PART I

Traditional Birth Attendants/Traditional Midwives
In poor countries one of the leading causes of maternal and child mortality and morbidity is the insufficient number of trained staff to attend labor and delivery. Data in this area of global health is notoriously unreliable for poor countries because much of this morbidity and mortality occurs outside of official health systems. Improving these outcomes has also been a difficult challenge for many countries, for many complex reasons, some of which will be explored in the case studies.

Because of brain drain, poor countries have a hard time retaining the nursing and midwifery staff they do train, and even those numbers are often inadequate. Furthermore, women tend to want to give birth in the comfort of their homes for many reasons. Sometimes travel is difficult for the women, especially when they are in labor, whether it is because they live in remote areas that are hard to traverse in the best of times or because transportation is costly or slow and uncomfortable during labor, such as on the back of a bicycle. In addition, some hospital labor rooms are overcrowded (e.g., 30 laboring women in one large room with one midwife), understaffed, ill-equipped, and lack privacy or a place to accommodate supportive family members. Under these conditions it is difficult to convince women to leave the comfort of their homes to give birth, despite having untrained (or traditionally trained) attendants such as relatives or traditional birth attendants (TBAs) to assist them.

Despite their lack of training, TBAs serve a vital function in the health of mothers and children around the world. The challenge is that they are independent health workers that do not usually have official oversight, yet they are much more accessible than clinics and hospitals. Because they are local, the women also trust them because they know them. And they usually charge less than government or private hospitals, so it is not difficult to understand why women around the world, particularly rural women, often choose to use TBAs to assist them in their labor and delivery.

Some countries have decided to integrate TBAs into the healthcare system by giving them training and monitoring them, but other countries marginalize them by promoting clinic and hospital-based births, where women in labor and delivery can be monitored by medical professionals. Published research on the role of TBAs spans the globe. Their role as a community-based healthcare provider precedes formal medical training, and despite their limited skills, they are still the provider of choice for millions of women.
The goal of health interventions linked with TBAs has been to promote the use of skilled care—whether through additional training of TBAs or by promoting formally trained medical professionals. Organizations such as the White Ribbon Alliance work with governments, nongovernmental organizations (NGO), and communities to increase access and utilization of skilled birth attendants who have been formally trained because this reduces the risk of morbidity and mortality of both the mother and the child.
The Local, the Global, the NGO-ization of Birth in Southern Belize

Aminata Maraesa, PhD

Location: Toledo District, Belize, Central America

Name of Program/Project: Traditional birth attendant (TBA) training program undertaken by Giving Ideas for Tomorrow (GIFT),¹ a U.S.-based international nongovernmental organization (NGO) with a long history of childbirth and midwifery activism and affiliation with the alternative childbirth community in the United States

Sponsoring Organization (and Funders): UNICEF and GIFT

Target Population: Rural-dwelling women throughout the Toledo District; although ethnicity was specified, the majority of the rural-dwelling population and TBA trainees are Mopan- and Kekchi-speaking Maya

Project Goal: Childbirth attended to by a trained birth attendant, high-risk hospital referrals, and lower mortality rates

Project Objectives: Train rural-dwelling community members to provide trained assistance for perinatal care and high-risk referrals
BACKGROUND

The Belizean Ministry of Health has consistently demonstrated a great interest in participating in international maternal and child health initiatives and was one of the first countries in the world to initiate a TBA training program in 1957 with funding from UNICEF. In the 1990s, TBA funding diminished worldwide; however, GIFT was able to obtain funding from UNICEF for a pilot TBA project in Southern Belize based on a need-assessment/rural health survey conducted by UNICEF in 1998–1999. In two rounds of training from 2000–2001, GIFT trained 19 rural-dwelling women and 3 rural-dwelling men in the Toledo District to provide TBA services to their respective communities.

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The head of Maternal and Child Health Services narrowed her eyes as she surveyed the group of traditional birth attendants gathered in the hospital conference room, and with a flip of her wrist she provocatively exclaimed, “Where are all my TBAs? Where are the women I trained?” It was true that I had only invited to this meeting the TBAs on whom my research initially focused—those that had been trained by GIFT, an international NGO. And Nurse Lee was aware of this fact. However, I was to interpret this guarded reaction as an explicit testament to her many years of active service to the women in her community. Moreover, it was an implicit warning to outsiders—like myself—to be mindful of local ways of dealing with local affairs.

Despite substantial international involvement in training TBAs as a strategy for lowering maternal mortality worldwide, there may good reason to express doubt and even hostility when Belizean procedures are ignored by well-meaning foreigners who lack a connection to the local protocols governing social relations. Tacitly referencing a deep-seated divide between Belizean cultural practices and foreign development initiatives, Nurse Lee’s suspicious inquiry sheds light on a new way to understand how TBA programs are actualized in on-the-ground practice.

Previous anthropological research of TBAs has focused on those trained by the various ministries of health in developing nations (Brink, 1982; Cosminsky, 1986; Hunte, 1981; Jordan, 1978/1993; Pigg, 1995, 1997). This literature suggests that these training programs have not helped to reduce mortality rates primarily due to cultural barriers during the training process. Basing my research thesis on these previous analyses, I hypothesized that the TBAs trained by an outside agency professing a grassroots ideology and unilateral teaching methods would be better trained and have more successful birth outcomes than the TBAs.
trained by the Belizean Ministry of Health. However, I found that whether these TBAs may or may not have acquired the necessary skills to successfully attend births, most remained inactive or underutilized—hence ineffective. Nurse Lee’s emotional response suggests a possible explanation (Bradley & McAuliffe, 2009; Woolfrey, 2002).

This chapter looks closely at how cultural, structural, and interpersonal factors affected GIFT’s development initiative and how these factors have shaped the perceptions about and practices of TBAs in the Toledo District. This chapter begins with an overview of the district’s demography, cultural beliefs about childbirth, and the maternity services provided by the Ministry of Health. A historical look at the implementation of TBA training and a retelling of GIFT’s TBA training program qualitatively frame the quantifiable assertion that the presence of more TBAs has done little to alter reproductive behaviors in the region. This chapter closes with the outcome of the aforementioned meeting with TBAs and hospital personnel that exemplifies the kinds of enduring misunderstandings that impede the success of TBA training programs, yet it offers insight into areas for potential development.

THE REGION

Toledo is the southernmost district in Belize. Its one urban center, the seaside town of Punta Gorda, is surrounded by numerous landlocked rural villages that spread throughout the foothills of the Maya Mountains and along the eastern border of Guatemala. Forming a part of the Central American rainforest ecosystem, Belize is hot, humid, and prone to heavy rains and hurricanes, with Toledo receiving the highest annual rainfall in the country. The many potholed dirt roads that crisscross the district’s landscape are often flooded by the overflowing rivers that pour onto roadways and bridges, causing difficulties in both basic and emergency transportation, effectively isolating rural inhabitants from the rest of the country. Concomitantly, Toledo is marked by the worst economic and social indicators countrywide—the greatest poverty, the lowest education levels, the least access to safe water supply, and the greatest difficulty in obtaining emergency medical services (Government of Belize, 2004; Pan American Health Organization, 2001; Statistical Institute of Belize, 2007). It has the highest fertility rate and the highest rate of maternal mortality for the most recent 6 years for which statistics are available (2000–2006), averaging 203.08 deaths per 100,000 live births as compared to 84.58 for the country as a whole.
Recent statistics show that the majority of births countrywide take place in a hospital (76.0%), while 87.6% of those that occur outside of a medical facility are assisted by a medically trained attendant (medical officer, nurse-midwife) or a TBA (see Table 1-1). However, these national averages flatten the statistical anomalies found in the Toledo District where a substantially larger number of births take place in the home setting (36.9%), of which 67.0% occur without a trained attendant. Presumably this has adversely influenced mortality rates and the influx of development projects such as GIFT’s TBA training.

### TOLEDO TRADITIONS

The population of Belize is a melting pot of diverse racial and ethnic groups that emphasize their distinct cultural attributes while embracing a Belizean national identity. Although the Toledo District is similarly mixed, the majority of the population draws from ethnic groups known throughout the country for safeguarding the traditional ways of its inhabitants. The region is dominated by the rural inhabitants from two major ethnic groups (Kekchi- and Mopan-speaking Maya) who maintain their linguistic distinctions and ethnic clothing styles against
the creolization of the national culture and the heavy influence of imported cultural practices evident with the omnipresence of satellite television shows, music, and sneakers imported from the United States. A part of these persistent cultural traditions includes reproductive behaviors, such as the practice of childbirth within the confines of the home with limited extrafamilial assistance.

Among both the Kekchi- and Mopan-speaking Maya, attending to one’s wife during childbirth is considered one of the duties a husband is expected to perform. A husband is informally trained through observing his mother or mother-in-law at the birth of his wife’s first child. From this experience, it is expected that he learn how to physically and emotionally support his wife throughout the labor process and cut the umbilical cord after the delivery of the placenta. Complications are purportedly dealt with through prenatal assessment by the Ministry of Health nurses—who often recommend a hospital delivery to obviate risk—or by ritual specialists known in local parlance as bush doctors.

In Toledo, bush doctors are ritual specialists who administer bush (herbal) medicine, massage, and prayer to heal a variety of illnesses and physical ailments. Although their healing repertoire includes limited maternity services, bush doctors do not consider themselves to be midwives or to be practicing midwifery. With few exceptions, bush doctors do not attend births, nor do they care for the pregnant woman or the newborn during the labor and postpartum periods. Instead, they are called upon in times of maternal distress to ameliorate the condition that is causing discomfort or danger. One of the most oft-cited services provided by a bush doctor is to ascertain and ensure a vertex fetal presentation. When the position of a fetus is determined to be “good,” the bush doctor leaves the pregnant woman with her kinship support network and returns only after the birth if help is needed to expel a retained placenta through abdominal massage or herbal preparations. Indeed, it was repeatedly emphasized throughout my inquiries into the practices of bush doctors that “only people with problem [sic] go to bush doctor.” The same cultural logic influences the use of mainstream medical services.

**CHILDBIRTH IN THE BELIZEAN MEDICAL SYSTEM**

The Belizean government under the direction of the Ministry of Health currently provides all public health services, including maternal and child care. In
the Toledo District, free and comprehensive prenatal services are available at the medical centers located in town and in the larger villages as well as at the mobile clinics that service the rural areas. Because there are no obstetricians or gynecologists permanently stationed in the district, nurse midwives provide all maternity care including labor and delivery. Pregnant women in Toledo have been socialized to attend the prenatal clinics with regularity; however, they do not always comply with risk-reducing protocols, including the increasing push for hospital birth.

In Toledo, there is one hospital located in the town of Punta Gorda. It has a shared maternity ward and a separate delivery room with one delivery table. Here, the practices of nurse midwives conform to the highly medicalized and authoritative procedures characteristic of modern obstetric practice. Medication is often administered to augment labor and hasten contractions; however, epidural anesthesia is not available. Women giving birth for the first time (primiparas) are given an episiotomy, and all deliveries are conducted on a flat delivery table in the lithotomy (supine) position with the feet secured in stirrups. And the Kristeller technique of applying fundal pressure to expel the baby is routinely utilized. These procedures may contribute to the prevalent belief in the Toledo District that childbirth “hurts more” in the hospital than at home—a belief that was often cited when discussing why women preferred to stay home for childbirth. In addition, I heard many complaints from women who have given birth at the hospital about the treatment they received at the hands of the nurse midwives. They were often “scolded” for crying out during labor or outright ignored when requesting care.

Despite the general dislike of these attitudes and practices, women who live in town—regardless of ethnic group or previous cultural practice—give birth at the local hospital because there is a general understanding that partaking of the urban modernity entails birth in the hospital. Indeed, I heard of no instances where women returned to the villages to birth in a home setting. Moreover, the hospital is easily accessible. For women living in the rural villages, however, distance, transportation difficulties, and environmental factors are all cited as justifiable reasons to stay home for the birth, and homebirth remained a “cultural tradition” tolerated by the Ministry of Health nurses who instead placed greater emphasis on risk prevention during prenatal care and seeking the assistance of a trained TBA, whose training is recognized as a factor in official recommendations and subsequent TBA activity.
GENERATIONS OF TRADITIONAL BIRTH ATTENDANTS

As early as 1952, the World Health Organization (WHO) advocated for the training of what would become known in international public health parlance as the *traditional birth attendant* or TBA. Identified as “the untrained or partially trained indigenous midwife” (World Health Organization, 1952, as cited in Oakley & Houd, 1990, p. 175), standardized midwifery training programs were initiated worldwide with the belief that so-called traditional behaviors of lay birth attendants were an impediment to the modernization process and that maternal and child health outcomes in poor and developing nations could be ameliorated through a training and certification process that emphasized biomedical risk assessment and institutional referral. Belize, which has consistently demonstrated a great interest in participating in international maternal and child health initiatives, was one of the first countries in the world to initiate a TBA training program in 1957, made possible by funding from UNICEF. Individuals already known to be practicing midwifery were invited through formal letters of invitation to participate in a 6-month training program originally known as Practical Midwifery Course for Nannies to augment their skills through practical training in the main hospital in Belize City. Contained within the files of the Ministry of Health’s main office were yellowing copies of these invitation letters, the tone of which corresponds to Nurse Lee’s sentiments described at the outset of this chapter: a language of participatory healthcare characteristics of the early public health movement and the assertion of local directives under a burgeoning anticcolonial movement and fledgling independence.

Despite these enthusiastic beginnings, the country’s limited economic and human resources have meant that the number of TBAs trained by the Ministry of Health has always been small. By 1989, UNICEF’s funding for TBA training programs had dwindled, and the WHO began to question the value of these types of programs (World Health Organization, 1997). With the already small number of TBAs aging or dead, the recent disinterest of global funding organizations to cosponsor TBA training programs and the persistent environmentally harsh and isolating conditions of the Toledo District meant that significant numbers of pregnant women were without easy access to a skilled birth attendant. Although a few TBAs were later to be individually trained by Ministry of Health nurses who took it upon themselves to apprentice individuals from the rural areas, the
majority of the villages in the Toledo District, where home birth remains the norm, were without a trained TBA.

In July 1998, the Belize office of UNICEF conducted a survey of the rural areas to determine what the people themselves believed to be their biggest problems related to childbirth. It is unclear from the report who actually answered the questions: “What are the problems associated with deliveries in your community?” and “What do you think can be done to solve the problems?” However, the answers from the 25 villages surveyed overwhelmingly cited that a lack of emergency transportation could be ameliorated by the presence of a nurse or TBA stationed in the community. Although bush doctors are widely used to ameliorate certain perinatal emergencies, their position within the indigenous system of medical care is not officially recognized by the Ministry of Health. The survey does not explicitly state what additional services it was hoped could be provided by a TBA in case of an emergency, but it may have been thought that a trained birth attendant would be capable of handling emergencies on-site or that the presence of a ministry-approved liaison could facilitate a smooth transition from home to hospital care.

As a development NGO, GIFT had already been active in southern Belize since the mid-1980s with a health and nutrition program based on soy protein and environmentally sound, sustainable agricultural practices. Since GIFT’s parent organization is associated with a birth center and a direct-entry midwifery training program in the southern United States, when local representatives learned about the results of UNICEF’s survey it made sense that GIFT should mobilize its maternal health network to assist the people in the Toledo District. GIFT approached UNICEF with a proposal that addressed the concerns highlighted in the survey, whereupon UNICEF agreed to fund the first phase of GIFT’s TBA training project.

THE NGO-IZATION OF BIRTH

Prior to embarking on long-term fieldwork in Belize, I met with Samantha Wood, the program coordinator and first midwife instructor to lead Phase I of GIFT’s TBA training project in Belize, to discuss training methods, goals, and her perception of the program’s outcome. During our interviews, Wood expressed her awareness of Toledo women’s cultural differences, lack of basic education, and literacy impediments, and she described the ways through which she sought to convey information to the TBA trainees that was accessible both
culturally and with limited literacy. Consistent with the types of anthropological analyses that informed my thesis, she described the Ministry of Health approach as “telling someone what to do.” As an alternative, Wood “wanted to encourage decision making, because situations will arise when the TBA would need to use her own understandings. She cannot rely only on the scenarios she was explicitly told.” Wood also believed that her preference for “village” life—which is how she described her small community in the United States—allowed her to gain trust and create mutual understanding among the rural population of TBA trainees. In fact, one of the more literate and outspoken TBAs trained by Wood has continued to write letters to Wood about her experiences—usually to complain about the treatment she receives by hospital personnel who she believes do not recognize her as having been adequately trained to attend birth.

Wood’s commitment to the rural population was apparent. In a rickety Jeep, she traveled alone or, at times, with a translator to numerous villages throughout the rural areas of the Toledo District to meet face to face with village leaders and discuss what she referred to as “the village midwife project” at community meetings where she could solicit individuals for training. A total of 14 women, representing 11 of the villages surveyed, were identified to participate in Phase I of the project. Seven were Mopan-speaking and six were Kekchi-speaking Maya; one was Mestizo living in a village of predominantly Mopan-speaking Maya. Six of the women had previous experience attending births, one woman’s husband was a bush doctor, and three of the women were single without children.

Well aware of the critiques from local residents about “the gringos’ fascination with Mayans” and the attention and money given to this ethnic community at the expense of others, Wood spoke of the poverty and racism that she believed disproportionately affected this community. Although tourist guidebooks, websites, and even some academic ethnographies (McClurin, 1996; McClusky, 2001)—including my own (Maraesa, 2009)—speak of relatively harmonious ethnic and race relations within the Toledo District, Wood contends that she witnessed firsthand the discrimination to which the Maya populations are subjected by other groups. According to Wood, the way in which Maya women were attended to in the maternity ward by the predominantly “black” nurse midwives was “horrendous.” She insisted, “I wanted to train them for birth in the villages to keep them from this treatment.” Moreover, it was UNICEF’s intention to direct funds to the communities with the highest level of need and living in the villages with the least access to medical services. Thus, Wood found herself turning down requests for TBA training from
women of various ethnic identities who lived in town or areas close to the town center due to a perceived lack of relative need.

Unfortunately, I entered the field a number of years after GIFT’s training program had ended. Despite this shortcoming, I offer the following description of the initial training sessions based on my interviews with Wood and the TBAs she trained in 2000. As opposed to the small-scale, individualized, finite 6-month training intensives previously undertaken by the Belizean Ministry of Health, GIFT had proposed a project to train one or two TBAs from each village for a period of 6 months with a provision for continuing education and follow-up skills training. Wood explained that community members in the various districts of Toledo had expressed reservation about foreign NGO involvement in local affairs because they had grown accustomed to surveyors who would leave with information but never act on the requests made. Wood stated that she “did not want to let the population down” and convinced UNICEF to fund an extended program in which the rural-dwelling trainees would assemble for classes at a location in or around Punta Gorda once a week for the 6-month duration of the training. She envisioned the entirety of the project to span three phases, each of which would train 10 to 12 TBAs until every village in the Toledo District was covered.

The sessions followed an internationally acclaimed training manual written for cross-cultural use that included informational drawings helpful for non-English-speaking or illiterate populations (Klein & Miller, 1995). For one of the trainees who could not read or write but was married to a Spanish-speaker from Guatemala, Wood obtained a Spanish version of the book. The training was conducted using a combination of didactic methods and materials including lecture, demonstration and practice with dolls and anatomic models, group discussion, role play, and birth videos. After watching the first film, all of the women admitted that it was the first time they had ever seen a baby emerge from the vagina because most women who give birth at home remain clothed in the long skirts that are characteristic of their traditional dress. Mindful of these types of cultural sensitivities, Wood did not emphasize vaginal examinations to monitor cervical dilation; however, she taught that “from time to time they needed to go and look, even if that meant to take a peek once in a while to see if the cord is wrapped around the neck.”

At the end of this theoretical training, each of the TBAs was to spend 3.5 days at the local hospital to observe prenatal examinations as conducted by the nurse midwives and assist during the labors and deliveries of women in the hospital’s maternity ward. While undergoing their practical training, the TBAs slept in a room adjacent to the maternity ward. When I conducted my fieldwork, nearly
5 years after the last practical session had ended, the typed sign that said “Please wake us for a birth. TBAs are inside to serve you” remained affixed with adhesive tape to the door of this same room, which was now used to store medical supplies and equipment. One of the nurses on duty at the maternity ward explained to me that “GIFT mi put up the paper when they mi have their TBA trainings, but they no have TBAs sleeping inside again [any more].” Presumably, since it was GIFT that directed the program and put up the sign, it was GIFT’s responsibility to remove it when they were finished.

Indeed, the continued presence of this sign is an index of the disjuncture between the maternal health services provided by the Ministry of Health (MOH) and the TBA training program undertaken by GIFT that began when Wood commenced her work among the rural populations in 2000 and lasted into the present, as evidenced by Nurse Lee’s reactionary position toward the absence of “her” TBAs at the meeting I orchestrated during my fieldwork in 2006. Although UNICEF’s survey indicated a community desire for village-level maternity care, neither GIFT (nor UNICEF) approached the MOH to find a solution. Instead, the MOH was assumed to be at blame for neglecting the needs of the rural populations in the Toledo District. Both Wood and MOH officials mentioned the project proposal drafted by GIFT and submitted to UNICEF for funding, which explicitly cited the MOH as failing to adequately provide services to the rural areas. According to Wood, GIFT’s program would succeed where the ministry had purportedly failed. However, local ministry personnel interpreted the proposal as a personal indictment leveled by Wood and felt blamed for the implicit risk to which the women in the rural areas were subjected when they gave birth in their villages without the presence of a trained birth attendant. Although GIFT’s project proposal did not call out individual nurses in the Toledo District by name, they were too few in number to go locally unidentified in what was perceived as a blatant disregard for their personal involvement with early public health outreach campaigns and the training of a limited number of TBAs who were often partnered with and directly supervised by a rural health nurse with whom the apprenticeship was ongoing. Prior to GIFT’s involvement, UNICEF had funded TBA training through the Belizean Ministry of Health. Now, this crucial international funding was being redirected into a foreign institution—already distrust by locals because of the perceived lack of understanding for their actual needs and further suspect due to having made enemies before the project even commenced.
Belizeans in the Toledo District are also quick to point out the many development initiatives that were not sustainable and were ultimately deserted once the outside funding sources ran dry. Throughout the region, abandoned buildings with cracking façades, solar panels overrun by rainforest vegetation, and faded, peeling posters stand as testaments to the many development projects implemented with the good intentions of foreigners that ultimately ceased to function in the absence of continued international involvement. Likewise, the region is constantly bombarded with medical aid programs. At the time I conducted my fieldwork, there were six medical teams from North America that had registered with the MOH to provide services in the rural communities in Toledo. According to the director of Health Education at the district hospital, there are also the many medical teams or religious missions that come down without local authorization, “and we no know what they di do until they done do it!” According to MOH personnel, many of these aid organizations are not aware of the existing Belizean medical system and ultimately do more harm than good by providing unnecessary or inappropriate medical services for which locals ultimately pay by draining their non-recompensable resources: their land, their time, and their bodies (O’Neil, 2006).

Although Wood had much experience as a practicing midwife at a freestanding birth center in the United States and with development projects in different parts of the world, her experiences in places like Guatemala were radically different from what she would encounter in the Toledo District of Belize. According to Wood, “The government in Guatemala really didn’t care what we did. So the idea of getting permission from the authorities was kind of foreign to me, and I went into it ignorant, thinking to a great degree that it would not even matter that much. It seemed like we had done what we needed to do... And UNICEF Belize was funding me.” Indeed, most midwives have historically practiced outside of medical authority, and, by definition, NGOs are not governmental bodies. From Wood’s point of view, she had obtained funding from an internationally recognized health and welfare agency and did not need to involve the local MOH personnel in her training program. Furthermore, she wanted to differentiate herself from the kinds of MOH training models critiqued in scholarly journals that Wood summarized as “pretty racist... The women had not learned anything. They just slept through the class!”

However, it was not long into the training program when Wood realized that her work was ruffling the feathers of the MOH. She was summoned to a meeting at the local hospital:
Luckily a representative from UNICEF came to the meeting with me to back me up and not let them eat me alive. But one of the things that got said at that meeting was that they see over the years all of these NGOs come down and that nothing changes, so to them the money gets basically wasted. But if that money got put into some decent equipment that the hospital needs, “If that money got put into us, then maybe we can save some lives.” Well, I thought, if you miraculously had an attitude change... (Samantha Wood, 2005)

Wood explained that when she had tried to involve some of the local nurses, they would not show up when invited or would “show up late or come unprepared.” Rather than seeing their disinterest in the context of the historically all too familiar fly-by-night development ventures, Wood perceived their lack of interest in GIFT’s present project as being deliberately unhelpful. The misunderstanding between the local ministry personnel and GIFT extended to include the distrust of the TBAs that GIFT trained.

When Phase I of the project was completed, a graduation ceremony was held “Belizean style.” School children sang the national anthem, refreshments were served, and GIFT invited Nurse Lee to be the master of ceremonies. While she personally shook the hands of all the graduates as they received their diplomas, she would later refuse to acknowledge their credentials. Wood explained:

One of the things we felt was that because the Ministry of Health nurses were not involved in the training, they had no ownership of the project, no personal involvement in the project. So if the midwives showed up at the hospital, they would not treat them well because they didn’t know them. If one of the nurses had trained them with their own blood, sweat, and tears, then maybe when one of these women arrived they would say, “Oh, we know you,” and they would be more likely to be supportive of them. That was part of the learning process that it was important to have the Ministry of Health involved. So we tried to make up for it in the next phases of the project. (Samantha Wood, 2005)

After the completion of Phase I, UNICEF ceased to fund GIFT’s program. Nonetheless, Phase II commenced in 2001 with the NGO’s own financial resources and a different midwife coordinator who tried to repair GIFT’s relationship with the ministry. According to Wood, “One of the big jobs she had was to make friends with the MOH and be a different person than me.” GIFT asked the advice of local ministry personnel in selecting eight new trainees, and Nurse Lee was asked to lead the theoretical instruction with assistance from GIFT’s midwife who would “fill in the gaps” and act as a “liaison or facilitator.” To further help bridge the disconnect, many of the trainees in the second group were already affiliated with the MOH in some way as community health workers or rural health post caretakers.
After this second phase, a total of 22 TBAs from 19 of the 50 or so rural villages in the Toledo District had been trained. Some areas remained without a trained TBA, and the MOH suggested that GIFT facilitate additional trainings according to its method of the last 50 years: by funding 6-month internships at the hospital. However, this arrangement was never pursued by either party, and Phase III of GIFT’s project metamorphosed into a series of continuing education workshops and related services such as basic first aid and CPR training, as well as literacy skills instruction for the TBAs it had already trained. Phase III ended in 2004 when monetary and human resources dried up, and while GIFT continues to work on development projects in the Toledo District, it is no longer involved in TBA training or continuing education for the TBAs. In many ways, this disassociation has contributed to local pessimistic expectations of foreign-led initiatives and suspicion of program quality, thus reproducing an old cycle.

PERSISTENT PATTERNS

By 2002, there were a total of 28 trained TBAs available to attend to births in the rural areas of the Toledo District: 22 birth attendants trained by GIFT, two of the older nannies trained by the MOH, and four TBAs who had apprenticed with rural health nurses in the mid-1990s. However, the vast majority of the births occurring in the home setting continued to take place without a trained attendant (Table 1-1). A closer analysis of more recent data sorted by place of birth and birth attendant for one section of the rural population in the Toledo District confirms this statistical trend (Table 1-2).

According to the delivery records for the San Juan village catchment area (covering 13 villages in Toledo with a population of approximately 5,150) that are kept by the rural health nurse at the health post in San Juan and the delivery records kept at the local hospital, I found that in 2003, 75 percent of all births for women residing within the catchment area took place outside the hospital. In 2004 and 2005, this number fluctuated down to 70.8% and up to 72%, respectively. Of the 13 villages included in this statistical analysis, 7 had TBAs trained by GIFT, and the TBA trained by the MOH continued to work alongside the rural health nurse in San Juan until some time in 2005 when she moved to another district. Yet, among the births conducted at home in the villages, the use of a TBA remained steady but was still significantly lower than the percentage of births delivered without formally trained assistance. In other words, throughout the period 2003–2005, close to 70% of the births that took place in the home in
this large rural area were delivered with family members who had never received any formal midwifery training (mothers, mothers-in-law, husbands), or women delivered their babies alone. Moreover, these numbers changed little from the previous decade when a much earlier health survey conducted by the Belizean government found that from the time period 1994–1999 about 75% of deliveries that occurred at home in the rural villages were conducted without a trained birth attendant (Central Statistical Office, 2001; Woolfrey, 2002).

AN ENDURING MISUNDERSTANDING

After I had conducted individual interviews with the TBAs trained by GIFT and amassed a fair amount of statistical data, I found certain indexical consistencies—namely inactivity and an enduring misunderstanding between the TBAs and MOH personnel that I believed contributed to the TBAs’ inability to implement their training. In an attempt to bridge the gap, I organized a meeting where the TBAs could interact as a group with the public and rural health nurses in charge of providing government-sponsored maternity care. I hoped that the meeting would provide a venue for both sides to air their grievances and create a means through which to create the types of collaboration alluded to in the UNICEF survey that had prompted GIFT’s program in the first place. Because I had also spent a significant amount of research time at the

### Table 1-2  Rural health center data for the San Juan catchment area (2003–2005)

<table>
<thead>
<tr>
<th>Place of delivery and attendant for births within the San Juan catchment area</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Punta Gorda Hospital</td>
<td>47 (25.0%)</td>
<td>38 (29.2%)</td>
<td>35 (28.0%)</td>
</tr>
<tr>
<td>Village (at home)</td>
<td>141 (75.0%)</td>
<td>92 (70.8%)</td>
<td>90 (72.0%)</td>
</tr>
<tr>
<td>Village birth with trained TBA</td>
<td>42 (29.8%)</td>
<td>29 (31.5%)</td>
<td>27 (30.0%)</td>
</tr>
<tr>
<td>Village birth with family member</td>
<td>97 (68.8%)</td>
<td>62 (67.4%)</td>
<td>60 (66.7%)</td>
</tr>
<tr>
<td>Village birth with nurse-midwife</td>
<td>2 (1.4%)</td>
<td>1 (1.1%)</td>
<td>3 (3.3%)</td>
</tr>
<tr>
<td>Grand total of births from the catchment area</td>
<td>188 (100.0%)</td>
<td>130 (100.0%)</td>
<td>125 (100.0%)</td>
</tr>
</tbody>
</table>

hospital-based prenatal clinic—where I often heard the MOH personnel making disparaging remarks about the TBAs—I was able to arrange for the meeting to take place in the hospital conference room. And after Nurse Lee voiced her opinion about the attendees—or lack thereof—the meeting continued with a TBA’s retelling of a controversial incident that reached a conciliatory solution, albeit one that never manifested.

Two days before the meeting, one of “Wood’s TBAs” had a confrontation with the nurse–midwife on duty when a woman she had brought to the hospital as a transfer patient was ready to deliver. Filomena, the TBA, had been summoned by a man living in her village whose wife had been in labor for a few hours with no apparent progress. Acting in accordance with her training that emphasized detection of high risk and referrals, Filomena brought the woman into the hospital “just in case.” Filomena stayed with the woman in the maternity ward until it became apparent that the woman would soon deliver because she began to feel the urge to push. Filomena looked for the on-duty nurse–midwife. When she could not find her in the maternity ward, Filomena decided to bring the woman into the delivery room where she assisted her onto the delivery table. As Filomena was putting on the white delivery smock and latex gloves to prepare for the delivery, the nurse–midwife entered the delivery room and began to “cuss her out” for doing what Filomena believed to be her job as a birth attendant. At this point in the story, Nurse Lee sent for the nurse–midwife, who corroborated the story and added that a TBA is not allowed to perform a hospital delivery without a nurse’s supervision. Filomena, however, asserted her belief that she was acting in the best interest of the woman who was ready to push and could not wait until the nurse–midwife, who had apparently strayed from her post, was found. Nurse Lee ended the discussion by asserting that Filomena had endangered the life of the laboring woman through her disregard for hospital policy. Meanwhile, no official mention was made of the nurse’s “cussing” or of her disappearance from the maternity ward. The meeting then concluded with a date set for an entire one-day workshop to be held for the TBAs, hospital nurses, and public health officials to discuss protocols. Unfortunately, it was discovered a few weeks later that the Inspector of Nurse Midwives from the country’s capital city was not available on this date. A few days later a tragic roadway accident involving a MOH vehicle left two members of a local public health official’s family dead, and
the importance of holding a TBA meeting fell by the wayside. Shortly thereafter, I concluded my fieldwork in Belize and, according to ongoing communications with local colleagues, this meeting has never happened.

CONCLUSION

Throughout this analysis I have highlighted the various environmental, structural, and cultural challenges posed by the Toledo District vis-à-vis development initiatives that have influenced women’s reproductive behaviors and the statistical trend toward home birth. The Belizean MOH is aware of the need for trained attendants and has provided small-scale training consistent with its limited financial means. Because many of the rural areas of the Toledo District remained without a trained attendant, GIFT initiated a larger-scale program to provide culturally sensitive maternity care that adhered to internationally recognized conventions of maternal and child health. Although the training of TBAs appears to be one solution to the problem of unattended home births, their underutilization obviates their NGO-initiated presence.

Undeniably there are many factors that influence the ability of the TBAs trained by GIFT to effectively implement their midwifery skills. However, this chapter has focused on an aspect of the training program that may not be obvious without a situated analysis. Despite the apparent dedication of GIFT’s personnel to the rural communities and an awareness of traditional cultural values, a lack of sensitivity to larger cultural hierarchies between local and global levels, as manifested in the interpersonal misunderstandings between GIFT and MOH personnel, proved damaging to the integration of many of the NGO-trained TBAs with the national healthcare system. Without this integration, nurse midwives are unlikely to recognize their qualifications as capable maternity care providers. This chapter concluded with a recent example of the kind of mistrust that has characterized GIFT’s training program from the outset, further suggesting that GIFT’s TBAs will remain underutilized by the larger community without serious attention to rebuilding their relationship with the MOH. GIFT’s good intentions, the WHO-approved agenda, and the network recruitment of local trainees could not compensate for the slight they caused to national and regional protocols of birth.
Discussion Questions

1. How do you think the traditional role of Maya husbands in childbirth influences the process of birth for the mothers and the interaction with health personnel?

2. Discuss the push for hospital births in this context with the demand for home births in the United States and other rich countries.

3. Why should funding be given to NGOs instead of the Belizean government? Do you agree with the reasons given in this chapter? Why or why not?

4. Discuss possible reasons why there is a shift away from training traditional birth attendants.

5. Develop at least one strategy or policy that would coordinate foreign medical aid to the Toledo region (or any other service region in a poor country). Is this coordination necessary? Why or why not?

NOTES

1. Pseudonyms are used throughout to protect the identity of all private organizations and individuals.

2. In 2005, the year before I conducted my fieldwork, the annual rainfall countrywide was 84 inches. In the Toledo District, it was 199.9 inches, almost four times higher than any of the other meteorological readings from the rest of the country (Central Statistical Office, 2006).

3. In the Toledo District, the percentage of the population classified by the Central Statistical Office as poor is 79.0, while the countrywide total is 33.5% (2004).

4. The most recent statistics indicate that the total fertility rate for the Toledo District is 5.59, while the rate is 3.97 countrywide (Central Statistical Office, 2001).

5. The Kekchi- and Mopan-speaking Maya represent 65.4% of the population of the Toledo District (Central Statistical Office, 2006).

6. In the Toledo District, it is common to refer to all cohabitating domestic partners, both legally married and common-law unions, as husband and wife.

7. North American interest in the Maya, indigenous therapies, and herbal medicine has brought about the use of a nobler title—traditional healer—to refer to bush doctors (Arvigo, 1994). However, Belizeans in Toledo often laugh at this “foreign” way of referring to their local practitioners because they see nothing pejorative about the term “bush doctor.”
8. A second hospital, located in the largest rural village, was completed in 2009. Future research will be needed to determine if women will deliver in a hospital now that one is located nearer to their homes.

9. Later in our interview, Wood relayed a story told to her by a “black” woman from town who complained to her that the nurses at the local hospital were mean. Wood then clarified that it is not just the Maya who are mistreated, “but that all of the women complain about the treatment that they get at that hospital.”

10. A common Belize Creole linguistic structure is the copular variant “mi” (pronounced “mee”), which signifies the past tense of the Standard English verb “to be” (Escure, 1992). For example, “I mi see it” means “I was seeing it” or “I saw it.”

11. Information supplied by Health Education and Community Participation Bureau (HECOPAB).

12. “Di” (pronounced “dee”) signifies the present tense of the Standard English verb “to be” (see footnote 10).

REFERENCES


CHAPTER 1  The Local, the Global, the NGO-ization of Birth in Southern Belize


McClusky, L. J. (2001). "Here, our culture is hard": Stories of domestic violence from a Mayan community in Belize. Austin, TX: University of Texas Press.


