"WE ARE STRONG WOMEN":
A FOCUSED ETHNOGRAPHY OF THE REPRODUCTIVE LIVES OF WOMEN IN BELIZE

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University of Connecticut, 2002

Belize is a small country in Central America with a unique heritage. The cultural pluralism found in Belize provides an opportunity to explore the cultures of the Maya, Mestizo and the Caribbean. Women in Belize share this cultural heritage as well as the reproductive health issues common to women throughout the developing world. The experiences of unintended pregnancy, contraceptive use and abortion were explored with women using a feminist ethnographic framework. Key informants, participant observations, secondary data sources and individual interviews provided rich sources of data to examine the impact of culture in Belize upon the reproductive lives of women. Data were collected over a two-year period and analyzed using QSRNudist qualitative data analysis software.

Analysis revealed that regardless of age, ethnicity or educational background, women who found themselves pregnant prior to marriage experienced marriage as a fundamental cultural norm in Belize. Adolescent pregnancy often resulted in girls' expulsion from school and an inability to continue with educational goals. Within marriage, unintended pregnancy was accepted but often resulted in more committed use of contraception. All women had some knowledge and experience with contraception,

although some were more successful than others in planning their families. Couples usually made decisions together regarding when to use contraception, however misinformation regarding safety and efficacy was prevalent. While abortion is illegal, most women had knowledge of abortion practices and some had personal experiences with self induced abortions using traditional healing practices common in Belize.

Belizean culture is evolving as Belize grows and tries to find its place in the global marketplace. Education and employment have created new opportunities for women in Belize. However, these opportunities have resulted in challenges to the traditional roles and culture of families in Belize. Women in Belize enjoy somewhat better health than their geographic and cultural neighbors yet share many of the same concerns for their health and their families. Women strive to obtain quality health services and equality in employment and relationships, and share these struggles with women throughout the developing world.

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CHAPTER 1

Introduction

Unintended pregnancy (Ashford, 2001; International Safe Motherhood Initiative, 1997; Shane, 1997) affects millions of women throughout the world. It is a complex problem affected by the status of women in society, economics, politics, culture and the role of women in their families and relationships (The Alan Guttmacher Institute, 1999; The Center for Reproductive Law and Policy & DEMUS, 1997; United Nations, 1994b). In the developing world, women experience a disproportionate share of reproductive health care problems related to the control of their reproduction by limiting or spacing their children. Knowledge of the reproductive lives of women and the ways in which decisions are made regarding reproduction is important in the provision of culturally appropriate and accessible services for women.

The purpose of this study was to examine the concept of unintended pregnancy from the cultural perspective of women in Belize. While there is worldwide interest and statistical data about unintended pregnancy, there is little information about how women in the developing world define, view and experience unintended pregnancy. Belize is a small country in Central America in which the consequences of unintended pregnancy are reflected in the maternal and infant morbidity and mortality statistics, as well as in the words and lives of Belizean women. Maternal mortality is increased due to complications resulting from multiparity and closely spaced pregnancy.

This study was conducted in Belize where the researcher has participated in a maternal and child healthcare experience, for the past 11years. The results of this study provide valuable cultural data to inform nurses and other

health care providers about unintended pregnancy in Belize. This information may also be useful for non-governmental organizations (NGO's) that provide family planning services. Data from this study will also inform the international health care community about the experience of unintended pregnancy in the developing world. The unique multicultural nature of Belize provides information on reproductive health issues in similar Latin American and Caribbean cultures.

Feminist ethnography provided both the methodology and theoretical model for this study. Ethnography as a method originated within the field of anthropology and provides for the exploration of another culture using a variety of tools such as participant observation and key informants (Fetterman, 1989; Maanen, 1988; Roper & Shapira, 2000). Focused ethnographies in medical anthropology have been used to study the relationships of cultural beliefs and health behaviors as well as the "cultures" of specific illnesses (Roper & Shapira, 2000). Combining feminism with ethnographic methods creates a framework for honoring the experiences of women in their culture as "expert knowers", recognizes the role of the relationship of the researcher and her participants, and seeks to create new information that may help to improve the status of reproductive health care for women.

The complex problems of unintended pregnancy, unsafe abortion practices, and the widespread HIV/AIDS epidemic illustrate the stark reality of the reproductive lives of millions of women throughout the developing world. Approximately "one-third of the total disease burden (ill health and premature death) that women face is linked to pregnancy, childbirth, abortion, HIV and other reproductive tract disorders" (Ashford, 1995, p.25). In recent years, the concept of reproductive health for women has been expanded to encompass the emotional and social well being of women as well as the social, political and economic aspects of their lives (Reproductive Health Outlook, 2000). This new definition was formulated at the International Conference on

Population Development (ICPD) in Cairo in 1995 and confirms that women's health is influenced by the complex relationship of health, gender roles, politics and economy; women's health is more than the physiological aspects of reproduction. Understanding the impact of culture upon the lives of women is essential for those who wish to improve the lives of women and their families. Each year, over a half-million women die related to complications resulting from pregnancy, childbirth and unsafe abortion practices worldwide (Shane, 1997); 99% of these deaths occur in women in the developing world (Ashford, 1995). Poor child spacing within families contributes to the death of more than 11 million children each year; more than half of these deaths are related to malnutrition (Shane, 1997).

Culture plays a crucial role in the reproductive lives of women. If reproductive issues are examined without the perspective of women whose lives are intimately affected by pregnancy, childbirth and the challenges of contraceptive use, then important information may be missed. Understanding the role of culture in reproductive health and unintended pregnancy is particularly important for providing comprehensive reproductive health care services and improving the health of women and their communities. This creates a challenge to health care providers who care for women throughout the developing world. How decisions are made regarding pregnancy, contraceptive use and sexual health may affect the health of mothers and their families. Conducting this study in Belize, where the researcher had well-established health care and community relationships, as well as the cultural diversity present in Belizean society, provided a unique opportunity to explore the role of culture in reproductive health.

Belize

Belize, formerly British Honduras, is a small country in Central America that became independent from Great Britain in 1981. It has a population of approximately

242,204, 28% of whom reside in the largest urban area in the country, Belize City (The Central Statistical Office, 2000). Many ethnic and cultural groups have come together to form Belizean culture. In the north, a large portion of the population is of Mexican or Mestizo descent. Further south in Central Belize is a large Creole population, many of whom are descended from slave populations who intermarried with Scottish and British settlers in the 18th and 19th centuries. Further south is a population known as the Garifuna, who are descendants of peoples with West African and Caribbean Indian ancestry and the Maya; descendents of the ancient civilizations that populated the Yucatan and Central America (Pan American Health Organization, 2001; Sutherland, 1998). Finally, to the west are peoples from Guatemala and refugee populations from El Salvador, Honduras, and Nicaragua, which accounts for about 14% of the total population of Belize (Pan American Health Organization, 2001). Although the official language of the country is English, Spanish, Creole and Mayan are spoken throughout the country. The histories of Belize, Central America and the Caribbean have influenced the development and assimilation of multiple cultures and ethnicities within the small confines of Belize, the only English-speaking nation in Central America. At the same time, this cultural diversity creates challenges in understanding the relationship of culture and reproductive health. Exploring related cultures in Central America and the Caribbean may help to provide a clearer picture of reproductive health care issues in Belize.

Reproductive Health Care in Belize

In 1994, the main causes of maternal mortality rate in Belize were postpartum hemorrhage and other emergent obstetric complications (Belize Ministry of Health and Sports, Belize Ministry of Human Resources, Women's Affairs and Youth Development, 1997; Pan American Health Organization, 1999). While over 80% of births take place within a medical facility with trained midwives or physicians, those

facilities may be unequipped to provide necessary surgical interventions in a timely manner. Similarly, the 20% of women who deliver at home with traditional birth attendants (TBA's) are limited by geography and a lack of reliable transportation should an obstetric emergency occur. TBA's are often traditional midwives, but may be lay people nominated by their village to complete government-sponsored training in the conduct of normal pregnancy and birth, with special emphasis upon the recognition of deviations from normal processes (Boyer, Klima, & Jennrich, 2001).

Unintended pregnancy in Belize creates risk for women who may experience untoward effects of pregnancy and childbirth, as well as adversely affecting the social and emotional well being of women and their families. According to the 1991 Belize Family Health Survey, approximately 17% of women age 15-44 are at risk for unintended pregnancy, with rural women having little education and more than five children at greatest risk (Central Statistical Office, Ministry of Finance, Belize Family Life Association, Ministry of Health & Division of Reproductive Health, 1991). These statistics illustrate that despite its small size, women in Belize share similar reproductive health concerns with women throughout the developing world. Its small size also creates challenges, as the government resources are also proportionately smaller than its larger and more populous neighbors.

The following chapters will describe the exploration of the reproductive lives of women in Belize. Their experiences of pregnancies both planned and unplanned, their experience of contraceptive use and the role of culture in their reproductive lives will be examined from their perspective. In Chapter 2, a review of the literature will examine the scope and consequences of unintended pregnancy throughout the developing world. The role of culture in the reproductive lives of women will be explored and implications for the health of women and their families will be described. In Chapter 3, the country, history and culture of Belize will be described to provide the

backdrop for evaluating the results of this study and illuminating the special challenges that this small, multicultural country faces in improving the reproductive lives of women and their families. Chapter 3 will also describe the two districts where the research occurred. Chapter 4 will focus on the methodology and theoretical framework for the study. Chapters 5 and 6 will present the results of the research and using the womens' stories, weave a tapestry that depicts the reproductive lives of women of Belize. Chapter 7 will conclude with a discussion of the study, findings, limitations of the study and implications for further research.

CHAPTER 2

Review of the Literature

This chapter begins with an overview of the concepts of reproductive health care from a global perspective and highlights the socioeconomic, political and cultural concepts that affect the health of women and their families. The issues of unintended pregnancy and contraception will be explored and the consequences of unsafe and illegal abortions will be discussed. To provide a backdrop for this study the history of Belize and current cultural and demographic information will be provided. Finally, the health care system in Belize and ways in which women access health care services will be described.

The Evolution of Reproductive Health Care

The concepts and policies of reproductive health for women are evolving in response to complex social, political and health related situations throughout the world. Governments and international organizations play a major role in the health of people worldwide. Globalization has created a world where borders are less relevant, information is accessible to more people, and health and illness are a global concern, rather than a regional issue. To understand the current status of reproductive health, it is helpful to examine the development of policies and trends that have occurred and that shape current global reproductive health issues.

During the last half of the 20th century, there was worldwide concern about unprecedented population growth and its effects upon the resources of nations (Ashford, 2001; United Nations, 1994b). The most rapid population growth in history occurred between the 1950s –1970s and is commonly referred to as the "population explosion" (Ashford, 2001). The soaring birth rate, coupled with better access to health care and advances such as vaccines and medicines created a world where the population grew from 2.5 billion in 1950 to 3.7 billion in 1970 (Ashford, 2001). This

growth was especially problematic for the developing world, where the majority of this growth occurred, but the resources to support the population were lacking. Historically, population policies have addressed three areas responsible for population growth: birth, death and migration (Ashford, 2001). Although early policies of governments focused mainly on the birth aspect of population growth through the development of widespread family planning programs, only recently have policies addressed the complex nature of reproductive health and the lives of women and their children in a broad prospective. This shift in thinking did not happen quickly and is the result of decades of research and international forums that provide a place for the leaders of countries to discuss the complex issues of health and population growth.

Since 1954 the United Nations (UN) has held a global meeting on population each decade. The initial meetings focused upon encouraging fewer children and increasing access to contraception, thereby linking population programs with family planning programs (Ashford, 2001). However, little attention was paid to the cultural and social context of these family planning programs and in the 1970's the emerging consensus was that a better way to control population growth was to improve the standard of living through the economic and social development of countries. At the United Nations conference in 1974, the delegation of India declared, "development was the best contraceptive" (Ashford, 2001, p.2).

Despite the notion that a more comprehensive approach was needed to address population growth, during the next decades population programs continued to grow throughout the developing world with their main focus being family planning programs. However, the 1984 United Nations conference in Mexico City brought to the forefront many criticisms from a variety of groups and organizations that refocused the need to evaluate current population policies. For example, anti-

abortion groups linked family planning and abortion and voiced opposition to international aid to family planning programs. Similarly, conservative economists in the Reagan administration declared that free markets would curb population and the government should avoid attempts to control population growth (Ashford, 2001). Consequently, the United States, the largest contributor of international aid, announced it was "withdrawing funding from any organization that provided abortion services or counseling—even with funding from non-U.S. government sources" (Ashford, 2001, p. 2). This became known as the Mexico City Policy and was responsible for serious consequences for the health of women worldwide. This policy remained in place until the Clinton Administration took office in 1993 and has recently been reinstituted by the Bush Administration through executive order in 2001. However, the U.S. Congress is considering legislation to limit the ability of the executive branch to affect international population policies (H. R. 361, 2001). Likewise, women's rights advocates throughout the world also questioned the focus of population policies, asserting that they were based upon the coercion of women, a lack of regard for the health consequences of contraceptive methods and did not address the overall health of women and its effects upon the health of their families and communities (Ashford, 2001).

In 1994, the International Conference on Population and Development (ICPD) was held in Cairo. This conference brought together 180 nations and reshaped the policies of population growth, moving away from a focus on family planning and controlling fertility to a broad concept of reproductive health (United Nations, 1994b). The complex issues of gender, women's rights, social and political processes, and cultural and ethnic issues were integrated for the first time and resulted in new definitions and directions to achieve an improvement in the health of women and

families worldwide (Ashford, 1995, 2001; United Nations, 1994b). The following is the definition of reproductive health that emerged from the "Cairo" conference:

> Reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore 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. Implicit in this last condition is the right of men and women to be informed and to have access to safe, effective affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant... Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents...[these rights] also include [couples] rights to make decisions concerning reproduction free of discrimination, coercion, and violence...The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government and community-supported policies and programs in the areas of reproductive health, including family planning. As part of their commitment, full attention should be given to promoting mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of

adolescents to enable them to deal in a positive and responsible way with their sexuality (United Nations, 1994a).

The conference was historic in other respects as well, in that it brought attention to the fact that the health of women could not be addressed without also addressing harmful practices that were effecting the lives of women throughout the world, such as female genital cutting or mutilation, forced marriages and coerced prostitution. For the first time reproductive health rights were identified as basic human rights. Finally, the participation of NGO's in the provision of reproductive health services was recognized and their participation invited, so that governments, international organizations and local NGO's were all at the same table, discussing the challenges of meeting the goals of the ICPD from the community and governmental level (United Nations, 1994b)

While the 20-year goals of the Cairo conference were ambitious and reflected the complex nature of reproductive health, attention continues to focus on progress made so far and new goals have been developed for the year 2015. This continued attention will focus governments, policy makers and providers of reproductive health services on the new definitions of health and aid in developing and implementing the goals of the Cairo conference. These goals include:

1. Provide universal access to a full range of safe and reliable family planning methods and related reproductive health services.
2. Reduce infant mortality rates to below 35 infant deaths per 1,000 live births and under 5 mortality rates to below 45 deaths per 1,000 live births
3. Close the gap in maternal mortality between developing and developed countries. Aim to achieve a maternal mortality rate below 60 deaths per 100,000 live births.

4. Increase life expectancy at birth to more than 75 years. In countries with the highest mortality, aim to increase life expectancy at birth to more than 70 years.
5. Achieve universal access to and completion of primary education; ensure the widest and earliest access by girls and women to secondary and higher levels of education. (Bowman, 2000)

The question that arises now is: Has the Cairo conference made a difference? There is some evidence that, at least in some nations, noticeable change has begun to take place in the reproductive health of women and their families. The positive changes throughout the world include: the elimination of population targets in India, with a movement towards individual goals for reproduction; the addition of sex education in primary and middle schools throughout China; the participation of women's rights groups to effect comprehensive changes in reproductive health in Brazil; and new laws against domestic violence in some Latin American countries. In Africa, the area of the world with the most alarming statistics for women's health, there have been health policy changes. For example, one-third of the 28 African countries where female genital cutting is commonly practiced have legally banned the procedures and many countries have seen the introduction of screening services for sexually transmitted infections (STIs) (Ashford & Makinson, 1999; Bowman, 2000).

Gender and Health

If one were to ask what is the one concept that underlies the health of women and families throughout the world, the answer would be gender. The concept of gender goes far beyond the biological differences between men and women and encompasses the social, cultural, political and relationship issues of humankind. By examining the issue of gender, it is possible to begin examining the complexities of reproductive health in the developing world. Gender is a complex concept that is

culturally constructed so definitions evolve based upon the cultural context in which it is being applied. However there are some universal constructs that allow for an understanding of how gender affects women and men across cultures.

Gender is a way that societies are organized based upon the roles of men and women and the social and cultural practices that evolve relative to these roles (Ashford, 2001; Riley, 1997). Integral to these roles is the power that results secondary to these gendered roles. In every society, it is the gendered role of females that is afforded less power and therefore less influence in the creation of policies and health and socioeconomic practices (Riley, 1997). For example, if women have less power, they will have less access to education, money, land and other social resources. When one adds to this the fact that women have less power over men to effectively combat their lack of access to resources, it is easy to see how gender inequality has not only become pervasive throughout the world, but how it is at the core of the global crisis of reproductive health care for women and their families (Riley, 1997).

So how does gender inequality affect the reproductive health of women? The answer to this question is intricately linked and dependent upon cultural practices and social factors. For example, in countries where there is strong bias for male children, female children may die before birth as a result of sex-selective abortion practices or these biases may be played out in less food for female children and limited access to health care and education for girls. Throughout the world, women have been subjected to female genital cutting, coerced sex, and forced prostitution. Their lack of power in relationships also makes them more likely to contract STIs and HIV due to their lack of ability to negotiate safer sex practices with dominant male partners. Universally, women are more likely to suffer from the physical and mental consequences of domestic abuse (Santow, 1995). There are strong links between

health, status and fertility rates for women suggesting that gender equality is a critical strategy for policies to improve health and create stable population growth.

Because the definition of reproductive health includes the social, cultural, political and economic determinants of reproductive health, the role of gender inequality becomes more complex and points to the challenges of improving the status of women. Gender inequality is often identified as an underlying challenge to improving the health of women. The World Bank estimates that "reducing gender inequalities can bring about greater economic prosperity and help reduce poverty" (Ashford, 2001, p 3). Education, employment and poverty have been identified as areas that have a great impact upon reproductive health and even small improvements may result in significant gains in the reproductive health care arena.

Education

According to the World Bank, education is the "single most influential investment that can be made in the developing world" (Ashford, 2001, p.3). In almost every society, higher education levels are linked with lower fertility rates, increased contraceptive use, and smaller, healthier families (Ashford, 2001; Riley, 1997). Although the gender differences for primary school have lessened in the last decade, secondary education remains limited for girls in many regions of the world. Education is essential for women if they are to improve the economic status of their families, by allowing them access to higher paying jobs outside the home. Similarly, education is vital if women are to develop a more visible role in the political arenas of their communities and countries.

Employment

Employment is another avenue that allows women to improve their health status and that of their families. Increased income may allow more control over the resources of the family; in cultures where the decision-making power of women is

linked with income, work may increase women's participation in the family decisions. Similarly, employment outside the home also increases social contacts with other women as well as new ideas and information. While these benefits are overwhelmingly positive, they are difficult to attain for most women due to gender discrimination in the workplace. When women work outside the home, they increase their hours of work considerably as they are still required to maintain the family household in addition to the responsibilities of their outside work. At work, women are more likely to be paid less than men, with vast differences seen throughout the developed and the developing world. For example, in Bangladesh women in non-agricultural work, earn approximately 75% less than the salaries for men. In contrast, the disparity is smaller in Tanzania, Vietnam, and Australia where women earn about 90% of male salaries (Riley, 1997). Although the gender inequalities related to salaries and employment are problematic, the benefits of outside work are likely to empower women to have more input into their reproductive health decisions.

Poverty

Poverty is inextricably linked to reproductive health, with poorer women assuming a disproportionate share of poor health and poor reproductive health outcomes. In every region of the world, including the developed nations, poor women are likely to have more children, less likely to receive prenatal care, more likely to deliver their babies without trained personnel, have poorer nutrition, and have higher mortality rates for themselves and their infants (International Safe Motherhood Initiative, 1997; Shane, 1997; United Nations Population Fund, 1999). It is not hard to imagine the relationships between poverty, education and employment in the context of gender in respect to the reproductive health of women. The roles and status of women, their education, employment opportunities, and their health all contribute to their economic stance in their society.

Role of culture

Culture can be defined as the learned and transmitted patterns of thought, behavior, beliefs and life practices, shared by a social group that guides thinking, decisions and actions (Brown, 1998, Leininger, 1978). The concept of culture is dynamic and important for nurses to explore as they interact with individuals, families and communities on their journeys of health and illness.

The beliefs and values of every cultural group are intimately linked to the complex processes of birth and the control of reproduction. According to Jordan (1993) "there is no known society where birth is treated, by the people involved in its doing, as a merely physiological function...it is socially marked and shaped " (p. 3). Similarly, the control of reproduction is linked to the role of women in a cultural group, their belief systems regarding pregnancy, the role of the family, and the complex political and economic systems in which they live. By exploring the role of culture, the complexities of reproduction emerge and demonstrate the challenges nurses and health care agencies face in their attempts to address women's health problems.

In order to explore the consequences of the current status of the reproductive health of women globally, four critical components of women's reproductive health in the developing world will be examined: maternal morbidity and mortality, unintended pregnancy, contraception and abortion. Table 1 provides an overview of four critical components of reproductive health care of women and men in the developing world.

Table 1

Critical Health Issues for Women and Men Worldwide, 1990's

Health Concern	Total (annual)	Women	Men
Maternal Mortality	515,000	515,000	-------
Maternal Morbidity	15-20 million	15-20 million	-------
Unsafe abortions	20 million	20 million	-------
Couples with unmet family planning needs	100-250 million	-------	-------

(Ashford, 2001; Division of Reproductive Health, 1998; International Safe Motherhood Initiative, 1997; The Alan Guttmacher Institute, 1999)Maternal Morbidity and Mortality

Maternal morbidity and mortality has been recognized as having a profound effect upon the health of a family; a maternal death can increase the risk of death of remaining children under 5 by 50% (World Bank, 1993). Maternal mortality includes death from pregnancy related causes, complications of childbirth, and unsafe abortion and accounts for over 500,000 deaths each year (International Safe Motherhood Initiative, 1997). It disproportionately affects women in the developing world with almost 95% of maternal deaths occurring in the developing world (Ashford, 1995, 2001; Shane, 1997) (See Figure 1). Maternal mortality is a complex health issue and is influenced by variables such as maternal health, socioeconomic status, available health care facilities and providers, sociopolitical issues and cultural practices. Maternal mortality is also a problem that continues to elude effective strategies for significant improvement.

In 1987, the global Safe Motherhood Initiative (SMI) was begun by an international group of organizations, in an effort to raise awareness of the incidence and consequences of maternal morbidity and mortality. Its primary goal was to

reduce maternal mortality by half by the year 2000 (International Safe Motherhood Initiative, 1997). Although the goal has not been met, a recommitment to the goals of SMI, occurred in 1997 in Sri Lanka. Here international organizations and 65 countries reviewed progress, suggested strategies and created plans for implementation in attempts to reduce maternal mortality throughout the developing world (International Safe Motherhood Initiative, 1997). Some of their recommendations included making safe motherhood a human right, the empowerment of women, providing safe and adequate obstetric care with trained personnel, improving reproductive health services for women, prevention of unintended pregnancy and unsafe abortion and continued commitment by the governments,

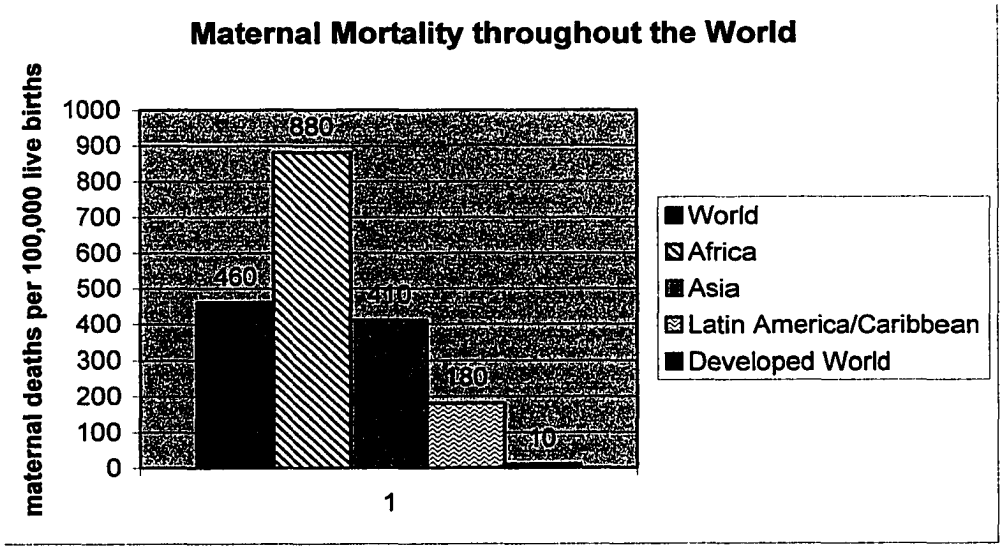

Figure 1 Maternal Mortality in the Developed and Developing World

Source: L. Parikh and B. Shane, 1998 Women of Our World (Population Reference Bureau, 1998) based upon data from WHO, UNICEF and the United Nations. Reprinted with permission.

NGO's and policymakers of the world to reduce maternal mortality and prevent morbidity of women (International Safe Motherhood Initiative, 1997; United Nations Population Fund, 1999).

To address the complexity of maternal mortality, conceptual models may be helpful in identifying causes and creating solutions. McCarthy and Main (1992) created a framework for exploring the determinants of maternal mortality and suggested that there are intermediate and distant factors that may result in a maternal death. Intermediate causes include maternal health status, reproductive status, access to health services, health behaviors and unknown factors; distant causes include socioeconomic and cultural practices (McCarthy & Maine, 1992). They propose that any efforts to reduce maternal mortality must somehow address one of three areas: 1) reduce the likelihood that a woman will become pregnant; 2) reduce the likelihood that a woman will experience a serious complication of pregnancy or birth; or 3) improve the outcomes for a woman who experiences a complication (McCarthy & Maine, 1992). If one uses this conceptual model to address maternal death, many solutions emerge that have far reaching implications for governments and health care agencies to consider when attempting to improve reproductive health. For example, when exploring the intermediate causes of mortality, maternal health status includes nutrition, pre-existing medical conditions like diabetes or hypertension, as well as, medical conditions like malaria that may have a deleterious effect on maternal health. Parity and age can have a significant impact on mortality with the very young, the very old and those with high parity experiencing the most morbidity and mortality (McCarthy & Maine, 1992). The more distant determinants of maternal death reflect the most difficult to address as they are the result of gender inequalities and complex political, social and cultural issues.

The Prevention of Maternal Mortality (PMM) network formed in West Africa to

address maternal mortality and used the conceptual model of McCarthy and Main to address maternal mortality. The group created the "three delay model" that targeted some of the intermediate and distant causes of maternal mortality. This model focused on how to resolve delays in emergency obstetric care that have an adverse effect on maternal health. Strategies were developed to address one or more of the following critical components of maternal health when complications arose during pregnancy or childbirth:1) Delay between the onset of symptoms and the decision to seek care;

2) Delay between the decision to seek care and reaching the facility; and 3) Delay in receiving care at health facility, or receiving substandard care (Prevention of Maternal Mortality Network, 1997).

This model explains many of the reasons for delay in care. Examples include a delay between the onset of symptoms and the decision to seek care, which may result in a woman's failure to receive care, untrained or inadequately trained birth attendants who fail to recognize a complication, provide inappropriate treatment or delay related to limited economic resources (Sundari, 1992). Other reasons for delay in care include lack of transportation services, impassable roads, or health facilities too far away from the women they serve (Sundari, 1992). Another reason for delay in services is that 60% of births in the developing world occur outside of health facilities. Although home birth can be safe for women, those with preexisting medical conditions and obstetric complications should birth in an appropriate medical facility (Ashford, 2001). Similarly, well-trained birth attendants who can recognize signs and symptoms of complications and who can administer appropriate therapies such as intramuscular (IM) ergotrates for excessive bleeding can greatly reduce maternal morbidity and mortality. Lastly, a health care facility should be staffed with adequate, properly trained personnel who can evaluate and initiate appropriate treatment, have

access to supplies, medications, safe blood products and surgical services and be able to initiate treatment in a timely manner (Sundari, 1992).

This model provides an example of the complex nature of solutions to maternal mortality. Sundari (1992) suggests "a drastic reallocation of national resources with a larger share for the health sector and a substantial allocation within the health budget for the health care of women" as a way to address maternal mortality and morbidity (p. 525). Health services at the community level should be strengthened to provide adequate facilities staffed with properly trained personnel and supplies to address the most common determinants of maternal mortality (Sundari, 1992).

Unintended pregnancy

Unintended pregnancy is a critical concept to examine in the context of the reproductive lives of women. The health of women and their families is intimately related to maternal health during and after pregnancy, infant health, family size and the spacing of children. However, unintended pregnancy is also influenced by culture, politics, geography and relationships. The 190 million pregnancies that occur each year resolve in one of three ways; wanted pregnancies, unwanted or mistimed pregnancies, and abortions (The Alan Guttmacher Institute, 1995). Unwanted pregnancy refers to a pregnancy unwanted at any time, whereas mistimed describes those that pregnancies that would be wanted at some time other than the present (The Alan Guttmacher Institute, 1995). While women will commonly describe pregnancies as unwanted or mistimed, these unintended pregnancies may have different personal and cultural significance. The incidence of unintended pregnancy varies across cultures, geographic areas and sociopolitical boundaries. For example, in Latin America it is estimated that 18-19% of pregnancies are unwanted compared to 9% and 3% in South and Southeast Asia and Sub-Sahara Africa respectively (The

Alan Guttmacher Institute, 1995). However, mistimed pregnancies do not seem to vary as greatly with approximately
10-15% of all pregnancies reported as mistimed in most regions of the world (The Alan Guttmacher Institute, 1995).

Unintended pregnancy has far reaching effects on women and their families. The resolution of unintended pregnancy is intimately linked with cultural beliefs about desired family size, the status of women and their ability to make health care choices, the availability and accessibility of contraceptive services and the legal status and availability of abortion. Whatever the reason for unintended pregnancy, the consequences for women and their families are significant. Poorly spaced pregnancies have serious consequences for children. Babies born within 2 years of their sibling are more than twice as likely to die in their first year of life and are more likely to be low-birth weight (Shane, 1997). Similarly, women who become pregnant too soon after birth may discontinue breastfeeding, which can have deleterious effects upon the existing children's health and nutritional status (Shane, 1997).

Women confronted with an unintended pregnancy may resort to unsafe abortion practices. It is estimated that 13% of all maternal deaths, about 70,000 women, are due unsafe abortion. About 20 million unsafe abortions take place annually in the developing world (United Nations Population Fund, 1999). Unsafe abortion is also associated with serious health consequences such as infection, infertility and damage to reproductive organs.

Contraception and Unintended Pregnancy

Contraceptive use is an integral component of the reproductive health care of women and has a profound effect on unintended pregnancy. Contraceptive use has increased worldwide in the last decade with 57% of couples using some form of contraception. However, there is wide variation in use between country of origin and

its related socio-political and religious affiliations (Ashford, 1995; Shane, 1997; United Nations Population Fund, 1999). In the developing world, contraceptive use varies widely, with rates as high as 76% in Brazil to rates as low as 6% in areas of Sub-Sahara Africa (Ashford, 1995; The Center for Reproductive Law and Policy & DEMUS, 1997). Contraceptive use rates in Latin America and the Caribbean suggests similar variations. In Mexico, 45% of women use contraception, while only 38 % of women in Guatemala report regular contraceptive use. However, in Jamaica, 67% of women report using a contraceptive method (Ashford, 1995; The Center for Reproductive Law and Policy, 2000; The Center for Reproductive Law and Policy & DEMUS, 1997). Similarly, the type of contraception used is variable and affected by availability, preferences, and cultural practices. In some countries women may be able to choose from a variety of methods, based upon their desires, cost, and comprehensive and accessible health care services. More commonly, however, contraceptive availability is limited to one or two methods, cost may be prohibitive for women, or women may experience side effects or risk factors that make some methods more dangerous than others. Women who experience difficulty in obtaining and maintaining their contraceptive choices are more likely to experience unintended pregnancy.

Contraceptive Challenges

The use of contraceptives also poses challenges to women. Women may experience undesirable side effects from a method, which makes it more likely that she will discontinue use or be forced to change to a less acceptable method. In many places the quality of reproductive health services is variable, cultural practices may not be respected, costs may be prohibitive, and services may be inconveniently located, especially in rural areas. It is common for unmarried women in many countries to be unable to access contraception.

Knowledge of reproduction and the menstrual cycle is essential for avoiding unintended pregnancy. In many parts of the world less than 20% of women understand the times in their menstrual cycle that they are most likely to become pregnant (The Alan Guttmacher Institute, 1995). Similarly, knowing that contraceptive methods exist and where to find them is vital for effective family planning. For example, in Nigeria 57% of women do not know of any contraceptive methods, whereas, in Guatemala approximately 30% were unaware of ways to prevent pregnancy (The Alan Guttmacher Institute, 1995). Frequently women and men may have differing beliefs regarding family size and child spacing, and some men may disapprove or prohibit their partners from using contraception (Shane, 1997; The Alan Guttmacher Institute, 1995). Lastly, women may fear side effects of modern contraceptives or possess inaccurate information regarding benefits, risks and side effects (Shane, 1997).

The unmet need for family planning services illustrates the possibilities for improvement in the reproductive health of women. It is estimated that 120 million women throughout the developing world are in need of family planning services (Ashford, 1995). These unmet needs contribute to significant numbers of maternal deaths each year, many of which are thought to be related to unsafe or illegal abortion practices (Ashford, 1995). Unintended pregnancy is a serious health problem with far-reaching effects upon the health of women and their families throughout the world.

Unintended pregnancy prevention entails more than the provision of contraceptive services. Although access to services is important, issues such as economics, politics, religion and the role of women in the family and the work place, all play a role in family planning. The use of family planning services is influenced by their affordability, and whether women have the decision making abilities within the

family to use contraception (Shane, 1997; The Alan Guttmacher Institute, 1999; The Center for Reproductive Law and Policy & DEMUS, 1997).

Religion is also an important factor in issues related to reproduction, family planning and abortion. The interface of religion and reproductive health is evidenced by the role that organized religion played at the 1995 Cairo Conference on Population and Development. For example, in countries with strong ties to the Catholic church, contraception and abortion services may be minimal or unavailable for women. These countries along with the Catholic Church voiced reservations over some of the recommendations, especially those regarding the role of abortion in population issues. However, the World Council of Churches supported the expanded reproductive health care goals of the Cairo conference, praising the participants for "...making recommendations concerning human rights, environmental sustainability, over consumption by the wealthy, gender equity and women's empowerment " (Ashford, 1995; United Nations, 1994b, p.11).

Abortion and Reproductive Health

Unintended pregnancy is inextricably linked with abortion and abortion complications. There is probably no other issue in reproductive health care that is as divisive and controversial as abortion. During the Cairo conference, for the first time, the abortion issue was discussed openly among nations with varying beliefs, laws and practices, and framed within the framework of the expanded definition of women's reproductive health (The Alan Guttmacher Institute, 1999). Worldwide, there are approximately 49 million abortions annually, with approximately 20 million of them considered illegal, although it is important to remember that legal does not necessarily mean safe (The Alan Guttmacher Institute, 1999).

Induced abortion refers to the termination of a pregnancy. The procedure is performed using a variety of techniques, usually based upon the gestational age of a

pregnancy. Abortion performed by trained personnel with appropriate attention to safety is one of the most common and safest of gynecological procedures with a morbidity rate of approximately 1 per 100,000 births (The Alan Guttmacher Institute, 1999; World Health Organization, 1994). However, unsafe abortions are a major source of morbidity and mortality, especially for women in the developing world (See Table 2).

Table 2

Abortion Deaths Worldwide

Region	Deaths per 100,000 abortions
Developed World	0.2-1.2
Developing World	330
Africa	680
South and Southeast Asia	283
Latin America	119

(The Alan Guttmacher Institute, 1999) Reprinted with permission

The World Health Organization defines an unsafe abortion as a "...procedure for terminating an unwanted pregnancy [carried out] either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both" (Division of Reproductive Health, 1998). While women of any age may choose to have an abortion, it is much more common at either end of their reproductive lives. Young women may become pregnant outside of marriage may desire to complete their education or simply feel they are too young to care for a child. Conversely, older women, who have reached their desired family size, may become pregnant and believe themselves too old to have another child, have health problems that may complicate a pregnancy, or need to work to support their families. Women of any age

may be victims of rape or incest, or become pregnant secondary to sexual coercion and wish to terminate pregnancies that result from these acts of violence (The Alan Guttmacher Institute, 1999).

The Availability and Legal Status of Abortion

The laws governing who may obtain an abortion, for what reason, at what gestation, where it will occur and who will perform it, vary greatly throughout the world. Socioeconomic status and whether one lives in an urban area, may also affect the availability and safety of abortion services. For example, some countries, in the developed and developing world, such as the United States, most of Eastern Europe, China, and South Africa, allow abortion without restriction in the first trimester of pregnancy (The Alan Guttmacher Institute, 1999). However, many of these "liberal" countries may impose restrictions such as limiting the types of providers and facilities that may perform abortions, have requirements for consent of family members or impose counseling and waiting periods on women prior to performing an abortion (The Alan Guttmacher Institute, 1999). Most countries in Latin America, the Middle East, and almost all of Africa restrict abortion to only those instances where it is necessary to save a woman's life (The Alan Guttmacher Institute, 1999). However, some countries have relaxed these restrictions so that protecting physical and/or mental health of a woman is an acceptable reason for abortion access. Financial considerations may be significant barriers to safe abortion, even in countries where it is legal. For poor women, the cost of an abortion or the time it takes to raise the funds may make access nearly impossible. There may be lax regulations concerning who or where abortions may be performed, leading to unsafe abortion practices. In some countries such as Chile or Nepal women may be imprisoned for obtaining an abortion (The Alan Guttmacher Institute, 1999).

The safety of abortion depends on the availability of qualified abortion providers. In many areas, especially urban centers, physicians provide services either in private offices, hospitals or other health care facilities. However, in the developing world, nurses and midwives may be trained in abortion techniques and the management of complications. In fact, the WHO considers manual uterine evacuation to be an essential obstetric procedure and a life-saving skill for anyone caring for women during pregnancy (Hord, Baird, & Billings, 1999). As 20% of pregnancies may end in miscarriage, manual uterine evacuation is an important skill and can be expanded to include women wishing termination of their pregnancies as well (Hord, Baird, & Billings, 1999; The Alan Guttmacher Institute, 1999). Lastly, abortion services may be provided by traditional healers, traditional birth attendants or by women themselves. Often times, herbal therapies, physical maternal trauma such as insertions of catheters or caustic substances into the uterus or the ingestion of substances like alcohol, medicines or poisons are often suggested to effect an abortion. Women may also attempt to self-induce an abortion through intentional, self-inflicted trauma or taking medicines or folk remedies to induce an abortion (The Alan Guttmacher Institute, 1999).

Whatever the method, unsafe abortion practices can lead to significant morbidity and mortality for women. Sepsis, hemorrhage, and uterine perforation are the most common complications and women who do not seek or do not have access to hospital care will more than likely die as a result of one of these complications (The Alan Guttmacher Institute, 1999; World Health Organization, 1994). Women who do not die can face a lifetime of disability resulting from injured pelvic and abdominal organs, chronic pelvic pain, and secondary infertility (World Health Organization, 1994). The costs of unsafe abortions also affect the health care resources of countries where women receive treatment for post-abortion complications. Some

countries, especially those where abortion is illegal, report that half of their obstetric and gynecology budgets are used to treat women with post-abortion complications and these women use a disproportionate share of resources such as blood products, medicines and hospital beds (The Alan Guttmacher Institute, 1999; World Health Organization, 1994). The legality of abortion seems to play a direct role in the incidence of consequences of unsafe abortion. For example in Romania, under the totalitarian government of Ceausescu, abortion was made illegal to encourage population growth and abortion related deaths rose to 142 per 100,000 births: One year after the government was restored to a democracy and abortion restrictions were lifted, the rate of complications declined by two-thirds (The Alan Guttmacher Institute, 1999).

Regardless of legality and safety, some women choose to terminate their pregnancies using abortion. For many, this will have minimal effects, whereas, others will pay with their lives. The recent expansion of the definitions of reproductive health care, along with the attention of several international conferences, has brought the abortion question to the forefront. It is no longer possible for countries, even where abortion is illegal, to ignore the role it plays in the health of women and the consequences it has for their societies.

Reproductive Health in the Caribbean and Latin America

The complexity of maternal morbidity and mortality makes it difficult to generalize from disparate cultural and ethnic groups in the developing world. Examining cultures most similar to Belize may provide background and insight into the reproductive health of women in Belize. This presents some interesting challenges. Although Belize has a population of almost a quarter of a million, most international surveys do not include countries with populations less than one million. Secondly, although Belize is located in Central America, it is the only English

speaking country in the region, and most often thought to have more Caribbean influence, rather than Hispanic, and is often excluded from Latin American surveys. Lastly, while Belize has strong Caribbean roots, it is geographically isolated from the rest of the Caribbean, and so often forgotten in evaluations of that region.

The cultural and geographic neighbors of Belize include Jamaica, Guatemala, and Mexico. Jamaica is a much larger than Belize, and its history as a British colony, as well as similar Caribbean cultural trends provides interesting comparisons. Similarly, Guatemala shares an often contested border with Belize, and also shares a cultural heritage with the Maya, as well as with a large population of refugees who fled to Belize during the protracted Civil War in Guatemala during the 1980's and 90's. Belize also shares a northern border with Mexico, along with a cultural heritage, especially in the Northern areas of Belize where the majority of this investigation takes place (See Figure 2).

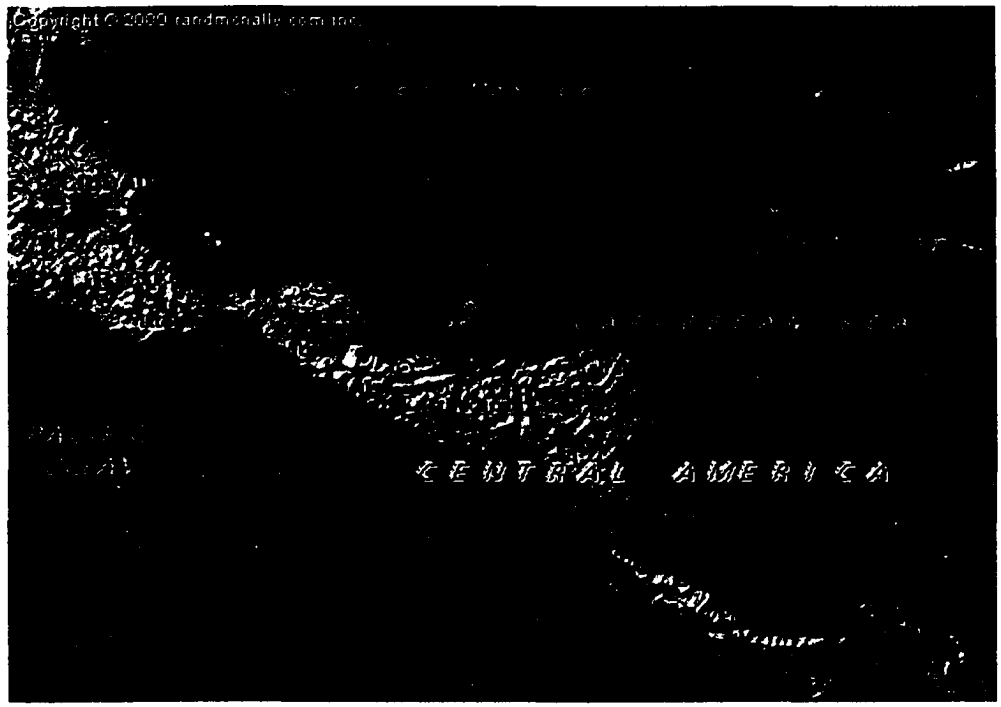

Figure 2 Geographical and Cultural Neighbors of Belize

Source: Rand McNally Get a Map
http://www.randmcnally.com/rmc/explore_maps Reprinted with permission

Belize is a part of the Latin America and Caribbean (LAC) region. This region is comprised of South America, Central America and the English, Spanish and French speaking Caribbean and comprises approximately 8% of the world's population. Many of these areas share many similarities in regards to their histories, socio-political and health care concerns (The Center for Reproductive Law and Policy & DEMUS, 1997). Over the last 35 – 50 years, the LAC region has shown improvement in many health related areas such as life expectancy, now 68.5 years, a decrease in infant mortality from 125 per 1,000 births in 1955 to 36 per 1,000 in 2000, an increase in vaccination coverage and a decrease in communicable diseases (Casas, Dachs, & Bambas, 2001). However, the LAC region also has the most unequal distribution of income in the world, with the wealthiest 10% of the population receiving 84 times the income of the lowest 10% (Casas et al., 2001). Consequently, many of these health

improvements may have escaped the poorest in the region. Maternal mortality for the Latin American and Caribbean region, is 194 per 100,000 live births which is the fourth highest in the world, with complications from illegal or unsafe abortion as one of the leading causes of maternal mortality among Latin American women (The Center for Reproductive Law and Policy & DEMUS, 1997). Maternal and infant mortality and the leading causes of maternal morbidity and mortality of Belize and its neighbors may be found in Table 3.

In the LAC region skilled birth attendants deliver approximately two-thirds of all women. Most of the maternal deaths are related to postpartum hemorrhage and hypertensive disorders of pregnancy (Pate, Collado, & Solis, 2001). However, 16% of maternal deaths result from abortion complications (Pate et al., 2001). Latin America overall has restrictive abortion laws and there are about 4 million clandestine abortions performed each year, resulting in 80,000 hospitalizations (The Center for Reproductive Law and Policy & DEMUS, 1997). Six thousand women die each year in Latin America and the Caribbean as a result of abortion related complications (The Center for Reproductive Law and Policy & DEMUS, 1997). Other indicators of health and population in Latin America and the Caribbean can be found in Table 4.

Review of these health indicators highlights some interesting comparisons. Central America and the non-Latin Caribbean have the most rural population and Central America has the highest fertility rate of all the regions. Infant mortality is significantly higher among all of the countries in the LAC in comparison to North America. With the exception of Mexico, North America spends twice as much on health care in relation to its GDP, than all other regions. It is unknown if or where Belize relates to the health indicators described for the LAC region.

Table 3

Maternal and Infant Morbidity and Mortality in Selected Latin American and Caribbean Countries

Country	Maternal Mortality (per 100,000 births)	Infant Mortality (per 1,000 births)	Major Cause of Maternal Mortality
Belize	*139**	26.2	hemorrhage
Jamaica	115	12	abortion complications
Guatemala	190	45	pregnancy complications
Mexico	61	35	pregnancycomplications

**per 1,000 live births*

(American Public Health Association, 2001; Belize Ministry of Health and Sports. & Belize Ministry of Human Resources Women's Affairs and Youth Development. 1997; The Center for Reproductive Law and Policy, 2000; The Center for Reproductive Law and Policy & DEMUS, 1997)

Table 4

Population and Health Indicators in Latin America and the Caribbean

Region	Total Population (Thousands) 2000	Urban Population (%) 2000	Total Fertility (Rate per women) 1995-00	Infant Mortality 1995-00	Drinking water (%) 1998	National Health Expenditures as % of GDP
Latin America & Caribbean	514,686	75.3	2.7	35.5	85	7.2
Central America	36,616	48.3	3.9	36	77	7.6
Latin Caribbean	31,390	63.4	2.7	45	74	6.6
Non-Latin Caribbean	7,872	58.9	2.3	22	90	5.0
Latin America	506,814	75.6	2.7	35.7	85	7.2
Mexico	98,881	74.4	2.8	31.0	89	15.6
North America	308,569	77.2	1.9	7.0	100	14.4

(Pan American Health Organization, 2000)

Knowledge of the geographic region as well as the cultural links to Belize, allows for a clearer picture of reproductive health to emerge. However, the history of Belize is important because it explains how cultural pluralism has taken hold in Belize and speaks to the unique nature of this small country which has it roots firmly planted in the cultures and practices of Latin America, the Caribbean and the indigenous peoples of the region now known as Central America. The following chapter will explore the history and culture of Belize as well as the two Northern districts where the research took place.

CHAPTER 3

Setting

This focused ethnography took place in another culture. Thus it is essential to provide a description of the setting, as it is a critical aspect of the research. An overview of Belize, its culture, history and health care system is important for the understanding the lives and experiences of women in Belize. The investigation took place in the two northern most districts in Belize, Corozal and Orange Walk. The researcher is most familiar with Corozal, as this is where the majority of time has been spent during previous health care experiences. However, recent changes in the health care delivery system have expanded the areas where health care activities take place to include the Orange Walk District.

This chapter will summarize the history and cultural pluralism of Belize. The socioeconomic and political elements of Belizean culture will be discussed and an in-depth analysis of the demographics and the health care system will be described. This chapter will conclude with a description of the two Northern districts in Belize to provide snapshot of the lives of women in Belize.

Belize

History

The history of Belize, formerly British Honduras, is intricately linked with the present day cultures of Belize. The complex history of domination of indigenous peoples, occupation by the British and Spanish, and its economic role in Central America and the Caribbean, all shaped present day Belize. In order to understand Belizean history, it is necessary to imagine a time before there were countries and borders; this is the time of the Maya. The earliest Preclassic Maya existed from 1200 BC to 250 AD. The Classic period of the Maya extends until 900 AD, followed by the Post Classic period until 1508 (the date of the first recorded Spanish contact with the

Maya (Shoman, 1994). Before the arrival of the Spanish in the 16th century, there was no Mexico, Guatemala or other boundaries in the Central and North American areas now known as Mexico.

The Maya occupied areas in what are now western Honduras, southern Mexico, El Salvador, Guatemala, and Belize (Shoman, 1994; Wright, 1991). The Maya were a complex civilization with a written language, extensive knowledge of architecture, astronomy and a diverse economic base, indicated by archeological evidence of widespread trading among groups scattered throughout the Central American region (Shoman, 1994). There were large Mayan "cities" or settlements throughout the regions, with estimates of 70,000 people at larger locations such as Tikal in the Peten region of Guatemala. At some point during the 9th or 10th century there was a collapse of the complex Mayan societies of the region. The cause is unknown and while the populations did not disappear, the culture underwent a transformation from a complex society to one in which there were newly developed political, economic and social systems (Shoman, 1994). According to Wright (1991) "...we have only the abrupt silence of the inscriptions and a growing body of circumstantial evidence. Theories of plague, invasion, soil exhaustion and peasant revolt have been advanced; but the collapse of a civilization is likely to be a complex affair" (p. 53).

The Spanish were the first to meet the Maya of Belize in the 1500's. During this time numerous Spanish military exercises conquered Mayan settlements throughout the area now known as Belize. During the oppression and the conquests of the Maya, many were killed, women were raped and the vestiges of the Mayan society destroyed. Catholic missions throughout the conquered areas of the Belizean region were begun to convert the Mayan to Catholicism, thereby exerting control over a new Mayan way of life. However, the Maya were not easily conquered and the

following 100 years were marked by multiple violent episodes against the Maya and multiple uprisings of the Maya against their Spanish conquerors (Shoman, 1994).

According to Bolland (1986), there is evidence that throughout the 16th and early 17th centuries, the Spanish were responsible for the decimation of the Mayan populations of Central America, through the introduction of diseases and an extensive slave trade. Despite disease and frequent slaving raids, the Maya's spirited resistance prevented the Spaniards from establishing a permanent hold on the land of Belize (Bolland, 1977; Shoman, 1994)

At the beginning of the 17th century, Spain's dominance of the Central American and Caribbean region was faltering, being replaced by other European powers, namely Great Britain, France and the Netherlands. Logwood, or dyewood, was much in demand in Britain, as it was capable of producing multiple dyes used in the British woolen industry. Along the "mosquito coast", of what is now known as Belize and Honduras, pirates, raids and pilfering were common, especially for the most sought after logwood. However, in 1670 the Treaty of Madrid was signed by the European powers with the intent to curtail the extensive piracy that was commonplace in the region. This led to the settlement of British Honduras as a settlement for "cutters" who traveled the coast in search of logwood. This initial settlement, while considered uninhabitable due to swamps and mosquitoes, was a prime location due to the Mopan River and the access it afforded to the Caribbean Sea (Bolland, 1986; Shoman, 1994).

As the "cutters" moved inland, they eventually expanded their search to include mahogany, a prized hardwood in Europe. A complex system of ownership and rights to large areas of land for cutting developed and a monopoly was created. Almost all of the land was in the control of a dozen wealthy men. The work created the need for slave labor to harvest and transport the more prized, yet harder to

harvest mahogany (Shoman, 1994). The widespread importation of black slave labor with African roots during the 18th century created a society in which the majority of the inhabitants of British Honduras were black. This would have a significant impact on the creation of the present day Belizean society.

The 1700's saw an expansion of the British log cutters throughout the remote territories that would later become Mexico, Guatemala, Honduras and Belize. However, this time was also marked by multiple conflicts between the Spanish and British. Spain was unable to maintain the military presence and attention that was needed to maintain its control of the region. The British defeated the Spanish at the Battle of St. Georges Caye in September of 1798, effectively ending the rule of the Spanish in what is now known as Belize (Shoman, 1994).

While the British were victorious, their struggles were not yet over. Although they were able to harvest and exploit the mahogany forests of what is now Belize, they also began to come into regular contact with the Maya. From their initial contact, conflict was inevitable. The main objective of the British was to cut mahogany and transport it out of the country with slave labor, imported mostly from Jamaica. Conversely, the Maya saw the land as a valuable resource given by the gods, for their use and that of future generations. Their economic base of sustainable farming and trading had supported many centuries of the Mayan people. These discrepancies led to inevitable conflict, but the limited abilities of the Maya to defend their land from exploitation were no match for the powers of the British Empire (Bolland, 1986; Shoman, 1994). However, the Maya were not easily displaced.

> They lived in harmony with the environment, they knew the land intimately, and were able to slip away into "secret recesses"; they knew the medicines that the forest offered them for their well-being; they learned to survive by adopting and adapting some of the culture

> of the conquerors, without completely losing their identity; they saved themselves by transforming themselves (Shoman,1994, p. 36).

During the 18th century, until the early 19th century, slaves were brought from Africa to Belize to provide the labor necessary to locate, remove and transport mahogany trees. Although the "slave trade" officially ended in 1807, emancipation did not occur in Belize until 1838. However, for the newly free men the economy offered little in the way of employment, except for continued work in the mahogany trade. Laws were enacted that prohibited the newly freed men from property ownership, due to a fear that the mahogany industry would collapse if all the labor left to begin individual farms and other work. Women fared poorly as well, with their efforts concentrated in domestic work, increasing their dependency on men to provide for them and their families (Shoman, 1994).

The last half of the 19th century brought events that would have a critical impact on the future of the geographical and cultural boundaries of Belize, and the continued evolution of its culture. The Garifuna people were the first new people to join the Maya and the British peoples in Belize in the middle of the 19th century. The Garifuna who settled in Belize were descendants of African slaves and the indigenous Caribs and Arawaks who originally migrated from the Amazon basin (Shoman, 1994). They came together on the island of St. Vincent, off the coast of Honduras. When the British took control of the island from the French, they displaced the Garifuna to Roaton, another island off the coast of Honduras. During the ensuing years they dispersed throughout a large region of Central America, with a large number settling in what is now Belize. "The largest immigration occurred on November 19, 1832 and this day continues to be celebrated as a national holiday in Belize and is known as Garifuna Settlement Day" (Shoman, 1994, p. 79).

Another large immigration occurred in Belize as a result of the Guerro de Castas or the Caste War in the Yucatan peninsula of Mexico in 1847. During this time, the Maya fought back against their Spanish conquerors and tried to escape the oppressive caste system that had been developed by the Spaniards. One result of this struggle was a huge immigration of approximately 15,000 Mayan and Mestizo from the Yucatan, who mainly settled in what is now known as the northernmost district of Belize--Corozal. Similarly, the treaties that evolved during and after the conflict helped to shape what is now the northern boundary of Belize with Mexico (Bolland, 1986; Shoman, 1994).

In 1862, Belize, then known as British Honduras, was officially declared a colony of the British Empire and by 1871, was under total control of the British government. The next decades were ones of expansion for the colony of British Honduras. There was a trend towards urbanization, expansion into other commercial enterprises such as chicle (the substance used to make chewing gum) and sugar. A shift in the economic ties of the colony away from England and towards the United States was prevalent in the early 1900's, and continues to this day (Shoman, 1994).

The Great Depression of 1929 was not an isolated event in the United States; it had profound effects on British Honduras and served as a catalyst for sweeping change in the politics and economy of the country. The rise of labor unions, riots and strikes all spoke to the disenchantment of the Belizean working class and also ignited a suffrage movement to revise the colonial voting system which depended on money and property as a prerequisite to suffrage, thereby eliminating the voices of thousands of men and women of Belize (Bolland, 1986; Shoman, 1994).

Belize joined in the movement towards independence that was growing among colonized nations throughout the world after World War II (Shoman, 1994). This movement was in turn supported by changes in Belize itself; a rise in the

educated class, the attainment of universal suffrage in 1954 and the important role of participation in local town boards and councils (Shoman, 1994). Universal suffrage changed the status quo of Belizean politics and allowed elections by the people. However, executive power still remained with a British appointed governor (Bolland, 1986). In 1964 a new constitution created a bicameral legislature, consisting of a house of representatives and a senate and for the next 20 years the British maintained control of only foreign affairs, defense, internal security and the civil service. While 20 years is an unusually long period for such a transition, the "Guatemala issue" prevented a more timely independence, as Belize could not run the risk of a Guatemalan conflict without the military defenses of the British.

When Guatemala gained its independence from Spain it assumed it also controlled the other sovereign territories of Spain, including British Honduras. However, the British never recognized this interpretation. The Anglo-Guatemalan treaty was signed in 1859 and recognized the current day boundaries and stipulated that both countries would work to build a road connecting the Pacific coast with the Caribbean Sea (Dobson, 1973; Shoman, 1994). The British surveyed the road and determined their job done, while the Guatemalans declared the British had defaulted and refused to recognize the treaty, thereby claiming British Honduras as its own (Bolland, 1986). The next 20 years saw numerous diplomatic and military attempts to reconcile the issue, without success. It was not until 1991, that the government of Guatemala officially recognized Belize and created official diplomatic relations (Bolland, 1986; Shoman, 1994). The "Guatemala issue", while currently silent, continues to erupt occasionally with mild border skirmishes and political bantering between the borders of the two nations.

Independence Day. At midnight of September 20/21,1981, the Belizean flag was raised for the first time and representatives from over 60 countries joined

Belizeans to celebrate the birth of the new nation of Belize. Five days later, Belize became the 156th member of the United Nations (Bolland, 1986; Shoman, 1994).

Over the next 30 years, Belize, as an independent nation, continued to grow, change and expand in many directions. Belize is integrating itself into the global economy, but this access comes at a cost. It must devote itself to free trade, without restrictions or preferential markets, which for a developing country, the size of Belize, may have disastrous effects upon its economy (Shoman, 1994). The widespread introduction of media into the culture has expanded access to the world but also draws attention to the lack of goods and services in Belize. Another large immigration of 30,000 refugees arrived in the 1980's as a result of the armed conflicts in El Salvador and Guatemala. The majority of these immigrants were poor, spoke only Spanish, and had little to offer in economic terms in exchange for their safety. Conversely, there is considerable emigration of Belizeans, who mainly settle in the United States. These Belizeans are usually young, educated and represent a significant loss of potential for the future of Belize. However, this exodus also has a significant economic impact on the economy as remittances from the United States averaged 21 million dollars during the 1980's, which was 15% of the gross domestic product of Belize (Shoman, 1994).

Belize has not been immune to the consequences of the illegal drug trade. The geographic location of the country makes it an important link in the distribution of illegal drugs to the United States. A rise in violent crime, gangs and substance abuse has all been seen in Belize during the last decade (Shoman, 1994). The health consequences of substance abuse, such as HIV/AIDS and crime continue to tax the health care resources of the country.

One bright spot in the Belizean economy has been the growth of tourism, with the number of tourists growing to 100,000 in 1990 (Shoman, 1994). While these

tourists bring their dollars to spend and create jobs, most of the jobs are in the service sector, which are traditionally low paying. The areas of tourism are diverse throughout Belize and encompass practically the entire country. However, the advantages of tourism such as the building of an infrastructure, the preservation of the environment (which is what brings the tourists) and an influx of capital for development have benefited Belize (Sutherland, 1998).

As Belize entered the 21st century, the society had a growing economy, but a widening of the gap between rich and poor. The last decades of the 20th century also brought an increase in the role of NGO's that provided services, which had been inadequately provided by government agencies. Belize Family Life Association (BFLA) is an example of an NGO that provides services that the government does not offer. Shoman (1994) also relates that there has been a growing women's movement in Belize. Through the use of community based activities such as income generation, advocacy and consciousness raising, efforts are being made to "...correct the traditional imbalances of power and opportunity between males and females and to address the inequities of the socioeconomic system from a gender perspective" (Shoman, 1994, p. 287).

This brief review of the history of Belize from its ancient roots to the present day illustrates the formation of a complex, multicultural society. While the many of cultures of Belize have maintained their language, customs and beliefs, they have also cultivated a "Belizean" culture. The emerging nation has carefully "...reflected and promoted important activities and institutions in which Belizeans share and take pride, and that in a common cultural process, promote their identity as Belizeans" (Bolland, 1986, p.47). This cultural pluralism recognizes the important contributions of each cultural group, while at the same time, promoting this multiculturalism as the unique national identity of Belize

Demographics

There are six districts in Belize, with the capital located in Belmopan, in the Cayo district. The capital was moved from Belize City after Hurricane Hattie in 1961 to provide a more protected environment for the national government, because Belize City is below sea level and is prone to significant flooding (See Figure 3). The most recent population estimates of 2000, suggest that the population of Belize is 242,204, and represents a growth of 2.7 per annum, since 1991

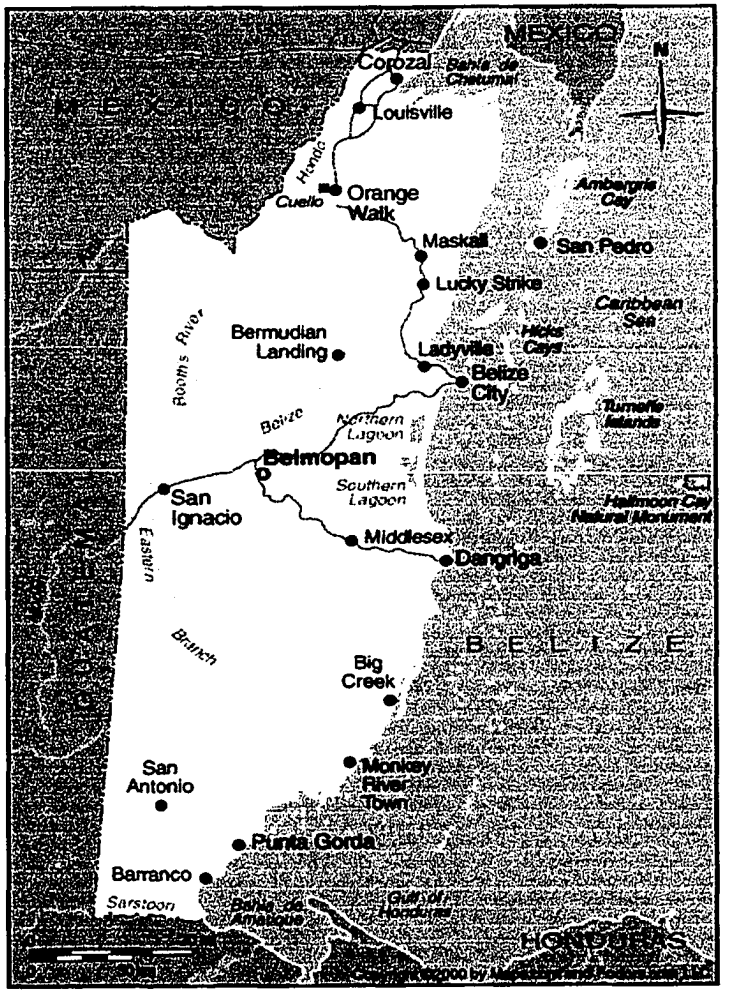

Figure 3 Map of Belize

Source: www.fodors.com 2002

(The Central Statistical Office, 2000). Approximately 52% of the population lives in rural areas, with the largest urban population in Belize City (The Central Statistical Office, 2000). The Corozal district has a total population of 32,708, with a larger portion of the population living in rural villages. Corozal Town has a population of 7,888 and experienced an 11.9% growth rate over the last decade (The Central Statistical Office, 2000). Orange Walk District has a larger total population at 38,890. Similarly, the rural village areas have a greater population and experienced a 36.3% growth rate; more than double that of Corozal. Orange Walk Town is almost twice the size of Corozal, with a population of 13, 483 (The Central Statistical Office, 2000).

The ethnic and cultural composition reflects the multicultural nature of Belize as well as its unique challenges. The Mestizo group (those of Mayan and Spanish descent) comprise 44% of the population, while the Creole group is 30%. The term Creole generally refers to "...people born in the Americas whose ancestors come from another continent"; in Belize this refers to those of African descent with strong ties to the slave trades throughout the Caribbean in the 1700-1800s (Shoman, 1994, p. 42). Other groups include the Maya (12%), Garifuna (7%), East Indian (4%) and Asian (2.5) (Pan American Health Organization, 2001). The effect of immigration is highlighted by the fact that 14% of the total population are immigrants, with the highest numbers coming from Honduras, El Salvador and Guatemala (Belize Ministry of Health and Sports & Belize Ministry of Human Resources, Women's Affairs and Youth Development, 1997; Pan American Health Organization, 2001).

The population of Belize is young, with 42% of its population under the age of 15 and 61% under 25 years of age (Pan American Health Organization, 2001). Although there are no gender differences in the younger population, life expectancy is gender dependent, with male and female life expectancy at 69.9 and 74.1years, respectively (Pan American Health Organization, 2001). The 1990 census reported a

sex ratio of 1.02, meaning that for every 102 males there are 100 females. This is comparable to most countries without extenuating cultural circumstances related to gender, and appears consistent throughout all the regions of the country (The Central Statistical Office, 2000).

Poverty affects the lives of many Belizeans. The percentages of those who live in poverty depend on the definition used. In comparison to the gross domestic product export earnings of other Caribbean and Latin American cultures, Belize does not appear to be a poor country. However, if one looks at the ability of its citizens to meet the basic needs of food and housing expenditures, then the picture looks quite different. In 1995, 33% of Belizeans were unable to meet their basic needs for housing and food. An additional 13% were very poor and unable to meet even their basic food needs (Pan American Health Organization, 2001; The National Committee for Families and Children & UNICEF Belize, 1997).

Nutritional status is correlated with the above poverty statistics, with those children living in the poorer districts, such as Toledo and Stann Creek having the highest levels of malnutrition. Overall, 20% of Belizean children had mild malnutrition, 5% moderate and 1.3% had severe malnutrition (The National Committee for Families and Children & UNICEF Belize, 1997). Malnutrition affects not only health status, but also growth and learning abilities as well, so these malnutrition levels are particularly worrisome to the health of the nation.

Education

Literacy in Belize is estimated to be about 75% and is defined as completing school through standard V, which is comparable to 7th grade in a the United States (Pan American Health Organization, 2001; The National Committee for Families and Children & UNICEF Belize, 1997). However, in 1996 the Central Statistics Office of Belize conducted a survey that measured reading and comprehension and found that

only 42% of 10-65 year olds were functionally literate (Pan American Health Organization, 2001). School is free and compulsory from 5 until age 14. However, 40% of children never complete their primary education (The National Committee for Families and Children & UNICEF Belize, 1997). Although education is free, parents are often required to pay for textbooks, supplies, uniforms and class fees. The education system in Belize is quite eclectic, with a combination of government, religious based and community based primary educational facilities. The Catholic Church manages 46% (127) of all schools, Anglican and Methodist each manage 22 schools, and there are 34 private schools. The government operates the remaining 42 schools (The National Committee for Families and Children & UNICEF Belize, 1997). Preschool education is available, mostly through community and religious based schools and is similarly financed; however, it is not compulsory. In 1995, it was estimated that 52% of teachers were formally trained; ranging from 60.9 % in Corozal to a low of 29% in the Toledo district (The National Committee for Families and Children & UNICEF Belize, 1997). Untrained teachers have completed secondary school, while trained teachers have received technical or university based education through a variety of mechanisms in Belize (The National Committee for Families and Children & UNICEF Belize, 1997). In 1996, student-teacher ratios in primary education were high at 27:1, however, if only fully trained teachers are included the ratio increases to 57:1 (The National Committee for Families and Children & UNICEF Belize, 1997).

Secondary education is available to students who qualify based upon national exams and their ability to pay. Only about half of the students eligible to attend secondary school in Belize do so (The National Committee for Families and Children & UNICEF Belize, 1997). There is at least one junior college in each district and university based education in Belize City at the University of Belize, Belize Technical

College, the Belize School of Nursing, Belize Teachers College and the Belize College of Agriculture (The National Committee for Families and Children & UNICEF Belize, 1997). Recently all of these professional schools have been integrated into the University of Belize (Jennrich, 2001).

Water and Sanitation

Water and sanitation services are integral to the health of any nation. In Belize, 84% of the population has access to a safe and consistent water supply, however while urban areas have total access, only 69% of those in rural areas have safe drinking water (Pan American Health Organization, 2001). The use of bottled water is growing in Belize and represents a new industry in the country, although there are no national standards that ensure quality and safety in the industry (National Human Development Advisory Committee, 1998). Wells and rainwater are the two most common sources of drinking water, however if wells and catchment areas are uncovered, then the risk of contamination increases significantly (The National Committee for Families and Children & UNICEF Belize, 1997). Wells dug too near to latrines present health hazards due to contamination with fecal coliform bacteria.

Sanitation is essential to maintain a safe water supply as well as to limit the spread of diseases. Only three areas have sewerage systems, San Pedro (the major tourist area), Belize City (only 60% of the city is covered) and the capital, Belmopan (The National Committee for Families and Children & UNICEF Belize, 1997). Only 39% of the population in urban areas has access to sanitation; with only 22% of those in rural areas have adequate and safe sanitation (Pan American Health Organization, 2001; The National Committee for Families and Children & UNICEF Belize, 1997). Lack of sanitation can become a major health issue, in times of environmental disasters, such as hurricanes. In the last 3 years Belize has suffered through three

major hurricanes, Mitch, Keith and Iris, and a lack of adequate sanitation caused the spread of diseases like typhoid, cholera and fecal coliform bacteria.

Health

The health status of the population of Belize will be described by presenting general statistics that reflect the health of the country, including communicable diseases and chronic illness followed by statistics that illustrate the status of reproductive health for women.

Communicable Diseases

Malaria remains a persistent health problem in Belize and the incidence of the infection among children is spreading. In 1995 there were 9,413 cases diagnosed, with some districts showing decreases and others showing increases (Pan American Health Organization, 2001; The National Committee for Families and Children & UNICEF Belize, 1997). Current strategies for malaria control are focused at the local level, by advocating for the use of sleeping nets, education regarding household practices that prevent infection, and thorough identification and complete treatment for all those thought to be infected (Belize Ministry of Health and Sports & Belize Ministry of Human Resources, Women's Affairs and Youth Development, 1997).

HIV/AIDS was first identified in Belize in 1986. In Central America, Belize has the highest per capita prevalence of HIV/AIDS. Through extrapolation, it is estimated that there are 4-5,000 HIV infected individuals (The National Committee for Families and Children & UNICEF Belize, 1997). As of 1996, there were 195 cases with the majority being in the 20-44 age range (Pan American Health Organization, 2001). Transmission is mostly through heterosexual contact with a male to female ratio of 1.6 to 1 (Pan American Health Organization, 2001). As of 1996 there were 5 cases of perinatal transmission. Testing is available throughout Belize at health centers, BFLA centers and periodic AIDS screening events. Recently, universal counseling and

voluntary testing of pregnant women was instituted. Since the fall of 2001, two HIV positive mothers in the Corozal district were identified through testing and these mother-infant dyads were treated with Nevirapine (Olgadez, 2002). Infant formula will also be provided for infants of infected mothers to eliminate transmission through breastfeeding. This represents the first treatment for the infection available to Belizeans who are unable to access the more comprehensive HIV treatments available elsewhere.

While the AIDS epidemic has created many new challenges to the already burdened health care system, health care successes have occurred. In 1990 Belize attained Universal Child Immunization which is defined as 80% coverage for each of the six major childhood illnesses in children under the age of one (The National Committee for Families and Children & UNICEF Belize, 1997). Measles was eliminated in 1995; there has been no reported polio since 1980, and no cases of neonatal tetanus since 1992 (The National Committee for Families and Children & UNICEF Belize, 1997). The measles, mumps, rubella (MMR) vaccine was introduced in 1996. The coordinated efforts of the child health clinics and the mobile health clinics have been identified as instrumental at attaining such high immunization rates (The National Committee for Families and Children & UNICEF Belize, 1997).

Adult and Child Health

The health of the adult population in Belize mirrors what are often referred to as "diseases of civilization", namely heart disease, diabetes and hypertension. While genetics are relevant when examining these conditions, diet, lifestyle, and activity level also play a significant role. In the over 50 age group, 50% of deaths are caused by heart disease, cerebrovascular accidents, respiratory illnesses and neoplasms (Pan American Health Organization, 2001). In the 20-49 year old population deaths from external causes was 24%, with more than half of these deaths related to road

traffic accidents (Pan American Health Organization, 2001). Males in this age group were more than almost twice as likely to die than females. In recent years more attention has focused on seat belt usage to improve survivability in road traffic accidents. Although, seatbelt use is mandatory, compliance is variable and enforcement is difficult. Adolescent morbidity and mortality reflect the challenges of adolescence. Male adolescents from 10-19 years of age were twice as likely to die than females; 8.7 versus 3.6 percent respectively and external causes were the most likely cause of death. However, complications of pregnancy (17%) were the most common reason for hospitalization in this age group (Pan American Health Organization, 2001).

In children ages 5-9 the mortality rate in 1996 was 5.5% with 43% of the deaths attributed to external causes. Respiratory illness was the most common morbidity for children in this age group (Pan American Health Organization, 2001). For children ages 1-5, mortality was 12.2%, however the causes of morbidity were similar to older children. External causes, including road traffic accidents accounted for almost one quarter of the deaths of children. Infectious diseases with respiratory complications were another major cause of mortality in small children (Pan American Health Organization, 2001).

Infant mortality in Belize has decreased in recent years, from 31.5% in 1993 to 26% per 1,000 live births in 1996. Thirty-six percent of infant deaths occurred during the perinatal period with asphyxia, low-birth weight and infections being the most frequent causes (Pan American Health Organization, 2001). Infectious diseases were the most common cause of morbidity and hospitalization in this age group (Pan American Health Organization, 2001). Currently there is a national movement to increase the number of infants who are exclusively breastfed as well as to increase the duration of exclusive breastfeeding. Currently only 46% of babies are breastfed

exclusively for the first three months of life (Pan American Health Organization, 2001; The National Committee for Families and Children & UNICEF Belize, 1997). The Corozal hospital is preparing to become the first "Baby Friendly" hospital in Belize. This official status identifies strategic components in hospitals, clinics and communities that help to promote and facilitate breastfeeding practices. Some of these components include the training of all staff regarding breastfeeding practices, the elimination of artificial formula and teats from the hospital and clinics, rooming-in and breastfeeding on demand. In addition, community-based breastfeeding support groups comprised of mothers who have breastfed, current breastfeeding mothers and pregnant women are instituted. The researcher has participated in preparations for this review over the past three years and the hospital is currently awaiting their accreditation visit.

Reproductive health care

Women of Belize are affected by all of the health problems described previously, as well as the added burden of their reproductive health. Reproductive health is complex, even in a small country like Belize. In 1991, the Belize Family Health Survey was conducted to assess the health of women and their families through exploration of fertility rates, contraceptive use and non-use and the risks of unplanned pregnancy among Belizean women. This was the most recent attempt undertaken in Belize to assess this information on a national level. The survey used a national household probability sampling design and 4,567 households were visited, in both rural and urban areas during a 3-week period in 1991(Central Statistical Office et al., 1991).

Fertility

Fertility rates are defined as the average number of children per women, based on figures for the last five years (The National Committee for Families and

Children & UNICEF Belize, 1997). The most recent estimates for the fertility rate of women in Belize is 4.6. However, this rate varies throughout the country. Urban and rural differences are seen in most health statistics in Belize and the fertility rate is no exception, with the fertility rates in urban areas being 3.9 and rural areas, 5.8 (The National Committee for Families and Children & UNICEF Belize, 1997). Women with higher educational levels had fewer children, as did women with more household amenities, perhaps associated with increased socioeconomic status (Central Statistical Office et al., 1991; The National Committee for Families and Children & UNICEF Belize, 1997). Women who worked outside the home had nearly half as many children as women who did not (Central Statistical Office et al., 1991; The National Committee for Families and Children & UNICEF Belize, 1997). Ethnicity was also associated with the fertility rate; Creoles had the lowest fertility rates (3.6); followed by Mestizo (4.8); others, which included the Garifuna and Maya, were 5.4; and the highest fertility was found among the immigrant population at 5.7 (Central Statistical Office et al., 1991; The National Committee for Families and Children & UNICEF Belize, 1997).

Contraception and Family Planning

One of the important determinants of fertility is the availability and use of contraception and family planning services. There is no national family planning policy or services in Belize (The National Committee for Families and Children & UNICEF Belize, 1997). However, as a result of the Cairo conference, Belizeans' rights to family planning services were affirmed and a population unit was begun in 1996 to formulate a comprehensive population policy (The National Committee for Families and Children & UNICEF Belize, 1997). The Belize Family Life Association provides almost all of the family planning services in Belize. BFLA is a NGO that began in 1985 through the work of concerned citizens who "...gathered together in an

effort to improve conditions affecting family life in Belize" (Belize Family Life Association, 2000, p.16). The organization is affiliated with the Caribbean Family Planning Association and the International Planned Parenthood Federation (Belize Family Life Association, 2000). In keeping with the expanded definition of reproductive health, the BFLA has also expanded its services in recent years, to include psychological and nutritional services as well as consultation for medical problems (Belize Family Life Association, March 1999).

Women participating in the national survey were knowledgeable regarding contraceptives, with 95% knowing at least one modern method of contraception (Central Statistical Office et al., 1991; The National Committee for Families and Children & UNICEF Belize, 1997). However, this knowledge did not always translate into contraceptive use. Only 33.6% of women were using contraception at the time of the national survey, with the highest rates of contraceptive use found among married women and those with visiting partners, 46.7 and 47%, respectively; the lowest rates of contraceptive use was among women who were single and separated/divorced or widowed, 6.6 and 31.1%, respectively (Central Statistical Office et al., 1991; The National Committee for Families and Children & UNICEF Belize, 1997). The average age at first contraceptive use was 27.9 years and usually occurred when women already had 3.8 children (Central Statistical Office et al., 1991; The National Committee for Families and Children & UNICEF Belize, 1997). The majority of women (66.8%) are using contraceptive methods to limit the numbers of pregnancies, rather than to space their pregnancies (Central Statistical Office et al., 1991; The National Committee for Families and Children & UNICEF Belize, 1997). This is highly correlated with age and number of children, with older women who have more children wishing to limit pregnancies, rather than space them as their younger counterparts are attempting to do. The most common method of contraception for

married women is tubal sterilization, which accounts for 40% of all contraceptive use, followed by oral contraception, injectables and other methods such as condoms and intrauterine devices (IUDs) (Central Statistical Office et al., 1991; The National Committee for Families and Children & UNICEF Belize, 1997). Overall urban women are more likely to use contraceptive methods, with younger women in both rural and urban areas using reversible rather than permanent methods of sterilization. Women who work outside the home and have higher educational levels are more likely to use contraceptive methods.

According to the 1991 survey, women obtain contraception in a variety of locations. The majority of tubal sterilizations are performed at government facilities (87%), with the remainder being obtained privately (Central Statistical Office et al., 1991). Sixty-five percent of oral contraceptives are obtained at pharmacies (often without verbal instructions) with the remainder obtained through BFLA (17.9%) (Belize Ministry of Health and Sports & Belize Ministry of Human Resources, Women's Affairs and Youth Development, 1997; Central Statistical Office et al., 1991). Injectable contraception and IUD's are obtained mainly through BFLA or private facilities (Central Statistical Office et al., 1991). Although most condoms are obtained through pharmacies, they are available at BFLA sites for a minimal cost.

When examining the use of contraception among women in Belize, it becomes apparent that the reasons for non-use are critical to examine if women are to achieve their reproductive health goals. Almost 60% of women reported that they were already pregnant, desiring a pregnancy, not sexually active, postpartum or breastfeeding, or not at risk due to age or sterilization (Central Statistical Office et al., 1991). However, 40% of women who were at risk of pregnancy were not using contraception and the three most common reasons were an occurrence or fear of side effects (9.2%), a dislike of available methods (8.0%) and a lack of knowledge of

methods available for use (7.9%) (Central Statistical Office et al., 1991). Other reasons for non-use included health reasons, money, opposition of spouse, embarrassment and religious reasons (Central Statistical Office et al., 1991). Of current non-users of contraception, almost 55% desire to use a contraceptive method, with 75% knowing where to obtain a method (Central Statistical Office et al., 1991). Young women seem to be at particular risk as 70% were not using contraception at the time of first intercourse, while less than 20% desired a pregnancy (Belize Ministry of Health and Sports & Belize Ministry of Human Resources, Women's Affairs, and Youth Development. 1997).

Using a broadened definition of reproductive health challenges health care providers and policy makers to reevaluate common reproductive issues from a different perspective, which encompasses all aspects of a woman's life affecting her reproductive health. In Belize, unintended pregnancy remains a health problem that contributes to adverse health outcomes for women and their families. While information regarding the numbers of women at risk and wishing to use contraception is known, little is known about how and why women in Belize choose to use or not use contraception, what cultural factors are relevant to these reproductive health decisions and the role health care providers play in these decisions.

Macke (1993) explored the role that certain cultural aspects play in the use of contraception in Belize. Using the Belize Family Health Survey, she found that social attitudes regarding contraception were more important than both education and socioeconomic status (SES). McClaurin (1996) in describing adolescent use of contraception in Belize believes that "...moral codes and religious values, combined with community ideals about family and children, produces a contradictory relationship between sexuality and the use of contraception" (p. 74). These contradictions may contribute to an adolescent's inability to use contraception and

may be reflected in the rates of adolescent pregnancy in Belize which approaches 19%, with more than 60% of these being unintended (Belize Ministry of Health and Sports & Belize Ministry of Human Resources, Women's Affairs and Youth Development., 1997).

Pregnancy Intendedness

In order for unintended pregnancy to be explored it is important to examine definitions that are culturally appropriate and the terminology used to estimate the intendedness of pregnancies. For example, some women in Belize, due to cultural or religious beliefs may be hesitant to describe a pregnancy as unwanted, and might prefer to describe it as mistimed (Anonymous, 1999). In Belize, pregnancies are most commonly defined as planned, mistimed (pregnancy desired, but sometime in the future) or unwanted (pregnancy not desired, even at a future time) (Central Statistical Office et al., 1991). Thirty-one percent of pregnancies were either unwanted or mistimed, with more women defining their pregnancies as mistimed (Central Statistical Office et al., 1991). Not surprisingly, younger women were more likely to report their pregnancies as mistimed and older women were more likely to report their pregnancies as unwanted (Central Statistical Office et al., 1991).

Maternal and Child Health

When pregnancy occurs, all women in Belize have access to prenatal care and 95% of women report that they received some prenatal care during their pregnancies (The National Committee for Families and Children & UNICEF Belize, 1997). Prenatal care is provided in all public health and rural health clinics by midwives, in mobile units by midwives and rural health nurses, and in homes by traditional birth attendants. Women may also obtain care through private doctors and women with complications of pregnancy can obtain care by one of the six obstetrician/gynecologist (OB/GYNs) in public health clinics (Belize Ministry of Health

and Sports & Belize Ministry of Human Resources, Women's Affairs and Youth Development, 1997). Trained personnel attend 96.9% of all births in the hospital, rural health setting or home (Pan American Health Organization, 2001). There has been a decrease in births at home from 38% in 1985 to 18% in 1995 (Boyer et al., 2001). Nurse-midwives attend approximately 80% of births, physicians 17%, with the remainder delivered by TBA's or untrained personnel (Belize Ministry of Health and Sports & Belize Ministry of Human Resources, Women's Affairs and Youth Development, 1997; Boyer et al., 2001).

Anemia is the most common complication of pregnancy and the incidence is increasing among women attending health centers for prenatal care. In 1995, the frequency of anemia varied from 32.1% in Orange Walk to more than 63% in the Cayo district (Belize Ministry of Health and Sports & Belize Ministry of Human Resources, Women's Affairs and Youth Development, 1997). While iron and folate supplements are required to be available for all pregnant women, more than two-thirds of all clinics reported that these vitamins and minerals were unavailable (Belize Ministry of Health and Sports & Belize Ministry of Human Resources, Women's Affairs and Youth Development, 1997).

Maternal mortality has decreased in Belize and is currently 12.4 per 10,000 births (The National Committee for Families and Children & UNICEF Belize, 1997). The main causes of mortality in Belize are postpartum hemorrhage, pulmonary embolism and hypertensive disorders of pregnancy (Belize Ministry of Health and Sports & Belize Ministry of Human Resources, Women's Affairs and Youth Development, 1997). As these complications are sudden and somewhat unpredictable, women in rural areas are disproportionately affected, with the majority of deaths occurring in the most rural areas. However, it is important to remember that maternal mortality is a mulitfactorial problem and is linked with poor nutritional status,

grand multiparity, poorly spaced pregnancies, geography that limits access to appropriate health care services, and rural areas with fewer medical services and personnel (International Safe Motherhood Initiative, 1997; McCarthy & Maine, 1992).

Abortion is illegal in Belize. However, it can be obtained through private doctors in private health care facilities in selected cases of fetal deformity, to save the life of the mother, or if the mental health of the mother is threatened (Belize Ministry of Health and Sports & Belize Ministry of Human Resources, 1997). The cost is approximately $1000 BZ ($500US) and is unattainable for the majority of women faced with an unintended or complicated pregnancy (Belize Ministry of Health and Sports & Belize Ministry of Human Resources, 1997). Illegal and self-induced abortions occur in Belize and often result in complications that must be addressed in government facilities. For example, in 1995 there were 441 admissions to the Belize City Hospital for abortion complications and only one-third were attributable to spontaneous abortions (The National Committee for Families and Children & UNICEF Belize, 1997). The other two-thirds were attributable to illegal or self-induced abortions, with hemorrhage and infection being the most common complications observed. Illegal abortions are provided by a variety of practitioners, including doctors, nurses, midwives, pharmacists, drug-store owners, traditional healers, and herbalists and usually involved the insertion of a catheter or similar instrument into the uterus (Belize Ministry of Health and Sports & Belize Ministry of Human Resources, Women's Affairs and Youth Development, 1997). However, selected herbs and plants may be ingested or inserted that may also cause a miscarriage to occur. These plant based methods are often provided by traditional healers or midwives in rural areas. Complications from abortion (both spontaneous and induced) account for 37% of all pregnancy related complications requiring hospitalization in Belize (Pan American Health Organization, 2001).

Women have access to regular health screening for both breast and cervical cancers in Belize. Recent campaigns to increase the awareness of breast and cervical cancer have been undertaken to increase the use of self-breast exams and pap smears. Pap smears can be obtained at public health clinics, at post-natal exams and through BFLA. It is unknown what percentages of women obtain yearly cervical cancer screening. During the past decade this researcher has been participating in an annual "Women's Week" in which pap smears and breast exams are offered at all BFLA offices and mobile units. It is common for women in their 30s to their 70s to attend for their *first* pap smear test. Over the last ten years attendance at these annual events has been increasing with almost 400 pap smears performed during Women's Week in the Orange Walk and Corozal districts in 2001.

Health Care System

In 1996, the government of Belize launched the Belize National Health Plan 1996-2000. This effort was brought about through a participatory effort of a large, multidisciplinary group of both national and international medical and nursing professionals and government officials, whose purpose was the design and implementation of a national health plan for Belize. This reorganization was based on the belief that "...health is an essential part of the development process..." and that the role of the government is to ensure "...that all citizens have access to the best possible health care regardless of ethnic origin, religion, socio-economic level or geographic area of residence" (Government of Belize, 1996, p. 13). The goals of this plan were to move from "...a disease-focused plan (1990-94) to a people focused plan and from a centralized and vertical medical culture to a decentralized and participatory one..." (Government of Belize, 1996, p. 9). This reform process has been active in Belize and has already had an impact on the provision of health services for the entire country.

Health care reform is centered upon the creation of Health Goals. It is hoped that these goals will form the basis for changes at both the national and district levels. Table 5 reviews the year 2000 health goals for the country of Belize and provides an overview of health issues as well as indicators that will be used to measure attainment and/or progress with these goals.

Table 5

Health Care Goals for Belize 2000

Goal	Key indicators
To ensure universal access to an agreed upon set of health care services of acceptable quality, utilizing the strategies of primary health care.	• 100 % coverage of primary health services in remote areas through mobile services • All public hospitals meet first level of accreditation according to international standards • 100 % of health facilities will have essential drugs within one week of request.
To ensure survival and healthy development of children and adolescents.	• Infant mortality rate decreased by 33% • Eradication of polio • Elimination of measles and neonatal tetanus • Mortality rate for diarrheal illness decreased by 25% in children under 5 • Universal access to school health and sports programs • Hospitalizations for abortion reduced by 10% among adolescents • Perinatal deaths decreased by 50%
To improve the health, well-being and development for all men and women in such a way that health disparities between social groups are reduced.	• 90 % of reproductive age men and women have access to information on how to prevent or optimally space pregnancies • 65% of women of reproductive age using contraceptive methods. • 100% of reported domestic violence managed appropriately • 60% of targeted women receive cervical cancer screening • 90 % of reproductive age men and

	women have access to information to prevent STD's, including HIV • Maternal mortality ratio decreased by 50% • Total fertility rate less than 4
To enable all people to adopt and maintain health lifestyles and behaviors.	• 50 % of population have access to physical education and sports programs • Mortality rate from cardiovascular disease and diabetes reduced by 2% in people over 50 • Road traffic accidents deaths decrease by 20%
To enable universal access to safe and healthy environments and living conditions	• 100% with access to sufficient and safe drinking water • 100% with access to adequate sanitation
To eradicate, eliminate or control major diseases constituting national health problems.	• Malaria • Tuberculosis • Cholera • Rabies • HIV/AIDS/STD's • Food-borne illness • Congenital syphilis
To reduce avoidable disabilities through appropriate preventive and rehabilitative measures.	• Establish disability screening mechanism • Development of interventions to prevent and manage disabilities by age group.

(Government of Belize, 1996)

The newly reorganized health care structure has evolved over the last 5 years with implementation beginning in the last two years. Karl Huesner Hospital in Belize City remains as the national referral hospital for the entire country. Three regional hospitals with surgical capabilities and some on-site specialties were created in Belmopan, Orange Walk and Dangriga. This required that the existing hospitals be upgraded in order to provide expanded services. For example, in the Orange Walk Regional Hospital there are now improved surgical services, including cesarean deliveries, in a newly built surgical suite. Remaining hospitals in other districts such

as Corozal, San Ignacio and Punta Gorda have had reductions in the services they were providing, with personnel being relocated to the regional centers. For example, in Corozal, all of the surgical services have been transferred to the Orange Walk Regional Hospital, including all surgical personnel. However, in districts without a regional center, some specialists will rotate to the ambulatory clinics to evaluate patients. For example, the gynecologist will travel from the Orange Walk Regional Hospital to the Corozal Clinic (approximately a 45 minute drive) on a weekly basis to care for women with high-risk pregnancies (Government of Belize, 1996). .

In 1996, there were 35 Public Health Centers, which provide the majority of ambulatory primary health care services such as prenatal care and child health. These centers are staffed with at least one public health nurse, midwives, and practical nurse staff. The public health centers are responsible for the rural areas of their districts and provide mobile health care visits to those areas without a rural health nurse. Rural health posts are small health clinics in remote, isolated areas staffed by a rural health nurse who is also a trained midwife (The National Committee for Families and Children & UNICEF Belize, 1997). These centers provide basic health services such as prenatal care and immunizations. Care is often supplemented by mobile health visits from a nearby public health center. In recent years, Cuban physicians who are working in Belize as a result of reciprocal agreements between the two countries have been placed in rural health posts to assist with the primary care needs of these isolated areas. Each of these ambulatory centers will usually care for between 2,000 and 4,000 people at the centers and through the use of mobile services (Belize Ministry of Health and Sports & Belize Ministry of Human Resources, Women's Affairs and Youth Development, 1997).

All hospitals provide some basic services such as maternity care, treatment of diarrheal diseases, respiratory infections, and other common illnesses. Over one

quarter of hospital admissions are for normal deliveries (Pan American Health Organization, 2001). In males, respiratory illness and intestinal diseases were the two most frequent causes for hospitalization, whereas complications of pregnancy, respiratory illnesses and abortions were the leading causes of hospitalization for women (Pan American Health Organization, 2001).

The newly organized health care system hopes to remedy some of the inadequacies of the previous health care systems. Due to its centralized nature, the collection and analysis of health care data from all the districts is difficult and there is a lack of trained personnel available to collect and analyze health care data. This has prevented the adequate identification of health care priorities and has limited the response of the health care system to important and emerging health care issues (National Human Development Advisory Committee, 1998; The National Committee for Families and Children & UNICEF Belize, 1997).

The financing of health care is a complex issue everywhere, and Belize is no exception. Special challenges exist in Belize due to its small size, its economy and its lack of a health care infrastructure. In 1995, the health sectors allocation of the national budget was 8%, which was a decrease from 9% in 1992. In 1999, health care expenditure was estimated at 4.8% of the Gross National Product (GNP) and this represented a total cost of US $16,553,250 or approximately US $68 per citizen of Belize (Pan American Health Organization, 2001). Despite the government's focus on primary health care, 74% of health care costs went to curative health care and hospitals, while only 17% of the health care budget went to public health programs (Pan American Health Organization, 2001). The health care budget did not change during the years 1993-96, and almost 75% of the Ministry of Health budget went for salaries (Pan American Health Organization, 2001). The maintenance of the hospitals and clinics is difficult as more than 60% of the funding for capital expenses

such as buildings and major upkeep comes from foreign aid (Pan American Health Organization, 2001). Foreign aid may be unreliable and perpetuates a dependence on other countries and organizations for essential services in the health care sector.

There is limited health care insurance, often provided by employers, to a small sector of the population. Although the government has been exploring the adoption of universal health care insurance, a plan is not yet in place. Primary health care is free in all of the public health clinics, but there is fee for medicine. Although patients are charged for in-hospital care, most fees remain uncollected; a report in 1989 revealed that less than 2% of costs were recovered, resulting in the government subsidizing the majority of hospital care. The inability to collect even a fraction of the of health care costs is mulitfactorial and attributed to informal and inconsistent exemptions, inadequate billing and collecting capabilities, and fee schedules that have not been changed since 1967 (The National Committee for Families and Children & UNICEF Belize, 1997).

There are a small number of private hospital facilities in Belize. These facilities usually provide similar hospital services such as surgery, maternity and some diagnostic procedures. The nurses are employed directly by these facilities and physicians may be solely devoted to the private facility, although many also practice in the government health care system. These facilities are limited to Belizeans who have the ability to pay for services rendered.

In addition, health care is provided by a number of NGO's and religious affiliated health care clinics. Perhaps the largest is the Belize Family Life Association (BFLA). BFLA provides family planning, sexual and reproductive health care services. BFLA serves women and men in one of their five clinics or through the use of mobile clinics to more remote areas. As there is no national family planning policy, BFLA provides the majority of contraceptive services for the entire country (Belize Ministry

of Health and Sports & Belize Ministry of Human Resources, Women's Affairs and Youth Development, 1997; Macke, 1993). However, women can obtain tubal ligations at government hospitals. In addition to contraception, BFLA also provides routine gynecological screening, diagnosis and treatment of sexually transmitted infections (STI's) as well as HIV testing and education regarding safer sex practices. Nurses and midwives provide care at all of the clinics and refer women to government clinics or hospitals with medical problems. Local physicians provide consultation and may even provide care to women with conditions such as abnormal pap smears or pelvic pain. Other clinics include the Mercy Clinic in Belize City, which provides care for the elderly, and a variety of small clinics funded and staffed by religious organizations, such as the Presbyterian Medical Center in Patchakan, a small village in the Corozal District.

There remains a steady stream of volunteer groups who routinely visit Belize to provide both basic and specialty services to the population. This includes nursing groups such as the Loyola/Chicago group, which the researcher has been involved with for 11 years. This group travels once per year to assist in community health screenings and reproductive health care services in the Corozal and Orange Walk districts. Other hospital groups regularly come to provide surgeries to repair congenital facial malformations in children or do cataract removal surgeries with the help of the Lion's Club. Almost uniformly, these groups bring supplies, medicines and personnel to assist in their efforts and are welcomed by the local health care community.

Allopathic Health

All of the physicians have trained in countries outside of Belize. Health care services are inconsistent and dependent on the training of the physician, availability of medicine and diagnostic procedures, as well as the site of care. In government

pharmacies, medicines are dispensed to those with prescriptions, although the variety of medicines is limited. Antibiotics to treat common infections are available in government pharmacies. Drugs to treat common illnesses such as hypertension, diabetes and heart disease are available; however, the formulary is limited. For example, many people with diabetes are prescribed oral hypoglycemic agents, but insulin usage is low, especially in rural areas.

Diagnostic testing is also available throughout the country, although the breadth of services is limited. Radiology services are available at all hospitals, albeit limited and CT/MRI imaging is available in Belize City. Ultrasound is available in most urban areas. All diagnostic testing requires payment, with the government centers costing less. There is one mammography screening unit at the Karl Huesner Hospital in Belize City, and two others located in private facilities in Belize City and the Cayo district (The National Committee for Families and Children & UNICEF Belize, 1997). However, there is no widespread routine screening of women for breast cancer. In 1996, the Belizean Nurse's Society launched a nationwide education campaign to increase awareness about breast cancer and the Belizean Cancer Society was formed by a group of survivors and those interested in helping all citizens of Belize increase their knowledge of cancer as well as to help those afflicted by cancer (The National Committee for Families and Children & UNICEF Belize, 1997).

There is limited intensive care available in Belize City. There is a neonatal intensive care unit in Belize City to care for sick and or premature infants; however, surgical and medical interventions are limited. Treatment for cancers is limited to selected surgical options, as no chemotherapy or radiation therapy exists within the health care system of Belize. For those citizens who develop serious treatable illnesses or sustain injuries needing advanced care, policies exist for treatment to be

obtained out of Belize at government expense. The country has reciprocal agreements with Mexico and Guatemala, to provide this care, however these processes are time consuming and often unable to address the ongoing needs of those that will require long-term medical or pharmaceutical care.

Traditional Medicine

The unique cultural heritage of Belize has also provided a rich tradition of traditional healers and traditional medicine. The Mayan culture has a long history of healers and traditional plant based medicines. Before the Spanish invaded, the Mayan culture flourished with the help of healers and an in-depth knowledge of healing plants and medicines. These were recorded in books or codexes. The valuable written source of these traditions was lost forever when it was burned by the Spanish (Arvigo & Balick, 1993). Since that time, the intergenerational transfer of healing traditions has often been oral, with each successive generation, learning less and less about the healing traditions of their ancestors. There is a Traditional Healers Association in Belize, which holds regular meetings for the advancement of the knowledge of traditional healing. This group hopes to maintain and promote the healing traditions of Belize so that the valuable information is not lost forever. To assist in this effort, the Belize Ethnobotany Project was begun in 1987 as a joint venture of Dr. Rosita Arvigo of the Ix Chel Medicine Trail and Dr. Michael Balik of the New York Botanical Garden, with the purpose of recording the "...endangered information about plants used as medicines, foods and fibers; in construction and agriculture; during religious ceremonies and as part of spiritual beliefs" (Arvigo & Balick, 1993). While there is information available about traditional plant-based medicines of Belize, there is little information about the use of these medicines to promote health and treat illness in Belize; however, this will be explored in the current research.

Health Care Providers

The number of health care personnel has grown in Belize over the last decade. In 1994 there were 465 active health care workers, with 75% of these working in the government sector (Pan American Health Organization, 2001). Physicians, dentists and nurses account for 58% of the health care personnel, with professional nurses making up the largest group. There is disproportionate number of health care workers in the Belize district as more than half of the health care workers in the country are located there, while only 28% of the population resides in this area (The Central Statistical Office, 2000; The National Committee for Families and Children & UNICEF Belize, 1997). Belize has low numbers of physicians with estimates of 7.4 physicians per 10,000 of the population. The coverage of nurses with 15.7 professional and 5.9 practical nurses, totaling 22 nurses per 10,000 population (Pan American Health Organization, 2001; The National Committee for Families and Children & UNICEF Belize, 1997). By comparison North America has 27.5 physicians and 96.4 nurses, Mexico has 15.6 physicians and 10.8 nurses, and Central America has 10.2 physicians and 5.1 nurses per 10,000 of their respective populations (Pan American Health Organization (PAHO), 2000). In 1996 there were 117 midwives with a ratio of 5.9 per 10,000 population (The National Committee for Families and Children & UNICEF Belize, 1997).

Physicians are educated outside of Belize, as there are no medical schools for local students. A new medical school has recently opened in San Pedro, Belize that has scholarships available for a limited number of Belizean students. Physician training takes place in the United States, Mexico, Guatemala, and the University of the West Indies (The National Committee for Families and Children & UNICEF Belize, 1997).

In contrast, the Belize School of Nursing has been training nurses since its inception in 1894. The nursing school educates professional and practical nurses, which are similar to registered nurses and licensed practical nurses in the United States. Additionally, after completion of basic nursing education, additional certificate training is available for public and rural health nursing, midwifery and psychiatric nurse practitioners. Education in other nursing specialties is also available through educational experiences outside of Belize. For example, nurses may be selected to attend school in Jamaica for advanced training in perioperative nursing or nursing education. Recently, a Nurse Anesthesia educational program was offered in Belize in conjunction with a U. S. based program. The government has subsidized the majority of nursing education, with nurses attending school without cost and then working in government service for a number of years. However, it is possible to attend school as a paying student, without a requirement for subsequent government service.

In recent years, a decision to move nursing education into the university setting was made and is now underway in Belize. The basis for this move actually began over 30 years ago, when PAHO/WHO conducted a survey of nursing education in the Caribbean and suggested standardization of education throughout the region (Herrman, 2001). In 1993, the Principle Nursing Officer and the Minster of Health attended a meeting in Barbados to explore the process of transferring education from the Ministry of Health to the Ministry of Education (Herrman, 2001). This undertaking seeks to raise the level of professional nursing practice and education to a higher standard. The baccalaureate degree in nursing was established at the University of Belize in 2000. There is concern that future funding for nursing education may be limited with this new structure (Boyer et al., 2001; Herrman, 2001).

Other health care personnel in Belize include community health workers (CHW's). These are persons identified by local villages and are well-respected members of their communities. The majority of CHW's are women who receive training in the recognition of common health problems, first aid and disease prevention. They provide health information and notify members of a community when a mobile clinic or a health talk will be take place. They work closely with rural and public health nurses to identify those individuals in their village with specific health needs. Recently, in an effort to attain Baby Friendly Hospital Status at the Corozal Hospital, the CHW's attended a number of breastfeeding workshops and then returned to their villages to begin breast-feeding support groups.

Traditional birth attendants (TBAs) are important members of the maternal-child health team, especially in rural villages, isolated from health care facilities. In 1996 there were 135 TBA's in Belize, with the majority receiving some biomedical training through government or NGO programs in Belize (The National Committee for Families and Children & UNICEF Belize, 1997). TBAs generally learn their skills through an apprentice-type model, in which they work with another TBA or they may possess these skills from personal experiences (Sibley, 1993). Although trained as birth attendants, many are also skilled herbalists and traditional healers who have learned their craft in the oral traditions of midwifery and traditional medicine that is prevalent throughout the world. Almost all women have access to medical care for pregnancy and childbirth, however geography, weather, culture, finances or personal choice influences the use of TBA's for birth and the postpartum period. However, homebirth, using the traditional practices of TBA's is declining in Belize. In 1995, only18% of registered births took place at home, which is a decrease from 38% in 1985 (Boyer et al., 2001). Anselma Yam, an 87-year-old traditional midwife and TBA, believes that a fear of birth by many women and health care providers has prompted

women to deliver in hospitals, and Anselma is not convinced that this is good for mothers and babies (Boyer et al., 2001).

The Ministry of Health instituted a national training program in 1952 to register TBA's as well as provide basic biomedical training to ensure safety, (Sibley, 1993). Initially, this program was supported by UNICEF and PAHO and has since come under the purview of the Ministry of Health (Heredia, 2000; Sibley, 1993). A standardized training manual and terminal objectives were developed. The TBA's were trained to be able to identify signs and symptoms of pregnancy and care for women in the antepartum, intrapartum and postpartum period. They refer women with complications, conduct safe home deliveries using aseptic technique, keep records and report all deliveries as well as give advice regarding child-spacing (Sibley, 1993).

A typical TBA training program consists of one month of classes followed by one month of antepartum clinical experiences in a Public Health Clinic with a nurse-midwife and attendance at 20 hospital births (Boyer et al., 2001). Following the training program, a nurse-midwife observes the practice of a TBA within their community. Successful completion of these components allows the TBA to practice independently. Currently, literacy is a requirement for TBA training, although this has not always been the case (Boyer et al., 2001). TBA's attend regular refresher programs to remain current in their knowledge and skills. They will usually charge US $25 for a delivery, which includes at least one antepartum visit to assess the home and 8 –10 days of postpartum home visits to care for mother and child, assess for complications and promote breastfeeding (Boyer et al., 2001). The researcher has had extended contact with a number of TBA's in the two northern districts of Belize. They are very dedicated, knowledgeable and skilled women who care for women in remote areas. They have an extensive knowledge of the healing properties of many

local plants and many use herbs and other traditional practices in their care of women during and after pregnancy.

Corozal and Orange Walk

The following sections will provide a picture of the two Northern districts of Corozal and Orange Walk. These two districts provided the backdrop for the research and exploring them in detail will allow for a richer understanding of the experiences of women in Belize.

Corozal

Corozal is the northern most district in Belize and the only town, Corozal Town, is only 8 miles from the Mexican border. The town and its surrounding villages have approximately 32,708 people or about 14% of the population of Belize (The Central Statistical Office, 2000). Sugar cane farming is the major industry in the area, with the majority of men working as cane cutters, farmers and cane truck drivers. The majority of women, especially in the rural areas do not work outside the home. Many operate small tiendas, (home-based businesses which sell food and domestic products), while at the same time care for the home and family. In the villages, water is provided by village wells and cisterns that collect and store rainwater. Public transportation mainly serves the urban areas; however limited bus service is provided to most rural areas.

Each town has a central square that is often a central meeting place. In Corozal, trees filled with noisy black birds surround the town square. Key government buildings like the courthouse and post offices and local services such as a bakery are located around the town square. When court is in session the street is blocked off to vehicle traffic and can only be reached on foot. On one side of the square, the library and town hall are located, on another side is found the Catholic Church and primary school. Another side contains businesses and one of the three

banks in town. Throughout the day, the center is usually a busy place and there will often be children playing, older adults and mothers with babies sitting on benches. Down the street is the market where fruit, vegetables meat and fish are purchased as well as various household and personal items like pots, hammocks and shoes. Grocery stores are numerous; however, they usually do not sell perishable items. The town is located directly on the "sea", which is really the Bay of Chetemal, and is the main source of seafood for those in Corozal.

Corozal Hospital, a 32-bed government funded hospital and an adjoining outpatient clinic serves the majority of people in the area. The newly built Corozal Public Health Clinic was recently relocated to the hospital compound, which is located about one-half mile from the town center. Although its new location is no longer in the center of town, the new location provides safety in the event of a hurricane. In the last three years, three major hurricanes--Mitch in 1999, Keith in 2000 and Iris in 2001--have threatened the town of Corozal, so the move was a positive step towards disaster preparedness for the town. The clinic and hospital are hurricane shelters for those living close to the sea. There are a few small, private clinics in outlying villages as well as private physicians who provide care to those who can afford to pay. There are community health workers in almost every village who perform basic health screening activities like blood pressure measurement, distribute common medicines like Tylenol®, provide health education, coordinate workshops and make referrals to the health centers.

There are four rural health clinics in the Corozal district, which are staffed by a rural health nurse who is also trained as a midwife. This nurse provides the majority of health care to the village, including prenatal care and delivery of normal pregnancies. It is the responsibility of the Chief Public Health nurse to visit these health centers on a regular basis and the researcher has taken part in many of these

mobile visits. The district rural health nurses stationed in the town of Corozal also make regular visits to the surrounding communities, maintain contact with all the CHW's and assist in public health efforts. Mobile health clinics are regularly scheduled visits to communities by the Corozal public health nurses and they provide well-child care, including weights and immunizations to remote villages in the area. The CHW's will alert residents when the day for the "mobile" approaches and when the government vehicle carrying the nurses arrives it sounds its horn loudly and women emerge from their homes with their children for their visits, usually conducted in the community center or under the shade of a tree. These visits are a vital part of the immunization program in Belize. However, they may be canceled or postponed due to the unavailability of government vehicles resulting from accidents or repairs.

In recent years, as a part of a national health care reorganization, surgery services and the operating theatre personnel were transferred from the Corozal Hospital to the Orange Walk Hospital. This reorganization has been a source of conflict in the Corozal district to the patients and health care providers and has already had an impact on maternity services. The lack of surgical services necessitates that women with pregnancy complications be transferred to the Orange Walk District Hospital, adding stress to the family and potentially delaying needed surgery. As this is a recent occurrence, the impact of this change will remain to be seen.

There is no BFLA office in the Corozal District. Reproductive services are provided by a bi-weekly clinic in the government public health center by BFLA staff. Here women from Corozal and surrounding villages may obtain reproductive health care. The closest BFLA office is in Orange Walk Town, about a one-hour bus ride from the town of Corozal.

If one proceeds north on the Northern Highway for approximately 8 miles, the Mexican border will be reached. This is a destination for many Belizeans from as far away as Belize City, as the major city of Chetemal is on the other side, and is a common destination for shopping and health care. The Belizean buses take passengers all the way into the center of Chetemal. One will also pass the "Free Zone". This shopping area, while located on the Belizean side of the border, is off limits to Belizeans; its goods are duty free for Mexicans who arrive from Chetemal. Prices are cheap, especially for American goods, which often have high duty in both Mexico and Belize. While only Non-Belizeans are allowed to entrance to the free zone, other rules prevent others such as Americans in Belizean vehicles from entering as well. Some Belizean business owners are able to obtain a special passes that allows them access to the "Free Zone".

So an interesting scenario has developed with the Belizeans crossing the border to shop in Chetemal and the Mexicans crossing the border to shop in Belize. A border crossing is a time consuming experience and requires stops at both Belizean and Mexican immigration stations and the changing of currency. If one imagines a bus with 100 people all having to be processed through both Belizean and Mexican immigration, it is easy to see why a shopping trip will last the whole day.

Orange Walk

Orange Walk district separates the Corozal district from the Belize district and is approximately 30 miles from Corozal town or a one-hour bus. It is approximately 60 miles from Belize City, which usually takes two hours by bus. The population of Orange Walk district is estimated at close to 38,890, which is 16% of the population of the entire country (The Central Statistical Office, 2000). During the bus ride south from Corozal on the Northern Highway, one passes through numerous small villages interspersed with miles and miles of sugar cane. It is common to see large fires

burning in the cane fields and the air to be thick with smoke. During the harvest season, large cane trucks, overflowing with sugar cane stalks, move slowly down the roads on the way to the processing plant on the south end of Orange Walk. These trucks are often a major source of road traffic accidents as overzealous drivers try to pass them on the two-lane highway. As one approaches the town of Orange Walk, sugar cane stalks litter the road due to strategically placed speed bumps. The hospital compound is the first indication that you have reached Orange Walk Town.

The newly refurbished Northern Regional Hospital in Orange Walk has been upgraded particularly in the areas of the surgical suite, and now performs all of the surgery, including cesarean deliveries for both districts. Currently, there are approximately 60 beds for obstetric, pediatric and medical/surgical patients. A BFLA office, as well as the government-funded outpatient clinic is located on the grounds of the Hospital. A fence surrounds the entire compound and a guard is posted at the entrance, mainly to keep unauthorized vehicle traffic from entering the grounds. There is a taxi stand and bus stop outside. There is a large covered outdoor waiting area where people wait for appointments with doctors, the administrative office, diagnostic services or to see relatives during visiting hours. There is a small tienda selling snacks and soft drinks and pushcarts selling snow cones and chips. The only air conditioning in the hospital can be found in the administration area, the operating theatre, the delivery rooms and the surgical ward. The Orange Walk district has three rural health clinics in addition to the large public health clinic in town.

The Orange Walk town center is reached after traveling south for approximately one-half mile. This is a much larger town than Corozal, but is planned in a similar fashion. Around the town square is located the major business area of the city and it is always busy. The town is a rest stop when riding the buses to and from Belize, so there are always people selling food, snow cones and drinks to the

hundreds of bus riders who pass through every day. As one continues out of town, the smell of burning sugar cane fills the air as one approaches the processing plants. The towers of the sugar refinery plants can be seen from the road billowing smoke and miles of cane trucks can be seen waiting on the access road for their turn to unload their cane. Unfortunately, this is often a long period of time, sometimes a day or more, and soliciting prostitution is common among the idle workers. As one leaves Orange Walk and continues on to Belize City, there is nothing but cane fields and a few small villages for an hour or more. Prior to arriving in Belize, the bus enters the small town of Ladyville. Here the entrance road for the only International Airport is found, as well as many small businesses and warehouses. A large Chinese community lives near Belize City, many of whom settled here from Hong Kong prior to its reversion back to Mainland China. Soon one notices the urban sprawl of Belize, evidenced by traffic, noise, people and a view of the sea.

Although many villages were visited for data collection and each is unique, similarities were observed in the villages. Each village has a center with a soccer field, a common sport in Belize and a community center. These centers are large rooms that can be used for community functions like meetings or health fairs. Many small home based tiendas are scattered throughout villages, identified by "Coke®" and "Fanta®" signs where soft drinks and other food items may be purchased.

Each village has at least one primary school; larger villages may have more. For example, a village may have a Roman Catholic ("RC") and a Methodist school. They usually consist of a number of low buildings which may hold many classrooms separated by thin walls or large chalkboards. The classrooms have wooden desks and tables and are decorated with children's work and the alphabet. Children arrive, some in uniforms, some in regular clothes, with and without shoes. They begin

everyday with the Belize National Anthem, and schools with a religious affiliation usually begin with a prayer. Children go home for lunch and return for the remainder of the day. Village animals often roam school grounds and occasionally even enter classrooms.

Pumps are placed sporadically throughout a village and are usually the source of potable water for the community. There are a variety of houses, from traditional huts with thatch roofs and dirt floors to cinder block houses with cement floors. Chickens are common throughout the villages as well as the occasional pig. There are numerous emaciated dogs and cats. Throughout the day, there is a virtual absence of younger men, as they are working in the cane fields. Mothers and their children are everywhere, performing daily tasks of cleaning, washing and cooking. In the two northern districts almost all of the villages have electricity and telephone access. While most everyone has taken advantage of the option for electricity, telephones are found in fewer households. Almost every home, regardless of other amenities, will have a television. Almost everything and everyone in each village can be reached by foot and this was the most common mode of transportation for data collection in this research.

The preceding descriptions help to paint a picture of the two settings for this research. Where people live, how they go about their activities of daily living and what they do are important in a focused ethnography. When exploring the reproductive lives of women in Belize, it is important to discover where and how women live, how they access health care and information, their relationships with partners and family, and what they believe regarding their reproductive health. The following chapter will review the research questions for this focused ethnography and examine the methodology chosen to guide the research.

CHAPTER 4

Methodology

The previous chapter provided a glimpse of the culture and history of Belize, creating a context and grounding for the words and experiences of the participants regarding their lives and culture. This chapter will focus upon feminist ethnography as the conceptual framework of this research, the design and procedures followed during the research process, and the characteristics of the women whose words informed the following research questions.

Research Questions

These following questions were used to guide this ethnographic study:

1. How do women in Belize define and experience the problem of an unintended pregnancy, specifically what emic terms are used to describe the phenomenon?
2. What approaches are used (ethnic/ cultural/ medical/other) when a woman experiences an unintended pregnancy in Belize?
3. What are women's experiences of reproductive health in Belize?

Design

Feminist ethnography provides both the theoretical framework and methodology for this investigation. Ethnography allows for the discovery of cultural information and contributes both descriptive and explanatory theories of cultural beliefs and actions. Ethnography has its roots in the field of anthropology and was used by early anthropologists to study cultures and primitive societies in remote and isolated areas. However, as the discipline of anthropology evolved so did its methods. Feminist anthropologists explored the relationship of gender and the cultural lives of women and added women's' voices to anthropology for the first time

(Babcock, 1995; Cole, 1999; Lamphere, 1995). Feminist ethnography explores the lives and experiences of women and reflects both the philosophies of the researcher and feminist theory. Assumptions in feminist ethnography include a) reflexivity, or the awareness that the beliefs and experiences of the researcher are essential to the research process, b) the recognition that most of the psycho-social-biological knowledge is really based upon the realities of the male and not reflective of the female experience challenges the researcher to focus on the generation of knowledge that illuminates the experiences of women, discovered through a feminist process (Cook & Fonow, 1990; Williams, 1995) and c) that power inherent in the researcher-participant relationship and the powerlessness of the women-participants are critical components in feminist ethnography. Ensuring that the research questions focus upon important agendas of the participants, while at the same time allowing the voices of women to be heard addresses the power differential. Cole (1999) suggests that feminist anthropologists remain committed to communities of women, and allow them to find their voices and tell their stories, while at the same time challenging the hierarchical processes of the discipline and "mobilize differences among women as creative force in the innovation of theory, method and practice" (p29).

Nurse researchers have used ethnography to study unique cultures within our society as well as to investigate health-related issues in other cultures and countries. Germain (1993) proposed that ethnography in nursing can "promote understanding of the meaning of health and illness experiences for clients and providers, present nursing practice realities to the scientific and lay communities and influence health policy, while contributing to a worldwide ethnology of nursing" (p.266). Ethnography strives for a holistic perspective that captures the breadth of activities, knowledge and beliefs of the group being studied, within the context of their culture and society

(Roper & Shapira, 2000). While some ethnographic work may focus on a culture as a whole, a focused ethnography concentrates on a small group or particular activity or concept. This focused ethnography explores the reproductive lives of women in Belize, with special attention to their experience of unintended pregnancy and the control of reproduction.

Ethnography involves the use of fieldwork, participant observation, and the reliance upon expert cultural informants for the purpose of learning about and exploring a particular culture or group. Fieldwork experience is a hallmark of ethnography, and begins with the immersion of the researcher into a culture and community in an effort to explore and examine phenomena, people and their relationships. Participant observation is one tool used in fieldwork and places the participation in the daily lives of people and communities within a framework that allows for the interpretation of events and interactions in a different light (Fetterman, 1989). For example, during this research, as a participant observer, routine health care encounters became richer experiences, elicited new perspectives and created new questions that I had never seen before.

Cultural or key informants are another important instrument in ethnographic research. Key informants are often thought of as cultural experts with a unique knowledge and perspective of the research questions. For example in this study, a key informant was a reproductive health care worker with a unique perspective of women's reproductive health care needs, a broad knowledge of the health care systems and a referral source for other cultural informants. Throughout the research process both formal and informal interviews were used to create a picture of the reproductive lives of women in Belize. Lastly, field notes provide the documentation of the perceptions and suppositions of the researcher, preserving indigenous meanings

and cultural experiences. Emerson, Fretz and Shaw (1995) highlight four important aspects of field notes:

> 1) What is observed and ultimately treated as data or findings is inseparable from the observational process;
>
> 2) In writing field notes, the field researcher should give special meaning to the indigenous meanings and concerns of the people studied;
>
> 3) Contemporaneously written field notes are an essential grounding and resource for writing broader, more coherent accounts of others' lives and concerns; and
>
> 4) Field notes should detail the social and interactional processes that make up peoples' everyday lives and activities (p. 11).

In a cross-cultural study such as this, feminist ethnography provides the necessary framework to study the lives of women, while at the same time addressing some of the inherent complexities in doing research in a culture different from my own. This ethnography has helped to discover the experiences of women from their own perspectives, respecting their roles as expert knowers. Because ethnography often takes place over a long period of time, and, in this case, over multiple periods of time over many years, it is helpful to examine each phase of the research process.

Entry Phase

In ethnography, the researcher strives to contextualize the meanings and experiences by living with and experiencing the culture, while at the same time becoming enmeshed in the culture (Roper & Shapira, 2000). As ethnography is dependent upon the ability of the researcher to develop an in-depth understanding of the culture and its inhabitants, this ethnography really began in 1992, when I arrived

in Belize for the first time. The multiculturalism witnessed from the back of a pick-up truck during the 2 hour ride from Belize City to Corozal, was unique and remains a lasting impression of what would become a long-standing relationship with the people and cultures of Belize. During the ensuing years, relationships were developed with women and health care providers based upon trust and respect. Many became friends and colleagues. This extended time allowed for an immersion into the Belizean culture, informing the researcher's knowledge of the cultural traditions, people and barriers to be identified prior to beginning the formal research process. In this focused ethnography of the reproductive lives of women, observations have been recorded for the last two years, during the author's experiences in Belize. Data collection ended in the spring of 2001. The following summarizes the data collection process:

Observation Phase

The researcher was known within the network of health providers and in many communities. Focused observations of women going about their daily work were conducted. Field notes were kept of these observations. The researcher attended events that highlighted the role of women in family life, such as social gatherings, women's groups and school events. Key informants were identified and social structures that had an impact upon the reproductive lives of women were clarified.

Observation-participation Phase

Two types of key informant interviews were identified:

1. Institutional key informants were experts from agencies and institutions that provide reproductive health care services to women. Included in this group were experts in traditional medicine with knowledge of womens' reproductive lives.

2. Women of reproductive age were identified by key informants or who were known to the researcher through previous experiences or from contact in the observation phase.

Participation Phase

Interviews with women, traditional healers, community health workers and midwives in villages were conducted. The researcher continued to work with women and health care providers in settings where women obtained reproductive health care services, such as BFLA offices and mobile clinics. For example, during the annual Women's Week, participant observations occurred while the researcher was on-site as a provider of health care services, and women were identified by staff as willing and appropriate participants for interviews as key informants. Participant observations and interviews with individual key informants were common during participation in village activities with women and community health workers

Observation and Reflection

Closure with key informants occurred during the last phase of the research. Validation with informants and plans for sharing of results of the final study with all of the participants were made. Permission to contact key informants for clarification during the data analysis process was obtained. Field notes reflected the researcher's experiences of the entire experience. Debriefing sessions with key informants, women's groups and interested health officials is planned for after the completion of the project.

A timetable of the research process is summarized in Table 6

Sample

The women of Belize were the experts who provided the answers to the research questions. Experts in ethnographic research are often referred to as key

informants. These individuals were members of the different cultural groups, who were insightful, articulate and often possessed special knowledge of the experiences of women in Belize. In this study, key informants included health care providers, community health workers, traditional healers and women in villages and towns with reproductive health life experiences. These women were identified through the use of institutional key informants and the researcher's participant observations. Twenty-one women of reproductive age, health care providers, administrators and other key informants were interviewed were selected because of the important roles they played in the reproductive lives of women in Belize. All participants read and signed an informed consent developed and approved through the University of Connecticut Committee on the Use of Human Subjects in Research (Appendix A)

Table 6

Timetable of research activities

Time	Activities
1992-present	On-going experiences in Belize with immersion into the culture
Spring 1999	Formal research begins
	Participant observations with minimal interviewing of key informants
January 2000	Interviews with key informants identified by researcher and other key informants
	Participant observations
March 2000	Participant observations
	Key informant interviews
March 2001	Participant observations
	Interviews and clarification with key informants
	Formal research process ends and debriefing

Most interviews with institutional key informants were conducted at their places of employment or in a public place near their work or home. Interviews with women took place in their homes or at BFLA centers where the women sought reproductive health care. The interviews were usually started with a broad question such as "Tell me about meeting your partner and your own desires for children. Did you and your partner talk about your desires for children?" and ended with specific demographic questions.

It was common for other women to be present during interviews and they frequently agreed to participate in the research. Women did not seem concerned about talking with others present. Two participants invited their husbands to be present during the interviews, but asked my permission first. Women were encouraged to have anyone they chose present during the interview process. The interview sites presented numerous challenges. Children were almost always present and were often quite curious about the small tape recorder, requiring some creative interviewing techniques. Early in the research process, it became obvious that toys were necessary to distract children during the interviews. Whether at home or in a BFLA office, noise was always a problem; loud trucks, telephones, children and visitors all contributed to interruptions. Interviews were often long and fragmented while women accomplished their daily tasks.

The sample proved to be culturally diverse and mirrored the cultural pluralism found in Belize. All but two of the interviews were conducted in English. The Spanish interviews were conducted with a translator because women reported being more comfortable speaking in Spanish. The majority of the participants reported that they were fluent in two languages, most commonly English and Spanish; two reported fluency in three languages including Creole. Only one woman described herself as

only speaking English. The demographic characteristics of the sample provides information regarding the reproductive lives of women in this research and can be found in Table 7.

The participants were equally divided between rural and urban areas. All but one participant had completed their education through Standard 4 and five had completed high school or beyond. The majority of the participants did not work outside the home; only five participants reported work outside the home. The ethnicity of the sample was diverse with seven Mestizo, three Creole, five Mayan and three women of other ethnic

Table 7

Demographic Characteristics of Participants of Reproductive Age in Belize

N=18

	Range	Mean	SD
Age	22-41	30.7	6.25
Pregnancies	0-6	3.2	1.65
Children	0-5	2.4	1.29

origin. The majority of the sample reported their religion as Protestant, with three Catholics and four others. All women reported that they had electricity in their homes; however eight did not have "pipe water" and were required to obtain their water from a well or village pump. All but four women reported that they had refrigerators in their homes. Only one participant reported that they did not have a television.

Procedures

The investigation took place during multiple visits to Belize over a two year period. Three data gathering strategies were used: a) semi-structured interviews

were conducted with key informants and cultural informants using an interview guide (Appendix B); b) field observation notes from participant observations, informal interviews, cultural and personal interactions were created by the researcher immediately following interviews and interactions; and c) relevant cultural and reproductive health care data including international, government, and NGO documents provided information regarding the health of local and national communities.

The semi-structured interviews were tape recorded and then transcribed by a transcriptionist. The researcher then reviewed these transcripts for accuracy with the tape-recorded interviews and corrections were made. Field notes were handwritten by the researcher as soon as possible after an event or interview. These notes were later transcribed into text. Newspapers, radio and cultural activities often provided valuable insight and illuminated cultural aspects of reproductive health in Belize. For example, BFLA publications found in clinic waiting rooms illustrated mechanisms for the dissemination of health care information and provided a glimpse into the reproductive health care programs available for women throughout Belize. Participation in community health fairs provided insight into the health care needs of communities. In addition, government and NGO documents summarized reproductive health in Belize and provided supplementary data that suggested specific health concerns as well as areas for future research. The 1991 Maternal and Child Health Survey was a valuable source for information regarding the status of reproductive health for women in Belize. Although these data are already a decade old, it is the last survey of its kind to have taken place in Belize. Other reports released in the last decade provided additional information regarding women in Belize. *From Girls to Women:*

Growing Up Health in Belize focused upon the need to develop comprehensive and equitable health services for girls and women and how culture and society interact to affect the health of women in Belize. This report was intended as a resource for the government and NGO's and was developed with the assistance of numerous international organizations including UNICEF, WHO and PAHO (Belize Ministry of Health and Sports & Belize Ministry of Human Resources, Women's Affairs and Youth Development, 1997). Similarly, *The Right to a Future* focused on the health of children and highlighted the relationship between infrastructure, education, family relationships and health. This report was a joint effort between UNICEF and the National Committee for Families and Children in Belize (The National Committee for Families and Children & UNICEF Belize, 1997). Preliminary results from the most recent census have been made available and when possible are reflected within this research.

Data Analysis

All interview and field note data were read by the researcher in order to gain a general overview of the data. Next, the data were reread and coded to reflect units of meaning, recurring themes, and descriptions of experiences related to the research questions and reproductive health care experiences. For example, women's descriptions of contraceptive decision-making were coded and reflected a breadth of experiences. Similarly, how women described an unplanned or unintended pregnancy reflected the complex nature of this reproductive experience. Two members of the dissertation committee with experience in ethnographic research methods also coded a number of interviews. This helped to ensure credibility of the results through the development of consensus during the coding process. When coding was completed, interviews were then entered into QSRNudist©, a software

program designed for the analysis of non-numerical, qualitative data. This program allowed for complex coding of large amounts of data into index systems created by the researcher. QSRNudist© can also search text for patterns and words and allowed the researcher to analyze large amounts of data based upon emerging themes and theories. Initial coding was entered and subsequently new coding emerged as the data was reviewed for a third time. Codes were then organized into an index system that indicated relationships and patterns. For example, all of the participant descriptions of their experiences with contraceptive decision-making were coded together and then delineated further into joint or individual decision-making. Text searches were carried out using key words to ensure that all information regarding a particular subject was coded. Reports were created that allowed for the comparison of groups; for example urban and rural women's descriptions of contraceptive decision-making were compared. Interview text was supplemented with field notes to substantiate experiences and reflect the relationships between the perceptions of the researcher and the experiences of women in Belize.

The following chapter will present the results of this feminist ethnography. The words and experiences of the women of Belize will unearth the complexities of women's lives and their experiences of reproductive health. Their stories will bring to light the multifaceted nature of their reproductive lives as they recall challenges with unintended pregnancy, contraception and family relations.

CHAPTER 5

Results

Introduction

> *I came across this beautiful textile woven in the village of Chiclé, its whole surface was covered with closely spaced patterns in many well-blended colors of silk. In the midst of the brightest colors was a small area which was worked with white wool. I inquired the reason for this and was informed with great seriousness that no human being was supposed to produce a perfect piece of weaving this being a privilege only of the gods. (de Jongh Osborne, 1965, p. 84).*

Mayan women, who are the indigenous peoples of Belize and Central America, weave beautiful tapestries that identify and distinguish them from their cultural neighbors, yet maintain the collective traditions of their ancestors. The weaving traditions are handed down by the women of each generation, and girls enter womanhood when they have become accomplished in these traditions. These fabrics become the everyday clothes they wear as well as a celebration of their history and culture.

Similarly, this feminist ethnography explored the tapestries of the lives of women in Belize and uncovered how the threads of their experiences and culture shape their reproductive health. During the course of this study the experiences of unintended pregnancy, contraceptive use and abortion were described through the words of women in both rural and urban areas in Northern Belize. The women of Belize provided their own emic perspective within the complex social and cultural context of Belize and wove the threads to reveal the detailed fabric of their lives. This chapter will be my tapestry, my attempt to tell their stories, illuminate their traditions

and provide an opportunity to reflect on women's lives, their health and their futures within the cultural pluralism of Belize and the global environment.

A focused ethnography was used in this research to take advantage of my previous experiences in Belize as well as to allow for episodic, intensive periods of data collection over a prolonged period of time. Participant observations and secondary data sources such as government documents provided additional data in the exploration of the reproductive lives of women in Belize. Feminist ethnography provided the conceptual framework for this study, a perspective which honors the experiences of women from their perspectives while at the same time respecting that, as a researcher, I was a guest in their culture. Throughout these pages, I have struggled to present their stories, while at the same time giving credence to my own experiences and interpretations of events and relationships that help to form the answers to the questions that guided this research.

The Colors of the Thread

Just as Mayan women use a variety of plant and animal materials to achieve the vibrant colors for their *huiples* (blouses), this focused ethnography used many data collection strategies to explore the lives of women in Belize. Key informants provided rich background related to the health care experiences of women, the changing attitudes of society and the clients served in health care facilities throughout Belize. They also addressed the role of and the challenges faced by the government of Belize, and most importantly were a vital referral source for participants who would be willing to tell their stories. Over the last decade I have had the opportunity to participate as a health care provider, an invited guest to cultural events, a friend, colleague and cultural observer in the homes of Belizean women and have been continually amazed at the richness of Belize. These participant observations provided insight and background for the experiences that were described by

participants and key informants. Field notes chronicled my thoughts, feelings and observations of events, encounters and experiences in Belize and provided reflections from which to examine the experiences of women within the social and cultural fabric of Belize.

Reproductive Health Care Revisited

In order to provide a framework to analyze the experiences of women in Belize, it may be helpful to review the multifaceted nature of women's health. A comprehensive definition of reproductive health was developed at the Cairo Conference on International Population Development and elevated reproductive health to a human rights issues for the first time. Reproductive health care should allow women and their partners access to safe, affordable and culturally appropriate care free from violence and coercion, acknowledge issues of gender inequality and correct them in order to provide men and women, girls and boys with education, access to resources and an equal voice in their own destiny (United Nations, 1994b). This expanded definition also acknowledges that reproductive health and outcomes are intimately related to the socioeconomic, political, environmental and cultural environments of the communities in which women and their families live. Revisiting this definition reveals the need to explore Belizean women's experiences amidst the backdrop of the cultural pluralism and the socioeconomic and political realities that shape their lives.

This chapter will first explore the social context within which the reproductive lives of women are embedded and the evolution of the cultural roles of women in Belizean society. Women's relationships will be considered and the impact of these roles on their health will be examined. A woman's place in Belizean society will be explored through the words and actions of women. As one begins to envision this society, the roles women play unfold and the opportunity to consider their

reproductive lives are realized. How women experience control of their reproductive lives and what happens when an unintended pregnancy occurs will be probed through the stories of women who have been affected by unintended pregnancy. Abortion is one aspect of reproductive health that is often secret. Women's knowledge and experiences of abortion will be explored. Lastly, emerging themes from this study will be reviewed and how they reflect the challenges that women in Belize face will be discussed. How these challenges are met will have an impact upon the future of women in Belize.

A Woman in Belize: Weaving a Complex Existence

Although family relationship structure is an integral part of a woman's life, so too is the way that she relates to the culture in which she lives. When exploring this concept in Belize it is important to remember that the three dominant cultures of Mestizo, Caribbean and Mayan all exist together throughout most regions of Belize. In the Northern districts of Orange Walk and Corozal, it is common to interact with all cultures in a single day running errands, going to school, working or accessing health care services.

An Evolving Tapestry of the Belizean Family

Some evidence suggests that there are major changes occurring in the basic fabric of the Belizean family. In Belize, distinctions are made between the definitions of families and households and this distinction is important when analyzing changes in families. A *family* refers to the "...two partners, of the opposite sex, living together with children of the partners or adopted, together with other relatives" (National Human Development Advisory Committee, 1998). However, this definition may also include relatives who do not live in the same household. On the other hand *households* are defined as one or more persons living together under one roof, sharing at least one daily meal or sleeping under one roof for most nights of the week

(National Human Development Advisory Committee, 1998). The "household" definition includes all people who are interacting on a regular basis, rather than the more traditional "two partner" definition. During the 1980's to 90's, there was an overall decrease in household size with an average household size being 4.9 in 1991. The statistics from the most recent census in 2000 are not unavailable.

One change in households is an increase in the numbers of households headed by females. The 1991 census data indicate that 28% of households were headed by females, an increase of 7% from the previous decade. There is no reason to think that this trend would not continue. Similarly, the 1991 census data also indicates that 13% of household members are not comprised only of the nuclear family, suggesting that the concept of an extended family remains important in descriptions of households in Belize (National Human Development Advisory Committee, 1998).

Economics: More than Just a Job

There is little information available regarding the status of women and work. BOWAND (Belize Organization for Women and Development) is the official government organization that is charged with addressing the challenges women face in the workforce, as well as to identify mechanisms to resolve inequities and conflicts that arise in the employment sector for women. Women comprise about 35% of the labor force (Belize Ministry of Health and Sports & Belize Ministry of Human Resources, 1997). However, this number is quite misleading because it does not include women employed in the "informal" sector which includes jobs such as sewing and washing done in the home, cooking for sale outside the home and some domestic work. In addition, women fill the majority of volunteer jobs, such as church groups, parent-teacher groups, NGO's and community organizations in communities. Community health workers (CHWs) are almost uniformly women, although they

receive a small stipend. This informal employment sector, while providing women with some extra income, also tends to be underpaid and unrecognized by government agencies such as Social Security. Women who work outside the home are usually employed as unskilled labor; less than two percent of senior management positions in the country are held by women (Pan American Health Organization, 2001).

The Department of Women's Affairs, another government agency, also suggests that women are denied an equitable share of the labor force and tend to be employed in lower paying jobs and often experience adverse working conditions (Belize Ministry of Health and Sports & Belize Ministry of Human Resources, Women's Affairs and Youth Development, 1997). These low paying jobs, often in the manufacturing industry, are also a source of occupational injuries and adverse health outcomes related to unsafe or unsanitary working conditions. Women working in the informal sector are not entitled to benefits should they become ill and are not covered by government Social Security benefits. Sexual harassment does occur in Belize although there are no current estimates as to its frequency. Some cultural groups such as the Maya or Mestizo may be more likely to be affected by sexual harassment because of their more traditional cultural values regarding sexual relations (Belize Ministry of Health and Sports & Belize Ministry of Human Resources, Women's Affairs and Youth Development, 1997).

Work outside the home also seems to play a role in women's reproductive lives. According to the Maternal/Child health survey in 1991, almost 64% of the women who worked outside the home were using a contraceptive method, compared to only 42% of women who did not working outside the home. Even women who reported work from inside the home had higher contraceptive use (54%) compared to their non-working counterparts (Central Statistical Office et al., 1991). There are a

number of explanations for increased contraceptive use among working women. For instance, working women may have higher incomes so might be more likely to afford contraception, they may have more incentives to use contraception in order to maintain outside employment, or have different world views as they are out in the world and interacting with other women. These reasons may be interrelated.

In this ethnography most women did not work outside the home. A few women reported supplementing their income with home-based activities such as food selling and sewing. However, when women in this group did work, they worked in the professional sector, rather than the service industry, which is the most common sector for women to be employed in Belize.

Politics-Having a Voice

Although the constitutional head of state in Belize is a woman (Queen Elizabeth), there are few women involved in politics at the national level. There is one woman in the 29 member House of Representatives and there are two women in the Cabinet of the current Prime Minister (Government of Belize, 2002; Pan American Health Organization, 2001). Dolores Garcia is the minister of Human Development, Women, Children, Families and Civil Society and Patty Macero is a Minister of State. So, although women are active in politics, representation in the national government is minimal. However, women are active on the local level, often outside of the local government circles. There are a number of women's organizations through which women may effect change in their communities. One example is the women's auxiliary of the Corozal Hospital. This dedicated group of women raises money, secures donations from international donors, and performs improvements for the hospital and clinics. The membership of the auxiliary is diverse, with most of their work being carried out "behind the scenes".

Increasing attention to issues that significantly impact women and their families indicates a changing focus of the government and other agencies. In the last decade, significant legislation has been enacted to offer women protection and legal recourse in cases of domestic violence. In 1993, the Domestic Violence Act was passed and identified domestic violence as a crime and offered protection for women and their children through the use of protective orders, financial compensation and legal recourse (Judiciary System, 1999). There is one domestic violence shelter in Belize and over 500 cases of domestic violence were reported in the year 2000 (Government of Belize, 2001). The local judiciary system uses justices of the peace and women are represented in this branch of government in every district, thereby promoting the importance of a woman's perspective in regards to enforcement and implementation of the laws of Belize.

Education--A Critical Thread

According to the World Bank, education is the most important investment that can be made by a country and its citizens to improve the status of women (Ashford, 2001). The education system in Belize provides primary and secondary education to its citizens; however, only 75% of the eligible population is actually enrolled in primary school and more boys than girls attend (National Human Development Advisory Committee, 1998; The National Committee for Families and Children & UNICEF Belize, 1997). However, when secondary schools are examined, only 42% of eligible students are attending and more of these students are girls (National Human Development Advisory Committee, 1998). All but two of the participants in this research completed primary education, five completed their secondary education and one attended school at the university level.

The reasons that eligible students do not attend school are complex and are related to economic and cultural circumstances. The Belizean government suggests

that the rising costs of registration, fees and books, along with parental indifference are responsible for the primary school attendance numbers. Although, these economic concerns are important, they may be misleading. Gender issues that place less importance on girls' attendance at school may be to blame. Most agree that primary school is essential to attain basic skills like reading and writing as well as the basis for job skills later in life. The foundations for literacy are in primary school, so a lack of participation has a significant impact on the individual as well as the country. One participant, who left school after Standard IV related her story:

> I was only 13 and I was pregnant. My parents had taken me out of school at Standard 4. Me and all my sisters and brothers. That was as far as we got, it was too much money, my parents were very poor. I was at home already when I got pregnant. Now I think that I was too young, the future was all messed up.

Despite the above statistics, many of the participants who had children placed a high value on their children's education and often cited it as a reason to limit the size of their families, so that they would be able to afford to send their children on to secondary school and beyond. Mrs. I. from a rural village related that:

> Me and my husband think that three are sufficient. We don't want more because we will have two girls in high school and this boy is going to school. I think with having children you have to think if you can afford to give them what they need. That's why I think it's better not to have more. We would not be able to... things are getting more expensive every day

Another participant stressed the importance of education and the sacrifices she has made to provide her children with optimal educational opportunities.

> We were living in the village [about 45 minutes by bus] but I didn't want the children to go to school there, they are sometimes backward in their studies. So we decided to bring them to school in Corozal. So each morning we would get on the bus, one child was still asleep, my son would need breakfast before he goes to school. Then he would come here, I would drop him off, be at my mother's house, do some cooking, pick him up, feed him lunch, bring him back to school and wait for him to be done. Then we would go back home to the village, then I had to do my work, cooking, cleaning. It was hard; we did this for 5 years. My husband said if he make good grades then we can move back to Corozal and that is what we did then. Now we live here and it is easier, but it is still a full time job, being a mother. They do good in school in their work because I know what they are doing. Because they see that they do good in school because I help them. I help out at school, help their teachers with work. I tell my son that I didn't go to school and I want him to finish his school. That is all that we can do for you now. Don't make the mistake mom make. There is time for everything. Don't rush for anything.

Literacy. In Belize, literacy is defined as completion of Standard V in primary school. Using this definition the most recent statistics indicate a literacy rate of 75%, a small increase from the 1991 rate of 70% (National Human Development Advisory Committee, 1998). This definition of literacy can be deceiving as it is common for students to leave school without basic reading skills. However, there also appears to be gender, ethnic and geographic differences when literacy is examined closely. For foreign-born citizens, most of whom are refugees from other Central American countries and Mexico, lower literacy rates are found with a higher percentage of

literate females. Similarly, if geography is considered there appears to be some differences between the districts in regards to literacy. The highest literacy rate of 92% is reported in the Belize district whereas the lowest rate of 59% is in the Toledo district. Corozal and Orange Walk literacy rates are 63% and 72%, respectively (National Human Development Advisory Committee, 1998). According to the official definition of literacy in Belize, two of the participants were illiterate, however; all the participants reported being able to read.

Environmental Issues

The environment in which women live can directly and indirectly affect their overall health and well-being. For example, if safe water is unavailable then a woman and her family are at risk for health problems like diarrheal illnesses. Other environmental factors like air quality, types of cooking fuel, use of refrigeration and availability of electricity and adequate sanitation also affect health. Participants shared that they all had access to potable water, however a little less than half did not have pipe water in their house and used a well or a village pump. Lack of pipe water means that, families must collect water for the day every morning. The water is usually kept near or in the kitchen and covered with a lid or a large plate to maintain cleanliness. This water is used for cooking, cleaning and drinking.

Adequate sanitation is another important determinant of health. All of the participants who lived in the urban areas of Corozal and Orange Walk had access to indoor facilities, whereas the majority of participants used latrines for sanitation. All but a few women reported access to refrigeration and all of these women resided in urban areas. A lack of refrigeration requires that all perishable foods be bought and cooked on the same day, which may be a hardship for village women. A lack of refrigeration results in diets that use less animal proteins and are predominantly based upon rice, beans and vegetables, which can be obtained locally. Many women

in the rural areas raised chickens for eggs and meat and it was common to see pigs roaming freely in many villages. In urban areas, it is common for women to have prepared foods, eat in restaurants or obtain carryout foods for themselves and their families. In rural areas, women spend large amounts of time grinding corn for tortillas, making rice and beans and special dishes like tamales. In the urban areas, women can purchase fresh tortillas at one of many tortilla factories.

Two things affect air quality in the Northern districts--dust and cane burning. In the dry season from December through June, rain is infrequent, so the unpaved roads become dry and dusty, especially with passing vehicles. The dust can make breathing difficult and driving dangerous, so government trucks will frequently wet the roads to decrease the dust. Similarly, the main crop in the northern districts of Corozal and Orange Walk is sugar cane. To harvest the cane, fires are started on portions of the fields and the leaves are burned until only the stalks are left, and then they are collected. When the fields start burning, the air in the villages often becomes thick and there is a sugary smell in the air. Respiratory illnesses are the most common reason for childhood morbidity and hospitalization, and the second most common reason for admission to the hospital for women after pregnancy related conditions (Pan American Health Organization, 2000; The National Committee for Families and Children & UNICEF Belize, 1997).

Propane is the most commonly used cooking fuel, yet in the villages it is common to find women cooking with wood in traditional oven/stoves. Those that cook with wood are more at risk for respiratory illnesses. Luckily, the kitchens are often well ventilated, however if the temperature drops or a storm comes, then the windows are shuttered and the air quality deteriorates.

Every participant reported having electricity and all but three participants had a refrigerator and all but one had a television. During visits to Belize 8 or 10 years

ago, when rural electrification projects were still underway, it was common in the villages to visit homes without electricity yet find televisions being run with car batteries and children watching cartoons.

Links to the Outside World.

There is probably no other area that has seen more change during the past decade than communication. A little over a decade ago, modes of communication were limited, and sporadic. Ten years ago if I wished to communicate to health care colleagues in Patchakan, only 11 miles from Corozal, a call could be placed to the village phone, where I would announce whom I needed to speak with, and then call back in 20 minutes. During that time, someone on a bicycle would ride to the house, let them know they had a call and then someone would return to receive the call. There was a "town" fax at the corner hardware store in Corozal where one could check for messages from the United States. Personal computers and cell phones were non-existent, and the worldwide web had yet to reach Belize. Letter writing and occasional calls were the only means of communication between "the States" and Belize.

A little over a decade later, phone service arrived in most of the villages around Corozal and Orange Walk. Currently, many more people have phones in their homes, friends and colleagues communicate via email, computers are more prevalent, cell phones are everywhere and trips to the "town" fax machine are no longer necessary. Some schools have computers and children are being introduced to the skills necessary to participate in the global economy during their "computer time" in primary school. The ability to communicate with friends and relatives in Belize and abroad has changed the pace of life in Belize. Prior to the communication boom, life seemed a bit slower and less hectic. Now, when riding the bus, or eating

in a restaurant it is common to hear cell phones conversations, instead of just the friendly conversation of your neighbor or seatmate.

Television connects Belize to the outside world and the effects of television on Belizean life are significant. Some Belizeans believe that the ability to access information from other countries, mostly the United States, is a source of entertainment and information, previously unavailable to most Belizeans. On the other hand, some find that the information and entertainment available emphasizes the vast differences between Belize and the developed world and destroys the traditional family values that many believe serve as the framework of Belizean culture. According to Shoman (2000), "...television not only brings us *Another World* and *Dos Mujeres Un Camino* (a well known Spanish soap opera); it also tells us "what is news" and conditions us in our reactions to that news. Most importantly, however, television seduces us into the hedonistic web of unrestrained consumerism" (Shoman, 1994, p.280-81).

Looking for Health...

The participants and key informants as well as participant observations during this research provided a unique opportunity to explore the experiences of women in the health care system in Belize. The majority of women access reproductive health services through either the government health system or BFLA, the NGO that provides reproductive health services to many non-pregnant women in Belize. A description of a typical day at a BFLA clinic may provide insight into the experiences of women as they try to maintain their health.

The clinic begins early, usually around 8 am and there are usually women already at the door when the clerk and the midwife arrive. Women from rural areas will have taken the only bus that will drop them in the town center and they must be done at the clinic by the time that bus makes its return trip a few hours later. Going to

the clinic is often not their only task for the day, and they will run errands while in town. Women will often be accompanied by at least one or two children. They check in with the clerk who writes their names down on a first come basis as there are no appointments scheduled. The women take their place on a bench or folding chair in the sparsely decorated waiting room. Posters in the waiting room inform them in Spanish about condoms, safer sex and breastfeeding. Once they are called they enter one of the two exam rooms and the midwife or nurse determines the purpose of the visit. Regular clients are usually there for an injectable contraception or a yearly pap smear. Patients who have health screening done, like pap smears, sexually transmitted infections testing, or blood tests will need to return for their results. Interestingly, there are few records kept in the clinic, even for their regular clients. However, women commonly carry a small card with their contraceptive information. The exam rooms contain an exam table, writing desk, some cabinets and a sink. Exam lights are present, but often do not work. However, latex gloves are available and are not reused. Contraceptive supplies are usually dispensed at a minimal price but the availability of other medications such as treatments for vaginal infections or sexually transmitted infections are often in limited supply if available at all. Prescriptions can be written for nearby pharmacies at the hospital or town but these can be expensive.

Clients at BFLA have the opportunity to pay an annual fee and then receive services at no additional cost, including an annual pap smear throughout the year. Once per year, during Women's Week, BFLA in conjunction with government health services offers Pap smear screening and breast exams at a reduced cost. During this week, it is not uncommon for 75 –100 women to arrive each day for exams in the Orange Walk clinic. The waiting room quickly fills up and women are sitting and standing outside the clinic, often for hours. Similar to the developed world, this may

be a woman's only contact with a health care provider for an entire year, so in addition to the gynecological exam, women receive blood pressure, weight and blood glucose screening as well as information on breast cancer, HIV, cervical cancer and menopause.

Women describe varied experiences within the health care system through the different facets of their reproductive lives. Almost all women access care through government health care systems at some point in their lives. All the participants reported that they received prenatal care at government health clinics. Nurses and midwives provide most of the care and one participant remarked that the midwives were a great source of support and education during her first pregnancy when she was scared and uninformed. Most of the younger participants would have delivered their babies in the hospital, as is currently the trend in Belize. However, older women more likely would have had their babies at home with rural midwives or traditional birth attendants. This change in place of birth has been occurring over the last two decades throughout all but the most rural areas of Belize, where home birth is almost a necessity. The reasons for an increased use of hospital birth are unknown. Other than pregnancy, most women of childbearing age have little contact with the health care system unless they are seeking contraception, or other reproductive health services such as a pap smear, or care for an acute illness. However, women experiencing a reproductive health problem such as a miscarriage or ectopic pregnancy as well as women seeking permanent sterilization have contact with doctors and nurses. Two participants indicated that these experiences resulted in unfavorable outcomes and provided examples of paternalism in the doctor-patient relationship in Belize.

S. was a Creole woman who had become pregnant with her fifth child. She admits that she had not had good luck with men and did not use contraception

regularly to plan her pregnancies. However, she was finally with a man who cared for her and her children and so while her pregnancy was unexpected it was accepted. She relates her story:

> I thought I couldn't have anymore. So I was shocked when I found out I was pregnant because [I] just start getting sick, vomiting. So I didn't know I was pregnant until they examined me. A specialist in Belize [City] did it. And when he find out that I was pregnant he said I needed an emergency operation. The emergency operation was due to a tubal pregnancy. "That shocked me and I started crying. I didn't expect that to happen. I thought, why me, but, God knows why. The doctor decide that it is best for me to take my tie-up and so I can't have any more children.

S. went along with the doctor's recommendation yet, still has some regrets as she would have liked to have a child with her current partner. She relates:

> I am not too happy about it because the gentleman I am with is a very nice person. He look out for me and my children. Try to be there. I'm not happy, like I tell him over and over, right, that I had to make that decision to stay here for the other four children. He understood [sic].

The above scenario illustrates health care relationships that are not based upon mutual respect and trust and raises concerns regarding the issues of informed consent and coercion. These issues are particularly important when permanent sterility is considered. One of the tenets of reproductive health care is access to care and information that is free from coercion. Thus, it is paramount that decisions regarding fertility control be made using informed consent and health care relationships based on trust and respect of patients' wishes (United Nations, 1994b). Although

sterilizations without informed consent occur, other participants disclosed difficulties in obtaining tubal sterilizations from the government health services.

E. related that she had decided after her second child that she was finished, she wanted no more, despite only having boys. She decided she would use contraceptives.

> Because I didn't want any more children. Then it [oral contraceptives] started to give me so much problems. Headaches and can't sleep [*sic*]. All of those things so, I just stopped it. I went to that doctor to see if he could give me a "tie-off" and he said no, I was too young. I got pregnant.

Another woman related a similar experience and goes on to describe what happened when at 24 she was ready to have a 'tie off'.

> Yes. I talked to my husband. I didn't want anymore, and I said if he doesn't want me to use any drugs and I can't take care of myself, then he must do something because I do not want to plan children with not enough money for all of them. So, he decided yes. I was only 24 in Belize you cannot do those things until you are 30. I had to sign papers, my husband had to sign papers and the doctor had to sign papers. I was in labor when I had the baby and [*sic*] they took me straight to the operating room.

These accounts underscore the importance of the health care relationship when providing reproductive health care services for women. Paternalism and coercion in health care relationships can undermine a woman's reproductive options, expose her to added health risk resulting from future unintended pregnancies and can serve to disempower her from making her own health care choices.

Being a Woman in Belize-A Tapestry of Roles and Relationships

Women in Belize, like women throughout the world, have many roles, like threads, which they weave together to create their lives. Although reproductive life is just one role, it is an important one as it intersects with almost all aspects of their lives.

Belizean culture is complex, due in part to its many cultural groups as well as the unique challenges it faces as it attempts to secure its place in the global economy. Cultural attitudes appear to be changing in Belize in regards to the roles of women and men, families and broader networks of neighbors and communities. The traditional roles of wives and mothers, while still prevalent, are being expanded to include working outside the home. Some of these changes have emerged as a result of expanding global communication, new employment opportunities, improved educational offerings and an overall improvement in health. However, some of these changes are more subtle and may reflect how the culture of Belize is enabling women to envision new futures for themselves and their daughters.

"Stay Home, Have babies"–Traditional Colors of a Woman's Life

These words reflect the traditional roles of many older women in Belize. A woman explained that to be a "proper housewife", one must stay home, focus all energies on the home, children and the man of the house. This role was the expected route of many young women two decades ago in Belize. This life was hard, both physically and emotionally for women, although women described satisfaction and purpose in their roles as mothers. One woman described the "strength" that is needed to raise children, referring to the physical strength as well as an emotional commitment. S. explains:

> Having a child, many people have a child and then they don't think about the educational side, emotional [side] that they

need to provide. So, if you don't have the strength to teach a child while they grow up, the child will just grow like that. But the responsibility is for parents not to depend on the schools or anywhere but they should [be] the foremost interest in their child. For them to get trained right. You can't depend on schools and things. You have to help.

Many women described the joy they felt from their children and saw them as an investment in their own lives as well as for the future. Another woman described the challenges and happiness that her children have brought to her life.

...I didn't really have much of a life before I had time to live. Because I went straight from school into pregnancy, there was no in-between. But I think that they have educated me. I have learned so much. I have learned to be a counselor. I've learned to be a housekeeper, a cook, and all those things that come with motherhood and so on. And I think it's quite a blessing. It's been a blessing. It's been a good experience. I know they love me. They know I love them. We really close. We're really close. They've all learned to care for each other, [and] take care of each other.

While mothers often spoke of the joys of motherhood and satisfaction realized from their children, some described relationships with partners that were disappointing. This fulfillment often came at the expense of personal aspirations and a life that was often isolated. One woman who had lived in a village and then moved to the town described her life this way:

I think it's nearly the same from year to year because I lived there locked up [in the village] and I live here locked up [the town]. The same. Because I don't go nowhere, ... I don't take

> him to the park... because my husband is very reserved. When he gets home he wants to find the wife home, and find hot food and everything. He wants his wife to take care of him and do everything for him. I tell him he is like my other child. I have four, I don't have three. I have four.

A life of isolation can also indicate a relationship that is complicated by jealously and insecurity. For E. the jealousy and machismo described below complicated the relationship with her husband.

> He was never happy with none of them [the children]. He wanted to tell me it's not from him [sic]. Until they come into this world and he sees they look like him and he says, okay, it's mine. He was so jealous. He is a jealous of his own shadow. [Men] could do whatever they want but not the woman. The woman can do nothing. Everything the woman do should do for respect but the man no, they shouldn't. They have their own rules, rules for the man.

Weaving a new pattern. While the above description characterizes a disheartening relationship, this same woman described how she had made her own way in the world, raised her children without the financial or physical presence of her husband and envisions herself as an example of an independent Belizean woman who has taken control of her life. E. has worked her entire adult life, raised 4 children who have or are in the process of finishing secondary school, and feels that she has been successful. She describes the changes she has witnessed for herself and her children. She relates how different things are for her daughter and tells the following story of a traumatic event in her own adolescence:

> When I was a child of 16 my mother was having her last baby. They told me the babies are dropped from an airplane and I knew no

> different. At this time, during and after childbirth, men were sent away for three days and the children were practically locked out of the house. I was crying because I knew my mother was having a baby because the midwife and my grandmother were there and I was convinced the airplane would come and no one would be there to catch the baby and it would die. We were not allowed to see our mother for three days and did not know if we had a brother or sister.

She contrasts her knowledge with that of her daughter who is now entering puberty.

> Now, I *think they are reading. Maybe they are knowing more. When* I used to go to school they never used to teach you nothing about sex and nothing about that. That was private thing. And now at school the teachers talk to them about their period and about taking care of themselves and how their breasts are going to grow and this and that. That's good...they are learning to respect themselves.

Her story illustrates the transformation that is happening in Belize in regards to how girls become women and what type of women they will become. Young women today will be more likely to be knowledgeable about their reproductive health and have a vision of the opportunities and choices before them. Many of the participants in this study believe that this is a positive trend for women in their country. One remarks, "We are strong women of Belize".

Although some relationships with partners seem to be based upon distrust and control, others reported relationships, which illustrate the cultural changes occurring in Belize. Women often described a partnership with the men in their lives, one in which decisions were made mutually, especially decisions regarding family size, pregnancy and contraceptive use. It was rare that women discussed the need

for subversion in their relationships, despite the fact that most women found themselves in traditional roles of wife and mother. Although traditional roles are prevalent, the two-income family is becoming more commonplace over the last decade in Belize. Reasons for this probably have their basis in economic realities in Belize, appreciation of the value of education, need for higher family incomes, and a greater number of educated women. Educational success leads to more opportunities for work and a population that is more globally aware and focused.

A Unique Tapestry-Independent Women in Belize

A few women in this study experienced a high degree of independence in their relationships. While these seemed to be an exception, their lives provided a glimpse of what a truly independent Belizean woman might be like. L. described her choice to have her first child and elaborates upon some of the difficulties her "independent lifestyle" brought to the relationship:

> To this day I have never asked him for anything or anything like that and it's like. I remember, he took me to buy baby things and I was totally offended when he paid for things. You want to buy anything for the baby, you go and buy it and then you bring to us. I bought the things, I picked the things, and then we went to the cashier, he pays. I didn't say anything, but when we got home I took out my money and I said, this is your money. This is what you paid and he was so upset about this thing and he said, do you want me to be a part of this or you don't want me to be a part of this? And I said, well because I struggle over who has control over what, as I said, I welcomed some of his attention, [yet] I didn't appreciate him trying to take over completely.
>
> That is how I feel. How I saw my relationship. He feels threatened.

> He had been in a previous relationship where he had been the one to manage everything from budget, food and bills and then he gets into this relationship and then, it was like, what role do I play here or whatever. And most men, I suppose, because of that, I don't know if it is part of socialization or what, most of them see that as... I mean I am still a single woman, I'm still a single parent and I think it's because of that. When I come in contact with men, it's like, they always feel, I mean I know that because friends have told me this, it's like I'm always control. I always feel like I am always in control and I supposed men don't like that at all. They don't appreciate that. Most men probably. I don't think I have met anybody that could accept me as I am.

Her story illustrates a woman who has chosen a different pattern for her life, has supported herself, and has attained professional stature within her community. Despite her beliefs that men have difficulty with women such as her, the male professionals with whom she works respect her. Perhaps her life is an example of a movement away from the concept of traditional roles as the only option for women. She was raised in a traditional Belizean family, however she described herself as always being independent. L. pursued her education and completed college and professional training, which also fostered her independent lifestyle.

Families in Belize-Retaining the Traditional Tapestries

Families remain the basic fabric of society in Belize, regardless of the status of a woman's relationship with her partner. Women in the traditional roles of wife and mother, often live either with or near their parents. For women who work outside the home, their extended families are the main source of childcare and support for a growing family in which both parents work.

In traditional families it is customary for men to ask permission of a woman's family prior to marriage and, sometimes, even for dating. A woman in a village described it this way:

> If he wishes to spend time with me, he must first come and make his intentions known to my family. If they agree, then he may visit, but these visits will be with members of my family present. It would not be appropriate for us to go out alone. When he is sure that he has the means to support me, has a house etc then he can ask my family for permission for us to get married.

While this describes how a traditional Mayan courtship might ensue, this is in sharp contrast to a more modern interpretation where dating and even premarital sex occurs prior to marriage. Many more women described the latter as perhaps the more common Belizean dating ritual.

Although courtship rituals are changing in Belize, the family remains an important source of support and information for women as their roles transform to wives and mothers. Mothers seem to be the most likely source of information for girls and women in regards to pregnancy. However, many of the women described going to friends or health care professionals for contraceptive information. Perhaps, the mothers were of an age that they had very little experience with modern contraceptive methods and their daughter's knowledge surpassed them due to education and discussions with peers.

CHAPTER 6

Women and their Reproductive Health Care

The previous pages provide the background for the tapestry upon which women weave their roles and experiences. Reproductive health is one of the threads that are common to almost all women in Belize. Their words and descriptions afford a perspective of women's lives that cannot be gleaned from government statistics and census data. Three areas of reproductive health will be examined: the contraceptive decision making experience, the cultural experiences and consequences of unintended pregnancy, and the role abortion plays in women's lives in Belize.

Contraception-Changing Attitudes in Belize

The perceptions of a number of key informants who were providers of health care and family planning services offered insight and an important historical perspective regarding the changing attitudes and trends of contraceptive practices of women in Belize. Currently, contraceptive usage is popular among women and their partners. Key informants attribute this to many factors. Education, in schools and in the media has brought the issues of sex, family planning and sexually transmitted disease (STD) prevention to the forefront. More than one participant related that they were happy to see that schools were teaching children about reproduction and how that was a change from when they attended school.

A number of key informants also suggested that increased educational opportunities for women seemed to be increasing contraception usage, especially among urban women. They relate that in the main urban area of Belize City, there are many female heads of household and that these women

have taken control over their lives and their families and make independent decisions regarding their reproductive lives. This observation appears to be correct as the number of female heads of households has grown to 22% nationally, with an even higher rate of 33% in the Belize district (National Human Development Advisory Committee, 1998). However, this independence is not universal and it remains that women in rural, isolated areas, are more likely to be less educated, live in more traditional household settings and have larger families. For example, the village of Sartenja is a small rural fishing village, a two–hour bus ride from Orange Walk, with a small rural health center and a full-time nurse. During a visit to the village with the Public Health Nurse, the researcher provided gynecological care to women requesting health screening and contraception. The only available contraception was oral contraceptive pills; there were no injections, or IUD's. Condoms were unavailable through the health center. A health care provider suggested that this small village had a high rate of HIV infection due to the transitory nature of the fisherman who lived in and visited the village. The lack of condoms for STD prevention in the area is particularly troubling

Although geography presents barriers for women to access contraceptive services, other cultural barriers exist despite educational advances and increased access to information.

Weaving Contraceptive Folklore

There were several common threads describing fears and folklore that emerged when women related their experiences of contraception. There was a belief that some forms of contraception, especially hormonal methods, can cause cancer. This was discussed by many participants and supported by two key informants. None of the participants could identify the source of this information and was frequently

attributed to "someone told me". Another woman shared her experiences with oral contraceptives.

> Well, you keep hearing stories that something is going to be wrong with you if you keep using those pills. Even though the pills did not affect me. You know like I didn't feel my stomach ache, I didn't forget to take them, I always remembered. And as far as I know, it hasn't effect me. Something might happen...I just wanted to change to another form of contraception. Just one month I stopped taking them. Cause one lady told me at ... eight years, her daughter took them and she hasn't got pregnant. So I thought after ten years I won't have any either. (She later became pregnant with her last child)

Although the fear of cancer is prevalent, one key informant who is integral in the provision of health care services for women, indicate that women who had five or six children will say "you have to die of something" and will use the contraception, despite their fears, rather than have another child. Some participants related fears that their previous use of contraception prevented them from conceiving when they wanted to become pregnancy. This lack of timely conception was often linked with previous contraceptive use. Some participants discussed their concerns about taking medication regularly, even for contraceptive use, and this was supported by key informants.

Access to information regarding postpartum contraception is problematic because women receive little information regarding contraception on hospital discharge and the rates of postpartum visits are low. So, only those women who attend postnatal clinic or seek information about contraception are likely to use contraception during the postpartum period. There were concerns about taking any medication during lactation, so contraceptive failures were common during the

postpartum period. Three participants related stories of pregnancy during breastfeeding, none were using any contraception, and one described, "being told not to take any medicines while breastfeeding". The women indicated that they had heard about "breastfeeding protection" for pregnancy, and two did not become pregnant until their babies were over a year old, suggesting success well beyond the recommended 6-month period of the Lactational Amenorrhea Method.

It is often stated that women who have positive contraceptive experiences, meaning successful use with minimal side effects, are more likely to use contraception consistently and correctly to plan their families. The experiences of many of the participants support this idea. Women who had been successful using a method before pregnancy were more likely to resume the method afterwards. The participants who indicated that their pregnancies were planned were in this group of successful users. Women who had numerous side effects or contraceptive failures were more likely to remain ambivalent about contraceptive usage or resort to permanent sterilization when they reached their desired family size.

While all weavers may use the same threads, no two tapestries will be the same. Similarly, all the women in this study related experiences with contraception, but their experiences were diverse. How they came to use contraception, what they used and how successfully they used it emerged as a complex process. Cultural beliefs, relationship issues and previous experiences all affected their contraceptive experiences. First, the decision making process will be explored, followed by the relationship of contraceptive use and family spacing and, lastly, what attributes tend to lead to successful contracepting habits of partners.

Who Decides When Enough is Enough

The experience of contraceptive decision-making among women and their partners was complex and related to cultural beliefs and values, family size, previous

contraceptive use and reproductive health care services in Belize. While no two women had the same experience with contraception, some patterns emerged that help to explain contraceptive use in Belize.

About one-half of the women in this study had experience with unintended pregnancy prior to marriage and almost all of the women subsequently married the fathers of their babies, before or shortly after the birth of their children. The other half of the participants reported that at least one of their children were planned, and the pregnancy occurred after they were married, regardless of whether they engaged in premarital sex.

Planning ahead. Half of the participants reported having discussions with their partners prior to marriage regarding when and how many children were desired. It was common for male partners to want to have more children than their wives wanted. Women described negotiations that resulted in compromises as to the numbers of children that were desired. Many participants who reported an unplanned first pregnancy, described subsequent discussions about the timing of subsequent pregnancies and family size.

> When we were planning to have this marriage, I said to him, we are only going to have 2 kids, that's all, 2 kids. But then it turned out that the first one was a boy, then a girl and then another girl. So he said we have to go for another boy. I said no way, no more. That was it. Three.

A key informant confirmed that she thought that this was common. "After the first one, that is when you start".

Family size. All of the participants thought that raising children was a big responsibility and seemed to equate family size with the ability to successfully raise

children. Many mothers shared their beliefs about the important responsibilities of raising children. "My whole outlook on life I suppose has changed. It is not like thinking about you and what you want. Everything you want totally affects her". Families valued education and recognized the time and financial commitment required to raise children. S. shared her thoughts about parenting; "the responsibility of children extends beyond the schools, that parents must have the strength to teach children, not to depend only on schools." Another reported that every day children "need help with homework, need to be read to and it is a full-time job". Many women, had sole responsibility for child-rearing activities, even if they worked outside the home. It was expected that women prepare breakfast, get children off to school each day, pick them up at lunch, help with homework and maintain the household. Only women who worked full time outside the home had assistance with child-care activities. These beliefs were reported by the majority of participants; thus family size was often an important factor in determining contraceptive use.

Reaching the breaking point. Perhaps as a result of these responsibilities, women in this sample often determined family size and family spacing. It was common for participants to relate "they decided no more children". Even if the partner was not in agreement it was common for him to respect the wishes of his partner. Although these decisions were most commonly made in relationship to family size, maternal health often affected decisions regarding future childbearing. If a woman experienced a difficult pregnancy or significant medical complications, it was common for partners to decide to complete childbearing to assure continued maternal health and prevent future suffering with subsequent pregnancies.

"Decisions are my own". Completely independent decision-making regarding family size was uncommon, but a few participants emphasized that they were responsible for their own contraceptive decision-making. Two of these women

represent opposite ends of the spectrum; as one was a single mother who decided that it was her time to have a baby, and the other woman was married and made permanent decisions regarding her fertility. L. relates her experience this way:

> Yes, the decision was mine. As I said, I had never planned like to live with this person, but it was at the point and time that I think I was ready to have a child. I had finished school. I was working. I was living by myself. I had my own place. And it's like, I am ready to have a child and I stopped using it [contraceptives]. I told him I am not taking my pills anymore and he said okay. So it was taken for granted at the time. It was not something that I was talking about. So I just told him that I was stopping to take my pill. It was my decision. It was something I needed I suppose.

On the other hand Y., although married, relates her decision-making experience differently:

> I made it solely. I didn't even tell him. Other people probably make decisions with their husbands. What really changed my mind from getting my tubes tied; I was like, what the heck? What do I need to get mine tied for, why doesn't he go and get cut? And then I thought, well, he's not going to get cut because he is way too old. I supposed... Well, he said you can do what you like. It's your body. You know what you're going through.

Similarly, A. explains that after her first pregnancy was unintended and resulted in her "having to get married", she alone made the decision to use contraceptives as well as when to get pregnant again:

> It was very hard for us because we were just married with the baby. It was very hard to understand each other. I took a decision, it was

> mainly MY decision, to have no more babies for the time being. It was very hard to get adjusted. I was so young. The circumstances [*sic*], when my baby was three years old, I decided well, it's time to have another baby. Because she was already big, before she gets any bigger I should have another one. I got pregnant this time with my decision

We decide together. Joint decision-making regarding contraceptive use and contraceptive type was more commonly described by women and supported by the experiences of key informants. G. described that after her first baby "We talked about that and I did not want to use any of those pills or injections. He used condoms for four years until I got pregnant again". However, even if a woman indicated that her and her husband made a decision to space their children by using contraception, a woman might defer to her husband regarding a method, or acquiesce to their preferences or concerns concerning a particular method. B. relates that she spoke to her husband regarding choices:

> They have the one that they call the needle and they have the one that you take in the pill. My husband didn't want me to use anything because he said that after a time it can affect your child or something. So, I didn't take any drugs.

They subsequently used condoms and eventually B. had permanent sterilization. Similarly, another participant explained "that my husband didn't want me to use drugs, he heard they were bad, so he made the decision to take care of himself." A number of participants related that although they had made a decision to postpone childbearing, a method was never chosen, or if one was chosen, was not initiated or compliance with the method was not consistent. This seemed to occur more frequently in those couples that had not reached their ultimate family size, suggesting

some underlying ambivalence regarding contraception and pregnancy. Whether the decision was to postpone future childbearing or finish with childbearing, most couples seem to make these decisions together. This observation was confirmed by a number of key informants who thought that most couples to made these decisions together.

Information gathering. Once a decision was made to prevent or space future pregnancies, it was common for information gathering to take place. This often happened with a network of female friends and relatives, and sometimes included a community health care worker, and sometimes a health care provider in BFLA or a public health center. It has been the experience of the researcher, that most women have a method in mind when they come to a clinic.

All participants were familiar with most of the available contraceptive methods. It was common for women to use more than one method, especially if side effects were experienced with a particular method. Although contraceptive decisions were usually made jointly according to the women in this study, some participants were aware that some women had to use contraception secretly, without knowledge of their partners. According to one key informant, this still occurs but much less frequently than in the past, and seems to occur mainly in rural areas.

All of the participants in the study related little difficulty in obtaining or paying for contraceptives. Most received contraception from BFLA and were happy with the services provided. However, a key informant did relate that she believed that money might sometimes be a reason for noncompliance with method continuation. Although women are expected to pay for services and contraceptives, it is the researcher's experience that BFLA will accept partial payment or timed payments to facilitate women initiating or continuing contraception. However, a number of women related that the price of contraceptives was not an obstacle they encountered. Women may have viewed contraception as money well spent

for themselves and their families. Some participants related stories of misinformation regarding contraception from family and friends, but this was a rare cause of contraceptive failure or unintended pregnancy.

Unintended Pregnancy

The preceding pages reveal how multiple threads form intricate patterns in the fabric of reproductive lives of women in Belize. While the size of the country and its multiculturalism makes it somewhat unique in the developing world, the women share many experiences with women globally. One of these common experiences is unintended pregnancy.

Marriage as the cultural norm

Marriage emerged as the most important factor in the experience of women who experienced unintended pregnancy. Marriage is a fundamental cultural norm in Belizean culture, regardless of age, ethnicity or educational background. Although data suggest that there are more female heads of households, this trend may not be viewed as culturally acceptable or appropriate by Belizean society. In order to examine the experience of unintended pregnancy it is necessary to examine the differences that occur when a pregnancy is unintended outside of marriage or mistimed but accepted within a marriage.

Mistimed...but accepted. It was rare for women to describe pregnancies that occurred during marriage as unintended. While it was common that babies might come when they were not planned for, they were more often described as mistimed pregnancies and accepted. This concept of "mistimed" was first discussed with a key informant in Belize City in the early stages of data collection, and seemed to describe unplanned pregnancies that occurred during marriage. It was common for one of these unplanned or mistimed pregnancies to result in a desire for permanent sterilization or the use of a highly effective contraceptive method. Couples commonly

reached a so-called breaking point at which they were definite that they wanted no more children, reliable contraception was often not sought until this point was actually reached. One participant shared that "Well I still think about that to get the tie up after a while [sic]. But I don't want no more children. Three is enough." She continues to use injections successfully, while another states that after five children, despite encouragement from her mother-in-law to have another, that "he [my husband] already decided that we are not going to have anymore babies. We are going to try to get a tie off. Yes this was a decision we made together."

So while an unplanned pregnancy within a marriage might result in undue emotional and financial strain, it was viewed as an unexpected but accepted event within the relationship. However, because of cultural attitudes and beliefs, a pregnancy outside of marriage was a life-changing event for a woman and her partner.

Scared and alone. Almost half of the participants reported an unintended pregnancy outside of marriage. Almost all recall feeling afraid and isolated.

B. related:

> Well, I was scared. I was so scared because I didn't know where to go. I didn't have anybody to help me. The first one to know was my bigger sister, I told M., she was the only one for me. She talked to me...She helped me out and she talked to my husband and we decided we have him in six months. I was scared because I didn't want to raise a baby alone.

Confusion about what to do was common and a number of women described initially trying "to hide" the pregnancy from family. However, when families were confronted with the news of an unintended pregnancy, they were most likely to be supportive for women confronted with the prospect of an unplanned pregnancy.

Some of the participants related that their partners were a not a source of support. Some women suggested a reluctance to disclose the pregnancy to their partner because they were unsure about how their partner would respond. S. describes how she felt when she found out she was pregnant:

> Well, I was a bit scared. I hide it from my grandmother. She still find out. She told me it was best for me to have my kid and we went through it. Me, my grandmother and my aunt [we went through it]: The baby's father, well, we were mad with him because he did not want to accept that the child was his. So we didn't have him around for a long while.

Ready or not. Almost all of the women believed that "if it happens you have to get married". One women who became pregnant at age16, explained that it was "her responsibility" to raise the child. This idea of responsibility was common throughout the experience of unintended pregnancy. The responsibility to raise and support a child, regardless of age, was expected. Fathers of babies were expected to marry their partner and many readily accepted this responsibility and moved forward with plans for marriage. However, some women indicated that their partners were not motivated for marriage. In these cases, families were the main support for women experiencing an unintended pregnancy.

One key informant explained that in rural areas, marriage is the only acceptable response to a pregnancy outside of marriage. However, one participant from a rural area who became pregnant as an adolescent related that her family suggested that she place her baby for adoption, so that "a family can care for her and educate her". The adoption was arranged with a local pastor and N. continued her education. This is not the first time that the researcher had experience with this process, so adoption may be more common than indicated from this ethnography.

The cultural beliefs regarding marriage were prevalent among almost all participants regardless of ethnicity, education status, or place of residence. However, the women's age of occurrence and the level of education at the time of conception have important ramifications for the future.

Consequences of Unintended Pregnancy

Age and attainment of educational goals are important concepts to consider when exploring the consequences of unintended pregnancy, especially with adolescents. Worldwide, adolescent pregnancy is of growing concern because of the significant consequences it has on the physical, emotional, educational and socioeconomic futures for women. Belize is no exception to this worldwide trend. However, in the developing world where options are limited unintended pregnancy can permanently alter the course of a young woman's life.

In Belize, girls and boys who choose to continue their secondary education only do so with considerable financial commitment and support from their families. Young adults usually have aspirations and goals to attend university or have a professional career. Nonetheless, if a young girl becomes pregnant it is common for her to be expelled from school, with little hope of returning after the baby is born. A few of the participants who become pregnant while attending school described their feelings when they discovered they were pregnant. "Thankfully, I could finish high school and I could graduate without my pregnancy showing. Because if it had shown then I would have been expelled". Another participant shared her frustrations that boys did not get "kicked out" of school, only girls. She had planned to go to college, but when she became pregnant after high school, her plans had to change. Another related being encouraged to place her baby for adoption so that she could finish her education. A key informant confirmed that it is unlikely that a girl would return to school after leaving because of an unintended pregnancy. The girl's responsibilities

change and there is little support from families or the educational system to assist in the attainment of educational goals for girls who become pregnant. The expectation is to "stay home, have babies and be a proper housewife", especially in remote rural areas. A key informant did relate that there is a school for pregnant girls in Belize City. However, this school would be unavailable for girls living outside of Belize City due to its distance from most areas in Belize.

While the consequences of an unintended pregnancy for young girls usually result in termination of education, there are no such consequences for the boys who impregnate them. They are not forced to leave school; however, if they choose to marry, they usually leave school so that they can begin working.

There are other consequences for girls who become pregnant. A key informant relates that if a girl becomes pregnant, she may be seen "as a whore, [or one who] goes about". Failure to marry at this time may have a negative impact on her ability to ever marry. There are some "who have to stay single once they have a baby because it is a common belief that you have to be a virgin to get married. That is the culture here". However, marriage may also have untoward consequences, especially if the couple is young or had only been together a short time. For example, one young woman who became pregnant at age 16 related "it was very hard for us because we were just married with the baby. It was very hard to understand each other...it was very hard to get adjusted". Some participants also described feeling as though the "future was messed up" because of the unplanned pregnancy and subsequent marriage. Not feeling ready to be a mother or a wife was common among the women who found themselves pregnant and newly married, especially at a young age.

Abortion-A Widespread Secret

Abortion is one of the inevitable consequences of unintended pregnancy and is found in every culture throughout the developed and developing world. The incidence of abortion, types of abortion and consequences are reflected in cultural beliefs, religious influences and the legal status of women and reproductive health. In Belize, abortion is illegal except to save the life of the mother. However, the participants paint a very different picture of the status of abortion and the experience of women in Belize who are faced with an unintended pregnancy.

Unraveling the Secrets

More than half of the participants disclosed that they knew of women or had personal experiences with self-induced and therapeutic abortion practices. Just as traditional weaving practices are handed down through the generations, so too are the traditional practices employed to address unintended pregnancy. A number of participants shared that access to this information is usually obtained through discussion with friends or with "the old ladies". These women were usually traditional healers and traditional midwives who had knowledge of herbs and treatments that were meant to "bring down the baby". Even women in urban areas seem to know that certain villages had healers with information regarding self-induced abortion practices.

The network of abortion secrets also included trained personnel like doctors and midwives. Information regarding access to these physicians seems to be known to women through an informal network and are often referred to as consultations. However, the costs of these procedures are often prohibitive to the majority of women in Belize. One key informant revealed that women who wished to terminate their pregnancies and were unable to afford physician services would most likely seek out the services of less trained personnel or travel across the border to Mexico where

abortions, while still illegal, are cheaper. Another key informant related that there were some "hospital midwives" who would tell women who to contact who could help to terminate pregnancies; however, this happened less as gynecologists began providing services.

Abortion Practices: Old and New

Healers, traditions and herbs. Many women related that they had knowledge of whom to contact and where to go when faced with an unintended pregnancy. Women were less clear regarding the methods and materials used to interrupt a pregnancy. The clandestine nature of abortion, combined with the fact that traditional healing practices are known by so few, explains why women's knowledge of abortion practices may be minimal. However, a traditional healer was able to shed some light on these practices. Most abortion practices involve the use of certain herbs, tinctures and teas. These are used early in pregnancy, around the time of the first missed period and work to dislodge the pregnancy. Jack Ass Bitters and Sorosi were suggested as herbs that can be used to terminate a pregnancy. Jack Ass Bitters is a common plant in Belize that has many uses, one of which is a purge to rid the body of parasitic infections. It is common for some families to make a tea or tincture and use it once a month to prevent parasitic and other diarrheal illnesses that are common in Belize. However, the healer also emphasized that "over zealousness and trying to flush out the baby makes for a sick baby" if the pregnancy continues. She believes that the herbs may have an adverse effect upon placental implantation, which results in an unhealthy fetus. The healer confirmed that abortion information has always been "secret information" and was never common knowledge for anyone. There was always someone, either "the church, or the husband or the village council" whose interest was to prevent dissemination of this type of information. However, limiting this information has not always been "bad ", as it can be "a dangerous thing" and she

relates that women who attempt abortion too late in the pregnancy may be at risk for hemorrhage or shock. She recommends that women who use these treatments be monitored and have someone who can assess them for complications.

Abortion "urban legends". A number of participants discussed the use of quinine as an abortifacient. Quinine is a common for treatment for malaria and febrile illnesses in Belize and easily available to women. Large dosages were said to cause a miscarriage. One participant remarked that when she became pregnant at age 16 she tried this method, experienced episodes of gastric distress and did not successfully terminate the pregnancy. This "urban legend" of sorts seemed to be known to both rural and urban women and, according to a traditional healer, probably began when someone who was taking quinine, experienced a miscarriage and passed this information on to others. Another participant shared that she was told to take a large dosage of an aspirin-like medicine, commonly used for the flu, with large quantities of Coca-Cola. She shared that this suggestion was unsuccessful in terminating her pregnancy.

While these participants relate learning of "abortion secrets" through a network of older women, healers and friends, the use of quinine as an abortifacient has a long history of use during pregnancy. According to Dannenberg, Dorfman, and Johnson (1983) quinine has been used for vomiting, fever and malaria treatment in pregnancy and often used as a tonic in late pregnancy to ease labor and birth. They report that despite poor efficacy, its reputation as an abortifacient continues. However, there are reports of serious consequences for maternal and fetal health with large and toxic dosages of quinine. In a review of 72 patients dating back to 1932 there were 11 cases of maternal death, serious morbidity usually related to acute renal failure, and 55 infants with congenital anomalies, especially deafness. There were only 3 successful abortions (Dannenberg, Dorfman, & Johnson, 1983; Smith, 1998). So, it

is possible that quinine is a folk remedy that has passed down through the culture of women with some help from the medical profession.

Modern but not necessarily safe. A number of participants related that it was possible to go to a doctor early in a pregnancy for an "injection that would bring down the baby". Some key informants disclosed that there was a growing business of private abortions by trained gynecologists. The procedure most often performed was a dilatation and curettage (D & C). However, these procedures were expensive, about $250 US; prohibitively expensive for most women in Belize. Although D & C is a very safe method of abortion when performed under optimal conditions, key informants indicated that unsafe abortion practices performed by medical personnel continue in the black market of illegal abortions.

Consequences of Abortion Practices

A key informant discussed that abortion is "a taboo subject that no one wants to talk about". However, this informant revealed that "abortion complications are the second highest cause of women's health admissions to hospitals". This statistic is confirmed by many sources from within Belize and international health organizations (Belize Ministry of Health and Sports & Belize Ministry of Human Resources, Women's Affairs and Youth Development, 1997; Pan American Health Organization, 2001). She suggests "that the government and the Catholic Church are partially responsible for the lack of attention paid to this matter." Although illegal, knowledge of where to obtain surgical abortion and treatment for self-induced or assisted abortion was commonly known to most women and all of the key informants in this study. Many of the key informants told stories of women presenting to hospitals with serious complications such as septicemia, hemorrhage, and uterine perforation. One described a tragic story of a 15 year old who was brought to the hospital, following complications of a surgical abortion performed by a doctor, possibly with unclean

equipment. The young woman required a hysterectomy to save her life. Women who present to government health care facilities with complications from abortion practices are often treated poorly according to one key informant.

Similarly, many participants related the dangers of abortion practices for both the mother and resulting fetus. More than one participant related a story of a friend or acquaintance that had unsuccessfully used herbs or medicines such as quinine to terminate their pregnancies, and subsequently delivered babies who were sick, had congenital anomalies or died shortly after birth. One described a baby who was born with a "big head and only one eye, whose skin fell off" while another described a baby who was born "weak and died a few days after birth." One participant related, "When women come to me with that, I let them know they are playing with their life, definitely they could die, them and the baby".

Regardless of the legality of abortions, both safe and unsafe abortions are available in Belize. Although it is well known that there are serious consequences for women who seek abortion services, there is a lack of "official" attention from government health systems addressing the problem. Information on how to obtain safe abortion services, even for women who have the financial resources, is unavailable from NGO or government facilities. However, some individuals in those agencies provide this information outside of their official role. The researcher had the opportunity to witness what happened when a woman presented to a women's health care facility with questions regarding an unintended pregnancy. A small plastic fetus was removed from the drawer and the woman was counseled regarding the developing fetus. The unspoken message to this woman would likely would serve to dissuade exploration of abortion information. Whether this woman sought information outside of this health care facility, perhaps from the informal network of abortion

informants is unknown. But, if she did, she may have placed herself at risk for serious health consequences.

"We are Strong Women of Belize"

The words and experiences of the women of Belize have helped to create a tapestry that reflects their lives. While they live in a small country, commonly omitted from international statistics pages, they share commonalities with women in the developed and developing world. They live in a society in which their voices are limited by their gender, experience bias in the workplace, have fewer educational opportunities and bear the responsibility for their reproductive health and the health of their families. Despite these challenges, the women in this ethnography believe they are strong, are gaining power and making progress. They are weaving new patterns that reflect a better life for themselves and their families as well as a better Belize.

Women seem to value the strength they get from other women, and use this networking to improve their lives and their health. For example, when a community health worker brings together a group of women to act as a resource for breastfeeding in a village, they are helping to improve the health of mothers, their babies and the families of their village. These women-centered activities are common and help to form the fabric of communities throughout Belize.

New Patterns Emerging

A number of themes emerged during this research which illuminate the changing tapestry of the lives of women in Belize. While marriage and family remain important cultural markers, the definitions of families are changing. Two parent households, while still the norm, are being replaced by single parent households. This trend will prove to be a challenge to women and government resources as more women will need to work to support families and will rely on the government to accommodate their needs for adequate wages as well as child care. Similarly,

although the concept of marriage and family is strong, women and men faced with unintended pregnancy continue to face shame and isolation. Cultural mores often force women to marry before they are ready or force young women to abandon their educational dreams.

Couples weave their reproductive lives. Contraceptive information is more available, reproductive health information is more widespread and more couples are taking a role in family spacing and the prevention of unintended pregnancy. These activities help families to maintain their health and plan their future. These trends are likely to continue and hopefully will begin to spread to the more rural areas of Belize so that women in remote areas realize the same opportunities for health and control that their urban counterparts enjoy.

Abortion traditions. Despite the illegality of abortion, women seek information, obtain abortions and experience the consequences of unsafe abortion practices in Belize, as they do in the rest of the developing world. Networks of women provide access to the traditional practices that have been practiced for centuries, known only to women and the healers who care for them. As long as there is unintended pregnancy there will be a demand for abortion services. The quality of abortion practices available to the women in Belize remains in the hands of the government and the health care systems.

Challenges ahead. Women will face many challenges as Belize tries to carve out a space in the global markets. The health of women and families is directly related to the abilities of the country to make it's way in the world marketplace. Women will continue to be challenged by their need for culturally sensitive and technology appropriate care in the continually evolving health care system in Belize. The health sector will need to agree that an investment in reproductive health is an investment in the health of a Belize as a whole. The definition of reproductive health

encompasses the socioeconomic and political realms as well and women need to be able to have a voice and a place at the table so that the issues of women are at the forefront. Their place at this table ensures that their unique threads are woven into the ever changing pattern of Belizean culture. This is the challenge that the women of Belize and the country of Belize now face

CHAPTER 7

Discussion

This ethnographic investigation provides valuable insights into the experiences of women and their reproductive health care in Belize. Women's experiences, told from their own perspective, allows for an appreciation of the complexities of reproductive health. How their culture affects their lives has become clearer. The relationships between the political, economic, and the cultural spheres were examined and helped to place their experiences within the broader context of Belizean society. The voices of women illuminate the challenges women face in their daily lives, as mothers, wives and women in Belize.

Unintended Pregnancy

Many of the participants experienced an unintended pregnancy prior to marriage and this significantly altered the course of their lives. Almost all married within a short time of the pregnancy and birth, regardless of their long-term goals and plans. Many young women described feelings of isolation and fear after discovering their pregnancies. Pregnancy outside of marriage was culturally unacceptable for most women. For a few participants, pregnancy outside of marriage prompted them to attempt abortion, potentially endangering their lives, as well as their fetuses. For one participant, her baby was placed for adoption, since pregnancy would have resulted in expulsion from school and the termination of her education.

The participants and key informants shared that it was uncommon for women in their communities to raise children alone, and that their families were a source of support and guidance when faced with unintended pregnancy. For most women,

partners were supportive and proceeded with marriage plans either on their own or at the urging of families. However, some participants described feeling unready for the responsibilities of parenting and marriage and they regretted the "pressures" to get married.

Gender and age were important variables related to long-term consequences of unintended pregnancy. Adolescent girls who became pregnant were expelled from school upon discovery of their pregnancy. This policy can severely limit the future of young women. The educational system did little to emphasize the importance of continuing education for those who become pregnant. On the other hand, boys did not seem to experience the same consequences as girls if pregnancy occurred. However, many women explained that the decision to marry resulted in the boys quitting school so that they could seek employment to support their new families. So, unintended pregnancy for adolescents in Belize creates challenges for girls and boys alike.

Interestingly, the experiences of married women were different in regards to unintended pregnancy and are consistent with descriptions in the Belize Family Life Survey and other international health organizations. Married women were more likely to describe unintended pregnancy as unexpected and these pregnancies were accepted as part of family life. However, it was common for one of these "surprises" to result in couples reaching desired family size, followed by a serious commitment to contraception.

Contraceptive Experiences

All the women in this study had experience with contraception. Knowledge about contraceptive access and how to obtain it seemed to be common to the experience of all the women. So if this is the case, why did so many of the participants experience unintended pregnancy? I believe that this points to the

complex nature of reproductive health and the fact that accessible contraception is just one component of a complex process to prevent or plan pregnancy. Those women who experienced an unintended pregnancy described varied experiences that included a lack of contraceptive use and contraceptive failure. However, some of the women who became pregnant unexpectedly did relate that they had not talked about pregnancy and children prior to the initiation of sexual activity. This is especially true with those women who became pregnant during adolescence. Perhaps this is related to cultural beliefs about premarital sex or the role that women play in negotiating contraception in relationships. However, it may be explained by the missing piece of the puzzle that continues to elude health care experts hoping to effectively prevent or reduce the incidence of unintended pregnancy.

Overall, women who used contraception used it successfully. However, there seemed to be missed opportunities for women to learn more about contraception. Pregnancy and the postpartum period are times that women are regularly accessing the health care system. This could provide a valuable opportunity to dispel myths about contraceptive use and lactation, explain the limitations of LAM and stress the importance of the postpartum follow-up visit. Compliance with postpartum visits is low and efforts could be made to increase compliance through the use of CHW's and rural health nurses to encourage women to come for follow-up postpartum care. This is an important time to initiate contraception, as it is rare that women initiate any contraceptive method shortly after delivery. Contraceptive myths and fears about side effects were discussed by a number of participants. Exploring a client's reluctance to use contraception might uncover fears regarding contraceptive use and provide an opportunity for health care workers to dispel myths and assist clients in choosing appropriate methods. However, as many women discuss contraception with family and friends, it is also important to provide community health workers and

rural health nurses with the information necessary to allow women to explore contraceptive options in their own villages. Community health workers are most often women who are trusted and respected in the villages so they may be an important link in the promotion of family planning services.

Abortion

Abortion, while illegal in Belize, seems to play a role in the reproductive health experiences of some of the participants. Interestingly, there were few participants who were unaware that abortion information and services exists within Belize, however fewer women were able to explain how and where to access services. There did seem to be an informal network by which women would explore options when faced with an unintended pregnancy. A woman would probably first explore this option with a small network of trusted friends. It was rare that a participant would describe asking health care providers for information regarding termination of pregnancy. Many of the women's health providers agreed that abortion does occur and that women do experience serious health consequences as a result of these abortions. However, there seems to be minimal *official* attention paid to the incidence and consequences of abortion. Many participants related that they knew of someone who had attempted self-induced abortion, some of whom had serious maternal and or fetal consequences. In keeping with the goals of the Cairo Conference it would be important for the government to take a more active role at addressing abortion and reducing the serious consequences for women and their families resulting from unintended pregnancy.

A Time of Strength

Although this research did not focus on the experiences of pregnancy, women frequently shared stories of pregnancy experiences. These pregnancies tended to be planned and seemed to be a time of strength for most of the participants. Women

described a desire to take good care of themselves during pregnancy and most regularly attended prenatal clinics. However, those women who either had difficulty conceiving or maintaining a pregnancy or experienced complications related very different experiences. They discussed their frustration with the health care system, were troubled by a lack of attention to their concerns, misinformation and frequently a distrust of their health care providers. There was little continuity of care; women often went from provider to provider, sometimes in Mexico or Belize City searching for answers to their problems. This lack of continuity often resulted in more frustration and considerable expense as subsequent providers wanted new tests or exams that were costly and time consuming. Women expected that their health care providers would have the answers to their health care problems, and became frustrated and distrustful of the health care providers when complications were not addressed.

It is unusual in Belize for men to play a large role during the pregnancy or birth. It is difficult to determine if this is because men are usually working during the day when appointments occur, if there are cultural prohibitions regarding their involvement or some combination of both. Usually women are accompanied by family to the hospital and remain with them until they are in active labor, after which time they are separated and supported by midwives. There is no formal childbirth education in Belize, so women usually learn about labor from family and friends. They will usually stay in the hospital for 1-2 days and their baby will remain with them during this time. They will all breastfeed in the hospital, although according to statistics only a small percentage will remain exclusively breast fed for more than three months and even less at six months.

The previous discussion places the experiences of women in Belize within the context of their cultures and society. It may be helpful to expand this tapestry

somewhat in order to draw some conclusions regarding the experiences of women in Belize and other women both near and far in the developing world.

Women in Belize, Latin America and the Caribbean

Contraceptive Use

Remembering that Belize occupies a unique space within the geographic and cultural worlds of Latin America and the Caribbean (LAC), it may be helpful to compare some of the experiences of women in Belize to their neighbors. This study took place in the Northern districts of Belize, bordering Mexico. Not only do many women have cultural ties to Mexico, specifically the Yucatan peninsula, but they also frequently access health care services there as well. Mexican women report using contraception more frequently (66.5%) compared to Belizean women (47.6%), however the methods they use are similar (Central Statistical Office et al., 1991; The Center for Reproductive Law and Policy & DEMUS, 1997). Sterilization and oral contraceptives are used most frequently by women in both countries, however IUD use seems to be much higher in Mexico, with almost 18% of women reporting its use compared to about two percent in Belize (Central Statistical Office et al., 1991; The Center for Reproductive Law and Policy & DEMUS, 1997). While Belize shares it borders with Guatemala, it also shares the rich cultural traditions of the Maya; the indigenous peoples of the Central American region. Only 32% of Guatemalan women report using contraception, however their methods are similar to women in Belize with sterilization and oral contraceptives being the most commonly used methods. The two groups of women also have similar rates of IUDs and injectable contraception use (Central Statistical Office et al., 1991; The Center for Reproductive Law and Policy & DEMUS, 1997). Across the Caribbean Sea lies Jamaica, a cultural neighbor of Belize. In Jamaica, rates of contraceptives use are 68%, considerably higher than Belize, with oral contraceptives and injectables being the most frequently used

(Central Statistical Office et al., 1991; The Center for Reproductive Law and Policy & DEMUS, 1997). Methods of contraception should be viewed with caution however, as options may be limited for some women due to availability of the method or the availability of follow-up, especially for women living in rural areas.

Unintended Pregnancy and Abortion

It is more difficult to discern information regarding unintended pregnancy within the region, however abortion statistics highlight that unintended pregnancy remains a significant health problem for Belize and its neighbors. Like almost all countries in the Central American and Caribbean region, abortion is illegal, with varying degrees of exceptions to save the life of the mother. However, in some countries, such as Mexico and Guatemala not only is it a criminal offence to perform an abortion, but to procure one as well, so a woman may be imprisoned if she obtains an abortion. For countries with restrictive abortion laws, clandestine abortions take place with some frequency and the women and the health care system bear the cost of treating complications related to unsafe abortion practices. For example in Jamaica, 20% of all gynecological beds in hospitals are used to treat abortion complications and it is thought that these complications are a leading cause of death for women (The Center for Reproductive Law and Policy & DEMUS, 1997).

Similarly, the Mexican government estimates that there are 220,000 induced and spontaneous abortions per year, although NGO's estimate these numbers considerably higher suggesting that 500,000-1,500,000 abortions actually occur each year (The Center for Reproductive Law and Policy & DEMUS, 1997). Abortion related deaths are the fifth major cause of maternal mortality for Mexican women (The Center for Reproductive Law and Policy & DEMUS, 1997). In Belize it is estimated that about one third of all pregnancies are unintended or mistimed (The National Committee for Families and Children & UNICEF Belize, 1997). Abortions while illegal

do occur in Belize and national statistics as well as the experiences of the participants illustrate that it has an impact on the health of mothers and their families.

Almost all cultures and societies in the world place childbearing within the context of marriage or a stable union (The Alan Guttmacher Institute, 1999). Failure to abide by these cultural mores can result in adverse outcomes for women who are forced to marry, abandon their education and/or raise children alone or with little support. It is not surprising that abortion is often viewed as the only solution, even if it means jeopardizing their lives and health.

Latin America, the Caribbean and the World

If one compares Belize and its neighbors to the rest of the world in regards to contraceptive use and abortion, some interesting comparisons arise. Overall, in the world it is estimated that about 50% of married women use either sterilization or a modern, reversible method of contraception, if traditional methods like withdrawal and abstinence are considered that number climbs to 60% (The Alan Guttmacher Institute, 1999). When all of these methods are considered in the LAC region, close to 70% of married women are using some type of contraceptive method. Only East Asia has a higher rate of sterilization as a contraceptive method than women in the LAC region. Belizean women seem to use contraception less than the statistics for the LAC region suggest in that only about 47% are using a method of contraception and while sterilization is the most common, only 19% of women use it as a contraceptive method. For comparison, Africa has the lowest rate of contraceptive use with only 20% of couples using any contraceptive method.

However, when abortion is considered, women in Latin America and the Caribbean do not fare as well. In almost every LAC country abortion is illegal and restricted, so almost 20% of the world's illegal abortions occur in these regions, with close to 40 per 1,000 women obtaining abortions each year (The Alan Guttmacher

Institute, 1999). It is often difficult to pinpoint actual abortion rates in countries where abortion is illegal and Belize is no exception. Estimates suggest that about 40% of all hospital admissions are related to pregnancy complications and 37% of these are related to abortion complications. In 1995 there were approximately 400 admissions to the Karl Huesner Hospital in Belize City for complications related to illegally obtained abortions (Pan American Health Organization, 2001; The National Committee for Families and Children & UNICEF Belize, 1997).

Belize and Its Neighbors.

While comparisons of reproductive health indicators can provide a different context to evaluate the tapestry of Belizean women's lives, other comparison can enrich the colors of this tapestry. Politically, Belize has enjoyed a stable democracy since its inception. However, many of its cultural and geographic neighbors have not been as lucky. During the 1970's and 80's many countries in Central America, like Guatemala, Nicaragua and El Salvador were engaged in civil wars, some of which only recently ended. Years of political strife have left the health infrastructures in many of these countries in disrepair. Similarly, countries place different values on health, which may be reflected in the monies spent as a proportion of their gross domestic product. Belize spends 4.8% of its GDP on health expenditures, compared with Mexico's 4.1 % (Pan American Health Organization, 2001; Pan American Health Organization, 2000). However, when the larger regions of Latin America and the Caribbean are examined, Belize spends less than the 7.2% spent by its other neighbors in the region. Despite its lower spending, other indicators suggest that Belizeans may expect better health outcomes than their neighbors. For example, infant mortality has recently dropped to 21.3 (per 1,000 live births), compared to Mexico's infant mortality rate of 31 and a region-wide mortality rate of 35.5 (Pan American Health Organization, 2001; Pan American Health Organization, 2000).

Similarly, almost 97% of births in Belize are attended by trained personnel compared to 85% in Mexico, 92% in Jamaica and 35% in Guatemala (Pan American Health Organization, 2001; The Center for Reproductive Law and Policy & DEMUS, 1997). These health indicators help to broaden understanding of the complex nature of reproductive health, the relationships between the political and socioeconomic aspects of health and the role culture plays in weaving the tapestries of women's lives.

Some Perplexing Findings

Rural vs. Urban?

While the participants were equally divided between those living in rural and urban areas, there were some interesting differences that appear to contradict demographic statistics as well as commonly held beliefs regarding the role of urban and rural influences. According the Belize Family Life survey in 1991, rural women experienced more pregnancies and had larger families than women in urban areas. However, in this research the opposite occurred. While ethnography does not provide mechanisms for statistical analysis there may be a number of explanations for this interesting trend. The urban population tended to be older so would be more likely to have experienced more pregnancies and have more children. Another explanation is the concept of rural vs. urban. All of the participants lived in or relatively close to the towns of Orange Walk and Corozal. It is possible that the women were all more "urban" and that truly rural women were not represented in this research. Conversely, perhaps the only true urban area in Belize is Belize City and that the remaining towns identified as urban areas are really more "rural" in nature.

Implications for Nursing and Health Care

The results of this research have provided a new and rich description of the lives of women in Belize and the impact of their culture upon their reproductive lives.

Words and experiences have given new meaning to the statistics that are often the only method available to describe the reproductive lives of women in the developing world.

Women described the experiences of unintended pregnancy and provided new insight into the role it plays in their lives, especially for adolescents. For adolescents, it was a life-changing event, linked with fear and isolation resulting from cultural beliefs and mores surrounding pregnancy, premarital sex and marriage.

The experiences of women in this study provided valuable new information to nurses and other health care professionals in Belize. Nurses are the most important health care provider for women throughout Belize and have a responsibility to provide culturally sensitive and appropriate care for women and their families. This research challenges nurses to remember the important role culture plays in women's reproductive lives. Opportunities to explore these cultural experiences may lead nurses to provide reproductive health care in new and innovative ways that address the needs of women from *their* perspective. If nurses and other health care professionals devote themselves to the definitions of reproductive health developed at the Cairo Conference, then it is more likely that women will receive health information and services that are culturally appropriate and free from coercion.

Health care professionals who interact with women in other parts of the developing world may wish to revisit the concept of reproductive health and question current health services and delivery systems. Whose needs are being addressed? Are the goals of health care based upon the needs and experiences of women or the government and bureaucracies in which health care is delivered? Commonly in the developing world, cultural strangers arrive with the best of intentions to improve health and promote wellness, yet fail to begin with an exploration of the cultural beliefs and life experiences of those who they have come to help.

This research also challenges nurses who work in the developed world to examine the important role that culture plays in the reproductive lives of women. All women are not the same; they do not have the same information, control of their reproductive health or desires for fertility and contraception. Unless these important concepts are considered women and their families may suffer serious health consequences and life goals may go unmet or unaddressed.

Feminist ethnography provided the framework to explore the complex tapestries of women's reproductive lives. It allowed their stories to unfold and their experiences to be honored as the focus of this research. Now that the stories have surfaced, other important issues in women's reproductive lives emerged that were unexplored as a result of this feminist perspective. For example, women discussed often making decisions regarding family size with their partners, so it is important to hear their perspective as well. Keeping true to the feminist perspective, if these relationships are important aspects of women's lives then it is important to explore them, as they may contribute critical threads to the tapestry.

Recommendations

The tapestries described by the women of Belize created new perspectives of that may be valuable to health care providers and agencies in Belize. This research supports the concept that unintended pregnancy in Belize is prevalent and also a major determinant in women lives. It is particularly devastating to young women and men. Within the educational systems, every effort should be made to discuss sexuality with adolescents, provide information about abstinence, contraception and safer sex practices to help teens to make informed decisions. As all learning does not take place at school it is important for parents to have information about how to talk to their children about sexuality, pregnancy planning and the exploration of life goals. Especially for girls, focusing on the increasing opportunities for women in

Belizean society and the importance of education may help to empower young women to make choices conducive to their life goals. Despite these strategies, unintended pregnancies will still occur and adolescents should have the opportunities to finish their education. This will require more than simply allowing girls and boys to stay in school. Culturally, pregnancy is strongly embedded within the context of marriage, regardless of age, so that other support systems from society, and families will be necessary to address this particular consequence of unintended pregnancy.

Contraceptive decision-making was explored, highlighting that joint decision-making regarding family planning and spacing is prevalent. This requires that both partners have accurate information regarding methods, efficacy and side effects. Women tended to access information through networks other than health care providers. Ensuring that CHW's are well trained so that they are a source of information and support for families within their own villages would make information available and reliable. If expansion of the roles of the CHW's in providing contraception is continued, then women will be able to access contraception closer to home and may be more likely to initiate and maintain contraceptive use.

Despite all efforts unintended pregnancy will continue to challenge the health care system in Belize. Without different policies making abortion safe and legal, women will continue to experience the consequences of unsafe abortion. Health care providers, especially those in the communities have an obligation to inform women about the risks of unsafe abortion practices and other options that may be available. If health care providers remain nonjudgmental in caring for those women experiencing unintended pregnancy, women may choose safer options for themselves. It is important to remember that abortion is always a difficult choice for a woman, and perhaps even more so, when it is illegal. If women present to health care facilities for care after such procedures they deserve respect and high quality

care as well as information regarding contraception to prevent unintended pregnancy in the future.

The well-developed public health infrastructure in place in Belize is an asset that may be underutilized in regards to reproductive health care. The same system that has worked to attain commendable immunizations rates might also be used for other purposes. The communities in which women live may be the best places for women to receive basic family planning information. Over the last decade I have been a part of this public health system that seeks to promote primary health care by providing pap smears and breast exams in the community. Women frequently come to community centers to attend discussions on breast-feeding and menopause. Expanding the agenda to include family planning and spacing will similarly contribute to the overall health of women and their families.

Strengths and Limitations of the Study

The participants in this ethnography provided a unique opportunity for cultural strangers to develop an understanding of the complexities of Belizean culture and how these might relate to women's reproductive health care. My long-standing relationship with many of the key informants and participants facilitated entry into important cultural experiences that strengthened the research. My knowledge of the culture helped to create an atmosphere of trust with the participants. This relationship allowed women to discuss what was sometimes intimate and secret information allowing a richer tapestry to evolve. The opportunities to interact with women in their health care settings provided rich participant observations and highlighted critical areas to explore in discussions with the participants. The feminist framework created the basis for the voices of the women to be heard and their perspectives honored throughout the research process. This women-centered standpoint helped to ensure that it was their experiences and perspectives that

informed the research, ensuring that this was an ethnography by and about the women of Belize.

Some limitations existed due to the complexities of research in another country without the benefit of an extended stay in Belize. It was necessary to intensively collect data in relatively short periods of time, without the ability of follow-up for another year. Ideally, an extended stay would have allowed for data analysis to begin while still "in the field", thereby permitting exploration of new avenues as a result of on-going analysis. While my cultural knowledge developed over a decade, the multiple roles that I play when "in country" sometimes blurred the lines of the researcher, health care provider, friend and colleague. In retrospect the "going native" phenomenon does occur inadvertently and it was sometimes a challenge to juggle the many hats I wore while conducting the research.

This juggling act was also made more difficult due to my own lack of experience in ethnographic research and ethnographic research techniques. While my expertise with interviewing grew throughout the research, frequently during the data analysis comments were revealed that begged to be explored or questions I wish I would have asked became obvious. This highlighted another benefit of preliminary analysis while still in the field, allowing for follow-up with participants.

Data collection was limited to the northern districts due to researcher's experiences as well as time constraints. This resulted in populations of women whose voices were not considered but whose contributions could have been important. The only truly urban area of Belize City would have provided a rich source of information and offered some true depictions of the challenges and experiences of women who live in a "real" city. Key informants often made inferences about women in Belize City and these stories would have added much to this tapestry of women's lives. Similarly, remote, rural areas were not explored and my past experiences in

these areas suggest that these women have important stories to tell and challenges to meet as they seek reproductive health.

Implications for Further Research

The focused ethnography provides an emic viewpoint of the context of women's lives in Belize. However, it provides only a glimpse of this life in the two northern districts of Belize. Expanding this ethnography to Belize City as well as some truly remote areas would enrich the stories and result in opportunities for some interesting comparisons. However, this would require extended time and funding as travel and lodging in multiple areas would be required.

It has been over a decade since the last Maternal-Child Health Survey and this limits our understanding of the experiences of women, and the changes in their reproductive lives over the last ten years. As there have been changes in Belize over the last decade, it is likely that women's contraceptive experiences have changed as well. This lack of information prohibits the NGO's and government health services from adequately planning for the health care needs of women and their families. In times of fiscal constraint, spending money on ineffective or unnecessary care may not be prudent. Descriptive and epidemiological research on the knowledge and use of contraception will allow for the comprehensive planning of reproductive health care needs based upon recent and reliable data.

Interventional studies exploring alternative ways to provide contraceptive information using community health workers and rural health nurses within communities may increase contraceptive access and compliance. Similarly, while much research is available regarding adolescent pregnancy worldwide, little is know about the phenomenon in the unique cultural environment of Belize. Exploratory studies may help to explore adolescent pregnancy and suggest prevention strategies that will be effective within Belizean culture.

The abortion issue in Belize will continue to contribute to maternal morbidity and mortality if a "head in the sand" approach continues. Research that can focus on the practices and health consequences of abortion would document the problems and perhaps promote dialogue among policy makers, health care providers and opponents to develop strategies to address the problems of illegal and unsafe abortion practices.

Conclusion

The women of Belize shared their stories and experiences and provided a unique description of their lives, relationships and their country. Their experiences confirm that they share many things with women all over the developing world. They relate challenges raising families and juggling roles of wife, mother, daughters and friends, however they reveal an inner strength as they create these roles. They face unintended pregnancies, try to plan their families and often accept the consequences of limited knowledge and cultural mores. They are the backbone of Belize, raising children, working, often unrecognized, and constantly weaving what is the cultural pluralism of Belize. One woman remarked "we are strong women of Belize" and they are.

Appendix A

University of Connecticut
School of Nursing

Consent Form for Research Study

Unintended Pregnancy in Belize: An Ethnographic Approach

I _____, have been asked to take part in the research study below as outlined by Carrie Klima CNM, MS.

Description of the project:
I have been asked to take part of this study that will explore the cultural aspects of unintended pregnancy for women in Belize

What will be done?

If I decide to take part in this study the investigator will interview me. The interviews will be audiotaped. I will be asked to describe all of my thoughts and perceptions about women' s experiences with unintended pregnancy. I may also asked specific questions about women's health care and unintended pregnancy in Belize. I understand that I do not have to answer any questions and can withdraw at any time. The interview will be transcribed verbatim and the researcher will look for common themes among different interviews.

Risk or discomfort
There are no anticipated risks or discomforts associated with this study.

Benefits of the study
There are no personal benefits to be gained. The results will help to broaden our understanding of unintended pregnancy and how culture can affect the health care of women in Belize.

Confidentiality
My part in the study will be confidential. None of the information I provide will be identified with me by name. Audiotapes will be coded with a number and be destroyed upon completion of the study. The information obtained may be published.

Decision to quit at any time
The decision to take part in this study is up to me. I understand that I do not have to participate in this study and that I may quit at anytime.

I have read the consent form. My questions have been answered. My signature below means that I understand the information and agree to participate in the study.

_____	_____
Participant Signature	Researcher Signature

Appendix B

Ethnography-Unintended Pregnancy

Interview Guide

1. Tell me about meeting your partner and your own desires for children. Did you and your partner talk about your desires for children.

2. What was your experience of having children? How did you find out about your first pregnancy? Were you happy? What about your second pregnancy? ...

   Were all of your pregnancies planned? Did you ever plan your pregnancies? If so when did you make the decision to plan? How did you do this? Was it successful?

   If you didn't plan what did you do?

3. Women all over the world sometimes consider abortion when faced with a pregnancy that was mistimed? Did this ever happen to you? Did you know about other women who might have considered this?

4. What is your life like now? What is a day in your life like?

5. How do your children affect your life now?

Demographic Information

Education _____ Age _____ Work Status _____

Language _____ Ethnic Group _____ Religion _____

#Pregnancies _____ # Children _____

Ages of Children _____

Household; electricity water refrigeration television

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