# Field Notes



# Understanding Family Planning in San Ignacio, Belize


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## Abstract

This study focuses on women's decisions and experiences related to family planning in San Ignacio, Belize. The authors sought to identify family planning resources available in San Ignacio, as well as barriers to accessing these resources. Furthermore, this study explored how local barriers affected the use of contraception in San Ignacio. The first author traveled to San Ignacio and carried out four semi-structured interviews and one focus group with local women. She also conducted nine semi-structured interviews with community leaders. Women discussed their own knowledge and use of contraceptive methods, barriers to contraceptive use, the value of planned pregnancies and their pregnancy experiences. Community leaders reported that contraceptive methods were available but also admitted to the existence of perceived barriers to contraceptive use.

Women stated that planned pregnancies were desirable, but often unachievable because of religious beliefs, cultural norms, the opposition of family members, lack of knowledge of contraceptive methods and male partners seeking control over women. Community leaders reported that men are often unsupportive of contraceptive use and that religious groups often seek to discourage contraceptive use. Both women and community leaders stated that in San Ignacio, women are expected to have families and that local religious groups discourage the use of contraception.

Use of contraceptives among women in San Ignacio is thus not solely determined by the availability of contraceptives. Organizations that aim to promote family planning must implement multilevel initiatives that address the needs, desires and perspectives of community members, promote healthy relationships and challenge gender inequitable social norms.


## Background

In 1934 Aldous Huxley wrote, "If the world had any ends, British Honduras would certainly be one of them," citing the region's isolation and small population as reasons it is "the end of the world."[1] Eighty years later, women living in this area can still be described as being at the end of the public health world. Little is known about their health needs or the social and environmental factors contributing to these needs. A search in the NIH/PubMed database using the terms "Belize" and "women" returns only 24 articles, only eight of which have been published in the last ten years.

The past British Honduras is now the nation of Belize, a Central American and Caribbean country that is approximately the same size as the state of Massachusetts. Although small in size,

Belize is characterized by ethnic diversity. The major ethnic groups are Mestizo (Spanish-Amerindian, 48.7% of the population), Creole (Afro-European, 24.9% of the population), Maya (Amerindian, 10.6% of the population) and Garifuna (Afro-Amerindian, 6.1% of the population), while the remaining population includes people of Chinese, Indian, and German ethnicity.[2] Yet the nation's gender norms traverse all ethnicities and shape women's lives in areas including gender-based violence, unequal job opportunities, dependence on men's financial assistance, child-raising and women's ability to decide if and when to become pregnant.[3]

Gender norms in Latin America and the Caribbean create expectations that "masculine" men have many female sexual partners and that women have a limited influence on the situations in which they have sex.[4,5] "Marianismo" is the cultural ideal that women will be obedient, pure, modest and dependent on their spouses. Its male counterpart is "machismo," the notion that men are dominant, independent, knowledgeable, aggressive and promiscuous. These gender norms contribute to a lack of communication between partners about sex and also result in women being hesitant to seek sexual health services.[4,6]

The most well-known work on women in Belize is anthropologist Irma McClaurin's 1996 book *Women of Belize: Gender and Change in Central America*, in which she discusses the importance of gender in Belizean culture. She elaborates on how gender roles are ingrained in children: from a young age, girls are discouraged from outdoor play activities and chores and instead are taught to focus primarily on domestic chores, while boys are encouraged to play separately from girls and to imitate their fathers. This distinction is maintained throughout life, and women are viewed as "different" or "less than" men. Because of cultural and social expectations that women should focus on the home, they are often economically dependent on men, which leads to poverty and a greater vulnerability to sexual harassment, as well as physical and mental abuse.[3]

These gender norms contribute to a lack of communication between partners about sex, and also result in women being hesitant to seek sexual health services.

In the prologue of her book, however, McClaurin states "[c]hange in Belize is ever-present."[3] One of the most important changes that occurred in the last decade is the rise in girls' accomplishments in secondary school attendance and graduation.[7] Anderson-Fye (2010) has observed that girls are increasingly pursuing secondary school as a means of gaining independence and avoiding gender-based maltreatment. Other changes include national government efforts to promote women's equality. In 1999, Belize ratified the Convention to End All Forms of Discrimination Against Women, an international agreement that sets standards for the protection of women's rights in all areas of life.[8] The Belizean government has also promoted women's wellbeing by sponsoring gender policy analysis and creating a government agency specifically for promoting women's equality—the Women's Department.[9]

Despite this progress, gender inequitable norms continue to persist in Belize. The World Economic Forum's gender gap index is a measure of gender equality based on women's economic participation and opportunity, educational attainment, health and survival and political empowerment. In 2012, Belize was ranked 102nd out of the 135 countries included in the index.[10] Guatemala was the only Latin American or Caribbean nation to score lower than Belize. Recently, the Belizean National Women's Commission conducted an analysis of the status of women and found that women are recruited and promoted at lower rates than men and receive lower salaries and fewer employee benefits than men in the same positions. The report also stated that teen girls are often expelled from school when they become pregnant, while males who impregnate female students do not receive any sort of disciplinary action.[6] In Latin American and Caribbean nations, women's sexuality is expected to be restricted to procreation and childrearing within common-law unions or legal marriages.[5] Thus, women who engage in sexual activity outside of these boundaries often face severe social consequences, including being labeled as promiscuous or immoral.

## Fieldwork in Belize

This study explored one aspect of women's lives in San Ignacio, Belize—their decisions related to family planning and use of contraception. Family planning was chosen as the topic of this study because the Cornerstone Foundation, the organization with which the first author worked, identified the issue as an important challenge for women in the communities where it implements programs. Family planning is an issue of great importance, as it can dramatically impact women's achievements in education and employment and is critical to the socio-economic development of women around the world. The ability to limit pregnancies and space the time between pregnancies allows women to pursue education and employment opportunities, thereby reducing both female and family poverty.[11] Moreover, use of contraception allows women to avoid pregnancies at both extremes of their reproductive years, when the risk of maternal mortality is highest. Contraception also improves infant birth outcomes by enabling women to space their pregnancies.[11] Short intervals between births are associated with higher rates of preterm births and low birth weights, a pattern which persists after controlling for factors such as the mother's age, race/ethnicity, prenatal care, mother's previous pregnancy outcomes and tobacco or alcohol use during pregnancy.[12] It is believed that the poor birth outcomes associated with closely spaced birth are the result of maternal stress and depleted nutritional reserves.[13,14,15]

The work presented in this article provides insight into Belizean women's experiences with decisions about contraception and family planning and explores the factors that influence these choices. The authors sought to understand the perspectives of both individual women and community leaders in San Ignacio, in order to construct a more complete picture of the context of family planning decisions and behaviors.

Cornerstone Foundation is a grassroots nongovernmental organization (NGO) located in San Ignacio that is actively working to serve and empower Belizean women. San Ignacio is the capital of the Cayo district, which is the largest district in Belize, and is the second largest population center in the nation. Because San Ignacio is the district capital and largest city in the district, many residents of other parts of Cayo travel there for commerce, healthcare and other needs. Cornerstone Foundation was registered as a non-governmental organization in the district of Cayo in 1999.[16] Since then, the organization has served the district as a community development organization. It currently has seven program areas: women, health, youth, HIV/AIDS, relief & aid, literacy and community service.[17] The program's activities include preparing meals for children and elderly in the community, computer classes for women, hosting a women's group, English as a second language (ESL) tutoring, HIV education and maintaining free condom boxes in San Ignacio.

The volunteer recruitment information on Cornerstone's website identifies unintended pregnancies, lack of knowledge about family planning and access to contraceptives as difficulties facing the women of Cayo.[18] In this paper, we use the World Health Organization definition of family planning:

> Family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility. A woman's ability to space and limit her pregnancies has

a direct impact on her health and well-being as well as on the outcome of each pregnancy.[13]

The purpose of this study was to identify both the family planning resources available in San Ignacio and the barriers to accessing these resources. The authors also sought to understand how local barriers affected the use of contraception in San Ignacio.

## Research Process

The first author lived and worked in San Ignacio during July 2010 to investigate the questions posed in this paper. Before the first author left for San Ignacio, all authors collaborated to develop survey and interview instruments for the study. The authors sought to triangulate data from a variety of sources in order to develop a more accurate understanding of the context of family planning in the San Ignacio area.[19] Because of the exploratory nature of the research questions, the authors chose to use a primarily qualitative approach. By using qualitative methods, they were able to engage in an in-depth exploration of participants' perspectives and experiences.

Four sets of questions were ultimately developed: a structured questionnaire for conducting surveys with adults (ages 18-60) in San Ignacio, an open-ended guide for in-depth interviews with women (ages 20-50) about their personal experiences with family planning, a focus group guide for women (ages 20-50) and an open-ended guide for in-depth individual interviews with community leaders about their perceptions of family planning and contraceptive use. All study activities took place in English, the national language of Belize. The authors used a convenience sampling strategy to identify survey participants and then a combination of convenience and snowball strategies to identify focus groups and individual interview participants.[20]

> She stated that she did not learn about contraceptives until after completing childbearing.

The structured survey questionnaire was intended to provide a broad snapshot of social norms and attitudes towards family planning held by Cayo men and women. In-depth interviews with individual women were used to learn about their personal experiences with contraceptive use. The focus group was used to gain a greater understanding of women's perspectives on factors influencing family planning and contraceptive use in their community. Individual in-depth interviews were carried out with community leaders in order to learn about their observations of local trends and challenges in family planning, and to get their opinions on the reasons for these trends and challenges. While men's perspectives are critical to these issues, the authors were limited by the fact that the first author was a young woman traveling alone. One cultural norm in Belize is that many Belizean men choose to supplement their income through romances with female tourists.[21] The authors felt that at best this cultural norm would make it unlikely that men would share honest information about sensitive issues with the first author and at worst could place her in a compromising or dangerous position. Some male perspectives were included in the study through men's survey responses and interviews with male community leaders; however, the preponderance of female respondents is an important limitation of the study.

The authors chose to conduct semi-structured interviews based on an interview guide with individual women and community leaders because this approach provided an appropriate balance of structure and flexibility. Semi-structured interviews ensured that all participants would be asked the same standard set of questions, but also allowed the interviewer freedom to probe for additional details when the interviewee directed the conversation in an unexpected and potentially illuminating direction.[22]

After the first author arrived in San Ignacio, the Cornerstone staff reviewed all questions to ensure that they were culturally and locally appropriate. The staff approved all questions with the exception of the demographic questions on all instruments, which were altered to be more representative of the local population. Two changes were made to the demographic questions: East Indian was added as a response option for ethnicity and common-law, as well as an open-ended "other" category, were added as response options for marital status.

Throughout July 2010, the first author conducted surveys with men and women at parks, bus stations, local businesses, the open-air market and the San Ignacio hospital. For the qualitative component of the study, the first author conducted additional open-ended, in-depth individual interviews with women and community leaders and held a focus group with Cornerstone Foundation's women's group (see Table 1 [available online] for a summary of study activities and participants). The women who participated in the focus group were enthusiastic about the project because they considered it extremely relevant to their community, so they volunteered to assist with recruiting survey participants. In order to recruit participants, the first author (and occasionally focus group participants) approached bystanders who appeared to have no pressing obligations and asked if they would be willing to participate in a brief survey. The first author read the survey questions aloud to the participants and handwrote their responses.

Findings from the interviews and focus group have been combined because of the commonality of themes. Themes emerging from both the open-ended interviews and the focus group include women's knowledge and use of contraceptive methods, barriers to family planning, the value of planned pregnancies and individual experiences with family planning and pregnancy (both personal and secondary accounts). The primary themes from interviews with community leaders were the variety of contraceptive methods in San Ignacio and the local barriers to contraceptive use.

### Findings from surveys with men and women

Due to space constraints and the small sample size, survey results are not discussed in detail. However, selected findings are worthy of mention because they provide additional context for the qualitative data. Out of 24 survey respondents, 12 were unable to provide a definition of family planning when asked (common reactions included "What is that?" and "I don't know"). When asked whether their first pregnancy was planned, approximately equal numbers of survey respondents reported planned and unplanned first pregnancies—a pattern that was consistent for both men and women. These findings are intriguing because they suggest that some men and women are able to overcome barriers in order to use local family planning resources, while others are not. Further research needs to be conducted with a larger sample size in order to document the rates of planned and unplanned pregnancies among the population of San Ignacio.

### Findings from open-ended interviews and focus group with women

Four women were interviewed individually, all at their places of employment. Because of the sensitive nature of the interview questions, Cornerstone Foundation staff referred the first author to women who they thought would be comfortable answering questions about their experiences with family planning (often their friends and family members). The focus group was carried out at a regular weekly meeting of the Cornerstone Foundation women's group, and three women participated. There was a broad range of ethnicities and ages represented among women who participated in the focus group and interviews. Demographic information for these women is found in Table 2 (available online).

## Contraceptive Methods:

All women interviewed were familiar with at least one method of contraception. One of the older women (age 49) interviewed said that she had not learned about contraception until after her children were born. She was the only woman of the four interviewed who had never used any contraceptive method. The most commonly

mentioned methods of contraception were oral contraceptives, the "calendar" method (in which women count the days between their menstrual periods to estimate when they are ovulating), hormonal injections and the intrauterine device (IUD). Women perceived the "calendar" method as less reliable than the pill.

> "Well, about using the calendar, it's like not choosing the drugs, no? And you are clear of the drugs in your body but it's still not quite as safe as the pill." –Interview participant, Creole, 49.

One participant interviewed (Creole, age 46) stated that birth control pills and condoms should be used together because "you don't know who has diseases." Another participant commented that young people should use pharmaceutical contraceptives (i.e. injections or pills) because young people are not careful enough to use home remedies or the "calendar" method correctly.

Women also discussed their experiences with the IUD, birth control pills, condoms and emergency contraception. Perceived efficacy of contraceptive methods and side effects of the method were both factors that influenced women's choices about contraception. One woman (Mestizo, age 49) reported that birth control pills and injections made her "feel sick" and "get fat," ultimately causing her to switch to the IUD. The youngest woman in the group (Creole, age 24) stated emphatically that she did not like the pill and instead chose to rely on condoms and emergency contraception, because she believed them to be effective methods. She described her experience saying "Condoms can break. When it comes to the morning after, I think it's a safer method, because…it obviously works because I don't have any kids right now" (Creole, age 24). The third woman (Creole, age 46) explained that she had chosen the pill because she believed it was the most effective method and had never used any other form of contraception.

## Barriers to Contraceptive Use:

Religion was the only barrier to contraceptive use identified by women in individual interviews. While no interviewees described lack of knowledge as a barrier, one interviewee stated that a lack of information prevented contraception use; she did not use contraception because she did not learn about it until after completing childbearing. Interviewees specifically reported perceiving that the Catholic Church teaches that contraception is sinful and that the Seventh Day Adventist church discourages the use of medicine. In the focus group, women mentioned religion but also described cultural expectations as another obstacle to family planning. They stated that parents, because of their own cultural backgrounds, pressure children to get married young and have children. When women discussed their own pregnancy experiences, they mentioned religious convictions of family members, their own lack of knowledge about contraceptives and the desire of others, such as relatives or partners, to control their family planning choices as the primary barriers to their own contraceptive use:

> "I have two of my daughters born in the same year, a week before one had a birthday, the next one was already born, and I was very unhappy, because it was my husband saying that I didn't have no rights to plan nothing, and he was the man and if I had any time to plan, it was because I was having an affair with someone."- Focus group participant, Mestizo, age withheld

Focus group participants reported that they were grateful that some religious groups teach men to be faithful to their wives, but complained that these same religious groups also teach men that the primary purpose of women is to have children.

> "[Faith-based groups] are also part of the problem that men find, that is why women are having children without planning, because they would believe that this is what our life is made for, this is what I want in my wife, because I want to have children. Doesn't matter how hard life seems to be, but that's a belief, it's a cultural thing also." -Focus group participant, Maya, age 33

## Pregnancy experiences

When the women spoke about pregnancy experiences (whether of their own or that of their friends), they frequently emphasized the relationship between unplanned pregnancy and a consequently probable life as a single parent. One woman interviewed (Creole, age 49), described a pattern of unplanned pregnancies and unstable relationships—she gave birth to her first child at the age of sixteen and experienced a total of eight unplanned pregnancies with three different partners. She stated that she did not learn about the existence of contraceptives until after she had finished childbearing. Another interviewee (Creole, age 46) explained that after her first unplanned pregnancy, she decided to start using oral contraception because she could not manage more than one child as a single parent. Two women (Mestizo, age 49; Creole, age 46) reported a friend getting pregnant in spite of using the "calendar" method of birth control. The youngest woman interviewed (Creole, age 24) described her friends as being "scared" of unplanned pregnancies; these young women were fearful about how they and/or their partners would care for the child.

When women reflected on their own pregnancy experiences, they frequently spoke of the demands of having many children close together in age, in addition to the burden of single parenthood, as outcomes of their unplanned pregnancies. Two of the three women in the focus group had their first unplanned pregnancies in their teens; they described both their own and their family's reactions to these pregnancies. One woman expressed gratitude that her mother prevented her father from forcing her to leave the home when she became pregnant. In contrast, another woman in the focus group stated that when she became pregnant at age 19, she was pressured to marry the child's father. As a result, she spent many years in an unhappy marriage.

### Value of Planned Pregnancies

Two of the four interviewees stressed the importance of planning a pregnancy. One woman (Creole, age 49) said that children are expensive and it is difficult to raise many of them. Another woman expressed fear that the male partner would leave as a primary concern in unplanned pregnancies:

> "I think most people should plan things rather than have that whole oops situation happening. Because I think most people when they're pregnant it's more of a scary situation, rather than joy[ful]…wondering what they're going to do and if the father's going to sustain a child." -Interview participant, Creole, age 24

In the focus group, women continually associated planned pregnancy with happiness. They felt that planning a pregnancy meant that a woman would be able to look forward to the birth of a child with anticipation, knowing that she had a stable relationship with her partner and that they had the resources to provide for a child. One participant focused on the joy of anticipating the birth of a planned child:

> "Because it's just like when you are planning your birthday. And you say "I will plan my birthday, and you go and buy your stuff, when you say, I'm happy because I'll bring my friends and we'll have a good time. It's just like that, because this young lady, she is like [the woman who planned her birthday celebration]. She's happy because she has planned it." -Focus group participant, Mestizo, age withheld

Women felt that planning a pregnancy enables both the mother and the father to prepare for parenthood. They stated that women should not have children in their teens because "a child cannot raise a child" (Focus group participant, Mestizo, age 45). Some women in the focus group suggested that a woman should wait until she is "maybe 22 or 30" (Focus group participant, Mestizo, age withheld) and knows what she wants. Another participant objected, saying that she had her first child at 22 and was not prepared—she did not have a home of her own and did not have the resources to provide for a child. The desire of the women in the focus group to plan a pregnancy emphasizes the perceived importance of being able to provide a good life and an education for one's children.

> "I was 22 when I had my first child, and I did not feel prepared. First of all, I didn't have a home of my own, I didn't have economical, it was very hard. I think that we need to have means to have things for a child, prepare before we have children. It's very hard to deal with education, with feeding,

with whatever." -Focus group participant, Mestizo, age 45

Another participant said that she had initially discouraged her daughter from marrying and having children young. She went on to express approval of her daughter's husband and his commitment to their children.

> "I have a daughter, she's 23 now, she has her second child. I didn't actually want her to get married or have children. It was her decision…She has her home, and he's very responsible and it's very important for them to have a responsible husband on their side, because if you make children, you have equal rights, and equal responsibilities to take care of children." -Focus group participant, Mestizo, age withheld

Most of the women in this study were unable to plan their own pregnancies according to their personal desires due to factors outside of their control. However, despite this lack of control, these women felt that avoiding unplanned pregnancy is an important strategy against single parenthood and financial hardship. Women reported that they strongly encourage their own children and other young people with whom they interact to learn about contraceptives and avoid unplanned pregnancies. Several women stated that it is now more difficult to financially support a large family than when they gave birth to their children. For these women, being able to ensure a good life for one's children was more important than conforming to a cultural ideal and existing gender norm.

Focus group participants agreed that even though their unplanned pregnancies caused unhappiness, they were joyful about the births of their unplanned children. Once the child was born, they wanted and loved him or her. They felt that this was an important component of conversations about planned and unplanned pregnancies.

> "You don't plan that child, but [when] that child comes into the world, and you look on it and say "I not plan you, but I love you, and I want to keep you," that make[s] you be happy, because even if you don't plan it, then you give birth to it, you can't give it away. So the child make[s] you happy at the time, you see? At the end." -Focus group participant, Mestizo, age 45

While women loved their unplanned children, this love did not erase the challenges they faced. In both the interviews and the focus group, women talked often about how they wanted their children to avoid unplanned pregnancies in order have better lives than they did.

## Findings from Interviews with Community Leaders

Community leaders that were interviewed included both local healthcare providers (mostly physicians and pharmacists) and opinion leaders. Opinion leaders were identified by Cornerstone Foundation or other interviewees as influential members of the community. As can be seen from Table 3 (available online), these community leaders held a variety of positions in the community. Interviewees included providers of medical services (mostly physicians and pharmacists) and directors of local NGOs. Two interviewees (the herbalist and the retired maternal and child health nurse) were included because Cornerstone Foundation identified them as important pillars of the community (i.e. they had held leadership roles for many years and were trusted by many community members). Participants were identified through suggestions from Cornerstone staff, announcements in church bulletins, signs for local businesses and suggestions of other interviewees. All community leaders were interviewed at their place of employment in order to maximize comfort and convenience for them. Interviews focused mainly on the various kinds of contraceptive methods and family planning counseling that were currently available in the community, as well as what they perceived to be the main barriers to contraceptive use.

### Family Planning Resources

Most of the community leaders that were interviewed held occupations directly related to family planning, and thus were providers of family planning resources. All practicing healthcare professionals, i.e., the general surgeon, both pharmacists and the nurse director of the Belize Family Life Association (BFLA), stressed the importance of providing counseling about contraceptive use in conjunction with pharmaceutical and medical services. Three community leaders–the general surgeon, a pharmacist and the director of the faith-based pregnancy resource center—stated that their primary role was to provide women and couples with accurate information about contraceptive methods and to allow them to choose for themselves.

Community leaders identified a wide variety of contraceptive methods available in San Ignacio, and some interviewees described their own roles in providing contraception. One interviewee commented that "[e]verything's on the market …the contraceptives and condoms. And the Belize Family Life has a section, and [the hospital has] oral contraceptives, injectables, the IUDs" (OB-GYN, male). The pharmacists and the BFLA offered oral and injectable contraceptives. One pharmacist mentioned that her pharmacy only provided hormonal contraception and emergency contraception to adults, "because we don't want to take a risk on a minor" (Pharmacist, female). This pharmacist went on to express frustration that teenagers try to "get away with murder" by coming into the pharmacy asking for emergency contraception, saying that their mothers sent them to get it. Condoms are available in the BFLA office and both of the pharmacies. Additionally, the BFLA and an obstetrician-gynecologist (OB-GYN) performed tubal ligations, a surgery in which a women's fallopian tubes are tied and cut to prevent eggs from travelling through them.[23] The faith-based pregnancy resource center offered fertility appreciation awareness and instruction in natural family planning. In this approach to family planning, couples rely on a woman's fertility signs, primarily waking temperature and cervical fluid, in order to identify when she is ovulating and time intercourse appropriately either to avoid or to achieve pregnancy.[24] This organization discouraged condom use because of its stance that sexuality is a gift which should only be expressed by committed married couples and that "in order for [sex] to bring fulfillment in the couple, and to achieve its final purpose…it must be open to life" (Director, faith-based pregnancy resource center).

### Barriers to Contraceptive Use:

Community leaders reported that the cultural norms around expectations for women and their male partners impacted contraceptive use in several ways. They stated that the dominant attitude in Belizean culture is that if women are married or in a common-law union, they should have children. One pharmacist described how women's perception of community expectations influences their use of contraception.

> "I think maybe a barrier that they have is that they will be judged for using contraception…They have some reservations about coming. Maybe they don't want people to know that they are sexually active. And for the married women, I think a lot of them believe that once you're married, you really shouldn't be on a contraceptive, you should be having a family." -Pharmacist, female

During interviews, community leaders reported that many men are often unsupportive of contraceptive use, but that a number of women use contraceptives without telling their husbands. One interviewee stated that Belizean men take pride in having a large number of children. Several of the leaders interviewed complained about the unfair burden women face because all of the responsibility for contraceptive use falls on them. In the words of one interviewee:

> "It's women, women, women. She gets pregnant, she minds the baby, she has to take care of herself not to get pregnant. But I always tell the patients that whenever they have to go through a process of family planning, it's always the woman carrying the load, in a nutshell. Do I agree with it? No. Do I promote it? I wouldn't like to. But at the end of the day, we're looking to better women's health." -General surgeon, male

Another interviewee stated that contraceptive methods that rely on periodic abstinence are not practical options for Belizean women because their male partners do not cooperate. Similarly, she claimed that Belizean men are resistant to using condoms.

> "Men here in Belize, no. Don't believe in abstinence. If they want to have relationship, they will have a relationship. I think men are becoming more and more conscious of using condoms because of the spread of AIDS. But before AIDS

was so rampant, men would go without using any type of contraception. Even though you [are] telling them about the condom, they don't want to know." -Pharmacy assistant, female

Surgical sterilization of women has long been a major component of family planning in Belize. In 1999 (the year of the most recent Family Health Survey), female sterilization was the most commonly used contraceptive method in Belize, accounting for 18% of all contraceptive use.[25] In this same year, reported vasectomy use was so low that vasectomies were not even reported as a separate category in the Family Health Survey report—they were combined with other rarely used methods such as diaphragms, jellies, foam and lactational amenorrhea to form an "other" category. Approximately 2.1% of women and 3.5% of men surveyed reported using one of these "other" methods.[25] Both physicians interviewed felt that surgical sterilization of men should be integrated into family planning in San Ignacio because of the lower rate of complications from vasectomies compared to that of tubal ligations; tubal ligations are 20 times more likely to have major complications than vasectomies and 12 times more likely to result in death.[26,27] The general surgeon complained that in spite of his own interest in vasectomies, no local men were willing to undergo the surgery. In his words:

"I would love to promote male family planning. And vasectomies. I haven't done a vasectomy, that's just to tell you how different it is. The OB/GYNs end up doing a lot of tubal ligations, and I'm still waiting for my vasectomy." -General surgeon, male

Community leaders have observed that Belizean men often either do not get involved in family planning decisions or that they actively create barriers to women's use of contraception. This is congruent with the women's descriptions of their partners' opposition to family planning.

Like the women who participated in the study, community leaders mentioned religion as a barrier to contraceptive use. They expressed concerns that religious groups try to discourage their members from using contraceptives and may distribute incorrect information about contraception. According to one participant:

"One of the challenges that we usually encounter would be the religious groups. For example, the Catholic Church, where they are against family planning. To them, family planning is abortion and they will tend to discourage their women from coming." -BFLA nurse, female

It is a basic human right to be able to make decisions about one's reproduction, including whether to have children, how many children to have and when to have children.

One pharmacist interviewed also stressed that the Catholic Church is not the only religious group that is opposed to artificial contraception, and that there are many Christian groups which create barriers to contraceptive use. In her words:

"I know we give the Catholics a hard time, but I think we have a very high, high population that is practicing Christian faith in many [churches], so sometimes the information that is out there from these groups that are anti-artificial contraception really gives the wrong information as well." -Pharmacist, female

Community leaders reported that the ability to effectively access and use contraception varies with education and socioeconomic status. In particular, they felt that people who are poor, people with only a primary school education and people who live in villages have the greatest unmet need for contraception. This perspective is consistent with findings from developed nations that show a relationship between low literacy rates and lower levels of utilization of health information and services.[28] The U.S. Institute of Medicine defines health literacy as:

The degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions.[29]

While community leaders did not explicitly use the term "health literacy," the difficulties they described clearly fall into this category. In the interviews, community leaders explained that lack of education is a barrier that prevents individuals from seeking information and services related to family planning and that a lack of education also makes it more difficult for individuals to understand information they do receive. One pharmacist described her experiences trying to counsel women with low levels of formal education about contraceptive use:

"I really don't think that a woman who doesn't have a lot of formal education can understand the complexities of her biological makeup. Even for women that have [a university education], but maybe [are] not educated in biology, sometimes I'm sitting here . . . I am telling the women 'well you know you have a cycle' . . . and then sometimes I'm talking an hour, and they pop me a question which tells me they didn't get it." -Pharmacist, female

Overall, the community leaders felt that sufficient contraceptive methods and information are available in San Ignacio, but they are underutilized. Both community leaders and the women who participated in the study identified the same sorts of major barriers to contraceptive use, i.e. religious teachings, difficulties with male partners and cultural gender norms. Because women are unable to effectively use the family planning services in San Ignacio, many are unable to make informed and independent choices about the number and timing of their pregnancies.

## Conclusions

It is important to note that the present work is a small, qualitative pilot study with a convenience sample. Therefore, these findings are not representative of every Belizean woman's experience. The strength of the study's qualitative approach is that it allowed participants to identify and describe the barriers to family planning that they observed in their own lives and communities. The authors believe that the lived experience of Cayo residents is an invaluable resource for understanding the context in which family planning occurs in this community. The findings of this study have the potential to shape further research and interventions around family planning in this community, though further research is needed to understand Cayo men's experiences with family planning and contraception. Additionally, quantitative studies exploring the prevalence of the barriers identified in this work and their varied effects on different ethnic and age groups are important next steps.

It is a basic human right to be able to make decisions about one's reproduction, including whether to have children, how many children to have and when to have children.[30] In order to exercise this right, couples and individuals must have access to contraceptive methods and must also be able to make informed choices about their use.[31] Therefore, contraceptive services and education must be both present and accessible for these rights to be supported.

Additionally, family planning provides significant health benefits for both women and infants. The use of contraception reduces maternal mortality by decreasing pregnancies and limiting the need for unsafe abortions.[11] Modern contraceptives are highly effective when used properly; however, not everyone who could benefit from modern contraceptive technology is able to utilize it.[32] In order to reduce the unmet need for contraceptives, healthcare providers and family planning NGOs must better understand why contracep-

tives are not presently utilized. The United Nations Children's Fund (UNICEF) reports that the prevalence of contraceptive use in Belize dropped from 56% in 1999 to 34.3% in 2006.[7] Almost one-third (31.2%) of women in Belize wishing to avoid pregnancy were not using contraceptives in 2006, the most recent year from which these statistics are available.[7]

The focus groups and interviews summarized above suggest that the unavailability of contraceptives is not the driving factor behind patterns of contraception use in Belizean women. Instead, culturally defined gender norms shape women's decisions about family planning—particularly the beliefs of their male partners, religious community and family. These findings can be better understood using McLeroy et al.'s social ecological model, which depicts five levels that influence behavior: intrapersonal, interpersonal, organizational, community and societal. This model highlights that determinants of health include not only individual behavior but also larger socioeconomic and political factors such as family, community, laws and policies. By doing so, the model reminds researchers and practitioners to create health promotion interventions that will address the multiple dimensions and determinants of health behavior.[33] For women seeking to avoid unplanned pregnancies in San Ignacio, intrapersonal factors include their own knowledge about contraception, experiences with side effects and belief in the effectiveness of contraception. Interpersonal factors include women's relationships with their partners, family members and health care providers. Two organizations that influence women's family planning are presented in this paper: the BFLA and the local faith-based pregnancy resource center. The BFLA provides counseling, condoms, hormonal contraception and surgical sterilization for women, while the faith-based pregnancy resource center supports family planning by encouraging men to respect their female partners and educating couples about their fertility. However, staff at the resource center discourage the use of modern contraceptives and reinforce cultural expectations of established gender roles. At the community level, the authors found that community gender norms, religious teachings and expectations about family size impact women's choices about family planning. Participants stated that some religious groups describe the use of contraception as "sinful," distribute misleading information about artificial contraception and lead men to believe that women exist in order to care for their children and home.

## Solutions

Efforts to promote family planning should consider interventions that go beyond change on the individual level, such as improving knowledge and awareness about family planning, to include change at interpersonal, community and societal levels as per McLeroy's model. Examples include promoting healthy relationships and challenging gender inequitable social norms. The latter could be accomplished through media campaigns, in which messages about gender equality and contraception are embedded in entertainment, microfinance programs, and educational interventions.[34,35,36,37] These approaches would help to promote Belizean women's equality and empowerment through outreach to entire communities—women, men, girls and boys—rather than simply targeting individual women.

In order for family planning services to be delivered effectively, it is important to understand the context in which they are delivered. Many of the women who participated in this study survived tremendous challenges: some had raised over half a dozen children, some were single mothers and some had left abusive partners. After overcoming so much, these women look forward to a time when their daughters, sisters and friends would have better lives–lives in which women can make their own choices unconstrained by the demands of partners and expectations of society.

References and tables available at **JGH Online, www.ghjournal.org**