatemala, women’s individual concerns are seen to align with the national reality.

**Gender inequity**

Mayan culture is patrilocal, in that women live with their husband’s families, and patriarchal (Chirix García, 2010). Patriarchy “refers to historical power imbalances and cultural practices and systems that accord men on aggregate more power in society and offer men material benefits, such as higher incomes and informal benefits, including care and domestic service from women and girls in the family” (World Health Organization, 2007). Gender inequity was never labelled as such by participants from the study, however, imposing a gendered lens on the interpretation of interview data indicates several examples of patriarchy, touching on issues of unequal educational opportunities, the meaning of being a woman in this context, potential dangers of gender-based violence and power differentials in decision-making about family planning.

**Education**

When discussing the merits of spacing her children, one participant mentioned she would like to have fewer children so she can educate her daughters. She described that during her own childhood:

“Well, in my case I wanted to study, but I didn’t have the support of my father. He said men are worth more because women get married… My brother had the opportunity but he didn’t know how to take advantage of it. Well, he didn’t want to, and, well, I wanted to, but nothing could be done because I’m the eldest and I have to cook; I have to go the fields and get my sisters ready. They don’t go to school. And lots of things that truly, sometimes I feel very alone and really sad… I want to have something and give studies to my daughters.”
Conceptualizations of gender certainly influence access to education in Guatemala. The population who are 15 years or older have on average 4.5 years of education, with non-indigenous, urban men having the highest average years of schooling (8.9 years), and indigenous women from rural areas the lowest (1.2 years) (Dary et al., 2004; UNICEF, 2007). The patriarchal and machista\textsuperscript{38} organization of Guatemalan society influences girls’ access to education as much as poverty itself, with “lack of education [a result of] preconceived notions about the role and value of women in society, along with their intellectual capacity” (Dary et al., 2004, translation by the author). Indigenous girls are not only in school less than their Ladina and male counterparts, but they tend to have higher age to grade ratios: Indigenous children start school an average of 0.5 years later than Ladinos and indigenous girls from poor families start school an average of 1.2 years later than the non-poor (UNICEF, 2009). This contributes to higher dropout rates for indigenous girls, as many are embarrassed to study in classrooms with younger children (UNICEF, 2007). This unequal access to education for boys and girls in Guatemala is expressed by interview participants and reflects a gender inequitable society, with impacts on power differentials in decision-making about family planning.

Both supply and demand issues affect the lower educational attainment of indigenous girls in Guatemala. Investment in education as a percentage of Guatemalan Gross Domestic Product is among the lowest in the continent, at 1.9%. Despite efforts to decentralize and regionalize schools, linguistically and culturally, particularly at the junior high school and secondary levels, they continue to be heavily centralized, representing what the permanent commission for educational reform refers to as a situation where the government perpetuates racism and marginalization (UNICEF, 2007). However, national surveys show that access to schools is a minor reason for children not going to school, with lack of money, disinterest, domestic responsibilities and needing to work more often cited. These reasons are often compounded for young girls, upon whom the burden of domestic responsibilities falls, and whose education is not considered to be as important as that of their brothers (Bucher, 2007; Hallman, Peracca, Catino, & Ruiz, 2007; UNICEF, 2007; United Nations, 2002). Once Mayan children begin school, they often face language barriers, with two thirds of Mayans in first grade

\textsuperscript{38} Machismo “typically involves the domination of women, who are viewed as responsible for raising children and serving men” (Arciniega et al., 2008).
having teachers who do not understand or speak their native language, and following a curriculum developed by non-indigenous people which excludes Mayan teachings (UNICEF, 2007). Furthermore, indigenous girls who do manage to start junior high school are often discouraged due to race-based discrimination and being made fun of by their peers for their different language, accent or ways of dressing (UNICEF, 2007; UNICEF, 2009). Furthermore, early marriage, which is much more common for girls from poor, rural households, is also a significant contributing factor to dropping out of school and early childbearing (Hallman et al., 2006; Hallman et al., 2007). Lower school attainment by indigenous girls directly relates to lower uptake of family planning methods by this group later in their reproductive lives. Internationally it has been shown that educational attainment is positively correlated with use of family planning and smaller family size (Cleland et al., 2006).

_Ser mujer – Being a Woman_

Participants commonly described women’s identities in their community being tied closely to having children. Even women who do have children risk the criticism of not being a woman (‘¿No sos mujer?’) if they do not provide many children for their husbands (6 of 16 participants described this in detail). This expression of womanhood is an interesting variant of the common stereotype of Latin American men as machista and their feeling that having many children is an important signal of their manhood (Zelaya et al., 1996). Participants describe criticism for not being a woman by neighbours, husbands, mothers in law and women themselves (Table 2).

<table>
<thead>
<tr>
<th>Source of critique</th>
<th>Data</th>
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<tr>
<td>Neighbours</td>
<td>“People say that you’re not a woman, that’s why you can’t, you can’t take care of yourself, that you can’t have children, and like that… Someone passes and they say, ‘she’s not a woman; she can’t have a lot of children or like that. It bothers me.”</td>
</tr>
<tr>
<td>Husband</td>
<td>“Well before he didn’t want to hear about methods. With the papers [about family planning] there, I start to talk to him, and he no, he tells me ‘No, for what? So you’re not a woman then?’”</td>
</tr>
<tr>
<td>Mother-in law and husband</td>
<td>My neighbour says that her husband scolds her: ‘If you don’t want children why did you come then? For that, you’re not a woman.’ That’s what her husband says. But I think that if it’s forced like that</td>
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Sufrier de madre – Suffering as a mother

The hardships that accompany the rearing of many children are described by participants as falling heavily on the mother. Not only does the woman bear the physical burden of pregnancy, miscarriages and childbearing, but she is the one described as suffering most when there are many children. Suffering includes the pregnancy itself, pregnancy related risk, birth, the hardship of many children, and the hardship of children and an alcoholic husband (Table 3).

### Table 3 – Mother’s suffering

<table>
<thead>
<tr>
<th>Aspect of mother’s suffering</th>
<th>Data</th>
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<tbody>
<tr>
<td>Pregnancy</td>
<td>“Carrying a baby for nine months is also hard, hmm, it’s hard.”</td>
</tr>
<tr>
<td>Pregnancy related risk</td>
<td>“With so many pregnancies there’s a lot of risk, let’s say, for a woman. Ay, maybe sometimes, due to a pregnancy, the woman dies, or, let’s say she is left without strength when there are miscarriages... Let’s say, it’s a big help for a woman to take care of herself, let’s say, it helps her a lot, so that a woman no longer suffers with so many children.”</td>
</tr>
<tr>
<td>Birthing</td>
<td>“But how a woman suffers; she suffers so much giving birth.”</td>
</tr>
</tbody>
</table>
| Hardship with many children | “Because if the next one [child] comes fast, like I see with others; one example I see with others is that they [the children] are small and here comes the other one. It’s hard to have job, plus the diaper and they get sick, plus a ton of diapers. That’s what I say, this shows me that they [the children] should grow a bit and then they should have another brother [or sister]. Even they [the children] themselves suffer because they’re just little and then there’s another one. One suffers as a mother and the children suffer too.”  
“Well, the advantage [of using family planning] is that, one does not suffer with having lots of children”  
“They [people who use family planning] live better, because they live with two children and they don’t suffer more.” |
Suffering with many children and husband drinking

“My mother told me, ‘It’s good, my daughter, that you are taking care of yourself because if one has tons of children, it’s so hard. And what if you find your husband drunk and he doesn’t work and children and children and a mother suffers with them, and it’s hard like that. Yes, I like that you’re taking care of yourself.’”

The conceptualization that women are defined exclusively by their reproductive roles has been noted by scholars of policy in Guatemala, and helps to put these gendered feelings about having children in context. For example, Berger traces policy development related to women’s rights in Guatemala, and notes that restricted gender conceptualizations have limited the development and implementation of comprehensive and empowering laws (Berger, 2006).

Women’s groups have pushed to challenge patriarchal institutional structures during the “political modernization project of the postauthoritarian era in Guatemala” (Berger, 2006). Laws passed since the end of the Civil War in 1996 show movement towards a gender-equitable discourse, however closer examination shows persistent patriarchy (Berger, 2006). Guatemala’s constitution, created in 1985, defines women as having special treatment, but in restrictive ways relating to their roles as mothers and wives. The 1996 Peace Accords recognize broader roles for women and specifically call for measures to reduce discrimination that limit their access to productive and technological assets. However, even the Peace Accords uphold in some parts racist and patriarchal ideas about indigenous women, recognizing, for example, “the special vulnerability and defenselessness of the indigenous woman,” such language being anything but empowering (Berger, 2006).

The slow passing of laws against gender-based violence also exemplifies this latent conceptualization of women as merely mothers and wives. Rather than condemning all violence against women, and despite efforts by women’s groups to make the law more comprehensive, the 1996 Law to Prevent, Sanction and Eradicate Violence within the Family, as its title suggests, limited its scope to violence ‘in the family.’ In an effort to remain “neutral,” final wording of the law removes the gendered definition of violence, denying the reality that it is in fact men who are most often perpetrators of this intra-family violence. These deficiencies are all the more glaring when the Guatemalan law is compared to the Interamerican Convention signed 2 years prior in Brazil, which treats the prevention, sanction and eradication of all forms of violence against women (Berger, 2006, emphasis added). Furthermore, the Guatemalan law does not specify
punishment for such acts of violence, focusing only on measures to protect women who were subjected to intra-family violence. Thus, Berger contends that “In its entirety, the law does much to uphold the culture of violence against women rather than attack it at its patriarchal core” (2006).

The 1999 Law to Dignify, Protect and Promote Women, while more progressive in denouncing all forms of discrimination and violence against women, still defines women in relation to nuclear families, thus narrowing “the conversation about and possibilities for femininity and masculinity constructs” (Berger, 2006). However, the law does at least direct families and government to facilitate women’s working outside the home, which until 1999 in the Civil Code was allowed only “if it did not prejudice the interests and care of the children” (Civil Code, 1963, as in Berger, 2006). The 2001 Social Development Law still defines women in relation to families, but at least extends the definition of family to include single-headed households and non-married partnerships. The law also promotes family planning and sex education, in addition to the state’s role in helping families meet their children’s education and health needs. The lack of implementation of the sex education and family planning clauses of the law is due in large part to advocacy by the Catholic Church, as will be discussed below.

This analysis of recent laws and policies relating to gender and women’s rights shows a clear pattern where Guatemalan society is reluctant to define women beyond their roles as mothers and wives. Thus, it is not surprising that in interviews with individual indigenous women, participants speak about women’s identities as closely tied to having children, and the brunt of reproductive work falling on women’s shoulders.

Culture of violence against women

While the passing of Guatemalan laws discussed above indicates a progressive condemnation of all violence against women and recognition of the wider contribution of women to Guatemalan society, the impunity with which pervasive violence against women persists shows the deep roots of patriarchal violence and gender inequity. One indication of the lack of seriousness with which violence against women is approached is evidenced through the scarce public resources assigned to CONAPREVI, the national office tasked with ensuring the effective implementation of intra-family and gender-based violence laws. This office is not sufficiently independent from the presidency, and has not received sufficient national resources to carry out its mandate (Berger,
2006). CONAPREVI was finally disbanded in 2012, leaving women’s groups concerned about the government’s lack of commitment to addressing violence against women (INTERDEM, 2013).

Beyond a policy-lens, evidence about the prevalence of gender-based violence in Guatemala speaks for itself. In the most recent national survey of infant-maternal health (Ministerio de Salud Publica y Asistencia Social, 2010), 24.5% of Guatemalan women report having suffered physical violence at some point in their lives, with reports of verbal abuse even higher. In the Department of Chimaltenango, where this elicitation research was carried out, more women reported having experienced verbal and sexual violence than the national average (Table 4; Ministerio de Salud Publica y Asistencia Social, 2010).

**Table 4: Reports of Violence by Guatemalan Women (violence suffered at some point in their lives). Source: MSPAS/ENSMI, 2010**

<table>
<thead>
<tr>
<th>Type of violence</th>
<th>Verbal</th>
<th>Physical</th>
<th>Sexual</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>42.2%</td>
<td>24.5%</td>
<td>12.3%</td>
</tr>
<tr>
<td>Chimaltenango</td>
<td>44.9%</td>
<td>23.9%</td>
<td>14.3%</td>
</tr>
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</table>

The most extreme expression of violence against women in Guatemala is the staggering number of women being murdered, labelled *feminicidios* (femicides), with 8.38 women murdered annually per 100,000 people in Guatemala. In Latin America, Guatemala, El Salvador and Mexico have the highest rates of women being murdered, with Guatemala having the unfortunate distinction of being the only one of these three countries to report annual increases in these figures (Castresana, 2009). In 2007, more than 700 women were murdered in Guatemala (Castresana, 2009). Between 2005, 2006 and 2007, 1,986 women were murdered in Guatemala, two thirds of who were killed by men with whom they are close (partners, husbands, fathers, etc.). Perhaps still more shocking is the impunity with which these murders are committed, with only 2% of perpetrators being successfully convicted (43 convictions out of 1,986 women murdered between 2005 and 2007). Concerted efforts by women’s groups, civil society and allies in government led, in 2008, to the passing of the Law Against Femicide, denouncing these extremes levels of violence against Guatemalan women and designating greater measures to promote prevention of, protection against, and justice for gender-based violence, including setting up special courts for violence against women (Amnesty, 2012). However, continuing
high levels of violence against women, including 695 women murdered in 2010, 631 homicides of women in 2011 (Amnesty, 2011; Amnesty, 2012), and almost complete impunity for these crimes, are emblematic of entrenched and dangerous patriarchy in Guatemala, institutionalized violence against women and a weak legal system. This represents a legacy of violence against women connected to the civil war (Berry, 2010), and lends credence to the concerns of individual women who fear violence from their husbands if they use family planning without their knowledge or consent.

Despite these high levels of violence against women, this topic is very much shrouded in silence, such that women are less likely to share openly about experiences or fear of violence. During the civil war silence was a learned protection strategy used by indigenous people, who were the targets of violence from rebels and especially the state. Indigenous families would not identify their own relatives killed in counter-insurgency operations, for fear of being killed themselves (Lovell, 2010). The violence affected “particularly Mayan people, whose women were considered to be the spoils of war and who bore the full brunt of the institutionalized violence” (Lovell, 2010). Indigenous women were used as pawns during la violencia and considered the enemy’s property (Consorcio Actores de Cambio, in García Chirix, 2009).

Recognizing the hesitancy to come forward about instances of violence is important for understanding nuances in interviews with individual women. For example, many women refer to ‘problems’ in their marital relations which could transpire if they used family planning without their husband’s knowledge and he subsequently found out, and fear of even bringing up the topic of family planning. Due to evidence from some women who were more explicit, and nurse practitioners in the municipality, it is highly likely that the term “problems” is often employed as a euphemism for violence (Table 5).
Table 5: Women’s discussion of “problems” and violence

<table>
<thead>
<tr>
<th>Situation</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced “problems” when used family planning and husband was not in agreement</td>
<td>“If your husband does not agree with planning, if one wants to plan and the other no, it’s not possible to plan because problems arise… The first time [I used family planning] yes, I had problems because he was not in agreement that I plan, and since I decided, well, because, because, because my first baby almost died, and it was already like that, and I said to him that I don’t want anymore, I’m going to plan. He didn’t want to and since I wanted to, I went to ask and they gave [a family planning method to] me. But then he started to suspect; we started to have problems [‘problemas entre pareja’]”</td>
</tr>
<tr>
<td>Potential marital “problems” referring to violence</td>
<td>“I would say no [I would not use family planning if my husband were against it], because he would find out anyways…There would be a fight, because we don’t have the same opinion”… And do you think in these cases there is danger of violence, that a wife might get hit because of this?* “I say yes, yes because maybe the husband forbids her and she, because she wants to help herself, she takes care of herself, maybe there would be problems”</td>
</tr>
<tr>
<td>Problems and violence when husband gets drunk</td>
<td>“Sometimes they say that the husbands don’t want to [use family planning], so he threatens his woman, or because of this he hits her… If the husband does not agree sometimes there are problems because one takes care of herself… For example, when he’s healthy maybe he can’t say anything to you, or, or until he gets drunk, and then he starts to hit you in the house”</td>
</tr>
<tr>
<td>Would have used family planning without husband’s consent, but in fear of problems, including violence</td>
<td>“Maybe he would get really angry, and start to scold me, I say… Yes, also afraid that he would have hit me…”</td>
</tr>
</tbody>
</table>

*Text in italics denotes the voice of the interviewer

Special care was taken not to inadvertently expose women’s family planning status when they were recruited for this study. Thus, participants were less likely (than the average indigenous women in this age category) to currently use family planning without their husbands knowing. However, women’s testimonies, and reports from nurses imply that this situation is common. The nurse who provides extension health services in El Llano, the rural district where most of the elicitation interviews were carried out, described having had to attend to a situation of domestic violence in an adjacent community, where a woman sought medical services after
being beaten by her husband when he found out she was using family planning. In Chuinimachicaj, another rural district where interviews might have been carried out, the nurse did not feel comfortable collaborating with recruitment, as she knew many potential participants were using family planning without their husbands knowing, and had already tended to several cases of intra-family violence relating to husbands finding out about their wives using family planning. Taken together, participants’ implicit and explicit comments about fear of violence, the experience of nurses in the area and national statistics and policies about gender-based violence, all point to persistent gender inequity underpinning women’s limited sphere of decision-making regarding family planning.

*Whose decision is it?*

When asked who is responsible for decisions about the number of children to have or family planning, on the surface, participants’ responses mostly embody a more equitable view about this decision-making process between her and her husband. However, often later towards the end of interviews, or if one cross-references with other responses, a pattern can be seen whereby husbands essentially have veto power over the decision to use family planning. The decision is only a ‘shared’ one, as many women describe, once the husband has already expressed his approval.

One participant revealed her husband’s opposition to using family planning only slowly through the course of the interview. When initially asked, “What does your husband think about that [family planning]? She responds, “He agrees.” Later, when discussing fear of God in relation to using family planning the participant admits, “He’s pretty much not in agreement [about using family planning]” (‘El casi no está de acuerdo’). Finally, when discussing her confidence in using family planning according to various scenarios, the participant confirms, “He’s not going to be… he’s not going to be in agreement.” She goes on to elaborate that she would not feel comfortable using family planning without her husband’s support, because she fears being abandoned and losing her husband’s help in the case of her becoming ill.

When asked directly, most participants say they believe that using family planning is a joint decision of both the husband and wife; however, many of their elaborations show that the husband effectively holds the definitive decision-making power in this realm:
“Whose decision do you think it is to use family planning, more the woman’s, the man’s or both of them?”

“Both of them, in my opinion, of both of them, because between the two of them they have to be in agreement. No, one won’t come, one doesn’t have problems, let’s say. And if only one is in agreement and the other one not, there, there are problems.”

Another participant is more forthright that the husband has to be in agreement about family planning:

“At any rate it [family planning] is good, but yes, both have to agree, with the wife and the husband, then you can. If just the woman, pretty much no. For my part, I wouldn’t do that because, if one day he found out it would be a problem… Yes, for me, we’d have to both talk to use those methods.”

One woman is explicit about not being able to dictate to her husband:

“I can’t just dictate to him. I can’t decide all by my little self (‘solita’), so we have to be in agreement both of us. Yes, that’s how it is.”

National surveys have found Guatemalan women commonly feel they need their husband’s permission to use family planning (56.6%), and even to leave the house alone (77%) (Ministerio de Salud Publica y Asistencia Social, 2010). For the Department of Chimaltenango, these numbers are even higher than national averages, with 80.1% of women needing to ask permission before leaving the house, and 62.3% before using family planning (Ministerio de Salud Publica y Asistencia Social, 2010). This shows clear power differentials between women and their husbands, whom they feel they must obey. Also of note is the way women in this study speak about family planning as a joint decision, almost as if they are unaware of their inferior decision-making status. They internalize their husband’s stances, while ostensibly feeling family planning decisions are made jointly, which is reminiscent of Marx’s concept of “false consciousness,” defined as “the holding of false beliefs that are contrary to one's social interest and which thereby contribute to the disadvantaged position of the self or the group” (Jost, 1995). The Kaq’na Mayan Women’s Group (2004) describes how Mayan women must fight their unconscious internalization of oppression as women and as Mayans, as “this power relation, which has lasted years, centuries, makes us introduce elements of the oppressors vision to our interiors, and this we pass on to our children, grandchildren and great-grandchildren” (translation by the author).
The most proximal influence of the Church on family planning is through the way Guatemalans’ religious affiliations influence their understanding and opinions about using contraception. Eleven participants out of 16 discussed how the conceptualization of family planning as a sin could be a barrier to use and access. Of these, five participants actively attend Church (4 Catholic and 1 Evangelical) and two have a strong ‘fear of God’ that is definitive in dissuading them from using family planning. Even if women did not themselves attend Church, they are often influenced indirectly by what they understand to be the Church’s teachings, and by family or community members who hold strong beliefs about contraception being a sin:

“Sometimes we prescribe that God’s law well, it does not, not, and more the religious communities don’t permit that… So not that [family planning]. Let’s say it’s a sin, because while we seek a husband it’s to have children, because God himself said so, that’s what I think…”

“And why do you think your mother would not be in agreement?”

“Like I told you before, she, in the first place it’s a sin, to do that, to use all those methods, that’s what I think.”

Another participant discusses the repercussions of using family planning in relation to God:

“It’s a sin in front of God. Yes, because maybe he has plans to send the children here to earth, but we don’t want them, hmmm… Well, what I think is that God sends blessings through children. Yes, for each child that is born He gives us all that parents need. Because of the children, the parents eat. And if one, I think that if one uses methods it’s because, because one wants to, and there won’t be as many blessings… We’ve thought of using methods, but at the same time we feel remorse, due to a fear of God, who knows? (¿saber?)”

Despite these strong beliefs held by some women, family and community members, many participants resist the idea that contraception is a sin, explaining that having more children than one can care for is a worse sin, or that they are exempt from this restriction for other reasons (please see Richardson et al., submitted, for a detailed discussion of the grounds for this resistance). The Church has, nevertheless, contributed to an overall repression of sexuality in Guatemala and to “reproducing the subordinate condition of women compared to men” (Chirix García, 2010, translated by the author)).
Individual beliefs of some health service providers also contribute to mixed messaging about contraception. The same participant whose fear of God is quoted above, described how her doctor, who she visited at a private practice in the municipal head of Patzún, gave her contradictory advice about family planning:

“Well in the clinics, sometimes they also tell you, even though they say that you have to plan, but at the same time they tell you it’s not good.

“And why do they say that it’s not good, in the clinics?”

“Because as I told you that, that it’s like, if one does not want to receive the children, the ones that God wants to send one… Yes, that’s how it is.”

“And that’s how it was with the doctor you saw? She said, how did it…?

“She says that it’s ok, if one wants to, one decides what one wants more, but at the same time it’s not good, she says. So, she says that each couple has to discuss if they keep having children or not anymore, it depends on the couple.”

The Church, and Catholic Church in particular, has had a profound effect on family planning at more macro levels, affecting international and Guatemalan policies on family planning. Van Liew (1994) maps and analyzes how “the Vatican controlled international population policy” in a centralized way through direct influence on World Health Organization leaders and delegates to suppress any discussion of family planning in annual Health Assemblies of the early 1950s and to threaten to withdraw their countries from the organization entirely if resolutions relating to population policy were not squashed. The Vatican also directly influenced specific country-level policy initiatives, including with Catholic leaders making public pronouncements and imposing heavy pressure on national delegates who favoured a discussion of family planning (Van Liew, 1994, Richardson, 2011). Pope Pious XI labelled contraception a “grave sin” that is “intrinsically evil” in 1930 (Van Liew, 1994). To the dismay of modernizers within the Catholic Church in Latin America and Guatemala, in 1968, Pope Paul IV upheld this position in the much anticipated “Humanae Vitae,” which banned all forms of modern birth control (Santiso-Galvez & Bertrand, 2004; Stycos, 1971; Van Liew, 1994).

In Guatemala the Catholic Church’s influence in governance dates back to colonial times, when it was arguably as significant as that of the secular bureaucracy (Bendaña, 2010; Calder, 1970b; Few, 1995). Few (1995) documents how the Holy Office of the Inquisition of Santiago de Guatemala exerted power and social control over colonial subjects, both from the elite and
poorer parts of Guatemalan Society. She traces how individual women from indigenous and mestiza ethnicities used religious symbols and superstition as resistance strategies to the entrenched patriarchy that was part of the colonial order. Through these stories she documents the extent to which the Catholic Church was involved in controlling colonial populations, and shaping notions of gender. Conceptions of what it meant to be a virtuous woman for the elite included being discreet in affairs of sexuality, and generally, “Women's sexuality [was] constituted by the church and civil authorities as dangerous to the social order in a broad sense” (Few, 1995). The Church systematically attacked the healthier and open sexuality of indigenous people, attempting to replace it with more oppressed and “decent” sexual customs (Grupo de Mujeres Mayas Kaqla, 2004). This sexual oppression went hand in hand with other types of exploitation, since “the experience of healthy and vital sex makes us more free, and while more individually free, we accept less the oppression that they want to impose” (Grupo de Mujeres Mayas Kaqla, 2004, translated by the author).

The Catholic Church cemented its influence over the last half century, poising the Church well for decisive influence on population policy. The Truth Commission’s report written at the end of the Civil War documents how the Catholic Church consolidated power in the Guatemalan state during the 1950’s. The decade prior to the 1954 overthrow of Arbenz has been labelled the ‘democratic spring,’ due to the period’s rapid institutional changes in favour of modernization, diversification, inclusion of peasants, educational and agrarian reform (Comisión para el Esclarecimiento Histórico, 1999). Guatemala did not escape the political and ideological polarization of this era, with the Cold War and concerns of communist spread increasingly salient. The Catholic Church took advantage to energetically join the crusade against communism, “issuing pastoral letters warning the faithful of the growing influence of communism in the country” and ultimately supporting the military coup which overthrew Arbenz (Muñoz, 2010; Shiffman & Valle, 2006b). The Church strongly supported subsequent military regimes, whose “governments reciprocated by amending the constitution to restore Church privileges such as tax exemption and a declaration that the teaching of religion in schools was in the national interest” (Shiffman & Valle, 2006b). During the same period, the Church’s geographical reach was reinforced by the evangelizing and social work of foreign missionaries who lived and worked in Guatemala’s most rural and abandoned communities, often becoming
strong proponents of social and community development (Calder, 1970a; Comisión para el Esclarecimiento Histórico, 1999).

It should be mentioned that Catholic Church stances on family planning are not monolithic and have fluctuated across time and place. Media coverage and citizen awareness about family planning in Latin America burgeoned in the mid-1960s, when “Church liberals, seeing a morally revolutionary and socially liberal issue on which they were backed by their parishioners, began to use it as part of the platform for church reform” (Stycos, 1971). In Chile, the Latin American Center for Family and Population was founded as a Catholic organization working towards “moving both the hierarchies and the Catholic populations of Latin America toward acceptance of family planning” (Stycos, 1971). Necochea (2008) documents how in Peru in the 1960s and 70s, a Catholic physician from the United States, with explicit support from the local Cardinal, worked with priests in Lima to set up a family education program that provided birth control pills. The data from the elicitation interviews in this study also shows that local religious leaders sometimes support family planning, with one participant describing how a local pastor from her evangelical church broached the topic of family planning with her individually, endorsing her decision to use a modern contraceptive method.

The Catholic Church’s influence on Guatemalan population policy has nevertheless largely served to limit access to and use of contraception. When Guatemala’s private family planning organization, APROFAM, was founded in 1962, many leaders were discouraged from starting or continuing as board members due to constant pressure from the Church that opposed family planning (Santiso-Galvez & Bertrand, 2007). After some gains were made in improving family planning services, the Ministry of Health succumbed, in 1979, to pressure from the Catholic Church, which claimed intra-uterine devices were abortifacient, suspending its family planning program and ordering all intra-uterine devices to be removed (Santiso-Galvez & Bertrand, 2004; Santiso-Galvez & Bertrand, 2007). Representatives from the Catholic Church successfully lobbied to make sure the new constitution in 1985 protected life “from the earliest moment of conception” (Santiso-Galvez & Bertrand, 2004). In 1986 the archbishop of Guatemala wrote to President Reagan urging the United States to withdraw funding of family planning programs in Guatemala, based on the allegation that APROFAM was carrying out
sterilizations of indigenous women without their consent39 (Santiso-Galvez & Bertrand, 2004; Santiso-Galvez & Bertrand, 2007). Berger (2006) documents the Catholic Church’s powerful lobby against any provisions about family planning and sex education in the Social Development Law. Thanks to activism by women’s groups, leadership by the Guatemalan Republic Front, “a party rooted in Christian evangelical movements and less beholden to the influence of conservative elements of the Catholic Church than its predecessor,” and careful lobbying including with leading Catholic bishops, the law was eventually passed in 2001. However, the implementation of its more contentious elements has been severely hampered by the strong opposition of conservative elements in Guatemalan civil society, including the Catholic Church (Berger, 2006; Shiffman & Valle, 2006a). Santiso-Gálvez & Bertrand (2004) argue that even though many of the Church’s accusations were false, a significant degree of advocacy must take place even to partially overcome these obstacles, and energy deflected from family planning service provision. Furthermore, by creating such a hostile environment for reproductive rights, the Catholic Church successfully raises the political cost of pronouncement or action in favor of family planning, making it understandable that no government in Guatemala publicly endorsed family planning until 2001 (Richardson & Birn, 2011; Santiso-Galvez & Bertrand, 2004).

The influence of the Catholic Church is also evidenced by Guatemala’s international diplomacy on issues of sexual and reproductive health. At the International Conference on Population and Development in 1994, Guatemala’s delegation was forced by its devoutly Catholic President to support the stance of the Vatican and “oppose all mention of reproductive rights, sexual rights, reproductive health, fertility regulation, sexual health, sexual education, services for adolescents…” (Santiso-Galvez & Bertrand, 2004). At the five year anniversary meeting of the 1994 International Conference on Population and Development, Guatemala joined Argentina and Mexico in again supporting the conservative stance of the Vatican on issues of induced abortion, family planning and sexual education (Langer & Nigenda G., 2000).

Another important caveat is that Catholicism, in and of itself, is not enough to explain the lack of contraceptive prevalence in Guatemala, as these same influences were present in other

39 Reagan responded by sending a commission to Guatemala, which found the allegations to be false (Santiso-Galvez & Bertrand, 2004).
Latin American countries too, such as in Chile and Colombia where contraception rates are higher (Robinson & Ross, 2007). Rather, it is a confluence of factors in Guatemala, and the “close ties between the Catholic Church and the ruling elite on the issue of family planning” as pointed out by Santiso-Gálvez and Bertrand, that contribute to the “delayed contraceptive revolution” in this country (Santiso-Galvez & Bertrand, 2004).

*Women’s Sexuality shrouded in silence*

Overlapping ethnic and gender based inequity, colonial history as well as the influence of the Church, have all contributed to a situation where women’s sexuality is a taboo topic in Guatemala across all social classes, and even more so for Mayan women (Chirix García, 2010; Pick et al., 2008). Emma Chirix, a Kaqchikel academic from Comalapa, Chimaltenango, writes compellingly about the ways Mayan women’s sexuality has been repressed. She describes how pre-Hispanic clay depictions of Mayan women show the human figure including erotic images, without a negative connotation. Her historical analysis of the Mayan body politic traces how Western conceptions of beauty and chastity have led to a ‘colonization of the body,” furthering and embodying exploitation, guilt and a double morality (Pineda, 2000 in García Chirix, 2009). Starting with Colombus’ arrival, Spanish invaders were scandalized by the nudity of Mayans, and Spanish priests later imposed this “morality” (García Chirix, 2009). Between 1768 and 1770 the Archbishop Pedro Cortés visited Patzún and noted, “The Indians have an abundance to eat; there are some naked people, for lack of shame, as it is cold land and they have things to wear” (Gall, 1978, translation by the author). In the 1940’s General Ubico in Guatemala ordered Mayan women from Palín, who used short huipiles (skirts typically used by Mayan women), to wear long huipiles. Christian Mayan women are “obligated by oppressive, conservative and moralist thought to cover themselves and dress like the Virgin Mary.” (García Chirix, 2009).

Thus, according to Chirix, Mayan women’s conceptualizations of nudity and sexuality have been transplanted through the imposition of another “vision of value and ways of dressing, and sexuality has come to be understood as impure, dirty, private, embarrassing and sinful,” with the “human body unworthy of pleasure” (García Chirix, 2009, translation by the author). Mothers, culture and the Church socialize behaviour patterns that uphold prohibition, supported in turn by laws that maintain the status quo, relations of domination and “freeze feelings of pleasure and love” (García Chirix, 2009).
As expected, repression of women’s sexuality was not mentioned directly by participants, but it can be observed through several lines of interpretation. Five participants spoke about sex on a total of seven occasions, though never using the term directly. Participants referred to ‘having relations’ in four instances and to “taking care” in three others. Across the interviews, the term “take care” takes on many meanings, most often to describe using family planning, both natural and modern methods. In two of the three instances in this context, women referred to “taking care” as avoiding sex with their husbands during the fertile period of their cycle, when they were using the rhythm method:

“If one does not take care of the days that one cannot be with him, but, if one could not take care, then one gets pregnant.”

Never was sex mentioned in regards to women’s enjoyment or pleasure. On the contrary, two women talked about being fearful of having ‘relations’ with their husbands when they were not using a modern method of family planning, because they did not want to get pregnant:

“One feels fear, feels fear when having relations because what if I get pregnant again and I don’t want to, and like that... One can even feel badly for this. Due to this there can also be problems, because the husbands find out that one, well, does not, not, let’s say, one does not, not feel good with him.”

In these instances women had trouble experiencing pleasure in sex because they were so concerned about the reproductive implications. For women with unmet need for family planning, who prefer to wait to have children but are not using a modern method, the fear of becoming pregnant appears to overshadow any possibility of pleasure, and may create new sources of anxiety.

The topic of reproduction in general goes relatively unspoken, with lines of communication about having children typically delayed, even among mothers, daughters and siblings, until after the first pregnancy has begun:

“Well, we talked about it [having a family] sometimes, but it’s not, it’s not the same as when you are living it, then they orient you more than, than when you’re still not, just a comment that simply passes. When one is living it already, it’s, it’s more, more significant the comment they give you”

“And is having children something you plan, or something that simply happens?”
“Well in my case I think it’s, something that, that happened to me and, like that, it happened.”

Discussion of contraception with one’s family is even less common, with many participants finding out about family planning through health service providers once they already suspect being pregnant or have given birth to their first child. While this underscores the importance of information provision through educational and health services, it also highlights that reaching out only to married women may miss a critical window for some who might otherwise have wanted to use family planning before becoming pregnant.

Husbands employ several delay and avoidance tactics to discussing family planning. For example, one woman describes how her husband preferred to talk about family planning after having their first child, then confirmed he was against it:

“Yes, we talked about it [family planning] but after he said that ‘There, let’s talk about this after, when we already have our first child,’ he said, ‘to define things well.’ Aha, but yes, we talked a bit [after the first child] but he’s pretty much not in agreement.”

Discussions that do occur between young spouses when the husband does not want to use family planning seem to be largely one-sided, with the husband not revealing his reasons for disagreement:

“Mmhh, he’s not in agreement, no”

“And why does he say, why do you think he’s in disagreement?”

“About that, yes I don’t, he tells me he’s in disagreement”

“He simply said he was in disagreement and that’s where the conversation ended?”

“Yes.”

Another participant described being so fearful of bringing up the topic of family planning that initially she felt comfortable doing so only in jest:

“Yes, the first day I spoke to him about this [family planning] I was scared of how to start to telling him so I started to say it with jokes. Jokes, I told him, and jokes and jokes and like that, and until one day I did speak to him seriously… The joke that I told him is that I said, ‘What do you say if one day we use a method?’ I told him like that, then he started to laugh and he said ‘No, no I don’t want that,’ and we started to laugh. Like that, with jokes.”
Humour can facilitate “expressions of thought and acts which are not normally permitted” and jokes are sometimes used to try out “certain views only half seriously” (Wellings, 2000). Expressing herself initially through jokes, this participant was able to broach the sensitive topic of family planning.

In a few exceptional cases, participants describe discussing family planning with their husbands, prior to or early in their marriage. However, in some cases even when the husband is not against using family planning, he wants to know as little as possible about the matter. One participant reports:

“He didn’t tell me anything [about methods]. He just said, ‘Ay, yes, who knows what you do?’ He said, ‘We’ll see what you do’… ‘Go’ that’s what he said… And he didn’t tell me that, he didn’t tell me, ‘Ay, no, no you’re not going to do that.’ He didn’t say that. It means that he wants it (laughter). Yes, well that’s how he told me, but he didn’t get angry with me, no.”

Laughter is often a way of expressing discomfort with a certain topic of conversation (Wellings, 2000). Examining the interviews for patterns of laughter shows that participants laughed most frequently when discussing if they had been pregnant, how many children they want to have, and whether the timing of their last birth was ideal for them or not. This laughter is another indication that conversations about reproductive decisions are likely uncommon and somewhat uncomfortable for participants in the study. Chirix (2009) documents how in Comalapa, Chimaltenango, the topic of sexuality provokes laughter, with many women expressing their feelings, emotions and sexual experiences through jokes. Often using metaphors, women refer indirectly to intimate parts of the body, showing resistance to the dominant patterns of sexual repression.

*Population politics*

*International*

The evolution of international population politics is complex, and only key points will be discussed here as they relate to interpreting expressed and unexpressed barriers to family planning mentioned by participants. Prior to and after the Second World War, most discussions of population on the international stage focussed on concern with overpopulation versus the availability of arable land and food, and geopolitical concerns about population pressure as a
cause of war (Bashford, 2008). Family planning was largely left out of the discussion, in part due to pressure by the Catholic Church, as discussed above, but also because communist delegates objected to the neo-malthusian logic, asserting poverty was a symptom of the capitalist economic system, not of overpopulation and insufficient resources (Bashford, 2008; Stycos, 1971). United States’ foundations were big proponents of studying international population issues, and helped to establish initial population related structures within the United Nations, but it was not until later in the Cold War that the United States began to see population concerns as extensions of their foreign policy, drawing associations between population, development and anti-communist efforts (Bashford, 2008). The Alliance for Progress, established in 1961, articulated United States’ intentions to help fight poverty, show the benefits of the capitalist system, and control the spread of communism (Comisión para el Esclarecimiento Histórico, 1999). In the same year the United States established its Agency for International Development, with population a major pillar (Chirix García, 2010). Specific birth control methods were heavily subsidized by the United States (Raúl, 2008). Latin American governments were under pressure and funded to enact policies of population control, ostensibly as a measure to discourage instability and the ensuing threat of communism (Birn & López, 2011; Raúl, 2008). A critical view of this motivation was perhaps most eloquently captured by Eduardo Galeano: “In Latin America it is more hygienic and effective to kill guerrilleros in the womb than in the mountains or the streets” (Galeano, 2009). In her exposé about the “imperialist rationale behind population planning,” Mass (1976) asserts that in Guatemala:

“There are 77 large multinational corporations investing in Guatemala and the government in power, which has guaranteed the safety of these investments, is protected by a militia heavily supported by US funds… It is in the corporate interest to maintain the status quo – at all costs preventing nationalization and redistribution of vast tracts of corporation land. The methods employed to maintain the subjugation of the Guatemalan people range from open killing to the subtler, more liberal-humanitarian sterilization of indigent people” (Mass, 1976).

The fact that most funding for family planning in Guatemala has come from external sources fuels internal critiques that these efforts are simply part of an imperialist agenda. Despite international rhetoric about family planning taking a decisive turn by the 1970’s towards a more feminist understanding of population politics, with women’s rights at the centre, some critics still allege population policy to be imperialistic and imposed from outside (Shiffman & Valle, 2006b). The recent finding that the United States Public Health Service conducted
syphilis and gonorrhea experiments in Guatemala on uninformed women and men does not help the argument that all United States’ efforts in reproductive health are altruistic (Galarneau, 2013).

National population politics

Previous qualitative research on family planning in Guatemala has quoted individual men and women from Mayan Quiché communities to be against family planning because they believe it part a “Ladino plot to do away with the Mayan population” or a “U.S. plot to diminish the strength of Guatemala” ((Metz, 2001; Ward et al., 1992). Especially in light of the recent civil war, this may not have been completely untrue in the past. In her critique of family planning as an imperialist strategy, Chirix (2010) documents how the state of Guatemala was accused in a 1976 newspaper article of massive sterilization campaigns in the Western Highlands. Guatemala’s leading academic institution, the University of San Carlos was a bastion of leftist sentiment, where “family planning was seen as part of an imperialistic plot by the United States to control the masses of its developing-country neighbors.” This vocal opposition reinforced governments who were neutral or against family planning, and contributed to a vacuum in service provision, as doctors and nurses who graduated from the San Carlos were not trained in providing contraceptive services (Santiso-Galvez & Bertrand, 2004).

This national version of the imperialist critique is echoed in the ethnographic findings of Nelson (1999), who found Mayan women were criticized for undermining the indigenous movement if their activities strayed too far from childbearing: “Discussion of the genocide suffered by the Maya and emphasis on the role of women in passing on the culture to their children have resulted in a marked pronatalist stance among the Mayan rights movement.” Nelson describes the contradictions some Mayan feminists have faced, and a pattern of glossing over gender inequity in an effort to stay united in the Mayan movement, invisibilizing the oppression of Mayan women by the already oppressed Mayan men (Nelson, 1999). While this rationale for rejecting family planning was not raised directly by participants in this study, it could be an underlying reason why older generations are in some cases staunchly against family planning and pressure their daughters and daughters in law to have many children.

While the sample for interviews is not statistically representative, it is still noteworthy that seven of the eight women using contraception chose Depo-Provera as their method of
choice, with one participant opting for condoms. The predominance of this choice warrants further exploration at both the individual and political economy levels. Depo-Provera is a family planning method that is injected every three months, and six women in the study mentioned they thought this was the best method to use because it was less easy to forget. For example, one woman comments, “The injection is the easiest; it’s the one you can remember easiest because the other ones you forget.” Another woman explains, “Yes, I first tried with those (birth control pills) but no, that was when I became pregnant again with my daughter. I don’t know why that would have been; I don’t know if it was because I wasn’t controlling ['llevando el control’ or managing] the pills.” Depo-Provera may also be chosen due to its convenience, since women have to come only once every 3 months to receive the injection, and also due to its non-permanence, as women can discontinue this method when they wish to become pregnant again. Discretion may be another factor, since being injected once every three months is more subtle than using the pill every day or using condoms, in the case of women using family planning without their husbands knowing.

The reason why so many women opt for injection is no doubt determined by individual preferences, but a deeper exploration shows that policy and the supply environment are also important. A 1978 study of family planning use in Highland Guatemala, commissioned by the United States Agency for International Development (USAID), concluded that injections would be the preferred contraceptive method of indigenous people, were it not so expensive\(^{40}\), due to their familiarity with injections as cures for common illnesses (Annis, 1978). In a somewhat patronizing tone, Annis explains:

> “Throughout the Highlands, curanderos, health promoters, auxiliary nurses, pharmacists, and persons called injectionists routinely inject their neighbors with large, costly, and probably useless quantities of vitamins, antibiotics, and revitalizers. In many areas, a body of lore has evolved which explains the efficaciousness of these remedies in terms of traditional "hot/cold" concepts of disease classification ("it burns and stings when it goes in, therefore it must be good for such-and-such 'cold' sickness"). Vitamin pills, on the other hand, are scarcely used” (Annis, 1978).

\(^{40}\) In the Department of Quiché where the study took place, private pharmacies charged about $5 per injection, and the Ministry had discontinued injections (Annis, 1978).
More recently, Maupin (2011) confirmed that in “Guatemala, injections are a powerful symbol of efficacy, knowledge and power, and for many promoters constitute their primary source of revenue” (Maupin, 2011). In the rural districts where interviews were carried out, Depo-Provera is now provided free by the Ministry of Health, which, perhaps in part due to preferences of external donors such as the United States, and findings such as those in Annis’ (1978) report, seems to have overwhelmingly thrown its weight behind Depo-Provera. Another re-enforcing factor is that the Ministry of Health sets targets for the number of new users of family planning by department and municipality. For example, in the municipality of Patzún, the Ministry is expected to meet the target of 1596 new contraceptive users in 2013. These targets are distributed among the rural health posts and extension services in Patzún, and the municipal health post must provide an explanation to the Ministry if these targets are not met. What is more, the targets for contraceptive users are designated by type of method, with Depo-Provera occupying the large majority of the overall target (1244 out of 1596 new users).

Table 6: 2013 Municipal targets for new contraceptive users in Patzún, Chimaltenango

<table>
<thead>
<tr>
<th>Method</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depo-Provera</td>
<td>1244</td>
</tr>
<tr>
<td>Pills (Lo Femenal)</td>
<td>80</td>
</tr>
<tr>
<td>Copper T (Intra-uterine device)</td>
<td>22</td>
</tr>
<tr>
<td>Condoms</td>
<td>57</td>
</tr>
<tr>
<td>LAM (Lactational amenorrhea method)</td>
<td>174</td>
</tr>
<tr>
<td>Cycle beads</td>
<td>19</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1596</strong></td>
</tr>
</tbody>
</table>

It cannot be determined from this study whether the supply environment is encouraging individual women to opt for the injection method, or vice versa, however, it is clear that a re-enforcing loop exists which promotes the three month injection over other types of family planning methods.
The lack of availability of a wide array of family planning methods\textsuperscript{41} was one of the concerns raised in 2013 by an indigenous leader from civil society, Noemí Racancoj, who worries about the centralized way laws relating to reproductive health are enacted and implemented (Orozco & Morales, 2013). In a televised interview with \textit{Diálogo Libre} (Free Dialogue), Ms. Racanjo criticized planning in reproductive health for taking place in the capital without sufficient consultation in rural areas, leading to the imposition of certain methods without adequate counseling, and insufficient consideration of local culture. Given that Mayans represent the majority of the country’s population, one might wonder why they do not have more clout in the government, with a representation of just 11.4\% in the current national congress (National Democratic Institute, 2013). Many have pointed to the scant support for Rigoberta Menchú, who received only three percent of votes as the first Mayan woman to run for president in 2007\textsuperscript{42}, as evidence of disunion and incoherence in Mayan civil society (Tally, 2008; Tally, 2008). A further drawback relating to the prompt and adequate drafting of reproductive health legislation has been the weak representation of women in Congress, with only 21 of 158 (13.3\%) members of the current congress being women, and just three of these (1.9\%) indigenous women (National Democratic Institute, 2013; Vásquez V. et al., 2013). This participation by women in Guatemala’s national congress is low by regional standards\textsuperscript{43} (Idea International, 2012). Women’s political participation in Guatemalan is curbed due to structural obstacles, such as “unconscious discrimination, product of the machista and patriarchal culture, the way society assigns domestic work exclusively to women, exclusionary spaces and schedules, and women’s scarce dominion over information, which cause men to disqualify their contributions” and subjective aspects, “such as the internalization of inferiority which causes women to undervalue their contribution to social and community spaces” (Dary et al., 2004, translation by the author). In a similar manner, ideas and discourses about Mayan inferiority, dating back to colonial times

\begin{flushright}
\textsuperscript{41} The Family Planning Law calls for 16 family planning methods to be available (Orozco & Morales, 2013).
\textsuperscript{42} Rigoberta Menchú ran again for the presidency in 2011, once again winning less than three percent of votes (Bevan, 2013).
\textsuperscript{43} Guatemala is grouped with Uruguay and Brazil for having low representation of women in national legislatures (12\% or less) compared to “Nicaragua, Costa Rica, Argentina and Ecuador, where women hold more than 30 per cent of lower house/unicameral legislature seats” (Idea International, 2012).
\end{flushright}
when these justified their subjugation, persist today, particularly among political elites, further discouraging participation of Mayan women (Grupo de Mujeres Mayas Kaqla, 2004).

Berger’s (2006) analysis of state politics through a gendered lens relates Guatemala’s high levels of violence to the continued election of male leaders. Several feminists have “noted the relationship of the state to patriarchal power and gendered violence” (Berger, 2006). Following the logic of Hobbes, strong, “good” men are posited as necessary to protect vulnerable women from “bad” men. In Guatemala, Berger develops this theory to explain how rising violence in general, but particularly against women, in the lead up to the 2003 election, was used by presidential candidate Ríos Montt to substantiate his platform as the security candidate. While in Berger’s example Ríos Montt was not elected, her same logic is applicable to the most recent national election in 2011, when Otto Pérez was elected on a platform of mano dura (iron fist), with security valued above all else in order to protect the vulnerable populace from rising violence. In this way political candidates indirectly benefit from ongoing violence, and ‘strong’, male leaders are elected to protect vulnerable populations.

In his analysis of Guatemala’s poor maternal health outcomes compared to those of Honduras, Shiffman (2006) points to “conditions of right-wing military rule, political instability and insurgency” complicating the development of a thriving health sector, which would in turn affect the provision of family planning services. In reference to reproductive health law-making, Shepard (2000) describes patterns of Latin American governments, and points to a “double discourse” which permits great inconsistency between law-makers’ public and private decisions about sexual and reproductive rights. Ultimately, restrictive laws are passed which limit women’s access to reproductive services, especially by poor women who have no lobbying power and are the most disenfranchised in society. The political elite continue to make conservative laws, whose consequences they do not feel directly since they access much more permissive private health care. This “escape valve” allows political elites to maintain their “double discourse” (Shepard, 2000).

Despite the existence of this “double discourse” in Guatemala and low representation of indigenous people and women in congress, the passing of the Law for the Universal and Equitable Access to Family Planning in 2005 shows promise about the Guatemalan state taking ownership of family planning. This law establishes sex education for all school children and a
National Commission for the Procurement of Contraception, meant to ensure universal access to a wide array of family planning methods (Reynolds, 2009). The passing and implementation of this law was vigorously fought by representatives from the Catholic and Protestant Churches, who claim parents should be solely responsible for children’s sex education (Reynolds, 2009). Despite this powerful lobby, which did delay the required regulations from passing until 2009, the eventual passing of this law is a testament to relentless efforts by reproductive health advocates and does signify a step by Guatemala towards ensuring “the right of people to freely decide the number and spacing of their children,” as is spelled out in the law and consistent with international reproductive rights frameworks (Ministerio de Salud Publica y Asistencia Social, 2009). However, the relatively few family planning methods available to women interviewed in this study shows that this law is still far from being fully implemented.

Local population politics

While national policy-making and implementation may have been slow and lacking, a human rights approach to reproductive health, which has been evolving internationally since the 1970’s, has found echo in efforts and evidence at the local level. The development and planning document for Patzún (2011) was written based on participatory consultations with citizens of the municipality, who emphasize the role of the government, as duty-bearer, to improve their social services. The document emphasizes the lack of health services available, particularly in the most rural parts of the municipality, and a deficiency in quality due to inferior services and lack of infrastructure, equipment and medical supplies. Another important initiative started in 2009, when the Reproductive Health Observatory of Chimaltenango was launched, whereby 16 civil society organizations carry out audits and promote dialogue and participatory policy-making in favour of reproductive health, including maternal and child health and family planning (OSAR Chimaltenango, ).

The quotes of some individual participants in this study evidence a conceptualization of family planning that is consistent of the vernacular of human rights:

“We parents should think in helping ourselves, and, like that, valuing ourselves, like that as women. Yes, value ourselves, our body; we have to take care of our dignities (dignidades) too.”

Another participant comments,
“I thought if he’s [her husband’s] not going to accept me, I have to use my method in any case, because I have to take care of my body too. Aha, I have to take care of myself, my body.”

Discussion of results and conclusion

As has been traced through the above analysis of political, economic, social and cultural factors, individual decisions about family planning are shaped by larger social and societal forces. In Guatemala, the combination of historical and recent ethnic-based discrimination and violence, gender inequity, powerful and influential Churches, and international, national and local population policy, make overlapping contributions to increasing inequities in family planning access and use. The blend of these factors helps to explain why Guatemala’s family planning trajectory is so different even from that of other Central American countries, many of which share some of these structural issues, but not all to the same extent and with the same compounding effects. Socio-political factors, including the Catholic Church and education system, affect the reduced availability of family planning methods. A gender-inequitable society and weak legal system perpetuates institutionalized violence against women and creates a culture of fear and intimidation around family planning.

The only paper about contraception in Guatemala to exclusively examine political and historical factors is that of Santiso-Gálvez & Bertrand (2004). They outline how “the convergence of four factors in a single country explains why Guatemala lags far behind its Latin American neighbors in the acceptance of family planning…. the anti-imperialist leftist movements of the 1960’s and 1970’s; the large percentage of the population that is indigenous; the civil unrest that peaked in the 1980s and paralyzed social programs, especially in the western highlands; and the powerful alliance between the government and the Catholic Church” (ibid.). Where the analysis of Santiso-Gáleve & Bertrand falls short, however, is in their compartmentalized, historically frozen and de-politicized consideration of these factors. For example, they describe “a resumption of normalcy in the western highlands” after a long period of civil unrest, which is “no longer problematic,” without identifying the state as the perpetrator of the vast majority of this violence, and with insufficient attention to lasting impacts and overlapping influences of the four factors they consider (Santiso-Galvez & Bertrand, 2004). This analysis shares some of the factors previously explored by Santiso-Gálvez & Bertrand (2004), such as the long civil war and the influence of the Catholic Church, however, the factors
are examined in a more critical way, implicating guilt on the part of the state when appropriate, and recognizing the current proximal impacts of past societal determinants of family planning, such as the ongoing influence of the civil war on warranted mistrust of the state by indigenous populations.

These findings suggest that reducing the gap between indigenous and non-indigenous rates of unmet need for family planning in a lasting and meaningful way will require a significant re-ordering of social relations in Guatemala. While the influence of the Catholic Church and gender inequity is significant for both indigenous and Ladina women, factors such as the legacy of violence, poverty and racism have a concentrated influence on reduced access to family planning for indigenous women in Guatemala. Poverty alleviation and redistributive efforts, such as the cash transfer program that has survived from the last government of Alejandro Colom to Otto Perez’s current presidency, if sustained, will likely continue to improve the political participation of indigenous people in Guatemala. The new initiative for bilingual intercultural schools, which grew out of the Peace Accords, will likely help to remedy the cultural barriers to education, and girls’ education in particular, through the provision of high-quality, culturally appropriate education by bilingual teachers in adequate and dignified facilities (UNICEF, 2007). Programs and policies that contribute to gender equity may help to reach children and adolescents before inequitable gender relations become engrained. Policies across sectors, such as through implementing the right of women to own land and participate politically, would help to improve equality between sexes. Reproductive health policy and planning that is more inclusive and participatory may help to beyond the provision of basic services and take into account local culture and religion. Given the historical legacy of mistrust that must be overcome for indigenous women to accept family planning services, service providers would be well-served in ensuring all staff, whether community-based or not, understand the importance of, and take all steps to protect, confidentiality. Family planning and reproductive health advocates may be able to build on past successes and lessons learned, such as with the passing of the Social Development Law, where discreet and timely lobbying with Catholic bishops helped to pre-empt the Catholic Church’s inevitable opposition.

This deeper examination of individual family planning decisions increases understanding of the complexity of these issues, but findings suggest that deep political change may be needed. An examination of more proximal barriers could lead to suggested solutions that relate directly to
immediate obstacles, such as the expansion of the number of days that reproductive health services are available, however, a political economy analysis points to policy solutions that are more complex, slow and realistic. Bringing a political economy perspective to research on contraceptive self-efficacy has not been done before, and this approach helps to differentiate the aspects and origins of unmet need for family planning that are more individual, social and societal in nature. Through this novel framework, barriers to accessing family planning mentioned by women in individual interviews are considered in a simultaneous and reciprocal way with larger structural influences that frame their experiences. By taking a longer historical view, barriers that are not specifically mentioned by women in elicitation interviews are still considered, past struggles are honoured, and an overly biomedical and simplistic view of family planning choices is avoided. This combination of health behaviour theory with a political economy perspective represents a methodological approach that is useful for a holistic and pragmatic understanding of health issues both within and outside the realm of reproductive health.

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Authors’ Contributions

ER was principal investigator of the study and led writing of this manuscript.

KA helped conceive of and plan the study, supported the analysis and helped write drafts of the manuscript.

AB helped conceive of and plan the study, supported the analysis and helped write drafts of the manuscript.

DG helped conceive of and plan the study, supported the analysis and helped write drafts of the manuscript.

AC provided advice for fieldwork, supported the analysis and helped write drafts of the manuscript.

All authors have read and approved the final manuscript.
Appendix 2 – Elicitation Interview Guide

**General information**
What is your name?
What is your ethnicity?
Which languages do you speak?
How old are you?

**Schooling & work**
Did you go to school?
Do you still go to school?
  - If yes – which grade are you in?
  - If no – what is the highest grade you completed?
Are you able to read and write?
Are you working in a paid job at the moment? If yes, which job?

**General ideas about family and pregnancy**
Among your friends and sisters, how do you talk about pregnancy and having a family? [Probe as necessary: Are children something that is planned or not planned?]

**Current – marriage and children**
Are you currently married or living together with a man as if married?
Have you ever been pregnant?
Do you have any children?
  - If yes, how many?
  - Have any of your children died?
Are you pregnant now?

Now I have some questions about the future. Would you like to have (a/another) child, or would you prefer not to have any (more) children?

If want a/another child - How long would you like to wait from now before the birth of (a/another) child?

**Knowledge of contraception:**
There are various ways or methods that a couple can use to delay or avoid a pregnancy. Which of these ways or methods have you heard about?

**Use of family planning:**
Some couples use various ways or methods to delay or avoid a pregnancy. Are you currently doing something or using any method to delay or avoid getting pregnant?
If yes, which method are you using?

Impressions of family planning and self-efficacy

There are different kinds of family planning. When we say family planning we want you to think of modern methods of family planning, such as the pill, injectables, implants, condoms, spermicide, IUD and male or female sterilization.

How do you feel about family planning?

What would be the advantages or good things that would happen if you used family planning?

What would be the disadvantages or bad things that would happen if you used family planning?

What kind of person do you think typically uses family planning? [Probe as necessary: Imagine someone who uses family planning. How would you describe that person? What are they like?]

What kind of person do you think would never use family planning? [Probe as necessary: Imagine someone who never uses family planning. How would you describe that person? What are they like?]

What makes it difficult or impossible for you to use family planning? [Depending on barriers mentioned, probe – how confident to you feel in overcoming [different barriers – for each barrier]; Tell me more about how that works, how that is; please give me an example; can you give me an example of scenario like that?]

What makes it easier for you to use family planning?

If you want to use family planning, how confident are you that you can? [Why?]

Who do you think would object or disapprove if you used family planning?

Who do you think would approve or support you if you used family planning?

Do you have any other thoughts about family planning you would like to share?

Thank you! Would you like to receive a summary of results from this study?
Appendix 3 – Information Letter and Informed Consent

Hello. My name is ____________________________ and I am a doctoral student working under the supervision of Dr. Allison at the University of Toronto and Professor Andrés Castañeda at the University del Valle, with funding support from the University of Toronto and the Canadian Institutes for Health Research. We are interviewing a group of women who are between the ages of 20 and 24 to learn about their ideas and experiences with family planning.

Would you like to hear more about this study?

[ ] NO  →  [ ] YES  →  Continue

End of interview

Some of the women we are interviewing are using family planning and others are not using family planning. The questions that we want to ask you ask about your knowledge, opinions and experience with family planning. Some of the information we ask about is personal. We are collecting this important information among several women. Do you have any questions so far?

[ ] NO  →  [ ] YES  →  ASK ABOUT AND ANSWER QUESTIONS

I would like to ask you to participate in this study. Your participation is entirely voluntary and there is no penalty for not participating. There are no direct benefits to you if you decide to participate and I do not expect there to be any health or other risks to you. If an issue is uncovered that needs follow-up, I will refer you to a local counselor or health service. If you decide to take part in the study, you may stop at any time. If you do not want to continue there is no penalty for withdrawing from the study. You also have the right not to answer any particular question. Do you understand?

[ ] YES  →  [ ] NO  →  ASK ABOUT AND CLARIFY POINTS

You are being asked to participate in an interview which will take about 45 minutes. I will ask you some questions, and I will record our interview with this audio recorder. Do not worry about answering any question wrong. There are no right or wrong answers in this study. Okay?

[ ] YES  →  [ ] NO  →  ASK ABOUT AND CLARIFY POINTS

[If participant prefers not to be recorded, explain that the interview can still proceed but the interviewer will have to take notes during the interview.]

All information collected from you will be kept strictly confidential. No one will know the answers that you give, including from your community. No information that could identify you or your household will ever be released. Do you have any questions?

[ ] NO  →  [ ] YES  →  ANSWER QUESTIONS

If you agree to participate in the study, I will ask you to please sign or write your initials here to show that you understand the information that I have told you and that you agree to participate voluntarily in this round of questions. I can sign below instead if you do not feel comfortable signing. However, it is important that you understand the information I read to you and that you agree to participate voluntarily.

Do you voluntarily agree to participate?

[ ] YES  →  [ ] NO  →  SIGN, END

Respondent __________________________ Date ___________________

IF PERSON AGREES BUT IS UNWILLING TO SIGN/INITIAL OR UNABLE TO READ OR SIGN/INITIAL: I [the interviewer] sign here indicating that the information was read and, if the person agreed to participate, that consent was given voluntarily.

Signature of Interviewer __________________________ Date ___________________

If you have any questions about this study please contact Emma Richardson, the principal researcher at emma.richardson@utoronto.ca or [cell phone number in Guatemala]. If you have any questions about how you have been treated as research participants, please contact the Office of Research Ethics at the University of Toronto at ethics.review@utoronto.ca or 1 416-946-3273.

LEAVE A COPY OF THIS FORM WITH THE PARTICIPANT
Appendix 4 – Brief Summary of Study for Participants

Investigación en Patzún -
Resumen para participantes

mayo a agosto, 2013

Contexto del estudio:

Este estudio forma parte del doctorado en salud pública que está realizando Emma Richardson en la Universidad de Toronto en Canadá, y en la Universidad del Valle en Guatemala, con el apoyo de un equipo local. Se realizaron entrevistas en Patzún, Chimaltenango con mujeres Kaqchiqueles, casadas o unidas, entre las edades de 20 a 24 años. El tema del estudio es planificación familiar, y se hicieron preguntas para entender las opiniones de las mujeres sobre la planificación familiar, y cuáles son las posibles barreras para mujeres quienes quieren esperar más que dos años para tener un bebé, pero que no estén usando métodos de planificación familiar. Abajo se resume algunos de los hallazgos iniciales del estudio, y las opiniones que expresaron las mujeres.

Ventajas de espaciar los hijos:

Las mujeres mencionaron varias cosas buenas en relación a espaciar sus hijos, y también algunas desventajas de tener muchos niños muy seguidos. Entre las ventajas de espaciar se menciona:

✓ La salud de la mujer, del bebé y del esposo
✓ La mama puede disfrutar con su bebé
✓ El poder alimentar al bebé, darles comida, vestuario y estudios en lo que crezcan, y poder darles sus cositas
✓ Permite darles a todos los hijos igual (“... tener unos dos tres no más para que a todos pues les des igual, les trates igual, verdad, porque a veces donde hay mucha familia algunos tienen estudios y algunos no, entonces es mejor tener solo dos o tres, planificar bien para que todos tengan igual partes pues...”)
✓ Los niños crecen en un ambiente feliz, sienten el aprecio, la atención y dedicación, el amor y el cariño que tiene sus padres
✓ Hay más posibilidad de darles lo mejor y proveer para un futuro mejor

Desventajas de tener muchos hijos muy seguidos:
• Pueden venir enfermedades y no hay dinero
• Sufren los niños ("porque ya cuando entre más temprano tengan hermanitos pues ya de chiquito ya lo dejan a un lado, ya le atienden al bebe y ya él, ya lo dejan para otro lado")
• Cuesta mucho con niños chiquitos (por ejemplo, para llevarles todos a Patzún)
• Puede complicar la salud de la mujer ("y a la mujer tampoco aún no ha esperado sus fuerzas perdidas y ya se queda embarazada otra vez")
• Pueden estar desnutridos los niños ("hasta el bebé sufre en su vientre porque no tiene ninguna alimentación")
• Se deja de mamar muy pronto
• Difícil ponerles atención a todos los niños ("man yajosq’ij ta, man naya’ ta ri atención chke riye’ y na’an chqa disfrutar rat ke re’ at te’ej..." – "no los mantiene limpios, no les pone atención y disfrutas ser madre").
• Complicado trabajar en el campo con muchos hijos ("que así va crecer otro poco la nena, porque nos vamos en el trabajo abajo del sol o debajo de la lluvia y las nenas sufren. Ay no, mejor que crezca un poquito.")

Ventajas de usar un método de planificación familiar:

Algunas ventajas de usar un método de planificación familiar que mencionen las mujeres son:

✓ Ayuda a la mujer a cuidar su cuerpo y su salud ("porque ya llevar nueve meses a un niño también a uno le cuesta")
✓ Permite que la mujer puede gozar de relaciones con sus esposo, sin miedo de embarazarse
✓ Puede administrar bien su tiempo ("que una mujer pues, pueda trabajar, pueda administrar bien su trabajo porque con muchos hijos el tiempo a uno ya no le alcanza")

Barreras para el acceso y el uso de métodos de planificación familiar:

• Falta de conocimiento sobre los métodos de planificación familiar
• Pocos tipos de métodos en oferta
• Miedo de efectos secundarios y la infertilidad
• El esposo se opone o no quiere hablar del tema (y miedo de problemas en el matrimonio, violencia intrafamiliar y el abandono)
• El esposo se siente incómodo usando el método (condón)
• Presión por la parte de familiares (papas, suegro/as, etc.), quienes no quieren que se use planificación familiar
• Miedo de crítica por la parte de vecinos
• Entender que la planificación familiar es un pecado
Otros hallazgos

En muchos casos hay escasa comunicación sobre planificación familiar en general, sobre todo antes del nacimiento de un primer hijo o hija. Muchos jóvenes esposos no quieren hablar del tema, o están en contra de usar métodos, sin expresar porque. A veces las esposas han convencido a sus esposos sobre usar planificación familiar, empezando a hablar del tema a través de bromas, o explicando porque quieren espaciar sus hijos. Lugares donde se ha aprendido sobre métodos de planificación familiar incluyen: en las charlas y folletos del servicio de extensión de Renacimiento, en el Centro de Salud de Patzún, y a través de conocidas, amigas de confianza o familiares quienes ya están usando un método.

Para más información sobre este estudio se puede contactar a Emma Richardson en el correo: emma.richardson@utoronto.ca