

**POWERFUL BIRTH:
THE GLOBALIZATION OF CHILDBIRTH IN THE VALLEY OF PEACE, BELIZE**

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On a rainy July night in the Valley of Peace, Belize, Marinela, a nineteen year old, *primipara*¹ and immigrant, began to have contractions. As the night passed, her contractions intensified. In the early morning hours, Marinela and her husband, Julio, walked to her mother's house down the road. Marinela with the support of her family had decided to birth there with her mother, sisters, husband, and a traditional birth attendant (TBA), Doña Maria, in attendance. Doña Maria was sent for and the family anxiously awaited the birth of Marinela's baby. However, as the morning turned into afternoon, Marinela's labor made little progress and everyone, particularly Doña Maria, became concerned. It quickly became evident that Marinela was tiring and her concerted efforts to birth her baby were having minimal results. So, Doña Maria advised the family to find a truck to take Marinela to the nearest hospital in Belmopan, the capitol of Belize. Julio went quickly to the house of his cousin to hire him and his truck for the bumpy and sometimes difficult trip to the hospital. Soon, Marinela and Julio left for the hospital leaving heir families behind to wait for any news. Upon arrival at the hospital, rather than receiving empathetic and immediate care, Marinela was reproached for attempting to deliver her first child at home. The nurses told her that she would needed a caesarian, but the doctor was not immediately available. She would have to wait. As they waited, Marinela and Julio became more worried, unsure of what the nurses were telling them, and angered by the poor treatment they were receiving from the nurses. Emotionally and physically drained, they took matters into their own hands. They hired a taxi since Julio's cousin had already left and traveled an hour to another hospital in San Ignacio. At the other hospital, Marinela's serious condition necessitated urgent care. A doctor was available and a caesarian was performed. Tragically, it was too late and Marinela's baby girl was born dead. Marinela returned home with a wound that would become an ever-reminding scar of her stillborn baby girl.

¹ A woman who is pregnant and delivering for the first time.

Although Marinela, Julio, and their stillborn child are not real people that I came to know during my stays in the Valley of Peace, their story does reflect the narrative of many of the families I came to know as well as childbirth stories that were circulated, reconstructed, and retold, in particular the experience of one family during the summer of 2003. The death of Marinela's baby is tragic, predictable, and preventable. Through a critical examination of birth in the Valley of Peace, Belize, an immigrant community, I will illuminate the ways in which globalization, power, and, thus, resistance, and anti-immigrant sentiments converge upon and define childbirth. In essence, I will demonstrate how stories like Marinela's come to be.

Introduction

The production of authoritative knowledge occurs when one knowledge domain gains power over the other or others (Jordan 1993). Globalization has given biomedical systems of knowledge the power to infiltrate and even replace ethnomedical systems of knowledge. This shift in authoritative knowledge has significantly impacted all levels of the childbirth experience in communities worldwide. Through an ethnographic study, I will explore the impact of globalization on the childbirth experience in the Valley of Peace, Belize, a rural immigrant community largely consisting of traditional agriculturalists.

Childbirth is a physiological event experienced cross-culturally, yet the manner in which it is managed varies greatly from one group to the next. As Trevathan (1996:146) states, “It is cited as one of the four universal life-crisis events that are recognized with ritual in cultures worldwide.” Childbirth integrates the social and political domains of culture, and “political dynamics are often revealed in a close examination of who has the ultimate decision-making power in the management of birth and the treatment of the mother and child after birth” (Trevathan 1996:146). In most societies, birth and the immediate post-partum period are considered to be a time of vulnerability for the mother and child – a time of ritual danger. In order to deal with this danger, people tend to produce a set of culturally specific practices and beliefs designed to manage this time of uncertainty (Davis-Floyd 1992). Thus, childbirth is an excellent phenomenon for understanding social patterning and social construction and, in this case, the effects of globalization on traditional societies.

Furthermore, maternal and child health is an issue of international concern. Anthropological studies of childbirth have much to offer to national and international policymaking and policy action. Although anthropologists have long acknowledged the impacts

of culture on the effectiveness of health improvement programs, policymakers and policy enactors are just beginning to recognize the importance of cultural factors, in particular the cultural factors that shape the biomedical birth. The roles of anthropologists are critical and continually evolving. There is a need for research on the impacts of globalization on childbirth in traditional societies.

Although the effects of globalization on childbirth have recently been intensively documented, the manner in which these particular dynamics unfold in an immigrant community has yet to be fully examined. Women and healthcare providers in the Valley of Peace, Belize are finding creative ways to combine the medicalization of birth with traditional beliefs creating a unique combination of complex interactions and processes. Research such as mine can help to form maternal and child health projects that will work to minimize the negative impacts of globalization while optimizing its positive impacts.

CHAPTER 1

THEORETICAL CONCERNS

Reproduction has emerged as an important focus of anthropological study because of two significant historical occurrences (Ginsburg and Rapp 1991). The first event has been the recognition by feminists of women's reproductive constraints and possibilities as sources of oppression and power. The second has been the impact on traditional societies of the uneven globalization of Western medicine. Anthropology of reproduction places reproductive practices, policies, and politics at the center of social theory, and by doing so, we can understand how cultures are reproduced, changed, or contested as people envision and enable the reproduction of the next generation (Ginsburg and Rapp 1995).

The globalization of biomedicine has resulted in the increasing medicalization of childbirth. Traditional societies (ethnomedical systems of knowledge) tend to treat childbirth as a normal physiological event, while modern societies (biomedical system of knowledge) tend to view childbirth as an illness which must be overseen by a doctor in a highly controlled and sterilized environment. The medicalization of birth has been marked by changes in three major areas: 1) advances in medical and surgical techniques and an expansion in the role of physician in comparison to midwives; 2) demographic trends, specifically a decline in maternal mortality associated with a shift from home to hospital births; and 3) a shift in authoritative knowledge about reproduction as well as a change in the meaning of the birth experience (Obermeyer 2000). Although maternal mortality has been reduced, it has not been significantly reduced in many areas of the world impacted by globalization (Cosminsky 2001; Davis-Floyd 1992).

The childbirth experience has been significantly impacted by medicalization (Davis-Floyd 1992; Davis-Floyd and Sargent 1997; Ginsburg and Rapp 1995; Jordan 1993). Where the

birth was once owned by the woman herself, the birth has now been taken over by the doctor and medical technology. Focus is placed on the numerous machines attached to the woman, as if they are having the baby. Although biomedicine has saved the lives of many women and infants through medical interventions such as caesareans, it has also given rise to the routine performance of many unnecessary medical interventions. Some common, unnecessary medical interventions include the routine administration of an episiotomy (cutting the perineum to prevent tearing), the use of drugs (Pitocin™) to strengthen contractions and speed-up the delivery, and the administration of an epidural to numb pain. In many cases, these procedures are unnecessary and adversely affect both mother and child. Clearly the expansion of the medicalized birth is having significant and alarming effects on childbirth worldwide. This expansion must be documented internationally, through ethnographic case studies, so that a better understanding can be reached and maternal-child healthcare can be improved on a global scale.

A Framework for Exploring the Effects of Globalization²

Critical medical anthropology, influenced by Marxist theory and dependency theory, provides a framework for analyzing the impact of global economic systems, particularly capitalism, on local and national health (McElroy 1996). This framework has been further influenced by the works of Michel Foucault, emphasizing differentials in power and authoritative knowledge, and the body as an arena for ideological power struggles (McElroy 1996; McNay 1993). When describing the cultural ascendancy of biomedicine, Foucault (1978:140) referred to its cultural authority as “biopower,” which he defined as “disciplines of the body,” used as “numerous and diverse techniques for achieving the subjugation of bodies and the control of

² For the purposes of this study, globalization is defined as the uneven, global spread of biomedicine, in particular biomedically defined reproductive practices, technologies, and policies.

populations.” Thus, from Foucault’s perspective the biomedicalization of bodily processes, such as childbirth, is “subjugated and controlled” through “numerous and diverse techniques” of the biomedical institution, such as the routine use of the lithotomy position, episiotomies, labor-inducing drugs, and epidurals. The birthing woman’s body is disciplined and the birthing process is controlled.

Nancy Scheper-Hughes has also explored the body as an arena for ideological struggles. According to Scheper-Hughes (1994:232) “the body” becomes the terrain where social truths are forged and social contradictions are played out. It is the locus of personal resistance, creativity, and struggle. Faye Ginsburg and Rayna Rapp (1995) argue that women actively use their cultural knowledge and social relations to incorporate, revise, or resist the influence of seemingly distant economic and social forces. In particular, Ginsburg and Rapp are referring to women’s ability to revise or resist the power of the state, which is increasingly influenced by the globalization of new reproductive technologies. With the influence of postmodernism, the works of Foucault, and reproductive anthropologists such as Ginsburg and Rapp, “the body” has become a site for examining women’s reproductive activities, particularly as defined and acted upon by the biomedical establishment. This theoretical paradigm has provided a framework for exploring and understanding the effects of the globalization of biomedicine on women’s reproductive health (e.g., Davis-Floyd 1991; Davis-Floyd, Pigg, and Cosminsky 2000; Davis-Floyd and Sargent 1997; Jordan 1993; Ginsburg 1998; Ginsburg and Rapp 1995, 1991; Martin 1987; Rapp 2000).

Power

Eric R. Wolf (1994) has outlined four modes of power: 1) power as the attribute of the person, 2) the power of an *ego* to impose its will on the *alter*, 3) organizational power, and 4)

structural power. The fourth mode of power has recently been at the center of extensive anthropological inquiries about reproduction (e.g., Davis-Floyd 1991; Davis-Floyd and Sargent 1997; Jordan 1993; Ginsburg and Rapp 1995, 1991; Martin 1987). Structural power not only operates within settings, but also organizes and orchestrates the settings themselves, which in turn specifies the distribution and direction of energy flows (Wolf 1994). According to Wolf (1994), this is the kind of power Marx defined as the power of the capital to harness and allocate labor-power, and it is the basis for Foucault's notion of power as the ability "to structure the possible field of action of others" (Foucault 1984:428). For studying power in the context of childbirth, Marx's ability to harness and allocate labor-power should be understood as the ability to harness and allocate reproductive-power. In relation to Foucault's notion of power, power in the context of childbirth can also be understood as the ability to structure the possible range of choices and actions available in childbirth. In other words, childbirth is structured by the hegemonic or institutionalized power of the culture to deem what is or is not culturally appropriate.

Thus, the mother's body becomes a site for power struggles, in which multiple levels of social and political interests intersect. These multiple levels of social and political interests range from the individual interests of the mother to the interests of the state, religious institutions, as well as national and multinational corporations. The spread of biomedical childbirth practices, through globalization, has further exacerbated the hegemonic control of women's reproductive strategies and rights.

Authoritative Knowledge

During childbirth, the struggle for authoritative knowledge concerns the control and management of the mother's body, labor, and delivery. Brigitte Jordan first defined and explored authoritative knowledge as a source of institutional power (Wolf's structural power):

The central observation is that for any particular domain several knowledge systems exist, some of which, by consensus, come to carry more weight than others, either because they explain the state of the world better for the purposes at hand (efficacy) or because they are associated with a stronger power base (structural superiority), and usually both. (Jordan 1993:152)

In many societies equally legitimate knowledge systems coexist, and people move easily between them according to their desired goal. But more often than not, one knowledge system gains power or authority over others. As a consequence, alternate knowledge systems are devalued, and those who practice within them are seen as backward or ignorant. Thus, the production of authoritative knowledge should be seen as an ongoing struggle for "structural power". Explorations in medical anthropology have revealed that with globalization, Western medical systems of knowledge have ascended to legitimacy, and in the process overtaken ethnomedical systems of knowledge. The result has been an ideological struggle for the control of women's reproductive bodies, placing constraints on the range of women's reproductive choices and possibilities.

In relation to power and authoritative knowledge in childbirth, the following questions provide a research foundation: Who owns birth? Who possesses the knowledge to control and manage birth? Who has the power to make decisions about the birth? What power relations are played out between modern and traditional birthing systems? What affects the choices women make regarding birth? I expect that the answers to these questions are intricately interwoven with cultural ideas, beliefs, and practices, as well as increasingly influenced by globalization and the biomedical knowledge matrix.

The Impacts of Globalization on Childbirth

A great deal of research has been conducted in order to better understand the impact of these changes. Although this field of research does not explicitly address refugee communities, it will form the basis for my study.

Literature Review

The current literature demonstrates the complexity of childbirth when biomedical and ethnomedical systems of knowledge collide. Childbirth participants are forced to choose between varying and often conflicting ideas about how the birth event should occur. The resulting decisions can tell us a lot about cultural persistence, cultural resistance, and cultural change. However, more information is needed cross-culturally, particularly on refugee communities, to complete our understanding of the effects of globalization, an international phenomenon, on the local.

Sheila Cosminsky (2001) comparatively analyzes midwives in southern Mesoamerica, focusing on the indigenous Mayan groups of Guatemala, Chiapas, and the Yucatan. Cosminsky's analysis addresses the following questions: (1) What are the common patterns and the variations in the role of the midwife, and in her knowledge and practices? (2) What is the impact of medicalization? Cosminsky (2001:179) states, "More than any other type of healer, midwives have been bombarded with pressures of medicalization....The process of medicalization involves the contestation of midwives' authoritative knowledge by biomedicine, which becomes accepted as the authoritative one."

Cosminsky discovers that the biomedical model, upon which midwifery training programs are based, is not effectively transmitting obstetrical knowledge to the midwives. Despite the introduction of these training programs, there has not been a significant decrease in

maternal and infant mortality rates as expected. Instead, the training programs undermine the authoritative knowledge of the midwives and “ignore the sociocultural, economic, and political contexts of poverty, inequality, and underdevelopment that underlie high maternal and infant mortality rates” (Cosminsky 2001:210).

Cosminsky does note that midwives have adopted two biomedical practices that are not taught in the training programs: the use of oxytocin injections to speed up delivery, making women push before they should, and internal vaginal examinations. The adoption of these practices is evidence of medicalization occurring outside of the state-sanctified midwifery training programs. It can be seen as an expression of the authoritative knowledge of pharmaceutical companies and as an effect of globalization.

Paola Sesia (1997) addresses the interplay between the “hands-on,” authoritative knowledge of traditional midwives and the biomedical system. She focuses on prenatal care as it is taught in certification training courses, and then how it is actually practiced by the midwives in their communities. Like Cosminsky, Sesia finds that certification training courses have failed to replace ethno-obstetrics with biomedical obstetrics.

Sesia addresses three points that have significant implications for improving maternal health care programs. First, she discusses the fact that the conceptual gap between biomedicine and ethno-obstetrics is not given consideration in training courses. “Assuming the authority of biomedicine, training personnel never showed any interest in finding out what parteras do or why” (Sesia 1997:403). Second, after returning to their villages, none of the midwives continued practicing the biomedical conceptual framework taught to them in the training courses. “Contrary to the government health sector’s expectations, certification courses seem to be one of the variables that have had the least impact on changing local midwives’ views and practices”

(Sesia 1997:403). This study and others reveal that the initial experience of training to be a *partera* (a traditional, Hispanic midwife) and the extent and quality of interaction with the formal health sector after training have the greatest impact on local midwives' conceptual and birth managerial framework. Third, Sesia found that the majority of local midwives "shared and supported ethno-obstetric rationales and activities, regarding them as authoritative" (Sesia 1997: 404).

Elena Hurtado and Eugenia Saenz de Tejada (2001) examine the relations between traditional indigenous midwives and practitioners from the official health system in Guatemala.

In Guatemala, the tensions between traditional and biomedical systems of health care are complicated by the coexistence of indigenous and ladino ethnic groups, and by ethnic discrimination based upon language, appearance, and other characteristics. Tensions in the area of health care have to do with these elements of ethnic discrimination, with specific conflicts resulting from practices derived from different systems of health beliefs in these groups, and from geographical barriers (Hurtado and Saenz de Tejada 2001: 239).

Interviews revealed that the local midwives felt as though they were being attacked by the biomedical practitioners. Both groups felt that there were few attempts from the other to reach a mutual understanding and respect. The authors conclude by promoting the concept of a "traditional birth attendant (TBA)-friendly hospital" modeled on the WHO-UNICEF baby-friendly initiative and the Coalition for Improving Maternity Services (CIMS) (1996) mother-friendly childbirth initiative. Such initiatives have also been actively promoted by other anthropologists (e.g., Davis-Floyd 1992, 2001; Ginsburg and Rapp 1991, 1995).

Andrea Whittaker (1999) investigates discourses of modernity and tradition and their effects on birthing and postpartum practices in a rural village in Northeast Thailand. In Isan, Northeast Thailand, modern medical expertise is subordinating traditional knowledge and practices. The majority of women surveyed now give birth in the hospital, as opposed to a

traditional birth at home with a *mor tam ye* (traditional birth attendant, TBA). Whittaker is particularly interested in this shift of knowledge and practice, and how it is related to discourse on modern and tradition. Whittaker has also discovered, however, that despite the assumption that traditional medical system will succumb to more “rational,” western biomedicine, women continue to engage in traditional postpartum practices. The women of Northeast Thailand are constantly moving between western and traditional realms of knowledge, practice, and authority.

Power relations underlie the health care decision-making process. Through the media and other forms of representation, old-traditional medical systems are connected to ignorance and underdevelopment, while the modern medical systems are linked to development and improvement. Whittaker states, “While the women described in this paper make active choices about where and how they give birth, these choices take place within unequal relations of power between the institutionalized biomedical state health system and local practices and knowledge” (Whittaker 1999:240).

Regardless of the previously mentioned factors, women continue to observe traditional postpartum practices, such as staying by the fire and following dietary restrictions. Whittaker sees these practices as a form of resistance. On a daily basis women are moving between realms, making decisions that are driven by power relations. Their identity as Isan women is defined and redefined. Whittaker (1999:240) concludes, “The persistence of postpartum rituals in the village draws attention to the need to analyze reproductive health behavior through an appreciation of the political and historical processes at individual, social, and national levels that shape the social construction of reproduction.”

In a case study of motherhood in Morocco, Makhoul Obermeyer (2000) investigates choices women make regarding birth. The construction of authoritative knowledge plays a key

role in the mother's decision-making process. Morocco subscribed to the Safe Motherhood Initiative developed by the World Health Organization in 1987 to reduce maternal mortality, but like many other countries Morocco failed to see significant improvements in maternal mortality.

It has been postulated that the infrequent use of health services may be due to a lack of awareness of the risks of childbirth. Obermeyer, however, discovered that ideas about risk are found in the local construction of childbirth, and that women make decisions that reflect the options available to them. In fact, Obermeyer reveals that although two-thirds of births take place at home attended by a *qabla*, most births combine elements of both modern and traditional health systems. The women move freely between the two systems of knowledge, incorporating situational appropriate beliefs and practices. Obermeyer also addresses the power relations involved in creating authoritative knowledge in the biomedical system, as addressed by Whittaker (1999), Jordan (1993), and Davis-Floyd (1992).

The risk of childbirth is acknowledged by the local women through expressions, discourse, and strict regulations concerning women during pregnancy, childbirth, and postpartum. Local discourse addresses liminality and vulnerability (a between state of being) through the observation of *nfas* (40 day period postpartum). During this time the woman is considered to be *nafsa* and is given rights and flexibility, such as being a truth-sayer and exempt from labor rules. The women in Morocco are fully aware of the risks of childbirth and are constantly negotiating decisions concerning liminality and vulnerability. Often the fear of unnecessary medical procedures and an unfamiliar environment outweigh the risks associated with a traditional birth. Obermeyer (2000) concludes by encouraging us to think of the risk strategies related to childbirth as a "continuum of possibilities," with the representative modern birth on one end and the traditional birth on the other. "In contemporary Morocco, as elsewhere,

women's actions result from a negotiation between the two poles of modern birth and traditional birth, and for most, the choices fall somewhere in between" (Obermeyer 2000:198).

Gwynne L. Jenkins (2003) exposes the destruction of local midwifery in Costa Rica by exploring the multiple levels acting upon its practice in Buenos Aires, a rural community. Jenkins recognizes the impact of macro-level forces on the shift in locale and value from home to hospital births and uses policy analysis as a tool for its exploration. The impacts "top-down" are particularly illuminated by Costa Rica's midwife certification program, which co-opted rural midwives as bridges to biomedicalization based on programmatic statements issued by World Health Organization (WHO) Expert Committees and eventually led to the illegalization of home birth and other midwifery practices before national maternal-child health services were readily available to all women, most importantly rural and/or poor women. However, midwives' services are still being demanded in unanticipated ways that place the local midwife in precarious and even illegal positions. In addition to "top-down" forces, Jenkins reveals that the assault on midwifery is also occurring "bottom-up" as more women choose hospital births and devalue the services provided by local midwives. The services of the local midwife are no longer "embedded in a system of exchange that is socially and economically meaningful" (Jenkins 2003:1893). Consequentially, midwives are being alienated by a lack of respect and compensation in their client relationships and are, thus, limiting their services to the point of retirement, effectively burning bridges to biomedicalization. Jenkins (2003:1907) concludes "the local level is the most important for understanding health change: policies and programs are utterly ineffectual unless local level actors decide to take action." Jenkins goes on to suggest policy changes in order to prevent the destruction of local safety nets provided by midwives. These include: 1) further integrate local midwives into rural health care infrastructure; 2)

provide material support to local midwives, 3) provide a salary or honorarium in exchange for the work of local midwives; and, 4) create policies and programs that promote and train midwives as safety nets rather than temporary bridges to biomedicalization.

These studies reveal the effects of globalization on the local childbirth experience. Each of these case studies illustrates the unique negotiations occurring at the local level and their impact on maternal-child health. However, none of these case studies explores these negotiations in a refugee community. My research will expand anthropological knowledge on childbirth, allowing us to better formulate maternal-child health improvement projects.

CHAPTER 2

THE RESEARCH SETTING: THE VALLEY OF PEACE, BELIZE

In 1982, a joint venture by the Government of Belize and the United Nations High Commissioner for Refugees (UNHCR) established the Valley of Peace as a permanent refugee village. It is located in the heart of the Belizean jungle, off of the Western Highway, 15 kilometers from Belmopan, Belize's capitol. According to the 2000 Belize census, the population of the village is 1,800. As its name suggests, it is a haven for refugees and immigrants who have left nearby Central American countries in search of a better life. According to a UNHCR report, "...the Valley of Peace is a symbol of the refugees' willingness to integrate. It is a unique undertaking, and the village now has an elected town council and enjoys all the rights of other Belizean villages" (Ferrero 1989:13).

The Valley of Peace was developed to provide a new beginning for the large influx of refugees from El Salvador³. Refugee families began arriving in Belize in 1980. They were scattered about the country and in a desperate state. In 1982, the first fifty families were selected to settle in the Valley of Peace; they consisted of thirty Salvadoran families and twenty Belizean families, primarily Creole. The Belizean families were encouraged to co-settle in the village in order to promote the refugees' integration into national society. Today, only one of the original Creole families still lives in the Valley of Peace. In 1983, a second group of fifty families joined the first families. Again the fifty families consisted of thirty Salvadoran families and twenty Belizean families, this time primarily mestizos. And in 1984, the final group of fifty families was selected to resettle in the Valley of Peace. There were thirty more Salvadoran families and twenty Belizean families, who were mostly Kek'chi Mayas from the Punta Gorda area. The

³ Information concerning the history of the Valley of Peace was provided by José Amilcar Amaya, a local teacher and historian.

families that resettled in the Valley of Peace were given a one acre house lot in the center of the village and several hectares of land. This land is primarily used to grow maize, beans, and corn for local consumption. The families also received financial assistance for one year. Today, more than 150 families have joined the original 150 families in the Valley of Peace (Ferrero 1989). These families are economic immigrants, predominantly Salvadoran families who came to Belize at a later time and were not officially recognized as refugees, as well as families from Guatemala, Honduras, and Nicaragua.

The civil war in El Salvador during the 1980s prompted most of the families that have resettled in the Valley of Peace to leave their homeland. The poor campesinos of El Salvador rose up against the wealthy elite who owned and controlled most of the countries resources. The Valley of Peace families are campesinos who were usually caught in the middle. For most of the families, the loss of family members and the terror of everyday life forced them to flee El Salvador. Today, it is estimated that the Salvadoran civil war took the lives of over 100,000 people, more than 10,000 disappeared, and more than one million found political asylum in neighboring countries (UNHCR 2000).

Guatemala and Nicaragua were also experiencing civil wars during this time period. In each of these countries, insurgency and counterinsurgency also resulted in a huge loss of life and large-scale displacement. It is estimated that more than two million people in these countries were uprooted during this time period (UNHCR 2000).

In response to the area's refugee crisis, many Central American countries adopted the Cartagena Declaration of 1984. Like the 1969 Refugee Convention of the Organization of African Unity, it broadens the definition of a refugee given in the 1951 United Nations Refugee Convention to include those persons who flee their country "...because their lives, safety or

freedom have been threatened by generalized violence, foreign aggression, internal conflicts, massive violation of human rights or other circumstances which have seriously disturbed public order” (UNHCR 2000). The Belizean government utilizes the Cartagena Declaration as a guide for recognizing and managing refugees. Thus, the majority of settlers in the Valley of Peace are mestizos from El Salvador. However, there are also mestizos from Belize, Guatemala, Nicaragua, and Honduras, and Kek’chi and Mopan Mayas from Belize and Guatemala. Belize’s 1999 Amnesty offered all of the country’s refugees and immigrants an opportunity to obtain national citizenship. Although most of the refugees living in the Valley of Peace completed the amnesty process, many of the refugees were unable to and remain undocumented. In addition, many families who resettled in the Valley of Peace after its initial settlement were not officially recognized as refugees and, thus, were not able to apply for amnesty. These issues can often complicate help-seeking behavior and limit birthing options.

Although the Valley of Peace is only 15 kilometers from Belmopan, the capitol of Belize, travel time to the capitol city of Belize may take in excess of an hour. The road to Belmopan is an all-weather, dirt road and entails crossing the Belize River on the Young Ferry. Depending on the conditions of the river and the ferry itself, the ferry may not be in service. During the annual rainy season (June-December/January), the ferry may be flooded and unusable for months at a time. When this occurs, a walking, swing bridge is available that has never been flooded. Weather permitting, a bus, owned and operated by a local cooperative, services the trip from the Valley of Peace to Belmopan twice daily.

Unlike most Belizean villages, the Valley of Peace is not located along a major creek or river where people can easily access water. Through a joint project of the Belizean Government and the United Nations, the village acquired a water reservoir in 1995. Families, who could

afford to do so, were given the opportunity to acquire running water in 1998. The water is pumped from the Belize River and chlorinated. However, the pump and pipes break quite often and it is not uncommon for the village to go without running water for weeks at a time.

Previously, water was obtained from one of several village wells or from rain water collected in holding tanks. Many families continue to obtain water this way. In 1994 the village acquired electricity.

Currently, the Valley of Peace has two primary schools, a Catholic school and an Evangelical school, and a preschool operated by Rio de Aguavida, an Evangelical church. Both schools instruct students in English and educate grades one through six. In total, there are eight churches of four different denominations including Catholic, Pentecostal, Baptist, and Evangelical. Of the eight churches five are Evangelical, one is Catholic, one is Pentecostal, and one is Baptist. There is also a police station and a rural health clinic that has been in and out of operation since 1985.

In the Valley of Peace, language sometimes serves as a barrier. At times this barrier may isolate the community from national society, but it may also serve as a protective barrier by providing a channel for resistance. English is the official language of Belize, but Spanish is the primary language of the village. However, more and more of the Spanish-speaking immigrants are learning English. The Mayas predominantly speak Kek'chi, but there is also a small group of Mayas who speak Mopan. The Mayas may also know English or Spanish, or a little of both. Belizean Creoles who settled in the village primarily speak Creole and English. Thus, on an individual basis, there may be a situation in which neighbors may not be able to communicate effectively, but when there is a number of people gathered, language capabilities will overlap and

people will work together to communicate effectively. As will be discussed, language can have a substantial impact on childbirth in the Valley of Peace.

Anti-Immigrant Sentiment

It is of import to specifically address the issue of anti-immigrant sentiment since it can have far-reaching impacts on birthing. According to Salazar (nd:vii), Belize is the Central American country that has received the largest influx of immigrants since 1983, and in 1994 foreigners represented almost 20% of the country's total population. Salazar goes on to state, "The migrant population's heavy impact on services, access to land, and job opportunities has made them a constant and growing target for the local population's hostility and rejection." Following the literature, immigrants and refugees have been conflated in order to refer to this hostility as anti-immigrant sentiments.

The Valley of Peace is one of only three settlements that are predominantly settled by refugees. Salvapan and Las Flores are the other two settlements. All of these settlements are located in the Cayo District, which at 34.5% has the highest percentage of immigrants (UNHCR 1993). Thus, the Cayo District is an area of Belize that has been heavily impacted by the large influx of Central American immigrants, and due to the history and recent settlement of the Valley of Peace anyone from the community is readily identified and even targeted as an immigrant.

CHAPTER 3

METHODOLOGY

The results of a six-week pilot study conducted during the summer of 2002 (May 14-June 24) provides the basis for this study. Permission was granted to conduct the pilot study by the Department of Archaeology, Government of Belize under the Valley of Peace Archaeology Project, directed by Dr. Lisa Lucero, an Assistant Professor at New Mexico State University. While conducting the pilot study, I lived with Doña Maria, a TBA, and her family. I conducted participant observation and interviews on a daily basis in Doña Maria's home with her and the women she attended. Also I made weekly visits to the village's rural health clinic as well as the hospital in Belmopan where I also conducted participant observation and interviews. In addition, I interviewed Doña Juana, another TBA practicing in the Valley of Peace; however, due to Doña Juana's age her practice had become limited.

During this preliminary field visit I was able to attend a home birth with Doña Maria and spent a great deal of time with the three maternal-child healthcare providers in the Valley of Peace. As such, for my next field visit, as you will see in what follows, I decided to focus much of my energy and attention on getting to know the birthing women of the Valley of Peace. Relevant information gleaned during the pilot study has been incorporated into my research findings.

I conducted an ethnographic study in the Valley of Peace, Belize in two phases over the two years. The first phase of fieldwork was conducted during the summer of 2002 (May 14-June 24), and the second phase of fieldwork was conducted during the summer of 2003 (May 19-June 30). Permission for both phases was granted by the Department of Archaeology, Government of Belize under the Valley of Peace Archaeology Project, directed by Dr. Lisa Lucero, an Assistant

Professor at New Mexico State University. My approach included participant observation, semi-structured interviews, open-ended, in-depth interviews, and archival research.⁴ I interviewed four groups of women: 1) women who were currently pregnant or have had at least one child in the Valley of Peace, 2) two local TBAs, Doña Maria and Doña Juana, 3) the rural health nurse, Elita, and 4) a representative of the maternal-child health clinic at the Western Regional Hospital, Nurse Witt. In addition, I conducted participant observation on a daily basis in three locales: 1) the homes of women who were currently pregnant or have had at least one child, 2) the home of Doña Maria, and 3) the rural health clinic. During both phases of the study, I lived with Doña Maria and her family.

Participant Observation

As mentioned previously, I conducted participant observation in three settings. First, I conducted participant observation in the homes of six women who were currently pregnant or have had at least one child. This process not only allowed me to observe the women's childbirth-related behavior, but also the contexts of their behavior, such as their daily challenges, the amount of support they receive from spouses, family, and friends, as well as their economic situation. All of these driving forces involve issues of race, class, and gender and also impact childbirth options, decision-making, and outcomes. Second, since I stayed with Doña Maria, everyday involved participant observation. Women visit Doña Maria's home on a regular basis to receive prenatal and postpartum care and support. Thus, I was able to observe Doña Maria's interaction with the women. I was also able observe Doña Maria's daily activities and challenges, which affect the quality and quantity of care she provides as well as women's childbirth options, decision-making, and outcomes. Third, I conducted participant observation at

⁴ I have completed the necessary forms, according to New Mexico State University's Institutional Review Board, to conduct research involving human subjects. Each study participant was asked to sign a consent form. Please see Appendix A.

the rural health clinic on Wednesdays, the day reserved for maternal-child healthcare. As in the home of Doña Maria, I was able to observe the quality and quantity of care the women receive from Elita at the rural health clinic. Likewise I was able to observe the daily activities and challenges of Elita and the rural health clinic and their impact on women's childbirth options, decision-making, and outcomes. I found that this method of participant observation provided invaluable information about the six women I focused on, because I was not only able to observe them in maternal-child healthcare settings but also in their own homes. The home environments of these women revealed the intricacies of daily life that shape their childbirth experiences.

Semi-structured Interviews

I conducted semi-structured interviews with key maternal-child healthcare providers, including Doña Maria, Elita, and Nurse Witt. Each of these women represent the three maternal-child healthcare options available to women in the Valley of Peace, TBAs, the rural health clinic, and hospital care. Interviews took place on a daily basis with Doña Maria and a weekly basis with Elita. I conducted one lengthy interview with Nurse Witt. These interviews cover the scope of modern and traditional healthcare providers who have conformed to varying degrees of the medicalization of childbirth. Focus was placed on beliefs, practices, and preferences, as well as how healthcare providers perceive one another and birth in the Valley of Peace. I also inquired about the level of cooperation, interaction, and knowledge-sharing between healthcare providers involved in childbirth in the Valley of Peace.

Open-ended, In-depth Interviews

Open-ended, in-depth interviews were used to assess women's perceptions of childbirth in the Valley of Peace. On a weekly basis, I interviewed the same six women with whom I conducted participant observation. The interviews took place in the women's homes and were

conducted in English and Spanish, according to the preference of the interviewee. The six women I interviewed reflect the varying ages, backgrounds, and ethnicities of the women of the Valley of Peace. The women were asked to describe each of their pregnancies and births, with particular focus on the types of care they received before, during, and after delivery. They were also asked to identify and evaluate their childbirth options, choices, and outcomes. Furthermore, the women were asked to identify and rate the factors that influence their childbirth choices. In addition to information about their childbirth experiences, the women shared invaluable information about their family history, life history, and daily lived experiences.

Archival Research

Along with participant observation and interviews, I was able to retrieve archival documents that could further inform my description and analysis of birth in the valley of Peace. With Elita's permission I gained access to records of all the births that had occurred in the Valley of Peace during the previous year. I created a database of each birth, the place of birth, and the birth outcome. Names, medical history, or any other identifying characteristics were not collected in order to preserve anonymity. In addition, I obtained a copy of the national health statistics as documented and compiled by the Ministry of Health. Included in this publication is a record of all national births, which I have used for comparison and analysis.

CHAPTER 4

CHILDBIRTH IN THE VALLEY OF PEACE

Birth Options in the Valley of Peace

There are several healthcare options for pregnant women in the Valley of Peace. These healthcare options include TBAs, the rural health clinic, and the Western Regional Hospital in Belmopan.⁵ Since TBAs work in their community and have learned their skills through apprenticeship and experience, they are categorized as traditional health practitioners. This is in comparison to professional midwives or nurse-midwives, who have received extensive biomedical training in a hospital or maternity center setting. TBAs tend to utilize traditional healthcare practices, which are defined as practices not taught in biomedical settings; however, with the globalization of biomedicine TBAs are learning and incorporating biomedical practices. In contrast, the rural health clinic and the Belmopan hospital are biomedical institutions, and the maternal-child healthcare practitioners at these institutions have received formal biomedical training.

There are also a small percentage of women who do not utilize any of the above mentioned maternal-child healthcare options. These women tend to be Mayas who can communicate only in Kek'chi or Mopan. They choose to birth at home solely with the support of a spouse, family member, or friend because of cultural, social, and economic factors.

Home Care

In the summer of 2002, there were two licensed TBAs in the village. The TBAs are refugees who speak Spanish and know little, if any, English. Both women I interviewed learned

⁵ Women in the Valley of Peace may choose to access maternal-child healthcare and deliver at other hospitals in San Ignacio and Belize City, but the majority of women utilize the services at the Western Regional Hospital due to its proximity.

midwifery from their mothers who were midwives and had practiced midwifery in their country of origin. After settling in the Valley of Peace, both TBAs received licensure from the Belize Ministry of Health by completing a training course for TBAs. The training course, held at the Belmopan Hospital, requires the TBA to attend classes, watch 20 births, serve as the primary attendee for 20 births, and spend four days on call at the hospital during the final week of training. Both TBAs, Doña Maria and Doña Juana, provide prenatal, labor and delivery, and postnatal care in exchange for approximately \$50 Bze. (\$25 U.S.). They attend home births and, when necessary, transport women to the nearest hospital in Belmopan. Neither of these women owns an automobile and must rely on the aid and generosity of others. It is of import to note that payment is not always in the form of cash. For instance, Doña Maria often received food items, such as locally grown rice and beans, as payment. In other instances, a woman and her family may be unable or unwilling to pay. In such instances, there are no other avenues for the TBAs to receive reimbursement for their services.

The majority of women in the village give birth at home attended by one of the TBAs. As has been found in other research (see Cosminsky 2001 and Sesia 1997), both TBAs incorporate traditional as well as biomedical practices into the healthcare services they provide. For example, Doña Maria often uses *herba buena* (a weed-like herb in the mint family) to facilitate labor and still performs the *sobador* (a traditional massage), while at the same time monitoring the fetus' heart rate and using oral drugs, such as ergometrine, to stop postnatal hemorrhaging.

Although the Belize's Ministry of Health sanctifies their practice, there are restrictions on the care the TBAs can provide. These restrictions include:

- TBAs can only attend the second, third, fourth, and fifth delivery of a woman;

- TBAs may not attend births in which the fetus presents in an abnormal position;
- TBAs should never administer injections to aid the delivery of a child.

However, in a village such as the Valley of Peace, situations arise that necessitate the violation of these restrictions for the sake of the mother's and child's health. A lack of necessary support and infrastructure, such as transportation, decent roads, or a much needed bridge, often forces the TBAs to handle situations that are beyond the scope of their licensure. In addition, some women refuse to deliver at the hospital despite high-risk factors, such as first deliveries and deliveries beyond the fifth. The TBAs often willingly agree to attend these women, but are sometimes forced to attend a woman who should be delivering at a hospital. I have also witnessed the TBAs actively recruit women that restrictions prohibit them from attending. The TBAs assure the women, who are usually *primiparas* or pregnant beyond their fifth child, that everything will go smoothly and that they possess the knowledge and experience to guide them through labor and delivery.

Care at the Rural Health Clinic

The Valley of Peace's rural health clinic has been in and out of operation over the past twenty years. It is currently in operation and staffed by a Cuban doctor, a Belizean rural health nurse, and a local aide who is Maya. Concepcion, the aide, is responsible for various duties around the clinic, and also serves as an interpreter for the Maya population since she speaks Kek'chi and English. The doctor attends to a number of illnesses and infections, and also performs minor surgical procedures. He is available Monday through Friday. While conducting my pilot study, I established a relationship with the rural health nurse, Elita. Elita primarily communicates with the village women in Spanish, but she is also fluent in English. She lives in a house next to the clinic and is available during regular clinic hours, Monday through Friday,

and for after-hours emergencies. Elita allowed me to observe the care she provides to pregnant women and interview her on a weekly basis.

At the rural health clinic, Wednesdays are reserved for maternal-child healthcare. A prenatal health card is created for every woman that visits the clinic for maternal healthcare. It is duplicated and one copy is kept on file by Elita and one is given to the pregnant woman to keep in her possession. The prenatal card kept by the pregnant woman serves as a mobile medical record that ensures consistent care throughout pregnancy and birth. Women who develop signs of complications are encouraged to see an obstetrical doctor at the Western Regional Hospital's high-risk maternal-child health clinic in Belmopan. The woman will carry her prenatal card between the differing healthcare providers so that there is an accurate account of her prenatal status and care. During the prenatal visit Elita monitors the mother's weight, blood pressure, urinary levels of protein and glucose, and uterine height. The fetus' heartbeat and position is also monitored. These variables, along with social and medical history of the mother, such as number of years of education, literacy status, and family history of diabetes, are documented on the prenatal card.

At the time of the pilot study the clinic was not properly equipped for deliveries, only for primary healthcare and minor surgical procedures. According to Elita, the Belize Ministry of Health plans to equip the rural health clinic for deliveries in the future. When neither of the TBAs are available or when an emergency arises, Elita will attend birthing women in their homes and rarely at the clinic. During the final week of my field work, Elita received an examination and delivery bed from the Western Regional Hospital which had just received new ones. Although Elita did not plan to immediately begin attending births at the clinic, she did

think she would begin in the near future. In addition, Elita hoped to begin conducting pelvic exams as a routine element of well-woman care.

As with Doña Maria, a primary theme in my interviews with Elita was a lack of support and resources. Elita once said, “The Valley of Peace is remote, but not because it is actually remote, but because it is forgotten.”

The Hospital

As mentioned earlier, the nearest hospital is in Belmopan, and making the trip to the hospital in an emergency situation can be complicated and even dangerous. Consequently, women who are identified as having risks are encouraged to make the trip to the hospital days before they actually go into labor in order to avoid a dangerous situation. At the hospital, normal births are attended by a Certified Nurse Midwife (CNM), while an obstetrical doctor attends complicated labors and deliveries. Village women are usually transported to the hospital because of complications that, in many cases, result in caesarian. A normal labor and delivery at the hospital will cost a woman \$80 Bze. (\$40 U.S.), while any complications can result in increased healthcare costs. This cost is in addition to transportation costs which can range from \$20-80 Bze. (\$10-40 U.S.).

I also had an opportunity to visit the maternity ward and witness a woman in labor from the Valley of Peace be admitted. The maternity ward consists of several partitioned rooms with 6 beds in each area. There are two labor and delivery rooms with two beds in each room. One of these rooms is reserved for surgical deliveries. Since more than one woman can be potentially birthing in a room at once, it is a stated hospital regulation that men are not permitted to accompany their wives during labor and delivery, and no children are allowed to be in the maternity ward. Because of these regulations as well as the distance, money, and time women

delivering at the hospital are rarely accompanied by their husbands. If someone accompanies the birthing woman it is usually their mother or a sister; however, they are usually caring for the birthing woman's household and other children in the Valley of Peace.

In most cases, women combine these various healthcare options in a unique manner. Women negotiate the varying systems of knowledge, sometimes making trade-offs, in order to optimize their own health and the health of their unborn child, while maintaining a culturally valued birth setting and doing what is best socially and economically for their family.

Healthcare providers must also negotiate their identity, making diverging systems of knowledge complementary. Midwives, who are increasingly being marginalized by the medicalization of birth, must particularly recognize the limitations and strengths of both the biomedical system and her own system. She moves fluidly between these two systems in order to serve the women she attends. Davis-Floyd, Pigg, and Cosminsky (2001:113) describe the midwife as “a shapeshifter (she knows how to subvert the medical system while appearing to comply with it), a bridge-builder (she makes alliances with biomedicine where possible), and a networker.” This description is particularly true of the TBAs in the Valley of Peace, who are not only marginalized by biomedicine, but also by a nation who otherizes them because they are immigrants, and in this case cannot even speak the national language. However, despite these limitations the midwives continue to provide invaluable care to women in the Valley of Peace. In addition, they encourage women with complications to seek maternal-child healthcare at biomedical institutions.

Birth in the Valley of Peace

Based on mobile prenatal records, which eventually serve as a child's birth certificate, Elita, the rural health nurse, documented 62 births between May 2002 and May 2003. Twenty-

seven of the 62 (44%) were hospital births, while 35 (56%) were home births. Among the hospital births 10 (37%) were caesarians, and among the home births 3 (9%) were self-deliveries. In comparison to national birth statistics, which are 77% hospital births and 23% non-hospital births,⁶ a significantly greater percentage of women in the Valley of Peace are choosing to birth at home (Belize Central Statistical Office 2001). Yet, at the same time, there is a greater percentage of women within the Valley of Peace birthing in the hospital, particularly in comparison with their mother's generations.

The birth statistics of the six women I interviewed in-depth mirror the statistics for the Valley of Peace. For the purposes of examining birth and decision-making in the Valley of Peace, I am only reporting births of the six women that took place since resettling in the community. Among the six women there are 26 births that have occurred since resettling in the Valley of Peace. None of these women were born in the Valley of Peace, and three of the six have given birth in other communities as well as other countries.

Out of the 26 births 11 (42%) are hospital births. One woman, Ana, who has chosen to give birth to all of her children in the hospital accounts for 8 of the 11 hospital births. The three remaining hospital births are first deliveries, which included one caesarian. Eleven of the 26 births (42%) are home births, while 4 of the 26 (15%) are births that took place at the rural health clinic in the Valley of Peace⁷. When these statistics are categorized like the national statistics, 42% are hospital births and 58% are non-hospital births.

⁶ This statistic reflects all births occurring outside a hospital, including home births with TBAs, home birth self-deliveries, and clinic births.

⁷ Intermittently between 1991 and 1998, births took place at the Valley of Peace rural health clinic. These births were attended by a nurse-midwife, a local TBA, or both. During this time period a local TBA, who no longer lives in Belize, had good relations with the rural health nurses serving the community. The two women that gave birth during this time period in the clinic both said that it was their best birth experiences.

Birthing Women of the Valley of Peace

In the following section, I will provide a more in-depth look at the women I interviewed. Through these in-depth looks the reasons behind women's birthing choices emerge. Global, national, and local forces are grounded in their lives, childbirth decisions, and birth experiences. We see the ways in which power, globalization, and anti-immigrant sentiments converge to inform childbirth in the Valley of Peace.

Edith

Edith is a married, 42 year old, mother of eleven children. It is apparent that carrying, birthing, and caring for eleven children have taken a toll on her body. She is a refugee from El Salvador and is still haunted by the memories of the war and family members who died. Her husband is an agriculturalist.

Edith, who speaks only Spanish, gave birth to her first two children in a clinic in El Salvador and her next two children in a refugee camp clinic in Honduras. Her other seven children were born either at home or at the clinic in the Valley of Peace. Her youngest child, Sandra, who is four months old, was born at home with the help of Doña Maria. Edith has been to the maternal-child health clinic at the Western Regional Hospital, but did not like the treatment she received, and thus, she does not have confidence in hospital births. She said, "It's a problem at the hospital. They don't have someone there for me to speak with. They tell me I need to learn English. That is why I don't go to the hospital. No one tells me what is happening." Edith's explanations demonstrate how linguistic differences and anti-immigrant sentiments influence women's childbirth decision-making.

Edith was also the first woman to openly discuss with me the impacts of alcoholism and abuse on her life and her family's lives. Her husband is a verbally abusive alcoholic who

occasionally becomes physically abusive during his binges. Edith seemed driven to share this with me as well as the insults he hurled at her. Although I never interacted with Juan, on more than one occasion I witnessed him intoxicated and sulking about the household. This was something that I as a researcher was not fully prepared to handle, but as you will see in the stories of the other women I came to know in the Valley of Peace, it was something that I quickly had to learn to navigate.

Gloria

Gloria is a recently married, 21 year old, *primapara* (first-time mother). Her parents are also Salvadoran refugees. She was born in San Ignacio, Belize and was one month old when her parents came to the Valley of Peace. Unlike the other women I have interviewed, Gloria's family has had the means to educate her and her siblings, two of whom taught at the schools in the Valley of Peace. Gloria has completed primary and secondary school, and she is fluent in Spanish and English.

When I first met Gloria she was 30 weeks pregnant, and despite restrictions against TBAs attending *primaparas*, Gloria decided to deliver at home with the help of Doña Maria. She told me about a recent conversation with a doctor at the maternal-child health clinic at the Western Regional Hospital that had solidified her decision and convinced her that if she delivered at the hospital she would have a caesarian. Women in the Valley of Peace are wary of caesarians; they realize the financial burden and the extensive recovery time that accompany a caesarian. The women are also aware that the Belize Ministry of Health prohibits vaginal births after a caesarian (VBACs) and mandates automatic sterilization after three caesarians. Stories have circulated throughout the community about doctors threatening women with caesarians in order to control the number of children they have. Gloria said,

I told the doctor that I did not want to be cut [have a c-section], and I asked him what could be done to help move the baby [the baby was in a breech position which means an automatic c-section]. He told me, “Why? You want to have a lot of kids? You don’t see how the economy is. How many kids do you want to have?” And, I told him “I want to have seven.” And, then he said, “Whoa, you have a lot of money then. Three kids are enough. How will you provide a good education for so many kids?” He always says three is enough. They say that’s why on the first [delivery] you get cut [c-sectioned].

Gloria’s narrative expresses the power of anti-immigrant sentiments. It also expresses conflicting views on contraception between the women of the Valley of Peace and biomedical actors.

Gloria went into labor the second week of my field stay and Doña Maria was called to her house around 8:00 one night. With the permission of Gloria, her family, and Doña Maria I accompanied Doña Maria to the house of Gloria’s parents where she planned to deliver. Although Gloria was in visible discomfort her labor was not progressing—her contractions were weak and far apart. Doña Maria made some tea from *herbabuena* for Gloria hoping to aid the progression of her labor, still her labor did not progress. After a few hours Doña Maria decided that Gloria was not actually in labor, and as her contractions subsided we returned home and Gloria waited. A few days later Gloria contractions strengthened. This time when Doña Maria came to her the contractions were stronger and closer together, but still her labor was not progressing. Doña Maria, Gloria, and Gloria’s family decided it was time to transport Gloria to the hospital. Luckily, Gloria’s cousin owned a truck and had previously offered to take her to the hospital in Belmopan if necessary. Gloria cautiously climbed into the truck with the help of Doña Maria and made the lonely trip to the Western Regional Hospital. At the hospital Gloria’s contractions, which had now been occurring sporadically for four days, continued to strengthen but her cervix was not dilating. A caesarian was performed and Gloria’s handsome boy, Elvis, was born. After returning from Belmopan and a few days of recuperation, I visited Gloria at her

parent's house where she planned to stay for the first month after her son's birth. She shared her birth experience with me. Gloria was pleased with the birth of her healthy son, yet remorseful and in considerable pain. Doubting the medical necessity of her caesarian and mourning the large family that would not be, she said, "I knew they would cut me."

Rosa

Rosa is a shy, married, 23 year old woman and a mother of four. Her parents were also refugees from El Salvador. Her family resettled in the Valley of Peace when she was five years old. Rosa attended primary school and knows a little English. During our time together, we often sat in silence. I did all the asking, and my questions were never fully indulged. I usually walked to her house with apprehension, and never felt like Rosa and I fully connected.

Towards the end of our second meeting at her house I believe I gained some insight into Rosa's reasons for holding back. I heard a rustling noise and briefly saw her husband emerge from their partitioned sleeping area. I realized her husband had been laying down just feet away from us and the intimate conversation that I tried awkwardly to cultivate. I began to wonder if he always lay in silence, quietly listening, and, perhaps, judging. After this encounter, I knew I would never feel completely at ease in Rosa's house, and began to better appreciate gender relations, particularly between husbands and wives, in the Valley of Peace, an aspect of life that I was not privy to in the home of my host family since Doña Maria had fled both Honduras and her abusive husband. My feelings became even more poignant when Rosa shared with me that her previous partner and the father of her first two children had been abusive. I quickly learned that intimate partner violence and its impacts were never far from the daily lives of all the women I interviewed.

Because of the regulations on the practice of TBAs, Rosa had her firstborn in the hospital, but her other three children were born at home. Her youngest, 2 month old Denis, was unwittingly delivered with the help of Elita. Rosa planned to have Doña Juana attend her, but when she went into labor her husband could not find either of the TBAs. She said, “I had my sons at home because we do not have the money to pay for a truck to the hospital and then pay for the hospital. It is very expensive. And, my husband and my mother can not come with me. They both work. Who would take care of my other sons?” Unlike Edith and Gloria, financial reasons drive Rosa’s decision to birth at home. As discussed previously, in the Valley of Peace, having your baby at the hospital can be an expense well beyond your means. It is also a decision that may require the mother to travel to the hospital and birth alone if there is no one to accompany her, as well as a decision that requires her to find someone to take care of her household duties while she is gone. Thus, it is a decision that is often not financially or practically available to many women. In the case of Rosa, finances and convenience are primary reasons for delivering at home in addition to the knowledge that her own mother delivered all of her children at home with the help of a midwife. Of all the women I interviewed, Rosa’s home was the barest. There are very few items in the house, no decorations, and no appliances or electronics, not even a radio. Since they do not own a gas stove, Rosa still cooks over a fire. Moreover, Rosa and her husband were the only family I interviewed that did not own their home.

Concepcion

Concepcion is a single, 20 year old, working mother of one. Concepcion and her family are Kek’chi Mayas who moved to the Valley of Peace from Punta Gorda, in Southern Belize. Her son, Joshua James, was born a year ago at the Western Regional Hospital. She works part-time as an aide at the rural health clinic, and is the only woman I interviewed who works outside

of the home. In addition, she is the only single mother that I interviewed. For these reasons and others Concepcion represents a more “modern” and unique voice in my research.

Concepcion strongly believes that it is better to birth at the hospital, and I believe her choice has been heavily reinforced by working in a biomedical setting. Concepcion explained, “I am scared to have my baby at home. I am scared something bad will happen. There is nothing here to save my baby if something bad happens. I think that the hospital is better and safer, and they have pills they can give you for pain.” Clearly, the authoritative knowledge of biomedicine has had an impact on Concepcion’s childbirth decision-making. Her perception of birth, as a dangerous event necessitating pain-relieving drugs, reflects biomedical models of birth as an illness rather than a natural process.

However, further interviews revealed that the circumstances of Concepcion’s first birth were also formative experiences for Concepcion’s perception of birth. Concepcion became pregnant out-of-wedlock with a man who did not intend on supporting her or their child. Ashamed and scared, Concepcion denied and hid her pregnancy from her family. Only a few close friends knew of Concepcion’s expectant state, and with their confidences she was able to conceal her pregnancy. When her contractions began to come and strengthen, Concepcion knew her child was coming. She boarded the local bus alone and anxious and went to the hospital in Belmopan to have her son. It was not until she returned from the hospital with a newborn that Concepcion’s family learned of her pregnancy and their new grandchild. Although this revelation was difficult and trying for the family, they worked through it, and Concepcion continues to live with her parents who love her and support her. When Concepcion was fearful and all alone the biomedical care of the nurses and professional midwives at the hospital guided her through her liminal state and helped her deliver her son.

Ana

Ana is a married, 26 year old, mother of eight, who works out of her home and was currently pregnant with her ninth child at the time of this interview. She was born into an impoverished family in Guatemala City. At eleven she and her brother left her parents to provide for themselves since their parents no longer could. Ana came to Belize looking for more opportunities and heard about a Spanish-speaking, immigrant community where land was available. Thus, she decided to come to the Valley of Peace; she soon met her husband, James, a son of one of the original Creole families in the community and began her family. Ana has had all of her children in the hospital and planned to have the baby she was currently pregnant with in the hospital. During their years together, James had taught Ana English, and we were able to communicate easily. With this and Ana's youthful eagerness, we quickly developed an intimate friendship. I was always happy and astounded to see Ana, 7 months pregnant, riding a bicycle around the Valley of Peace—one of the only women to do so—visiting friends and delivering the sesame fudge she made at home and sold to local stores and families to supplement their income.

During the summer of 2003, there was a chickenpox outbreak in the Valley of Peace, and James, who never had chickenpox as a child, had contracted the virus from one of their children and was deathly ill. I'll never forget the sight of his sunken eyes and ashen skin covered with a white paste to relieve the itching when he greeted me at their door one afternoon. He had already spent several days in the hospital in Belmopan and was still running an extremely high fever. I had come to visit with Ana, but she had traveled to Belmopan to acquire more medicine for James' fever. In fact, Doña Maria's own grandson was just beginning to recover from the chickenpox when I first arrived that summer. He too was ashen and gaunt from the fever and

needed to make several visits to the Western Regional Hospital to monitor his illness and weight loss.

Despite her nearly always cheerful mood, Ana has known a great deal of pain. Her youth was difficult, and at the young age of 26 she has already born nearly nine children. The varicose veins on her legs are living evidence of this toll on such a young woman. Ana also lost her second oldest son, Steven Eduardo. He was run over a few years ago at the age of 7 when he was walking along the main road, which their house sits along on the outskirts of town. It has not been an uncommon experience for mothers to lose their children along this road to speeding cars and trucks. Moreover, Ana's youngest child, Alice May, suffers from a heart condition which necessitates frequent visits to the hospital. Eventually Alice will need heart surgery.

Ana often asked me about my own life—why did I not have any children and what were my reasons for being in the Valley of Peace spending my afternoons talking with her. She told me how when we first met during the first summer of my fieldwork she had thought I was training to be a midwife, but after an intense experience together she decided that I could not be training to be a midwife because I “feel the woman's pain too much.”

During my first stay in the Valley of Peace, Ana was pregnant with Alice. As with her previous children she intended to stay at home until her contractions were fifteen minutes apart, but her contractions had advanced quickly and before she had a chance to arrange transportation her water had broken. Fearing she would be unable to make it to the hospital in time she sent her oldest son, Victor, to get Doña Maria. When we arrived at Ana's house it was apparent that she was nervous and did not want to deliver at home despite Doña Maria's attempts to assuage her. Ana began to repeatedly tell Doña Maria that she had high blood pressure and needed to deliver at the hospital. At first Doña Maria did not budge with her intentions to deliver Ana's child.

Even though I was quite sure from observing Ana's prenatal visits with Elita at the rural health clinic that she did not have high blood pressure, I began to become concerned and this concern escalated as Doña Maria began to express the first signs of worry on her face. Because my husband and I had driven to Belize that summer along with Dr. Lucero and a few other students, I happened to have a vehicle in the Valley of Peace and offered to transport Ana to the hospital. Everyone quickly decided that this was the best decision and we were off. My husband, Alan, was driving, I was in the passenger seat, and Doña Maria, Ana, and an impatient baby were in the backseat. Luckily, little baby Alice was not born in my 1994 Toyota RAV 4. We made it to the Western Regional Hospital, and Doña Maria and I accompanied Ana to the maternity ward. She was taken to the delivery room and within 20 minutes Alice was born. Ana and Alice stayed over night, and Doña Maria, Alan, and I returned to the Valley of Peace basking in our adventure.

Despite this experience and the fact that Ana is well beyond her fifth pregnancy, Doña Maria still offered to help her with the delivery of her ninth child in the summer of 2003, but Ana always refused. Ana continued to use the fiction of high blood pressure as a convenient excuse. Since Doña Maria was allowed to assist with the birth of Alice in the hospital the previous summer, she affirmatively knew that Ana did not have blood pressure. Slightly offended and unrelenting, she continued to assert her abilities and offer her services. Similar to Concepcion, Ana explained why she and her husband felt it was best for her to deliver at the hospital, "I don't feel comfortable with the midwife. They don't have patience with me. At the hospital they know me and I have had all my children there. They give me the time I need. And, if something bad happens they can take care of it."

Ana's comfort at the hospital and discomfort with the midwife is indicative of her place within the community. Her house sits symbolically on the outskirts of the community. Her circumstances in coming to the Valley of Peace are not commonly shared, and her marriage to a black, Belizean also puts her in a unique situation. Despite their own mixed heritage, many of the mestizos living in the Valley of Peace harbor prejudice and unfounded stereotypes about people of African descent with black skin. Doña Maria never felt completely comfortable with me visiting Ana's house alone. She always wanted to know when I would be done so that she could come to Ana's house to retrieve me—something she never requested to do when I visited the homes of the other women I spent time with. Ana picked-up on this and shared her opinion that it was because her husband is black and there are stereotypes of black men as rapists and womanizers. Doña Maria never openly expressed this view, but she did always ask me if James was present when I visited Ana.

Ana also commented on more than one occasion that she preferred to leave the house to birth in the hospital where it was quiet and free of children and husbands. Once when I asked if she would like for her husband to be able to be with her in the labor and delivery room at the hospital she laughed and assertively replied, "No." She described how it disturbs him to see her in pain and how men are not equipped to handle birth, instead they just make things more difficult, and she prefers to birth on her own without the distractions of her husband or children. I have often thought that Ana probably enjoys the solitude of a hospital birth as well as the attention and care she receives from the nurses with whom she, unlike most women of the Valley of Peace, can communicate with in Creole.

Maria

Maria is 33 years old, married, and a mother of eight. She, her husband, Joaquin, and their first child came to the Valley of Peace from Honduras 14 years ago in search of a better life and more opportunities. They had heard about the Valley of Peace from Joaquin's brother who had already resettled there. When I asked if their life was better in the Valley of Peace, Maria replied, "*Es más tranquilo*" ("It is calmer"). They have found that things are less expensive and they can provide for themselves with the money Joaquin makes farming as well as the money she earns washing clothes for other women.

Maria's first son came very fast and was born at home, but there were complications and they had to take Joaquin, Jr. to the hospital where he almost died because they did not receive care immediately. She had her next son at the Western Regional Hospital because of the complications with her first delivery. Again, Maria did not have a good hospital experience. She said it was clear that the hospital staff did not want the immigrants and refugees in their country using their services, but one of the nurses spoke Spanish and was able to communicate with her. The next two children were born with the help of a nurse-midwife at the rural health clinic in the Valley of Peace, and her last four children were born at home with the attendance of a local TBA. Although her last daughter was born at home with Doña Maria, Maria insisted that it was better to birth at the hospital. She said, "I am no longer afraid of the hospital. I think it is the best place because they have everything for problems." She also said that she enjoyed her experiences birthing at the rural health clinic more than birthing at home.

As you can see, Maria's views on childbirth were sometimes conflicting. And, even though, she said it is better to birth at the hospital, she gave birth to her last four children at home. I believe for Maria a hospital birth is ideal, but the realities of a hospital birth, including cost, transportation, and anti-immigrant sentiments prevented her from realizing this ideal birth.

As with Rosa, I never felt completely relaxed interviewing Maria, and I think her own apprehensions played a major role. Her husband, too, was almost always present and intoxicated. He usually sat with us and would repeatedly try to engage me in a conversation with him, which usually included uncomfortable acclamations about my beauty. Doña Maria and her daughter had warned me that Joaquin was an alcoholic and an abusive husband. He would often go on drinking binges and would be away from the house days at a time. One time when I went to visit Maria he had brought home a young man who was also an alcoholic. During this time period I felt extremely uncomfortable visiting Maria and decided to keep my distance until the young man had left. Eventually he did, and this time when I visited Maria we were alone and she talked briefly about her husband's drunk and abusive behavior. She told me how when he went on his drinking binges he often drank all of the household's money, leaving her no money to feed the children.

Alcoholism and abuse weigh heavily in the lives of many of the women I interviewed. It was an issue that I had not expected to be so prominent in our conversations, and I was not prepared. I would always listen intently to whatever the women chose to share with me, but I decided that because I could not offer appropriate help or counseling that I would not actively pursue these issues. Nonetheless, as alcoholism and abuse impact these women's daily lives, it also impacts their reproductive lives and reproductive decisions.

CHAPTER 5

DISCUSSION & CONCLUSIONS

Discussion

All of the six women I interviewed chose either to birth at home or in the hospital for a variety of reasons. In some cases, the woman's birth outcome did not match her birth choice because of unforeseen obstacles, complications during labor and delivery, or life circumstances. Thus, I have chosen to categorize the women in either choosing a home birth or choosing a hospital birth based upon where she would currently choose to have a child. The women's responses are heavily influenced by their past birth experiences, and, in some cases, a birth experience where the woman's birth outcome did not match her birth choice. Among the six women, three, Gloria, Rosa, María, and responded that they would choose a home birth, while three, Maria, Ana, and Concepcion, responded that they would choose a hospital birth.

Home Birth

The response I most often heard from the women I interviewed when asking them why they chose to birth at home was *confianza*. The woman has more confidence, trust, and familiarity with the TBA and believes in the TBA's ability to guide her and her baby through their state of liminal transition. In fact, all of the women who preferred to birth at home invoked the notion of *confianza* on repeated occasions.

The notion of *confianza* was usually followed by a discussion of family support and a history of birth in the family. As in the case of Rosa, the women would explain that their mothers and sisters had all of their children at home with the help of a TBA—birthing at home was a family sanctified practice. Moreover, the women wanted to birth at home where they

could receive the support and guidance of their families, which most often included their mothers, sisters, and husbands. Most of the women would even discuss how they did not want to make the trip to the hospital to birth alone.

Along with fear of birthing alone, there was usually a general fear of the hospital and the anti-immigrant sentiments that were routinely expressed by the hospital staff towards the women of the Valley of Peace. Nowhere is this more evident than in Gloria's exchange with the obstetrics doctor. The fear of being "cut" was another common thread in these discussions. From numerous women I heard stories about other women who went to the hospital for a normal delivery and returned to the Valley of Peace with a "cut." It was also widely believed that the hospital staffs used caesarians as a means of controlling women's fertility; for, as mentioned previously, it is hospital procedure to sterilize women after the third caesarian, and the hospital does not permit VBACs. Although this practice is meant to protect the health of the mother, it can be easily abused. Language barriers were another fear that was often intertwined with fears of the hospital, anti-immigrant sentiments, and being "cut." As expressed by Maria and Edith, there have been many instances where women from the Valley of Peace are unable to effectively communicate with the hospital staff, and in some cases the Spanish-speaking women have been rebuked for not speaking English and were linguistically marginalized.

Finally, money and transportation also figured heavily into these women's childbirth choices. The financial burden of birthing at the hospital is more than many families can bear. For the women of these families, in addition to being familiar and close to family, birthing at home makes financial sense. The limited availability of transportation and potentially exorbitant cost of transportation to the hospital was another worrisome matter. Getting to the hospital to birth is not an easy endeavor in the Valley of Peace, and most women recognized this concern.

As in the work of Obermeyer (2000), notions of risk figure heavily into these women's preferences to birth at home. Fear of unnecessary medical procedures and an unfamiliar hospital environment inform the local construction of childbirth as well as risk strategies. Moreover, ethnic discrimination, which is predominantly expressed in the form of anti-immigrant sentiments and linguistic marginalization, further complicate notions of risk and liminality. As in the words of Hurtado and Saenz de Tejada (2001:12), "the tensions between traditional and biomedical systems of health care are complicated by the coexistence of ... ethnic groups, and by ethnic discrimination based upon language, appearance, and other characteristics." Yet, this framework, following Whittaker (1999), can be expanded beyond risk strategizing, to recognize preferences for a traditional, home birth as an act of resistance. Women, such as Gloria, who are educated, speak English, and have the socioeconomic resources for a hospital birth, but actively seek to birth at home despite a high-risk pregnancy particularly exemplify this act of resistance—resistance against the biomedical model of birth, resistance against hospital practices, resistance against anti-immigrant sentiments.

Hospital Birth

As with the preference for home births, women who preferred a hospital birth evoked the notion of *confianza*. Again, the women have more confidence, trust, and familiarity with the biomedical setting and its birthing process. And, in most cases this *confianza* was reinforced by family, friends, and life experiences, such as working at the rural health clinic. Coupled with *confianza* in the hospital was the knowledge that the hospital had the technological capabilities to handle complications that the TBAs can not. Furthermore, hospitals can offer pain-relieving drugs to women in labor, which TBAs can not. Here, again, an element of fear—fear of

complications, fear of pain—drives women to seek out a hospital birth. For Concepcion, the circumstances surrounding the birth of her child particularly compounded this fear.

In some cases, the women were aware of the restrictions on the practice of TBAs, and an awareness of the difficulties that can be associated with the first birth as well as any beyond the fifth prompted them to prefer a hospital birth. In other cases, such as Ana, the privacy and solitude of a hospital birth was a welcoming reprieve from a restless life where family support is not available.

Again, notions of risk influenced these women's preferences. These women also employed risk strategizing to come to their decision to birth in the hospital, but, from these women's perspectives, the risks of a home birth outweigh the risks associated with a hospital birth. These women have incorporated the globalized authoritative knowledge of the biomedical birth and its discourse of improvement and development. In some of their cases, this discourse is more readily adopted because the effects of anti-immigrant sentiments and linguistic marginalization are minimized due to the woman's ability to speak the language of biomedicine—English.

In summary, Obermeyer (2000) has encouraged us to think of the risk strategies related to childbirth as a “continuum of possibilities,” with the representative modern birth on one end and the traditional birth on the other. She states, “In contemporary Morocco, as elsewhere, women's actions result from a negotiation between the two poles of modern birth and traditional birth, and for most, the choices fall somewhere in between” (Obermeyer 2000:198). Based on the findings reported here, I would like to suggest that this analysis can be taken a step further by incorporating Jenkins (2003) recognition that in addition to “top-down” forces, birth around the world is also being impacted and molded by “bottom-up” forces, such as anti-immigrant

sentiments, poor road infrastructure, and the fear of being “cut.” As such, Obermeyer’s horizontal birth continuum only takes on meaning in the context of the vertical slice of “top-down” and “bottom-up” forces.

Conclusions

The globalization of the biomedical birth has impacted these women’s lives in numerous and unexpected ways. Although more women in the Valley of Peace continue to birth at home than in the hospital, this practice is shifting and notions of modernity and technology are settling in. What is telling about the birthing choices and experiences of these women are the ways in which hospital births have been linked to anti-immigrant sentiments, and the ways in which home births have become a form of resistance, continuity, and control over one’s own reproductive destiny. Further research, particularly in the setting of the hospital, could provide further insight on this issue and its implications of reproductive rights violations.

Moreover, these women’s narratives illustrate the importance of understanding the impact of the globalization of the biomedical birth at the local level. In this instance, the authoritative knowledge of biomedicine succumbs to *confianza* in TBAs, anti-immigrant sentiments, fear of being “cut,” cost, and lack of transportation. Yet, the authoritative knowledge of biomedicine does not go unnoticed, and its technological ability to handle complications and relieve pain is increasingly being acknowledged. It is now clear how stories like the stillborn child of Ana and Julio come to be.

As childbirth is a liminal state for both mother and child, the years that follow will be a liminal state for childbirth in the Valley of Peace. Elita is making plans to begin attending births at the rural health clinic. Doña Maria and Doña Juana are beginning to age, and neither midwife has begun the process of sharing her intimate knowledge with an apprentice. It is expected that

the road to the Valley of Peace will be improved and there has been political talk about building a bridge in place of the ferry. With these changes, the Western Regional Hospital in Belmopan will become more accessible. Westernization through commercial goods is also occurring. More households are acquiring satellite television, and more women are watching *novelas*, where birth exclusively takes place in the hospital and dramatic complications almost always arise. How will the women of the Valley of Peace be impacted by and act upon these changes? How will these processes restrict or expand women's birthing options? Will the practices of TBAs continue to be sanctified by both the Belize Ministry of Health and the women of the Valley of Peace? Of course, future research is paramount to understand the complex and unexpected impacts of global and local forces on childbirth in the Valley of Peace.

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