

The Roles of Mothers and Fathers in Health Care: Social Representations and Healing Practices in Paraíso del Grijalva, Chiapas, Mexico

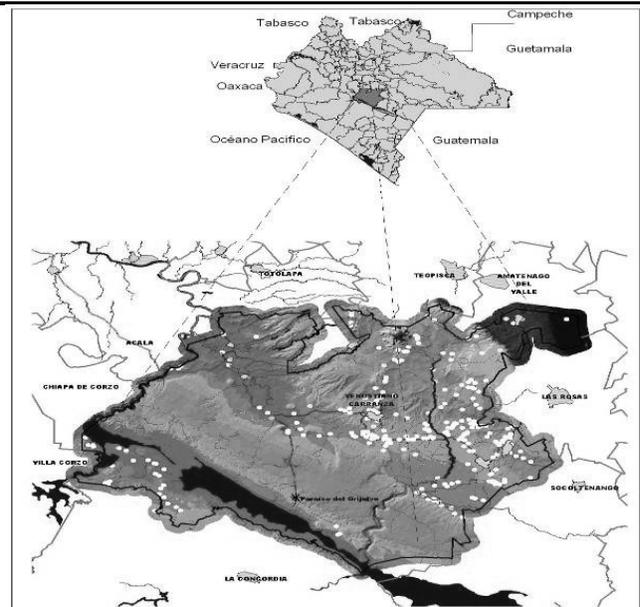
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Introduction

The fact that fathers play a minimal—or even non-existent—role in the processes of health and disease care has been observed in multiple studies (Browner, 1989; Dean, 1986; Litman, 1979, in Osorio 2001). Mothers typically are the first people to diagnose and triage primary health problems in the family, particularly for the youngest children. (Osorio, 2001). Across social sectors, the father/husband is either absent or has limited participation in health care of the family; often due to the division of labor within the family (Menéndez, 1993:139). However, there has been no research that examines the degree to which these social roles are inflexible; or if nuances exist based on the diverse contexts in which health and illness occur.

This study was conducted in Paraíso del Grijalva, a community located in the Venustiano Carranza municipality, in the State of Chiapas, Mexico. According to official statistics, Venustiano Carranza has a total population of 49,675. 10,355 inhabitants speak an indigenous language, most commonly Tzotzil ($n = 6558$ or 63.3%) (INEGI II, Coteo 2005).

We conducted interviews with seventy-five mothers and fathers about the causes of health and disease, symptoms, health care seeking behavior, and the health care they received. In several cases we recorded the family's social representations, perceptions and healing practices. Both qualitative and quantitative information was obtained. This data was supplemented by drawings done by six



Geographical location of Pariso del Grijalva
Source: Laboratorio de Análisis de Información Geográfica y Estadística, ECOSUR, 2009

children aged between 3 and 12 years, whose parents had been interviewed in depth. We chose younger children of both sexes because of their age, the time they spent with their parents, and their daily activities which nurtured the formation of close social bonds. The investigators' familiarity with the young children in the study fostered trust and promoted natural responses from them.

Setting

The community of Paraíso del Grijalva has a population of 1,930 (975 men)(INEGI, 2010). The prevailing climate in the region is warm and sub-humid with a summer rainy season. The hottest months are March and April; the rainiest are May to September. October to May is a dry season, with the humid season from June to September (Molina 1976). Paraiso del Grijalva is just 21 km from the municipal capital of Venustiano Carranza. However, the main road to Venustiano Carranza, the Tuxtla-Angostura-Comitán highway, is in very poor condition

The community has a kindergarten, a primary school, and a "Tele" secondary school. There is a

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Figure 1: Children in Paraiso del Grijalva wearing carnival masks;

Source: Field work, María Eugenia Balderas (2009)

Catholic church in addition to an evangelical group, the *Ministerio Internacional Vida Nueva, Jesús Paraiso de Dios*.

Material conditions in Paraiso del Grijalva

Paraiso del Grijalva has 194 inhabited dwellings supplied with electricity, running water and drainage. The water supply tends to be very irregular, requiring the inhabitants to fetch water from the river in order to satisfy their needs. The piped or river water is only used for domestic tasks such as cleaning, and drinking water is either boiled or purchased in bottles. Inorganic waste is burned in the open air or thrown into common areas while organic waste is used on family vegetable plots as natural fertilizer, or for feeding backyard animals such as dogs and pigs. These living conditions favor the proliferation of respiratory and gastro-intestinal infections.

Inhabitants earn their living by farming, mostly growing maize and beans. Salaried workers are overwhelmingly male. Women tend to the home; they prepare the food and care for the children. Some work with a waist loom, weaving cloth which is sold as canvas or made into clothes and bags. The money these mothers earn is put towards home expenses, usually the purchase of food and education. Families combine farming with activities such as fishing, caring for livestock and keeping backyard animals such as pigs, chickens and turkeys. According to the INEGI (National Institute of Statistics and Geography), in 2000 Venustiano Carranza municipality was classified as being of average marginalization.

Many young men between the ages of 16 and 32 migrate to the United States (personal communication by a 21-year-old male). Their experiences are quite varied. Some go back and forth, between the US and Mexico, several times a year; others emigrate for periods as long as four years. Men also emigrate to other parts of Mexico in search of

work. Tourist destinations in the State of Quintana Roo provide a source of jobs in areas such as Playa del Carmen and Cancún. They stay for six months working in the construction industry, restaurants and hotels requiring unqualified casual workers.¹

The community has a health unit run by the Chiapas State Health Department, in which the national health insurance scheme (*Seguro Popular*) and the Opportunities Program are offered.²

Materials and methods

We began with the assumption that people in their daily lives fulfill social roles but also have their own perceptions of what they experience. These perceptions can be objective or subjective.³ Objective elements include the economic, material, and social conditions experienced by the families which are *elements derived from the structure in which the actor carries on the activities of their lives*. These are objective factors or material conditions since they are external to the individual and beyond his or her control. Subjective factors are based on group aspirations, expectations, and values. The images, ideas, and beliefs which people develop regarding their lives—in this instance their thoughts about health, disease and healthcare—are considered subjective. They are defined as social representations, “... *ideas which are used consciously or unconsciously in daily life. They are the way in which a reality is seen, understood, interpreted or conceived; they are not causal nor are they isolated ...*” (Yáñez, 1998:33). Denise Jodelet (2000) maintains that social representations are a set of images, meanings or systems of reference that help explain certain social phenomena.

¹ In the state of Chiapas, net migratory flows are negative (-1.42%). For the period 1990-2000, 1.40% of Chiapas’ total population were immigrants from other states, while 2.82% emigrated from the State. There are no migration data at municipal level in the 2000 census (XII Censo General de Población y Vivienda 2000, INEGI), let alone at community level (at the time of writing).

² The Opportunities Program was designed to increase capacities and offer alternatives in order to improve levels of well-being, socio-economic conditions and the population’s quality of life. It provides support for health, education, nutrition and income, and linkages with new development programs and services (SEDESOL, 2010).

³ The concept of perception allows us to identify the values and meanings people give to their life experiences. It does not imply that their perceptions lacks a social character. We focus on the concept of perception because we are interested in recording and analyzing the subjective aspects of illness causation, as well as people’s experiences when seeking and receiving health care.

Thus, by perception we mean a human behavior which attributes qualitative characteristics to objects or circumstances in the environment based on experience. These characteristics are determined by specific cultural and ideological systems constructed and reconstructed by the group (Vargas, 1998)

For the purposes of this study, we adapted Osorio's conceptualization (Osorio 2001) and defined social representations as the set of ideas, knowledge, beliefs, attitudes, and opinions by means of which people experience and comprehend illness, as well as make decisions and carry out acts with specific health consequences for the family members. We were interested in knowing 1) how mothers and fathers in Paraíso del Grijalva interpret, give meaning to and define illness, 2) what were the beliefs, meanings and interpretations they used when seeking health care and 3) whether these subjective and objective references determine the role they play in the HDC process.

Fieldwork was carried out between January and October 2009 and consisted of 75 short interviews with both men and women.⁴ Most of the fathers interviewed were between 25 and 29 years old. Mothers' ages ranged from 20 to 24 years. Forty-seven percent (32/75) of those interviewed had completed primary school; thirty-six percent (27/75) had no primary school because they had to work from a young age. Only 6.7% finished secondary school; 4% began secondary school but did not finish. Six percent had no schooling at all. According to official statistics, the average number of live births among 15-to 49-year old women is 2.23 (INEGI II. Chiapas, 2005).

Mothers and fathers were interviewed independently; couples were not usually interviewed. The interviewees came from different homes chosen at random from the community. We were interested in collecting data from a variety of homes throughout the village, without focusing on a particular area or sector. The questions focused on the understanding of health, sickness, their causes, their symptoms and what people do when faced with ill health. Questions were about how women saw their husbands' illnesses and visa versa. The narratives we collected highlighted the interactions between spouses and the differences, conflicts and inequalities between them, their family, and the community.⁵

On our first field outing, we noticed that it was common for men to emigrate outside the community in order to find work. This raises the question of what proportion of men emigrate in search of work,

⁴ We interviewed 41 mothers and 34 fathers, after which we stopped interviewing because we had reached theoretical saturation and the data obtained by that point was sufficient to satisfy with the aims of the study.

⁵ The development of textual interpretation has suggested that the experience of being ill can be expressed in a meaningful way through narratives. Narrative is not only a research tool, but also plays a therapeutic role. Narrative allows us to understand how patient and healer construct their knowledge and how the experience of being ill interacts with a culture's symbolic forms and strategies of care for the sick. Through narrative the recounted experience, in addition to presenting the events in a significant, coherent order for the individual, describes experiences associated with those events and the explores the meaning they have for all those involved. (Cortés, 1997).



Figure 2: Cleaning cooking utensils. Source: Field work, María Eugenia Balderas (2009)

and whether and how this affects the way in which their families experience and respond to illness. Consequently, as we analyzed men's role in the HDC process, we classified families by level of income, and whether a male was present in the home. The majority of families were of low socioeconomic status; Forty-five (60%) earned less than the minimum wage. We found that in general, fathers spent more time living in the village than away from home.

The gender-based division of labor, the appropriate domestic roles, and male and female stereotypes were prevalent and continually reinforced in the social environment. They are found in the home, school, work, church, public spaces, transport, etc. The various institutions which make up the social environment each contribute to the normalization of different gender roles. (Ramírez, 2002) However, paternal and maternal roles in the home can differ from the norms and are not always what would be expected. Women, for example, earn income through handicrafts, thus contributing monetarily to the family and the survival of family members. Men take care of their children and look for alternative and better forms of healthcare. However, while domestic roles generate differences and inequalities, there is acceptance that variations from the norms can be positive for the family. (Hernández, 2009)

Mothers fulfill the traditional domestic roles; they care for the young children and maintain the

Gender	House-wife	House-wife and crafts-woman	Farmer	Student	Driver	Migrant*	Tailor	Total
Female	27	13	0	1	0	0	0	41
	36.0%	17.3%	0%	1.3%	0%	0%	0%	54.7%
Male	0	0	30	1	1	1	1	34
	.0%	0%	40.0%	1.3%	1.3%	1.3%	1.3%	45.3%
Total	27	13	30	2	1	1	1	75
	36.0%	17.3%	40.0%	2.7%	1.3%	1.3%	1.3%	100.0%

Economic activities of interviewees; Source: Fieldwork, María Eugenia Balderas Correa, 2009. * Note: This was a 34-year-old male who migrated to the US in March 2006. Now living in New York he is in touch with his family at least three times a week (they have their own telephone line) and sends cash remittances every month. He has not returned to Mexico since migrating and has no plans to do so. He agreed to a telephone interview because his wife and children talked to him a lot about me and he wanted to ‘meet’ me.

household. Consequently, they stay at home. Fathers are the main economic providers. They are the ones who must find a job that will pay enough to support the family, and assume public rather than domestic functions. There is an expectation for men to engage in physically demanding work and to stay healthy.⁶ Representations and ideas about what should be—about the proper roles played by men and by women—create individual, family and social pressures to conform. The resultant gender differences and unequal relationships are seen in the representations regarding health and disease among mothers and fathers

Parents suffer from primary health problems (i.e. those of mild severity) which include conditions such as headache, stomach ache, fever, vomiting or diarrhea.⁷ These can incapacitate people and cause pain and depression. When describing such problems both genders generally narrate what they experience and feel:

When I'm sick I feel very sad, I don't feel like doing anything. I can't even eat properly, let alone rest (28-year-old female).

Being bored because I can't get on with things (32-year-old female).

Getting sick is tough, not because of the physical

⁶ Luis Bonino (2000) draws on Brannon and David's (1976) 'four norms of masculinity.' These norms were identified on the basis of common phrases which described various beliefs/ideals/mandates about 'being masculine.'

⁷ Suffering is the subjective experience of symptoms and illness, i.e., the way a sick person expresses and experiences a problem and the way they react to symptoms and limitations which arise following any health problem or event. Culturally dependent syndromes are morbid complexes which are perceived, classified and treated according to cultural codes specific to each group and by which people resort to symbolic procedures to help the sick person recover (Zolla et al., 1988:31)

symptoms, but because of the worry, since you need money to get better (27-year-old female).

The social representation of ill health is linked to the concepts of *sadness, boredom* and *worry*. Women express their health problems in terms of *not fulfilling their duty as wives or mothers*. For example, if they are sick, their children will not have food to eat or clean clothes for school; they won't be able to care for their husband when he returns exhausted from working in the fields.

When asked about what it means to be healthy mothers and fathers speak of "*having the energy to work,*" and "*having the strength to complete their tasks.*" These concepts refer to being in the optimal condition to perform of their designated roles and accomplish daily activities.

Being in good health means having the will to work. Working in the fields is hard labor. I have to be healthy in order to do it so I can bring home food (29-year-old male).

When I'm not sick I have the strength to complete all my tasks without any stress in my daily activities. I have my children and I need to look out for them. This means that I must be active and work (36-year-old craftswoman).

Women spoke of health in terms of *physical and mental well-being*. Men used terms related to *not having any financial worries* and *being able to do their work*.

I can't say I'm in excellent health; I often don't eat properly because I'm working. But I have no complaints. There are others who are worse off. At least I can work and bring money home so my children can eat (36-year-old male).

A similar difference is observed in the representation of illness. Mothers understand states of

health in medical terms. As we shall see below, this is consistent with their needs.

Many people drink un-boiled water, don't wash their hands before preparing food, or—even worse—don't clean their homes, leaving their bathroom filthy (28-year-old female).

The men, most of whom were farmers, use concepts related to the optimum performance of their tasks. Illness implies a high social cost (inability to fulfill their domestic role as providers) and financial losses (medical care expenditures). To be healthy, above all, is to avoid these financial problems or worries.

Causes of illness in spouses, children and the elderly: The viewpoint of “the other”

Our interviews with mothers, fathers, and children allowed us to examine gender differences in social representations of disease etiology in those closest to them (children, spouses and elderly parents). These differences spring from contradictory representations about health and disease and the social pressures to fulfill (or not fulfill) domestic roles. These results were particularly interesting because the questions were asked so as to neither over-estimate the role of the father as the “agent” in the family⁸ nor to underestimate the mothers as merely the passive receptor of their spouse’s decisions.

Women, in their partners’ opinion, become ill through *carelessness* in looking after their bodies or their children:

Worries about children, exhaustion and getting upset with us can make women get sick (40-year-old male).

Meanwhile, the women believe their husbands suffer a wider range of illnesses which the men do not mention:

They get sick because they're always sloshed and womanizing and not taking care, they can get AIDS, then at home they infect their wives (27-year-old female).

We get sick as a result of getting angry with our husbands, of being mistreated. We get colic and become angry because we are upset by their drinking. Sometimes we can be in labor for four days and the men are dead drunk the entire time (37-year-old female).



Figure 3: Preparing food. Source: Field work, María Eugenia Balderas (2009)

Drink and drugs are a purely male illness, and the worst thing is that there is no cure. It wrecks their nervous system and makes them aggressive and they don't work (35-year-old female).

Without the experience of working outside the home, women seemed unaware of certain risks experienced by their husbands. For example, in reply to the question *What is the cause of your husband's illnesses?*, it was particularly noticeable that accidents were not mentioned—or even hinted at—by the women. Men, on the other hand, do mention or employ the concept of ‘accidents’ as causes of illnesses. This indicates the existence of a significant life experience among fathers which was available only to them.⁹

Yet not all health problems are represented only by those who suffer them; this is particularly when those problems expose or contradict stereotypes or accepted social roles. Men, for example, seem to

⁸ Even in gender studies on domestic and intra-family violence, it is proposed that any research on the subject must necessarily include males without considering them *per se* as perpetrators of aggression or physical and emotional violence against women. The suggestion is that this reflection should take place in an interactive manner, rather than being a dichotomy with one the active agent and the other the passive agent (Ramírez, 2002).

⁹ Methodologically, the inclusion of males in any study on the HDC process in the home is essential. Their life experiences and perceptions are determined by their own needs and aspirations. This is the basis on which they make decisions and seek to understand, explain, and act on health and sickness within a family. Sharing a home does not guarantee being able to decipher what happens within each family member, but it brings people closer. Living together generates perceptions and individual behaviors derived from social interaction. However, there are other perceptions which, while also originating in family interaction, can only be ascertained by the involved individual.

suffer ill health as a result of drinking, drug abuse, and extramarital sex. However, it is not they but rather their wives who describe men's health problems with statements such as: "gets sick because he's always sloshed", "drowning in alcohol", "because of their womanizing."

Why are these health problems not expressed by men? Perhaps the difficulty lies in family and social¹⁰ stigma,¹¹ in the fear of undermining a stereotype (Ramírez, 2002), of rejection and punishment by the family (there is clearly family rejection, since it is the wives who report this behavior)¹² or, most likely, in family and social pressures which are felt when the assigned domestic roles are not fulfilled. As we will describe below, when assessing their wives' representations of the health of their children and elderly relatives, fathers' opinions appear to question the *female domestic role* as well as children's representations about their health.

Children and ill health arising from 'carelessness': the fathers' perception

When fathers were asked about their children's health problems, their answers referred to *carelessness*:

Children get coughs, fever, and stomach aches because their mothers don't take good care of them. If, as their father, one doesn't keep an eye on them, it's very easy for the little ones to get sick (27-year-old male).

It is impossible to keep track of children. Fathers find it difficult to be chasing after them all day, particularly if they work, so they can end up getting wet, falling down or eating something which can make them ill (29-year-old male).

Children become ill with coughs, fevers, stomach ache. This happens to them because their mothers don't look after them properly (27-year-old male).

However, concepts such as *infections, diarrhea, vomiting and poor nutrition* were common in the representations of mothers:

¹⁰. Stigma is severe social disapproval of personal characteristics or beliefs which go against cultural norms. Social stigma frequently leads to marginalization.

¹¹. We feel that, regardless of the results, women's perceptions of their partners are equally vital in any analysis of HDC processes in families.

¹². It is, perhaps true, that as women become more active in the public sphere (selling handcrafts) and their partners are always out at work, they have a heavy workload both inside and outside the home. But this also enables a growing awareness of their self-sufficiency in terms of looking after their home and their children. This fact affects their social insertion and usual roles (Bringiotti 2005). It also impacts on their male partners' roles, resulting in a devaluation of tasks, attitudes or ideas.



Figure 4: Preparing for the Baptismal Feast, an annual community-wide event.

Source: Field work, María Eugenia Balderas (2009)

Children are always putting things in their mouths, they don't notice whether they're clean or dirty and that causes infections (25-year-old female).

Poor health can start during pregnancy, especially if the mother doesn't eat properly (36-year-old female).

Other recurrent concepts—though less common—were the *lack of vaccinations* and *dust*:

Children get sick from the dust, this causes problems in their small lungs and gives them flu and coughs (32-year-old female).

Before, fathers used to hide their children. My father would hide us so that they wouldn't vaccinate us because he said we cried a lot, but my mother would take us to be vaccinated (31-year-old female).

The use of explanatory concepts such as *infections, diarrhea, vomiting, poor nutrition, lack of vaccination and dust* indicates some influence by the health sector on mothers' representations. Mothers tend to favor the medical/allopathic approach. Fathers, however, see things differently and often resorting to concepts such as 'carelessness' to explain their children's illnesses. According to



Figure 4: Children's drawings.
Source: Field work, María Eugenia Balderas (2009)

their assigned social roles and prevailing stereotypes, mothers are *par excellence* the ones who care for children. The mention of "carelessness" as a cause of children's ill health would appear to signal out *maternal non-observance of a social norm* with which they do not totally identify (Montoya and Harold, 2009).

When children were asked to represent their own health problems, their depictions of health and illness referred to this *carelessness* and problems we identified in the opinions of some fathers.

We asked the six children interviewed (two girls and four boys aged between 3 and 12 years) to draw sick and healthy children. They explained their drawings as follows:

The girl got sick because she was playing with earth... she didn't wash her hands and went to eat like that (7-year-old girl).

The girl got sick because she was playing with water, afterwards she didn't change her clothes... this gave her a bad cough, she didn't look after herself and died (10-year-old girl).

The boy got diarrhea and got sick (3-year-old boy).

The boy got a fever and headache (6-year-old boy).

The boy was playing all afternoon in the rain, he didn't take his shoes off... he got a cough and flu (10-year-old boy).

The boy was playing out in the sun for a long time, he didn't have his T-shirt on, nor did he drink any water... he got a high fever and his skin got burned (12-year-old boy).

It was most revealing to find that children used the idea of *carelessness* to explain their illnesses and health problems. This was further confirmed by

certain practices the children highlighted for us.

If children are a vulnerable group, requiring care for their best possible development, what happens to the elderly? In the opinion of the mothers interviewed the causes of their health problems are related to concepts such as *age, poor nutrition and lack of defenses*

Rheumatism happens to people as they age, their bones get very painful. The worst is that once you get it, you can't get rid of it, you're prone to it for the rest of your life. It's painful and annoying. Here in Paraíso we use some home remedies, such as finely crushed garlic which you leave in alcohol for a few days. Then you rub the rheumatism with that alcohol. Dry tobacco will also do. This wretched rheumatism happens when you don't look after yourself. Often your body is hot and you bathe in cold water, or take your shoes off and step on the cold floor, barefoot. 'Pomada del Viejito' ointment is also good for rheumatic pain, as is putting eucalyptus leaves in the bath. I've also been told there are injections, but I don't know much about that (35-year-old female).

Significantly, fathers used the concept of *mistreatment* as the cause of health problems in the elderly.

Sometimes the old men are left alone for long periods, we go out into the fields and the women go about their business. There's an old man whose wife has died, he's alone, all his children are married. Sometimes they take him food, but there are days I don't see anybody go to see him (23-year-old male).

The old men get sick because their families don't take care of them. If they took them to the doctor, they wouldn't become ill (29-year-old male).

They come down with flu, cancer, lung problems and arthritis. They can become ill because of mistreatment by their families, not eating properly and poor hygiene. Old men wouldn't get sick if their families took them to see the specialist, that's how people get cured (27-year-old male).

Children and the elderly are two groups needing care, support, and constant supervision. Caring for them is demanding.

Women, on the other hand, mention *carelessness* less often. It is likely that by avoiding the use of concepts such as *carelessness and mistreatment* with respect to children and the elderly expresses a desire not to expose any non-fulfillment of their assigned 'duties.'

Health practices: Biomedical discourse and the need to see to their children's health problems

immediately and at low cost

The health concepts and ideas used by mothers suggest a significant acceptance of the biomedical recommendations promoted via the health sector. In fact, adults of both genders mention going initially to the physician at their local health center (43.4%), or a private physician at the municipal capital (40.0%), particularly for cases of serious illness.

When I feel ill, I go to the doctor, she checks me out and gives me medication. Sometimes she gets annoyed but sometimes it's our fault because we don't do as she says (32-year-old female).

Once, a few years ago, I got dengue fever. My temperature was really high and I felt unbearable pain in my joints and muscles. I was taken to the doctor and she gave me medication and sent me home to rest (37-year-old male).

When asked about the causes or reasons for seeking local or municipal allopathic medical care, interviewees regularly use ideas such as “because of the care I receive,” “because of my Opportunities Program appointment”:

We have to go when we have an appointment, or they record it as a missed appointment. We also have to get there early, otherwise the doctor records it as a late arrival. Missed or late appointments mean they discount money from our social security. Sometimes we also have to go and clean the health center and do housework at the school (35-year-old female).

The use of local or municipal allopathic care is common and goes hand-in-hand with concerns about caring for the health of children and fulfilling daily tasks and social roles. It is mothers who have to go to the health center to receive the grants for their minor children (Opportunities Program). They go for medical check-ups and developmental assessments. They follow recommendations so that they can receive financial aid: “I go to the health center because of the Opportunities appointment for my children.” This situation creates a close link between the health sector and mothers. However, the link is not without its problems. Some men and women did not using the clinics explaining: “No, I never go. There is no medication and the care offered us is poor.”

A recurring theme among both mothers and fathers was that: “I only go to see the private physician if my children become seriously ill, as it costs a lot.”

We always try first with something at home, an infusion or herb, depending on what we have. If it doesn't work, then we go to Carranza to see the doctor (25-year-old female).

Other women replied that they go to see municipi-

pal medical staff because the medication is bad at their local health center:

Sometimes they give the wrong medication, they're ineffective. Often they don't examine us properly, as though they don't want to touch us. That's why people don't trust them (27-year-old female).

The expression “medication is bad” suggested that participants go to the doctor with an expectation that medication will offer an immediate and effective cure for certain conditions. It raises the question of the extent to which medication forms part of the care sought from physicians, and to what extent it is an aspect of self-care?¹³ When specifically asked about the use of medication without going to the doctor, the majority (64%) reported they did not do this. However, mothers in particular (23%) mention often using aspirin, Neo-Melubrina and VapoRub.¹⁴ Fathers tend not to use terms referring to medication.

I use Naproxen for inflammations and Ambroxol for coughs (36-year-old female).

I have high blood pressure. When I lived in the US I received medical care and took my medication, but since I returned to Chiapas I don't, I can't afford to (26-year-old male).

Fathers conceptualize problems with the health care system as related to patient mistreatment and negligence.

I've heard of doctors who leave tools in one's belly... or they stitch it up badly and cause infections. People can die as a result (47-year-old male).

I'd almost rather not go to the doctor. They're very rude, sometimes they don't even examine us before they send us away to buy really expensive medication (32-year-old male).

Very often they don't even know what's wrong with you, sometimes they only guess. There's too

¹³ Self-care implies connotes a series of activities aimed directly or indirectly at biological and social reproduction within the family group. These activities, as far as health/disease processes go, integrate nutrition, hygiene, curing and preventing disease. For the purposes of this investigation, self-care includes diagnosis, selection and prescription of a treatment and its administration. This can include physical actions, mental procedures, patented medication, use of home remedies, etc.

¹⁴ Montoya and Harold (2009) mention that, in general, women consume three to four times more painkillers and tranquilizers than men, and often self-medicate, trying to alleviate everyday discomfort. Moreover, medicalization at the end of the 19th century in the Western world implied, on the one hand, greater access to medical services and, on the other, the influence of rules of hygiene in all spheres of life and death, whether in sexuality, nutrition and leisure, school and work, or in dreams, beliefs and desires.

much negligence, but what can we do? (25 -year-old male).

Doctors seem to work sloppily, they're totally uninterested and we're the ones who pay the consequences (29-year-old male).

They don't treat people properly, they're incompetent and difficult, some are abusive and they want to charge us more because we're natives (37-year-old female).

Mothers tend to be more accepting of biomedical care and treatments. Men, on the other hand, consider medical care expensive and associate it with negligence and mistreatment.

The use of traditional medical resources, the presence of non-Catholic churches and the low healing efficacy of biomedicine

Since the inhabitants of Paraíso see allopathic medical care as a useful but somewhat problematic resource, we wanted to assess their representations concerning traditional medical care and practices.¹⁵ The existence of local healers suggested that there was a certain demand or, at the very least, recognition of their role. We asked parents: *Have you ever consulted a healer?* The majority (52%) replied that they had not, although many (43%) reported they had seen a healer at some time. Male farmers were more likely to have seen a healer.

When my children were babies I thought they cried too much, nothing would pacify them. When this happened we'd take them to the healer, who would tell us they'd been given the evil eye. It hasn't happened with this new baby because we are preventing it by putting a deer's eye charm on his hand (39-year-old farmer).

Our results don't allow a precise estimate of how frequently healers are consulted and by what percentage of the village. However, these findings clearly signal that healers are valued and utilized.

The presence in Paraiso del Grijalva of evangelical churches and the Jehovah's Witnesses likely influenced the responses and opinions we obtained about the use of traditional medicine. Many of these churches forbid the use of or belief in traditional practitioners. The majority of our interviewees who recognized and valued the work of healers were Catholics. Parents from evangelical churches admit to having used traditional medicine at some point, but only before conversion to their new religion.

Final reflections

We found significant cultural differences between mothers and fathers in their perception and

¹⁵. There are four traditional healers in the community who are recognized by the inhabitants: a midwife, a *sobandera* (a traditional healer who works with massage and manipulation, in this case female) and two herbalists.

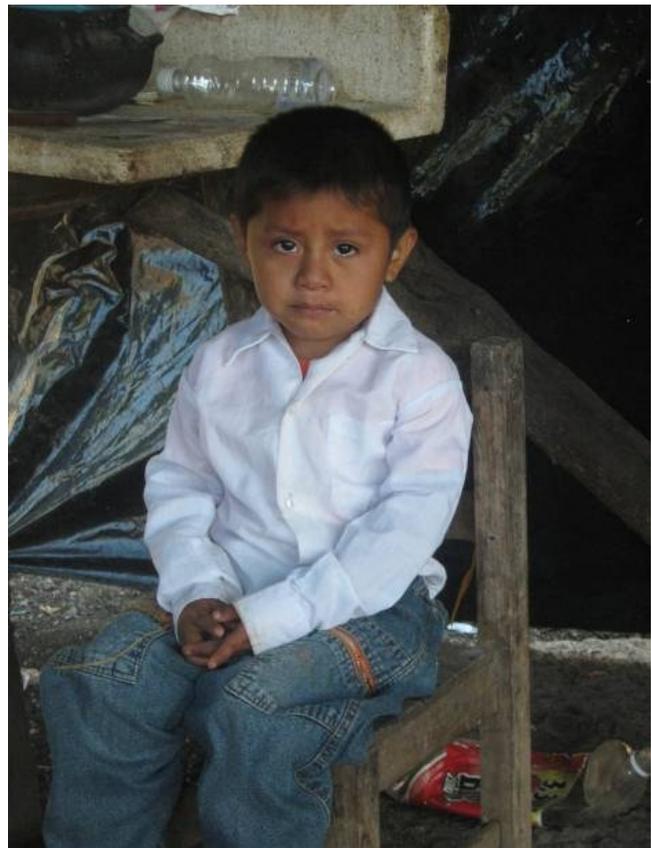


Figure 5: The Experience of Suffering
Source: Field work, María Eugenia Balderas (2009)

understanding of health and disease, as well as in the type of care they sought. Mothers are heavily influenced by biomedical discourse in their concepts and the health care they seek. Their children's illness is a greater worry to them and they make diagnoses based on the child's mood and physiological state. They dictate marital and family norms in which drinking and extramarital sex are frowned upon and seen as sources health and family relation problems. The men themselves don't see these behaviors as problematic since they are not felt to be in contradiction with their assigned social and domestic roles. The male refusal to see alcohol and extramarital sex as problematic, along with the maternal reluctance to speak of carelessness¹⁶ and ill-treatment in children and the elderly leads us to suggest a lack of adaptation and acceptance by mothers and fathers of their respective domestic and social roles.

¹⁶. Child neglect has been considered by several investigator part of an environment where physical neglect and abandonment are common. A distinction has been made between abuse due to negligence and physical abandonment. Negligence occurs when the caretakers of a minor child act inappropriately. This occurs typically in families where there are other priority needs; the abuse may be conscious or unconscious in nature (i.e. due to ignorance, poverty, etc.). Physical abandonment is a state of neglect in which the degree is extreme and the physical consequences for the child are very severe. (Moreno, 2002)

Mothers seek medical attention at the community health center because their alternative is a trip to the municipal capital and payment to a private physician. Both parents seek private care when they feel it is needed for their children. If medical staff treated them improperly or the prescribed treatment received was not efficacious, mothers attribute the failure to a poorly made diagnosis or lack of the proper medication. Medical staff are seen by males as professionals who *cost money*, who do a poor job of communicating their diagnoses, and who are incompetent and abusive; in other words, they generate uncertainty. To go to a traditional doctor or healer is one of the health care alternatives. However, admitting to the use of traditional medicine and a discussion of its utility was difficult for our interviewees.

Conclusions

The social representations we observed were determined by a context of financial hardship, gender-based domestic roles, daily activities, family norms and values, biomedical hegemony, the mobility of some men who emigrate to work, the presence of non-Catholic churches and the healing experiences of mothers and fathers. Our interviews with 75 parents revealed a series of marital and family conflicts or differences and a rejection of assigned social and domestic roles. Social representations determine to a certain extent the role played by mothers and fathers. But these representations are not limited to gender-based domestic roles; they involve all the factors outlined above.

It is indeed the women who initially decide what to do and what steps to take when a member of the family becomes ill. However, illness is a process which develops over several days. Paraíso del Grijalva families live in a context of marginalization and poverty. They have a series of health-related beliefs, knowledge and experiences acquired during their interactions with the various doctors they consult. Based on these factors we concluded that males play a determining role in seeking health care and medical support. Rather than saying that males or females are the ones who decide what steps to follow when a member of the family becomes ill, we propose that it is “subjects” who act based on diverse personal, family and social representations and experiences which develop when falling sick, diagnosing and receiving treatment.

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