THE REPRODUCTIVE HEALTH OF GUYANESE WOMEN

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ABSTRACT

The health of "Third World" women is important to development because of their contribution to both society and economy. Caribbean women are no exception as they provide care to children, elderly and the infirm, and paid labour in the informal and formal sectors (Allen, 1997, p. 171). Consequently, health and reproductive health are important issues to Caribbean women because it affects how they perform their roles.

Many Caribbean states, including Guyana, have not recognised the importance of women's health to development. Consequently, many non-governmental organizations (NGOs), like Red Thread in Guyana, are advocates for women's health. Red Thread devotes resources to the education of low income Guyanese women about health and reproductive health issues. In 1994, it undertook a questionnaire-survey to determine the level of knowledge among low income women and have used the data to create an educational booklet for dissemination. Three years later, I did the preliminary analysis of this data and based the collection of my data upon this analysis. Red Thread participated in my research project with the aim of uncovering Guyanese women's reproductive health experiences as well as the meanings they attach to these. The findings from this research have also contributed to the educational booklet.

Given the objective and nature of the project, a feminist methodology has been employed to guide the research process. It links academic research and political activism through its involvement with Red Thread, and an effort has been made to interrogate the

power relations implicit in the "field". Both quantitative and qualitative methods have been used to illuminate Guyanese women's reproductive health experiences and knowledge. The quantitative data is from the 1994 survey analysis and the qualitative data is from the in-depth interviews completed for this research.

The findings center around four themes: women, knowledge and the medical establishment; the fragmentation of women's experiences; attitudes towards motherhood and sex; and women and kin networks. The reproductive health experiences of Guyanese women have been marked by the lack of consultation, information and education from the medical establishment. Furthermore, as a result of the low quality of care provided by Guyana's public health system, women have been forced to cope with health problems through their networks of friends and family which provide support and information, or by consulting "bush" doctors or private doctors for fees. Given the Guyanese government's continuing cutbacks in health care, there is little optimism for women's health and reproductive health care concerns. Consequently, NGOs, like Red Thread, must carry the burden shed by the government to maintain current standards. Otherwise, the future health and reproductive health of Guyanese women looks grim.

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TABLE OF CONTENTS

Chapter 1: Introduction 1

Chapter 2: Guyana 11

Chapter 3: Methodology 32

Chapter 4: 1994 Reproductive Health Survey 63

Chapter 5: Women, Knowledge and the Medical Establishment 88

Chapter 6: Women and their Reproductive Health Experiences 103

Chapter 7: Women, Motherhood and Sex 119

Chapter 8: Women and Kin Networks 135

Chapter 9: Conclusion 146

Appendix A 151

Appendix B 152

Bibliography 167

CHAPTER 1

INTRODUCTION

Introduction

The health of "Third World" women is important to development due to the labour that women contribute to society and the economy as reproducers and producers (Allen, 1997, p. 171). Their ability to effectively and efficiently perform their role as caregivers to children, the infirm and elderly, and as paid labourers in the informal and formal sectors of the economy is greatly affected by their health; thus "Caribbean women might therefore be said to carry the greater burden of tasks related to the development needs of the region, and ill health among women can threaten to jeopardize this development" (Ibid., p. 172). It is the burden of work that falls on Caribbean women which makes health and reproductive health issues important to them. However, the failure of some Caribbean states, like Guyana, to fully recognize the health needs of women has contributed to ill health among women, especially in relation to their reproductive roles (Ibid., p. 174-5). Consequently, many non-governmental organizations (NGOs), like Red Thread, a Women's Development Programme in Guyana, are advocates for women's health and devote resources to the education of low-income women about health and reproductive health issues. It is in this context that Red Thread undertook a questionnaire-survey in 1994 to determine the level of reproductive health knowledge

among low income Guyanese women and has also participated in this research project to uncover women's reproductive health experiences and the meanings they attach to these.

The purpose of this chapter is to lay out the analytical framework of this research project with respect to women's health in the Caribbean and Guyana. The objectives and methodology are also discussed and the organization of the thesis' contents is outlined.

Health Care in the Caribbean and Guyana

The health conditions of women and their access to quality health care varies across the Caribbean region with Guyana generally at the "lower" end of the scale in relation to other Caribbean states. Such differences are a product of capital and infrastructural commitment to health care in terms of services and public education in the prevention of disease (Ibid., 1997). These differences have been exacerbated by the implementation of structural adjustment policies in the early to mid-1980s (Ibid., p. 204) as well as increasing public and foreign debts as a proportion of gross national product. Relatively wealthier Caribbean countries, like the Bahamas (with a Human Development Index (1992)[1] of .854), Barbados (.894), Antigua and Barbuda (.796) or Trinidad and Tobago (.855) are able to provide greater quality of health services to their populations, in contrast to countries like Guyana (.580), Belize (.666) or Grenada (.707). Given the

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The Human Development Index (HDI) was devised by the United Nations to estimate the socioeconomic conditions of a population using life expectancy, adult literacy and years of schooling, and gross domestic product per capita adjusted for inflation (UNDP, 1994). Figures from UNDP, 1994.

disparities between the countries, it is no surprise that the shortest life expectancies are in Guyana (65) and Belize (69) with the exception of Grenada which has the same expectancy for the region as a whole (71) (UN, 1994). However, such statistics reveal little about the health status and welfare of women (Allen, 1997, p. 180) as the following discussion about the situation of Guyanese women and children suggests.

Guyanese women's health and reproductive health is poorer in comparison to the rest of the Caribbean. For example, UNIFEM (1993) reports life expectancy in Guyana is now five years less than in other parts of the Caribbean, and the still birth rate and proportion of babies with low birth weights are higher compared to the rest of CARICOM[2]. However, the proportion of Guyanese women with AIDS, which is 38.5 per cent of the number of AIDS cases reported up to 1993, is slightly lower than the proportion of Caribbean women with AIDS (39.0%) (PAHO, 1993).[3] These figures are indicative of the fact that health and reproductive health issues receive little attention among policymakers. However, reproductive health is an important issue to Guyanese women at all stages in the life-cycle because it forms a large part of their lives: over 90 per cent of Guyanese women become mothers.

2

Guyana is a member of the Caribbean Community which is a trading bloc of English-speaking Caribbean countries.

3

The AIDS statistic for Guyana are questionable due to the poor quality of health statistics in the country (UNIFEM, 1993).

The deteriorating situation of women and children in Guyana is seen in infant, child and maternal mortality rates. In Guyana, between 1985 and 1990, the infant mortality rate was 56 per 1000 registered births (UN, 1994). This is the highest infant mortality rate in the English-speaking Caribbean: neighbouring Trinidad and Tobago has a rate of 10.2, Barbados 9.1 and 19.7 for the region as a whole for the same time period (UN, 1994). This high rate is partially due to malnutrition, which is sometimes due to the introduction of liquids, such as tea and water, to babies after the age of one month. The maternal mortality rate for 1984 was estimated at 180 per 100 000, and at three public hospitals the rate ranged from 213 to 442 per 100 000 in 1990 (UNIFEM 1993, p. 30). The main causes of maternal mortality are abortion which is the major form of birth control, toxaemia in pregnancy, and haemorrhage and sepsis during childbirth (UNIFEM 1993, p. 31). Another indicator of the situation of women and children in Guyana is birth weight since the undernutrition of mothers manifests itself in low birth weights (less than 2.5 kg) and still births. In 1986, 17.2 per cent of the total registered births had a low birth weight and the still-birth rate was 23 per 1000 live births (UNIFEM 1993, p. 30).

The level of poverty of women, as indicated by the low birth weight and still-birth rates, can be attributed to the lack of household food security and the unavailability of health care (UNIFEM, 1993, p. 11). The power to purchase food has been compromised by low wages, the removal of food subsidies, and inflation (UNIFEM, 1993, p. 11). This is especially true for female headed households which comprise almost 30 per cent of all households. Consequently, women's participation in the formal and informal economies

has increased greatly (Peake and Trotz, forthcoming). But, it also must be noted that women's participation in these sectors is often restricted by their reproductive responsibilities since child care is largely unavailable, and women friends and relatives who could help with the duties are also seeking employment (Peake and Trotz, forthcoming). Health care[4] is largely unavailable because 95 per cent of the services are provided by the public sector which are deficient in equipment, skilled staff and simple medical supplies such as bandages due to spending cuts. Private hospitals are simply not an option for the 65 per cent of the population who live below the poverty line. There is little hope for the amelioration of low-income Guyanese households given that social services continue to be drastically cut. For example, the Inter-American Development Bank (IDB) reports in its Socio-Economic Report for Guyana that in real terms public expenditure in health dropped by 36 per cent between 1980 and 1988, and in 1990 the health care sector received only 4 per cent of national expenditure (IDB 1993).

For many Guyanese women the issue becomes one of having too many children, too early or too late. Early pregnancy, for example, is potentially a health hazard for both mother and baby. In Guyana, the highest proportion of infant deaths occur to mothers

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The hospitals tend to be highly concentrated: there are five or six private hospitals and one public hospital in Georgetown, and Linden and New Amsterdam each have one small, semi-private hospital. The clinics, which provide limited services, are located along the coast with few in the interior. The health care system in Guyana is suffering from a shortage of trained medical staff, there are no oncologists or psychiatrists for example, and basic supplies. Those who can afford it travel to Trinidad and Tobago or Barbados for care. UNIFEM, 1993.

aged 14 years and in 1991 25.3 per cent of low birth weight infants were born to mothers under the age of 20 (UNIFEM, 1993, p. 35). The majority of Guyanese women do not use modern contraceptives because birth control is not available on a regular basis. Consequently, abortion is a major method of birth control and it is not uncommon for some women to have multiple abortions which may have consequences for their long-term health (UNIFEM, 1993). And in later age, fibroid hysterectomies are a common practice; very rarely are alternative treatments explored. Furthermore, the Guyanese diet is nutritionally poor because it is high in sugar and starch and low in vitamins and minerals derived from fresh fruit and vegetables. As a result of this diet, many women suffer from high blood pressure, anaemia, diabetes and very painful periods.[5] Many of these conditions can make pregnancy, childbirth and overall health problematic. It is for all these reasons that reproductive health is a major issue for Guyanese women.

The Research Objective

The objective of this research project is to uncover Guyanese women's experiences of reproductive health and the meanings and values they attach to these. The underlying purpose is to uncover the power relations which shape and give meaning to

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[5] Officially, Guyana does have one of the lowest female age-adjusted mortality rates for diabetes mellitus in the region: 20.6 compared to 24.5 per 100,000 women. The same is for deaths from hypertension where Guyana's age-adjusted rate is 17.0 and the region's is 28.2 per 100,000 women (PAHO,1990). However, the reliability of the figures for Guyana is questionable given the poor quality of health statistics in the country.

the reproductive health experiences of Guyanese women, and to empower women through education about reproductive health issues so that they have a greater ability to choose what happens to their bodies. The ultimate goal of such empowerment is to influence how reproductive issues are approached by the medical establishment and government in Guyana, and thereby improve the health and well-being of Guyanese women.

This study is also an extension of a reproductive health survey of Guyanese women which was completed in 1994 by Red Thread (hereafter referred to as "the survey"). This questionnaire-based survey gathered information on women's knowledge of sexually transmitted diseases (STDs), reproductive health issues, childbirth and child care, and menopause. The study explored the extent of women's clinical knowledge with little attention to their attitudes and practices regarding reproductive health care. My research project augments this survey by collecting data about Guyanese women's reproductive health experiences to provide a picture of the meanings and values they attach to their experiences and the extent to which these vary among women according to 'race' and stage of the life-cycle.

Methodology and Methods

Given the objective and nature of the project, a feminist methodology has been adopted to guide the process. The feminist methodology employed in this study is concerned with the links between academic research and political activism whereby the

researcher makes the commitment to question and challenge the social relations which structure difference and works towards social change (Women and Geography Study Group, 1997, p. 87). Furthermore, it is one in which the power relations implicit in the research process are constantly interrogated. The project links academic research and political activism through its involvement with Red Thread: a reproductive health booklet for dissemination in low-income communities has already been generated from the combination of this research and the survey. The booklet will help Red Thread towards its goal of empowering women through knowledge. (A further discussion of feminist methodology as it relates to this project is presented in Chapter 3.)

Both quantitative and qualitative methods have been used to capture a picture of reproductive health issues as they relate to Guyanese women's experiences and knowledge. The quantitative information is from the survey which provides generalizations about Guyanese women's knowledge of reproductive health issues and their behaviours (although on a very limited basis). These generalizations, presented in Chapter Four, allowed me to pinpoint the issues which appeared to be of importance. With this I proceeded to build on that analysis in hopes of improving and increasing Guyanese women's understanding of reproductive health. Consequently, the survey became the foundation for my in-depth interviews which were conducted in the summer of 1997.

My interviews provide the qualitative data and give a more detailed understanding of Guyanese women's lives as they relate to reproductive health. The combination of

both methods helped to gain a better understanding of Guyanese women's reproductive health in terms of experience and knowledge. Four themes emerged from the interviews and form the core chapters of this thesis: women, knowledge and the medical establishment, women and the fragmented body, women, motherhood and sex, and women and kin networks.

Organization of the Thesis

This thesis is organized into nine chapters. The introduction has concerned itself with the purpose, methodology and methods of the project. The second chapter is a discussion of Guyana, the place and the people, and Red Thread. The purpose of this chapter is to provide the reader with a sense of Guyana's place in the Caribbean so that the analysis can be contextualised in a broader context. The methodology chapter provides a discussion of the literature regarding the politics of fieldwork and the politics which operated in the "field" defined by this project, as well as the methodological issues encountered with the survey and the interviews. Chapter Four presents the analysis of the survey based on the life cycle groups of the women who participated and helps to contextualise the interviews.

Chapters Five through Eight are the core chapters and are based on the four themes, generated by the interviews from this study, relating to Guyanese women's reproductive health experiences. The analysis of the questionnaire survey conducted by Red Thread and the interviews in which I was involved are presented in these chapters

with attention given to difference related to stage in the life-cycle, 'race', and religion. Chapter Five is a discussion of women, knowledge, and the relationship between women and the medical establishment. The sixth chapter explores women's reproductive health experiences, and the seventh looks at their attitudes towards their bodies and sex. The last core chapter, number eight, examines how women's networks shape their reproductive health experiences. Chapter Nine concludes the study, tying together the findings and contextualising them.

CHAPTER 2

GUYANA

Introduction

This thesis is about Guyanese women's reproductive health experiences; however, these experiences can only be understood in their context -- that is the lives of women living in the place called Guyana. This necessarily involves a brief examination of the country of Guyana in terms of its history, politics, economy and society. Having some knowledge as to what a place may look and feel like helps to make any research project come to life. I have also included a section which provides a biography of Guyana based on my experiences which provides hints to other (lived) realities. The last portion of the chapter looks at Red Thread: its conception, objectives and day-to-day realities. It is important to include Red Thread because its activities impact upon the material circumstances of Guyanese women as well as their ontologies. Red Thread is working towards changing Guyana's social and political landscape in terms of 'race', gender and class, and their efforts should be acknowledged.

Guyana's Social Landscape

Guyana is an English speaking[6] country located on the northeastern shore of South America, situated west of Venezuela, east of Surinam and north of Brazil (Appendix A). Georgetown, the capital, is located on the coast, east of where the Demerara River empties into the Atlantic Ocean. Guyana gained independence from Britain in 1966 and it has historical and political links with the English-speaking Caribbean as a member of CARICOM (Caribbean Community) and takes its place among the islands which served as large sugar plantations for colonial Britain.

The population is approximately 723,000 (1995) and the annual growth rate is -0.81% (Central Intelligence Agency, 1997). Ninety per cent of the population resides in the coastal area which is a narrow strip some 15 to 65 kilometres wide where most of the production of sugar and rice occurs. South of the coastal area lies the interior which is forested and home to primary activities such as mining and logging, and the Rupununi, a large savannah. The interior is home to Amerindian populations whereas the remainder of the Guyanese population live on the coastal belt. The majority live in rural areas, but over 32 per cent reside in the capital of Georgetown. Guyana recognizes itself as a land of six peoples: the population is composed of East Indian (51%), African (38%), Amerindian (6%), and European and Chinese (5%) (CIA, 1997). However, Guyanese

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[6] Although English is the official language of Guyana, there are many Creole dialects.

politics and economics are guided by the racial discourses constructed around Indo-Guyanese and Afro-Guyanese identities.

Such constructions, although fluid, have historical roots dating back to colonial times which were further entrenched by politics after independence (Peake and Trotz, forthcoming). Nonetheless, current politics are dominated by two parties: the People's National Congress (PNC) which is largely supported by Afro-Guyanese and was in power under fraudulent conditions from 1968 to 1992, and the People's Progressive Party (PPP) which legally gained power in 1992 and was re-elected in 1997, and is mainly supported by Indo-Guyanese. Recent violent events surrounding October 1997's elections illustrate the inherent dangerousness and volatility when political forces use 'race' as a vehicle to power (Peake and Trotz, forthcoming).

Guyana is the second poorest country in the Western Hemisphere in terms of gross national product per capita. Social conditions continue to deteriorate in Guyana because of the tenuous economic conditions brought about by historical factors and current economic policies and the implementation of structural adjustment policies (SAPs) since 1988. Guyana's national debt is US$1.5 billion (1997) and half of its foreign exchange earnings are committed to reducing the debt (Colchester, 1997, p. 42). Debt repayment has been aided by increases in GDP since 1991 which is used as evidence to claim Guyana as a structural adjustment success story. The economy is dependent upon the export industries of bauxite, gold, sugar and rice to eliminate its foreign debt.

Gold production has increased with the opening of the OMAI Gold Mine[7] in the interior, the largest open pit gold mine in South America, and plywood production for export by the Korean-Malaysian company, Barama, is growing rapidly. In the wake of the need for foreign investment and foreign exchange, it appears the Guyanese government is almost handing over the country's national resources to foreign-owned multinational companies with little or no regard for the social, economic and environmental costs (Colchester, 1997). The cyanide spills at OMAI in 1996 attest to the government's inability to cope and watch over the activities of its multinational guests.

The standard of living for the majority of Guyanese has decreased due to very low wages and high prices. In fact, UNIFEM (1993) reports that between 1985 and 1991 that the cost of living index increased by 1000 times and the minimum wage (US dollars) declined by 65 per cent. Consequently, women living in rural and urban areas are increasingly seeking employment to supplement men's wages in order to maintain their households (Peake and Trotz, forthcoming): in 1992 the participation of women in the labour force was 47 per cent, up from 28 per cent in 1970, and figures for rural areas are similar where the rate increased from 14 per cent in 1970 to 36 per cent in 1992 (IDB 1994, Tables 5 and 6). Many Guyanese families are in precarious circumstances as their

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Ninety-five per cent of the mine is owned by a Canadian company and 5% by the Guyanese government.

average household incomes[8] struggle to cover the cost of housing which can vary from G$12,000 to $15,000 per month to rent a decent two bedroom apartment or small house in Georgetown. Not only is the difficulty of low wages exacerbated by the high cost of housing, but also by the prices of everyday goods such as toiletries and foodstuffs which are no different from what Canadians pay, and the costs of sending multiple children to school (uniforms which range in price from G$3500 to G$5000, school "fees", textbooks, extra lessons, pencils and paper).

The future prospects for Guyanese do not look promising as the government continues its spending restraints due to debt repayments. Furthermore, the potential to earn foreign exchange weakens as the government carves up Guyana's natural resources, for lower returns, among foreign multinationals to hasten development and quickly fill public coffers on the short term (Colchester, 1997). These policies have further enslaved households because they must develop strategies for survival in the face of declining services and real wages as well as increases in indirect taxes through "user fees".

A [Privileged] Visitor's Description of Guyana

As the plane was about to take off from Timehri airport, I thought to myself, "Canada has a lot to learn about hospitality." Although I am aware of the unfairness of

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[8] The average annual income for the female employed population is G$46,773.00 and G$56,125.00 for the male employed population (Table 10.12, Population and Housing Census, 1991). Average monthly household income statistics are not available from the 1991 Census.

this statement towards Canadians, it was something I could not help but feel given the welcome I received from Guyanese. I know I have never been treated so well as a guest as I was in Guyana. In fact, I felt a deep sadness in going because I was leaving behind my "family" as I did back in Canada.

My experiences in Guyana were privileged because I was allowed to enter many intimate spaces. I saw a Guyana that the majority of tourists would never see or experience: I ate barbecue chicken in the company of twenty or more avid partiers on the Essequibo; on one hot Saturday morning I went to a Seventh Day Adventist church where I was received with open arms; I was piggybacked on bicycles so that I did not have to walk along the Berbice highway; and the family I stayed with in Georgetown treated me like a daughter when I was included in family gatherings and bought popsicles for treats on some of those incredibly hot August afternoons. My Guyana was lived through the experiences of staying and living with Indo- and Afro-Guyanese families, working with the Education Team members of Red Thread, and seeing the urban and rural landscape whiz by the mini-bus window. And it is from these experiences that I speak about Guyana in terms of the urban, rural and social landscape.

My trip to Guyana was my first to a "Third World" country and my first outside of North America so I really did not know what to expect or even what to do. I was a very naive and unseasoned traveller. My first couple of weeks were spent in a state of shock or system overload. I could not get over the degree of poverty which was evident in the state of the roads, sewers, buildings, houses and poorly clothed children. In fact, I was

quite afraid to leave the comforts of the home in which I was staying in Kitty and venture "out there". I was afraid for my safety because I was visibly a tourist, given my whiteness, and fearful for being mistaken for somebody who had money. It took many mini-bus rides from Kitty to Lacytown and strolls along Georgetown's streets to realize that I was in no danger. Eventually, my fears subsided, and the poverty I saw melted away. Georgetown and Guyana became a very beautiful place to live. It sometimes takes a very long time to see the beauty hidden behind the mask of difference which is born of fear.

Georgetown is the capital and major city and is laid out in a grid-like fashion and divided up into districts or areas, each referred to by name, e.g. Kitty, Lacytown, Albouystown, Bourda, and Queenstown, etc. Many of these districts seem to have a stronger class identity than a racial one. The roads in the city are fairly poor given that only the main roads are paved and side streets are dirt and gravel. There are many potholes on all streets which aid in their flooding after a heavy rain, and in some cases these roads became almost impossible to navigate. The sewers are open ditches and carry wastes, including litter, presumably to the Demerara River and out to the Atlantic Ocean, as my field diary notes comment:

> The city itself is very dirty. The ditches are filled with filthy water containing animal, human and garbage waste. Foul smells often waft to your nose around these ditches. During the week [July 18th, 1997], a taxi carrying three passengers fell into a ditch in Albouystown. None of the residents wanted to go into the ditch to save them, and as a result three of the four occupants drowned. I don't think I would have jumped in either (Topelko, 1997).

The landmark buildings in the city date back to the colonial period and they include government buildings, two major hotels, diplomatic homes and churches. Many of these structures are magnificent and signify the wealth accumulated by the British and epitomize the images of colonial style buildings imagined by a Westerner. Some of the more architecturally modern buildings are home to national banks or foreign-owned businesses. The majority of the structures are very old, wooden-framed, and in need of repair or painting. Houses come in all shapes and sizes and most houses are elevated off the ground by wooden or concrete stilts. The wealthier homes are now made of concrete and are often painted white or sometimes a pastel colour. They tend to have a veranda in the front to "catch breeze" and are equipped with running water and toilets. Poorer households reside in small homes that are built from miscellaneous materials and often lack glass windows, running water and sewer systems. In many instances there will be two or four houses on a city lot and extended families within one household.

The city streets of Georgetown are alive with activity. Even though there are two central markets, Bourda and Stabroek, the streets are filled with women vendors selling housewares, foodstuffs and undergarments, street vendors selling items like handcrafted shoes and jewellery, traders selling designer-labelled clothing like Hilfiger, Calvin Klein and Guess?, and peddlers, usually young boys or men, selling genips (a small fruit), soda or candy. Georgetown's informal economy is very important to Afro-Guyanese women and men, and for both Indo- and Afro-Guyanese young boys and men. There is certainly

no shortage of customers; however, buyers have room to haggle and definitely shop around for good prices:

> I have no idea as to how the common Guyanese woman or man makes a decent living. I guess they really don't. I make this observation because of the great competition for entitlements. For example, mini-bus drivers must compete for customers who pay G$20 (C$0.20) for a one-way ride, and on every street women traders are peddling the same goods -- cosmetics, undergarments, towels, toiletries, hair accessories, housewares, and inexpensive jewellery -- for the same market. In Bourda and Stabroek markets, vegetable and fruit, and meat vendors are selling the same goods to the same customers. The competition is very stiff...(Topelko, 1997).

In fact, a great deal of women's time and energy is spent shopping for the best prices which can entail many trips to various venders before deciding to purchase. This is not done out of the luxury of choice but necessity because money is hard to earn and goods are expensive.

The local retail businesses are generally owned by Indo-Guyanese whose family members are employed in the businesses. The businesses are specialized in the sense that they sell certain kinds of goods. There are many textile, electronic, housewares, and building supply stores. There are very few businesses offering services. One large department store is state controlled and offers a wide range of products, but the selection is limited and rather expensive. I am unsure if some of the local manufacturing plants are owned by Indo-Guyanese as well; however, Afro-Guyanese men are employed in the factories.[9]

9

The concentration of Indo-Guyanese owners in the retail sector and Afro-Guyanese in

I also stayed in an interior mining town called Linden for a week. Compared to Georgetown, Linden was a breath of fresh air except when the wind whipped up the fine red bauxite dust which has settled over the area. No matter where you go in Linden, the bauxite processing plant (Linmine) is always looming in view, belting out thick grey and blackish smoke. It is also a constant reminder of the town's former economic success as the mine has been downsized and restructured and its financial difficulties have trickled down to households. Beyond the plant, you can see the source of the red dust lifting off the denuded and sculptured slopes of the bauxite mine. The commercial part of Linden is located on the outskirts of the bauxite plant on both sides of the Demerara River. The plant is located on the side called Mackenzie where there is a Courts shop which is a British owned business selling appliances and furniture, the bus park to Georgetown, two national banks, a couple of restaurants and a small market. In Wismar, which is on the other side of the bank, there is a continuous stream of vendors and garden restaurants and bars along the bank, including a cinema playing American movies, together resembling "the strip". It becomes quite costly to obtain transportation to go back and forth from the market and "the strip": G$30 by boat and G$60 by mini-bus one way. Housing and lot

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vending and factories is a result of historical and economic processes. The People's National Congress (PNC) government (1968 to 1992) favoured the appointment of Afro-Guyanese to civil servant jobs and blocked Indo-Guyanese from entering the public sector. Consequently, Indo-Guyanese found employment opportunities in the private sector by starting their own businesses. However, with the institution of SAPs in the late 1980s, many Afro-Guyanese have faced retrenchment from the public sector and it is no longer an attractive employment opportunity due to low government wages (Peake and Trotz, forthcoming).

sizes are much the same as in Georgetown, however there are fewer homes made of concrete and more are made of wood and miscellaneous materials. Linmine provides electricity and running water for the majority of households; however, the availability of both utilities varies according to time of day.

West Coast Berbice provided a far greater breath of fresh air since the breezes come off the Atlantic Ocean. I stayed in Village 40 which is a small, low density, rural village. Berbice is rural; however, its urban connections are never forgotten due to the highway running through it from New Amsterdam and Georgetown. There is only one store -- a rum shop which also sells cigarettes, soda, and a small variety of household items -- so locals have to travel to New Amsterdam, Mahaica or Georgetown for staple goods. The majority of the houses are made of wood and all are located along the highway on very large lots. Behind them the land is used for agricultural purposes such as growing rice, and grazing goats and cattle. It is one of Guyana's richest agricultural areas due to rice cultivation which has greatly increased production levels in the 1990s. When I was there rice was laid out on the highway to dry so the husks can be removed. This was certainly no obstacle for mini-bus drivers for they drove just as quickly as they manoeuvred around the strips of drying rice.

I also stayed in Vergenoegen which is a small village about 24 kilometres west of Georgetown on the East Coast Demerara. Like West Coast Berbice, the houses are located along the highway connecting Georgetown and Parika. Here houses are made of concrete or wood and the lots are very large in comparison to Georgetown lots. As in

Berbice, residents kept livestock such as chickens, ducks, goats and sometimes cattle; however, this was not a way of life for many. Unlike West Coast Berbice, agriculture was limited to the sugarcane estates. There are very few family-operated farms. The women who won Guyana's largest lotto jackpot (G$20 million or so) operated one of the vendor's stands along the highway running through the village. These stands sell household goods and foodstuffs, much like our convenience stores, to local residents. Most residents go to the Parika market which opens every Sunday. In this market, clothing, music, designer sunglasses and watches, cosmetics, prepared foods, fresh fruits and vegetables, and housewares can be purchased. There are not as many vendors as Stabroek and Bourda markets, and prices appear to be a little higher.

One of my most memorable times in Guyana was a Sunday afternoon barbecue on a beach along the Essequibo River just outside Parika. Over twenty of us, all Guyanese except myself, piled into the back of a cane truck which carried us, beer, spirits, soda, marinated chicken, fried rice, roti, barbecues, and inner tubes to the beach. It was a really hot August afternoon and the barbecue chicken and beer tasted really good, and my company of friends grew intoxicated as they day wore on and kept me in stitches. When I was not eating or drinking, I drifted in an inner tube or danced in the water with the women and children. I think we all let loose that day.

Having stayed with families I was afforded the opportunity to see how households operate. While in Georgetown I stayed with a middle-class Indian family. In this household, the mother works very hard to keep the house clean and she cooks three times

a day for the family. Her daughters were away in Canada while I was staying, so she enlisted the help of her niece, age fifteen, to help run the home. She was "on call" all the time to perform tasks as they arose and do the daily housework which included sweeping and mopping the floors twice a day, laundry, and daily cleaning of two bathrooms. She also assisted in the preparation of the meals and was responsible for cleaning up after eating. I'm sure the situation is no different for her two daughters. On the other hand, her son, who was nine at the time, did little to help around the house, but is responsible for daily cleaning the outside which involves sweeping the concrete and washing it down. Her husband does not contribute any labour towards the physical maintenance of the house; however, he often works ten to twelve hours a day and sometimes six days a week at his job in Georgetown. A great deal of male productive and female reproductive labour goes into maintaining this middle-class Indian home. Furthermore, this gender division of labour was also evident in the lower-class households that I stayed in. But, I noticed that the women had longer days (eighteen hours) due to the absence of time-saving appliances such as a gas stove and washing machine, and children who were not able to work because the daughters were too young or they had sons.

The only occasion I had to stay with an Afro-Guyanese family was when I was in Linden. The household is very poor and there is a constant struggle to put a healthy meal on the table for the young children. The home has two bedrooms, a small kitchen and living room, and houses four grandchildren, four adult daughters and one adult son, a

niece and the head of the household who is known as grandmother, mother and aunt.[10] Three of the daughters and the son contribute financially to the household and are also responsible for household duties as they relate to their children. However, it should be noted that the son does not contribute labour to housework, but will lend a hand when it comes to disciplining the children or getting them ready for bed. The youngest daughter and the niece are responsible for cleaning the house and helping to care for the children. The head of the household also earns an income and supports her children and grandchildren with it. Despite such crowded conditions, they all get along fine and they all continually pray for things to change -- namely a bigger house.

My experience of 'race' relations varied according to place. In the spaces outside of Red Thread and the members' homes, there is a very real divide continually constructed between Indo- and Afro-Guyanese. From my experience, Indo-Guyanese think that Afro-Guyanese "tief", commit violent acts and pull Guyanese society down. On the other hand, I did not hear the Afro-Guyanese construction of Indo-Guyanese, which is a reflection of Indo-Guyanese current political and economic power. But I did attend an assembly celebrating the abolition of slavery, and the speeches emphasized that the "poor" political and economic circumstances of Afro-Guyanese are a product of colonialism and continued discrimination against "black skin". The greatest fear among

10

For the week I stayed in their home, I was given a bed of my own which was usurped from one of her daughter's and her child. Both had to sleep on the floor for seven nights. I did not feel good about this, but no one would have it any other way. They also went to considerable expense and effort to prepare fresh fruits for me on a daily basis.

Indo-Guyanese was the return of the PNC party to power in the October elections. Indo-Guyanese have projected their blame onto Afro-Guyanese for the oppressive and repressive rule of Forbes Burnham (PNC) and the tenuous state of Guyana. One Indo-Guyanese said to me that "they [Afro-Guyanese] don't know how good they have it and they keep complaining that not enough has been done," and it is this "complaining" which worries Indo-Guyanese about the elections.

The descriptions of my experiences of Guyana's urban, rural and social landscapes complement the standard geographical description in the sense that it paints a picture of Guyana which is alive and lived in. It also provides the reader an opportunity to visualize the things I saw and uncover the assumptions and understandings I have made about what I experienced. Having had the opportunity to live with families, I was able to get a glimpse of the relations which operate in the household, how households are structured, and how identities are constructed and reconstructed. But I was not always just an observer and many times I felt like a family member or a honoured guest. From the things that I experienced, it does not take much to surmise the great deal of time, effort and expense it took to show me "Guyana" and to make me feel at "home".

Red Thread

Red Thread, a Women's Development Programme, is a unique organization in Guyana's political landscape. Its uniqueness stems from its objective to empower women, to bring women together of different 'races' to discuss the issues important to

their lives, and to realize the connections between their lives and lives of others. It was formalized as an organization in 1986, but its conception by seven women members from the Working People's Alliance (WPA), who helped to organize grassroots women to protest food shortages, dates back to 1982. From the early days of protest, grassroots women and the WPA members quickly realized that more effort was needed to address the realities of women's lives. One common reality among all women is their burden to care for their families in an economic and political environment which diminished or limited their ability to secure entitlements for their households. This understanding caused Red Thread to embark upon income-generating projects -- the first to grind corn into flour during the wheat ban and then embroidery -- to help women feed, clothe, and educate their children. Over time, Red Thread has expanded its activities and is the longest established women's organization in Guyana which bridges perceived racial differences and offers a space for women to speak and construct their own [liberated] identities. The core group of middle class and educated women, who are supporters of the WPA and have local and international connections to governmental and non-governmental organizations, are responsible for running and funding Red Thread.

Red Thread's aim is to empower women so that they will have a greater degree of choice when it comes to their families, employment, and personal lives. There are five objectives which guide Red Thread's activities and programmes:

1) to help women to earn money individually and collectively;

2) to tie personal development to community development with a strong emphasis on community leadership;

3) to assist in the training and educating of women;

4) to increase women's awareness of their own conditions and their common conditions; and,

5) to help women gain experience in paid work which involves some degree of autonomy and does not position them as subservient (Hart, 1996).

All of Red Thread's objectives are materialized through the efforts of the Education Team. The Education Team is an amalgamation of the health team, research team and the workshop team, and includes twelve active members. The workshop team was formed in 1987 out of the need for better and greater internal communication and organization; the health team was started in 1989 by Dr. Nesha Haniff with the objective to educate women about health issues and for them to take a more active role; and the research team was formed by Dr. Linda Peake in 1993 to train the women in data collection techniques such as designing and administering interviews.

The Education Team consists of ten Afro-Guyanese women, one Indo-Guyanese and one dougla[11] woman and all are non-residents of Georgetown. The women are literate, most having an educational background up to some level of secondary school, and they come from poorer households where survival is a key issue. The group is bifurcated in terms of age: there are older women who are in their forties and fifties, and

11

People who have one Indo-Guyanese parent and one Afro-Guyanese parent are dougla.

younger women who are in their early twenties, drawn to Red Thread by a relative who is a member. The members meet on almost a daily basis and some women travel three to four hours by mini-bus to get to Georgetown where Red Thread is located. Travelling not only involves a great deal of cost, anywhere from G$600 to G$800 a day, but a considerable effort to arrange their domestic duties so that they can devote their day to Red Thread. Many of the women start their days at 4 a.m. and work until ten or eleven at night to maintain their households and keep sometimes "unhappy" husbands somewhat content. Through their devotion and hard work, the members of the Education Team get Red Thread's projects "off the ground" and into communities.

Red Thread engages in activities ranging from community workshops on various issues, income generation projects, using different forms of media to disseminate information, counselling individual woman and advocacy work. During the seven weeks I was working with Red Thread, three two-week workshops were organized in three different communities. The workshop in Linden focussed on reproductive health issues for teenage, child bearing and menopausal women, and personal development which sought to increase women's awareness about improving themselves through education and training (that they and their children were worth the investment). Another workshop was conducted in the interior, Rockstone, requiring a day of travel for the members. Here the women held a two-day workshop on the issue of violence against women in the home and the Team sought to include men so that dialogue could dislodge the discourses surrounding violence. This was the first time that the Team had men involved in a

"women's" workshop, and the members found it to be a productive of way of getting at the issues and changing women and men's views of violence. The third workshop was in West Coast Berbice and focussed on teaching bookkeeping skills to women entrepreneurs.

Some of the income generation projects include the Red Thread press, sale of textbooks and a laundry in Linden. The press was formally established in 1990 out of the recognized need for low cost textbooks. The Red Thread women's press also produces, sells and distributes textbooks to communities at a fraction of the cost of mainstream published materials. Community women are hired to sell and deliver the textbooks and they receive a commission based on their sales. Another income generation initiative is the laundry in Linden where local women are paid to do other households' laundry. Currently, Red Thread focusses less on these kinds of projects, and concentrates instead on providing monetary and human resources for Guyanese women to start their own businesses.

The Education Team also works hard to bring "private" issues into the "public" and to make "public" issues more public. The women have used radio programmes, dramas, information pamphlets, and newsletters, to bring issues such as poverty, violence against women and children, education, health and women's rights into the "public" forum. This is very important politically in Guyana since issues of concern to women are not openly discussed because they are deemed "private" matters and are not linked to the greater community in which these issues are embedded. The Education Team has also

disseminated legislative information in an accessible form pertaining to women's legal status within the state, economy, home and family, e.g. abortion and property rights. Furthermore, the members often act as counsellors and advocates for women by providing advice, support and even accompanying women to court appearances. While I was at Red Thread, at least one women a day would turn up at Red Thread's door seeking advice about an abusive relationship, harassment at work, employment opportunities, and problems with making ends meet.

Red Thread has created a space whereby grassroots Afro- and Indo-Guyanese women can come together and create alternative discourses around the issues of 'race', gender, class, poverty, violence, health and politics. It has proven to be a successful endeavour as evidenced by the types of activities the Education Team undertakes, and by their ability to work, meet and talk with women outside their own 'race'.

Summary

The most striking feature in Guyana's social and political landscape is the effort and energy extended to continually construct the identities of Indo-Guyanese and Afro-Guyanese (Peake and Trotz, forthcoming). Politicians have used the perceived racial differences to gain political support among Afro- or Indo-Guyanese constituents which further entrenches the act of identifying and naming. In their everyday lives, the economic and political conditions facing Indo- and Afro-Guyanese are explained in terms of racial difference -- one group being lazy or not knowing any better and the other

fighting hard to "keep us down". However, there is one discursive space which seeks to disrupt these discourses. Red Thread is committed to bring all women together to discuss their problems, situations, ideas, and opinions, and to break down the barriers constructed on the basis of 'race', class, gender, religion and other differences.

CHAPTER 3

METHODOLOGY

Introduction

This research project's framework is based on feminist methodology. From the onset it has been a goal of mine, Dr. Peake's and Red Thread's, to have the project contribute to the Education Team's political objective to empower women through education. Consequently, it is of great importance that I am aware of my own positionality in the construction. Positionality involves an awareness of my own and the Education Team's world view which are implicitly reflected in the set of power relations which permitted the design, doing and the writing of the project. This necessarily involves an investigation of myself as the person who is the researcher, how the Education Team made the research possible, and the research process. I also provide a synthesis of some of the literature relating to the politics of research which highlights the importance of *who* is doing the research and with *whom*.

The Politics of Fieldwork

Despite the incoherent nature of Woman, many feminists assert that it is possible for white feminists to research and work with black women and for "First World" feminists to do so on and with "Third World" women (Peake, 1993, p. 419; Radcliffe,

1994, p. 29). Such interaction or intersubjectivity is possible through what Brah terms "politics of identification" which are coalitions based on common political interests or struggles (quoted in Maynard, 1994, p. 19). Before any alliances can be constructed, the researcher must know how she/he engages with the social world and what this means politically.

The importance of identifying who one is and one's politics is brought sharply into focus by fieldwork. It is here that the researcher leaves the security of the written world/"home" and is forced to interact with others who may indeed be "Others" to her/him, and it is here the researcher is challenged to examine herself/himself in relation to the research and researched -- to discover the centralities and/or marginalities and their implications. The interaction which ensues can greatly shape the subjectivities of the researcher and the researched, the data and the representation of the data.

The last statement suggests there is something different about feminist research. Nowhere is it assumed that the researcher is an objective, value-free and detached observer. Instead, what is argued is a researcher who is situated in terms of gender, 'race', class, sexuality, and dis/ability, etc. Mediated by experience and history, these markers have simultaneously aided in the construction of the researcher's identity/subjectivity on her/his own and society's terms. This becomes the researcher's consciousness: "...[a] medium through which research occurs" (Stanley and Wise, 1993, p. 157). The end result of the research process is the creation of partial and situated knowledge -- "a piece of the truth" (Pratt, 1988, p. 16). The partiality and situatedness of the researcher and the

research, and ultimately the knowledge produced, has implications for the research participants in terms of the following aspects of the research process: methods, experience of the research process, and authorial and political representation[12]. The same holds true for the researcher since one's identity and politics can open and close doors in the "field".

Here I wish to examine the "betweeness"[13] of a feminist conducting fieldwork on and with people who are located outside of her/his ontological framework. This necessarily involves a theoretical examination of politics and difference, knowledge, and radicalised and gendered identities, as they relate to the researcher and the researched. This will be followed by a discussion of my relationship to the "field" in Guyana.

The deconstruction of the category of Woman has meant that feminism may no longer make universal claims on the premise of a common experience. Instead, feminism has had to acknowledge the existence of many feminisms based on sexuality, 'race', and class, etc., and has to find a way to remain a cohesive movement without denying multiple subjects their politics, experience, and knowledge (Harding, 1992). In the late 1980s and the early 1990s, this possibility seemed unattainable because many of those

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12

Authorial representation refers to the describing and making visible the research subjects, and political representation is invoked when the researcher speaks on behalf of the subjects (Radcliffe, 1994, p. 28).

13

Betweeness refers to the social distance between the researcher and the researched. Social distance is in constant negotiation since there is never any absolute position of insidedness or outsidedness (Nast, 1994, p. 57).

marginalized by mainstream feminism believed that their experiences could only be known by their own kind. This ontological argument nearly paralysed feminism since many feminists felt and believed they no longer had the right to research on or with those outside their location. However, to ascribe to such an argument suggests an essentialist notion of what it means to be "black" or "white" for example. As Audrey Kobayashi suggests, a negotiation on the basis of skin colour involves a "slippery slope argument" (1994, p. 76) since identities are always fluid and never fixed. Instead, many feminists believe that the "politics of identification" are a means to overcome the divisive nature of difference.

Difference is a concept used to distinguish individuals from each other. It can be based on 'race', class, sexuality, and dis/ability, etc. Many feminists have researched how 'race' creates a range of experiences for women (Frankenburg, 1993; Peake, 1993; Edwards, 1990), and that "black" and "white" are not coherent categories. However, merely studying difference does not lead to political analysis. Feminists must extend their descriptive accounts of experience further since difference is hierarchically organized. The politics and the power reside "in the assigning of value to difference, which is then used to justify denigration and aggression, not in difference per se" (Maynard, 1994, p. 19). Sandra Harding (1992) notes that there is a tendency in feminism not to provide an analysis of the power relations which structure difference, and she attributes this to the speaker's perception that there is not enough information, time or space for the analysis; or it is not the main concern; or is not qualified because they do not

share the same experiences, and therefore do not possess the same consciousness.

Harding's last point is the ontological argument which has stricken fear in many white feminists who want to conduct research about and with women of colour. Linda Peake agrees with some black feminists that there are spaces which white feminists cannot occupy due to their distance from the pain inflicted by domination and oppression (1993, p. 419). Nonetheless, the suggestion by some black feminists that white feminist research only perpetuates racist thinking is unproductive and divisive. This leads to that "slippery slope" since the category "black" is diverse as not all blacks share the same experiences or politics. Furthermore, following this ontological argument to its logical conclusion, Harding suggests that it is absurd to think "that no one can ever learn anything from anyone else's experiences" (1992, p. 178); however, she does highlight the importance of marginalized people naming and describing their own experiences to create their own subjectivities and their own knowledge (1992, p. 186-7). In this way no researcher can ever claim to speak for or represent the subjectivities of the marginalized which is a critical issue for many black feminists and feminists of colour. The marginalized are given a voice, and therefore, are given the power to represent themselves. However, it should be noted that members of marginal groups are not legitimized by virtue of their skin colour, but by their history and roles within the group -- difference is not essentialized and partial commonality is found in the shared experiences of racism and sexism (Kobayashi, 1994, p. 76).

Brah advocates a "politics of identification" as a means to overcome the hierarchy of oppression created by identity politics. Coalitions can be constructed upon the recognition of other groups' politics and struggles, at a global or local scale, as well as our own (Brah as quoted in Maynard, 1994, p. 19). Peake terms this as the process of intersubjectivity and believes that this is the ground needed to unite political and epistemological tensions between the multiple subjects of feminism (Peake, 1993, p. 420). It is on this basis that white feminists can do research on or with black women or "Third World" women for example. Political commonality will ensure that the research is both meaningful for the researched and the researcher, and will help prevent researchers from taking on projects which are academically fashionable or exotic. Given this, it is essential that feminist researchers discover their own politics that are the basis of their research. For example, Kobayashi (1994) has married her academic work with political activism as demonstrated in her involvement with the Japanese redress movement.

For the researcher, this concern necessarily involves discovering what issues and struggles are important and why they are important. In the field, such identification will help narrow the "betweeness" among the researcher and the researched. However, this alone is not enough since the field represents a continual challenge to a researcher's political and theoretical underpinnings. Reflexivity helps the researcher to negotiate these challenges since it forces her/him to critically examine the subtext of what she has

identified as politically and theoretically important. By subtext I mean the situatedness and partiality of the researcher which informs her/his consciousness.

All knowledge is situated and partial since the researcher is not able to transcend the body which is located in space and time. This is contradictory to the claims of the Enlightenment and the Scientific Revolution which suggests that objectivity, rationality and rational knowledge are attainable when the researcher is removed from reality. (Here, the "betweeness" is at its greatest.) Hence, Donna Haraway (1991) terms this "the view from nowhere" which is really a view from somewhere: a masculinist, bourgeois, and heterosexist view.[14] This is a myth and it is evident in Geography's racist, sexist and imperialist past which continues into the present (although less pervasive and explicit). In other words, this is a view from the dominant position -- a view from the centre. Consequently, all knowledge is partial and situated since it cannot escape the producer's values, attitudes, politics, beliefs and experiences, which are all shaped by 'race', gender, class, etc., and this has implications for the research process and the researched.

Feminists rely on reflexivity to uncover their feelings, thoughts, convictions, beliefs and politics so that they are cognisant of what informs their viewpoint. Kim England defines reflexivity as "self-critical sympathetic introspection and self-conscious analytical scrutiny of self as researcher" (1994, p. 82). In the broader context, reflexivity is a continuous process since the researcher is never removed from the field; however,

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14

The evolution of masculinist thought in geography is mapped in Gillian Rose's Feminism and Geography: The Limits of Geographical Knowledge, London: Routledge, 1993.

within the context of the "field" defined for specific research purposes, reflexivity allows the researcher to chart her/his subjectivity in the research process and with the research participants. This helps to identify how one thinks and feels about what one sees, and how one's understandings affect the kinds of questions asked, the kind of research conducted, the audience chosen, and most importantly, how the research subjects are represented.

Researchers who are unaware of their positionality can create descriptive and political representations which are racist, sexist, heterosexist, and ethnocentric. The result is a representation of the "betweeness" which exists between the researcher and the researched (England, 1994, p. 85), and may not necessarily represent the social world as experienced by the researched, i.e., the "truth" is closer to the researcher's than the researched. This is exemplified in the criticisms launched by black and "Third World" feminists against white "First World" feminists with regard to unauthorized representations (Radcliffe, 1994, p. 29). It seems that the "betweeness" has been maintained among white "First World" women and "Third World" women through authorial descriptions which position "Third World" women as unprivileged and excluded: "According to many black critiques, "we" white women have constructed "Third World" women as static loci of eternal suffering, a privileged recipient of First World concern" (Radcliffe, 1994, p. 26). So it seems that many "First World" feminists cannot move beyond "Othering" "Third World" women and essentializing the material and social differences that exist between women living in the "First World" and the

"Third World". Such essentialising has done little to advance "Third World" women's political interests.

The practice of reflexivity helps to confront the politics of representation by forcing the researcher to confront her/his epistemological heritage which positions research participants in unequal power relations (Callaway, 1992, p. 33). The researcher's consciousness of this unequal relation should then question whose authorial and political representation is being voiced and heard. If power relations are more equal than unequal, Sarah Radcliffe suggests that through dialogue "First World" feminists could find commonalities with "Third World" women which are located in the discourses of racism, sexism and "world order" (1994, p. 28). In this way, "Third World" women are not positioned as unwitting victims but as women who know the power relations implicit in racism, sexism and so on. This dialogue provides the opportunity for "Third World" women to describe and name their own experiences which allows them to create their own subjectivities and knowledge. Consequently, women are given a voice and the power to represent themselves authorially and politically.

Researchers must also confront what their gender and 'race' may mean in the "field". What matters is not their physical attributes, but what they represent and mean to both the researcher and the researched. They may be stumbling blocks for the researcher in gaining access to domains of knowledge or they may provide a way in. For the white feminist researcher this means coming to terms with whiteness and determining what whiteness means to her/him, as well as what her/his whiteness might mean to the

participants. As for some of the implications of gender, the fact that the researcher is a woman is sometimes not enough to gain access to the research subject's social world; however, the commonality of having relationships with men and women or motherhood may help to breakdown the "betweeness".

The category "white" continues to be the unquestioned "norm" and the "neutral". It seems that white people do not think they possess a "white" identity which influences or dictates how they engage with the social world. In her research Ruth Frankenburg (1993) discovered three dimensions of whiteness: first, privileges which guarantee greater access to entitlements, such as education, employment opportunities, and housing; secondly, whiteness is a way of seeing oneself, others and society; and lastly, there are a set of cultural practices which define whiteness, but are often labelled as "American" or "normal". These dimensions are not apparent to the majority of white people since they seldom question the conditions of people of colour. "Whiteness" and white identity has been maintained through economic and educational privileges, racially segregated neighbourhoods, assertions of white superiority, fear of people of colour, and the notion that the cultures of people of colour were only great in the past (Frankenburg, 1993, p. 27). To move away from this centrality and this racist heritage, white feminists must confront in their own life what it means and has meant to be white. This may mean having to accept that whiteness may be viewed negatively among people of colour and

that people of colour may not want to work with white researchers regardless of their politics.[15]

Some feminist researchers have claimed that it is easy to develop rapport with their female interviewees because of the nonhierarchical woman-to-woman relationship (Oakley, 1981; Finch, 1984). According to Finch (1984), women talk easily with female researchers because they are accustomed to questions about their private lives, and interviewing in the subject's home is more likely to lead to woman-to-woman conversations (p. 76). However, neither Oakley or Finch reveal if their experiences are the same when interviewing women of colour. Rosalind Edwards (1990), a white British woman, encountered many problems in trying to find black women to participate in her study about mature mothers attending school. She discovered that by contacting the black women through the schools, they identified her as white, middle-class and racist (Edwards, 1990, p. 485). Consequently, very few black women agreed to be interviewed, and after interviewing two women, she realized that she was identified as a white woman and not just as a woman. Rapport and the woman-to-woman conversations did not come

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15

Both Pratt (1984) and Diane Jeater (1992) speak of the need to reconceptualise our "white" identities in a positive manner. Too often the identity "white" is seen as racist since racism has been politicized as a problem existing at level of individuals and not at the structural level (Jeater, 1992, p. 117). Consequently, the personalization of racism has meant that people have attached negative connotations to the "white" identity and not to the institutions which perpetuate it. The challenge is to define "whiteness" in a positive way, and Pratt does so by confronting the system which makes "whiteness" "bad". In a similar vein, Jeater suggests that we should confront "racial politics" through praxis, that is to assault the system which creates the dominant definition of "white" (1992, p. 116).

easily for Edwards. She was allowed limited entry into the women's lives only after acknowledging that she was located at a different structural position with regard to 'race' and that there were no shared assumptions on that basis (Edwards, 1990, p. 486). She found that there were shared understandings about home life and the guilt associated with going to school and raising a family; however, she noted that 'race' constrained the understanding of their experiences when it came to the public world (Edwards, 1990, p. 489). Edwards concludes that white researchers must take into account the meanings of 'race' for black women (1990, p. 477). This means that when designing research projects, researchers must think about how black women will interpret and react to the method of contact for finding interviewees, the interviewer's identity, the way questions will be asked and the types of questions to be asked.

This synopsis highlights the importance of a political grounding meaningful for both the researcher and respondents when undertaking feminist research. Once this is established, it becomes the researcher's responsibility to be aware of how her/his world view and identity impinges upon the research process and the participants. This aspect of the research process receives attention below.

Myself as the Researcher

To determine one's positionality requires a great deal of self-awareness and knowledge of your centre of being or grounding. This is a philosophical, spiritual and personal journey: positionality is not static -- it constantly evolves as the individual

grows. This is something I have come to know and understand only recently and I can honestly admit that I had no idea who I was prior to my enlightenment. I now know the centre of my existence and what informs my being and thinking, and this text. I find it somewhat unfortunate that I did not have this explicit understanding while I was in Guyana; however, in hindsight, my experiences in Guyana had opened the door to discovering myself. I thank the women from the Education Team for that.

What follows is a discussion of my world view and how it has informed my politics and the research process. I have enclosed this not so much for the benefit of the reader, but for myself as I believe that this is necessary to do since my passion for writing is stemming from within and will be what guides the production of this text.

My world view is grounded in my belief that I am a part of an indivisible whole which means I am not separate from anyone or anything living in this world. This is a spiritual understanding of life: a belief that we are all interconnected by a greater energy which some may call God, Tao or Self. I call it God or the Divine Spirit. I do not consider myself to be separate or different from anyone because we are all made in the likeness of the Divine Spirit. This has very important implications for how I interact with people because I see them as divine beings.

Identity in terms of gender, class, 'race', sexuality, etc., dors not have any meaning for me. Underneath the visible body is a soul whose essence is that of the Divine. When I see someone, I see my sister or my brother and my pattern of orientation is that of love: I do not judge them because it would mean my judgements are based upon

only knowing what I see and the judgements I have made of myself; and, I honour what people do or say because they do so based on their beliefs and feelings which are never right or wrong. However, it is my service to show a different way of knowing and being. With this understanding and careful self-observation, I try to see events and people without imposing my personal will, perceptions or criticisms.

I am very well aware that how I see others is not how others may see me. In my everyday spaces at home, I am aware of my gender and this is especially true when dealing with men in authority positions. In these cases, I try to uncover how I am positioned so that I may deal with the event appropriately. For example, I have noticed on many occasions that men in authorial roles will treat me like a daughter who does not know better or a second-class citizen who does not deserve respect and appropriate attention. When the relation becomes paternalistic, I try to find ways to distance myself from the individual and assert my independence. However, I find dealing with men who treat me as a second-class citizen to be the most difficult because I have to criticize their assumptions which often means defensive posturing by the men.

I am aware of my whiteness because my environment is "white". As I examine the spaces I occupy I realize that there is an absence of people of colour. The absence is not a result of conscious choosing on my part, but due to the more privileged spaces I occupy. York University is a multi-racial environment, but my interaction with people of colour is non-existent because I spend my time in the Geography Department which is basically white. I live in a white neighbourhood and I shop at a grocery store which is

patronized by white people. When shopping at the two largest malls in my city, Kitchener-Waterloo, I can count the number of people of colour on one hand. Issues of 'race' and racism do not appear in my local newspaper. Where I live and work is exclusionary towards people of colour.

My white and female identity took on a whole new meaning in Guyana. I received a great deal of attention from Guyanese men because of my skin colour. It was explained to me that a woman is more desirable the lighter her skin is. This holds true for white, Indo- and Afro-Guyanese women. I was quite astonished by the attention despite looking so plain in terms of dress and make-up. This made me aware of my whiteness and the attention it attracted from men while travelling in Guyana. This did not make me feel uncomfortable, but it did take time to adjust to because I was accustomed to being anonymous. I had taken for granted the ease of walking down city streets without being noticed or the fear of being noticed. This is a part of my privileged white identity at home.

The women members of the Education Team focused on my identity as a university student. It should be noted that the members were not given the choice to work with me or to do the project. Speaking for myself, I think that some of the members feel taken advantaged of by students because they feel they become the means to obtain the degree. Consequently, I had to prove myself to the Education Team that I was not "just another student coming down [from the "North"] to get her degree." I think I quickly overcame this barrier with the women because I was so keenly interested in their work

and I wanted to learn from them: it was my first opportunity to experience how feminism can operate in the everyday world. The women gave me the opportunity and privilege to stay in their own homes, travel with them to conduct workshops, sit in on the workshops and speak. I often felt that I had nothing to give back to the members, but I hope I did so through friendship based on equality and respect. I came to realize that it was quality and not quantity that mattered since I could never match the knowledge and the experiences the women gave me as well as the time and effort they gave to this research. My attitude is what mattered: I went to Red Thread everyday to learn, listen and understand, and in no way did I consciously pass judgement or infringe on their "feminism" which I think was very important to the women.

My presence in the in-depth interviews received mixed receptions regardless of location or 'race'. I was welcomed in an interview if the Education Team member was a friend or an acquaintance of the respondent. Under these circumstances, I was treated with great attention because I was a white student from *Canada* and I was in *their* house, and the interviews became more like a visit with friends. In fact, I felt awkward having them respond to the interview because it was a matter of "business" and no longer seemed appropriate at the time. This did not seem to matter to these respondents since some of the better interviews came from them. I think it became a situation of a friend helping out friends. On the other hand, I was greeted with coolness or suspicion when a respondent did not know the member. In these interviews, I think my presence was negative because they could not understand why it was necessary for me to be present during the interview

despite knowing that I was a student from Canada who was helping Red Thread. The respondents seemed to be quite nervous and would shift eye contact between myself and the member who was doing the interview. The uneasiness was further heightened when I had to ask for an answer to be clarified, a question rephrased or to ask a missed question. It would have been preferable for us to spend time with an unknown respondent to break down some of the barriers so that the interview could be a conversation instead of a series of questions. Unfortunately, time did not permit this.

The logical outcome of my spiritual world view is a personal politics based upon the understanding that everyone's suffering is my own. I am responsible for the well being of others, and consequently, identity politics has no room in the way I view the world. I am not dismissing the existence of a hierarchy of oppression, but I am stating that no single "group" or category of people can eliminate oppression based on difference when it advocates difference. In other words, identity politics perpetuates the systems of oppression. The goal for all people, regardless of identity, should be to forego self-interest and work towards eliminating oppression for all.

I firmly believe that it is necessary for individuals such as myself, who have more centralities than marginalities, to use their louder voices, on behalf of the silenced and weaker ones, to get the messages out and demand change. I am not suggesting that privileged women and men should appropriate the voices of the un- and under-privileged people: what I am advocating is a partnership where the marginalized choose to allow others to speak for them. This means that those who have the power to speak must honour

the power of the marginalized to choose. This can only be done out of mutual trust. Over time, the silenced and the weaker voices will gain strength and be able to speak for themselves which is important because there are some spaces that privileged people cannot occupy due to their distance from the pain inflicted by domination and oppression (Peake, 1993, p. 419).

Given this, I have no difficulty in researchers working with and doing research about people who do not share the same subjectivity. I do have a problem when work is undertaken without a partnership between the researcher and the researched, and the only type of partnership possible is political under the conditions of intersubjectivity. Both parties must have non-conflicting political goals otherwise the research becomes meaningless to the researcher and/or the researched may feel objectified or victimized at the extreme. In my situation, I have a direct partnership with the Education Team of Red Thread which has a direct partnership with Guyanese women. Together we have the political goal of educating Guyanese women about reproductive health issues so that they have the power to choose what happens to their bodies with the ultimate goal to influence how reproductive health issues are approached by the medical establishment and government. So why is this politically important to me?

The question for me undertaking this research project was not one of can I or should I do it, but why do it. My interest in "Third World" women's reproductive health issues grew from my undergraduate development courses which focused on women in the "Third World". It was from these courses I learned of the barbarism inflicted on many

"Third World" women in the name of population control. I was outraged and my passion was channelled into my Bachelor of Arts' thesis entitled "Breeders" and Coercion: Capitalism, Population Control, and Women of the "Third World". It was a rather ingenuous Marxist account of how population control maintains and benefits capitalism and how the health, social and economic costs of maintaining and perpetuating the system are borne by "Third World" women (Topelko, 1996a).

While writing my undergraduate thesis, the connections between some of my reproductive health experiences and those of women living in the "Third World" became evident. However, what differed was the quality of the experiences. I was certainly never subjected to barbaric practices, but in many cases I was treated as an object. In other words, there is the same set of power relations underlying my experiences and those I read of "Third World" women, but the quality or degree of the affect was far greater on their lives than on mine. It was more important to me to address how women in the "Third World" were treated by the medical/corporate establishment because their lives and well being are endangered to a far greater degree than many women living in the "First World". It was my hope that my undergraduate thesis would provoke discussion since it is far easier to tackle obvious and blatant systems of oppression than those that are more insidious in the "First World".

It was my intention to continue the same theme for my Master's thesis. Through Dr. Peake I was able to review a reproductive health survey completed by Red Thread in 1994. After examining the design of the questionnaire-surveys I determined that there

were some glaring omissions in the data. For example, the women were not asked about abortion, current contraceptive use, how long they breast feed, and what kinds of reproductive health information they receive. More importantly, Guyanese women's reproductive health experiences went unaccounted. I identified four problems with the 1994 reproductive health questionnaire-survey:

> 1) The questions were designed by a Canadian postgraduate student, training as a medical doctor, working with Red Thread. Given her academic background, the questions asked were medical and based on Western conceptions of reproductive health. There was no consideration to the fact that Guyanese women may experience and therefore define reproductive health differently.
>
> 2) The women were treated as objects (as opposed to subjects) because the only concern was to produce an inventory of their clinical knowledge.
>
> 3) There were some omissions in the data since the women were not asked about, among others, employment history, diet and abortion.
>
> 4) Nowhere in the interview process were the women given the freedom to discuss their experiences of reproductive health and the meanings and importance they attach to these.

As a result of these problems, the survey did little to elucidate the actual reproductive health of Guyanese women in terms of the meanings and values they attach to their experiences and the extent to which these very among women at different stages of the life-cycle. This presented me with a research opportunity to extend the survey by conducting in-depth interviews to uncover the social relations which structure Guyanese women's reproductive health experiences. Consequently, my Master's thesis allows me to continue what I started with my undergraduate thesis, but in a more concrete and real

way. The information which comes out of this project can be used to develop those linkages between the reproductive health experiences of women living in the "First World" and the "Third World".

My medical knowledge, as it relates to reproductive health, is rooted in Western, "scientific" medicine and in experience. I have also read literature pertaining to development and "Third World" women's reproductive health. Almost all of this literature is written by women, who have no formal medical training, reporting on the affects of population control policies on women living in "Third World" countries (Hartmann, 1992). I have also read some anthropological literature on Caribbean women's reproductive health (Sobo, 1997). My reading and own reproductive health experiences form the basis of my medical knowledge of reproductive anatomy, pathology, terminology, practices and procedures. My attitude towards Western medicine is positive because I believe it can and does help some women who experience reproductive health problems. However, I take issue with medical practices which render women as objects to be manipulated and show no concern for their general health and well-being.

The Research Process: Asking, Interpreting, and Writing

This section examines the set of power relations which are implicit in the undertaking of this research project. The questions asked during the interview, the way in which the answers were analysed and then written up has to come from somewhere. The discussion begins with an overview of the survey including its conceptual problems, and

then a look at how the interviews were designed, conducted, and transcribed, followed by an examination of how the data was interpreted and written up.

In the late summer of 1994, the survey was conducted in three locations in Guyana.[16] One location was Meten Meer Zorg East, a small, coastal, rural settlement on the West Coast, Demerara. Meten Meer Zorg East is dependent upon the sugar industry and is populated by Indo-Guyanese. The second location was Linden which is an interior bauxite mining town populated by Afro-Guyanese. The other location is West Coast Berbice where villages have an ethnically mixed population. A total of 425 women were interviewed and are divided according to three life-cycle groups: 157 Child bearing women (women who had given birth), 132 Menopausal women (those who were in menopause or experiencing the symptoms of menopause), and 136 Non-child bearing women (women who had not yet given birth).

As mentioned, the objective of the survey was to determine the level of knowledge the women had about reproductive health. The questionnaire contained a general section which asked all women about their age, religion, ethnicity, education, employment, knowledge of contraceptives and their use, knowledge of STDs and other risks to the reproductive system, and a second section which asked specific questions according to the reproductive status of the women. For example, Guyanese women who had never given birth were asked questions about their sexual activity and menstruation,

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16

Chapter 2 provides an in-depth discussion of the three locations where the interviews were conducted.

and Menopausal Guyanese women answered questions relating to symptoms of menopause and their knowledge of the increased risk of cervical and breast cancers.

The survey had not been analysed prior to this project. Consequently, I spent much time analysing the data, using SPSS PC. The analysis revealed several conceptual problems which are a result of a poorly designed questionnaire. Some of the problems of incomplete data come from the failure to follow-up questions or to address an issue at all. For example, in the general section of the survey, answered by all women, there was no follow-up question asking why a woman does not use contraceptives if sexually active. Nowhere in the survey are women asked about abortion, diet and reproductive health or their employment. There was also a methodological problem with the category "mixed" under the heading 'race'. The design of the question did not allow respondents to indicate what "mix" they were. This is very important since some women may identify themselves as being, for example, Afro-Guyanese instead of dougla. It was decided to equally divide the "mixed" category, containing 64 respondents, between the categories "Afro-Guyanese" and "Indo-Guyanese". The placement of a respondent was dependent upon her location: women living in Linden were delegated to "Afro-Guyanese", and those living in Meten Meer Zorg East and West Coast Berbice were designated "Indo-Guyanese".[17]

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The division of the respondents who were of mixed 'race' according to place was based on Dr. Peake's knowledge of identity and place as it relates to Linden, Meten Meer Zorg East, and West Coast Berbice.

The greatest problem was inconsistencies in the delivery of the survey. Inconsistencies are apparent within individual surveys and the life-cycle groups as a whole. This is indicated by the level of response for some questions which were either very high or very low suggesting that the questions were not asked in a consistent manner. For example, the interviewer was instructed to tick if the respondent knew an item contained in a list; however, it appears that some interviewers read the list and checked off the items known (high response) whereas others left the respondent to list items that she knew and ticked off those named on this list (low response). Furthermore, some interviewers failed to follow the directions of the survey by failing to ask a follow up question or by asking a question which did not apply. Both instances skew frequencies. Questions affected by these conditions were not included in the analysis. The quantitative analysis is restricted to frequency counts given the unreliable nature of some data which renders cross-tabulations and more sophisticated statistical analyses questionable or meaningless. Nevertheless, the data does provide generalizations which are perhaps more meaningful at the nominal rather than the interval level.

Since this research project is to build upon the survey, the in-depth structured interviews were conducted in the same three locations. Members of the Education Team of Red Thread did the interviewing in the three locations and were responsible for locating women who responded to the survey in 1994 for the interviews. In total 18 women were interviewed: six women in each place of which two women represented each stage of the life-cycle. Generally, there was no difficulty in locating women who

were considered Child bearing or Menopausal; however, there was greater difficulty in finding women who had not given birth after three years. An effort was made to make the samples representative of the ethnic compositions of the locations which meant that the six women interviewed in Linden were Afro-Guyanese, the women interviewed in Meten Meer Zorg East were all Indo-Guyanese, and three Indo- and three Afro-Guyanese were interviewed in West Coast Berbice. The following is a summary of the characteristics of the women grouped according to stage in the life-cycle:

Non-child bearing women:

- Four of the women are Afro-Guyanese and their churches are Seventh Day Adventist, Pentecostal, Wesleyan and Fruits of the Valley. The two Indo-Guyanese women interviewed are Hindu and Muslim.
- The ages ranged from 14 to 20 with the majority in their late teens.
- All are single except for one Indo-Guyanese woman who is legally married.
- One woman is still in primary school while the others have completed it. Three women, two who are Afro-Guyanese, went onto to secondary school, but only two wrote their CXCs.
- Two Afro-Guyanese and one Indo-Guyanese women earn money, but only one, who is Afro-Guyanese, contributes directly towards her household.

Child bearing women:

- Four of the women are Indo-Guyanese and two are Afro-Guyanese. The religions of the Indo-Guyanese women are Lutheran, Pentecostal, Muslim and Hindu, and Jehovah Witness and Seventh Day Adventist for the Afro-Guyanese.
- Most women are in the late twenties and early thirties with the youngest being 23 and the oldest 42.
- All of the women had men in their lives: three Indo-Guyanese women were married while the others were in visiting unions. The average number of children for both Indo- and Afro-Guyanese is three.
- All of the women had primary education, but only one women, an Afro-Guyanese, went on to complete secondary school although she did not write her exams.
- Two of the women, one Indo- and one Afro-Guyanese, earn money to help support their households.

Menopausal women:

- Four of the women are Indo-Guyanese, and of these three are Hindu and one is Christian. The two Afro-Guyanese women are Catholic and Seventh Day Adventist.
- Their ages are 49, 49, 51, 53, 67, and 70.
- All of the Indo-Guyanese and one of the Afro-Guyanese women interviewed are married and the other never married but had children. Only one women, who is Indo-Guyanese, had no children.
- All of the women completed primary school, but none went on to secondary school due to marriage or being held back to help in their parents' household.
- Only one woman, an Indo-Guyanese, earned an income.

The interviews took place in the respondent's home when no other adult family members were present and I was present for all interviews. Generally, the interviews lasted from 45 to 75 minutes depending upon the interview administered: Child bearing interviews on average took longer than the other two interviews.

The questions for the three interviews were designed by the Education Team and myself (Appendix B). The overall structure of the interviews was guided by the results of the survey which my research project was designed to augment them. From this survey, I determined the issues which appeared to be of importance to the lives of Guyanese women. For example, over 50 per cent of menstruating women complained of painful periods. After reviewing the data from the survey, the following issues were identified for each of the three groups:

Women who have not had children:

- sexual activity including pregnancy which did not result in a birth
- contraceptive use
- STDs
- reproductive health problems
- painful periods

Child bearing Women:

- contraceptive use
- STDs
- reproductive health problems
- painful periods
- child bearing including abortion
- delivery
- breast feeding
- child care

Menopausal Women:

- contraceptive use
- STDs
- reproductive health problems
- menopause

Having identified the main issues for the three groups, I worked with the Education Team to develop the questions. This involved conducting workshops and helping to keep the designing on track; however, the women were responsible for developing the questions since they possessed intimate local knowledge. They knew what questions needed to be asked, what issues should not be avoided, and how to phrase the questions. For consistency, the terminology used in the survey was also adopted for the in-depth interviews. The Education Team then tested the interviews to see if there were any unclear questions and if any questions were not included but needed to be asked.

The end result was the creation of an interview for each of the three life-cycle groups. Women who have not given birth were asked to relate their experiences to issues of sexual activity including pregnancy not ending in childbirth and painful periods. Those women who gave birth were asked to answer questions relating to painful periods,

child bearing including miscarriage and abortion, delivery, breast feeding and child care. Menopausal women were asked to reveal their experiences relating to the symptoms of menopause, changes in activities, and their relationships. All three groups were asked personal information regarding marital status and union status, employment, education, and household status, and all women were asked about their experiences relating to contraceptive use, reproductive health problems as defined by the respondents, and STDs. Furthermore, all were asked a general set of questions which aimed to uncover their attitudes and values towards abortion, sex education, their bodies and sex, and parenting.

The interviews were conducted by members of the Education Team and I was present during the interview. My presence during the interviews was strictly to ensure consistency and to clarify answers or questions, and to aid me with the transcribing process. Implicitly there was a hierarchy present in the sense that I had to ask the interviewer to clarify or ask a question which then rigidified the situation of me at the top followed by the interviewer and the respondent. The women used supplication as the interview method (England, 1994) and this worked well and helped the respondent to open up knowing that she would not be judged but understood. In some instances I spoke of my own experiences when they seemed pertinent and this was met with receptiveness on the part of the respondent because now she was talking to two people who understood her perspective.

The interviews were analysed using content analysis. After transcribing the interviews and working with the interviews to produce the reproductive health booklet, I

became very familiar with their contents. Consequently, it was easy for me to uncover the stories contained in each women's interview and to survey the collection of stories to develop the themes. The difficulty in interpreting the data has to do with contextualizing. This is especially problematic for this research project because of the lack of literature on reproductive health in Guyana, and on the lives of Indo- and Afro-Guyanese women. It is very important to contextualize the analysis as close as possible to the lived realities of Afro- and Indo-Guyanese in order to mitigate judgments I may make in interpreting what I see. The data was analysed according to life-cycle group and 'race'. However, I did not analyse the data in terms of place because the analysis revealed no place specific factors: the content of the women's experiences was similar in all three places.

Given the lack of literature and my experience, I relied on the Education Team and Dr. Peake to root out interpretations which approximate my understanding instead of that of Guyanese women. This is where writing the issue of representation becomes crucial. The question becomes one of how will I differentiate my world view of their reproductive health experiences from that of Guyanese women, and how will I represent their world view. The answer is not any easy one, but my way of dealing with this issue is to lay claim to my interpretation using first person pronouns, and represent Guyanese women's interpretations using testimonials and making sure that their views are explicitly represented in the text.

It should be noted that both I and the Education Team members transcribed the interviews. I transcribed when I could easily understand what was being said and so I left

the more "difficult" interviews to the women to transcribe. Regardless of who transcribed, the interviews were translated from Creole to standard English so that I would be able to understand what the respondents were saying and their implied meanings. In hindsight, I wish we had taken the time to transcribe in Creole and English so that both could be represented in the text and be more accessible to Guyanese women and not just to standard English-speaking women.

Summary

When employing feminist methodology it is important that the researcher is aware of her positionality and how this infringes upon all aspects of the research design process. The goal of this awareness is to produce a finished research project which is representative of the subject's world view and experiences. However, if the researcher fails to practice reflexive research, the product is more representative of the researcher's point of view because the interpretations will be imbued with her values. What is important for the feminist researcher to understand is that she must be aware and "fixing" is not the issue.

In the case of my research project, I have more power than the respondents and the Education Team as I am the writer; however, just being aware of this imbalance of power will hopefully help me to present a more balanced finished product. The finished product should strive to be a reflection of the subject's "truth". But, the "betweeness" that exists between the researcher and the researched must be small for this to occur. That is the

social distance between the researcher and her subject must be of a lesser degree because mutual trust and understanding would have to be developed for the researcher to be able to represent their "truth". The ability for me to represent the "truth" here is hampered by the fact that I was only able to spend a short time in Guyana. Although I was very privileged because I was allowed to occupy many personal spaces, my insights into Guyanese women's lives is limited. Consequently, I must rely on the Education Team and Dr. Peake to help in representing the "truth" of Guyanese women's reproductive health experiences.

CHAPTER 4

1994 REPRODUCTIVE HEALTH SURVEY

Introduction

The information about Guyanese women's reproductive health contained in this chapter was collected by the Red Thread Education Team in 1994. Presented here is the analysis for the life cycle stage from the survey. The analysis reveals the extent of Guyanese women's knowledge of reproductive health issues and examines some behaviours as they relate to contraception, STDs, breast feeding, and their ways of coping with health risks or problems. Please note that the terminology used here is that of the survey's author, who was a Canadian postgraduate student training as a medical doctor.

Non-child bearing Women

The number of women, who were menstruating and without children, surveyed was 135 which represents one third of the sample. Their ages ranged from 13 to 21 and all but two women were between the ages of 13 and 19. Fifty-five per cent were Indo-Guyanese and 44 per cent were Afro-Guyanese. The dominant religions for this group were "traditional" Christian (39%), Hindu (26%), and Evangelical (15%).[18] Only 44 per

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[18]One per cent failed to respond when asked their religion.

cent of the women were in school,[19] and 13 per cent of them completed primary and 24 per cent completed secondary school.[20] No one attended school beyond the age of 18.[21] Of those women who did not go to school (72), 59 women were homemakers, 10 worked outside the home and 3 were self employed. It should be noted that those who stay at home probably engaged in some income earning activities, such as making and selling sweets, however, the questionnaire does not address the possibility that the home may be a site of production.

Twenty-seven per cent of the women have engaged in sex and 59 per cent know what contraceptives are.[22] Most of the women knew at least one contraceptive method (78%), and 43 per cent knew at least three methods, however, 22 per cent did not know any methods. Only 7 per cent of the women use contraceptives and 6 per cent have used contraceptives in the past.[23] Some past contraceptive users (8 women) stopped because of pregnancy (1 woman) or forgot to use them (2 women). The main sources of information on contraceptives come from friends (41%), school (30%) , television (21%),

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[19]Three per cent of the women did not reply if they were in school.

[20]Fifty per cent of the respondents did not answer the question relating to what school level they completed.

[21]Forty-seven per cent did not reply when asked what age they left school.

[22]One per cent did not respond to the questions relating to sexual activity and knowing what contraceptives are.

[23]When asked if they use contraceptives, 8 per cent did not respond, and 15 per cent did not reply when asked if they have ever used contraceptives.

books (15%), radio (12%), nurses (9%), parents (24%), siblings (14%), husbands or boyfriends (7%), healthcare workers (4%), and doctors (4%). The most familiar contraceptives methods are condoms (73%), the pill (56%), diaphragm (12%), injectable (36%), IUD (23%), foam (16%), gel (11%), and implants (4%). The women obtain their contraceptives from clinics (57%), hospitals (41%), pharmacies (20%) and friends (7%).[24]

Seventy-seven per cent knew that they could contract diseases by engaging in sexual intercourse.[25] The contraction of STDs was identified as having sex with an infected partner (22%), having unprotected sex (34%), having sex with many partners (2%) and the result of promiscuous behaviour (2%).[26] The STDs that the women knew of were gonorrhea (36%) and syphilis (30%), and a few knew of chlamydia (2%). HIV and AIDS were familiar to almost all of the women: almost all (98%) knew of AIDS and 81 per cent knew about HIV.[27] Many of the women came to know about STDs from their friends (55%), parents (31%), school (31%), television (46%), books (19%), radio (19%), parent (31%), siblings (13%), nurse (9%), healthcare worker (10%), husband/boyfriend

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[24]One per cent failed to reply to the question relating to where they obtain contraceptives.

[25]Two per cent of the women did not answer the question asking if they knew they can get sick from having sex.

[26]Thirty-seven per cent of the women failed to respond to the question relating to the ways of contracting STDS.

[27]Two per cent of the women did not respond to the question relating to their familiarity with HIV while only 1 per cent of the women failed to answer the same question for AIDS.

(7%), doctor (5%).[28] Eighty per cent of the respondents knew that condoms can protect them from STDs,[29] and few knew that STDs can be detected with blood tests (15%) and by pap smears (8%).[30]

When asked who can get AIDS the most common response was anybody (50%).[31] Many thought that people contracted AIDS because they were promiscuous (28%), engaging in unprotected sex (15%), having sexual intercourse with an infected partner (10%), dishonest or immoral (3%).[32] Most of the women thought that the primary means of contracting AIDS was through sexual intercourse (90%),[33] followed by blood (56%),[34] and drug use (41%).[35] Ninety-five per cent knew at least one way to contract AIDS and 67 per cent knew at least two ways. Only 4 per cent did not know of the ways AIDS can

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[28] One per cent did not respond when asked from where or whom did they receive information on STDs.

[29] Ninety-three per cent of the women responded to the question relating to the use of condoms.

[30] Seventy-three per cent of the women failed to answer the question as to how STDs can be tested.

[31] Thirty-six per cent did not respond as to who can get AIDS.

[32] Twenty-seven per cent of the respondents failed to answer why people contract AIDS.

[33] Ten per cent did not respond to the question relating to the contraction of AIDS through sexual intercourse.

[34] Forty-four per cent of the women responded when asked if AIDS can be contracted through blood.

[35] Only forty-one per cent responded to the question which asked if people can contract AIDS through drug use.

be contracted.[36] Familiar AIDS symptoms were weight-loss (59%),[37] sores (38%),[38] and diarrhea (25%).[39] The less familiar AIDS symptoms were sweats (4%),[40] influenza (11%),[41] and boils (1%).[42] Thirty-four per cent of the women knew that a person could be HIV positive and not have AIDS.[43] Ninety-five per cent of the women knew that AIDS could be tested;[44] however, fewer women knew that AIDS can be detected using a blood test (62%).[45] A very small proportion of the women have been tested (3%), but 41% would get tested if necessary.[46]

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[36]Only one per cent did not respond when asked how many ways AIDS can be contracted.

[37]Forty per cent did not respond to the question regarding if they knew weight loss was a sign of AIDS.

[38]Sixty-one per cent did not respond to the question if they knew sores were an AIDS symptom.

[39]Only 26 per cent of the women responded to the question if diarrhea was an AIDS symptom.

[40]Only 5 per cent answered when asked if the sweats was a symptom of AIDS.

[41]Eighty-eight per cent did not respond to this question.

[42]The response to the question as to if boils were a symptom of AIDS was very low. Only 2 per cent responded.

[43]Seven per cent of the women did not respond.

[44]Four per cent did not respond to the question whether AIDS can be tested.

[45]Thirty-five per cent did not answer the question if they knew AIDS could be detected using a blood sample.

[46]Eight per cent of the women did not respond to the question asking if they have been tested for AIDS, and 5 per cent did not respond to the question whether they would get tested if necessary.

The women were also questioned with regard to irregular bleeding which is defined as occurring during sexual intercourse, at times other than the regular period, and beyond menopause. Very few women experienced bleeding during intercourse (2%),[47] and outside their regular periods (2%).[48]

The women also answered questions about why they have their periods and the nature of their periods. When asked if they knew why they menstruated, 55 per cent of the women knew,[49] but only one third of the women responded as to the reasons why they menstruate. Their most common responses were age (58%) followed by anatomical/biological reasons (24%). The women received information about menstruation from their parents (61%), school (41%), friends (38%) and sister (14%).[50] Less popular sources of information were healthcare workers (6%), nurses (5%), television (6%), doctors (4%), husbands or boyfriends (2%), books (2%), radio (2%) and brothers (0%). Most reported that they had their period every month (87%),[51] and this was perceived as normal since 87 per cent of the 70 per cent of the women who

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[47]Forty-three per cent did not answer when asked if they experience bleeding during intercourse.

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Eighteen per cent did not answer the question relating to bleeding at other times then their regular period.

[49]One per cent did not respond.

[50]Only one per cent of the women did not respond to the questions which asked who they received their information from.

[51]Ninety-five per cent answered the question.

responded thought periods should come on a monthly basis. The majority (84%) had periods lasting three to six days while only 6 per cent experienced periods for seven days or more.[52] Of the women who responded (64%), over three quarters thought periods should last anywhere from three to six days while less than one fifth thought seven days or more. Heavy bleeding was a common experience for the women: 30 per cent or 41 women knew heavy bleeding was a sign of sickness for diseases such as endometriosis or fibroids.[53] Only 35 of the 44 women responded to the question as to what kind of sickness. Most of them cited heavy bleeding as a sign of anaemia (14%), fibroids (11%) and haemorrhage (6%). Fewer women experienced light bleeding (19%),[54] and the majority of the women (79%) did not know that light bleeding could also be a sign of illness, such as anaemia. Twelve per cent did know that light bleeding was significant, however, none of the women could specifically name a cause for it.[55] However, most knew that the absence of a period was an indicator of pregnancy (84%).[56] Of the teenage women menstruating (97%), 61 per cent reported painful periods while 46 per cent did

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[52]Ten per cent did not reply.

[53]Ninety per cent answered.

[54]The proportion of women which responded is 85 per cent.

[55]Sixty-five per cent of the twelve per cent responded to the question which asked what kind of illness.

[56]Ninety-four per cent of the women responded to this question.

not experience any pain during menstruation.[57] Of the women who experience menstrual pain, 44 per cent found relief through prescribed and over-the-counter medication and exercise (4%), although 34 per cent did nothing at all to relieve it. The majority of the women reported that their pain lasted more than one day (93%). Of those who suffered, only 5 per cent of the women had pain which lasted one day and 19 per cent experienced menstrual pain for 3 to 7 days. Although there was a low response (64%), 26 per cent thought that periods should be painful for more than 2 days and 43 per cent believed the pain should last less than two days. When asked why their periods were painful few women responded (22%).[58] Those who did respond suggested some causes were the uterus (11%) and small cervix (22%), while 1 per cent thought it was natural to hurt.

Child-bearing Women

Women who had children and were not experiencing the symptoms of menopause were given the Child bearing questionnaire. The number of child-bearing women interviewed is 145 which represents one third of the sample. Their ages ranged from 16 to 44 with most being between the ages of 17 and 32. The sample was almost equally split in terms of 'race': 48 per cent were Indo-Guyanese and 50 per cent were Afro-Guyanese.

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[57]Three per cent did not answer.

[58]Nineteen women of the 83 who suffer painful periods answered this question.

The dominant religions among this group are Christian (50%) and Hindu (24%).[59] Only one per cent of the women were in school,[60] and 14 and 5 per cent of them had completed primary and secondary school respectively,[61] with the majority (82%) leaving school between the ages of 14 and 18. While three quarters of the women were homemakers only 11 per cent worked outside the home and only 2 per cent had their own businesses.[62] Again, it should be noted that those who stay at home probably engage in some income earning activities.

Only 32 per cent use contraceptives and another 18 per cent have used contraceptives in the past despite the fact that almost all (98%) of the respondents have engaged in sex.[63] The problem appears not to be one of knowledge since 90 per cent knew what contraceptives were. Only one per cent of the sample did not know any methods of birth control; however, 77 per cent knew at least three methods. The main sources of information on contraceptives comes from friends (38%), nurses (56%), television (15%), books (17%), radio (10%), school (10%), husbands or boyfriends (19%), parents (10%), and siblings (8%). Only 14 and 8 per cent received contraceptive

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[59]One per cent did not respond when asked what their religion is.

[60]Twelve per cent of the women did not respond.

[61]Only 22 per cent of the respondents answered the question.

[62]The remaining 10 per cent of the respondents failed to answer the question relating to whether they were employed or homemakers.

[63]Two per cent did not respond to this question.

information from doctors or healthcare workers respectively.[64] The most common types of contraceptives known are condoms (90%), the pill (90%), IUD (40%), foam (45%), gel (26%), implant (12%), diaphragm (14%) and injectable (68%).[65] Most of the women obtained their contraceptives from clinics (88%), hospitals (53%), pharmacies (28%) and friends (4%).[66]

Many of the women knew that they could contract diseases from engaging in sexual intercourse (94%).[67] Thirty-two and 39 per cent identified that having sex with an infected partner and having unprotected sex, respectively, are ways of contracting STDs.[68] When asked if they were familiar with some of the names of STDs, 57 per cent knew of syphilis, 60 per cent knew of gonorrhea, and only 7 per cent knew of chlamydia.[69] Almost three quarters (73%) of the women knew about HIV and almost all (98%) of the

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[64]One per cent did not reply when asked where they heard about contraceptives from.

[65]Four per cent did not respond when asked if they were familiar with certain contraceptive methods.

[66]One per cent did not reply to the question asking where they get their birth control from.

[67]One per cent of the women did not answer the question.

[68]Sixteen per cent of the women failed to respond to the question relating to the ways of contracting STDS.

[69]Ninety-two per cent of the women responded to the questions asking if they were familiar with the names of syphilis, gonorrhea and chlamydia.

women knew of AIDS.[70] Many of the respondents came to know about STDs from their friends (51%), television (45%), radio (37%), books (27%), doctor (19%), nurse (28%), husband/boyfriend (19%), parent (12%), school (8%). Very few women received information from their sister (8%) or brother (3%), and healthcare workers (9%). While 90 per cent of the respondents knew that condoms can protect them from STDs, the extent of their usage is unknown.[71] Many of the women knew that STDs can be detected with blood tests (21%), by pap smears (12%), and by urine (1%).[72]

When asked who can get AIDS the most common response was anybody (71%).[73] In addition, many thought that people contracted AIDS because they were promiscuous (24%), engaging in unprotected sex (15%), having sexual intercourse with an infected partner (8%), dishonest or immoral (5%).[74] When asked how people contracted AIDS, 92

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[70]Four per cent of the women did not respond to the question relating to their familiarity with HIV while only two per cent of the women failed to answer the same question for AIDS.

[71]Ninety-six per cent of the women responded to the question relating to the use of condoms.

[72]Twenty per cent of the women failed to answer the question as to how STDs can be tested.

[73]Twenty-three per cent did not respond as to who can get AIDS.

[74]Twenty-three per cent of the respondents failed to answer why people contract AIDS.

per cent cited sexual intercourse,[75] followed by blood (56%),[76] and drug use (44%),[77] and 74% knew at least two ways of contracting AIDS. Familiar AIDS symptoms were weight loss (64%),[78] sores (50%),[79] and diarrhea (36%).[80] The less familiar AIDS symptoms were influenza (16%),[81] and boils (1%).[82] Only 39% knew that a person could be HIV positive and not have AIDS.[83] Ninety-six per cent of the women knew that AIDS could be tested;[84] however, fewer women knew that AIDS can be detected using a blood test

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[75]Eight per cent did not respond to the question relating to the contraction of AIDS through sexual intercourse.

[76]Twenty-two per cent did not answer the question when asked if AIDS can be contracted by blood.

[77]Sixty per cent responded to the question which asked if people can contract AIDS through drug use.

[78]Thirty-four per cent did not respond to the question regarding if they knew weight loss was a sign of AIDS.

[79]Forty-nine per cent did not respond to the question if they knew sores were an AIDS symptom.

[80]Only 38 per cent of the women responded to the question if diarrhea was an AIDS symptom.

[81]Seventy-nine per cent did not respond to this question.

[82]The response to the question as to if boils were a symptom of AIDS was very low. Only 4 per cent responded.

[83]Eight per cent of the women did not respond.

[84]Four per cent did not respond to the question whether AIDS can be tested.

(74%).[85] A very small proportion of the women have been tested (6%), but 54% would get tested if necessary.[86]

The women were also questioned with regard to irregular bleeding which may be a sign of cervical cancer. Irregular bleeding is defined as occurring during sexual intercourse, at times other than the regular period, and beyond menopause. Most of the women did not experience bleeding during intercourse (89%),[87] and outside their regular periods (87%).[88]

The women answered questions about pre-natal care, childbirth and post-natal care. Seventy-eight per cent of the women had their first child between the ages of 16 and 21 with some women becoming mothers as early as fourteen and fifteen (8%) and late as 28 (2%). Over half of the women had unplanned pregnancies while 43 per cent had expected ones.[89] Some thought they would have their next child within 2 years (16%), 3 years (9%), and beyond 3 years (26%).[90] When asked at what age a women

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[85]Twenty-four per cent did not answer the question if they knew AIDS could be detected using a blood sample.

[86]Six per cent of the women did not respond to the question asking if they have been tested for AIDS, and 5 per cent did not respond to the question whether they would get tested if necessary.

[87]Five per cent did not answer this question.

[88]Seven per cent did not answer the question.

[89]Two women did not respond to this question which represents 1% of the sample.

[90]Eleven per cent of the women did not answer.

should become a mother, 83 per cent responded between the ages of 17 and 22.[91] Only 3 per cent suggested between the ages of 14 and 16, and 10 per cent thought between 23 and 28 were appropriate ages to have the first child. Furthermore most of the women (49%) believed that a mother should wait at least two years before the next child while others suggested less than two years (9%) and more than two years (29%).[92] Many of the women learned about how pregnancy happens, how to take care of their baby, etc., from parents (41%), friends (31%), nurses (28%), books (25%), television (15%), radio (7%), school (13%), siblings (12%), husbands or boyfriends (12%), doctors (9%), and healthcare workers (6%).[93]

Most of the women claimed to have received regular pre-natal care (93%) during their pregnancy.[94] Eight-one per cent went at least once a month and 3 per cent went twice a month. When the women went for their check-ups, most were examined by nurse only (46%), medic or midwife (15%), doctor (8%), or by more than one (29%).[95] When they went for their medical visits, most of the women had their blood pressure checked

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[91]One per cent did not respond.

[92]The proportion of women which did not respond is 39%.

[93]Almost 12 per cent of the women did not respond to the question.

[94]Almost 7 per cent of the women did not reply.

[95]Ninety-nine per cent of the women responded to this question.

(92%),[96] blood tests done (61%),[97] and were weighed (86%).[98] Fewer women received pelvic examinations (41%),[99] and asked about their diet (42%).[100] However, 88 per cent indicated that a healthcare worker had told them to eat during their pregnancy,[101] and 67 per cent of them were following all the recommendations while 17 per cent were following some.[102] Although only 17 per cent of the women responded, some reasons for not following the diet strictly or at all were lack of money (71%) and feeling ill (9%). Furthermore many of the women did take food supplements (70%), but it is unclear if it was done on the advice of healthcare providers or family members or friends, etc.[103] Possible supplements were vitamins (32%) and iron (14%).[104] Almost all of the women (98%) were eating greens and many were eating greens more than three times a week (60%) or between one and three times a week (28%).[105] The greens are most commonly

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[96]Three per cent did not respond.

[97]Six per cent or 8 women did not answer the question.

[98]Ninety-seven per cent responded.

[99]9 per cent of the women did not answer.

[100]Fourteen women or 10 per cent did not respond to the question.

[101]Two per cent did not respond.

[102]Five women or 4 per cent did not answer this question.

[103]The proportion of women which did not respond is 4 per cent.

[104]Of the 70 per cent, only 84 per cent, or 85 of 101, responded to the question as to what supplements they used.

[105]Ninety-four per cent of the women responded.

prepared by steaming (42%), frying (13%), stewing (4%), or a combination of methods (17%).[106]

Most of the women will or did have their babies delivered by a doctor (12%), nurse (39%), midwife (32%) or by a combination of all three (7%).[107] The majority of the babies will be or were delivered in a hospital (88%) and the hospital was the preferred location (84%).[108] Other preferred locations were the clinic (6%), their home (4%) and the parental home (3%). Only 10% did deliver or plan to deliver in their parental home. The women thought some of the clinic staff's duties were to deliver the baby (26%), deal with emergencies (16%), give advice or assistance (15%), help with breathing techniques (1%) and to keep the mother calm (1%).[109] Fewer women responded to the questions asking if it was their duty to time contractions, push, or to practice their breathing techniques. No one thought they should time the contractions,[110] but a few thought they should breathe to reduce pain and stress (7%).[111] To make delivery less painful, only 57

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[106]Eighteen per cent or 25 women did not answer the question as to how they cook their greens.

[107]Three per cent did not answer.

[108]The proportion of women which did not respond is 4 per cent.

[109]Four per cent of the women did not respond.

[110]Only 36 per cent of the women responded to the question asking if they should time.

[111]Only 37 per cent responded to the question as to whether they are responsible for practising their breathing.

per cent of the women knew that breathing,[112] holding their ankles (66%),[113] and drinking water between contractions (12%) were methods to reduce stress.[114] Fifty-four per cent responded to the question about whether they were supposed to push, and of these 90% responded positively. When asked how babies can be delivered the majority of the women were almost equally familiar with giving birth by caesarean section (74%),[115] but the most familiar way was vaginal (90%).[116]

Almost all of the women claimed that they will or do breast feed (92%),[117] and 15 per cent had a history of breast feeding.[118] Fewer women (62%) gave reasons for breast feeding, and of these, most cited that it was the best way (47%), to make the baby grow healthy (34%) and to protect the baby from illness (5%). Of the 8 women who will not or did not breast feed, a common answer as to why was that it did not satisfy the baby (17%). As well, many women did not answer why they stopped breast feeding. Only ten per cent of the women responded to this question and their most common answers were that the baby wanted to stop (29%), the baby was old enough to stop (14%), and breast

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[112]Four per cent of the women did not respond.

[113]Eleven per cent of the women did not answer.

[114]Eighty-six per cent of the women responded to this question.

[115]Eight per cent did not answer.

[116]Ninety-seven per cent of the women did answer this question.

[117]The percentage of women who did not respond is 2.

[118]Eighteen per cent responded when asked if they breastfed in the past.

feeding was too painful (14%). Only 22 per cent of the women thought that what they ate did not affect their breast milk.[119] Few of these women responded as to how their breast milk could change, but some suggested a change in the nutritional value (4%) or in the amount of milk produced (4%).[120]

Most women were aware that high blood pressure was dangerous (93%).

Menopausal Women

The number of Menopausal Guyanese women surveyed was 146. These women were in menopause or experiencing the symptoms of menopause. Their ages ranged from 40 to 92 with the greatest number between the ages of 40 and 61. With regards to 'race', 56 per cent were Indo-Guyanese and 41 per cent were Afro-Guyanese. The dominant religions were Hindu (30%), Christian (32%) and Evangelical (12%).[121] Aside from one woman attending adult education classes, 73 per cent of the women were homemakers, 10 per cent worked outside the home, and 6 per cent were self employed.[122]

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[119]Eleven per cent of the women did not respond.

[120]Twenty-five of the 32 women responded as to how their milk is affected.

[121]Three per cent of the women failed to respond when asked their religion.

[122]Eleven per cent did not respond to the question relating to their occupation.

Only 65 per cent[123] of the women knew what contraceptives are, and 16 per cent use birth control,[124] and 27 per cent have a history of use.[125] Of those who had a history of use, some stopped using birth control because they became pregnant (3%), had repeat pregnancies despite using contraceptives (8%), and the method was incompatible (23%).[126] Almost all of the women have engaged in sex (97%).[127] The main sources of information on contraceptives comes from their friends (38%), nurses (34%), doctors (23%), television (16%), books (16%), radio (10%), healthcare workers (7%), school (1%), husbands or boyfriends (3%), parents (1%), and siblings (7%).[128] The most common types of contraceptives known are condoms (75%), the pill (74%), injectable (58%), IUD (36%), foam (27%), gel (22%), diaphragm (16%), and implants (5%).[129] Only 10 per cent of the women did not know of any types of contraceptives while 79 per cent knew at least two and 63 per cent knew at least three methods. Most of the women

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[123]One per cent of the women did not reply if they knew what contraceptives were.

[124]Two per cent of the women did not answer when asked if they use birth control.

[125]Ten per cent did not respond to the question relating to the prior use of contraceptives.

[126] Twenty-six of the 39 women who used contraceptives in the past responded.

[127]Two per cent did not respond when asked if they have had sexual intercourse.

[128]One per cent did not answer the question relating to their sources for information on contraceptives.

[129]One per cent of the women failed to respond about the number of methods they knew.

obtained their contraceptives from clinics (65%), hospitals (47%), pharmacies (25%) and friends (2%).[130]

Many of the women knew that they could contract diseases from engaging in sexual intercourse (88%).[131] Most identified the ways to contract STDs are by having sex with an infected partner (34%), having unprotected sex (18%), sex with many partners (7%) and promiscuity (7%).[132] When asked if they were familiar with some of the names of STDs, 62 per cent knew about syphilis, 61 per cent knew of gonorrhea, and only 3 per cent knew of chlamydia.[133] More women knew about AIDS (95%) than HIV (56%).[134] Many of the respondents came to know about STDs from their friends (50%), television (40%), radio (26%), books (24%), doctors (19%), nurses (19%), husband/boyfriend (3%), siblings (9%), healthcare workers (7%), parents (3%), school (1%).[135] The majority of the

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[130]Two per cent did not answer when asked where they obtain their contraceptives.

[131]One per cent of the women did not answer the question.

[132]Twenty-one per cent of the women failed to respond to the question relating to the ways of contracting STDS.

[133]Ninety-eight per cent of the women responded to the questions asking if they were familiar with the names of syphilis, gonorrhea and chlamydia.

[134]Three per cent of the women did not respond to the question relating to their familiarity with HIV and AIDS.

[135]One per cent did not respond when asked where or whom have they received information on STDs.

women (81%) knew that condoms can protect them from STDs[136], and many knew that STDs can be detected using blood tests (19%), pap smears (18%), and urine samples (1%).[137]

When asked who can get AIDS the most common response was anybody (58%).[138] Many thought that people contracted AIDS because they had many partners (27%), engaged in unprotected sex (12%), had sexual intercourse with an infected partner (6%), were dishonest or immoral (6%).[139] When asked how people contracted AIDS, 88 per cent cited sexual intercourse,[140] followed by blood (60%),[141] and drug use (30%).[142] Seven per cent of the women did not know how AIDS is contracted while 91 per cent knew at least one way and 65 per cent knew at least two ways of contracting AIDS.[143]

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[136]Ninety-five per cent of the women responded to the question relating to the use of condoms.

[137]Twenty-five per cent of the women failed to answer the question as to how STDs can be tested.

[138]Twenty-five per cent did not respond as to who can get AIDS.

[139]Twenty-eight per cent of the respondents failed to answer why people contract AIDS.

[140]Twelve per cent did not respond to the question relating to the contraction of AIDS through sexual intercourse.

[141]Forty per cent failed to respond when asked if AIDS could be contracted through blood.

[142]Only thirty per cent responded to the question which asked if people can contract AIDS through drug use.

[143]Three per cent of the women are not included.

Familiar AIDS symptoms were weight loss (51%),[144] sores (42%),[145] and diarrhea (32%).[146] The less familiar AIDS symptoms were influenza (5%),[147] sweats (3%),[148] and boils (1%).[149] Only 27% knew that a person could be HIV positive and not have AIDS.[150] Eighty-nine per cent of the women knew that AIDS could be tested;[151] however, fewer women knew that AIDS can be detected using a blood test (76%) and even fewer knew that the virus could be detected by a pap smear (1%) or urine test (1%).[152] A very small proportion of the women have been tested (2%), but 37% would get tested if necessary.[153]

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[144]Forty-nine per cent did not respond to the question regarding if they knew weight loss was a sign of AIDS.

[145]Fifty-eight per cent did not respond to the question if they knew sores were an AIDS symptom.

[146]Only 32 per cent of the women responded to the question if diarrhea was an AIDS symptom.

[147]Ninety-three per cent did not respond to this question.

[148]Only four per cent of the women responded when asked if the sweats were an AIDS symptom.

[149]The response to the question as to if boils were a symptom of AIDS was very low. Only 1 per cent responded.

[150]Eight per cent of the women did not respond.

[151]Four per cent did not respond to the question whether AIDS can be tested.

[152]Twenty-one per cent did not answer the question if they knew AIDS could be detected using a blood sample.

[153]Eight per cent of the women did not respond to the question asking if they have been tested for AIDS, and 4 per cent did not respond to the question whether they would get tested if necessary.

The women were also questioned with regard to irregular bleeding which may be a sign of cervical cancer. Irregular bleeding is defined as occurring during sexual intercourse, at times other than the regular period, and beyond menopause. Most of the women did not experience bleeding during intercourse (91%),[154] outside their regular periods (82%),[155] and after menopause (52%).[156]

A slight majority of the women who were experiencing menopause were menstruating (58%) and 42 per cent of them reported to have periods which were shorter or longer. The majority were experiencing the symptoms of hot flashes (62%),[157] night sweats (65%),[158] and mood changes (66%).[159]. However, far fewer women were experiencing physical weakness (47%),[160] and 18% claimed to have brittle bones.[161] Some of the women were trying to relieve their symptoms by sleeping regular hours

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[154]Five per cent did not answer the question asking if they experience bleeding during intercourse.

[155]Ten per cent did not answer the question relating to bleeding outside their regular period.

[156]Forty-five per cent of the women did not answer the question as to whether they experienced bleeding beyond menopause.

[157]Fifteen women or 10 per cent did not respond to the question.

[158]Sixteen per cent of the women or 14 did not answer this question.

[159]Twenty-three Menopausal women, which is 16 per cent of the sample, did not reply to the question.

[160]Twenty-three per cent of the women did not respond.

[161]Sixteen per cent did not respond.

(27%),[162] and by eliminating caffeine from their diet (23%).[163] With regard to brittle bones, many of the women did not know that their bones could break during menopause (81%) while 16% did know.[164] Of these who knew about bone breakage, 16% or 23 women, all responded that they were attempting to prevent breakage by taking calcium supplements (8%) and through diet (63%). Almost all of the women (93%) knew that they could not have children after a certain age,[165] and most knew it was due to the absence of periods (51%).[166] The other 49% thought it was because of being too old (4%) or too weak (5%), or due to natural causes (9%).

The women were asked what menopause was and 60 per cent did know,[167] and learned about it from their doctors (22%), nurses (17%), healthcare workers (6%), friends (31%), parents and siblings (12%), husbands or boyfriends (1%), books (18%), television and radio (9%) and school (4%). The women were also asked if they knew that menopausal women are at an increased risk of cervical and breast cancer. Almost one fifth of the women knew about the increased risk for both types of cancers.[168] More

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[162]Thirty-one women or 21 per cent did not answer this question.

[163]Twenty-three per cent did not reply.

[164]The proportion who did not respond to this question was 3 per cent.

[165]Only 2 per cent of the women did not answer.

[166]The proportion of women which did not answer this question is 16 per cent.

[167]Only two women did not respond.

[168]Nine women or 6 per cent did not reply to the question.

women responded to the question about the signs of breast cancer (42%) than cervical cancer (35%). Of the 42 per cent, two thirds of the women indicated that a sign of breast cancer was a breast lump found during examination. Some women indicated that a test from a doctor (23%) will indicate breast cancer. With regard to cervical cancer, the 35 per cent who responded suggested that some signs were heavy bleeding (22%), pap smear (10%), and bleeding after menopause (2%).

Conclusion

There are differences among the life cycle groups with regards to knowledge of the common reproductive health issues, such as contraceptives and STDs, as well as behaviour. These differences are discussed in the following chapter entitled Women, Knowledge and the Medical Establishment.

CHAPTER 5

WOMEN, KNOWLEDGE AND THE MEDICAL ESTABLISHMENT

Introduction

Guyanese women's relationships with the medical establishment are tenuous due to the lack of a partnership based on health management between the women and health care workers. This is a product of two forces: one being the lack of adequate funding of health services (only 4 per cent of national expenditure devoted to health care in 1990 (IDB, 1993)) which limits the availability of doctors and treatments, and the other being women's difficulty in getting to the hospital or clinic and their lack of time to wait for services. Consequently, Guyanese women have come to avoid the doctor unless necessary because it is more of a "hassle" to get to the hospital, only to be treated "rudely" by receptionists and nurses, and wait hours to see a doctor who cannot really help given the paucity of resources available. This has resulted in a situation where preventative care is virtually non-existent, with the exception of pregnant women. Women have come to rely on their networks of friends and family for health information.

The purpose of this chapter is to examine Guyanese women's medical and health knowledge, their construction of the medical establishment and how it affects the way they use medical services. Please note that in this and subsequent chapters, data from the 1994 survey is used and here to referenced as "Red Thread". As well, the terminology

used by the survey is adopted for simplicity and continuity. It is my hope that the in-depth interviews from my research project build upon the survey's analysis so that Guyanese women's understanding of reproductive health will improve.

Women and Knowledge

The medical establishment has not been able to take an active role in community development due to lack of government support in terms of logistics and finances. As a result health education has become a private sector responsibility. NGOs like Red Thread and the Guyana Responsible Parenthood Association (GRPA) have made a commitment to educate women, men and children about reproductive health. The GRPA has shifted towards educating children in schools and it is now working to develop the curriculum and train teachers (1993, p. 6). Red Thread has already been noted for its interactive reproductive health workshops which are conducted in both rural and urban communities. The reliance on the private sector to educate people about reproductive health is evident by the number of Guyanese women who rely on "unofficial" sources for knowledge about reproductive health matters (Red Thread, 1994). These unofficial sources are friends, family and, to a lesser extent, media and non-governmental organizations (NGOs). The reliance on information sources based in civil society versus formally coordinated efforts by the state can create a situation where women's knowledge is uneven and incomplete. Conversely, the efficacy of formalized and coordinated education is recognized by the perceived need for sex education in schools, GRPA's delivery of contraceptives, and the

efforts by the state to displace child bearing from the "private" domain of women to the "public" domain of the medical establishment.

Women's knowledge about STDs is limited to contraction with few knowing the names and symptoms of diseases. Of the women in the survey, 88 per cent of Afro- and of Indo-Guyanese, respectively, knew that diseases could be contracted through sexual intercourse (Red Thread, 1994). However, few women are aware of how this actually happens: only 30 and 25 per cent of Afro-Guyanese know that a person could contract a STD with an infected partner and by having unprotected sex (Red Thread, 1994). The figures for Indo-Guyanese women are similar with 29 per cent aware that an infected partner can lead to contraction and 36 per cent citing unprotected sex as the culprit (Red Thread, 1994). It is important to note that a misconception is present since a sizeable proportion of women believe that STDs can be contracted with an infected partner. Although this is true it is not always the case if the proper precautions are taken.

The reliance on formal and informal sources of knowledge is made clear when examining the recognition of STD names. Broken down according to Indo- and Afro-Guyanese women respectively, 39 per cent and 61 per cent knew of syphilis, 40 and 68 per cent had heard of gonorrhea, and 97 and 98 per cent knew of AIDS (Red Thread, 1994). More know of AIDS than the others because it receives far more media attention, and Ministry of Health has campaigned the public about AIDS prevention. This is also evident in the proportion of women who know that condoms protect against transmission (89 per cent of Afro- and 81 per cent of Indo-Guyanese) (Red Thread, 1994). The

differences between the proportions of women who know STD names and know of AIDS illustrate the effectiveness of mass education versus education through family and friends[169] which may tend to focus on contraction rather than prevention and detection.

The women we interviewed know that diseases could be contracted through sex and their greatest concern is their men engaging in extra-sexual relations. This fear is present among all the life-cycle groups and is a reflection of the way in which men's sexual behaviour is constructed -- that is promiscuity is acceptable and expected -- and their own -- where promiscuity is forbidden or not sanctioned. When asked if they thought they could contract a STD, many said no unless it came from their men:

> *Do you know what STDs are, you know bad sick or leak (STDs)?*
> Yes, but I don't worry about them because I don't go around. I just stay in by myself. I don't go out dancing or anything...
> *If you knew a woman who had bad sick, what would you think of her? Would you think she is a bad person or irresponsible? What would you think?*
> I would think she is bad because she was about.
> *What about her husband, if she didn't know he was going about?*
> Yes.
> *Why? She didn't know?*
> No? Well she really should have known better [she should have expected/known about her husband's activities]...She should have her own sense about those things.
> *Even is she didn't know that her husband was going about?*

169 From the survey, over half of Afro- and Indo-Guyanese women heard about STDs from friends and 21 per cent of Indo- and 33 per cent of Afro-Guyanese learned from their family. Information also came from television and health care workers (doctors, midwives, nurses) although it varies among Indo- and Afro-Guyanese respectively: 40 and 51 per cent from television, and 28 and 42 per cent from health care workers (Red Thread, 1994).

> She should expect it (Child bearing Indo-Guyanese, age 28, West Coast Berbice).
>
> *Now, how do you protect yourself from STDs?*
> Well I don't mix, and he is far away and I don't go out.
> *And it does not concern you that he maybe going about?*
> No, when he comes back we will both get tested (Non-child bearing Afro-Guyanese, age 18, West Coast Berbice).

STDs are seen to come from men only because of their expected sexual behaviour. The women said they protected themselves by testing if they had been apart from their man, abstaining from sex or not mixing about. They were also asked what they thought of a woman who had a STD and some felt remorse for her since it was presumably caused by a man "going about" on her:

> *If you knew of a woman who had bad sick, what would you think of her?*
> Our church prayed for a person who had an STD. We prayed for two weeks to make her get better. She got better and there was no more sick. Now, she is preaching and she goes and prays for those who have HIV or AIDS, and she preaches and teaches about AIDS and things.
> *So you wouldn't think she was bad?*
> No, I would do something for her to get rid of the disease (Non-child bearing Afro-Guyanese, age 18, West Coast Berbice).
>
> *If you knew a woman who had bad sick, what would you think of her? Is she a bad woman or is she irresponsible for going about?*
> I wouldn't say that she was bad really, because sometimes it could be from her partner (Menopausal Indo-Guyanese, age 67, West Coast Berbice).

Although such remorse is lost if it was thought that it was the women's own behaviour which lead to the disease:

> *What would you think of a woman who had STDs, AIDS, or bad sick?*

> Well, I would think they would pull up themselves and I think all women should pull up themselves about not going about and having sex with this men and the other men, and don't let any men fool them.
> *Do you think it is only women alone?*
> No, no, not the women alone, the man, the man as well (Menopausal, Indo-Guyanese, age 51, Meten Meer Zorg East).
>
> *What do you think of women who have STDs?*
> I will think bad about them. They know this thing going around, and they will put themselves to get it. I am too old to get mixed up with them things that (Menopausal Afro-Guyanese, age 70, Linden).
>
> *If you knew of a woman who had bad sick, what would you think of her?*
> Well it depends upon her life.
> *Let's say she is not married and she is just running about?*
> Well then I would call her somebody bad because I mean you could try, you know, and it could be somebody decent who trained from home to make life her own...It doesn't mean she didn't have a good life (Child bearing Indo-Guyanese, age 33, West Coast Berbice).

The stigmatization of STDs is entirely dependent upon the women's behaviour conforming to acceptable sexual practices. In their own lives, the women are well aware of the dangers associated with their men's behaviour and trust is an important factor. One woman we interviewed knows of her husband's activities and has asked him to use condoms for which he replied, "those are for sweet ladies" meaning for women "on the side".

Women's knowledge of contraceptives is limited to methods which are available and not their attendant risks. This is a result of the GRPA's emphasis on "acceptors"[170] as suggested by the fact that all those who visited their clinic in Georgetown also became

[170] "Acceptors" refers to those who accept contraceptive methods from the organization.

contraceptive users (GRPA, 1993, p. 23). Most of the women we interviewed use contraception or had a history of contraceptive use. All said that they were told about how to use the method, but none were told about the complications or side effects with use. Such knowledge is not shared freely by providers because the fear is that they will not accept the method knowing the risks: "the goal of many "Third World" health and family planning programs is simply to achieve or exceed specified "contraceptive acceptance" targets; and that counselling, follow-up, provision of a range of contraceptive options, and information on risks and benefits are secondary concerns, if they are concerns at all" (Hartmann, 1987, p. 31). In fact, some of the women were suffering from the side effects of the pill, foam and IUD, and one consulted with friends who told her it was "normal":

> *What were you told about the method [IUD]?*
> A friend told me about how when I use it that I will get a little bleeding and sometimes my back will hurt me a little. The nurses or doctor never told me how it works. I asked for it because my friend told me about it (Child bearing Afro-Guyanese, age 33, Linden).

The side effects lead two of the women, one Child bearing Indo-Guyanese and Non-child bearing Afro-Guyanese, to abandon their birth control methods and they did not adopt new ones.

Perhaps this is why contraceptive use is low among women: only 18 per cent of Indo-Guyanese use and 18 per cent have used contraceptives, and only 20 per cent of Afro-Guyanese women currently use whereas 24 per cent have a history of contraceptive

usage (Red Thread, 1994). These figures are despite the fact that over three quarters of the women have had sex and that almost 90 per cent of them know at least one contraceptive method (Red Thread, 1994). The well known contraceptives are those which have the greatest side effects: 74 and 56 per cent know of the pill and injectable form respectively (Red Thread, 1994).[171] Given the fact that most Guyanese women learn about contraceptives from friends (40% for both Indo- and Afro-Guyanese) and family (27% for Afro-Guyanese and 17% for Indo-Guyanese) (Red Thread, 1994), many must become aware of the side effect experiences of certain contraceptives and decide not to use them. This situation could possibly be prevented if the GRPA consulted and provided the necessary information and options so that the women can find a birth control method which works best for them. However, it appears that treating women not as knowers and only as "acceptors" has created a situation where women are using unsatisfactory birth control methods and telling other women about their experiences with them.

The concept of sex education in the school curriculum is new for Guyana because of silence surrounding the issue. However, all but one of the women we interviewed thought that children should be educated about sex at school and thought the appropriate age was twelve or thirteen. It is interesting to note that some of the older women made

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171

In 1995, the GRPA distributed 31,161 contraceptive pills, gave 13,081 injections and inserted 847 IUDs. 18,484 condoms were also distributed, but it is unknown if they were requested by visitors or handed out to them (GRPA, 1996, p. 24).

references to teenage girls and not boys. This is illustrative of the fact that motherhood is largely considered a woman's responsibility. Consequently, some thought that girls should be taught about conception and prevention:

> *Do you think children should be educated about sex at school?*
> Yes, yes well they must know.
> *From what age?*
> Fourteen years.
> *What do you think they should know?*
> Tell them what is bad about it, good about it, what will happen about it. Like when young girls go out with boys and they have sex they can get pregnant. And sometime if they go out with a person, some boy who has something wrong, they can get something and when they sleep around and around. They should teach the children the experience in school (Child bearing Indo-Guyanese, age 42, Meten Meer Zorg East).

> *Do you think children should be educated about sex at school?*
> Yes, but they know about it already.
> *At what age?*
> These children turning young ladies early at age, ten, so they can start telling them about sex at that age.
> *What about?*
> What to expect and prevention (Menopausal Afro-Guyanese, age 70, Linden).

> *Do you think children should be educated about sex at school?*
> Yes.
> *At what age?*
> Them girls at a little age because I really think at twelve years old who is vexed with her boyfriend because her boyfriend is after she. When they become a young lady (Menopausal Indo-Guyanese, age 67, West Coast Berbice).

Many of the younger women, mostly in the Non-child bearing and a few Child bearing strata, were not explicit about who should be targeted by sex education, but thought that it should also focus on issues of pregnancy and prevention. Perhaps this group sees that

child bearing is not strictly a women's responsibility and that men must also be responsible for their actions. This change is important when considering how child bearing and child rearing is so difficult for women given the economic circumstances. These younger women would be quite familiar with the hardships, given that they would see their mothers struggle as well as their friends. As one women states, a single mother and her children live in poverty:

> *And who should be having children? Married people? Okay for teens?* It is okay [for teens] but they have to be married. Now-a-days, these boys are out and they got this girl and that girl pregnant and then the boys are gone. And now that woman or girl becomes a single parent, and in Guyana, a single parent is a person who punishes (Child bearing Indo-Guyanese, age 33, West Coast Berbice).

It is clear that the women recognize the benefits of a formal educational programme in school because it captures a sizeable proportion of the youth population which can lead to change.

The responsibility for health education rests largely with the private sector as little government money is spent on coordinated mass education programmes. NGOs have taken up the responsibility to educate women and men about reproductive health matters. But, it has proven difficult for these organizations to reach the larger population given their available resources and the logistics of carrying out a mass education programme. The result is knowledge which is uneven and incomplete. This is further exacerbated by women's tendency to consult other women, instead of doctors or other professionals, about reproductive health matters or concerns. As a result, incomplete knowledge is

further circulated and leads to misinformation. This can only be circumvented by a formally coordinated programme which can deliver information clearly and consistently, as in the case of the medical establishment with child bearing and sex education.

The Medical Establishment

It seems that the medical establishment, defined here as doctors, nurses and other health care workers in local clinics and hospitals, is viewed with reservation by Guyanese women. As mentioned this is in part due to the financial constraints faced by the health care profession in its ability to deliver quality care; however, much has to do with the logistics involved for women to access such services. The women who use public hospitals are very poor. They lack the time and the money to purchase transportation for themselves, and sometimes for their children, to see doctors. While attending the Linden workshop, the treatment by nurses and receptionists was a complaint among participants for many felt they were treated rudely for being late for appointments and for having children accompany them. One women commented to the effect of "don't they know how hard it is to come when you have children to look after?" and another stated, "I don't like going because I have to wait most of the day and I don't have the time". Going to see the doctor can become a "hassle" for most Guyanese women because of the need to arrange transportation and find money to pay for it, arrange babysitting for children or bring them along, and the long time spent waiting for appointments which means their other work does not get done.

The result of inadequate health care provision and the constraints faced by women is that preventative care is not a priority. In Guyana, health care management is characterized by "crisis" management because doctors only see those who are in need of treatment. None of the women interviewed have ever had an annual examination including an internal examination and a pap smear. To go and see the doctor when feeling well is unthinkable:

> *Do you have a physical examination by a doctor on a regular basis?*
> No.
> *Why not?*
> I do not have the time and I do not feel sick (Child bearing Afro-Guyanese, age 33, Linden).
>
> *Do you go to the doctor on a regular basis?*
> I would only go to the doctor if I was sick (Non-child bearing, Afro-Guyanese, age 18, West Coast Berbice).
>
> *Do you have a physical examination by a doctor on a regular basis?*
> No.
> *Why not?*
> I don't get sick (Menopausal Afro-Guyanese, age 70, Linden).

These narratives indicate that the medical establishment is constructed as only being needed during illness. It has no other role in the maintenance of their health. For this construction to exist, the medical establishment must also be involved in its reproduction. Only one women spoke of this aspect:

> *Do you go to the doctor on a regular basis?*
> No.
> *Only when you are sick?*

> Sometimes, when I'm sick. Because, right now, I am feeling good, and if I tell him I'm not feeling good he [doctor] will say "you always sick" (Child bearing Indo-Guyanese, age 33, West Coast Berbice).

Access to formal medical attention has been constructed as only available to those who are ill and, therefore, in need of it. However, the exception to this construction is women who are pregnant whose "condition" has been constructed as requiring ongoing medical attention.

The Guyanese medical establishment has constructed pregnancy as "problematic" and requiring medical supervision. Almost all Guyanese women have reasonable access to local clinics or hospitals which provide pre-natal care. In fact, 95 per cent of Afro-Guyanese and 88 per cent of Indo-Guyanese women received pre-natal care (Red Thread, 1994) as well as all the women we interviewed. Pre-natal care consists of monthly examinations for women up to seven or eight months pregnant and then bi-monthly examinations for the last two months. Although the content of the examinations vary from woman to woman, most involve blood pressure checks, blood tests, urine tests, and the monitoring of weight (Red Thread, 1994). However, some of the women involved in the survey received pelvic examinations: 44 per cent of Afro-Guyanese and 39 per cent of Indo-Guyanese women received pelvic examinations, but the frequency of the examination is unknown (Red Thread, 1994). Most of the women received advice from health care workers and some found it useful while others did not:

Did you get helpful information?

> Yes, from my mother-in-law. She told me what to eat with my low blood count. She even buy these things for me to eat. The nurses information was good also and helpful. During my pregnancies I always had to take blood before I get my babies because in my eighth month the blood drops low, low (Afro-Guyanese, age 33, Linden).
>
> *Did you get any useful advice from the clinic?*
> They don't really know. I used to go with my mother when she was pregnant with my last sister. I know those nurses tell you what to eat, how to cook your food, you know, they used to give demonstrations.
> *So they weren't useful to you?*
> No (Indo-Guyanese, age 33, West Coast Berbice).
>
> *Did they tell you any advice?*
> They would tell me when I was going to the clinic [and] not to do work or I could hurt the baby.
> *So your pregnancies were fragile?*
> But me didn't worry then. I still do my work and as long as things were well. I would get up and cook supper for the children, and then I would sit down and then go on as normal all the time (Indo-Guyanese, age 28, West Coast Berbice).

The advice given by the health care workers may indicate an underlying assumption that women do not know how to take care of themselves during pregnancy. It also implies that pregnancy is a "problematic" condition requiring special care as illustrated by the fact that pregnant women are the only ones that health care workers expect to see on a regular basis whether they feel well or not. Guyana's high infant mortality rate is largely due to the malnutrition of women and has less to due with pregnancy complications (Peake and Trotz, forthcoming).

Women tend to consult other women about their reproductive health care concerns as a result of the medical establishment's emphasis on "crisis" management and

its construction as a place that need only be visited when ill. This is prevalent across all of the life-cycle groups regardless of ethnicity and location.

Conclusion

Guyanese women's relationship with the medical establishment is weak due its emphasis on reactive instead of preventative health care. This focus is a result of the lack of financial resources available to the health care sector which reduces doctor availability -- the system can only afford to treat the sick and not the healthy. Consequently, it is constructed by doctors and women as a place for "sick" people only. Furthermore, Guyanese women, regardless of life-cycle stage, 'race' or location, try not to use the health care system because of the problems involved in getting to the hospital, and the long wait to see a doctor. Instead, many rely on friends and family, private or "bush"[172] doctors, for medical advice and treatment. Informal education programmes are also important vehicles for providing health knowledge for women, however, it appears that the knowledge can be incomplete and uneven.

172

"Bush" remedies, based on folk medicine, are very common, easily accessible, and sold on the market by "bush" doctors. They are used by both Indo- and Afro-Guyanese and sometimes in conjunction with therapy administered by doctors.

CHAPTER 6

WOMEN'S REPRODUCTIVE HEALTH EXPERIENCES

Introduction

In her book, The Woman in the Body: A Cultural Analysis of Reproduction, Emily Martin discusses the fragmented nature of the woman's body. She claims this fragmentation has its roots in modern medical science which detaches the feeling person from the body, and this process affects women far more than men due to the way in which medicine constructs women's bodies (Martin, 1991, p. 20-1). Western medicine treats the body and not the person. This discourse has filtered down to people's everyday assessments of how their bodies are performing. The metaphor "your self is separate from your body" (Martin, 1991, p.77) is used by individuals when discussing their body and is so naturalized it is not detected.[173]

Although such analysis is applied to North American society, it is also applicable to Guyanese society. Its applicability is due to Guyana's colonial history and its adoption of Western models of medicine and medical practices. It was difficult to locate reproductive health literature which reflected the experiences of Guyanese women, and

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173
This is certainly evident in how the questions were designed for the survey and the interviews, for example, "how long was *the* labour?" and "do you *get* hot flashes?", and in this thesis.

Martin's work resonated with the women's narratives. However, it should be noted that presented here is only one interpretation of Guyanese women's reproductive health experiences.

The Fragmented Body

The overwhelming image portrayed by the women's reproductive health experiences is that the body and the self are separate. For all the life-cycle groups, the perception is that their experiences are things which come over the body. They are processes or stages a body goes through whether it is menstruation, pregnancy and childbirth, or menopause. Most of the women described their experiences in terms of not doing or not possessing: "I *get* pain in my belly", "Two were delivered *by* doctors and two *by* midwife", and "No *it* just stopped like that". Statements like these are so naturalized that it is hard to imagine alternative discourses, but is it not the woman who pushes the baby out of her body or who stops bleeding every month? Some may argue that it is a matter of semantics; however, the difference is power. Fragmentation disempowers women and places power in the hands of the medical establishment. Having little or no control over the body may lead to the acceptance of health conditions and medical treatments which can adversely affect the experiences or quality of life for a woman as suggested by some of the informants' narratives.

Menstruation

The majority of the Non-child bearing and the Child bearing women experience painful periods as found in the survey. The survey indicates that 61 per cent of the Non-child bearing respondents reported painful periods with significant differences between Indo- and Afro-Guyanese (Red Thread, 1994). More Afro-Guyanese women reported painful periods (69 per cent) than Indo-Guyanese (53 per cent) (Red Thread, 1994). (Data for the incidence of dysmenorrhoea among the Child bearing group was not available from the survey.) They handle their menstrual pain by doing nothing, taking pain tablets or aspirin, and sometimes rest. Some of the women spoke[174] of the[ir] pain and its affects on their activities:

> *Do you have a painful period?*
> Yes.
> *For how long?*
> Only for the first day.
> *What does it feel like?*
> I *get* pain in my belly.
> *How does it affect you? Do you have to lie down or anything?*
> I have to lie down.
> *Can you work?*
> No.
> *Do you take anything, besides lying down, for the belly pain?*
> Sometimes I take a pain tablet for my urinary infections to stop *the* pain.
> *Does having a painful period worry you?*
> No.
> *Did you tell anyone?*
> I got a friend who told me that she gets *the* pain at the same time of *the month*.
> *So you aren't worried about it?*

[174]I have italicized those words which demonstrate fragmentation.

No (Non-child bearing Afro-Guyanese, age 19, West Coast Berbice).
Do you have a painful period?
Sometimes...
When do you find it painful? When you are under a lot more stress?
Yes, when I am under stress when he is drinking and I *take it on* and it is then I find *the* pain.
What kind of pain?
Back pain [lower back indicated].
For how long?
Just *the first* and *the second day*. *This* back pain is from when me *getting* babies and I don't lie down. With this girl here I don't lie down.
How long does your period last?
Five days.
That's not too bad.
When I am under stress, *it* lasts longer. Six to eight days.
When you have the pain, can you continue your work or do you have to lie down?
Well, I want to lie down, but I got the children there and I've got to pack his bag [breakfast and lunch], you've got to force down your feelings. Even if I tell him if I'm not well. May be if I'm sick in bed and I cannot get up, may be then I will have a rest. But, as long as I'm moving I am not sick [to her husband].
Do you take any tablet?
I take a tablet for *the* back pain, and I take aspirin for *the* cramps and that (Child bearing Indo-Guyanese, age 33, West Coast Berbice).

Painful periods are just a "natural" process the body goes through, as illustrated by the italicized words, and the woman just copes with her body through medication or rest. In fact, just over 20 per cent of the 1994 respondents believed that the pain is caused by the uterus (11%) or a small cervix (22%) (Red Thread, 1994). Given this, women do not think to ask health care workers about menstrual pain. Although only two of the informants consulted a nurse about it, they both received the advice that the pain will stop once they become pregnant (it is probably no coincidence that both are from Linden).

One woman, who is from the Child bearing group, says about this advice, "My mother and the nurse say when I get my first child it would stop. I don't believe that because I am still feeling pains." Nevertheless, the idea that menstrual pain is a natural condition had to come from somewhere and it is most likely originated from the medical establishment. However, dysmenorrhoea can be aggravated by diets high in sugar, salt and caffeine, as well as nutritionally poor diets which are prevalent among low income Guyanese households. None of the women who were involved in both the research projects indicated that they received information about diet from health care workers. This lack of information does not allow Guyanese women to exercise control over their lives as the pain can make it difficult for them to carry out their productive and reproductive work.

Menopause

The Menopausal women did not attach much value or meaning to menopause in terms of how it changed their lives. Two Indo-Guyanese women thought that menopause signifies getting old, but this getting old was not viewed negatively:

> *How did you feel when you were entering menopause? How do you feel? Feel happy or sad?*
> Well really me not sad. To me you feel like you get old. I always say old age is coming now (age 51, Meten Meer Zorg East).

Aside from this, the women talked about their symptoms, and again they did not attach any social meaning to them. It is as if the symptoms are only happening to the body and creating inconveniences, much like menstruation, that will pass:

> *What were you experiencing, like hot flashes or...*
> Well if I don't bath in the afternoon then I would feel hot at night. If I took a shower then everything would be all right (Indo-Guyanese, age 67, West Coast Berbice).

> *What about the hot flashes?*
> Well, you just try and make out. Me never go to doctor.
> *And you never use nothing?*
> Nothing. One time I was talking to some people about hot flashes. Some people say they really feel sick and some don't feel sick, you know? Some people said they got to run to the doctor. One time a lady told me about how she feels and so and how she had to go to the doctor (Indo-Guyanese, age 51, Meten Meer Zorg East).

The responses to the questions surrounding menopause are rather short as if to indicate there is nothing really to talk about. However, two women were happy about entering menopause because their worries about pregnancy were gone and they no longer had the extra work of cleaning rags. None of the women indicated that they felt they lost their womanhood despite the fact that "woman" is largely defined as being able or have been able to bear children (Peake and Trotz, forthcoming). Here the fragmented body is revealed in the attitude that menopause is just another stage in their lives. This was reinforced by doctors who simply told many of them that they would stop getting their periods with nothing more said. Few women knew of the increased health risks associated with menopause: for example, only 20 per cent of the 1994 respondents knew

of the increased risks of breast and cervical cancer while only 16 per cent were aware of the risk of bone breakage (Red Thread, 1994). The lack of information on menopause prevents women from taking control of their bodies to mitigate some of the risks.

Breast feeding

Although almost all of the Child bearing women indicated in the survey that they breast feed their children (Red Thread, 1994), UNIFEM reports that only 15.7 per cent of mothers are still exclusively breast feeding at three months of age (1993, p. 8). At five months of age only 38 per cent of mothers are still partially or exclusively breast feeding -- this is a 20 per cent decrease from the proportion still breast feeding at one month (UNIFEM, 1993, p. 8). It may well be that nearly all the mothers interviewed in 1994 breast feed; however, the duration is still in question (Red Thread, 1994). Is there something about the breast feeding experience that cause mothers to abandon it? Only two of the women liked the experience of breast feeding and one found it to be convenient because, unlike the bottle, there was no preparation:

> *Why [did you breast feed]?*
> Because the clinic say I must breast feed unto three months. My mother say breast is good it bring back the womb.
> *How long for each baby?*
> Six months.
> *Why did you stop?*
> Each child stop their self.
> *Did you partially breast feed?*
> No, I breastfed for six months.
> *Did you like the experience of breast feeding?*

> Yes, it bring me close to my baby (Afro-Guyanese, age 23, 2 children, Linden).
>
> *Did you like the idea of breast feeding?*
> Yes, yes.
> *Why?*
> Because when I hold the baby and start to nurse and me know that the milk inside me breast and when they cry in public, I think nothing because I just cover up.
> *Did you feel good?*
> Healthy, healthy. They grow fat when you breast feed than on bottle and you got to go search milk, go search glass in time and you just have to pull out your breast (Indo-Guyanese, age 42, 2 children, Meten Meer Zorg East).

The same convenience associated with the breast is also seen as an inconvenience for another:

> *Did you like the experience of breast feeding?*
> No.
> *Why not?*
> Sometimes when the mother wants to go out she cannot get to go or she will have to walk with the baby. She has to be taking out her breast all over the place (Afro-Guyanese, age 23, 4 children, Linden).

Most of the women introduced solid food in their babies' diet at three to five months of age, although it is ideal to introduce food at six months of age (UNIFEM, 1993). The local clinics try to encourage women to breast feed by emphasizing that it helps to "bring back the womb", aids in weight loss, and 'grows' healthy babies. Breast feeding is not "packaged" as an experience to be shared between mother and baby -- it is more biological or even mechanical. Again the body and the self become separated: the emotional connection between mother and child is lost in the medical discourse which is

concerned with the body. In doing so, the discourse undermines a necessary precondition for a non-mechanized complete self-concept, one having an emotional element, required for analysing the process itself (Martin, 1991). That is women are not given the discursive space to attach meanings to their experiences -- the entire process is bound by the body and has no meaning outside the body. For example, the reluctance to breast feed may not be constructed as a mental barrier, but as a physical problem that cannot be rectified. The mechanized construct prevents mothers from valuing the time spent breast feeding their children which may contribute to babies "pulling off" at young ages and the need to introduce food at an early age.

Abortions

Abortions are also perceived by the women as events or processes of the body. Four of the six Child bearing women, all Indo-Guyanese, had abortions and most had multiple abortions. The two Afro-Guyanese women from Linden did not have abortions. All described the abortion they had by "drink tablet" or "anaesthetic" as if the body was passing nothing more than menstrual fluid:

> *You have two children, you were twenty-one when you had the first, what age for the second?*
> Twenty-three for the second one. In between me get pregnant and had abortion. Me drink tablet. I went to doctor and the doctor said baby small because too soon to have baby. So he gave me tablet, three in a package, small, small, small.
> *You said that you had an abortion after the first one, did you have any after the second one?*
> Yes, four.

At what ages?
Thirty-nine the last one, 37 or 36, 1982 and 1983 two abortions, and one in 1993.
You use tablets to do one, what did you use for the others?
Well me went to the doctor and gave me anaesthetic. So me do anaesthetic.
So how do you feel about the experience?
Well, the last one the experience was very bad, and the reason why I take it right here [at belly]. Because the one I feel a lot of pain, belly hurt all night (Indo-Guyanese, age 42, 2 children, Meten Meer Zorg East).

What did you feel about it?
Well, after the doctor took, I was alright and there was nothing I could do about it (Indo-Guyanese, age 28, West Coast Berbice).

It was only later through events that women realized what they had done. One Indo-Guyanese women from Meten Meer Zorg East spoke regretfully about her multiple abortions because she has been trying to conceive for the last five years without success. Others felt regretful about their decision when they lost a child or did not have a son:

You had any regrets?
Yes, well me sorry because sometimes I think that I could have had a son. I've got two daughter. Between the four [abortions], I could and now me sorry because I could have had a son age of ten or fifteen years (Indo-Guyanese, age 42, Meten Meer Zorg East).

And how did you feel about the experience?
Well, you know, doing it at the time didn't take affect, but when the little boy born and died that is when you really think that before you did that abortion, may be that baby would have survived.
You felt kind of bad afterwards?
Yes, because you tell yourself you missed. This one you carried full term and it died, and you didn't give that one a chance to live, you know, to survive (Indo-Guyanese, age 33, West Coast Berbice).

Meaning is only attached to abortion when there is something in their lives that triggers them to rethink what they had done. Prior to this, abortion is just seen as an event of the body: seen as a manifestation of the physical until it is observed through the lens (experience) of regret where it then becomes a manifestation of the being. At this realization, the body and the self are not divorced but one.

Childbirth

The women describe the birth of babies in ways which render them invisible in the event. Childbirth is mechanized and removed from the mother in terms of experience because it becomes a process whereby the subject is subordinated by the object and is attended to by medical workers. Thus the birthing experience is turned into a production process where the body is the site of production, and the product (baby) is produced (delivered) by labourers (doctors or midwives and nurses).[175] The result of this process is a delivery which is happening to the body and not the whole:

> *How were your babies delivered?*
> Both of my deliveries were normal.
> *Who delivered your babies?*
> I was delivered by a midwife.
> *Were your pregnancies full term?*

175

Here my analysis of the process differs from Martin's where she sees the woman as the labourer and the uterus as the machine and the doctor as management (1991, p. 63). The woman's body is the site of production; however, it is not her "labour" that produces the child, but the medical attendant's as suggested by the statement "delivered by doctor/midwife". Women's work is rendered invisible and appropriated by the medical establishment.

Yes, both of them.
How long were you in labour?
For the first child I was five hours and the second I was eight hours.
Did you have difficult deliveries?
Not really. Only the long pain (Afro-Guyanese, age 23, 2 children, Linden).

Who delivered your babies?
Two was delivered by doctors and two by midwife.
Were your pregnancies full term?
Yes.
How long were you in labour for each birth?
For the first one I did not take long. For the second I took about ten minutes. For the third I took about one whole day, and the fourth as soon as the water bag burst the baby come out (Afro-Guyanese, age 33, 4 children, Linden).

Where you get baby?
At home.
Both?
Yes, at home.
Here?
No, by my daddy's house. The nurse come and the midwife came to home. Normal, no stitch, no burst, no stitch or nothing. Except for last one. Me get slight haemorrhage just like when I drink abortion tablet and she gone (Indo-Guyanese, age 42, 2 children, Meten Meer Zorg East).

The women express themselves in a passive manner since the process is happening to their body: the doctor or midwife is delivering the baby, not the woman, and the body bursts or requires stitch or is normal. The woman has lost control of the birthing process because it is the medical attendant who is in control by assessing the process and telling the woman when to push or how far she has to go. These are things that are happening to her body and it is as if she does not know that these things are happening to *her*. Martin (1991) comments that the loss of women's control has medicalized birthing to the extent

that amniotomies, c-sections, episiotomies, inducements and forceps become routine because doctors *know* that the patient is deviant from the textbook case (p. 139-155). However, it is the removal of control from women and into the hands of the medical establishment which often requires such invasive practices and alter the birthing experience for the mother and change the nature of her recovery and the relationship with the newborn child.[176]

Interpretation

The separation of the mind from the body results in an experience which has no meaning attached to it until the mind constructs or reconstructs the events. The interviews illustrate that the separation of the mind and body has operated quite successfully, but this false sense of separation falls apart when the women reflect on an event and transform it into an experience by reclaiming, e.g. regret for having an abortion. However, the question that exists is were there any women who were aware of their fragmentation or dislocation? One woman spoke of her treatment after giving birth to twins:

> *The twins were a difficult birth because of the haemorrhaging?*
> Yes.
> *After you had the twins, how long did it take you to get back on your feet again?*
> I used to work around and I get a spinning in my head and I used to be weak. And the twins were a forcep delivery. The forcep cut a piece of my flesh. That doctor in there, if you don't tell him you don't want to go

176

Some women report that they feel that they never delivered a child because of the invasive medical practices employed (Martin, 1991, p. 65, 84-5).

> home, it is you are bringing a car for me and you give the children to me mother. Because I don't feel right but I never knew what was the problem until I see the stitch...The doctors treat you like animals...nothing for the pain. It was only when I started quarrelling with the nurses did the doctor give me something for the pain (Indo-Guyanese, age 33, 3 children, West Coast Berbice).

This narrative brings into focus the object/subject split and wholeness. Here the woman realizes that she is merely an object due to her "animal"-like treatment received from the doctors, not being told about being cut by the forceps and receiving a stitch, and not given any painkillers. Simultaneously, doctors and nurses are forced to treat her as a subject because she demands relief for the pain she is feeling and to stay in the hospital due to her inability to take care of her reproductive duties at home. And it is this claiming of experience which leads to the reunification of the mind and body: she is aware of the events which are impinging on her body and her mind constructs the events in terms of subjectivity. In this instance, she is asking not to be treated as an animal, but as a person and she reclaims control over her body. As a result, her experience became quite different in the sense that she made herself more comfortable by requesting painkillers.

Conclusion

The separation of the body and the mind leads to reproductive health experiences located in the body and removed from the mind. Almost all of the women perceived their experiences as things which come "over" the body. Whether it is menstruation, childbirth or menopause, all reproductive health events are viewed as processes or stages a body

goes through as indicated by the lack of claiming experiences. Women *got* their periods or had their babies delivered *by* doctors or midwives. It appears that meaning was only attached to reproductive health experiences when there is something to trigger the women to rethink what they have done or what has happened to them. As in the case of feeling regret about having an abortion or being cognizant of the fact that they are being treated as an object by medical workers.

It is suggested that the mind/body split disempowers women and gives power to the medical establishment. Power is largely contained within the medical establishment because of its ability to construct women's choices when it comes to dysmenorrhoea, breast feeding, abortion and child bearing. Choices are constructed on the mind/body split and fail to consider the woman's experience of her body's condition and its treatment (Martin, 1991). Consequently, any "deviations" from the medical model of the body are treated as problems of the body and are not contextualised: painful periods are not linked to diet or stress, failure to breast feed is not linked to the mother and child experience, abortion is not connected to long-term mental and physical health, and child bearing is not linked to the mother's experience of the event.

Guyanese women's internalization of the split can prevent them from questioning the ways in which doctors, midwives and nurses practice because they distrust or discount their own bodily experiences and their feelings about them. In not claiming to know their bodies, Guyanese women become vulnerable to medical practices which are dangerous to or neglectful of their emotional and physical well-being. Although reproductive health

knowledge is limited among Guyanese women, their reproductive health could be improved by including bodily experiences and their meanings in diagnosis and treatment as this would make medicine more holistic and allow women to become subjects.

CHAPTER 7

WOMEN, MOTHERHOOD, AND SEX

Introduction

The body has been largely theorized by "First World" feminists who focus on the need for women to control, protect and "defeminise" their bodies (see for example Judith Butler (1990), Nancy Duncan (1996)); however, little has been done in the context of the "Third World" where the politicized body may have a different form and/or meaning to "Third World" women. In the context of this project, it appears that the woman's body as mother or child bearer is the predominant view among Guyanese women and men. Almost all of the women primarily identify themselves as mothers or future mothers for it signifies womanhood. The preeminence of motherhood has implications for attitudes towards sex and abortion for most believe that sex should be confined to marriage, and that abortion is wrong because the child is seen as a "gift". However, these attitudes do not always bear out in reality as the number of female-headed households grow and the prevalence of abortions. Poverty may be to blame for this seeming paradox as men are unable to take on the work of having more children. Given this, it appears that a politicized body for Guyanese women may be very different from a "First World" one: a body which is guaranteed access to basic human rights.

What follows is an exploration of the Guyanese women's body as a place of social construction in terms of motherhood and the implications this has for women's attitudes towards sex, abortion and birth control.

Women and Motherhood

Motherhood is perhaps the most important identity and source of fulfilment for many Indo- and Afro-Guyanese women. Its importance is twofold: one is that to become a mother is to become a woman -- it is a rite of passage, and secondly, children are a valuable resource for a household because of their paid and unpaid potential labour contribution and ability to secure a man who can contribute money; therefore, children become an alternative to the formal and informal labour markets which are highly restrictive for women in terms of opportunity and competition. For many Guyanese women their labour is not a marketable product and their children are the only product they have. This has important implications for attitudes towards sex and abortion.

Motherhood is the most important identity for many of the Menopausal women. When they were asked how they feel about being a woman, half responded that they felt good because they had a family[177]:

So, tell me how you feel about being a woman? You feel happy?

177

Only two Afro-Guyanese Menopausal women were interviewed and each responded that they felt good about being a woman; however, their responses were not followed up.

I am happy to be a woman because you can make other people happy. If you have children, you can make your children happy, make your husband happy. You live happily in your home (Indo-Guyanese, age 51, no children, Meten Meer Zorg East).

How do you feel about yourself as a woman?
I'm not sorry that I never turned out being a man.
Why?
You are born as a woman and you have to be, what ever comes, you have to accept it.
What makes you happy to be a woman? Is it because you born children, you clothe them, you feed them, what makes you to be a proud woman?
Well I feel proud because I got children (Indo-Guyanese, age 53, 5 children, West Coast Berbice).

How do you feel about being a woman? Do you feel good?
Well, me feel happy to be a woman.
Why do you say that?
Well, because me got me children and they all are doing well (Indo-Guyanese, age 67, 9 children, West Coast Berbice).

Even the one Indo-Guyanese women who did not have any children identified with mothering in terms of making her husband happy and living in a happy home. With regard to the Afro-Guyanese respondents, they replied "I feel good" when asked how they felt about being a woman. However, their identity as a woman would no doubt be linked to their mothering because none of the women engaged in productive activities outside their homes -- they have dedicated their lives to reproductive work. Nevertheless, none of the respondents mentioned alternative forms of identity in terms of their linkages to church, family and fictive kin networks, and communities, but all found motherhood as a source of fulfilment.

The Child bearing women also primarily see themselves as mothers. With the exception of two women who were critical of the identity, none of the women defined themselves outside the mothering role when asked how they felt about being a woman. An Indo-Guyanese women perceives the ability to mother as a special skill women possess and which can be transferred to public space:

> *How do you feel about being a woman?*
> Well great.
> *Why?*
> Because being a woman you know a lot and you learn a lot and you can be anything you want...I mean you learn how to take care of children and you can be a nurse or something (Age 33, 3 children, West Coast Berbice).

Her statement is indicative of the professions open to Guyanese women. They are teachers, nurses or civil servants, but seldom professors, doctors or politicians: many of the positions open to Guyanese women are reproductive in the sense that their work makes the work of male-dominated positions possible. The other two women were not specific as to why they felt good about being a woman; however, both expressed satisfaction about being able to care for their children:

> *How do you feel as a mother?*
> I feel okay.
> *Why?*
> I feel okay because I have got children and they are growing and they are healthy (Indo-Guyanese, age 28, mother of 3, West Coast Berbice).

> *How do you feel as a mother? Why?*
> I feel good because I am always at home taking care of my babies (Afro Guyanese, age 23, Linden).

As noted, two Child bearing women expressed the limitations of the mother identity. One of the limitations identified was the inability to earn her own income because of the children:

> *How do you feel about being a woman?*
> If I tell you something you will laugh at me.
> *What is it?*
> If I could have been a man, I would feel different.
> *So, you don't like yourself as a woman?*
> No.
> *Why? Tell me.*
> Is a lot of things I can't tell you.
> *Tell me one of them? A little piece.*
> I like to work for my own money.
> *Do you like your body?*
> Yes, I like my body because I can make children but why I say I want to be a man is to earn my own living.
> *But, you still can do so as a woman.*
> No, I have to stay home and look children. May be when they big I can do it.
> *But you like yourself as a woman?*
> Yes (Afro-Guyanese, age 33, 4 children, Linden).

Her statement reflects the reality surrounding motherhood in Guyanese society. Guyanese women have so few opportunities to earn their own income because of the absence of maternity leave for most, and the lack of child care and support from female friends and relatives who must also seek paid labour. It is presumed by the government and its agencies that women stay at home and look after their children and have no aspirations to earn their own money. This construction of woman persists despite the reality that women are being forced into labour markets to support their households.

The construction of woman as mother in Guyanese society leaves very little room for women who cannot have children or do not wish to do so as one respondent eloquently states:

> *How do you feel about being a woman?*
> Well me don't think got to be pleased by having children. I am married. I am glad I got me baby, I got me husband and baby. And if you don't get a baby, then how would you feel -- not a good woman, not a proper mother, not a proper wife. No, but when you don't get you don't know, but me all right. Feel proud about yourself because deliver baby? No. Me know everything in life now? (Indo-Guyanese, age 42, 2 children, Meten Meer Zorg East).

However, this same woman was also proud of her ability to conceive and raise two daughters:

> *How do you feel about yourself as a mother?*
> Me feel proud about meself because me got children. I got big daughter, and me feel nice and happy. And me husband and I are proud about that...and that I didn't have go to hospital, I delivered right at home because doctors give me this, make me do that and all those things.

In many Caribbean societies, childless women are stigmatized and given little social status and recognition by her community (Senior, 1991, p. 67-8). The fact that infertility was not addressed in the 1994 survey and in the interviews reflects the naturalization of women as mothers. In the discussions with the Research Team, the theme of infertility was never raised nor is it considered a part of their reproductive health workshops.

The majority of the Non-child bearing women identified themselves as future mothers. Regardless of 'race' or location, all wanted to have children. Most wanted two

or three children, however, one wanted four children (out of the desire to have two boys and two girls). The number of children they desired was an indication of what they thought they could care for: "More than two does be too much" (Afro-Guyanese, age 17, Linden) and "Two is good enough!" (Afro-Guyanese, age 14, Linden). All the women wanted to wait until they were married to start their families whether Christian, Hindu or Muslim. Furthermore, they wanted to start their families when they were in their late teens or early twenties, restricting their entry into the labour market as some had aspirations of being teachers and one wanted to be a bookkeeper. Clearly other alternative identities are subservient to the identity of mother as indicated by these women's responses:

> *How do you feel about being a woman? Some people say that they don't like themselves, do you feel the same?*
> Yes, sometimes I wish that I could be a boy because the things that boys do I want to do them too.
> *So who tell you that you can't do the things that boys do?*
> I can't do them because I am a girl.
> *So you don't like yourself as a woman?*
> Yes, but I am glad if I was a man (Afro-Guyanese, age 14, Linden).
>
> *Why do you want them? You want to be a mother?*
> Yes, because of the special days, like Mother's Day, and sometimes I think, "God, I am not a mother and I want to be a mother" (Afro-Guyanese, age 19, Linden).

Statements like these are reflective of the naturalization of "woman" and "man" in Guyanese society and these constructions are so rigid that it seems as if destiny is determined by gender. The devaluation of Guyanese women's labour in the public

domain has helped to institutionalize motherhood and the goals of these adolescent women attest to its power.

Most of the women said they were "good" mothers because of their ability to take care of their children. Care was often defined on a material basis -- feeding, clothing and schooling -- as well as on a personal basis as she is to teach her children:

> *How do you feel about yourself as a mother?*
> Well, I have children and I can take care of them, and you make sure they're clean and fed and everything...
> *What makes you a good mother?*
> Well I think myself to be a good mother because I take care of my children, I think I give good care to my children (Child bearing Indo-Guyanese, age 33, 3 children, West Coast Berbice).

> *What qualities make a good mother and father?*
> Look after the children, show them love, find time to talk to them, play games with them (Child-bearing Afro-Guyanese, age 33, 4 children, Linden).

> *What qualities make a good mother?*
> I feel how she carries herself, especially when she is pregnant. What she do, how she behave. The child would do the same. She does teach them the right things and set the right examples (Non-child bearing, Afro-Guyanese, age 17, Linden).

> *What qualities make a good mother and a good father?*
> You must treat your children nice, bring them up in the right way, support them and be with them (Menopausal Afro-Guyanese, age 70, 5 children, Linden).

The frequent mention of providing the necessities of life as illustrative of good parenting is an indication of the difficulty for mothers to provide for their children. In Guyana, feeding, clothing and schooling children is expensive and difficult to do because of the

insecurity of household wages: taking care of children is not a given which is evidenced by the growing population of street children and the problem of school absenteeism (Peake and Trotz, forthcoming). Nevertheless, regardless of life-cycle stage, location or 'race', women primarily identify with motherhood despite its attendant difficulties. Motherhood signifies womanhood, and other identities will not be able to compete unless this prevailing attitude changes.

Women and Sex

Among the informants, the prevailing attitude towards sex is that it should be confined to marriage. This is true among Christians and Hindus and one of the Muslim women: 16 of the 18 women interviewed believed that sex is for married people only. This represents the dominant view that when women socialize with men it inevitably involves sexual relations and pregnancy. This is in part supported by the notion that it is perfectly acceptable that a man demonstrate his masculinity by pursuing sexual favours from women while dating or courting (Senior, 1991, p. 73). Visiting unions[178] are not considered desirable by Indo-Guyanese society and Christian churches with Afro-Guyanese followings because their form is not considered stable like marriage. I attended a Seventh Day Adventist (S.D.A.) lesson for adolescent women and men where it was stressed that both should not engage in behaviour where "one thing might lead to

[178] A visiting union is a relationship where the couple does not live together, but have sexual relations.

another". The men were asking questions about what is deemed appropriate behaviour and their inquiry certainly pushed the limits of what the Church was trying to establish. With regards to the other two women, one Muslim and in the child bearing stage, and the other Hindu and Menopausal, thought it was acceptable for unmarried women to engage in sexual relations because they have desires. However, they did stipulate an appropriate age to engage in sex: they both suggested that when women start their menses that they develop the desires and feelings for sex, and it is at this point they are mature enough.

Attitudes towards sex during marriage are rather mixed. Four of the 18 women thought that sex is something to be enjoyed by both partners:

> *How do you feel about sex? Is it a good thing or a bad thing?*
> Well, a good thing.
> *Why?*
> Because it relaxes the body and relaxes the mind. It takes your mind off everything. Basically the relaxation (Child bearing Indo-Guyanese, age 33, West Coast Berbice).

> *How do you feel about sex?*
> Good.
> *Why?*
> I feel good because I could make children also enjoyment (Child bearing Afro-Guyanese, age 23, Linden).

However, two of the Menopausal women, one Christian and the other Hindu, believed that sex is a part of marriage and a duty to satisfy their husbands as well as their desire:

> *What are your feelings about sex? Is it a good thing, bad thing, pleasure or procreation?*
> I think it is part of your marriage life and so to satisfy your partner and your desire too (Indo-Guyanese, age 67, West Coast Berbice).

This attitude is also held by some of the Child bearing women for they had sexual intercourse right up until the due date:

> *For how long into the pregnancy [did you have sex]?*
> I stopped when I found out that I had high blood pressure and that was three days before birth.
> *Why? To keep your husband happy or because you wanted to?*
> I guess to keep him happy because he was away. He was in town and only saw him on weekends and to keep him satisfied, you know, if he didn't love is wife he wouldn't come, you know (Indo-Guyanese, age 33, West Coast Berbice).
>
> *Until what month? Throughout your pregnancies?*
> Yes, yes, until it was time. Just because you're pregnant you can't have sex?! For nine months you're going to keep your husband away from you? (Indo-Guyanese, age 42, Meten Meer Zorg East).

For most Guyanese women, the sexual revolution is not a part of their lives. Sexual relations with men generally equates with pregnancy, which should ideally occur within a marriage as indicated by the informants. Although the growing numbers of Afro- and Indo-Guyanese female-headed households reveal that this is an attitude which does not necessarily bear true in reality. Furthermore, sex is often seen by women as a means to "tie" their men to them so that they will continue to support the household thus the prevalence of visiting unions among Afro-Guyanese and Indo-Guyanese. It is for these reasons that sex and the identity of mother are inextricably linked: sex to gain access to motherhood and to "tie" a man to help financially support mothering.

Over half of the women, regardless of 'race' or stage in the life-cycle, believed that responsibility for birth control and deciding on family size rests with both partners.

This is consistent with the attitude that sex and child bearing should ideally be confined to marriage. However, one woman points out that it is popularly believed that issues of motherhood rest solely with women (Peake and Trotz, forthcoming):

> *In your mind, who do you think is responsible for birth control?*
> Guyanese believe it is the woman alone. But for me, I like to converse with him because if the side effects come, he would say, "you didn't tell me anything." You see when you're not at work, the money has got to come from somewhere. And the first thing he would say was, "you didn't tell me anything," and then I have to find the money (Child bearing Indo-Guyanese, age 33, legally married, West Coast Berbice).

Others noted that the responsibility of birth control is their own and it is an issue of control. These women are all Afro-Guyanese, and are from the Non-child bearing and Child bearing groups. One Non-child bearing woman stopped using contraceptive pills her mother made her take when she started her menses at age eleven:

> *Have you used them [contraceptives] in the past?*
> Yes.
> *Was it your decision to use?*
> My mother made me use it. She said that she does not want me to become pregnant...
> *Why did you stop using the pills?*
> I just feel to stop when I stop using it. I does get a lot of pain in my belly for four days during menstruation.
> *Who do you think is responsible for birth control? Your's, your mother's, your boyfriend's?*
> I think that I should have made my own decision (Afro-Guyanese, age 14, Linden).

Although the women speak of a joint decision, the reality is that most women are the ones who visit their local clinics to obtain birth control. Those who use or had used

contraceptives went to the clinic and obtained what they needed. The Guyana Responsible Parenthood Association's (GRPA) statistics show that women frequent their clinics much more than men do: in 1995, 1,063 women and 90 men visited their clinics for the first time, and the figures are much the same for 1996 where 1,341 women and 87 men also attended for the first time (GRPA, 1997, p. 23). From these statistics it is quite clear that the responsibility of birth control is primarily women's.

Women and Abortion

Given the value placed on motherhood it is no surprise that the informants expressed negative attitudes towards abortion. Their views towards abortion are largely informed by their religious beliefs and their own conscience and experiences. Very few of the women knew how their families felt about abortion; however, this may be indicative of how the question was asked rather than not knowing. Nevertheless, few are aware of a parent's attitude if they share the same religious beliefs or that the actions of a parent stand in contrast to their own views. The range of attitudes were from "murder" to "not good". Three women who believed that abortion is murder are Afro-Guyanese, Christian (two S.D.A. and one Pentecostal), and each are from one of the three life-cycle groups. Their attitude stem from their religious teachings:

> *How do you feel about abortion? Do you think it is wrong?*
> Yes, a woman shouldn't have one.
> *Why?*
> Because it is murder.
> *Is this your own feelings or your Christian beliefs?*

My Christian beliefs (Non-child bearing, age 18, Pentecostal, West Coast Berbice).

How do you feel about abortion?
I feel it is murder.
Why?
I feel so is because that same child could turn out to be something good (Menopausal women, age 49, S.D.A., Linden).

How do you feel about abortion?
I don't like it because the Bible say thou shall not kill.
How does your family feel about abortion?
They feel it is a sin (Child bearing, age 23, S.D.A., Linden).

Most of the women feel that abortion is wrong because a life is involved. Eight of the women felt this way and many of them are Indo-Guyanese (six) who are either Muslim or Hindu. Two Christian Afro-Guyanese held this opinion as well and they are both Non-child bearing and from Linden. The reasoning behind their views is that a woman is given a child and to take that life away is wrong:

How do you feel about abortion?
It is not good.
Why you say it is not good?
It could be your only child you will ever get, then you will go and kill it.
How does your family feel about abortion?
My mother was getting a baby and the condition we were living in, make she throw away the child. I told her she should have kept it (Non-child bearing Afro-Guyanese woman, age 14, Sunday Worshipper, Linden).

How do you feel about abortion in general?
Well to me, me don't like it when women do abortion. They should use prevention...because abortion, God gave you those children then and then you do abortion, you kill them and put them in the sink. Alright, I don't like that. Well they should use prevention. They've got family planning and they should go to family planning...(Child bearing Indo-Guyanese woman, age 42, Muslim, Meten Meer Zorg East).

However, there are three Christian Indo-Guyanese women (two Child bearing and one Menopausal all from West Coast Berbice, but different churches) who believe that abortion is not wrong under certain circumstances such as rape or illness. And finally, there are those who do not feel as strongly about abortion as indicated by the words "not good" or "dangerous" because the mother can lose her life. There are three women who hold this position and they all are Afro-Guyanese, Christian, with each at a different stage in the life-cycle, two from Linden and the other from West Coast Berbice (none have ever had abortions). Their attitudes are not unfounded given the dangers Guyanese women face when they undergo abortion. Doctors have reportedly done abortions up to six months which presents a host of complications. Furthermore, women are sent home to continue their workload after their abortions. Women are not given a recovery time supervised by a medical worker to ensure there are no complications. Despite the legalization of abortion, women still undergo considerable risk and sepsis is not uncommon.

Conclusion

The identity of mother is the strongest for Guyanese women since it signifies womanhood and it is a means for them to find their place in society given that their labour is undervalued in the formal labour force (Peake and Trotz, forthcoming). The preeminence of motherhood has implications for attitudes towards sex and abortion. For some Guyanese adolescent women, their parents expect that they may become pregnant

when they start their menses because this "inevitably" leads to "mixing" with boys (Senior, 1991, p. 75). For others, sex is for marriage where the conditions for raising children are at an "optimum" and serves as a "legitimate" form for men to prove their "manhood" and fulfil their desires. However, married status does not always prevail as noted by the increasing numbers of female-headed households and visiting unions. Nonetheless, sex is a means to ensure a man's loyalty for these family structures. Although most of the women believed that birth control is a joint decision, their history of use suggests otherwise and is indicative of the widely held assumption that motherhood is a women's issue. With regard to abortion, all women expressed negative attitudes towards abortion regardless of religious background. But, attitudes varied from "murder", reflecting religious affiliations, to "not good" or "dangerous". This finding is not surprising given the importance of motherhood. However, this is surprising given the prevalence of abortions in Guyana. Silence surrounds abortion in Guyana as household poverty forces many women to choose abortion so they may take care of their existing children.

CHAPTER 8

WOMEN AND KIN NETWORKS

Introduction

Kin and fictive kin (friends) networks are important institutions for Guyanese women and especially for poor women. Many women would not be able to cope with their reproductive responsibilities without the assistance of these networks: "family and to a lesser extent friends and neighbours play a major role in the survival strategies of Caribbean women and might be an answer to what outsiders discern as 'no visible means of support' (Senior, 1991, p. 139). These networks provide assistance to women in the form of goods such as foodstuffs or clothing, services like sewing, washing or cooking, finance, i.e. lending money or providing remittances, and child care which enables the mother to obtain paid work.

Importance of Networks

Networks help women cope through times of financial distress, child bearing, illness and school holidays when baby-sitting is required (Senior, 1991, p. 79). This is evident in the lives of the women who participated in this research project. Furthermore, the women also indicated that networks are important sources of reproductive health information as the medical establishment is difficult to access as discussed in Chapter 5.

The women's networks provided them with the opportunity to discuss their reproductive health concerns and provided support to child bearing women while recovering after childbirth.

Kin and fictive kin networks help make the institution of motherhood possible by expanding the resources available to a household. Household insecurity is a growing problem in Guyana as the government continues its austerity programme with cutbacks on health care, child care, and housing and the decline of real wages. The result has been that male wages are unreliable in terms of sustaining a household. Consequently, women from poorer Guyanese households have been forced to enter the paid labour markets to sustain their families (Peake and Trotz, forthcoming). This has not been an easy task given that Guyanese women are largely excluded from the formal labour market due to skill, low wages, and discrimination in the form of lack of child care and maternity leave.[179] The result is that women are more likely to enter the informal market where pay is irregular, but jobs afford flexibility in terms of child care and illness.[180] However, there are still the problems of reproductive work and financial security as household and care

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179

However, civil employees and those employed in "skilled" or "professionalized" work do receive maternity leave.

180

There is a tendency among women vendors to form networks which are designed to help each other to sell their goods despite illness, childbirth and other family responsibilities. It is not uncommon to see women taking care of other women's stalls or taking their produce and selling it for them.

giving work must still be done and wages from informal work are inconsistent and sometimes unreliable.

Networks and the Household

Networks help working women get their reproductive work done. Within a household an extended family operates by dividing reproductive and productive work among its members. In the case of one Afro-Guyanese Child bearing woman's household, her mother and her three sisters and brother earn incomes while her other two sisters and a cousin took care of the five children and do all the cooking, cleaning and washing. They also took in a three-year-old child from a relative who could not afford to take care of the boy. In this household, the children become the responsibility of the entire family and not just the mothers: it is not uncommon for the aunts or grandmother to discipline and care for the children as their own. The concept of the extended family also operates on a community basis where friends and sometimes neighbours are recruited to take care of children and the house in times of need. The relationships are reciprocal where everyone does not think twice about helping the other out as illustrated by the following quote from Senior:

> Sometimes you see children, you don't even know them, but they are going with their clothes tear down and so you call them and fix them up, especially girls. Sometimes if I am feeling sick, neighbours come and wash the children's clothes free. But you know I have a conscience, they leave their work and come [so] I give them something. And like how I can sew sometimes they come, they ain't have money, I would run up anything

> for the children or even them. That is how we live... (Senior, 1991, p. 140).

It is the networks which allow many households to function and cope by sharing human and financial resources. On the one hand, networks make mothering possible, but on the other it prevents the government from feeling or seeing the effects of its policies which are based on gendered assumptions about the household: male wages are enough to sustain a household and that women only need assistance in the act of child rearing, e.g. SIMAP baby formula programme[181] and free birth control. Nevertheless, the presence of networks help to mitigate the stresses associated with poverty by providing emotional and financial support.

All of the Child bearing women relied on their networks to help them with their reproductive duties while they recovered from childbirth. Mothers, sisters, and other close female relatives helped out with household duties such as caring for the other children, washing clothes and diapers, or cooking:

> *How long recover?*
> Didn't take long. I could get up. After done born the babies, me feel alright.
> *Both babies?*
> All two, no pain at all. No nothing wrong.
> *Anybody help you recover?*
> My sister and mother.
> *So how did they help?*

181

SIMAP is a programme developed by the Ministry of Health to provide free infant formula for up to four or five months. Its aim is to reduce the incidence of malnutrition among babies.

> They would bring me tea or boil something and give to drink or eat up on the bed. Not make me come down or move, move too much. Wash clothes and such and me lay down.
> *For how long?*
> Until the ninth day finish, and after then me sister live home to me mother (Indo-Guyanese, age 42, 2 children, Meten Meer Zorg East).

> *How long did you take to recover after you get your babies?*
> Not long. Shortly after I walked.
> *Did anyone help you while you recovered?*
> Yes, my mother and my sister help me to wash for two weeks (Afro-Guyanese, age 23, 2 children, Linden).

> *How long did it take you to recover after your deliveries?*
> Sometimes it will take me about two days.
> *While recovering, did you get help? Who helped and how the person help?*
> Yes, my sisters-in-law would come and clean, wash and cook for me until I am well again (Afro-Guyanese, age 33, 4 children, Linden).

The labour provided by the family allows the mother to rest without the worry or stress of having to do work. Although the help may only last a week or two, it gives the women some time to heal and get their strength back to take on a full day's work again for they do not have labour-saving technology and all work has to be done manually. Furthermore, family members were also active in helping to care for the babies:

> *You could take care of your babies?*
> Yes. I take care of my babies. I had no problems.
> *You stay home all day?*
> Yes.
> *Did you have to go out to work?*
> No.
> *Do friends or family help you care?*
> Yes.
> *How do they help care?*

By helping to buy food, clothes and help to take care of the babies (Afro-Guyanese, age 23, 2 children, Linden).

Did friends or family help care for the babies, although you were not working? Yes, they used to come and carry away the babies for walks or spend the day to give me some space or time for myself (Afro-Guyanese, age 33, 4 children, Linden).

Relatives and friends are important resources in child rearing because they provide emotional and financial support for mothers which is formally absent in Guyanese society. However, help from others does not come without costs since they too are expected to help them in their mothering roles:

Did your family help care for babies?
My sister there, the big sister, nurse, and second daughter. Because when me get baby, she would get baby (Indo-Guyanese, age 42, 2 children, Meten Meer Zorg East).

The women certainly do not rely on men to help out with babies and children. Although all women reported that their men will get up in the middle of the night if she does not wake, but few reported having partners who change diapers:

Did you husband help take care?
Well if the baby wakes up and I don't then he get up. But changing diapers no. But like that [child] and this one, he just lie down and snore and I get up (Indo-Guyanese, age 33, 3 children, West Coast Berbice).

Did baby's father help?
Well, when sometime I'm sick, sometime I feel good, sometime I sleep. He'd get up and help.
He did it all alone?
Yes (Indo-Guyanese, age 42, Meten Meer Zorg East).

All of the women were asked what they thought made a good father and many believed that his responsibilities rest with material provision and care giving:

What qualities make a good mother?
A good mother must take care and teach the right thing to her children.
What qualities make a good father?
He must take his responsibilities as well as set good examples (Child bearing Afro-Guyanese, age 23, 2 children, Linden).

However, women do not demand help from their partners in the day- to-day raising of their children because they do not expect them to help. This is not surprising given that Guyanese women are largely responsible for mothering.

Women expect that their men will financially support the household and provide for the children (Peake and Trotz, forthcoming), and men expect their women to be good wives and mothers (Senior, 1991, p. 170-1). This gender division does not provide women with the freedom to off-load or down-load some of their reproductive duties to men, and consequently, they must rely on female networks for support.

Women feel that they are responsible for the long term well-being of their children and will ensure it even if it means staying with an abusive man or the risk of losing one:

Do you think about the possibility of getting a STD?
I will say as long as you don't go out you can't get it...
How does a person protect themselves from STDs?
Personally now I have to protect myself because the children father that I get he has all types of different women. I am abstaining now.
Are you starving the man? Are you not afraid that he will leave you?
I do not care if he leave me. I have to protect myself (Afro-Guyanese, age 33, 4 children, Linden).

Looking back would you change anything?
One thing different I would do is that I would stop quarrelling [about his drinking and mixing] and think only of my children. I have children to live for...

He treats them [children] well?
Yes. It is me he uses as punching bag and not the children (Indo-Guyanese, age 33, 3 children, West Coast Berbice).

The women's statements indicate that the burden of child care falls on their shoulders and it is their presence which ensures the welfare of the children. This attitude possibly stems from the accepted behaviour of Indo-Guyanese and more so for Afro-Guyanese men for "going about" on their women. This leaves many women in a very insecure position because they cannot depend upon their man to support the family on a long term basis for they usually end up leaving. Consequently, most Guyanese women must keep a vigil on their men's activities to protect their children from further economic hardship.

Networks and Reproductive Health

Many of the Guyanese women spoke of their reliance on networks of female friends and relatives for reproductive health information. They used their networks when they had a reproductive health problem, such as painful periods or irregular periods, to determine if what they were experiencing was "normal". After consulting their woman friends and family members, few if any women turned to the medical establishment for additional consultation. It appears that their networks carry a great deal of credibility and are deemed reliable sources of information. Two Indo-Guyanese women, both from West Coast Berbice, learned of menopause and knew what to expect through their networks:

When you stopped getting your periods, did you think you were pregnant?
No.

No concern like that?
No, because I hear people that say like you know... "you've gone upstairs".
You knew what was happening to you?
Yes...because the people older than me had it stopped and they used to tell me that I was going to stop soon.
These were your friends?
Yes, we would talk.
You didn't go to the doctor when it stopped?
No (Indo-Guyanese, age 67, West Coast Berbice).

At the time did you think you were pregnant?
No.
What did you do when you started feeling different?
I would take a bath.
Did you say anything to someone?
Yes, I told bigger people and they tell me because I am in the age, over fifty, and you stop seeing and you get hot flash.
And that made you feel better?
Yes (Indo-Guyanese, age 53, West Coast Berbice).

The two Afro-Guyanese women from Linden did not rely on their networks for information about menopause. One woman thought she was pregnant and the other was experiencing pain in her "right tube", and consequently, both went to the doctor and found out that they were starting menopause. One Indo-Guyanese women from Meten Meer Zorg East used to work for Red Thread and gave seminars on menopause. She has become a source of information for her network and had informed the other woman who we interviewed.

The majority of the Non-child bearing and Child bearing women confided in mothers or friends about their painful periods. Most wanted to know why they had pain, if it was "normal" and what to do about it. Many felt content about the information they received:

Do you use anything to relieve your back pain?
No.
Why?
I don't like drugs.
Did you tell anyone about your pain? Who?
I tell my mother and she explain why it happen (Afro-Guyanese, age 17, Linden).

What kind of pain did you have?
Belly pain. I had to lie down for the day.
Did you tell anyone? Who did you tell?
My mom.
Did she say anything?
No, not really.
You weren't concerned about this sudden pain?
No (Afro-Guyanese, age 18, West Coast Berbice).

Do you take anything? Anything to relieve the pain?
Pain tablets.
And that helps?
Yes.
Does the pain worry you?
No, it's just normal.
You always had it?
Yes.
Did you tell anyone about your pain? Did you tell your friends?
Yes! Me told my friends and they say they have pain when they get (Child bearing Indo-Guyanese, age 28, West Coast Berbice).

Most are willing to accept their pain knowing that it is "natural" because their friends or family deem it to be "normal". This alleviated any worries. The women did not subsequently go and see a health care worker which indicates the degree of trust women place on their networks. This can be problematic if the problem is misdiagnosed by the network.

Conclusion

Kin and fictive kin networks are important to Guyanese women because they help manage their reproductive duties, provide emotional and financial support as well as give information about reproductive health problems or concerns. Child bearing women use their networks to help them recover from childbirth by allowing the members to do her washing, cooking or cleaning, etc. Assistance was not just provided at childbirth as many women received help in the day-to-day caring of their children as some women received food, clothes and time away from her children. This kind of assistance is required given that mothering is constructed as a woman's responsibility and there are no formal organizations or institutions that help in child caring. Men are not expected to engage in child-caring or -rearing, but are considered responsible for providing the material necessities. Aside from helping in the giving of care, networks are also important sources of information about reproductive health matters. Many asked their female friends or family members about a problem and sought advice from them. Few consulted doctors about their problems and trusted the information they received from their networks. Both facets attest to the significance and importance that social networks play in the lives of Guyanese women and how they help to ameliorate the conditions women find themselves in.

CHAPTER 9

CONCLUSION

The role of Caribbean women as paid labourers in the informal and formal sectors and as caregivers within households, underscores the importance of women's health to development (Allen, 1997, p. 171). Many Caribbean states have not attached great importance to women's health care, as evidenced by high female mortality rates for hypertension, diabetes and childbirth, or have a myopic view of what constitutes women's health. In the case of Guyana, preventative health care for women is limited or even absent, and that which is available focuses upon only one stage in a women's reproductive cycle: child bearing. This is not surprising given that Guyanese women are identified foremost as mothers. Their reproductive health experiences have been marked by the fragmentation of the body, and the lack of consultation, information and education from the medical establishment. As a result of the lower care quality provided by the public system, women have learned to cope with health problems through their networks of friends and family which provide support and information, or by consulting "bush" doctors or private doctors, both requiring payment of fees, for more persistent problems.

The relationship between Guyanese women and the medical establishment is weak due to the latter's emphasis on reactive health care instead of preventative care. Clinics have been constructed by doctors and other medical staff as a place for "sick"

people only due to the lack of financial resources which have resulted in the shortage of staff and supplies. This construction is reinforced by Guyanese women who try to avoid the clinics due to the long waits, transportation and lack of attention paid by attending health care workers. Consequently, many have come to rely on networks of family and friends, and private or bush doctors, for medical help. Furthermore, informal education programmes from non-governmental organizations have proved to be important in disseminating reproductive health knowledge; however, it appears that the knowledge can be incomplete and uneven as it is for STDs and contraceptive use. This suggests the need for formally coordinated programmes which can deliver information clearly and consistently.

Networks are important to Guyanese women because they help in managing reproductive duties, and provide emotional and financial support as well as reproductive health information. Child bearing women tend to rely more heavily on their networks because of the need for assistance in caring for and supporting their households. This is necessary as mothering is constructed as a woman's responsibility and there are no formal organizations or institutions which assist in child care. Men are not expected to engage in child care activities, but are expected to provide the material necessities. However, networks do help to provide clothing, food or money when men are unable. And as already stated, women of all life-cycle stages rely on networks for information about reproductive health matters. The reliance on networks attest to the importance they play

in the lives of Guyanese women and their ability to ameliorate the conditions in which they find themselves.

Whether it is menstruation, childbirth or menopause, all reproductive health events or problems are viewed as processes or things which come "over" the body. This is identified as the mind/body split. It is suggested that this split disempowers women and gives power to the medical establishment because medical choices are constructed on this basis. Such choices fail to consider the woman's experience of her body's condition and its treatment. Consequently, health problems are connected to the body and not to the woman's living conditions, diet or health practices. Guyanese women's internalization of the fragmentation can also prevent them from questioning the ways in which health care professionals practice because they may distrust or discount their own bodily experiences and their feelings about them. In fact, it seems that women attached meaning to their reproductive health experiences when something triggers them to rethink what they did: for example, the feeling of regret about having an abortion.

For many Guyanese women, the identity of mother is of primary importance because it signifies womanhood and provides a valued role in Guyanese society which undervalues their labour. For men on the other hand, their rite of passage is sexual intercourse and potency. Given these gendered views of sex, it is generally understood that sex leads to pregnancy; however, this is perfectly acceptable to most as long as it occurs within a marriage. However, the increasing numbers of female-headed households and visiting unions suggests a gap between attitudes and behaviour. Under these

circumstances, women view sex as a means to "tie" a man to her household in order to secure some kind of support. Because of the preeminence of motherhood, most women attached negative attitudes to abortion regardless of religious backgrounds. Again this represents a gap between attitudes and behaviour given the prevalence of abortions in Guyana. However, an explanation for both "anomalies" is household poverty, as limiting the number of children reduces household stresses and visiting unions ensures some form of support from men.

The health and reproductive health of Guyanese women is poorer in relation to other parts of the English speaking Caribbean. The life expectancy in Guyana is five years less than other countries', and the still birth rate and the percentage of babies with low birth weights are higher than other member states of CARICOM. Despite these differences in health, many Caribbean women share common concerns about the state of health care and their treatment by the health care system in their countries. Some of the findings from this study are similar, if not the same, to the ones found by Patricia Rodney (1998).[182] The health care concerns of Caribbean women focus on preventative care, a holistic approach which includes reproductive health care for all stages of the life-cycle and overall health, exchange of information between the medical establishment and women, and the need for greater public education on health issues for prevention.

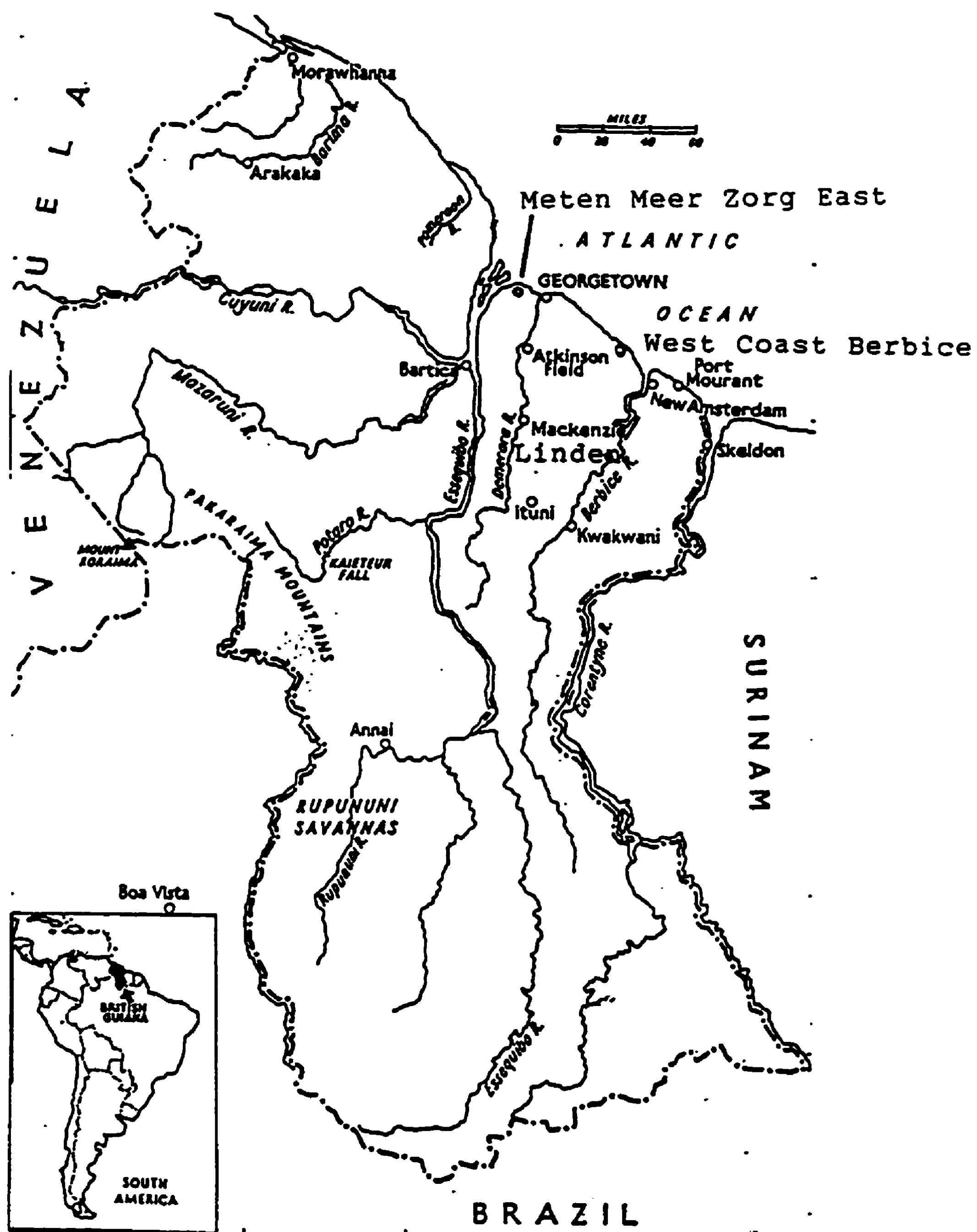
182

Rodney's findings are published in her book entitled, "The Caribbean State Health Care and Women: An Analysis of Barbados and Grenada". Although the study period is 1979 to 1983, the findings are more than likely still relevant as the health care systems have not improved greatly or even declined.

In Guyana, there is little hope that women's health care concerns will be addressed by the state as the government continues to restrain its spending on social services such as health, education and housing. Given this, Guyana's public health care system will continue to feel the financial "squeeze" which has created understaffed clinics, poorly paid health care workers, fewer services, lack of preventative care, shorter patient consultations resulting in less discussion between patient and health care worker, and longer waiting periods. This means that non-governmental organizations, like Red Thread, must carry some of the health care burden the government has shed in order to maintain the current level. As well, they must assume some of the responsibility for preventative care, such as pap smears, STD testing, diet for hypertension and diabetes, breast examinations and osteoporosis, and holistic care where all health problems are diagnosed and treated, and encompassing the reproductive health concerns of not just Child bearing women but also Non-child bearing and Menopausal women. Otherwise, the future health and reproductive health of Guyanese women looks grim without the commitment of non-state help given the spending restraints in health care.

APPENDIX A

Map of Guyana



Source: Newman, 1962.

APPENDIX B

Appendix B comprises the three interviews administered respectively to Non-child bearing, Child bearing and Menopausal women. They were completed in the summer of 1997, and eighteen women were interviewed in Meten Meer Zorg East, Linden and West Coast Berbice.

<u>Reproductive Health Interview for Non-child bearing Women</u>

N.B. [] indicate examples which may help the respondent understand the question.

I Personal Information

1) what is your age?
2) what is your 'race'?
3) what is your religion?
4) what is your place of birth?
5) what level of education did you complete and when?
6) do you have any qualifications?
7) what is your union status?
8) how many times have you been married?
9) who do you live with?
10) do you contribute financially to your household? what do you do?
11) who else contributes financially to your household?

II Sexual Activity

12) are you sexually active?

If no - why not?

If yes - why?
- at what age
- did you want to
- have you ever been pregnant

- if yes
  - how many times
  - how did you feel when you found out

- what happened to the pregnancy

- if aborted
  - how many times
  - at what age/ages
  - why
  - what type/types
  - how many weeks pregnant
  - who did you tell and why; how react
  - any after effects and how cope
  - how feel about experience
  - any regrets

- if miscarry
  - how many times
  - at what age/ages
  - how feel about experience
  - what did doctor say

- if still born
  - how many times
  - at what age/ages
  - how feel about experience
  - what did doctor say

- did event change your feelings toward sex

III Contraceptive Use

13) at present, are you using contraception?

14) have you used contraceptives in the past?

- if yes to 14 or 15
  - was it your decision to use
  - what method
  - why use that method
  - how long use
  - where did you get it
  - did you pay for it
  - what were you told about it
  - any side effects
  - get pregnant using method

- if used in past also ask why stopped using method

15) who do you think is responsible for birth control?

IV Sexually Transmitted Diseases (STDs)

16) do you ever think about the possibility of getting a STD?

17) have you ever been tested?

- if yes
  - how feel about being tested
  - at what age
  - were you treated
    - if yes
      - what about your partner
      - how make you feel
      - has it changed you

- if no
  - why not

18) how do you protect yourself from STDs?

19) what do you think of women who have STDs?

V Reproductive Health Problems

20) do you have any reproductive health problems or worries? [e.g., heavy bleeding or lump in breast]

if yes
- what is it
- how long have it
- how has it affected you
- did you go to doctor; if yes, what happened

21) do you have a pap smear on a regular basis?

- if yes
  - how often
  - since what age

- if no
  - why not

22) do you have a physical examination by a doctor on a regular basis?

- if yes - how often
  - since what age

- if no - why not

VI Painful Periods

23) do you have a painful period? [bloating, cramping, aches]

    if yes - since what age
    - how long pain
    - before or during menstrual cycle
    - how long period last
    - what kind of pain
    - does it affect what you do
    - how relieve pain
    - does pain worry you
    - have told anyone
        - if yes - who
            - what did they say
            - give useful advice/information

VII General Questions

24) how do you feel about being a woman?

25) how do you feel about your body?

26) how do you feel about your sexuality?

27) do you think children should be educated about sex at school?

    - if yes - at what age
        - what about

28) how do you feel about sex? [pleasure, procreation, enjoy etc.]

29) who should have sex and not have sex? [e.g., married people only, not teens]

30) do you want to have children?

- if yes - when
  - how many
  - why

31) what qualities make a good mother and a good father?

32) how do you feel about abortion?

33) how does your family feel about abortion?

34) anything else?

---- end ----

Reproductive Health Interview for Child bearing Women

I Personal Information

1) what is your age?
2) what is your 'race'?
3) what is your religion?
4) what is your place of birth?
5) what level of education did you complete and when?
6) do you have any qualifications?
7) what is your union status?
8) how many children do you have?
9) how many times have you been married?
10) who do you live with?
11) do you contribute financially to your household? what do you do?
12) who else contributes financially to your household?

II Contraceptive Use

13) at present, are you using contraception?

14) have you used contraceptives in the past?

- if yes to 14 or 15 - was it your decision to use
  - what method
  - why use that method
  - how long use

- where did you get it
- did you pay for it
- what were you told about it
- any side effects
- get pregnant using method

- if used in past also ask why stopped using method

15) who do you think is responsible for birth control?

III Sexually Transmitted Diseases (STDs)

16) do you ever think about the possibility of getting a STD?

17) have you ever been tested?

- if yes
    - how feel about being tested
    - at what age
    - were you treated
        - if yes
            - what about your partner
            - how make you feel
            - has it changed you

- if no
    - why not

18) how do you protect yourself from STDs?

19) what do you think of women who have STDs?

IV Reproductive Health Problems

20) do you have any reproductive health problems or worries? [e.g., heavy bleeding or lump in breast]

if yes
- what is it
- how long have it
- how has it affected you
- did you go to doctor; if yes, what happened

21) do you have a pap smear on a regular basis?

-if yes - how often
- since what age

-if no - why not

22) do you have a physical examination by a doctor on a regular basis?

- if yes - how often
- since what age

- if no - why not

V Painful Periods

23) do you have a painful period? [bloating, cramping, aches]

if yes - since what age
- how long pain
- before or during menstrual cycle
- how long period last
- what kind of pain
- does it affect what you do
- how relieve pain
- does pain worry you
- have told anyone
    - if yes - who
        - what did they say
        - give useful advice/information

VI Child bearing

24) did you want children? why or why not?

- if yes - when did you want to start a family

25) at what age did you have first child?

26) had you been pregnant before that?

- if yes - what happened
- at what age/ages

27) at what age did you have your other babies?

28) were any of your pregnancies planned?

- if yes
  - how did you space them
  - who made the decision

29) have you ever had an abortion?

- if yes
  - how many
  - at what age/ages
  - why
  - type
  - how many weeks or months pregnant
  - did baby's father know and agree
  - who did you tell, why, and how react
  - any side effects and how cope with them
  - how did you feel about experience
  - any regrets

30) how do you feel about abortion?

31) how does your family feel about abortion?

32) have you ever miscarried?

- if yes
  - how many times
  - at what time in your pregnancy
  - how did you feel emotionally at time
  - what did doctor say

33) have you ever had a still birth?

- if yes
  - how many times
  - at what time in your pregnancy
  - how did you feel emotionally at time
  - what did doctor say

35) did you have sex during pregnancy?

- if yes
  - why

- until what month in pregnancy

- if no - why not

36) how did your pregnancy affect you?

VII Pre-Natal Care

37) did you receive pre-natal care for your pregnancy/pregnancies?

- if yes
  - where
  - how often
  - did you keep appointments
  - who did you see [doctor, nurse, midwife]
  - how examined
  - what did you discuss
  - receive helpful information

- if no - why not

38) did anyone else give you information and was it useful?
  - who and what

VIII Delivery

39) where did you deliver your baby/babies? why?

40) who delivered your baby?

41) was your pregnancy full term?

42) how long were you in labour?

43) how long did it take you to recover after delivery?

44) did anyone help you recover? who? how?

IX Breast feeding

45) did you breast feed only? [meaning no partial breast feeding]

- if yes - why
  - all babies
  - until what age for each baby
  - why did you stop for each baby

46) did you partially breast feed your baby?

- if yes - why
  - all your babies
  - at what age for each baby
  - for how long for each baby
  - what food did you give your baby

47) did you like experience of breast feeding?

48) IF NO Breast feeding, why not?

- did you ever consider partial breast feeding
  - if no, why not

X Caring for Baby

49) did you want to take care of your baby?

50) could you take care of your baby?

- if yes - you stay at home all day

  - do/did you have to go out to work
    - if yes - how many hours a day
      - when during day
      - how many days a week
      - what work
      - who care for baby while at work
      - does/did cost you money for care

  - do friends or family help care
    - if yes - how help

  - receive help/support from governmental agencies or from other organizations

- if yes
    - what ones
    - how help

- if no
    - why not
    - who is taking care of baby
    - does baby live in your household
    - how are you involved in your baby's care and raising

51) did/does baby's father help to take care of baby?

- if yes
    - how
    - did you have to ask

52) did you take care of a baby before you had your own?

- if yes
    - did you know what to expect when you had your own
    - did it make you feel prepared

- if no
    - anyone prepare you for what it's like to care for baby?
        - if yes
            - who
            - how
            - what did you expect
            - felt prepared
        - if no
            - what were you expecting

53) find it hard to cope when you had your first child?

54) how did your expectations change after your first child?

55) how do/did you feel as a mother? why? [e.g., good mother because say at home]

56) would you do anything differently?

XI General Questions

57) how do you feel about being a woman?

58) how do you feel about your body?

59) how do you feel about your sexuality?

60) do you think children should be educated about sex at school?

- if yes
    - at what age
    - what about

61) how do you feel about sex? [pleasure, procreation, enjoy etc.]

62) who should have sex and not have sex? [e.g., married people only, not teens]

63) what qualities make a good mother and a good father?

64) anything else?

---- end ----

Reproductive Health Interview for Menopausal Women

I Personal Information

1) what is your age?
2) what is your 'race'?
3) what is your religion?
4) what is your place of birth?
5) what level of education did you complete and when?
6) do you have any qualifications?
7) what is your union status?
8) how many children do you have?
9) how many times have you been married?
10) who do you live with?
11) do you contribute financially to your household? what do you do?
12) who else contributes financially to your household?

II Contraceptive Use

13) at present, are you using contraception?

14) have you used contraceptives in the past?

- if yes to 14 or 15
    - was it your decision to use
    - what method

- why use that method
- how long use
- where did you get it
- did you pay for it
- what were you told about it
- any side effects
- get pregnant using method

- if used in past also ask why stopped using method

15) who do you think is responsible for birth control?

III Sexually Transmitted Diseases (STDs)

16) do you ever think about the possibility of getting a STD?

17) have you ever been tested?

- if yes
  - how feel about being tested
  - at what age
  - were you treated
    - if yes
      - what about your partner
      - how make you feel
      - has it changed you

- if no
  - why not

18) how do you protect yourself from STDs?

19) what do you think of women who have STDs?

IV Reproductive Health Problems

20) do you have any reproductive health problems or worries? [e.g., heavy bleeding or lump in breast]

if yes
- what is it
- how long have it
- how has it affected you
- did you go to doctor; if yes, what happened

21) do you have a pap smear on a regular basis?

-if yes - how often
- since what age

-if no - why not

22) do you have a physical examination by a doctor on a regular basis?

- if yes - how often
- since what age

- if no - why not

V Menopause

23) at what age did you start menopause?

24) what signs or symptoms did you have?

25) did you think you were pregnant?

26) what did you do? [e.g., speak to doctor or friend]

27) how did you feel about entering menopause? [e.g. end of life for women]

28) how did your husband react?

29) did your family or friends notice any changes in you? how react and cope?

30) what did you discuss with your doctor?

31) who gave you information?

32) was information useful?

33) did you suffer from any other health problems as a result of menopause?

34) how has your life changed? [e.g., sex, work, social life]

VI General Questions

35) how do you feel about being a woman?

36) how do you feel about your body?

37) how do you feel about your sexuality?

38) do you think children should be educated about sex at school?

- if yes
    - at what age
    - what about

39) how do you feel about sex? [pleasure, procreation, enjoy etc.]

40) who should have sex and not have sex? [e.g., married people only, not teens]

41) what qualities make a good mother and a good father?

42) how do you feel about abortion?

43) how does your family feel about abortion?

44) were you prepared for menopause?

45) anything else?

---- end ----

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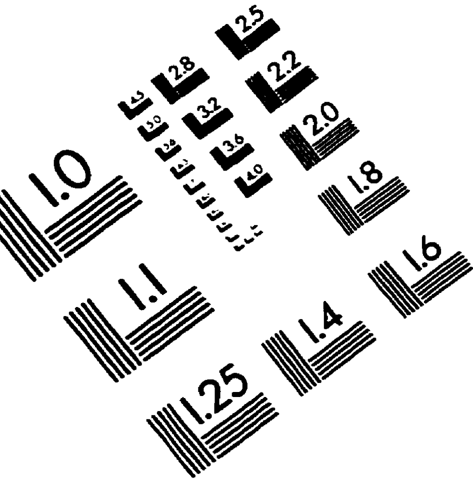
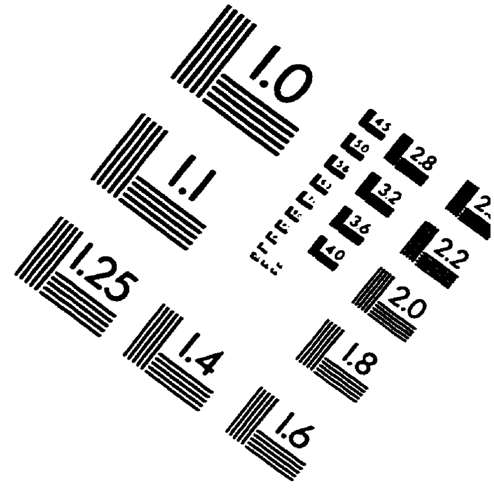
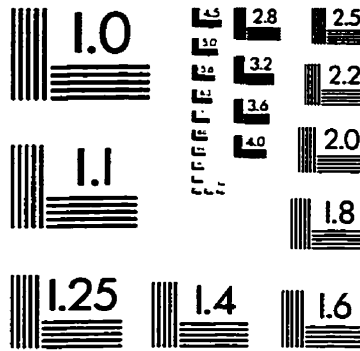
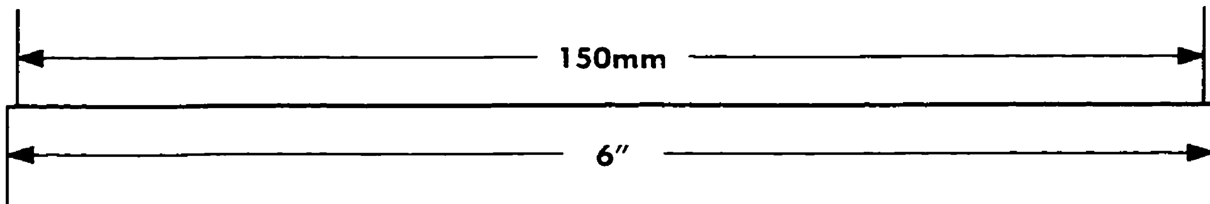
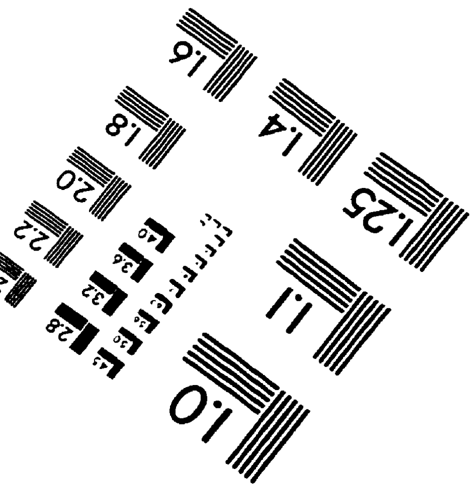
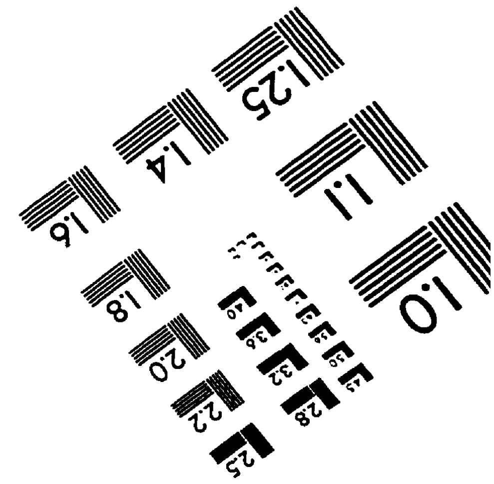
IMAGE EVALUATION TEST TARGET (QA-3)

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