

CICRED'S SEMINAR

**RETHINKING THE MEANING AND SCOPE
OF WOMEN'S "UNMET NEEDS":
THEORETICAL AND METHODOLOGICAL
CONSIDERATIONS AND UNCERTAINTIES
ON EMPIRICAL EVIDENCE
IN RURAL MEXICO**

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Rosa María CAMARENA

Social Research Institute, National University of Mexico, Mexico¹

Susana LERNER

Center for Demographic and Urban Studies, El Colegio de México, Mexico²

1. Introduction: The locus of the problem

The last twenty-five years of the 20th century were characterized by the presence of intense debates and the confrontation of approaches and cosmovisions regarding both the interactions and interventions in the field of human reproduction and health, and in the research undertaken in this field. In both issues, efforts by some researchers have focussed on redefining, modifying and expanding the programmatic and strategic frameworks as well as the conceptual and methodological

1. IIS-UNAM, Circuito Mario de la Cueva, Ciudad Universitaria, Mexico City, D.F., Mexico. E-mail: rcamaren@servidor.unam.mx.

2. El Colegio de México, Camino al Ajusco No. 20, Pedregal de Santa Teresa, Mexico City, D.F., 10740, Mexico. E-mail: slerner@colmex.mx.

schemes used. There has been a shift from the narrow, hegemonic paradigm of “population-driven forces” prevalent in the 1970s and 1980s that focussed on reducing population growth, primarily through fertility control, to the more comprehensive “human rights- and gender equity-driven forces” referring to the population’s sexuality and reproductive health (Balán, 1999; Cervantes, 1999; Lerner and Szasz, 2000; Mundigo, 1999; and Satia, 1999).

Underlying these approaches is a deep-seated tension over societal, national or public goals, interests, concerns and needs versus individual, private and intimate ones. The former is the dominant perspective under the population-driven approach, the latter being one of the central premises underpinning the reproductive health approach. The concern for individuals’ needs – women’s or couple’s needs – at the International Conference on Population and Development (ICPD, held in Cairo in 1994) stressed the interaction between reproductive rights and choices and individuals’ control over their reproductive life as key elements in the physical, emotional and economic wellbeing of the population. The Programme of Action endorsed at this Conference stated:

“Reproductive Health (RH) ... implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so” (United Nations, 1994, p. 7.2).

Nevertheless, it is important to recognize that the concern for women’s needs for family planning, the control of their bodies and their reproductive capacity, was one of the main banners of the first women’s movements in the early 20th century (Gordon, 1977). Furthermore, for a long time, the acknowledgement of women’s reproductive and sexual self-determination, as part of their sexual and reproductive health needs and of their human rights, has been one of the main demands of women’s health and rights advocates (Cook, 1995; Correa and Petchesky, 1994; Costa, 2000; Dixon-Mueller and Germain, 1993; Sinding, 1993; Tuirán, 1988; Zurayk, 1999).

The origin and further development of the concept of “unmet needs” is regarded as part of these paradigms and has been extensively used from diverse perspectives and for different objectives. Various authors have advocated a criticism and evaluation of its meaning, significance and scope, pointing out the conceptual assumptions, biases and limitations in the way surveys define and measure it (Casterline *et al.*, 1996; DeGraff and De Silva, 1996; Dixon-Mueller and Germain,

1992; Bongaarts and Bruce, 1995; Westoff and Bankole, 1995 and 1996, among many others). Anthropological or qualitative studies, or a combination of these with statistical approaches, have also served to discuss these limitations and their results have enriched the analysis of this problem (e.g. Visaria, 1997; Yinger, 1998).

Other efforts related to the RH approach have focussed on demonstrating the importance of linking this concept to other dimensions such as human rights, particularly women's reproductive rights and gender inequities and inequalities, suggesting extremely important, thought-provoking proposals of a theoretical and methodological nature that reflect the potentialities and richness of the concept, in which the individual's needs are the central focus (Dixon-Mueller, 1999; Dixon-Mueller and Germain, 1993; Visaria, 1997). Nevertheless, the comparison between unmet needs as defined by women themselves and those identified by programs and interventions would appear to be the most important underlying sphere of debate and confrontation at both the theoretical and methodological, and the political and ideological level. The conceptual schemes developed to explain the changes in the various spheres of reproductive behavior (the concept of unmet needs among them), the production of data and the interventions by governments, civil organizations or specific power groups, are not divorced from theoretical, political and ideological positions and should therefore be addressed as part of a previously defined and structured theoretical problematic.

One can infer from the above that the history of the concept of unmet needs points out to the need for a profound criticism of its theoretical and methodological assumptions used in research, its operational definition, the significance and scope of the empirical evidence resulting from various surveys, as well as for its instrumental and programmatic purposes and interventions. Although this task exceeds the limits of this text, its contents seek to contribute to this line, and should be considered as a preliminary and exploratory stage of the work to be done.

This paper begins with a brief, schematic account of certain initial thoughts on the main questionings of the concept of unmet needs in light of the two paradigms mentioned earlier: *a)* the conventional one underlying the anti-natalist position, the population approach, oriented mainly towards the expansion of contraceptive coverage to reduce fertility, in which population's needs are basically defined in terms of the

achievement of these objectives by State leaders, FP program directors and service providers, as well as by some academic researchers; in other words, as part of the public realm, and *b*) the reproductive health approach that favours the individual's perspective and the private sphere and focuses on reproductive rights and gender inequality conditions. In other words, with a rationale based on individuals' needs, particularly those of women, which do not necessarily coincide with those derived from public interests. In this paper, both interpretations are drawn from the population studies field and from some of the contributions of feminist literature, as well as from the Mexican experience.

With these two paradigms in mind, and using data from a survey carried out in 1999 on Mexico's marginal rural contexts, where one of the health programs designed to attend this population operates, in the second part we seek to explore what we can learn about women's unmet needs in relation to their reproductive health. Despite the inherent limitations of the data from the survey, particularly as an instrument for gathering information on opinions, attitudes, preferences, intentions and assessments – subjective dimensions which are socially constructed and differentially internalized by the individuals –, the analysis of data on these aspects offers thought-provoking insights, provided, as Bourdieu says (1980) that one is aware and adopts a critical attitude to the information used.

Thus, unlike classical demographic analysis, which seeks large-scale behaviours, we have used an unconventional approach when analyzing the database. Using the logic of small but significant relative numbers, we look for empirical evidence in the interstices of data to illustrate some of the situations of greatest social vulnerability for women regarding the various components of their reproductive health³. It is an exploratory interpretation in process of which we will attempt to highlight the discrepancies, ambiguities and uncertainties in survey data regarding what is conventionally regarded as women's needs and, in some cases, health providers' opinion that intervene in

3. As most of the surveys' data offer a very limited and homogenized view with respect to women's needs or unmet needs, due mainly to the predefined answers (or codes) to questions on subjective dimensions, we have recovered and examined the open answers given by women that are included under the so-called "Others" survey's code, to obtain a more comprehensive and perhaps a different, more accurate picture of them.

and influence women's reproductive health⁴. Due to data available in the surveys analyzed, the main emphasis in this illustration is closely related to access to and quality of health services.

Finally, we conclude with a series of considerations that we suggest as subject for debate, which in the future will enable us to deal with alternative and complementary analytical strategies to enhance our understanding of how poverty and social vulnerability are related to women and men's needs and unmet needs in the reproductive health field.

2. The meaning of unmet needs from different perspectives

Dealing with the concept of "unmet needs" regarding the problematic sphere of human reproduction raises the following key questions: Needs for whom? Needs by whom? Needs for what RH components or with what objectives? Needs based on what assumptions? Who defines the main components to be considered and how are they defined? Under which prevailing material, cultural and ideological conditions, whether public or individual, are these needs being raised, confronted and solved or otherwise? With these questions in mind let us examine some of the various meanings and scopes of the concept of unmet needs and its limitations and potentialities, according to the two paradigms identified: the population-driven and the reproductive health approach.

2.1. *Population-driven approach: unmet needs as a societal and public concern*⁵

The population-driven perspective of the 1970s and 1980s is characterized by an anti-birth orientation in the sphere of reflection and research, as well as in debates and interventions. This orientation was part of the international and hegemonic debate over causal relations between population and development⁶, with the first term of this bi-

4. Data for health service providers taken from "Survey on Family Planning Institutions" (ENINPLAF) conducted by CONAPO-IMSS in 1996.

5. A broader analysis of the two paradigms is available in Lerner and Szasz (2000).

6. We refer to the four World Population Conferences organized by the United Nations: Rome 1954, Belgrade 1965, Bucharest 1974 and Mexico 1984. Since the

nomial relation, population, becoming the central and almost virtually exclusive sphere for actions designed to regulate fertility. Some of the main aspects of this initial scenario include:

* *The birth control view as the hegemonic position* resulting from the international and national debate at both the theoretical and programmatic level, in which the unprecedented levels and rates of population growth in developing countries were viewed as an obstacle and threat to development. High fertility levels were regarded by developed countries as being the cause of slow economic growth rates, aside from their geopolitical concerns about the increase of south populations. The hypothetical rationale underlying the recommendations issued at the world population conferences assumed that the anti-natalist initiatives would reduce poverty in developing countries, thereby improving the population's living standards and reducing the gap between rich and poor nations.

* *The reductionist and bias feature of population policies*, which, although in theory covered the three basic components of population dynamics – fertility, mortality and migration –, in practice were oriented and limited, through the establishment of demographic goals, to reducing fertility levels. The gap between the rhetoric and practice of population policy, as well as its reductionist orientation, was also reflected in the conceptualization, design and operation of the Family Planning Programs (FPP).

* *Changes in the spheres of influence and intervention in fertility control* through a shift from the private, intimate sphere of the family and religious, moral and cultural norms, which prevailed virtually exclusively in the past to growing State intervention over the last three decades. This has been achieved through the design and implementation of public policies, mainly population policies, FPP, health services and a broad range of information, education and communication activities related to FPP, that assumed various shapes and forms and were mainly carried out by a variety of public institutions (Thomas and Grindle, 1994; Lerner and Quesnel, 1994).

* *The restricted central features that have characterized the initial modus operandi of FPP*: its orientation towards women of childbearing age with higher parity and the design and implementation of a unique pro-

Belgrade Conference, but particularly after Bucharest, the debate on the need to design and implement population policies has been ever-present.

grammatic model; that is, with a virtually total lack of consideration of the diversity of economic, social, cultural, institutional and ideological circumstances and barriers of the population that might limit their access to family planning services. Another distinctive feature is the exclusive responsibility granted to health institutions and their agents for the implementation of these programs, which led to the medicalization of procreation, without taking into account other social actors that intervene in and influence reproductive behaviour.

Thus it is hardly surprising that this perspective has led to the “segmentation of the population”, by focusing exclusively on the unmet contraceptive needs of certain groups of women, excluding other groups in similar if not greater risk situations. Interventions targeted married women of childbearing age and those who did not use either modern or traditional contraceptive methods. At the beginning of FPP in Mexico, as in many developing countries, these policies included married (or in consensual union) women of an intermediate or advanced age (35 and over) and with high parity (3 and more children); namely the so-called “target women” who were not currently using a method of contraception, regardless of their reproductive preferences. Among them, emphasis was placed on those from the poorest, most marginalised sectors.

Moreover, it is neither surprising that the concept of unmet needs for contraception (UNFC) has become a central and relevant strategic policy tool for designing, justifying and implementing FPP, focussing its services on certain population groups and assessing the impact of these programs on population dynamics, particularly on changes in fertility. Nor it is surprising that this concept has been defined and interpreted on the basis of women who report that they are not practising contraception and at the same time express their desire to stop or delay childbearing, meaning that they are defined as being at risk of becoming pregnant⁷. As Dixon-Mueller and Germain so rightly point

7. This concept has its origins in the classic theoretical frameworks implemented during the first fertility surveys conducted in the 1960s (i.e., survey on rural and urban fertility in the case of Mexico and Latin America). These surveys compared the inconsistency between women’s statements about their family-size ideals and preferences, their views on the advantages and disadvantages of a large or small family, or asked about the so-called KAP-gap for birth control. Their results were interpreted and regarded as indicative of women’s unmet needs for contraception, although

out (1992), this is a concept that is not defined by women themselves but one that is attributed to or imposed on them by researchers and those responsible for FP programs who deduce this from the apparent inconsistency between their contraceptive practices and their stated family preferences.

This explains the programmatic and operative nature of the UNFC concept and its doubly restrictive feature. The first of them, as its name suggests, “*Unmet needs (only) for contraception*”⁸ results from comparing the demand with the supply of FP services (number of potential users of contraception vis-à-vis current women users), and forms part of the components for estimating the material and human resources required to provide these services. Its rationale reflects the principal political concerns and those of various academic and social sectors that prioritise the policies and actions for increasing the use and effectiveness of modern contraceptive methods for regulating and controlling fertility as well as for improving women’s access to contraceptive services. Therefore, their stated justification, as a public need, lies in the assumption of regarding universal contraceptive practice as the main (and often only) means for reducing fertility levels, counteracting the results of the high population increase and thereby achieving a greater common good (Sinding, 1993; Bongaarts and Bruce, 1995; Westoff and Bankole, 1996).

In keeping with this interpretation, some authors link the meaning of UNFC to the presence of lower or higher costs – not only material, but also social, psychological and health –, associated with knowledge, a favourable attitude, and contraceptive use, as opposed to a lack of knowledge, an unfavourable attitude and non-use of contraceptives. The conclusions on the subject are also predictable: the benefits of contraception for women – which are usually limited to preventing

doubts were raised about its ambiguous meaning (Berelson, 1966; Berquó, 1979; Conning and De Jong, 1976; Patarra and De Oliveira, 1974; Westoff, 1988).

8. The terms “unmet need for contraception” and “unmet need for family planning” tend to be used interchangeably in the literature, which is justified to the extent that FPP were virtually exclusively reduced to actions aimed at achieving greater contraceptive use. Nevertheless, the original concept of FP included other aspects. At the theoretical-discursive level, it refers to the free, informed decision by couples to limit the number of their offspring and opt for contraceptive methods, including the latter’s right to practice FP voluntarily. In practice, however, these initiatives were reduced to expanding the contraceptive coverage of women under the responsibility of health service providers.

pregnancy —, are supposedly greater than the costs (consequences) of using contraceptive methods, mainly the modern ones, including sterilization. The opposite is true for women with unmet needs who are forced to bear extremely high costs (Easterlin, 1975; Bongaarts and Bruce, 1995). This analytical framework could also be related to the work done by some authors who seek to describe the risks derived from reproductive behaviour, although the majority of them continue to adopt a narrow, simplistic definition of risk circumscribed by the possibility of unplanned pregnancy for non-users of contraception. Studies showing the positive or harmful effects as well as the advantages or disadvantages of certain practices and interventions in contraception, procreative events and other reproductive matters, in relation to the conditions of both women's and men's physical and emotional health and wellbeing, provide a different perspective on the meaning of risk (Koblinsky and Nachbar, 1999). However, a great deal still remains to be done from a broader conceptual perspective regarding reproductive behaviour risks as a result of modern technological innovations, power relations and social control that influence this behaviour (as in the perspective developed by Beck, 1992).

The results of surveys undertaken in Mexico in the 1970s showed the existence of a need that was both felt and expressed by women with high parity who did not know of any methods for spacing or limiting pregnancies. The availability to meet this demand largely explains the effectiveness of the early stages of FPP⁹ (Lerner and Quesnel, 1994), but also suggests that the deep-rooted tension over societal or public interest and needs versus private and individual ones, at least at the discursive and theoretical level, were quite similar. However, as mentioned below, the mechanisms, rationale and practices implemented by health services to achieve these goals at the programmatic and intervention level, did not always respond to the individual's inter-

9. In 1974, the Mexican Government passed a new Population Law redefining and implementing its current population policy; in 1977 it launched the first FPP at a national level. Prior to these initiatives, it is estimated that, in 1973, approximately 23% of the total number of married women used modern contraceptive methods, a figure that rose to 32% in 1979 as a result of the legalization of contraceptive use and the impact of FPP, to 41% in 1982 and 45% in 1987 (Camarena, 1991). It is estimated that by 1997, contraceptive use had risen to 73% in urban areas and to 54% in rural areas (CONAPO, 2000a).

est, preferences and needs, regarding not only the use of contraceptive methods, but also their access to quality reproductive health services.

2.2. Reproductive health approach: unmet need as an individual (women's) concern

The background to this perspective, which gave rise to the emergence of the concept of Reproductive Health (RH)¹⁰, lay in the widespread, growing participation at the national and international level of women from civil society who challenged the orientation, justification and legitimisation of population policies and FPP (issues that have been widely documented in the literature; see for example Sen *et al.*, 1994; Mundigo, 1999). It is also found in the work of several researchers who pointed out the uncertainty regarding the success of these initiatives, given the perverse effects, whether intentional or otherwise, that were observed (i.e., Faría, 1988; Lerner and Quesnel, 1994). Furthermore, there are certain studies that underlined the need to analyse the consequences of the implementation of unfavourable economic and social policies such as the neo-liberal ones that resulted in the dramatic, growing impoverishment of the population and their reproductive health conditions as a key issue related to this approach (Lerner and Szasz, 2000).

Without underestimating the success of FPP – the rapid decline in fertility and the subsequent reduction of maternal and child mortality rates – there is an underlying simplism and fallacy in the justification and legitimisation of the rationale inherent in these interventions, which were regarded as central mechanisms in the reduction of the conditions of poverty of the majority of the population. Empirical evidence suggests the opposite, confirming one of the arguments put forward by various critics regarding the anti-birth-control position. Unless adequate social and economic development policies are implemented, and the population's felt needs and circumstances of life are taken into account, successful interventions in demographic dynamics will not lead to greater wellbeing among the population (Lerner and Quesnel, 2002; Sen *et al.*, 1994; Welte, 1998; Szasz and Lerner, 2002).

10. A concept initially defined by the World Health Organization (WHO) and adopted by the ICPD held in Cairo in 1994.

The debates and confrontation of approaches regarding State interventions to regulate fertility, include the following critical issues and perverse effects, whether intentional or otherwise.

* *The partial and questionable view of interventions in FPP and maternal and child health programs*, whose services focus almost entirely on the reproductive events most closely linked to procreation, such as pregnancy, childbirth, and to a lesser extent, the postnatal period. Moreover, and aside from its positive effects, these events – particularly childbirth and maternal and child health services – became spheres of intense State influence, in some (or many) cases of a coercive nature, for introducing modern contraceptive practices, particularly irreversible ones, and thereby controlling and reducing fertility levels.

* *The initial exclusion from reproductive health care services of broad groups of the population*, such as teenagers, single women and mothers, women once but not currently married, infertile women or those who have been sterilized, women going through the menopause and men of all reproductive ages. This was compounded by the scant attention paid to reproductive health problems apart from those mentioned above.

* *The questionable and unfavourable conditions and practices related to access to quality family planning services*. At least three issues, widely documented and debated in the literature, should be pointed out:

- The limited range of reversible contraceptive methods offered to women and above all, their lack of appropriateness for women's physical and emotional conditions and with their reproductive life cycles¹¹. This has led to an expanded and almost exclusive supply of safe or permanent methods such as IUDs and above all, feminine sterilization¹², with frequent cases of mismanagement and misapplication by FP service providers.

11. According to ENINPLAF data (1996) it is estimated that of the eight choices of traditional and modern methods managed by the official health institutions, including sterilization, only an average of 3.7 methods are available.

12. The type of method used by women in Mexico to regulate their fertility has changed radically over the past 25 years. During the initial stages of official FPP (1976), 36% of married women of childbearing age used the pill as a contraceptive, 23% utilized traditional methods, and 19% were fitted with IUDs. By 1997, use of the pill had dropped by one third while the use of traditional methods had halved. Conversely, feminine operation, accounting for 8.9% in 1976, had increased fivefold to 45%, becoming the most common method used, followed by IUDs in second place with 21% (Dirección General de Planificación Familiar, 1989; CONAPO, 1999).

- The high frequency of female sterilization and Caesarean sections, the latter frequently linked to female sterilization, is largely indicative of the logic imposed by health institutions to reduce fertility levels¹³. This not only reflects professional malpractice, which can be interpreted as part of the material, social and cultural poverty of health institutions, but is also part of the social vulnerability to which women are exposed. It mainly affects women from the poorest socioeconomic strata, given the inadequate, insufficient and poor structure of options available to them in the reproductive health sphere which is not unrelated to other spheres such as education, food and work.
- The social, economic, cultural and work conditions of health institutions and their agents as well as the rationale imposed by these institutions, which in turn has repercussions on the unfavourable service environment for the interaction between suppliers and women users of reproductive health services. These problematic issues include, among others, achieving FP goals, particularly regarding the use of irreversible methods, the excessive workload, the short time available for consultations, the low salary levels of service providers and the frequent lack of both contraceptive methods and medical instruments. Likewise, the unequal power relations between users and providers, characterised by the imposition of health professionals' technical expertise, as well as the homogeneity of programs and interventions, together with their lack of fit with the specific demands of the diverse population groups, are just some of the factors that affect the interaction between these actors (Camarena, 1991; Cervantes, 1999; Gautier and Quesnel, 1993; Jasis, 2000; Lerner and Quesnel, 1994, 2002).

* *The gender insensitive approach and the violation of women's reproductive and sexual rights*, as well as the failure to take into account women's (and men's) perceptions, needs and priorities in the sphere of health, reproduction and sexuality are some of the key issues extensively documented in the literature. This is compounded by the social inequality

13. According to estimates based on survey data, the rate of Caesarean sections for all urban areas in Mexico was 29% in 1995, with a range of variation from 20% to 42% (Cárdenas, 2000). Nationwide, the prevalence of this practice by the public sector is estimated at 24%, a figure that varies between 21% and 46% according to information provided by various health institutions (Foro Nacional de Mujeres y Políticas de Población, 1999).

that exacerbates the already adverse conditions of vulnerability of the great majority of women (Dumbl, 1999; Figueroa, 1999; Kabeer, 1998; Petchesky, 1995; Sen *et al.*, 1994).

This scenario of intense criticism was undoubtedly one of the crucial factors that led to the institutionalisation and legitimisation of the RH approach, after the Cairo Conference. In fact, this approach became the broadest field of reference for sociodemographic research as well as for the definition of actions at the international and national level, particularly in the following spheres.

- The field of human rights, which has seen a shift from the recognition of the right to FP to a broader range of women and men's sexual and reproductive rights.
- Health care, which has adopted a more comprehensive and in some cases more balanced view of the services (and the quality of the latter) required in the various components of sexuality and reproduction.
- The gender perspective, where efforts have been made to break away from the hierarchical conceptualisation of previous FPP. Emphasis is placed on the importance of empowering women and turning them into active subjects involved in decisions that are crucial to their own lives and those of their families. In other words, there is an explicit recognition of women's ability to make decisions and not merely to subject them to the spheres of family influence or to professional medical spheres that used to decide and, in some cases, continue to decide what the best options for them would be.
- Finally, in the realm of sexuality and risk practices related to individuals' health where, due to the rise and intensification of HIV/AIDS and STDs, health and education programmes have included awareness and preventive interventions, apart from health services attendance.

As part of this perspective, we would like to emphasize three aspects related to the meaning and scope of the concept of unmet needs, in light of the potentialities offered by the reproductive health approach. The purpose of this exercise is to identify lines of research that will use a more suitable and proxy analytical strategy for estimating the magnitude of and gaps in women's needs, not only for contraceptive information and services but also for other health components related to their reproductive lives.

As mentioned earlier, an initial aspect refers to the prevalence of a segmented orientation, which translates into the exclusion of the perceptions, needs and demands of large groups of women (and men) from FP and RH services. **Needs for whom? Needs by whom?** Under the RH approach, these groups should include teenagers, single, separated, divorced or widowed women and mothers, those who live in unions that have not been formalised, those engaged in the sex trade and obviously men at various stages of their lives. But there are also others with unmet or unsatisfied needs or unsatisfied current users, amenorrheic, sterilized or infertile women as well as those going through the menopause. Although the levels of UNFC of these excluded groups are supposedly lower, they include large population groups¹⁴ that are also in a possibly even greater state of vulnerability regarding their reproductive health conditions. Likewise, in order to reduce the tension between societal, national and public interests, concerns and needs, versus individual, private and intimate ones, it is essential to consider that these needs must be mainly defined by women and men themselves and not merely by researchers, service providers, policy makers or conservative groups.

A second consideration is linked to the unforeseen intentions concerning the means of identifying and delimiting the reproductive needs of the different population groups, in other words, **Needs for what?** Even if we restrict ourselves to the UNFC of these groups, they are obviously not necessarily the same for all the population groups; on the contrary, they vary according to their specific needs, living conditions, world views and the stage they are at in their reproductive lives. Among women classified (by a third party) as having unmet needs for contraception, do all of them really need contraceptive services? Do they really want to space or limit their offspring? Or more importantly, what type of contraceptive methods or FP services do they really need? What are the unmet needs of current users? Are all of them satisfied, correct and appropriate method users or on the contrary, are some or most of them dissatisfied, incorrect or inappropriate method users?

14. Given that surveys fail to record the unmet needs of these groups, the few estimates available for some of these groups show the immense proportion of women in this situation. For example, in the case of Peru, if one considers unmarried women (42%) plus married women who are users (46%), it is estimated that over two thirds of women of childbearing age are excluded from the consideration of their unmet needs (quoted by Dixon-Muller and Germain, 1992, p. 332).

What are the specific needs in this field for teenagers, single women and those who have had abortions or miscarriages? (Germain, 1993). Moreover, what are the unsatisfied needs of these groups of women in relation to other related reproductive health components, such as the prevention and treatment of infertility, RSTIs (Reproductive and Sexual Track Infections), HIV/AIDS, breast and cervical-uterine cancer?

As Dixon-Muller and Germain (1993) have pointed out, if the challenge is to meet the reproductive needs of men and women, there is also an urgent need to broaden the scope of unmet needs while taking into account the specific demands and conditions of the various population groups:

“i) the needs among non-users who are at risk of an unwanted or untimely pregnancy for any method of contraception...; ii) the need among certain users for a more effective, satisfactory or safer method...; iii) the need among both users and non-users for the treatment of contraceptive failure, in other words, for safe, accessible abortion services to terminate untimely or unwanted pregnancies; and iv) the need for related reproductive services...” (p. 13).

A third aspect is related to the structural, institutional, *intersubjective* or personal circumstances required to respond to the needs and demands of individuals in the basic components of their reproductive health and lives. According to the approach adopted in Cairo, reproductive health involves considering the following aspects: i) that people are **able** to have a satisfying and **safe** sex life (which implies that individuals can have sexual relations **free from the fear** of unwanted pregnancies or sexually-transmitted diseases); ii) that they have the **ability** to reproduce and **the freedom** to decide if, when and how often to do so (which means that men and women have the right to be **informed** and to have **access to safe, effective, affordable and acceptable methods** of family planning **of their choice** for the regulation of their fertility, and which are **not against the law**); iii) that women will have **safe** pregnancies and childbirth, and iv) that the results of pregnancies will be successful for the survival and wellbeing of mother and child (implicit in these two conditions is the **right of access to appropriate (quality) health-care services**) (Barzelatto, 1994 and 1998; Fathalla,

1992; Ford Foundation, 1991; Sai and Nasim, 1989; Salles and Tuirán, 1995; UN, 1994)¹⁵.

Even if this approach provides a more appropriate and realistic view of individuals' needs and demands in the basic components of their reproductive life, it also has significant implications and poses major, complex challenges for meeting those needs, both in the research strategies (theoretical and methodological ones) to be undertaken, and above all for translating their results into better public interventions in this field. From the above aspects involved in this concept certain research and strategic questions that are insufficiently assessed should be addressed: What are the main societal, economic, cultural and political barriers affecting women's or individuals' own ability or capacity to freely and safely opt for a sexual and reproductive life without unwanted pregnancies and sexually-transmitted diseases? What are women's personal circumstances in their partners' and family contexts, in their economic situation, in the restrictions imposed by the State, and by certain institutions or power groups that prevent or facilitate women's freedom to decide on and exercise their reproductive rights? What are the conditions, obstacles and rationale of health institutions and service providers that prevent or enable individuals to have access to safe, effective, affordable and suitable family planning methods of their choice and to exercise their right to access to quality health services? What is the availability and quality of health and family planning services for offering a wide and appropriate range of contraceptive services rather than suggesting or imposing those either available and/or regarded as being the safest and most effective? Finally, what is the role of state and health institutions in the reproductive health agenda that will lead to a reduction in the adverse situations of individuals in this field? Will the hegemonic model dominated by market forces, which has led to renewed attempts to relegate the responsibility for health prevention and attention to individuals, maintain if not increase social inequalities as well as health inequalities? What is the role of the other public institutions (educational, legal, etc.), and of organizations in civil society and academia and international organizations in this new scenario?

15. Despite their apparently simplistic meaning, the words in bold deserve a more explicit and solid interpretation, giving account of the required circumstances to acquire and exercise these attributes according to specific circumstances in each society, such as social and gender inequalities, power relations, etc.

It is within this critical scenario, full of unanswered questions, different conceptual approaches and diverse nuances, interests and objectives, that we feel future theoretical and methodological research efforts should be oriented in order to have a better and more comprehensive view of women and men's unmet needs. For the time being, and despite all the survey-data limitations, it is our aim to illustrate, within this scenario, what can be learned about women's unmet needs regarding some of their health reproductive issues, based on a survey undertaken on the most marginalised and vulnerable population in rural Mexico. In addition, some evidence based on health providers' opinions regarding their interventions is considered in order to show the influence they exert, according to their own rationale, on defining women's needs.

3. The meaning and scope of unmet needs in light of empirical evidence in marginalised contexts in Mexico

This overview concerns present-day Mexico, which has undergone a series of major transformations at the political, social, economic, demographic and cultural level. Suffice it to say that the successful FPP begun nearly thirty years ago has been accompanied by the development of a broad medical infrastructure since the mid-20th century, women's growing participation in the labour market, and the socialisation and legitimisation of new values, attitudes and practices in various spheres of social, familial and personal life, all of which have produced significant changes in reproductive patterns (CONAPO, 2001, 2002, 2000b, 1999). The country has also experienced a profound economic crisis resulting from the structural adjustment model adopted and above all, the persistence and increase of sharp social inequalities among the population, with the subsequent marginalisation of large sectors of society.

Our main interest in this second part is to show how in a country that has implemented a successful FPP and responded to women's demand for contraception, achieving high contraceptive coverage and a significant decrease in fertility levels, women still have unmet RH needs. Focusing on one of the extremely poor and marginal population groups living in rural areas in Mexico in 1999, we search for empirical evidence that might indicate who the women with unmet needs are,

what their RH needs are and what some of the barriers and obstacles, whether public or individual, are that hinder the satisfaction of their needs in this field. This is a preliminary exploration based on survey data which, despite its conceptual and methodological limitations, allow us to illustrate and partly answer these questions, in some cases through the very uncertainties that arise from the facts and figures in some of the RH components drawn from the evidence considered.

3.1. Sociodemographic characteristics of the population

The Reproductive Health Survey was conducted in 1999 to gauge the impact of the actions carried out by the IMSS-Solidarity Program that began operating five years prior to the survey. The population under study includes 2,733 women aged 15-49 living in 160 rural communities in eight out of the thirty-two States in Mexico. The women interviewed live either in localities where the IMSS-Solidarity rural medical units operate or in villages that are the object of intensive action by the same program, through mobile medical units and health agents who periodically provide their services in these localities (51% and 49%, respectively; 60% of the latter have these services once a month). The largest sector of the population interviewed is non-indigenous (81%), the remainder being indigenous (defined according to the language they speak). Both are distributed in a similar fashion among localities with medical units and those with intensive action, 74% of the latter are localities with less than 1,000 inhabitants as opposed to 36% of the former (see Table 1). This population's marginalisation is also reflected by the low level of education attained, where half of the women have not completed elementary school or have not had any schooling at all, although there has been a significant improvement among the younger generations. The sharpest inequalities are to be found between indigenous and non-indigenous women (75% and 44% respectively have not completed elementary school).

With regard to the fertility conditions that characterise the population under study, the following main features should be mentioned (Table 1). The first refers to the almost universal practice of conjugal union among the women interviewed, as well as the persistent practice of early age at marriage: 96% of women aged 35-49 and 46% of those aged 15-24 had been ever married. Regarding their age at first union, data show a median age of 18.8 years, with a slight increase of nearly a

year both between the youngest cohort and non-indigenous and the oldest cohort and indigenous women, while age at first union among women with greater educational attainment is three years higher than for those without schooling. The second feature addresses the differences observed in women's fertility behaviour by ethnic status, with a higher proportion of indigenous women with high parity (37% of indigenous women as opposed to 23% of non-indigenous ones with five or more children). This fact may be due to a combination of factors, such as the different pattern in their fertility calendar and the impact of family planning actions on the indigenous and non-indigenous population¹⁶. The third is the continuation of a young pattern regarding age at birth of first child among the cohorts (with a mean age of 20.2). On average, half of all the women interviewed had their first child 1.4 years after their first union. Finally, the fourth and last aspect refers to the evidence on children's survival that suggests a much higher infant and general mortality rate in the marginal rural areas considered by the survey in comparison with the rest of the country¹⁷. Nearly one out of five women of childbearing age that have had borne live children have experienced the death of at least one child, ranging from 7% of young women aged 15 to 24 to 29% among those aged 35 to 49 (Table 4).

Although we are aware of the risks involved in the analytical strategy of the "small numbers" we have used and of the possible statistical non-significance of some of the inferences made, we would like to stress, once again, that our aim is to highlight the existence of cases that diverge from the average or apparently common behaviours and situations, as well as of the discrepancies, ambiguities and uncertainties revealed by survey data in order to show some women's RH needs and unmet needs that warrant further attention in both research and the programmatic and intervention field. Moreover, as mentioned below, we should not underestimate the fact that the small relative numbers may represent a significant numerical number when assessing the

16. In order to contextualize fertility level in marginal rural areas, in 1996 the TFR for all Mexican rural areas was 3.5 as opposed to 2.3 for urban ones (CONAPO, 2001). The figure for marginalized women under study is 3.9.

17. Nationwide, in 1997, an average of 9.1% of women in reproductive age with live-born children had experienced the death of at least one child, a figure that rises to 15.1% for rural women (estimates based on ENADID 97). The corresponding one for marginalized rural women in 1996 is 19.6% (see Table 4).

country's entire population living under similar or worse conditions (see note 19).

***3.2. The versatility estimates of unmet needs for contraception:
Needs for whom? Needs by whom?***

One of the first issues to be dealt with concerns the self-definition of women's contraceptive needs: Whose needs? Needs for whom? Needs by whom?. The criteria used for defining them have changed

Table 1
Sociodemographic characteristics of the survey population

	Total	Ethnicity		Education			Locality size		PRO-GRESA		Age			Parity				Locality type	
		Indigenous	Non-indigenous	None	Incomplete primary	Complete primary or +	< 1,000 inhabitants	1,000 inhab. or +	Yes	No	15-24	25-34	35-49	zero	1-2	3-4	5 or +	With medical clinic	Intensive action
Indigenous	18.8			50.9	16.1	9.5	17.2	21.3	25.2	14.8	14.4	20.4	22.6	11.4	16.7	20.4	27.3	18.4	19.2
Non-indigenous	81.2			49.1	83.9	90.5	82.8	78.7	74.8	85.2	85.6	79.6	77.4	88.6	83.3	79.6	72.7	81.6	80.8
<i>Educational attainment</i>																			
No schooling	17.4	47.1	10.5				16.4	19.0	22.5	14.2	8.6	17.1	28.4	6.7	11.3	18.2	34.0	17.2	17.6
Incompl. primary	32.2	27.5	33.3				35.7	28.4	35.2	30.4	21.0	32.2	45.9	18.7	27.7	36.4	47.3	28.6	36.1
Compl. prim. or +	50.4	25.4	56.2				47.9	52.7	42.3	55.3	70.4	50.6	25.7	74.6	61.0	45.3	18.7	54.2	46.3
<i>Size of locality</i>																			
<1,000 inhab.	54.2	48.9	55.5	50.6	59.8	51.8			53.2	55.0	55.5	55.3	51.6	54.6	52.0	53.3	56.6	36.4	74.0
1,000-5,000 inhab.	45.8	51.1	44.5	49.4	40.2	48.2			46.8	45.0	44.5	44.7	48.4	45.4	48.0	46.7	43.4	63.6	26.0
<i>Benefits from PROGRESA</i>																			
Yes	38.7	51.7	35.7	49.9	42.2	32.5	38.4	40.2			36.8	37.9	41.8	32.1	33.1	39.1	50.7	35.9	41.7
No	61.3	48.3	64.3	50.1	57.8	67.5	61.6	59.8			63.2	62.1	58.2	67.9	66.9	60.9	49.3	64.1	58.3
<i>Age</i>																			
15-24	38.0	29.2	40.1	18.7	24.8	53.1	38.9	37.0	36.2	39.3				83.4	49.3	12.9	0.4	38.3	37.7
25-34	30.9	33.5	30.3	30.5	31.0	31.1	31.5	30.2	30.3	31.3				10.8	35.1	54.0	28.4	30.4	31.5
35-49	31.1	37.3	29.6	50.8	44.2	15.8	29.6	32.8	33.5	29.4				5.8	15.6	33.1	71.2	31.3	30.8

<i>Mean age</i>	29.1	30.8	28.7	33.9	32.3	25.3	28.9	29.3	29.3	28.9	19.2	29.4	40.8	20.5	26.6	32.0	38.2	29.1	29.0
<i>Parity</i>																			
Zero	28.0	16.9	30.5	10.8	16.2	41.4	28.1	27.6	23.2	31.0	61.3	9.7	5.2					29.1	26.8
1-2	23.6	21.0	24.2	15.3	20.3	28.5	22.6	24.7	20.1	25.7	30.6	26.7	11.8					24.1	23.0
3-4	23.0	25.0	22.5	24.1	26.0	20.7	22.6	23.4	23.2	22.8	7.8	40.1	24.5					22.9	23.1
5 or +	25.5	37.1	22.8	49.8	37.4	9.4	26.7	24.3	33.5	20.6	0.3	23.4	58.4					24.0	27.1
<i>Type of locality</i>																			
With medical clinic	51.4	51.2	52.4	51.2	48.3	56.1	35.3	73.0	48.4	54.5	52.6	51.4	52.5	54.3	53.4	52.0	49.1		
Intensive action	48.6	48.8	47.6	48.8	51.7	43.9	64.7	27.0	51.6	45.5	47.4	48.6	47.5	45.7	46.6	48.0	50.9		
<i>Marital status</i>																			
Consensual union	19.1	32.2	16.1	33.3	20.5	13.4	19.6	18.9	22.0	17.3	18.0	22.0	17.7	6.7	27.5	24.0	20.6	19.5	18.8
Married	51.1	48.3	51.7	52.9	59.5	45.0	50.4	51.9	50.3	51.5	25.5	63.7	69.9	9.1	58.3	70.2	73.1	49.8	52.5
Widow	1.8	3.1	1.6	4.1	2.3	0.8	1.8	1.8	2.6	1.4	0.1	1.6	4.2	0.1	1.4	2.5	3.6	1.7	2.0
Divorced	0.3		0.4		0.5	0.3	0.2	0.4	0.4	0.2	0.3	0.3	0.3	0.1	0.5	0.5	0.2	0.1	0.5
Separated	3.3	2.0	3.6	2.1	4.0	3.3	3.5	3.1	3.5	3.2	2.3	3.9	3.9	0.4	8.4	2.7	2.4	3.3	3.2
Single	24.4	14.4	26.6	7.6	13.2	37.2	24.5	23.9	21.2	26.4	53.8	8.5	4.0	83.7	3.9	0.1	0.1	25.6	23.0

Source: Reproductive Health Survey, IMSS-Solidaridad-CONAPO, México, 1999.

over time, particularly as regards the social actors who decide what a contraception need is, which women are regarded as having that need and the circumstances in which that need may be considered unmet, all of which are closely related to the actors' world view and to the objectives, concerns and interests involved in the definition.

Consequently, the estimates of women's contraceptive or unmet needs may vary greatly, depending on the criteria adopted: some are more restrictive and exclude various sectors of women, while others are more comprehensive. In both cases, whether rougher, conventional or more refined definitions are used, the aim is to distinguish women who are apparently exposed to the risk of having an unwanted pregnancy, taking as a starting (and an ending) point whether or not a woman wishes to have children, and her contraceptive practice. In some cases, the fact that a woman is pregnant or not, her condition of infertility, marital status and breast-feeding are considered; in others, needs are distinguished according to whether they wish to space their pregnancies or permanently avoid them. The main purpose of the various estimates is to gauge the potential demand for contraceptive methods. They also attempt to determine whose needs are not being satisfied, as central elements for programmatic purposes, establishing FPP coverage goals, focussing actions on certain population groups and estimating the economic and human resources required to implement these actions.

In order to illustrate the impact that the diverse criteria used may have on the various estimates, we have calculated the unmet needs for contraception for marginalised rural Mexican women of childbearing age (15-49 years old) on the basis of four different criteria. For all the estimates, we follow the usual practice when working with survey data; namely, considering that a woman has unmet needs for contraception if she declares that she does not want any/more children and that she does not use any form of contraception. The variations of estimates we provide depend upon the characteristics used to identify who are the women at risk to get pregnant, that, according to the information available, they refer to their reproductive background (i.e., pregnant, infertile, menopausal, sexually active women, etc.), the reasons given by them for not using contraception and their reproductive preferences, either to space or limit their childbearing. Table 2 shows the four estimates; the upper panel refers to currently married women, while the lower one refers to currently married, once married and not married

Table 2
Quantitative contraception unmet needs. Married women and married-unmarried women

	Total		Ethnicity		Education			Age			Parity			
	% all women	% married women	% indigenous	% non-indigenous	% non educated	% incompl. primary	% complete primary or +	% 15-24	% 25-34	% 35-49	% parity zero	% 1-2 children	% 3-4 children	% 5 or + children
<i>Married</i>														
% married women	70.2	100.0	80.5	67.8	86.3	80.0	58.4	43.5	85.7	87.6	15.8	85.8	94.3	93.8
Unmet1	15.8	22.5	29.7	12.6	33.7	19.1	7.6	7.7	15.7	25.9	1.5	13.5	21.3	28.7
Unmet2	9.2	13.1	19.0	6.9	18.4	12.6	3.8	4.4	10.0	14.2	0.8	6.0	12.0	18.8
Unmet3	7.6	10.8	17.3	5.3	17.1	9.8	2.9	3.6	8.0	12.0	0.6	4.5	8.5	17.2
Unmet4	17.1	25.3	30.0	14.1	29.4	18.5	12.0	17.0	19.1	15.0	7.1	20.8	20.1	21.9
<i>Married and unmarried</i>														
Unmet1	16.5		30.7	13.2	35.2	19.8	7.9	8.2	15.9	27.1	1.8	14.7	21.4	29.7
Unmet2	9.6		19.2	7.3	19.4	12.9	4.1	4.7	10.3	14.9	1.0	6.6	12.1	19.5
Unmet3	7.9		17.6	5.6	18.0	10.1	3.0	3.8	8.3	12.5	0.7	5.1	8.5	17.8
Unmet4	17.5		30.4	14.5	30.5	19.0	12.2	17.5	19.4	15.5	7.4	21.7	20.1	22.5

Unmet1 = Rough unmet contraceptive needs = Non contraceptive users, do not want more/any children.

Unmet2 = Non contraceptive users, non-pregnant, non-infertile/menopausal, do not want more/any children.

Unmet3 = Non contraceptive users, non-pregnant, non-infertile/menopausal, sexually active, do not want more/any children.

Unmet4 = Non contraceptive users, non-infertile/menopausal, sexually active, do not want more/any children or wanting one after two years in the future.

women who have had at least one child, have been users of contraception in the past or are sexually active.

Centring our attention on the upper panel, the first estimate (Unmet1) corresponds to the rougher, more conventional definition. It includes all currently married women of reproductive age who, despite their stated wish not to have any more children, do not practice any form of contraception. According to this estimate, we find that 22.5% of married women have unmet contraceptive needs (which represents almost 17% of the total number of women of childbearing age, married and unmarried). However, this criterion tends to overestimate the scope of UNFC since it does not consider the possibility that some of those women were not really exposed to the risk of becoming pregnant, such as the currently pregnant, the infertile or menopausal, amenorrhic or those who do not have active sex lives. On the other hand, it also underestimates these needs by failing to include women who, at the time of the survey, only wish to space their pregnancies (spacers).

The second estimate (Unmet2) shows how wrong it can be to indiscriminately consider all women who do not wish to have any more children and who do not use contraceptives, as potential demanders. When including only those women who do not wish to have any more children, do not use contraceptives and are potentially exposed to the risk of getting pregnant (as long as they are not pregnant, infertile or menopausal), the figure of unmet needs for contraceptives is 42% less than the previous estimate, with 13% of married women having those needs (10% of all women).

Moreover, when considering some of the reasons given for not using contraception, there is a small group of women who despite being married do not have sexual relations with their partners. This group includes women whose husbands are temporarily absent, mainly as a result of migration, which is relatively frequent in certain parts of the country, particularly the poorest areas. Others do not have sexual relations with their partners for various moral, cultural or personal reasons or because of illness. Excluding these women obviously reduces the estimate of UNFC (Unmet3), making it the lowest of the four considered, since it decreases to less than half the first estimate and is 17% less than the second one. On the basis of this criterion, women with unmet contraceptive needs account for 11% of married ones (less than 8% of all women). However, it is worth mentioning that this may be a questionable estimate since it ignores the risk to which those women

who do not have active sex lives for temporary or transitory circumstances, may be exposed when they renew them at any time.

The fourth and last estimate (Unmet4) includes not only women's present contraceptive needs, but also those that are foreseeable in the short term. It includes non contraceptive users, fertile and sexually active, who do not wish to have any more children, but also those who, whether pregnant or not, wish to wait at least two years before having a child (spacers). This is the most complete of all the estimates presented and therefore the highest: one out of every four married women (25%) has unmet contraceptive needs (17% of all women of childbearing age)¹⁸.

Despite the fact that all the women studied live in marginal areas, the living conditions of some are worse-off than others, a fact reflected in the different levels of unmet needs when women's socio-demographic characteristics are considered. These levels reflect the degree of correspondence between reproductive preferences and contraceptive practices, which may be conditioned by cultural factors, the lack or inadequacy of FPP, the possible adverse experiences in women's previous use of methods and/or their fear of the latter. Thus the proportions of married, indigenous women, with no schooling, and older women with UNFC are always higher than those of non-indigenous, more educated and younger women, regardless of the criteria used for estimating their needs. Thus, the figure of indigenous women with unmet needs is always more than twice that of non-indigenous ones. Moreover, the UNFC of women with no schooling are four times higher than for those who have at least completed elementary school; older women's (35-49 years) triple younger women's (15-24) while the percentage of those with the highest parity is two to four times that of women with 1-2 children, with the sole exception of the fourth estimate in all cases.

Excluding pregnant and infertile or menopausal married women (Unmet2), as well as women who do not engage in sexual relations with their partners (Unmet3), has different effects for women with

18. This last figure is slightly higher than the one reported in the official figures for 1997, although we do not know how the latter was calculated. According to this figure, the unmet demand of married women in rural areas of the country totalled 22.2%, 12.8% of which were spacers and 9.4% did not wish to have any more children. Nationwide, unmet demand totalled 12.1%, corresponding to 6.9% for spacers and 5.2% for those who did not wish to have any more children (CONAPO, 2001).

different characteristics. The relative difference between indigenous and non-indigenous women with unmet needs increases with respect to the first estimate, as does the difference between those with no schooling and those with higher educational attainment and between those with lower and higher parity. There is also a slight reduction in the differences between women of intermediate and older ages (25 to 34 and 35 to 39) in comparison with younger women. However, regarding the unmet needs either for limiting or spacing their offspring (Unmet4), the relative differences are reduced or even inverted inasmuch as this estimate is the one that yields the highest levels of unmet needs for younger (18%), more educated (12%) women and those with lower parity (7% of nullipara and 21% with 1-2 children) (see Table 2).

If one considers married and unmarried women (widows, divorcees, separated, single mothers and single women with an active sexual life), the lower panel in the Table shows that the total proportion with unmet needs rises between 0.3 to 0.7 points for the different estimates. Although the relative difference may appear very small, it is not insignificant in absolute numbers¹⁹. Even though this slight difference may be due to the almost universal pattern of marriage in Mexico, it may also be due to the limitations of the survey questions on which the estimates were based, which do not account for the risks to which unmarried women are actually exposed. The differences according to the women's characteristics show a very similar pattern to that observed for current married women, those differences being higher for the first estimate (Unmet1), especially among the non-educated, indigenous and older women, with higher parity, groups for which the percentages of women with unmet needs rise by 1.0 to 1.5 percentage points when including the non married.

What does this overview offer and how should it be interpreted? Regardless of the criteria used in each estimate, one should recall that these are definitions attributed to women; in other words, they are not drawn from direct questions about their own specific needs. Therefore, as stated earlier, this attribution responds to the logic, interests and

19. To have some idea of what this small percentage of the country's entire population means, it is worth noting that according to data from the census, the number of women of childbearing age living in localities with fewer than 2,500 inhabitants totalled 5.6 million in 2000. A rough estimate of the numerical significance of an additional 0.7% of women with unmet contraceptive needs would be close to 36,000 women.

purposes of diverse actors, in order to legitimise and justify FPP, their coverage goals and focused orientation, and the resources needed to implement these interventions, which have led to a greater segmentation and exclusion of the contraceptive needs of certain population groups, such as non married, pregnant, infertile or sexually inactive women. Moreover, these diverse definitions and estimations undoubtedly reflect the high variation of intensities of apparently unmet contraceptive needs observed at a particular stage of their lives, accounting for the conditions of greater vulnerability of certain groups, such as indigenous women, those who have had fewer opportunities of access to education, and those who live in a context of lack or weakness of FPP or one in which these programs have not been socially legitimised.

In this section, we have merely considered one aspect of the satisfaction of contraceptive needs, i.e. the one related to its coverage (registration, estimation). Without denying its importance and despite the issues raised earlier, it is essential to realise that this aspect does not cover all women's contraceptive needs, particularly those referring to the type of methods they require as a result of their specific life circumstances and above all, the broad range of needs emerging from the reproductive health approach. Some of these are described in the following sections.

3.3. Unmet needs related to women's reproductive goals

Women's desires or preferences for deciding whether or not to have another child was the original key concept for estimating unmet contraceptive needs. Since the beginning of family planning programs and from the traditional UNFC perspective, concern over the number of a woman's offspring has centred on women who have a high number of children, those who – at a specific moment (at the time of the survey) or stage of their lives – stated that they do not wish to have another child or that they want to have one later on, and those who mentioned they have already exceeded their reproductive goals. In other words, it has focussed on women wishing to limit or space their children, regarding them as being in need of contraception and taking its magnitude as symptomatic of the degree of necessity to expand contraceptive services.

Notwithstanding, from the point of view of the reproductive health perspective, particularly the right of each individual to have the

number of children he or she desires, unmet needs related to women's reproductive goals should not be circumscribed to the ability to prevent unwanted pregnancies or delay their occurrence. Having fewer children than the desired number, experiencing difficulties in becoming pregnant or achieving the desired number of children may also constitute major sources of dissatisfaction. This issue, however has tended to be overlooked in FP services, being neglected or being regarded as less important than having a higher number of children than desired. This dissatisfaction has also been ignored in research where very little is known about its intensity and characteristics. Even with the limited data available, some insights can be drawn regarding this issue.

Findings in Table 3 show that women in marginalised rural areas who have ever been pregnant report an average number of live-born children that is very similar to the ideal or desired number (3.9 and 3.8 respectively). However, when considering women according to certain indicators of social inequality, the picture obtained is quite different and more meaningful. Indeed, indigenous women without schooling or who have not completed elementary school, the oldest ones and those with the highest parity have had an average of 0.3 to 1.9 children more than they would like to have had. This group includes a large number of women whose childbearing years elapsed in a context in which family planning was not yet socially legitimised, meaning that their access to FP services was virtually non-existent. Conversely, women who completed their elementary education and belong to a generation or social context where these programs were already established (women under 35 years old) have between 0.2 and 1.5 fewer children than they would like to have. Obviously, some of these women include those who have not yet completed their reproductive lives, although there is also a shortfall in the number of children women wish to have among a substantial proportion of those who are near the end of their reproductive lives, as well as among those who have been sterilized. Around 26% of women aged 40-49 and 36% of those who have been sterilized have achieved their reproductive ideal, while 25% and 18% of them have had fewer children than they would like to have had. Conversely, 44% in both cases have had more than their ideal number²⁰.

20. It is worth mentioning that nearly 5% of the women fail to define their ideal number of children, since some of them answered, "The number God gives me" or "I don't know," when asked about the total number of children they would have liked to have. Failure to define the number of children, together with this type of

Even though the achieved/desired gap may be partially due to various sociocultural factors that go beyond the confines of FPP, such as women's marital status, the value placed on children, gender and power relations, the process of negotiation, and personal decisions within the couple, this gap may also partly be attributed to health institutional factors. We find, for example, women or their partners with infertility problems, women that experience difficulties in achieving full-term pregnancies or the survival of their live-born children, ones who have had favourable or unfavourable personal experiences in relation to the use of contraceptives and medical services, as well as women with the possibility of having risk-free sexual practices. The proper prevention and attendance of problems of infertility, pregnancy, childbirth, postpartum and puerperium and of children's health, as well as access to quality contraceptive services and sexual education programs are not only related to the individual's self-awareness and behaviour but also largely the responsibility of health systems.

Thus, for example, infertility is not only due to congenital and age-related causes, but may also be an acquired condition, resulting from infections and untreated reproductive tract ailments, the incorrect use of contraceptive methods, malpractice and the inadequate care of pregnancy, childbirth or other reproductive events. In the case of women in marginalised rural areas, 24% are infertile, 19% because they were sterilized and the rest because of difficulties in conceiving, because they are menopausal or due to other sterility-related factors. These women experience other forms of dissatisfaction. Just over one out of eighteen sterilized women, two out of five women who have difficulty conceiving and nearly two out of three sterile women expressed a desire to have another child, while just 2% of menopausal women would like to have another child. It seems important to note that although ethnicity does not seem to make a great difference in the proportion of infertile women, the underlying causes of infertility differ between indigenous and non-indigenous women. From the data shown in Table 3 suffice it to say that 58% of the cases of indigenous women's infertility are due to female sterilization versus 83% in the

response, is particularly common among older indigenous women and those who have had no schooling (11-13%).

Table 3
Dissatisfaction with the number of live-born children

	Total	Ethnicity		Education			Age			Parity			
		Indigenous	Non-indigenous	None	Partial elementary	Complete elem. or +	15-24	25-34	35-49	Zero	1-2 children	3-4 children	5 children or +
Mean number of children born alive	3.9	4.5	3.8	5.2	4.5	2.9	1.8	3.6	5.5		1.5	3.5	6.7
Mean number of children still alive	3.7	4.1	3.6	4.6	4.1	2.8	1.7	3.4	5.0		1.5	3.3	6.1
Ideal number of children	3.8	4.2	3.7	4.6	3.9	3.4	3.0	3.8	4.4	3.5	3.0	3.7	4.8
<i>Number of live-born children vs number of desired children</i>													
Women aged 40-49:	100.0	100.0	100.0	100.0	100.0	100.0			100.0	100.0	100.0	100.0	100.0
Less than desired	23.9	18.6	25.3	21.1	21.5	33.8			23.9	52.8	77.5	31.1	11.3
The ones desired	25.8	23.2	26.4	16.4	28.2	33.4			25.8	26.9	18.5	44.5	20.4
More than desired	45.4	45.4	45.4	51.5	46.9	32.8			45.4			23.7	61.7
Non-defined/Didn't answer	4.9	12.8	2.9	11.0	3.4				4.9	20.3	4.0	0.7	6.6
Sterilized women:	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0		100.0	100.0	100.0
Less than desired	17.6	7.5	19.2	11.6	16.3	21.7	13.7	20.8	16.2		44.9	19.9	10.9
The ones desired	35.6	38.3	35.1	19.1	34.7	43.9	61.3	39.9	31.4		51.3	54.0	18.8
More than desired	43.7	44.8	43.5	60.9	46.1	33.4	25.0	35.4	49.5		3.8	25.1	65.0
Non-defined/Didn't answer	3.1	9.4	2.2	8.4	2.9	1.0		3.9	2.9			1.0	5.3

<i>% of non-fertile women</i>	23.7	22.8	23.8	30.9	31.0	16.5	2.9	23.6	49.0	3.2	13.1	35.6	45.0
Female sterilization	18.6	13.2	19.8	18.3	25.3	14.4	2.2	20.1	37.0	0.1	7.4	31.4	37.5
Difficulties to get pregnant	1.9	3.6	1.5	4.2	1.6	1.2	0.4	2.5	3.1	0.8	2.9	2.1	2.0
Menopause	2.1	4.3	1.6	6.4	2.8	0.3		0.2	6.7	0	1.7	1.8	5.1
Sterility by other reasons	1.1	1.7	0.9	2.0	1.3	0.6	0.3	0.8	2.2	2.3	1.1	0.3	0.4
<i>Non-fertile women: Number of live-born children vs number of desired children</i>													
Less than desired	21.9	14.5	23.5	18.7	20.0	26.3	14.8	25.5	20.6		63.9	22.3	10.4
The number desired	33.4	38.4	32.4	21.0	33.8	40.9	60.5	39.9	28.7		33.2	53.5	19.2
More than desired	41.4	37.8	42.2	52.2	43.5	31.9	24.7	31.2	47.3		2.2	23.4	64.8
Non-defined/Didn't answer	3.3	9.3	1.9	8.1	2.7	0.9	0.0	3.4	3.4		0.7	0.8	5.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0		100.0	100.0	100.0
<i>% of infertile women desiring a child</i>	10.5	6.9	11.2	5.0	9.3	15.4	32.8	15.4	6.4	77.1	27.4	6.8	3.4
<i>% of infertile women desiring a child by infertility type</i>													
Female sterilization	5.6	1.8	6.1	1.8	5.1	7.7	10.8	7.7	4.0		14.5	6.4	3.3
Difficulties to get pregnant	38.4	11.4	53.5		43.0	79.6	93.0	62.1	10.2	87.8	63.9	19.6	2.2
Menopause	1.7		2.7	2.3	1.1				1.7		2.5		2.0
Sterility by other reasons	63.6	55.2	67.2	53.2	64.6	74.2	100.0	65.9	55.8	78.6	58.8		28.4

Source: Reproductive Health Survey, IMSS-Solidaridad-CONAPO, México, 1999.

case of non-indigenous women²¹. It is also worth noting that infertile women wishing to have a child account for 2.5% of the total number of marginal rural women, rising to 3.6% of those aged 25-34 and of those with 1-2 children.

Moreover, the prevalence of high infant mortality rates among the rural population, particularly the indigenous population, as well as the incidence of stillbirths among them, are factors related to the desire to have more children and cannot be regarded separately from the prevailing conditions of access and quality of medical care, as well as from the general socioeconomic and cultural poverty circumstances that characterise these marginalised areas. An analysis of the impact of children's mortality and comparing the mean ideal number of children with the mean number of children still alive shows a high degree of correspondence between them. However, it should be noted (Table 3) that indigenous women, those that did not complete primary school, older ones and those with high parity, have had an average of 0.5 to 0.6 children born alive who died. As shown in Table 4, a fifth of the women with live-born children have experienced the death of a child. This proportion rises to one fourth of indigenous women, just fewer than one in three for women without schooling and of those aged 35 to 49, and nearly two out of every five women with high parity. The effects of death are also reflected in the fact that the proportion of women with fewer surviving children than the number desired rises to one third among women aged 35 to 49 and to 23% in the case of sterilized women. It is also interesting to observe that 7% of women who have ever been pregnant have had at least one stillborn child and that stillbirths not only occur among older women with high parity and less schooling but also among younger, more educated women and those with the lowest parity. Finally, another key element is the high incidence of abortion; particularly among older, non-indigenous women and those with high parity (17% of once pregnant women have had at least one abortion).

21. Nineteen percent of indigenous women and 17% of non-indigenous women are 35-49 years old; of whom 19% and 10% respectively report being menopausal (8 and 7% aged 45-49, 26 and 17% of whom are menopausal). This suggests an earlier cessation (whether real or imaginary) of reproductive functions among the indigenous population. Moreover, among all age groups, the proportion of sterile women and of those who have difficulty conceiving is relatively higher among indigenous women.

Table 4. — Other issues related to women's dissatisfaction

	Total	Ethnicity		Education			Age			Parity			
		Indigenous	Non-indigenous	None	Partial elementary	Complete elem. or +	15-24	25-34	35-49	Zero	1-2 children	3-4 children	5 children or +
<i>Number of surviving children vs number of children desired</i>													
Women aged 40-49:	100.0	100.0	100.0	100.0	100.0	100.0			100.0	100.0	100.0	100.0	
Less than desired	33.2	32.7	33.4	34.1	30.3	39.2			33.2	52.8	77.5	35.8	24.0
The ones desired	21.6	17.8	22.6	14.2	21.7	32.2			21.6	26.9	18.6	39.9	15.7
More than desired	40.3	36.7	41.1	40.7	44.6	28.6			40.3			23.6	53.7
Non-defined/Didn't answer	4.9	12.8	2.9	11.0	3.4				4.9	20.3	3.9	0.7	6.6
Sterilized women:	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0		100.0	100.0	100.0
Less than desired	22.5	17.9	23.2	17.8	21.9	25.3	13.7	22.3	23.3		44.9	23.4	17.7
The ones desired	34.6	31.9	35.0	17.8	32.8	44.0	61.2	39.8	29.9		51.3	52.9	17.7
More than desired	39.8	40.8	39.6	56.0	42.4	29.7	25.1	34.0	43.9		3.8	22.7	59.3
Non-defined/Didn't answer	3.1	9.4	2.2	8.4	2.9	1.0		3.9	2.9			1.0	5.3
% women with ABC ^a	72.0	83.1	69.5	89.2	83.7	58.6	38.7	90.2	94.8		100.0	100.0	100.0
% women with ABC, at least one of which died	19.6	27.4	17.5	30.9	23.4	10.3	7.2	16.6	28.8		4.5	15.3	37.6
% women ever pregnant with stillborn child	6.9	7.4	6.8	7.7	8.3	5.3	4.5	7.0	8.2	7.4	3.1	5.8	11.4
% women ever pregnant with at least one abortion	16.6	9.3	18.6	13.1	19.9	15.4	6.8	15.0	23.4	26.2	10.7	14.6	23.3

Source: Reproductive Health Survey, IMSS-Solidaridad-CONAPO, México, 1999.

^a. ABC: alive-born child(ren).

We consider that the evidence mentioned above is clearly indicative of the prevalence of reproductive health problems. It points to the existence of other kinds of unmet needs, related to having the desired number of offspring, both among women and couples who have more children than they would like to have had and among those who have fewer than their ideal. The persistence of a high incidence of abortions, as well as of sterilization, particularly among young women, the prevalence of high levels of infant, child and/or youth mortality, continue to constitute significant reproductive health problems and unmet needs that warrant attention in themselves, especially among the poorest segments of women, the indigenous and the uneducated, where they are exacerbated.

How should one interpret the meaning of women's unmet needs in relation to their reproductive goals? Nowadays, the tension between societal or national goals, interests, concerns and needs and individual, private and intimate ones should not only be seen as related to the social concern or individual desire to prevent unwanted pregnancies or delay them, but also to reproductive unmet needs as regards the ability to reproduce and the freedom to decide if, when and how often to do so.

3.4. Needs for what or on what RH components related to FPP (contraception)

In this section we consider the well-known and traditional KAP indicators related to FPP and the concept of unmet need for contraception (KAP-gap). But instead of dealing with the concept of attitudes (which are poorly and insufficiently obtained through survey data) we prefer to talk about women's options, since this concept better reflects the reason and circumstances that led them to opt for a specific method. To address these issues, we should bear in mind the fact that the knowledge, options and practice of contraception for preventing pregnancy and reproductive tract infections (RTIs) among the different groups of the population should not only be attributed to the achievements and results of different actions and interventions that take place, mainly, at the political and institutional level. They are also due to changes in the social, economic, cultural, ideological and technological spheres of society that lead to different perceptions, attitudes, needs and demands regarding the options for contraception and, above all,

are a result of the socialisation, legitimisation and acceptance of FP or RH programs among the various sectors of the population.

3.4.1. Unmet needs for contraceptive knowledge

In most surveys, it seems to be commonly assumed that hearing about a specific contraceptive method means knowing about it, but it is highly questionable to assume that knowing or being informed that a method exists, necessarily means that a woman knows the benefits and implications of its use and how to use it, which would constitute an indispensable minimum for being able to talk about knowing a method. Therefore, the information provided by these data sources is extremely limited and misleading for analysing what women's unmet needs are regarding their knowledge and information about contraceptive methods. Nevertheless, the data from the Reproductive Health Survey (RHS-99) offers some interesting insights on this issue.

As Table 5 shows, 89% of married women living in marginalised rural settings had heard of at least one contraceptive method.²² However, the conditions of greater social backwardness and poverty in which indigenous women's lives take place, even within the already precarious conditions that prevail in these settings, and the inadequacy of health services provided within these areas for them, are reflected in the fact that barely 69% of the indigenous women are able to spontaneously mention any contraceptive method, as opposed to 94% of their non-indigenous peers. Likewise, only 72% of women without schooling were able to identify some form of contraception whereas among married women who have never practised contraception, only 67% said that they had heard of at least one method.

In the case of Mexico, contraceptive knowledge of specific modern methods for preventing pregnancy is partially the result of educational and preventive programs, and mainly due to the contraceptive information and services given by health providers. Therefore, it is not surprising that the most common contraceptive methods offered by service providers and the ones largely used by women are the ones they

22. This percentage and those given below correspond to the women who spontaneously mentioned a method for preventing pregnancy. In order not to overestimate knowledge of contraceptive methods, we have not included cases where women said they have heard about a particular method after the interviewer had mentioned it.

Table 5. — Contraceptive methods knowledge

	Total	Ethnicity		Education			Age			Parity				Contraceptive use		
		Indigenous	Non-ndigenous	None	Partial elementary	Complete elem. or +	15-24	25-34	35-49	zero	1-2 children	3-4 children	5 childr. or +	Never user	Ex-user	Actual user
<i>Married women</i>																
<i>% have heard about at least one method^a</i>	88.8	68.6	94.4	72.2	91.4	95.0	88.0	89.5	88.6	74.7	91.3	92.3	86.2	67.0	100.0	100.0
<i>% of married women who have heard about:</i>																
Oral pills	82.8	61.3	88.7	62.4	86.3	90.1	80.5	84.5	82.6	66.2	85.9	85.4	80.9	60.7	92.5	90.5
IUD	75.2	47.7	82.7	54.2	76.0	85.1	77.3	79.6	69.6	57.7	81.2	80.3	68.7	53.7	79.0	84.3
Injections	71.2	48.1	77.6	54.2	72.4	78.9	69.6	74.1	69.4	48.6	76.0	74.6	68.3	49.3	82.4	78.5
Feminine sterilization	54.0	38.2	58.3	44.9	55.9	56.9	42.0	54.8	60.5	28.7	46.9	60.6	58.6	31.6	46.3	66.8
Condom	48.6	15.8	57.7	20.7	49.6	62.0	49.6	51.2	45.5	37.9	57.2	52.1	40.3	25.0	48.9	59.8
Masculine sterilization	30.5	14.8	34.9	16.1	30.3	38.1	29.9	31.5	30.0	17.0	33.7	33.8	27.4	19.3	27.1	36.9
Rhythm, abstinence	13.1	5.0	15.4	5.5	12.0	18.0	9.7	14.3	14.1	10.4	13.7	15.7	10.8	6.2	13.2	16.4
Local methods	11.0	0.6	13.8	2.5	10.4	15.7	8.1	12.0	11.7	2.0	12.2	14.0	8.8	2.0	10.8	15.3
Withdrawal	6.0	1.0	7.4	1.4	5.8	8.6	3.4	7.8	5.8	7.5	5.9	7.3	4.7	2.7	5.8	7.7
Norplant	2.3	0.2	2.9	0.2	2.5	3.2	1.1	3.2	2.2	1.0	2.0	3.0	2.2	0.2	2.7	3.2
Other methods	1.0	1.1	1.0	0.9	1.0	1.1	0.5	0.7	1.6	0.0	0.7	1.2	1.3	0.5	1.0	1.3
Mean number of known methods ^b	4.5	3.3	4.6	3.5	4.3	4.7	4.2	4.6	4.4	4.1	4.5	4.6	4.3	4.0	4.4	4.7

<i>Non-married women</i>																
<i>% have heard about at least one method^a</i>	74.9	48.5	78.6	47.9	73.0	78.5	73.1	79.0	79.9	71.6	82.3	92.1	90.7	72.1	100.0	100.0
<i>% of non-married women who have heard about:</i>																
Oral pills	69.1	41.9	72.9	40.0	64.5	73.8	68.0	72.6	71.4	65.7	81.1	88.9	77.7	66.3	94.9	90.0
IUD	53.8	28.0	57.4	25.1	49.4	58.4	51.5	62.5	56.3	49.6	69.8	70.1	67.9	50.5	83.1	79.0
Injections	53.5	31.2	56.6	22.0	50.5	58.0	52.0	57.0	58.1	49.8	65.4	63.6	75.5	50.4	87.5	71.4
Feminine sterilization	34.9	15.9	37.6	16.0	34.1	37.4	31.7	44.9	41.6	31.8	38.4	52.6	59.7	32.0	51.0	67.1
Condom	44.7	13.2	49.1	8.6	35.8	51.5	46.3	47.0	33.4	45.4	44.1	51.1	31.0	43.2	60.2	53.2
Masculine sterilization	26.6	7.7	29.2	8.3	18.5	31.1	25.9	27.4	29.3	25.9	27.2	40.3	24.4	25.3	41.9	31.3
Rhythm, abstinence	13.2	2.2	14.7	2.2	4.2	17.1	12.5	17.3	11.9	13.6	15.0	9.5	6.5	12.8	20.2	11.2
Local methods	11.2	0.4	12.7		7.3	13.7	10.3	16.2	10.3	11.1	12.8	12.8	8.2	10.6	16.3	15.0
Withdrawal	6.1		6.9		1.5	8.2	6.0	8.3	4.1	6.3	6.1	8.4	0.7	6.1	9.5	2.5
Norplant	3.3	0.4	3.7		0.6	4.5	3.1	5.6	1.3	3.5	3.8	1.0		3.1	8.1	1.5
Other methods	0.6		0.7		0.2	0.8	0.6		1.1	0.6	0.8		0.9	0.5	1.6	0.9
Mean number of known methods ^b	4.2	2.9	4.4	2.5	3.7	4.5	4.2	4.5	4.0	4.2	4.4	4.3	3.9	4.2	4.8	4.4

a. Refers to women that spontaneously mention at least a contraceptive method when they are asked if they have heard about means or methods for not having children or spacing them.

b. Refers only to women that have heard at least about one method. Excludes those who do not know about any method.

Source: Reproductive Health Survey, IMSS-Solidaridad-CONAPO, México, 1999.

know best: contraceptive pills and IUD ranking in the first place as the ones more frequently mentioned (83% and 75%), followed by the injectable methods (71%), while feminine sterilization is familiar to just over half of all married women (54%), current users of any method being those who know most about it (67%). Male sterilization knowledge is only mentioned by 30% of all married women, a fact that confirms the traditional delegation of reproductive responsibilities to women as well as the dominant orientation of the FPP towards them. Moreover, indigenous women and those with no schooling have less knowledge of all the specific methods listed in the survey.

Knowledge of condoms warrants special mention, both as a contraceptive method and in the prevention of sexually transmitted diseases (STDs) and HIV/AIDS, due to the lower degree of knowledge about it. Although it is known as a contraceptive by nearly half of all married women (49%), it is only mentioned by one out of every six indigenous women, one out of every five with no schooling and a fourth of never users, which contrasts with the nearly three out of every five non-indigenous, more highly educated women and current users who identify it as a contraceptive. In turn, the rhythm and local methods (spermicides, ovules and the diaphragm) are known by nearly one out of every eight married women, whereas other methods such as withdrawal, Norplant and others (particularly herbal infusions), are known by 6% or fewer of married women, being in all cases known more by non-indigenous, more highly educated women and current contraceptive users.

Finally, the lower degree of contraceptive knowledge among unmarried women could be related to the lack of response to a potential need due to moral restrictions, or to less awareness of the risks involved in becoming pregnant. Even when they are not theoretically exposed to the risk of conceiving, they can become subject to this risk at any moment. It might therefore be plausible to consider that 25% of them are potentially exposed to the risk of an unwanted pregnancy because they were unaware of the existence of ways of preventing it. This risk is even greater among indigenous women and those with less schooling, particularly single women: two out of three single women with no schooling (67%) and just under three out of every five single indigenous women (57%) are unable to identify any method, in con-

trast with the 23-24% of single women who completed elementary school and to non-indigenous women²³ (see Table 5).

In short, it is important to stress the need for more adequate and better conceptual and methodological tools to obtain accurate data about women's and men's knowledge on contraception, as well as to know what information is offered to women and men by service providers and educational programs. We should recall that most surveys do not gather information on men. Undoubtedly, the content and understanding of the information given by service providers about the use of the methods and the benefits and consequences of their use are meaningful aspects when addressing the issue of knowledge.

3.4.2. Contraceptive practice

Knowledge of the existence of contraceptive methods is a factor that theoretically precedes the use of the latter. However, the fact of knowing about them does not mean that they are actually used, or that they are among the known methods from which the method used was chosen. In 1999, the level of contraceptive practice by married women (57%) was a little over the level observed for all rural areas in Mexico in 1997 (54%), which is 25% higher than that of users in 1992.

This increase is undoubtedly due to the strengthening and expansion of programs aimed at providing health services for the population in the poorest, most isolated rural localities, lacking permanent medical services, as well as to the population's felt needs and demands to space, reduce and control their fertility. The following factors have contributed to the expansion of contraceptive practice: the implementation of programs based on mobile brigades that periodically visit rural localities and provide them with basic health services, including those related to contraception; the link between official programs and traditional health agents, particularly midwives and their training as a strategy for the dissemination of contraceptive practice; and the increased access of marginalised populations to clinics located in adjacent localities for the care of more complex health problems or childbirth.

23. Figures for total number of unmarried women are 52%, 52%, 22% and 22%, respectively. The relative distribution regarding the knowledge of specific methods is similar to the one of married women.

Table 6
Contraceptive use

	Total	Ethnicity		Education			Age			Parity			
		Indigenous	Non-indigenous	None	Partial elementary	Complete elem. or +	15-24	25-34	35-49	zero	1-2 children	3-4 children	5 children or +
<i>Married</i>													
% users	56.7	35.3	62.5	38.5	59.1	63.8	44.2	59.3	61.7	9.0	55.3	63.4	60.6
<i>Method used:</i>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Feminine sterilization	44.8	43.1	45.0	53.8	50.6	37.2	11.6	39.0	64.8	7.8	14.0	50.6	64.0
IUD	29.9	29.3	30.0	26.3	24.5	35.5	60.6	30.9	15.6	9.2	55.0	24.6	16.1
Rhythm	6.7	8.1	6.5	6.9	6.5	6.8	4.7	8.0	6.3	49.8	7.2	4.6	7.1
Oral pills	6.3	4.9	6.6	3.0	7.5	6.4	8.1	7.3	4.7	7.4	10.0	5.5	4.3
Injections	4.2	8.3	3.6	3.1	4.5	4.4	7.3	4.5	2.7	14.2	5.2	3.6	3.9
Withdrawal	3.9	5.4	3.7	3.7	3.9	3.9	2.8	3.8	4.4		3.9	5.8	2.2
Condom	3.6	0.5	4.1	2.1	2.2	5.2	3.9	6.1	1.1	11.6	3.8	5.2	1.7
Masculine sterilization	0.4	0.4	0.4	0.4	0.3	0.6	1.0	0.2	0.4		0.9		0.5
Other ^a	0.2		0.1	0.7				0.2				0.1	0.2

<i>Non-married</i>													
% users	5.2	4.6	5.3	2.7	11.5	3.6	1.8	8.6	20.5	0.3	19.1	31.9	26.9
<i>Method used</i>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Feminine sterilization	50.0	100.0	44.0	100.0	59.5	36.6		33.4	82.8		28.9	71.9	69.2
IUD	33.6		37.7		32.4	37.8	80.3	26.4	14.3		57.1	7.2	30.8
Injections	6.1		6.7			12.5	3.6	21.0		18.3	10.4	3.4	
Withdrawal	2.4		2.7		5.0		9.5			48.1			
Condom	1.7		1.9			3.4	6.6			33.6			
Masculine sterilization	4.7		5.3			9.7		19.2				17.5	
Other ^a	1.5		1.7		3.1				2.9		3.6		

a. Includes local methods, abstinence and Norplant.

Source: Reproductive Health Survey, IMSS-Solidaridad-CONAPO, México, 1999.

Despite all these initiatives, in which the institutional supply seems to respond to women's demand for contraception, there are still sharp differences in the level of contraceptive use by the various groups of women within marginalised rural areas. Whether because of barriers imposed by health institutions through the quantity, quality and characteristics of the services they offer, or because of those derived from socioeconomic, cultural, familial and personal factors that limit women's access to contraception, the level of contraceptive use among indigenous married women and those without schooling is barely 60% of the respective level of use of non-indigenous women or those that have completed elementary school (see Table 6).

The high value that continues to be placed on motherhood in Mexico, its identification as the basic expression and crystallisation of female identity and women's activity, and the consequent need to prove their fertility, may constitute part of the principal barriers that explain why contraception mainly takes place after a woman has had at least one child and therefore at later ages. Just 9% of married nullipara²⁴ and 44% of those aged 15 to 24 use contraceptives, rising substantially to more than half for women with one or two children and nearly three out of every five for those over 25 years old. The latter proportion can be related to the economic and cultural changes that have taken place and helped reduce the social value placed on large families, as well as the rationale underlying FPP that, until recently, tended to focus mainly on women who had already had at least two or three children (see Table 6).

The rationale and orientation of FPP that favour the safest, irreversible methods over hormonal and less effective ones, which are also related to the side effects of the latter and women's preference for choosing more reliable or safer methods, is reflected in the fact that female sterilization and IUD are by far the most commonly used methods (45% and 30% respectively), as opposed to the lower use of contracep-

24. It is worth noting that nulliparae account for a tiny fraction of the total number of married women (6%), and that over half have been in a conjugal union for less than two years. Of the 91% that did not use contraceptives, the majority, 38%, were pregnant when the survey was carried out and 15% wished to be, while the other 20% had experienced difficulty conceiving. The remaining 18% did not use any kind of method because either they or their partners disapproved of the use of contraceptive methods, because they were afraid of side effects, or because of their partner's temporary absence or for other reasons.

tive pills and other methods such as injectables, rhythm, withdrawal and local ones, the method of choice for 7% or fewer users.

The high frequency of female sterilization, a characteristic pattern in many developing countries, is nonetheless worrying, particularly when it involves relatively young women. As Table 6 indicates, one out of every nine married users aged 15-24, two out of every five aged 25 to 34 and nearly two out of every three aged 35-49 have been sterilized. Even more striking and questionable is the existence of a small but not negligible fraction of women aged 15 to 19 in this situation (accounting for 5% of contraceptive users and 1.7% of married women in this age group). The age at which sterilized women as a whole were operated on shows that one out of every eight sterilized women were operated on before the age of twenty-five (0.8% being 17-19 years old and another 12% at 20-24) (Table 7).

At the same time, there is an inverse relationship between the percentage of women who have resorted to sterilization and educational attainment, which can partly be explained by the fact that those with less schooling are older and vice versa, although it is also possible that women with lower educational attainment were in a more vulnerable position during the negotiation and adoption of this method: 54% of users without schooling and half of those who have not completed elementary school have been operated on, a percentage that falls to 37% of users who have completed elementary school or have post-elementary studies. Likewise, it is the method most commonly used by women with higher parity (64% of users with five children or more) and by half of those with 3-4 children, although also by one out of every seven of those with one or two children, and, surprisingly, by a small fraction of those who have not had children (8%). It is interesting to note that the intensity of this practice is very similar between indigenous and non-indigenous women. The question, then, is whether this similarity reflects the predominance or possible imposition of this method by health service providers.

Failure to observe medical institutional norms regarding the performance of non-reversible methods, as well as the possible tension between these norms and the dominant FPP rationale imposed (i.e. contraceptive goals) emerges in the analysis of the opinions expressed by doctors themselves regarding the criteria they used to sterilize women: according to ENINPLAF survey data, only 54% believe there should be a minimal age for prescribing this method, which is 28.6

Table 7
Women sterilized

	Total	Ethnicity		Education			Age			Parity			
		Indigenous	Non-indigenous	None	Partial elementary	Complete elem. or +	15-24	25-34	35-49	zero	1-2 children	3-4 children	5 children or +
<i>Age at sterilization</i>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0		100.0	100.0	100.0
15-19	0.8	3.3	0.4		1.3	0.7	12.6	0.8			6.2	0.7	
20-24	11.9	9.0	12.3	3.2	9.6	18.0	87.4	18.4	2.8		28.3	21.5	1.5
25-29	30.5	24.0	31.5	21.4	34.4	30.2		56.4	18.8		39.5	46.0	17.1
30-34	29.6	38.8	28.2	30.8	28.1	30.9		24.4	34.6		15.4	18.6	40.5
35-49	27.2	24.9	27.6	44.6	26.6	20.2			43.8		10.6	13.2	40.9
<i>Mean number of children born alive by age at sterilization</i>													
15-19	2.3	2.0	2.7		2.0	3.0	2.0	3.0			2.0	3.0	
20-24	3.2	3.5	3.1	3.9	3.4	3.0	2.8	3.4	3.3		2.0	3.3	5.5
25-29	3.9	4.0	3.9	4.6	4.0	3.6		3.7	4.2		2.0	3.4	5.7
30-34	5.5	6.2	5.4	6.4	6.0	4.7		5.2	5.7		2.0	3.5	6.5
35-49	6.4	7.0	6.4	7.2	6.8	5.2			6.4		1.4	3.7	7.3

Source: Reproductive Health Survey, IMSS-Solidaridad-CONAPO, México, 1999.

years on average, with an extremely wide range of variation between different health institutions, ranging from a minimum of 24.9 years to a maximum of 30.3 years on average; moreover 18% stated that the operation can be carried out at the age of twenty or even earlier. Likewise, half the doctors mentioned that there should be a minimum parity for prescribing a definitive method, which is 1.7 children on average, although this varies from 1.3 to 2.9 children between the doctors at the various institutions (ENINPLAF 1996).

From the point of view of women, what are the implications of being sterilized? What are the costs and/or the benefits of eliminating any possibility of having a child in terms of their partners and of their own current and future reproductive aspirations, as well as the stage of their family life and their health status? What are the risks of being exposed to a surgical operation? What are the changes in their physical and emotional lives that women may experience after being sterilized? What are the tensions and conflicts experienced by women who have made the decision to be operated on, in terms of their participation in this decision, the circumstances under which it has been taken and the pressures they may have been subjected to? Based on the survey data being analysed only a few partial insights can be addressed about the last issue, as shown in the next section. For the moment, suffice it to recall, as we pointed out earlier, that 18% of the women operated on have had fewer children than they would like to have had; 23% of the women who have been operated on have fewer surviving children than they would have liked to have, while 1% of the total number of women would like to have a child but have already had their Fallopian tubes tied.

One last aspect to be considered refers to the contraceptive needs of unmarried women. Although, as is the case with most other surveys, the one we analysed does not ask women directly about their contraceptive needs or whether or not they are sexually active, regardless of their marital status, it is interesting to note that 5% of currently unmarried women, i.e. women who are single, widowed, divorced or separated, reported that they used some form of contraceptive method (see Table 6). Although half these women use a non-reversible method, perhaps as a result of their past needs and the options offered to them, the fact that the remaining half uses a non-definitive method may indicate that at least some of them maintain an active sexual life, meaning that they have current contraceptive needs. Which are the contracep-

tive needs of women who are not married? Do unmarried but sexually active women face greater moral, social and institutional barriers for adopting a contraceptive method, compared with their married peers? None of these issues has received sufficient attention from FP programs and researchers²⁵.

3.5. The circumstances and facts surrounding the choice of contraceptive method

The choice of contraceptive method is one of the key aspects of the reproductive health approach, since it entails women's right to free-informed choice, partly reflects women's subordinate condition and is closely linked to the quality of health services. It has also become one of the most highly debated issues regarding the decision-making process and the structure of options and conditions available to the users of contraceptive methods for making an informed, free choice. The adoption of a specific method may be due to a number of reasons, ranging from influences, recommendations and direct or indirect impositions by other social actors, such as service providers, partners, peers, members of their family, priests, etc., to women's convictions and beliefs, as well as their perceptions about other practical issues, such as the cost of acquiring a particular method, its availability and accessibility and the quality of care received when adopting a method.

According to data yielded by the survey, the main reasons that led women to choose the method are the desire for an effective method to prevent having children (37%) and the service provider's recommendations (33%). Other less important reasons include: fear of the side effects of other methods (12%), the form of use and ease of acquisition (7%), and their partner's preference (6%). It is worth noting that 0.8% of users had the method applied without their consent. The search for effectiveness and the influence of service providers are especially evi-

25. Findings from the National Fertility and Health Survey undertaken in 1987 point out that 6% of the total number of widows and 10% of those who are divorced or separated had engaged in sexual relations during the month prior to the survey and that nearly 6% of single women of reproductive age had had intercourse at some time in their lives. In addition, 12.6% of the total number of women without partners, generally regarded as not being at risk of conceiving, had active sex lives, at least one third of whom did not use any form of contraception (Camarena *et al.*, 1994).

dent among women who were operated on and the users of IUDs²⁶. On the contrary, the fears of side effects lead women to prefer the use of the condom as well as traditional and local methods, such as the rhythm method, withdrawal and abstinence, among others (see Table 8).

However, the way the question is put forward in the survey, particularly its circumscription within a battery of predefined answers, raises a series of doubts about its significance and how to interpret the findings obtained²⁷. We should ask ourselves what women understand in terms of an effective method. Are they aware that the effectiveness of the method depends partly on their own responsibility? Were they told and did they understand the way the method should be used? To what extent was the selection of a method the result of a recommendation rather than an imposition? Were the women told of other methods, their benefits and side effects? To what extent did they understand the explanations given to them? Did they have the ability and the freedom to decide when faced with the service providers?

Although the content of the survey does not enable one to answer these questions in great detail, some of the following findings allow us to address them as part of the circumstances and facts surrounding the adoption of a specific method. A fifth of the users that adopted a particular method on the service provider's recommendation (21%) and a similar proportion of those who did so because they wanted an effective method did not receive information on the existence and characteristics of other methods, a figure that significantly rises to 26% of those who were sterilized. A similar lack of information is reported for other methods (see Tables 9a and 9b). Likewise, 22% of the users were not told about the side effects and implications they might experience when using a particular method, while a similar proportion (20%) failed to understand the service provider's explanation. In both cases, these adverse situations are more acute among sterilized women.

26. Nearly half of those who adopted the method on the service provider's recommendation are sterilized and just over one in three are IUD users, while 66% who chose a method because of its effectiveness are sterilized and 30% use IUDs.

27. In fact, the figure of women that had had the method applied without their consent was obtained from the open text that accompanies the answers included in the code "Others" of the corresponding question as well as of other related questions.

Table 8. — Main reason for choosing the method currently used

	Total	Ethnicity		Education			Age			Parity			
		Indigenous	Non-indigenous	None	Partial elementary	Complete elem. or +	15-24	25-34	35-49	Zero	1-2 children	3-4 children	5 children or +
<i>Total</i>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Medical prescription	32.7	42.1	31.2	33.8	33.7	31.4	32.4	29.0	36.1	12.4	33.0	30.0	35.4
Fears of side effects	11.6	8.3	12.1	6.7	11.0	13.6	9.0	15.2	9.5	9.7	12.6	14.0	8.7
Ease of use, disponibility	7.0	4.0	7.5	2.3	4.2	10.7	14.3	8.4	2.6	36.7	12.8	5.5	3.0
Spouse preference	5.9	9.1	5.4	9.7	7.3	3.6	4.9	7.1	5.2	9.1	6.1	6.7	4.8
Method's effectiveness	36.9	31.1	37.8	41.3	37.0	35.5	32.2	33.8	41.8	18.2	29.2	37.5	43.1
Non consent	0.8		0.9		1.5	0.5		0.1	1.7		0.1	0.6	1.5
Other	5.1	5.4	5.1	6.2	5.3	4.7	7.2	6.4	3.1	13.9	6.2	5.7	3.5
<i>Feminine sterilization</i>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Medical prescription	34.5	42.1	33.4	34.4	33.8	35.5	16.1	34.6	35.7		42.5	34.5	33.0
Fears of side effects	3.3	1.0	3.6	1.9	1.2	6.2	5.8	6.0	1.6		1.3	4.6	2.5
Ease of use, disponibility	0.9	2.3	0.7		0.1	2.2		1.1	0.9		4.8	1.2	
Spouse preference	3.9	5.7	3.6	5.6	5.7	1.1	2.4	4.7	3.6		5.5	4.0	3.6
Method's effectiveness	54.2	45.1	55.6	56.5	54.5	52.8	66.0	51.0	55.1	100.0	40.5	52.4	58.0
Non consent	0.8		0.9		0.9	1.0			1.3				1.6
Other	2.4	3.8	2.2	1.6	3.8	1.2	9.7	2.6	1.8		5.4	3.3	1.3
<i>IUD</i>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Medical prescription	38.1	55.8	35.6	42.7	40.3	36.1	41.5	30.1	47.3	55.4	36.2	38.2	43.1
Fears of side effects	7.7	2.0	8.5	2.5	10.1	7.4	5.5	9.2	8.7		6.6	10.0	7.3
Ease of use, disponibility	9.0	4.3	9.7	5.9	5.9	11.4	8.3	11.7	5.1		12.3	4.7	6.4
Spouse preference	2.8	4.4	2.6	1.8	5.7	1.4	3.3	3.3	1.0		3.3	3.9	
Method's effectiveness	36.4	31.8	37.0	39.1	29.2	39.9	37.3	39.0	30.1		38.4	34.8	33.9
Non consent	1.4		1.6		4.0	0.2		0.3	5.8		0.3	2.4	3.0
Other	4.6	1.7	5.0	8.0	4.8	3.6	4.1	6.4	2.0	44.6	2.9	6.0	6.3

<i>Oral pills</i>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Medical prescription	30.6	15.8	32.3	70.8	37.1	18.7	18.8	26.3	45.5	38.6	21.7	17.1	62.5
Fears of side effects	19.7	28.2	18.8		24.0	18.6	14.9	28.7	10.6		23.1	20.2	14.2
Ease of use, disponibility	24.3	26.5	24.0	4.8	18.5	32.6	37.5	21.9	17.9		31.2	24.7	12.5
Spouse preference	1.7		1.9			3.5	7.2				3.8		
Method's effectiveness	11.2	21.7	10.0		18.3	6.1	7.0	11.8	13.4	61.4	6.6	25.3	
Other	12.5	7.8	13.0	24.4	2.1	20.5	14.6	11.3	12.6		13.6	12.7	10.8
<i>Injectables</i>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Medical prescription	38.3	60.0	31.0	62.0	55.9	20.4	34.3	30.3	56.6	38.4	25.4	21.0	68.4
Fears of side effects	20.2	29.3	17.3	11.6	13.9	26.7	15.0	24.3	19.7		24.6	22.9	15.4
Ease of use, disponibility	15.5		20.7		1.5	29.0	24.2	15.1	5.9		19.6	27.9	1.8
Spouse preference	9.5	10.7	9.1	26.4	11.5	4.7	11.6	6.8	11.6	61.6	3.1	10.6	9.4
Method's effectiveness	8.4		11.2		4.8	12.8	14.9	8.7			23.0		
Other	8.1		10.7		12.4	6.4		14.8	6.2		4.3	17.6	5.0
<i>Condom</i>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	99.9
Medical prescription	10.7		10.9		8.5	12.7	6.5	14.1			29.7		11.5
Fears of side effects	35.2		35.9	40.1	42.0	32.3	39.4	31.0	49.7	64.1	32.1	38.8	21.5
Ease of use, disponibility	22.2		22.6		13.1	27.9	43.3	19.6		35.9	25.5	20.3	17.8
Spouse preference	19.1		19.5	36.5	21.8	16.2	10.8	21.0	23.8		7.9	28.3	17.8
Method's effectiveness	2.7		2.8			3.9		4.1				5.6	
Other	10.1	100.0	8.3	23.4	14.6	7.0		10.2	26.5		4.8	7.0	31.3
<i>Rhythm, withdrawal, abstinence</i>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Medical prescription	12.7	13.0	12.6		10.6	18.9		14.8	14.6		15.1	7.5	17.6
Fears of side effects	43.4	27.9	46.6	34.1	43.7	46.3	15.2	42.6	53.6		35.9	57.3	44.3
Ease of use, disponibility	9.6	3.7	10.9	5.9	10.4	10.3	35.1	8.4	2.5	63.1	3.9	4.2	10.9
Spouse preference	20.7	34.4	17.9	41.5	20.0	14.2	10.6	23.1	21.6		25.2	21.0	19.9
Method's effectiveness	1.5	3.4	1.1		3.8		6.4		1.4	15.8			1.8
Other	12.1	17.6	10.9	18.5	11.5	10.3	32.7	11.1	6.3	21.1	19.9	10.0	5.5

In addition, the results from the survey on family planning institutions (ENINPLAF 1996) provide extremely relevant information about the doctors' views and practices in the process of adopting a contraceptive method. Thus, 42% stated that they themselves offered it to the patient; another 23% said that the patient herself requested a particular method; while the remaining 35% said that either the patient requested the method or the doctor offered it to her. Nevertheless, when doctors who attend births or miscarriages were asked about their responsibilities regarding family planning during the post-partum or post-miscarriage period, 42% said that it was their duty to offer FP advice, orientation or information, another 24% stated that it was their responsibility to ensure that the patient left the clinic or hospital with a contraceptive method, while 10% mentioned that it was their responsibility to persuade women to use a particular method.

Moreover, contrary to current regulations, which state that women should not be persuaded to use a particular contraceptive method, a further 10% of doctors felt that it was their duty to promote and/or apply a specific method, the IUD, while 4 out of 10 of these doctors were directly responsible for inserting IUDs into all patients. Even more drastic and questionable is the fact that 29% of the doctors who attend births or miscarriages believe that inserting an IUD during the postpartum is a decision that only the doctor is qualified to make, thereby preventing women from making choices and decisions. Furthermore, and transgressing women's reproductive rights, there is a small fraction of women who were given a method without their consent. Moreover, the method used in nearly half these cases involved tying the Fallopian tubes. The women who have experienced this situation are all non-indigenous women, most of whom have failed to complete elementary school (Table 8).

Another key aspect is the timing doctors consider most appropriate for offering and adopting a non-reversible method. A quarter of all doctors believed that there was no problem in suggesting it during labour, which directly contravenes the current regulations stating that contraceptive advice must not be given when a woman is in a fragile and vulnerable state. The information given by health providers indicates that 55% of female sterilizations carried out immediately after childbirth or a Caesarean section, another 5% after an abortion and 40% at other times.

Table 9a
 Proportion of users deficiently attended when contraceptive method was prescribed
 according to type of deficiency and reasons for choosing the method

Type of deficiency	Medical prescription	Fears of side effects	Ease of use, dis-ponibility	Spouse preference	Method's effective-ness	Other	Non consent
Were not informed about other methods	20.5	13.9	18.7	23.6	19.6	31.3	27.4
Were not given explanations about side effects	21.2	21.9	18.3	35.2	21.7	27.2	51.2
Did not understand explanations	19.0	14.6	17.5	25.2	18.8	34.8	51.2
Were not told to return in case of discomfort	14.2	11.8	6.0	18.4	15.2	29.8	27.4
Were not given enough time to inform them	20.0	17.4	12.7	29.4	20.5	28.4	27.4
Did not feel confidence to clear doubts	13.2	11.9	8.3	19.4	14.2	20.0	27.4
Did not have sufficient privacy	6.0	3.4	8.4	11.3	8.6	14.8	17.3
Were not respectfully treated	0.9	1.2	2.5	3.6	3.4		17.3
Were not satisfied with received attention	1.9	2.7	2.9	7.0	4.3	1.7	41.1

Source: Reproductive Health Survey, IMSS-Solidaridad-CONAPO, México, 1999.

Table 9b

Proportion of users deficiently attended when contraceptive method was prescribed according to type of deficiency and method

Type of deficiency	Total	Ethnicity		Education			Age			Parity			
		Indigenous	Non-indigenous	None	Partial elementary	Complete elem. or +	15-24	25-34	35-49	zero ^a	1-2 children	3-4 children	5 children or +
<i>Total (all methods)</i>													
Were not informed about other methods	20.1	16.2	20.7	18.5	22.0	19.0	19.6	19.1	21.2	20.0	21.6	21.9	17.1
Were not given explanations about side effects	22.3	23.7	22.0	14.5	22.4	24.4	18.9	19.4	26.4	20.0	17.5	26.2	22.2
Did not understand explanations	19.6	21.0	19.3	17.5	18.6	20.9	18.4	16.5	22.8	13.3	18.3	22.5	17.7
Were not told to return in case of discomfort	14.7	15.5	14.6	9.6	14.5	16.4	9.6	13.3	18.3	13.3	9.4	19.3	14.4
Were not given enough time to inform them	20.2	19.3	20.3	16.2	18.6	22.7	16.2	18.6	23.5	20.0	16.3	24.0	19.4
Did not feel confidence to clear doubts	13.8	12.8	13.9	13.7	13.2	14.3	11.5	11.2	17.1	6.7	12.4	14.2	14.6
Did not have sufficient privacy	7.7	4.5	8.1	4.2	7.2	9.1	4.6	7.6	9.1	13.3	7.8	9.0	6.3
Were not respectfully treated	2.3	2.6	2.2	2.7	1.7	2.6	2.3	0.9	3.5	8.3	2.8	2.1	1.9
Were not satisfied with received attention	3.6	3.9	3.5	4.6	3.3	3.4	2.6	2.2	5.2	8.3	3.0	3.2	4.2
<i>Feminine sterilization</i>													
Were not informed about other methods	25.8	21.6	26.5	21.0	26.1	27.6	18.4	26.2	26.1		35.2	31.3	19.7
Were not given explanations about side effects	30.3	31.5	30.1	14.5	29.8	37.7	27.5	27.2	32.2		33.9	33.3	27.5
Did not understand explanations	26.6	29.9	26.1	16.1	26.4	31.5	17.3	24.7	28.4		32.0	30.5	22.8
Were not told to return in case of discomfort	22.6	18.8	23.1	11.2	21.7	28.5	27.6	21.3	22.9		26.4	27.0	18.3
Were not given enough time to inform them	28.3	28.0	28.4	18.9	26.9	34.1	17.3	27.0	29.8		34.4	30.7	25.1
Did not feel confidence to clear doubts	20.1	17.9	20.5	14.3	20.3	22.5	17.3	18.1	21.4		26.1	20.9	18.5
Did not have sufficient privacy	10.3	7.5	10.8	3.5	10.1	13.6	8.7	10.4	10.4		19.7	12.5	7.0
Were not respectfully treated	3.3	4.2	3.1	2.4	2.5	4.5	8.7	1.1	4.0		6.7	3.4	2.5
Were not satisfied with received attention	4.8	5.5	4.7	4.4	5.3	4.5		3.3	6.0		2.5	4.7	5.4

<i>IUD</i>													
Were not informed about other methods	15.2	10.0	15.9	16.3	20.3	12.1	21.5	13.9	6.3		20.7	7.5	10.1
Were not given explanations about side effects	10.3	6.9	10.8	11.7	6.7	12.0	12.5	9.7	7.6		11.8	10.5	6.1
Did not understand explanations	10.2	10.5	10.2	20.1	5.4	10.8	15.8	7.2	5.8		13.6	8.6	3.3
Were not told to return in case of discomfort	3.3	8.5	2.5	5.1	0.4	4.5	4.2	2.9	2.4		3.0	5.3	1.0
Were not given enough time to inform them	11.5	13.1	11.2	15.4	7.6	12.7	14.0	12.1	5.8		11.7	16.2	4.4
Did not feel confidence to clear doubts	5.8	8.0	5.5	11.2	2.7	6.5	9.8	3.3	3.4		8.4	3.5	2.2
Did not have sufficient privacy	3.3	1.8	3.5	4.3	2.2	3.7	2.2	3.5	4.7		3.2	3.0	4.0
Were not respectfully treated	0.9	1.1	0.8	4.3		0.6	0.6	0.3	2.4		1.6		
Were not satisfied with received attention	1.5	1.8	1.5	5.4		1.6	1.1	1.5	2.4		2.0	1.4	0.5
<i>Oral pills</i>													
Were not informed about other methods	8.5		9.5		7.7	10.5	10.3	10.8	3.5		8.4	13.8	2.0
Were not given explanations about side effects	10.9	36.0	8.0		8.9	14.3	23.2	8.1	5.5		20.1	5.0	1.8
Did not understand explanations	9.4	7.8	9.6	11.6	2.4	15.7	26.2	4.5	4.0		16.8	2.5	5.1
Were not told to return in case of discomfort	9.7	10.7	9.6		6.1	14.5	19.0	9.4	3.2		15.1	8.6	1.8
Were not given enough time to inform them	12.0		13.4		2.4	22.8	32.0	9.0	1.4		21.1	7.4	1.8
Did not feel confidence to clear doubts	6.3	7.8	6.1	11.6	2.4	9.2	16.8	2.5	4.0		11.4		5.1
Did not have sufficient privacy	3.9		4.4			8.2	4.6	5.3	1.4		4.1	5.6	1.8
Were not respectfully treated	1.0		1.1			2.1		1.2	1.4		1.3		1.8
Were not satisfied with received attention	1.9		2.1			3.9	3.6	1.2	1.4		3.2		1.8
<i>Injectables</i>													
Were not informed about other methods	15.3	18.3	14.3		13.9	19.3	13.8	14.8	17.8		21.9	4.4	18.8
Were not given explanations about side effects	27.1	34.0	24.7	11.6	38.6	21.9	41.0	15.9	28.7		18.3	42.5	19.9
Did not understand explanations	23.1	17.6	24.7	37.9	19.5	22.5	21.7	22.7	25.6		22.0	27.5	15.0
Were not told to return in case of discomfort	18.9	18.8	18.9	15.1	27.4	13.5	13.8	17.5	27.3		16.0	22.0	22.0
Were not given enough time to inform them	13.8	5.5	16.6		14.3	16.1	17.5	14.9	7.7		9.5	16.3	10.6
Did not feel confidence to clear doubts	12.2	4.6	14.8	11.3	10.2	13.8	9.0	11.6	17.1		17.8	4.4	13.8
Did not have sufficient privacy	13.4		17.9		13.9	15.6	9.0	21.4	5.4		20.5	16.3	4.4
Were not respectfully treated	0.6		0.8		1.6			1.4				2.2	
Were not satisfied with received attention	4.6	4.6	4.5	11.3	1.6	5.4	9.0	1.4	4.5		7.6	2.2	3.6

a. The number of cases is insufficient to disaggregate by method.

Source: Reproductive Health Survey, IMSS-Solidaridad-CONAPO, México, 1999.

The lack of information and clear, comprehensive explanations given to women is the result of diverse factors that prevail on the supply side, among service providers and health institutions, which might be exacerbated in marginal and poor areas. Limited evidence from survey data illustrates the unfavourable service providers' attitude towards the patients. These include their perception of women's inability to understand the way contraceptive methods work²⁸, or their reticence to clarify patients' doubts and to provide them with indications about what to do in the event of discomfort or problems resulting from contraceptive use. There are other factors related to working conditions that are mentioned by service providers, such as the short time available during medical consultation for providing patients with essential information on the benefits and consequences of the specific method adopted²⁹, the lack of contraceptive supplies, as well as the limited variety of non-reversible methods offered, which place additional restrictions on women's range of choices³⁰.

The above findings speak for themselves and merely constitute a limited, vague and uncertain illustration of the degree of freedom and options that women have regarding the method to be chosen, and the questionable practices regarding the conditions that prevail for making an informed free choice. Moreover, they probably reflect some of the deficiencies in the quality of care received by women when choosing a contraceptive method. These are aspects that warrant further research in order to have a more comprehensive and precise picture of the unmet needs in the circumstances and social actors that influence women's options.

Another proxy-analytical way to determine women's unmet needs regarding their contraceptive practice is to consider the reasons for non-use of contraceptives. Of all the women of childbearing age, 59%

28. Although virtually all doctors said that it is important for patients to understand the way contraceptive methods work, half of them estimate that around 20% of their patients are unable to do so.

29. Twenty percent of women users mentioned the shortage of time during medical consultation; and 13-14% stated their lack of confidence in doctors' ability to clarify their doubts and the absence of indications of what to do in the event that they experienced discomfort (see Table 9a).

30. Although health institutions deal with an average of 3.7 contraceptive methods – ranging from 3.1 to 5 methods – during the three months prior to the 1996 survey, 32% of the medical rural units were not able to provide one or more of the methods they offer.

do not use any method to prevent pregnancy. Of this group, 46% have never used any method while the remaining 13% have used it in the past. Indigenous women are the most vulnerable since the great majority are not current users (71%). Among the reasons for not using a contraceptive method, it is possible to distinguish five groups of situations in which there are important differences between non-indigenous and indigenous women (see Table 10). A first group refers to their own, their husbands' or their religion's disapproval (6% of non-indigenous and 18% of indigenous women)³¹. A second group addresses more specific reasons related to women's unmet needs, such as the fear of secondary effects of methods, and the lack of knowledge about them (5% and 12% respectively). A third includes women who reported not having sexual relations, such as single women (mostly adolescents and younger women), widows, divorcees and those that were separated, as well as married women whose partners were temporarily absent or women that reported not having sexual relations (59% non-indigenous and 28% indigenous). The fourth group comprises breast-feeding women (5% and 10% respectively) who due to the exclusive nature and segmented orientation of the FPP are not being conceived as having specific and different contraceptive unmet needs. The last group includes pregnant women (11% and 8% respectively) and those that wish to conceive (4% and 7% respectively).

At the same time, reasons for not using a contraceptive method vary according to other women's characteristics. For instance, fear of secondary effects of methods increases with age and parity and is greater among former users than never users, which is probably due to the women's greater awareness and better information; although it might respond more to the negative experience they have had when they used them.

Despite the reservations and restrictions concerning women's stated expectations regarding the use of a contraceptive method in the future, it is interesting to note that at the time of the survey, over half the non-users intended to use contraception in the future (56%). There are, however, sharp variations between the various groups of women. Although 61% of non-indigenous non-users planned to practice contraception in the future, the percentage of indigenous women with the

31. Unfortunately, the survey did not inquire about the meaning of the women's or their husbands' disapproval.

Table 10
Reasons for not using any contraceptive method

	Total	Ethnicity		Education			Age			Parity				Use status	
		Indigenous	Non-indigenous	None	Partial elementary	Complete elem.or +	15-24	25-34	35-49	zero ^a	1-2 children	3-4 children	5 children or +	Never users	Ex-users
Never users	45.5	58.4	42.6	52.5	35.1	49.8	71.5	29.8	29.5	96.6	28.1	20.4	28.3		
Ex-users	13.1	12.2	13.3	13.9	15.3	11.4	8.3	18.2	14.0	1.7	21.7	18.0	13.2		
Current users	41.4	29.4	44.1	33.6	49.6	38.8	20.2	52.1	56.6	1.7	50.2	61.6	58.5		
<i>Reasons</i>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Own/spouse disagreement	8.9	17.5	6.3	19.9	9.5	4.3	3.7	13.7	15.0	5.2	6.9	15.7	25.9	9.6	5.7
Do not know methods	2.4	7.5	0.9	5.7	2.5	1.0	1.4	3.7	2.9		1.9	5.0	4.9	3.0	
Fear of side effects	4.4	4.6	4.3	4.3	8.2	2.4	1.4	6.2	9.3	1.4	3.8	10.4	10.8	2.7	10.2
Non-married	46.5	24.6	52.9	17.7	32.4	64.8	68.4	26.0	19.9	5.4	20.4	10.2	8	57.1	10.6
Partner temporarily absent	3.9	1.3	4.7	1.6	5.9	3.9	2.5	7.1	3.9	2.4	10.9	7.6	2.6	1.9	11.2
Married without sexual relations	1.5	2.0	1.4	1.4	2.3	1.2	0.9	1.1	3.4	0.9	1.5	4.2	2.1	0.9	3.5
Breast-feeding	6.0	10.1	4.8	10.0	8.9	3.0	5.1	8.7	4.9		12.6	9.2	10.9	5.1	9.1
Non-fertile/menopausal	9.2	14.5	7.6	20.7	11.8	3.4	1.0	7.5	29.4	22.2	11.5	11.6	20.0	8.1	12.9
Pregnant	10.7	8.4	11.4	8.8	11.1	11.2	11.2	15.5	4.4	40.8	19.0	17.5	7.1	6.4	25.6
Child wanted	4.4	6.6	3.8	6.3	5.1	3.4	2.7	7.9	4.5	15.8	8.4	6.9	3.2	3.7	7.0
Other	2.1	2.9	1.9	3.6	2.3	1.4	1.7	2.6	2.4	5.9	3.1	1.7	4.5	1.5	4.2

a. Refers only to once married or once pregnant women.

Source: Reproductive Health Survey, IMSS-Solidaridad-CONAPO, México, 1999.

Table 11
Current use and future intentions to use contraceptives

	Total	Ethnicity		Education			Age			Parity				Use status	
		Indigenous	Non-indigenous	None	Partial elementary	Complete elem. or +	15-24	25-34	35-49	zero	1-2 children	3-4 children	5 children or +	Never users	Ex-users
Current users	41.4	29.4	44.1	33.6	49.6	38.7	20.2	52.1	56.4	1.7	50.2	61.3	58.5		
Non-users	58.6	70.6	55.9	66.4	50.4	61.3	79.8	47.9	43.6	98.3	49.8	38.7	41.5	100.0	100.0
Intend to use in the future	33.0	26.5	34.3	24.8	23.7	41.0	55.2	24.9	11.4	60.1	30.0	18.3	17.1	53.2	66.5
Do not intend to use in the future	15.9	26.1	13.6	28.6	19.1	10.1	8.9	15.6	27.7	14.9	13.4	16.5	19.7	27.1	27.1
Undecided	9.7	18.0	8.0	13.0	7.6	10.2	15.7	7.4	4.5	23.3	6.4	3.9	4.7	19.7	6.4
<i>Reasons for not using contraceptives in the future</i>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Own/spouse disagreement	19.3	24.8	16.9	24.0	15.4	19.2	24.4	25.4	12.7	17.1	12.4	19.0	26.0	16.5	21.5
Child wanted	11.7	16.5	9.8	15.0	8.4	12.6	6.6	21.2	7.9	7.0	18.1	20.3	4.5	10.1	13.0
Fear of side effects	16.2	9.0	19.2	3.6	23.2	19.3	22.1	14.2	14.9	13.1	18.7	16.1	17.6	16.3	16.3
Without partner or sexual relations	21.0	13.0	24.3	13.8	27.4	19.8	20.7	14.1	25.6	24.4	29.0	17.2	15.5	25.8	16.8
Infertile or difficulties to get pregnant	8.5	4.3	10.3	10.7	7.9	7.4		3.8	15.6	7.0	11.6	5.6	10.2	10.0	7.3
No intention to marry or have sexual relations	8.9	12.4	7.4	11.1	5.4	11.3	7.4	7.4	10.6	15.7	4.5	8.6	5.8	7.2	10.4
Other	14.4	20.0	12.1	21.8	12.3	10.4	18.8	13.9	12.7	15.7	5.7	13.2	20.4	14.1	14.7

Source: Reproductive Health Survey, IMSS-Solidaridad-CONAPO, México, 1999.

same intention was barely 38%. The diverse future scenarios are linked to the current stage of life of non-users. Older women and those with higher parity and no schooling shared these expectations to a lesser extent (26% to 41%), while two thirds or more of the younger, more educated non-users and former users, planned to use contraception later on (Table 11).

Finally, reasons for non-use of a contraceptive method in the future are related to women's current circumstances, reflecting the obstacles and barriers they face in meeting their reproductive and contraceptive needs. A fifth of the women did not plan to use contraception either because they did not have a partner or did not engage in sexual activity. Another fifth of women refer to the persistence of current values and attitudes, such as their own or their partner's opposition to using contraceptive methods, a fact which was more common among indigenous women, those without schooling, those with higher parity and, surprisingly, younger women, as well as former users. It is striking, although not surprising, that fear of side effects of methods is the third most important reason for non-use in the future, particularly among younger women and those who have not completed elementary school (22% and 23% respectively).

3.6. Unmet needs regarding access and quality of reproductive events: Under which conditions?

As has been stressed by the Programme of Action endorsed at the International Conference on Population and Development held in Cairo, key aspects of women's reproductive health concern the access and quality of care they receive during pregnancy, childbirth and post-natal periods. Although Mexican public health institutions have a long history of providing health services to a vast majority of its population dating from 1940, it was not until the implementation of FPP that they and their service providers were granted almost exclusive responsibility over reproductive events and fertility control. This has led to the medicalization of procreation, a process in which these events became spheres of intensive influence where the medical rationale and practices have been imposed. Despite the extended and massive institutional FP coverage provided for most of the population's socio-economic groups, there are still significant institutional, economic, social, cultural and even familial and personal barriers that prevent many women from

being able to effectively have access to quality health services in order to ensure safe pregnancies and childbirth. In this section we mainly address some of the service attendance conditions received by women during their pregnancy and childbirth periods, conditions that could also be viewed as part of the practices offered by service providers. The data refer exclusively to women whose last live-born child was born between 1994 and 1999.

3.6.1. Prenatal care

Prenatal care is a crucial factor in ensuring both that women have safe pregnancies and childbirth and that the results of their pregnancies are successful for the survival and wellbeing of mother and child. In general terms, the provision of this type of care is mainly oriented towards detecting and dealing with high-risk situations, referring women with specific risks to specialised health services and providing safe, timely care and treatment for any ailments that occur during pregnancy. Thus, while it is important for women to receive prenatal care, it is even more crucial to know what stage of their pregnancy they begin to receive it at, the frequency with which they receive it and the quality of the care offered. As stated earlier, it also represents a period where service providers promote and encourage women to adopt a contraceptive method.

Although prenatal care now seems to be a more universal practice characterised by a growing process of medicalization³², there are still considerable sectors of pregnant women who do not receive medical care, receive it late or less often than recommended or are given poor quality medical care. Indeed, findings on Table 12 show that although the majority of women were attended by a health agent during their last pregnancy, 5% did not receive any type of prenatal care, with indigenous women and those with no schooling accounting for the highest percentage (11%).

Similarly, the intense medicalization of prenatal care is evidenced by the fact that four out of every five pregnancies were attended, at least once, by a doctor (exclusively or in combination with other health agents) and another 3% by paramedical staff (such as a nurse, health

32. Between 1974 and 1976, health agents attended 67% of pregnancies, a figure that rose to 92% from 1994-1997 (CONAPO, 2001).

Table 12
Last pregnancy attendance. Women with child born alive during 1994-1999

	Total	Ethnicity		Education			Age			Parity		
		Indigenous	Non-indigenous	None	Partial elementary	Complete elem. or +	15-24	25-34	35-49	1-2 children	3-4 children	5 children or +
<i>% of women with prenatal care on last pregnancy</i>	95.0	89.4	96.8	89.4	96.4	96.6	94.7	95.9	93.6	96.2	96.3	92.3
<i>Prenatal care providers (%)</i>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Doctor	55.8	32.3	63.1	30.1	55.5	68.2	55.7	54.3	58.5	62.0	53.5	50.7
Doctor and other institutional agent	12.2	10.0	12.8	9.5	12.3	13.0	14.1	12.2	9.6	14.3	12.6	9.3
Doctor and midwife	11.9	16.4	10.6	19.7	11.4	9.0	12.8	11.9	11.0	10.6	12.8	12.5
Other institutional health agent	2.4	4.8	1.6	2.0	2.7	2.3	2.3	3.1	1.2	2.6	2.2	2.3
Midwife and other inst. health agent	0.9	1.5	0.8	0.6	1.5	0.6	1.3	0.9	0.5	0.8	0.8	1.3
Midwife	11.8	24.4	7.9	27.5	13.0	3.5	8.5	13.5	12.8	5.9	14.4	16.2
Without prenatal care	5.0	10.6	3.2	10.6	3.6	3.4	5.3	4.1	6.4	3.8	3.7	7.7
<i>Timing of first checkup (%)</i>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
First trimester	62.8	50.2	66.4	41.3	62.8	72.1	66.0	65.8	52.7	72.0	62.7	51.1
Second trimester	32.5	39.8	30.4	45.2	33.2	26.5	30.5	29.7	40.7	24.6	34.6	40.4
Third trimester	4.7	10.0	3.2	13.5	4.0	1.4	3.5	4.5	6.6	3.4	2.7	8.5
Mean month at 1st checkup	3.6	4.0	3.2	4.2	3.3	3.0	3.2	3.3	3.6	3.1	3.2	3.8
<i>Number of checkups during last pregnancy (%)</i>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
1-2 times	6.0	13.1	3.9	12.8	4.3	4.3	6.0	4.9	7.9	5.8	3.9	8.4

3-4 times	19.8	21.4	19.4	29.5	21.7	14.3	17.5	18.5	25.6	14.4	17.8	29.1
5 times or more	74.2	65.5	76.7	57.7	74.0	81.4	76.5	76.6	66.5	79.8	78.3	62.5
Mean of times	6.3	5.7	6.5	5.2	6.2	6.9	6.5	6.5	5.9	6.7	6.5	5.7
<i>% of pregnant women with prenatal care according to Mexican norm^a</i>	50.4	33.5	55.7	25.3	50.6	62.1	53.7	54.4	39.0	61.3	52.5	35.1
<i>Quality of attention (%)</i>												
Had blood pressure taken	86.7	70.9	91.3	68.3	85.4	95.8	91.2	85.2	84.0	94.4	84.4	79.4
Was weighted	85.2	68.4	90.1	64.9	84.7	94.6	90.6	84.5	79.8	93.4	83.3	77.0
Was given tetanus jabs	89.6	81.6	92.0	76.4	90.4	94.9	93.3	87.5	89.2	93.9	85.2	88.9

a. Refers to women that have had their first checkup during the first trimester and at least five checkups along pregnancy.

Source: Reproductive Health Survey, IMSS-Solidaridad-CONAPO, México, 1999.

worker or community promoter). Nevertheless, a significant group of pregnant indigenous women and those with no schooling found themselves in a more vulnerable situation regarding medicalized prenatal care: only 59% in both cases were attended by a doctor, while another 6% and 3% respectively received attention from a paramedic during their last pregnancy. The persistence and importance of prenatal care provided by midwives, either as the only agents who attended pregnancies or combined with medical care, is a relevant feature, mainly among indigenous women and those without schooling. The greater confidence in midwives, the warm care they provide that is also related to women's habits and cosmovisions, the difficulties and costs of obtaining access to medical care, as well as women's previously unsatisfactory attendance by medical staff, are among the reasons that lay behind the fact that midwives intervened in prenatal care in one fourth of all pregnancies (42% of indigenous women and 48% without schooling). They were the only agents who attended 12% of all pregnancies (24% and 28% respectively), and the remainder in combination with other agents.

Other conventional elements for assessing access to quality services during pregnancy are the timing of the first medical visit, the frequency of prenatal checkup and the exams and treatments received by women. The findings allow for a rough picture of the heterogeneous conditions among women in marginalised rural areas: only 63% of all pregnant women were attended during the first trimester, a third were attended for the first time during the second trimester and 5% during the third one. Despite the fact that pregnant women received an average of 6.3 checkups during their last pregnancy, 6% had just one or two checkups while 20% were given three or fourth medical revisions. However, the majority of women (85% to 89%) stated that they have received some kind of exams and treatments during their prenatal stage (measuring blood pressure, weight control and tetanus jabs).

Once again, the inferior conditions of access to quality prenatal care prevail among women without schooling, the indigenous ones, and those with higher parity and older than 35 years old (see Table 12). Suffice it to say that when considering the proportion of women who were given prenatal care during their last pregnancy, as well as the timing of first checkup and the number of times they had checkups, a large majority of women with no schooling, indigenous women and the oldest ones and with highest parity did not receive the minimum and required attention established by the official Mexican medical standards

(75%, 67%, 65% and 61% respectively, versus 50% as average for all women)³³. Moreover, nearly a third of indigenous women and those with no schooling (30% and 35% respectively) were never weighed or had their blood pressure taken and 18% and 24% respectively were not given tetanus jabs.

Given the above findings, can we say that the prenatal needs of women in marginalised rural areas are being met? If only the total proportion of women given prenatal care is regarded (95%) the picture obtained is misleading. As shown above, the existence of unmet needs emerges when one analyses the details of the care received by women, as well as the differences in their sociodemographic characteristics.

3.6.2. Childbirth attendance

Delivery care services play undoubtedly a crucial role in the health, survival and wellbeing of mothers and their children. This has been one of the most hotly debated issues not only as regards the availability of and access to quality services, but also as regards women's self-determination and their reproductive rights, due to some of the questionable medical practices or malpractice during this stage that have been documented by researchers, particularly women's NGOs.

The process of medicalisation of childbirth attendance in Mexico has been considerable over the past three decades³⁴. However, especially in rural and marginalised areas, there are still social, economic, cultural, institutional, familial and personal barriers that lead women to have their childbirth attended outside the institutionalised medical sphere in conditions that are not always safe for either their health or that of their children. Survey data is unable to analyse this issue in depth or to provide detailed information on the specific experiences women have had during their last childbirth, but their findings illustrate some of the main obstacles that prevent women from having their deliveries attended by health institutions.

33. The Official Mexican Standards for women's care during pregnancy, childbirth, puerperium and newborn babies state that women should receive at least five prenatal checkups.

34. The proportion of births attended by a doctor rose from 55% between 1974 and 1976 to 82% between 1994 and 1997. For rural areas the corresponding percentages were 38% in 1987 and 59% in the last period (Dirección General de Planificación Familiar, 1989; CONAPO, 2001).

Total	80.3	83.3	79.4	85.8	81.0	77.2	77.5	80.3	83.9	75.0	80.9	86.0
Need for specialized care	13.3	6.7	15.4	5.0	12.8	17.7	14.4	11.9	14.6	15.1	14.0	10.5
Affiliated to a health institution	8.7	10.0	8.3	6.7	7.4	10.7	8.5	9.0	8.5	9.2	9.5	7.4
Fear or lack of confidence	3.6	2.1	4.0	1.8	2.8	5.0	3.3	3.7	3.7	3.9	2.7	4.2
Obstacles to reach the clinic	14.2	22.5	11.6	21.2	16.9	8.8	12.4	13.1	18.4	9.3	13.2	21.2
Doctor's absence	16.6	9.7	18.8	13.6	17.9	17.1	15.6	16.9	17.4	13.1	19.1	18.3
Embarrassment to be seen by a doctor	1.8	2.2	1.7	2.8	2.1	1.1	1.9	1.6	2.1	1.3	1.8	2.4
Midwives preference or custom	11.3	24.4	7.2	27.3	10.0	4.7	9.7	12.0	12.1	8.2	11.3	15.0
Partner or relative decision	1.3	1.3	1.2	0.7	2.0	1.0	3.0	0.6	0.4	2.3	0.8	0.4
Living in other locality	6.6	2.2	8.0	4.4	3.9	9.7	6.9	8.6	2.5	10.4	5.8	2.8
Other	2.9	2.2	3.2	2.3	5.2	1.4	1.8	2.9	4.2	2.2	2.7	3.8
<i>% with post-partum attendance</i>	59.0	51.9	61.2	52.5	54.5	65.6	61.6	59.4	55.2	65.1	60.6	50.1

Source: Reproductive Health Survey, IMSS-Solidaridad-CONAPO, México, 1999.

Without underestimating the efforts and achievements of Mexican health institutions in this respect, just over half of women's deliveries of their last live-born children (that took place between 1994 and 1999 in rural marginalised areas) were attended by a doctor (55%), while 36% were attended by a midwife and 4% by a paramedic. Another 3% of births were attended by a relative or friend while 2% of women gave birth alone, without any form of care or assistance. The lack of medical care during delivery is particularly acute among women without schooling and indigenous women: only 21% and 25% consulted a doctor, another 57% and 61% were attended by midwives, 8% and 9% were assisted by a relative or friend and 5% and 6% gave birth on their own (see Table 13).

What is also striking and should be underlined is the fact that despite having received prenatal care from an institutional service provider, a high proportion of women still choose and prefer a midwife to attend their deliveries. This may be due to the fact that midwives are the only available alternative: two out of every three women (66%) who received medical prenatal care had their deliveries attended by a doctor, whereas 28% resorted to midwives (see Table 14). Of the small percentage who had pregnancies supervised by a paramedic, 37% had their deliveries attended by a midwife. Conversely, the last delivery of 90% of the women who were given prenatal care by midwives was also attended by the latter, while only 5% were attended by a doctor. Of

Table 14
Comparison between prenatal and delivery attendance
according to service providers

Delivery attendance	Last pregnancy care			
	Doctor	Paramedic	Midwife	Without prenatal care
Doctor	65.8	21.5	5.2	29.8
Paramedic	3.5	26.7	1.3	0.5
Midwife	28.0	36.6	89.8	25.7
Relative, friend	2.0	15.2	0.9	21.1
Nobody	0.7		2.8	22.9
Total	100.0	100.0	100.0	100.0

Source: Reproductive Health Survey, IMSS-Solidaridad-CONAPO, México, 1999.

those who did not receive prenatal care, 30% were attended by a doctor during delivery, 26% by a midwife, 21% were helped by a friend or relative, and 23% gave birth alone.

The place where delivery takes place is also important, both because of the conditions of hygiene and because of the infrastructure available (such as human resources, equipment, instruments and drugs), which may be required in the event of complications during labour. Although 45% of the deliveries were carried out at public medical units, a similar proportion gave birth in private houses (whether it was the woman's, the midwife's or a relative's house). Likewise, despite the precarious socioeconomic conditions of women in these areas, 13% gave birth at private medical units, most of whom were non-indigenous and more highly educated women. Conversely, 71% and 76% of indigenous women and those with no schooling had their last delivery in a private house and only 28% and 21% at a public or private health institution (Table 13).

Linked to the above, and contrary to commonly-held misconceptions, it is interesting to point out that the mere availability of health services in these marginalised areas does not ensure childbirth attendance at a medical unit. In fact, despite that half of the women interviewed live in localities where at least one public clinic (belonging to the IMSS-Solidarity Program) exists, and although the remaining half have medical services through this program's agents who periodically visit their localities, and theoretically have access to a relatively close public clinic where they can be attended, only a very low proportion of women (20%) have had their last delivery at the clinic assigned to them³⁵. The vast majority (80%) were attended either in a medical unit other than the one assigned to them or in a private home.

The reasons women gave for not seeking or being attended at their local clinic are mainly of an economic and cultural nature, and largely related to the adverse conditions of the public medical services offered in marginalised settings and the obstacles women face in gaining access to them. Thus, one out of every eight women (13%) did not have their last delivery at their local clinic because of their need for obtaining specialised medical services at a unit with a larger and better medical infrastructure, either because they had a high-risk pregnancy,

35. Henceforth, the appropriate clinic (IMSS-Solidaridad clinic) is referred to as the local one.

had had complications in previous deliveries, required Caesarean sections or wanted to have their tubes tied after the delivery. Another 11% had more faith in the services provided by midwives. Moreover, 16% did not have their deliveries at their local clinic because of the lack of medical personnel at the time of delivery. An additional 14% failed to reach the clinic at the time of delivery because of the distance and lack of transport, or because they could not afford to pay for transport or had no-one to take them, while 4% did not trust the services provided by the clinic (Table 13). In short, at least 34% of the women did not have their deliveries where they were supposed to because of their distrust and lack of confidence in the services offered, the practical difficulties of getting there or the lack of personnel.

These difficulties are exacerbated among indigenous women and those without schooling: their reasons for not having their last delivery attended in the local clinic are their preference for and greater trust in midwives (24% and 27%) and the obstacles for reaching the clinic (21% and 22%). However, the lack of a doctor (17% and 19%) and, to a lesser extent, the difficulty of getting to the clinic (9% and 12%), as part of the main reasons given by non-indigenous women and those with more schooling also reveal the adverse conditions faced by women in these marginalised rural areas.

Finally, the frequency and therefore excessive number of Caesarean sections and sterilizations are other crucial aspects linked to the quality of care during delivery at the health clinics and may be regarded as an indicator of institutional poverty and malpractice³⁶. According to the medical rationale that largely prevails in Mexican health context, having had two Caesareans is one of the main reasons used by service providers to persuade women to be sterilized. Although the survey data we have analysed do not include specific questions about women's attitudes regarding these practices, findings from other surveys and mainly qualitative studies have shown that these medical practices are one of the main obstacles to having their deliveries at health institutions (Lerner *et al.*, 1994).

36. Regarding the Caesarean practices it is worth noting that although health regulations state that the percentage of deliveries involving Caesarean sections should not exceed 20%, findings from the ENINPLAF survey show that by 1996 a total of 29.4% of all deliveries carried out during the previous month had been carried out by Caesarean sections (see also footnote 13 for other estimates of Caesarean sections).

The above findings illustrate the long way Mexico still has to go to achieve safe childbirth attendance. This should not be seen only as a simple quantitative problem of shortage of health services, but primarily as a problem related to the inability to offer the type of health services required in the places where they are needed, as well as to the need to eliminate the barriers and obstacles that have prevented a significant proportion of women from gaining access to these services even though they exist.

3.7. Unmet needs in women's reproductive health diseases

Within a broad concept of reproductive health, which includes the set of processes associated with reproduction, sexuality and sexual health and goes beyond family planning and maternal and child health, another important dimension is the prevention, timely detection and treatment of certain illnesses and disorders that may compromise the general state of women's health as well as the exercise of their sexuality and reproductive capacity. Foremost among these diseases, both because of their adverse implications and their rate of incidence, are infections of the reproductive tract, sexually transmitted diseases, HIV/AIDS, as well as cervico-uterine and breast cancer, topics that, aside from HIV/AIDS, have been underresearched and for which limited data is available. In this section we therefore give a very broad picture, based mainly on the knowledge and awareness that women have of certain preventive practices related to these diseases, in order to illustrate some of women's unmet needs regarding these reproductive issues.

Infections of the reproductive tract and sexually transmitted diseases (STDs) constitute a significant health problem among women, both in themselves and because of their implications for women's health and that of their children and for achieving reproductive ideals, as well as through their potential role in facilitating the acquisition of other diseases such as certain forms of cancer and HIV-AIDS.

The incidence of vaginal discharge (VD) among women in marginalised rural areas is difficult to gauge, since it is closely linked to women's knowledge, awareness and access to information and health care services. This is a field where health care services have a major role to play, not only in its treatment but also in enabling women to recognise its presence and determine whether it is normal or poses a health risk, an aspect that has yet to be dealt with in Mexican society.

Findings in Table 15 indicate some of the adverse circumstances that women in marginalised rural areas face regarding this issue. VD incidence seems relatively high: one third of all women admit that they have had it at least once in their lives, ranging from 45% to 22% among current contraceptive users and non-users. Although most women felt it was abnormal to have VD (79% of all women), it is important to note that a considerable proportion of women who had had it over the last five years failed to seek medical attention (25%). A significant proportion of women did not seek medical attention because they thought that this was normal or unimportant (47% and 13% respectively) or because they were embarrassed or had problems in obtaining access to health services (25% and 11%). Ethnic differences show that indigenous women are less aware of having had VD than non-indigenous ones (17% and 35% respectively) and that a smaller proportion of the former sought medical attention. Conversely, more educated women, older ones and women with higher parity, who are supposedly most aware, better informed about the health risks involved, were most likely to realise that they had had vaginal discharge.

As regards STDs, the differences between indigenous and non-indigenous women and those with no schooling or higher educational attainment who have heard about them are also very meaningful (39% and 80% in the first case and 44% and 83% in the second) (see Table 16). However, having heard about STDs does not always mean that women know how to prevent them. Thus, of the women who knew about these diseases, half of them realised that condoms were a means of preventing them (58%), although only a third of indigenous women and of those with no schooling were able to identify them. Engaging in sexual relations with a single partner is the second most frequently recognised way of preventing STDs (32%), with little variation between women of different ages, levels of schooling and those who did or did not speak indigenous languages. The remaining ones did not know how to avoid them (15%) – particularly indigenous women (35%) – and cited questionable means of preventing infection, such as abstaining from sexual relations (14%) or demanding their partners' fidelity (9%).

A similar situation prevails as regards the Acquired Immune-Deficiency Syndrome (AIDS). Although it is better known than STDs (86% of women had heard about it), it is also less well-known among indigenous women and those with no schooling (52% and 60%). More striking are the findings about women's perception regarding the

Table 15
Vaginal discharges (VD)

	Total	Ethnicity		Education			Age			Parity				Contracept. status	
		Indigenous	Non-indigenous	None	Partial elementary	Complete elem. or +	15-24	25-34	35-49	zero	1-2 children	3-4 children	5 children or +	Non-users	Users
<i>% of women with VD at least once</i>	31.3	16.7	34.7	22.8	35.8	31.4	22.3	36.2	37.4	14.1	38.9	38.5	36.5	21.6	45.0
<i>% considering it is normal to have VD</i>	20.6	34.3	17.5	25.5	18.9	19.9	24.7	19.0	17.1	25.7	16.1	21.5	19.0	24.5	15.1
Have had VD	18.4	27.9	17.4	17.7	17.6	19.2	27.8	15.6	14.3	34.0	16.6	18.7	13.4	20.9	16.8
Never had it	21.6	35.6	17.6	27.9	19.7	20.3	23.8	20.9	18.8	24.3	15.7	23.2	21.2	25.5	13.7
<i>% of women with VD in the last 5 years</i>	28.3	14.4	31.5	20.0	31.0	29.5	21.3	33.9	31.2	13.2	37.0	35.3	30.5	19.5	40.7
Sought for medical attention	21.3	9.2	24.1	15.0	25.1	21.2	13.1	27.9	24.7	5.7	30.1	28.4	23.9	12.9	33.1
Did not seek for medical attention	7.0	5.2	7.4	5.0	5.9	8.3	8.2	6.0	6.4	7.5	6.9	6.9	6.5	6.5	7.6
<i>Reason given for not seeking medical attention</i>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
It is normal	47.3	44.7	47.7	21.4	43.3	54.5	51.5	41.3	46.4	60.2	41.3	44.5	39.5	49.6	44.5
It is not an important problem	12.5	16.0	12.0	14.3	14.6	11.2	7.4	16.0	17.2	3.5	23.7	16.8	8.9	11.1	14.3
Embarrassment	25.2	23.4	25.5	47.4	29.6	18.7	26.2	26.9	22.2	24.2	20.6	23.2	33.1	29.0	20.6
Problems in access to health services	11.0	2.9	12.3	16.9	5.4	12.3	10.7	11.4	11.2	5.9	14.4	13.8	11.5	4.7	18.7
Other	4.0	13.0	2.5		7.1	3.3	4.2	4.4	3.0	6.2		1.7	7.0	5.6	1.9

Source: Reproductive Health Survey, IMSS-Solidaridad-CONAPO, México, 1999.

Table 16. — Sexually transmitted diseases (STDs)

	Total	Ethnicity		Education			Age			Parity				Contracept.	
		Indigenous	Non-indigenous	None	Partial elementary	Complete elem. or +	15-24	25-34	35-49	zero	1-2 children	3-4 children	5 children or +	Non-users	Users
<i>% having heard about STDs</i>	72.7	39.1	80.2	44.0	71.9	83.0	71.5	76.7	70.0	73.9	73.2	76.6	67.2	66.5	81.3
<i>% knowing means to prevent STDs</i>															
Condom use	57.9	33.9	60.5	32.6	49.9	66.8	57.9	59.3	56.3	58.8	59.6	60.4	52.3	54.3	62.0
Pills or ovule use	0.9		1.0		0.6	1.2	1.1	0.8	0.6	1.1	0.6	1.4	0.4	0.7	1.0
Sexual relations with a single partner	31.4	28.8	31.7	30.7	30.9	31.8	29.9	32.3	32.3	29.5	32.9	30.1	33.5	30.4	32.5
Demand partner's fidelity	8.6	9.6	8.5	11.1	7.4	8.8	5.8	10.3	10.2	5.5	10.1	10.3	9.0	6.8	10.7
Abstinence	13.9	10.0	14.3	12.7	11.3	15.6	16.1	13.6	11.6	19.2	13.2	13.7	8.3	16.8	10.6
Do not know	15.1	34.9	13.0	30.1	17.6	11.0	15.1	16.2	13.9	13.6	14.7	13.9	18.6	16.5	13.6
Another way	2.6	3.3	2.5	1.9	3.0	2.5	2.3	2.0	3.6	2.2	2.4	3.0	2.9	2.6	2.6
<i>% of women having heard about AIDS</i>	86.3	51.8	94.2	59.7	87.4	94.7	86.9	85.8	86.0	87.6	89.2	86.0	82.2	81.0	93.7
<i>% knowing means of acquiring AIDS</i>															
Sexual contact	77.1	59.0	79.4	58.1	72.8	83.8	76.1	79.6	76.0	78.7	78.4	81.0	70.4	75.6	79.0
Blood transfusion	34.8	12.4	37.7	12.1	26.7	44.5	33.2	38.2	33.6	38.8	36.2	37.6	26.3	31.6	38.8
Needles or syringes	24.5	9.0	26.5	7.9	19.0	31.4	25.9	25.2	22.2	31.0	23.5	25.5	17.0	23.1	26.3
Pregnancy and breast-feeding transmission	4.7	5.1	4.6	0.7	3.5	6.2	4.7	4.8	4.6	5.3	3.8	7.1	2.4	3.9	5.6
Daily contact with an infected person	4.0	2.2	4.2	4.0	3.4	4.4	4.1	3.6	4.3	4.8	3.3	4.3	3.6	4.3	3.6
Other mean (air, public bathrooms or swimming pools, insect bites, kisses...)	3.6	1.8	4.0	1.8	4.0	3.9	2.8	3.9	4.1	3.1	2.2	5.5	3.6	2.7	4.8
Do not know	20.2	37.5	18.0	36.2	24.6	14.1	21.7	17.5	20.9	18.4	19.5	16.5	26.3	21.0	19.1

Source: Reproductive Health Survey, IMSS-Solidaridad-CONAPO, México, 1999.

means of acquiring this disease. Despite the fact that a majority of them know it can be transmitted through sexual contact (77%), a low proportion of women realise that it can also be acquired through blood transfusions, or by needles or syringes, or that it can be transmitted to children through pregnancy if the mother is infected (35%, 25% and 5% respectively). Significantly, one out of five women did not know how AIDS is acquired while others gave inaccurate answers. Again the findings show the greatest social vulnerability among indigenous women and those with no schooling, 37% of whom did not know how the disease was transmitted.

A last topic refers to cervico-uterine cancer and breast cancer, two of the main reproductive health problems in women, the former being the third leading cause of death among those aged 30 to 44 in Mexico. Although the risks of suffering from these diseases increase with age, its lethality can be reduced by timely detection and increasing awareness of their existence.

The data yielded by the survey show (Table 17) that almost half the women aged 25 and over living in marginalised rural areas have had tests to detect the existence of uterine problems (44% of all women aged 25 to 34 and 52% of those aged 35 to 49). However, sharp differences are found among non-indigenous and indigenous women and between women with higher and lower educational attainment (55% and 24% in the first case and 57% and 29% in the second one). A striking fact, which is possibly symptomatic of the scant contact that women without children have with health institutions, or the erroneous belief that not having children implies they are exempt from the risk of cervico-uterine cancer, is the low proportion of women without children that have ever had a pap smear (18%). Moreover, the situation is even worse if one analyses the figures for women who have had these tests done over the past two years: only 16% of nulliparae aged 25 or over, 21% of indigenous women and 26% of those with no schooling, as opposed to 47-49% of non-indigenous women, those with 3-4 children or those who have completed elementary school.

A similar profile is obtained for breast cancer. Over half the women aged 25 and over received information on how to examine their breasts and had performed these examinations (57% and 56%). Table 17 reflects the differences between women with different ethnic and schooling backgrounds. The main reason women gave for not examining their breasts is the lack of pain or discomfort they experience,

Table 17. — Proportion of women 25 years and over that have had pap smear and have performed breast exploration

	Total	Ethnicity		Education			Age		Parity				Contracept.	
		Indigenous	Non-indigenous	None	Partial elementary	Complete elem. or +	25-34	35-49	zero	1-2 children	3-4 children	5 children or +	Non-users	Users
<i>% have had pap smear</i>	48.0	23.7	55.1	29.4	50.5	57.3	44.4	52.2	17.5	49.6	55.0	48.1	31.2	62.7
<i>Time since the last pap smear</i>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Never done	52.0	76.3	44.9	70.6	49.5	42.7	55.6	47.8	82.5	50.4	45.0	51.9	69.0	37.6
Last year	35.0	18.6	39.9	23.3	35.8	41.8	32.6	37.9	13.7	34.3	38.7	36.9	21.1	46.7
2 years	6.0	2.0	7.2	2.7	6.5	7.5	6.3	5.8	2.0	6.1	8.9	4.5	4.8	7.0
3-4 years	3.8	1.3	4.4	1.5	4.1	4.8	3.7	3.8	0.8	7.0	4.4	2.3	2.9	4.5
5-9 years	2.0	1.8	2.1	0.6	2.6	2.3	1.6	2.5	1.0	2.2	1.9	2.3	1.7	2.4
10 years and more	1.2	0.0	1.5	1.2	1.5	0.8	0.1	2.2	0.0	0.0	1.1	2.0	0.5	1.8
<i>% have received information on how to examine breasts</i>	56.7	40.9	61.1	41.5	58.4	64.1	55.1	58.4	44.5	57.9	59.1	56.5	47.5	64.5
<i>% periodically self-examine their breasts</i>	55.7	35.5	61.2	36.3	58.1	64.8	54.3	57.1	42.1	57.1	60.0	54.1	44.8	64.9
<i>Reasons for not examining breasts</i>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Absence of pain or discomfort	55.7	46.4	60.5	51.2	55.1	62.5	56.4	55.4	55.1	59.9	54.5	55.5	51.9	61.2
Do not feel it is important	13.3	9.9	14.9	13.2	14.9	11.5	12.0	14.8	16.2	9.0	16.2	12.6	2.6	2.3
Ignorance on how to do it	11.9	13.2	11.4	10.2	14.6	10.0	12.0	11.7	8.8	15.6	14.1	9.5	12.0	11.8
Other	2.5	3.1	2.1	2.0	1.7	3.8	2.4	2.4	1.4	2.7	1.3	3.3	10.6	17.3
Do not know	16.5	27.4	11.1	23.3	13.7	12.1	17.1	15.8	18.5	12.9	13.9	19.2	22.9	7.4

Source: Reproductive Health Survey, IMSS-Solidaridad-CONAPO, México, 1999.

a reason stated by just over half of those who do not do so and, quite surprisingly, this answer was given mainly by the most highly educated, non-indigenous women and current contraceptive users. The second most frequent reason is “*they don't know*” (16%), but the way this question was phrased in the questionnaire fails to show whether the interviewee does not know how to carry out the examination or whether she does not know why she failed to do it. Finally, other reasons stated by the women are the lack of importance they confer to the exams and their ignorance about tumours and how to examine their breasts (13% and 12%).

Despite the limitations of the survey data, these findings offer relevant insights related to some of the critical issues mentioned in the first section of this text. The narrow, partial view of FPP and maternal and child programs, which until very recently focussed mainly on contraceptive use and the reproductive events most closely linked to procreation, have overshadowed other reproductive health problems, where women still have many unmet needs that are not being taken into account and therefore not satisfied.

4. Final considerations

In previous sections we have presented an exploratory yet incomplete overview of theoretical and methodological problems related to the meaning and scope of the concept of unmet needs, as well as some empirical evidence surrounding the current status of RH and unmet needs in a marginal rural context of Mexico. From the overwhelming description of facts and figures assessed, we have pointed out some of the main uncertainties, ambiguities, and gaps that have yet to be dealt with in order to respond to many of the unanswered questions posed.

Our main purpose in this article has been to illustrate some of the crucial unresolved facts related to women's unmet needs in certain aspects linked to their reproductive health, based on survey data for a rural marginalised context. The research strategy followed has allowed us to explore some of the main aspects related to the narrow and misleading theoretical, methodological and analytical frameworks commonly used to define, identify and construct the concepts, dimensions, variables and questions posed in most surveys on RH issues. Unlike classical demographic analysis, which searches for large-scale behav-

ious, we have focussed on the small but significant relative numbers that are usually disregarded. Highlighting some of the risk situations for the most socially vulnerable women has produced a more comprehensive overview of their RH and unmet needs. This analytical strategy has also yielded ways of facing and reducing public and individual barriers to the satisfaction of women's needs in this field and bridging the gap between societal, institutional and individual needs. Nevertheless, our data fails to deepen our knowledge of these needs, and the facts analysed in this paper should be viewed as elements for preventing misleading actions from being undertaken by health policies and programs, which should be redefined according to the specific circumstances of the various and heterogeneous populations.

The main results include the enormous variations in UNFC levels, depending on the criteria used to estimate them. Also, regardless of the criteria used, we have shown the persistence of sharp inequalities between different population groups, where indigenous women, those with no schooling and, in most cases, older women, tend to have the highest unmet needs.

Secondly, as regards women's reproductive goals, although the number of children women have had and wished to have is almost the same, there is a non-negligible proportion of women who are dissatisfied because of having had either more or fewer children than they wished for. This last issue is significant for women who cannot have children due to infertility causes or sterilization and it is also a problematic aspect that has largely been overlooked. The high incidence of sterilization, particularly among young women, should be seen as part of women's unmet reproductive needs and the conditions that prevent them from reproducing and limit their ability to decide whether, when and how often to do so. In addition to the above, the prevalence of high infant, child and youth mortality, abortion and Caesarean sections are still significant reproductive health problems that prevail in marginal rural contexts and are becoming exacerbated among the most vulnerable groups.

Thirdly, despite the massive implementation of FPP in the various social contexts and population groups, sharp differences remain regarding contraceptive practice, where the proportion of contraceptive users among indigenous women and those without schooling is much lower than among non-indigenous women and those that have complete elementary school. However, when analysing the method used we

found that female sterilization is the most common contraceptive method, used almost equally by both ethnic groups although far less so among women with greater educational attainment. It is worth noting the existence of this practice, albeit in a small proportion, even among young women and those with low parity.

Moreover, the evidence on women's circumstances and their choice of contraceptive methods has revealed certain critical, questionable and adverse situations in health institutional practices, illustrating women's lack of freedom and options regarding the method to be chosen. These include influence and in some cases imposition of service providers of a contraceptive method, mainly sterilization and IUDs, regardless of age and parity and even without women's consent; women's vulnerability when they are sterilized immediately after childbirth or a Caesarean section; the narrow range of safe, reversible methods available at the health clinics; the lack of and/or limited information given by doctors on the characteristics and side effects of the method adopted or regarding other existing methods. These facts reflect the contradictions between the norms established by health institutions and the rationale imposed by the FPP, which are being exacerbated in marginal and poor areas and within them in the case of indigenous women and those with no education or incomplete schooling.

Fourthly, the overview we have given of health services that women have received during pregnancy and childbirth is still extremely unpromising and inequitable. Although nowadays prenatal care seems to be a more universal practice, the minimum medical standards established by the government (number, timing and frequency of prenatal checkups), are not being fully met, again mainly among indigenous women, those without schooling and higher parity and older women. Regarding childbirth attendance, suffice it to say that just over half of women's deliveries of their last live-born children between 1994-1999 were attended by a doctor. The lack of medical care in this case is particularly acute among women without schooling and indigenous women, where no more than a quarter of them were attended by doctors, since the majority of these women had their deliveries attended by a midwife, and a small proportion gave birth on their own.

There is a striking lack of consistency between women receiving prenatal care from medical institutions and having their babies delivered by midwives, either because they prefer it or because it is the only available alternative. This fact is related to the place where delivery

takes place, since almost half of all deliveries were carried out in private homes (whether the woman's, the midwife's or a relative's) as was the case for over 70% of indigenous women and those with no schooling. The lack of medical personnel, means of transport and financial resources at the time of delivery, the distance to the clinic, the distrust and lack of confidence in the services offered by public institutions, the excessive practice of Caesarean sections and sterilization are not only the main reasons for not seeking medical service during childbirth, but also evidence of the obstacles that have prevented a significant proportion of women from gaining access to health services.

Finally, in relation to other reproductive health problems, such as the knowledge, awareness, prevention, detection and treatment of STDs, cervico-uterine and breast cancer and HIV/AIDS, the picture is even more distressing. The findings indicate, on the one hand, the critical situation of women living in marginalised rural areas, where the greatest disparities in ethnic status, educational level and generations exist. On the other hand, there is ample evidence of the insufficient role played by health care services, which, due to the narrow and partial view of health and FP programs that has prevailed until very recently, has hampered the care of these reproductive health problems. A similar situation exists in the research field, where there is a need to analyse these problems using a variety of methodological tools within a broader conceptual frame.

The results of the data analysed highlight and confirm the precarious conditions and unsatisfied needs as well as the enormous disparities and inequalities between the various population groups regarding their reproductive health. Although these findings are hardly surprising since these women comprise population groups living in extremely poor, marginal and less developed rural contexts, it is worth noting the existence, within these contexts, of groups that are even more excluded and marginalised than others from the benefits of social and public policies, particularly from population and health interventions. This is the case of women who live in social, cultural and institutional contexts where they have had fewer opportunities of access to education, and have experienced the greatest gender and power inequity relations. These women live in contexts of weak FPP where programs are implemented with a political and medical rationale, without taking into account the specific economic, social and cultural conditions and needs of the various population groups.

Despite the massive expansion of health services, the success and achievements of FPP, their reorientation according to the RH paradigm and the interventions focussed on the most marginal areas in Mexico, many unequal RH conditions prevail. Also, although some RH components that were absent from FPP have recently received more attention from service providers, their interventions are still insufficient and in some cases critical, making them one of the most urgent challenges to be addressed by health institutions. These include the prevention and attendance of abortions, STDs, cervical and breast cancer, and symptoms related to menopause and climaterium, which will be exacerbated due to the ageing population and the growing number of adolescents and youth.

Other related problems on the institutional side are linked to the persistence of the hegemonic medical/institutional rationale that continues to overlook the cultural dimensions that influence RH behaviour, impose contraceptive methods that impede or restrict the performance of individuals' free and informed choice, and maintain the high frequency of Caesarean sections and sterilization practices. This not only jeopardises women's rights and health, but also contributes to the population's fears, distrust and lack of motivations to seek quality health services.

Likewise, although the gender perspective, adolescent and men's reproductive health problems have been included at the theoretical and rhetorical level, their adequate incorporation into medical services and practices is largely absent. This therefore constitutes a key aspect in responding to the specific needs and demands of women, men, adolescents and other specific population groups.

The reflections as well as the facts and figures described in this text are extremely thought-provoking in that they highlight needs and uncertainties in some critical RH aspects, pose challenges and suggest paths to follow. They point out the limitations derived from simplistic and conventional conceptual schemes and methodological approaches, as well as analytical strategies that are unable to deal with such a complex, dynamic, multidimensional problem. The potential of the reproductive health approach for achieving a better understanding and above all for policy purposes, in order to respond to "RH needs of individuals and of society as a whole" is still an urgent task that must be undertaken in the near future.

In the academic realm, research is required that will combine quantitative and qualitative methodologies to achieve a better understanding of the processes and social relations that influence sexual and reproductive behaviour. This implies the development of conceptual frameworks to be incorporated into the diverse methodologies and instruments for gathering information, which should include the following aspects: a) the specific economic, social, political, cultural and institutional circumstances in which human lives are “situated” and in which they elapsed, circumstances that largely influence and determine the options, limits and diverse responses to individuals’ actions; b) the spheres and social actors of influence that intervene in the reproductive and sexual life of the population (such as the family, health, education, legislative and religious institutions, NGOs, etc.); and c) the clear identification and definition of the main analytical categories and dimensions that influence the RH processes (social and gender inequalities, power relations, decision-making processes, etc.). In particular, in the design of surveys, better-designed questions, categories of responses and indicators are required for the accurate recording of the needs, preferences, intentions, experiences and practices defined by the individuals themselves, in order to avoid assuming and defining them a priori according to certain objectives and interests which reflect social, moral and political normative constructions. To this end, preference should be given to the voices of the different social actors that interact with each other. This priority strategy involves giving the necessary resources to academia to assume responsibility for data collection in order to prevent information gaps due to questions regarded as politically incorrect and misleading or focussing exclusively on certain themes, to suit particular political interests. The involvement of an interdisciplinary team and interaction with the authorities in charge of defining and implementing public policies and specific programmes is also essential.

As for the link between reproductive health and poverty, we should begin by dealing with the latter in a broad, multidimensional way; in other words, not restricting the analysis to material needs, such as housing, education and health, which, although fundamental, are only part of the picture. Research efforts require the development of concepts and indicators to learn about institutional, cultural and social poverty conditions that generate and express basic needs and unmet needs related to the quality of life of individuals and society. Special

emphasis must be placed on new and contemporary forms of vulnerability and social exclusion associated with the reorganization and restructuring of the economy at the global and local level. Regarding reproductive health needs, the challenges mainly lie in incorporating and relating the neglected or marginalised set of sexual and reproductive issues, which are closely interrelated, by referring them to all the population groups and not only to those in their reproductive life cycle, including as well the various aspects related to access and quality of care.

The knowledge derived from these research lines will also be extremely useful in defining and implementing more comprehensive and high quality RH programs. Many FPP failed to fulfil expectations largely because they refused to listen to women users' complaints about the unpleasant symptoms or negative effects of contraceptive methods or medical practices or to pay attention to the barriers faced by women in their access to quality health services. The lack of safe, appropriate health services for dealing with the high rates of abortion and the high frequency of Caesarean sections and sterilization not only calls for further research, but also for a solid, scientific debate on the moral, social and political interests, motivations and forces that guide the medical and health institutional rationale, as well as the actions and strategies to be implemented to modify them. In this respect, another critical aspect related to the sphere of public interventions has been the implementation of homogenous, indiscriminate programs and actions without adapting them to specific economic, social, cultural and institutional situations and contexts and according to the specific needs of the various population groups.

It is in the political sphere of interventions and actions that tensions, uncertainties and critical situations are most keenly felt. These must be identified and carefully analysed if they are to reduce the poverty gap, respect sexual and reproductive rights, reduce social and gender inequalities, respond to individuals' needs and improve the population's reproductive health and living conditions. The reduction of the role of the State and its resources in social programs, especially those related to reproductive health, as a result of structural adjustment programs, the imposition of market forces and globalising health reforms and the growing influence of fundamentalist and conservative positions are serious threats that hinder the achievement of individuals' sexual and reproductive rights. Individuals' right to control their bodies, their self-determination and empowerment in crucial aspects of

their sexual and reproductive lives, should also be considered as circumstances not exempt from tension that increase the vulnerability of large groups of the population.

From our point of view, sociodemographic research and the analytical instruments of demography can help identify the population groups subjected to exclusion, segregation, vulnerability and risky behaviours. Its results can also describe the conditions of precariousness and the mechanisms of discrimination and coercion by various social institutions and their agents in relation to interventions in the field of reproductive health. Above all, the incorporation of elements from the conceptual frameworks of other social sciences and maintaining a critical, responsible attitude are crucial not only for a better understanding of the population's RH needs. They are and should also be viewed as indispensable inputs to be included in the design and implementation of population and health policies.

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