

THE SOCIOLOGICAL APPROACH IN TERMS OF HEALTH
IN THE DISCUSSION OF PARENTHOOD

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ABSTRACT

MOTHERHOOD AND FATHERHOOD ARE BOTH CONCEPTS THAT REFLECT REALITIES THAT HAVE CHANGED ALONG HISTORY, EVEN WHEN THEY STILL HAVE A STRUCTURAL LOGIC OF A PATRIARCHAL KIND THAT IS REPRODUCED FROM ANCIENT TIMES TO THE PRESENT AND MUST BE CONSIDERED A SOCIAL DETERMINANT IN SEXUAL AND REPRODUCTIVE HEALTH BEHAVIOR NOWADAYS. THE REASONING OF GENDER IN TERMS OF HEALTH HELPS TO A CRITICAL VIEW OF ITS HISTORIC DESIGN IN CUBA.

KEY WORDS: HEALTH SOCIOLOGY, GENDER IN TERMS OF HEALTH, MOTHERHOOD, FATHERHOOD

Health Sociology is a novel discipline when compared with other sciences which have contributed to better define and provide a social approach to health. It was institutionalized in the 1950s, though references to its significance and relevance in this field of human activity date back to the 19th century when it came to light as a social science.

Its late arrival by no means minimizes the importance of the knowledge and approaches contributed to the study of human health. Likewise, in the United

States, sociological researches on health became in short time record-breaking publications and studies paving their way in different regions. Since the 1970s, its dissemination through Latin America was significant. It was not so in Cuba, where its takeoff is still to be seen.

The creation of a more complex and comprehensive view of health has been one of the contributions of this discipline. Though it has not been the common thought of all schools, it can be found in the Marxist concept and critique. In the 19th century, *The Situation of the Working Class in England* by Engels constitutes an example of the need to establish a relationship between health and poverty to understand the living conditions of a human group. Its best legacy was the dialectical method applied to social processes which, in the field of health, meant the capacity to assess the interaction or connection among all processes intervening as health determinants (economic, knowledge, cultural, political, psychological, legal, social and biological determinants) (1), and to acknowledge the fact that health is not only an outcome of these processes, but also a trigger (cause) to redefine economic and social policies having an impact on the migration and social mobility of families and groups, just to mention some of the many aspects on which it has an impact.

Another aspect of this concept is the need to assess the relationship between health and society as a historical construction that changes in accordance with social spaces and times. In this regard, Henry Sigerist¹ has been considered a pioneer in this field, since his historical research on medicine and health systems have always included a sociological perspective by assuming a relationship between the social structure and health and emphasizing the advantages of some health models over others and their close connection with progress achieved in both the scientific knowledge and the social and economic development. His study of ancient and Soviet medicine became lessons of a good historical analysis of health.

Unlike Health Sociology, family studies sprang up since the 19th century thus bringing about a broad spectrum in current knowledge which included the systemic

family-society relationship, its changing historical nature, prevalence in social transformation and in the construction of strategies to cope with the negative impact of policies, an invaluable legacy to understand the role played by this social institution in health care and its relationship with health entities.

The concept of society as a system and its interaction with the family throughout its formation as a social structure—in which all components are integrated—is fundamental to grasp the complexity of roles defining it as a social group or institution, specially the parental roles, namely, mother-child and father-child. Such integrating processes hardly ever take place in a harmonic fashion, since these roles emerge in contradicting societies pervaded by a social division of labor that creates social inequities—racial, gender, class, territorial, and so forth.

The family is a social structure, a subsystem of social relations within which different components can be identified. These relations are defined in accordance with kinship, coexistence and residence. The unequal gender and generational design of family roles determines if such relations will be highly conflicting, as shown by the cultural history throughout all times.

The health-oriented thinking prevailing in Cuba is highly influenced by the risk theory which, as Jaime Breilh said, is “a thesis with a clear-cut empirical script incorporating contingency or probability as a central interpretation element” (2). It advocates for individual causes and the role of individuals coping with their own health problems, including lifestyles, though does not clearly visualize historical, structural and permanent factors as health determinants. Besides, this is a thinking focused on a biology-based rationality, and sometimes is incapable of incorporating the complex concept of health seen as the physical, psychic and social wellbeing in accordance with the WHO publication in 1948.

As has happened in many areas of health, the risk theory and the biomedical approach have permeated studies of sexuality and reproduction, thus hindering the systemic and historical analysis of diseases and mortality faced by families and

their members. Hence the need to incorporate more complex social approaches, like sociology and gender theory, into the curricular training of doctors in order to conduct a more efficient work in research and primary and secondary health care, particularly in the prevention of primary diseases. The ideal training of doctors should include a sociological perspective of gender, health, sexuality, reproduction and family issues so as to improve their involvement in the National Maternal and Child Health Program.

WHY GENDER?

In health, the sexist discourse and thinking has had, in different historical periods, a harmful incidence on women's health, thus promoting a culture of inequality between men and women.

In health history, the medical discourse evolved from ancient times—when the Hippocratic School spread the belief that women were the passive receptacles of semen and attributed to men an active role in fertility and child's integration into the family—to modern times when the woman/mother was dignified though subjected to the man's authority in the 18th century. In each historical period, these medical discourses were supported and legitimized by civil and family codes and by a sexist culture in family life, politics, religion and economy, since they reinforced the belief that patriarchy, as a social system, was the suitable world for the development of a healthy reproduction. This was also the time in which, gradually, men/doctors had access to women's bodies, thus displacing midwives and establishing their absolute control over women's bodies.

The fundamental attention paid for such a long time to women's reproduction in the medical thinking prevented the study of their sexuality and other health problems they had. In medical history, the tradition of exploring male bodies and ignoring female specificities remained until modernity and contributed to the backwardness of gynecology and obstetrics. Such practice was based on prohibitions for men/doctors to have access to women's sex established by the Church. The medical

ignorance about women's menstruation turned this natural process into a female calvary; it was considered an evil blood that could be contagious so women had to be isolated throughout this process.

With his book entitled *Emilio*, the great philosopher-illustrator Jean Jacques Rousseau significantly contributed to exalt motherhood. Therefore, the parenthood concept we have currently inherited derives from the emergence of capitalism, from its denial of women's freedom and their subordination to the role "granted to them by nature: motherhood."

The medical science, which has vindicated both objectivity and detachment, has not always been so neutral. In this regard, just one more example confirms this idea: the breast-feeding discourse which, since the 19th century, showed its racist and sexist nature. The low-class black or white wet nurse was in charge of full-time breast-feeding because the high-class woman's husband demanded her sexual attention and believed that this activity was not appropriate for an aristocratic wife. Literature on maternal breast-feeding² still found in libraries confirms this discriminating ideology. Later on, when medical science realized the high infant and maternal mortality rates during the 19th century, the idea of wet nurses and non breast-feeding aristocratic mothers was gradually rejected.

Therefore, the Cuban doctor must have an articulated concept of historical gender and generational processes associated with the economic, political, familial, ideological and cultural processes affecting health problems within a specific context, without neglecting the international scenario, and past and present interactions.

Progress made in the biomedical thinking and in the practice of sexual and reproductive health specialties humanized the attention paid to pregnancy, delivery and child health, though it did not manage to rethink the patriarchal terms in which this activity continued until the feminist thinking first and then the gender theory in health provided a sociocultural perspective to this men and women health dilemma.

It was then when a critical discourse on sex discrimination emerged and the social research field, and men's and women's health, changed.

A unique feature of this proposal in the field of health is the need to acknowledge the dialectic between biological and cultural factors which determine the morbidity, mortality and different health problems experienced by men and women. In fact, the specialized training of researchers has not always made possible the interdisciplinary approach proposed by gender studies, though there are many findings explaining the role played by social and cultural factors in the creation of health inequalities still present in men and women.

The sociocultural view of parenthood assumes that men and women enjoy equal rights and liberty to decide whether to have children or not, always on the basis of sharing equal responsibilities. But research on gender, family and health shows that such liberties and rights, enshrined in a number of legislations, are constantly infringed in the political practice, in the daily life of families and in medicine. It is not only that nowadays children suffer from the violation of their rights, but also that the interests of mothers/women are still subordinated to the interests of the other two members of this triad, the father and the son.

WHICH ARE THE HISTORICAL REALITIES EXPERIENCED
IN TODAY'S CUBA PREVENTING A PARENTHOOD
BASED ON EQUAL RIGHTS AND RESPONSIBILITIES?

In relation to equal opportunities for men and women, the current situation in Cuba is inconsistent. There is a transitional culture from a patriarchal to an equity model which has not wholly succeeded. In women's and men's mind, and in the political and family practice, coexists a conflict between a human approach based on equal opportunities and another one fostering the reproduction of a model which overvalues motherhood to the detriment of women and devalues the role of men as fathers, though still reproducing them as the dominant sex.

As has been demonstrated, as long as household tasks and public and remunerated productive and reproductive tasks are not equally valued, women need an alternative economic project to develop their own capacities and their children's capacities. Before 1959, Cuban women only accounted for 12% of the labor force (3). In 2012, their economic activity rate was 57.4%, while that of men was 89.5%. That is, it is well above the rate of women employed in 1959, but it is still below that of men today. In Cuba, there are more women in professional posts: in 2012, they represented 59% of that occupational category. The professional work is considered a prestigious work and is acknowledged as an indicator to assess women's potentiality and, even though their incomes do not always cover all basic needs, from the salary point of view they are higher than other occupational categories. The paradox here is that women also account for the majority in lower-qualification jobs in community services, their unemployment rate is slightly higher (3.6) than in men (3.4), and the highest within the non-economically active population (4).

What does this situation mean for the exercise of motherhood? Women still have less economic power than men and this is a crucial factor to meet the material needs of children and the cost of pregnancy, delivery and child rearing.

Therefore, many women still look for a steady couple with economic capacity to keep this project. In 2012, most births were reported on women only working at home³ (49%); 90% of births accounted for mothers sharing this obligation and right with men, both as married women (18%) or with partners (72%) (5). That is, in 2012, most mothers were reported among women only working at home and married or with a partner.

Women's educational progress was shown in the educational level of mothers that same year: 75.5% were pre-university and university graduates. Educational level in mothers was high in urban and rural areas, though higher in urban areas (79%

and 64%, respectively), thus showing a greater disadvantage of mothers in rural areas (6).

Though schooling is not considered an absolute assurance for a responsible and free maternal culture, it does provide an opportunity to better assimilate the new health approach in the upbringing of children and to create personal expectations by combining alternative life projects to motherhood. We should not ignore this data, since a woman might not be working at the time of conception, but this does not mean that motherhood is her only life project. A woman's life is not confined to work and have children. It is expected that, in a country where women have been granted real rights and a discourse on equal opportunities has been disseminated, a cultural transformation beyond education can take place.

One of the most important rights achieved by Cuban women, that best reflects this progress, is the right to abortion at hospital level without any limitation in freely deciding what is more convenient to them: to have the child or postpone it. Restrictions are medically advised and protect women from mortality. This right provides women with a control over their bodies and fertility. It has had an impact on fertility reduction, though it must be analyzed in association with other determinants, particularly the gender ones.

We cannot ignore that this right is exercised within a gender context in which family planning is still the woman's responsibility. The international and national industry is still focused on the production of contraceptives for women. The 2009 National Fertility Survey shows how women usually use more contraceptives than men. In 2013, the percentage of women using the condom (14.1%) was still lower than those using intrauterine devices (50.1%) or sterilized (20.1%) (7). Research conducted by the author shows that even the use of condoms seems to be the women's responsibility who ensure their use during the sexual act to prevent infectious diseases rather than pregnancies.

The sexist distribution of roles, still existing in the couple's sexual life, affects the asymmetries observed during the upbringing of children. Motherhood is still overrated in terms of care. If women carry fertility control and child rearing on their shoulders and, besides, are at a disadvantage in the distribution of employment and incomes, the least society could do to reestablish some balance and allow them to devise strategies that might help them face such disadvantages, is to grant them the right to control their fertility. Why is it that almost everywhere this right of women is questioned by politics? Why is it that no rules exist to impose fertility control methods on men? Why is it that there is no reference on his duties and innovation in this field? The society is more tolerant with men, their promiscuity is not censured, their reproduction is not thoroughly studied, and there are no statistics on father's births. All standards are always based on women's reproduction and control of sexuality: ablation, the forced sterilization of women, and the penalization of abortion. It is impossible for this author to make an elemental description of paternity, like the one made of maternity, since the Demographic Yearbook only records births associated with mothers. From the demographic point of view, we know a lot about mothers, but almost nothing about fathers.

In Cuba, the working woman is protected by a Maternity Law granting her the right to enjoy a paid leave for a year and the possibility to take turns with her husband if the couple so decided. Not always women exercise all the rights granted to them by legislation; this might be due to gender stereotypes and sexist realities still prevailing in the public and familial division of labor. A 2013 survey⁴ conducted in two capital municipalities with 70 mothers to explore their knowledge on paternal paid leave revealed that none of them had seized that opportunity and 50% of them had no knowledge of its existence. The rest responded that they did not exercise that right for different reasons: her husband's salary was higher, the father did not agree, she provided a better care for her child or she was a single mother (8).

The Cuban State guarantees the pregnancy early detection and follow-up at primary care level, as well as hospital delivery with skilled personnel. All these services are free of charge. Such guarantee is enjoyed by women of all ages and races, aside from their occupation and geographic residence. However, access varies depending on their territorial availability. Among the Cuban provinces there are still differences in the availability of this kind of service; delivery is complicated for some women living in rural areas due to the distance they have to travel, despite the existence of maternal homes. The decades-long transportation crisis is worse in rural and mountain areas, and the cost of child-bearing is much higher. Nevertheless, seemingly, the highest fertility rates are found in rural and mountain areas especially due to the lower social development and as women have less options they prefer to have an early marriage and fertility career. In 2012, births of adolescent mothers living in rural areas accounted for 20.1% of all births in that area, while births in urban areas were 13% (6).

Early motherhood in Cuba is, above all, a gender problem in health. Doctors agree that one of the risks of early motherhood is the low weight at birth. However, in 2012 adolescent mothers only contributed with 17% of children with low weight at birth against 30% of mothers between 20 and 24 years old. Probably, this is due to the early follow-up of pregnant women at risk due to age. The fact is that the country reports no complications in maternal mortality due to early pregnancies, but due to a life project based on equal opportunities. Adolescents drop out from school and do not conclude education so they either have problems in finding quality jobs or have to devote themselves to traditional roles entailing their dependence to the family of origin first and then to the husband. In the 2012 research on poor families and health gender inequalities conducted in the San Isidro neighborhood, early pregnancy surfaced as a factor contributing to the reproduction of poverty among female heads of households.

Men's involvement in pregnancy and delivery follow-up, a goal proposed by the Responsible Parenthood Program, is not complied with. The above-mentioned breast-feeding survey also examined this indicator and revealed that only 6% counted on their partners during childbirth and 64% were not accompanied by a family member (8).

Today, the Cuban economic scenario is complex. Since the 1990s, Cubans live under a daily scarcity of products of all kinds, food vulnerability, inflation, loss of salary value and insufficient increases.

Today, the redefinition of the Cuban economic policy is aimed at efficiency patterns and a change in relations between institutions and social actors of different kinds with a significant social impact in families and in the daily life of its members. Likewise, prohibitions favoring access to more resourceful persons are repealed.

This approach is implemented in a period still under the United States economic blockade, worsened by the international economic crisis. An independent economic model has not been devised yet, there are no investments to improve employment, and the new labor alternatives are not enough, since processes are very sluggish. Labor inefficiency is still very high. Consequently, the final result with the greatest impact on parenthood is the deterioration of daily life, and the increasing social inequality and its feminization. We cannot ignore the fact that those having less economic power are in a more disadvantaged position to face the crisis, mainly in relation to gender, race, occupation and territory. Under these circumstances, social inequalities always worsen, for they account for the starting point and have not yet been overcome.

The coexistence of many of these factors (the precariousness of daily life together with the unequal exercise of gender-related roles and the overburden resulting from a participatory life project in different spaces) can lead women to reduce fertility, postpone it, reject it, migrate, and quit breast-feeding in order to make a better use of the maternity leave and look for income sources, just to mention

some. Likewise, under these circumstances, an active life project can demand a high cost for women's health, especially when they are subjected to an almost chronic stress due to the time it lasts.

Other factors add to this situation, namely, the precarious condition of housing and, therefore, the children's forceful need to procreate at their origin home as a result of this increasingly worsened social problem. In several researches conducted, men and women, when asked why they reduced their perceived ideal number of children, frequently stated not having a house to cope with the upbringing of their children by themselves. Generational conflicts derived from the appropriation of living spaces are frequent and are based on the different viewpoints between parents and grandparents concerning the care of children/grandsons and the involvement of the couple in this process, worsened by the frequent income limitations some children/parents have and the material dependence on their parents/grandparents.

These contradictions are reflected in certain fertility paradoxes. The number of women having children at an early age increases, as well as those between 30 and 39 years old. In this second case, we must bear in mind the combination of several factors; on the one hand, the late economic empowerment of sons/daughters under reproductive age who are not yet solvent to face this reality; on the other hand, the aging of a society where the right to retirement is not compulsory and does not provide enough resources to increase employment, thus resulting in the slow insertion of youngsters in the labor market. These obstacles faced by youth to prosper have different consequences: either migration or living at the expense of their parents for a while. These reasons weigh on the decision to postpone the exercise of parenthood.

The gender determinant adds to this dilemma. Professional women who, as we already said, are numerically relevant, begin their reproductive life when their labor life begins, setting their priority in attaining master and doctor's degrees, with a

professional performance that forces them to postpone motherhood in order to achieve a higher quality involvement in the market. Under current conditions, in which a male-dominant organizational culture still prevails in national institutions, where it is quite difficult to reconcile the public and the private, promotion turns into a thorny road for women, particularly for leaders and professionals, who look for immediate strategies to control fertility in order to progress and be in a better position to procreate in the future.

Undoubtedly, the postponement of motherhood together with a long time coexistence with invasive family control methods resulting from a non-shared responsibility, and the frequent use of abortion and exposure to STIs contributed to the female health problem: the increasing infertility. Women should know the cost of an independent life within the context of their greater disadvantages so as to be able to make decisions without harming their health. However, the solution should never constitute a limitation of their rights. The cost of abortion penalization and early motherhood is higher than the irresponsible use of abortion and infertility, especially because they impose a restriction to their freedom and humanity.

This reasoning leads us to the conclusion that the solution to problems faced by men and women in the exercise of parenthood is intersectorial and has to do with politics, as well as with the inclusion of a gender perspective. This is not merely a problem caused by the health system, though it might strengthen its presence and complex social approach with a critical view not only from the risk theory, but at least by incorporating an analysis of social and cultural factors as determinants of the sexual and reproductive health.

Health care is an individual fact. Doctors at the Primary Health Care level should find out what they know about the way in which these gender, social and economic problems affect their patients in exercising a responsible parenthood and how they affect the health problems faced by women during pregnancy and delivery.

The inclusion of this perspective can significantly improve the health educational and promotional work of doctors. In the primary health care level, the professional work of doctors can be improved with the support of the social worker to look for treatment alternatives in each case. Their work as actors in the decision—making of health policies can be improved. This is as important as lab tests, smear tests, a tomography or any other test indicated for a biomedical diagnosis.

Just one example: messages on maternal breast-feeding should not only include its benefits for the child's health. It is important to disseminate the women's interests, what it means for them, in terms of health, not to be accompanied by their partners and family during this process, and what it means doing it under stress and harmful living conditions. Breast-feeding is just another kind of work, it can cause pleasure depending on the conditions or can cause a great fatigue and exhaustion.

The exercise of motherhood demands information for women to make wise decisions, without pressures, and under a free environment. The free and responsible maternity, on equal grounds and opportunities with paternity, implies a co-participation and interaction of roles to be played: to care, protect and provide should be understood as the roles defining men and women's involvement in the upbringing of children.

NOTES

1. His works include *Los modelos cambiantes de la atención médica y la profesión del médico a través de las edades* [The changing models of medical assistance and the profession of the physician through the ages], though they had all included a historical perspective of health-disease processes.

2. See *Apuntes sobre lactancia artificial* by the Cuban doctor M. Valdés on estates in the Cuban island and *Memorias sobre la lactancia* by J. Castro. Both works were guides on breast-feeding in the 19th century and, due to the migration of Cuban

doctors to Spain, had also an impact in some regions where these doctors settled down.

3. In "household chores," under inactives in the Demographic Yearbook (5).

4. The survey was made by the team of Health, Gender and Family Studies from the Sociology Department of Havana University.

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