PREGNANCY IS NOT A SICKNESS: MATERNAL HEALTH KNOWLEDGE, WELL-BEING, AND DECISION-MAKING AMONG THE Q'EQCHI' MAYA

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ABSTRACT

For many communities, Indigenous knowledge plays a key role in maintaining health and well-being during pregnancy, labour and delivery, and postpartum. However, this knowledge is often placed at risk as a result of public health interventions and the medicalization and institutionalization of pregnancy and childbirth around the globe. Ethnographic research was conducted with four *iloneleb'* from the Maya Healers' Association of Belize and 36 Q'eqchi' mothers in the Toledo district of Southern Belize, as a way to gain understanding of the knowledge and experiences of providing and receiving maternal care. This thesis addresses the knowledge held by both *iloneleb'* and Q'eqchi' mothers as they navigate the changes that have occurred in the region as a result of medicalization. In-depth semi-structured interviews and participant observation were undertaken to gain a deeper understanding of the ways in which this knowledge and experiences of care, both Q'eqchi' and biomedical, contribute to women's health and well-being during pregnancy, labour and delivery, and postpartum in the past and present. Over the past 20 to 30 years, mothers have gone from relying on *iloneleb'* for prenatal care and delivering at home with the assistance of their mothers, mothers-in-law and their husbands, to attending routine prenatal clinics and delivering at the local hospital in the nearby town of Punta Gorda. While pregnant women and mothers of today continue to rely on the *iloneleb'* as a way to maintain well-being, they also feel they are legally required to access biomedical care during pregnancy and for birth. This recent medicalization and increased access to biomedical care has influenced where, when, and how they seek care, particularly during pregnancy and for labour and delivery. Despite these considerable changes in the region, this thesis demonstrates the continued importance Q'eqchi' knowledge and *iloneleb'* in facilitating well-being during pregnancy, which in turn impacts well-being during labour and deliver and postpartum.

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DEDICATION

For Alex, who encouraged me to take the first step.

TABLE OF CONTENTS

CHAPTER 1: Introduction

1.1 Introduction

Indigenous knowledge plays a key role in maintaining health and well-being for local communities around the globe (Adelson 2000; Izquierdo 2005; Abranches 2014), particularly in relation to maternal health and well-being (Berry 2008 and 2010; Hinojosa 2004 and 2015; Rogoff 2012). For these communities, notions of well-being move beyond biomedical indicators of good health (Izquierdo 2005) to encompass local understandings of care, prevention, and risk, all of which inform pregnant women's maternal well-being strategies and decision-making (Berry 2008; Maraesa 2009, 2014, 2018a, 2018b; Rogoff 2012). These local understandings of care and risk often centre on notions of balance and harmony in social and spiritual realms (Berry 2008; Maraesa 2009). However, with the introduction of biomedical health services, Indigenous knowledge is often placed at risk, threatening to undermine deeply ingrained cultural epistemologies that provide mechanisms of comfort, guidance, and resilience in times of change.

In the Q'eqchi' village of Indian Creek mothers, their families, and the *iloneleb'*[1] must now contend with increased biomedicalization, through which "biomedical knowledge of reproductive health and propriety [is] powerfully – and politically – constructed as more legitimate and as imbued with expertise, while alternative forms of knowledge are portrayed as backward, ignorant, and 'risky'" (Fordyce and Maraesa 2012, 8). As a result, the use of biomedical health services becomes synonymous with modernity and is presented to communities as a superior way of knowing (Cosminsky 2001b). Pregnant women and Q'eqchi' medical providers alike are provided with biomedical healthcare information that does not necessarily conform to locally held practices and beliefs. Local communities are taught to question not only their own knowledge and experiences but that which has been passed down by their parents and grandparents (Hinojosa 2004).

While the introduction of biomedicine has reshaped the local landscape of care, Q'eqchi' medical knowledge and *iloneleb'* remain, for now, an accessible resource for local Q'eqchi' women (Waldram, Cal, and Maquin 2009). Therefore, in approaching this research I seek to

[1] To acknowledge the authority, knowledge, and expertise of Q'eqchi' medical practitioners the terms *iloneleb'* (plural) or *ilonel* (singular) which translate to English as 'seer' or one who 'sees' are used throughout this thesis rather than healer or traditional care provider.

detail the knowledge of both Q'eqchi' *iloneleb'* and Q'eqchi' mothers[2] as it pertains to maternal health and well-being. In doing so, I provide insight into Q'eqchi' women's experiences with both *iloneleb'* and biomedical services, emphasizing areas of contradiction and compatibility, and documenting utilization strategies as they seek appropriate, financially prudent, obstetric care. By focusing on well-being, it becomes possible to present a nuanced picture of the diverse factors that impact Indigenous knowledge held by both the *iloneleb'* and Q'eqchi' mothers, and to frame the decision-making process of pregnant women and mothers that exist within the context of their daily lived experience, as well as biomedical and Q'eqchi' medical conceptions of health and risk.

My primary research question asks, what is the state of Q'eqchi' knowledge regarding maternal health and well-being, and when and how is this knowledge accessed and put into practice? Indigenous knowledge relating to maternal health and well-being is held by both *iloneleb'* and Q'eqchi' mothers, and as such, sub-questions are divided by these two groups of knowledge holders. The relevant sub-questions are:

For *iloneleb'*

- What knowledge do *iloneleb'* have regarding maternal health and well-being? And what is the source of this knowledge?
- What maternal health services do they provide, and how often are they called upon to provide these services?
- Is maternal health traditionally attended to by *iloneleb'* or is this a new role for them?
- How is maternal health risk constructed or understood by the *iloneleb'*?

For *Q'eqchi' mothers*

- What knowledge do Q'eqchi' mothers hold regarding maternal health and well-being? And what is the source of this knowledge?
- How do Q'eqchi' mothers understand and make use of longstanding Q'eqchi' knowledge in relation to their maternal health and well-being?
- Does accessing longstanding Q'eqchi' knowledge and medical practices contribute to Q'eqchi' mother's maternal well-being?
- How is maternal health risk constructed or understood by Q'eqchi' mothers? In relation to Q'eqchi' medicine? In relation to biomedicine?

[2] Throughout this thesis, I use the term mother to refer to those who have given birth at least once and in discussions of the postpartum period, while the terms woman and women are used in reference to those who are pregnant and the prenatal period in general. It should also be noted that these women occupy more than the role of mother, they are daughters, sisters, aunts, students, and entrepreneurs in addition to the role of mother.

- What factors inform decision-making practices of Q'eqchi' mothers and their families regarding access and use of available maternal care services (Q'eqchi' and biomedical), both hypothetically and in practice?
- Does a mother's experiential and therapeutic knowledge differ from that of *iloneleb'*?

1.2 Theoretical Framework and Literature Review

1.2.1 Critical-Interpretive Medical Anthropology

In approaching this thesis, I seek to prioritize the daily lived experience of the mothers of Indian Creek. In doing so I turn to critical-interpretive medical anthropology, which questions the ways in which the biomedical model of care conceptualizes notions of health, illness, disease, and treatment. Within a biomedical framework, the body is meant to conform to specific standards that are embedded within the context of science and technology. As such, science and technology are privileged and a woman is reduced to simply a body in which technological interventions are meant to mitigate risk. Critical-interpretive medical anthropology moves beyond the biomedical model's preoccupation with the body as a separate entity and provides spaces in which "medical knowledge is not conceived of as autonomous but is rooted in and continually modified by practice and social and political change" (Lock and Scheper-Hughes 1996, 44). As such, critical-interpretive medical anthropology seeks to attend to bodies that "refuse to conform (or submit) to presumable universal categories and concepts of disease, distress, and medical efficacy" (Lock and Scheper-Hughes 1996, 43) that emerge as part of dominant biomedical ways of knowing.

In re-conceptualizing the body, it is important to note that "people's images of their bodies in a state of well-being or in a state of distress are mediated by sociocultural meanings of being human" (Baer, Singer, and Susser 2003, 7). Critical-interpretive medical anthropology brings attention back to the individual experience. This is not limited to the experience with or of the body, but also encompasses the social, symbolic, and political aspects that influence one's experience of health and well-being. Furthermore, critical-interpretive medical anthropology provides a space for the lived experience to be situated within the broader social and structural contexts that impact not only individual experiences of health and well-being, but that of the community as well.

In situating this thesis within the framework of critical-interpretive medical anthropology my goal is to demonstrate the ways in which health and well-being are conceptualized at the

local level by Q'eqchi' mothers and the *iloneleb'* in relation to pregnancy, labour and delivery, and postpartum. In doing so, I centre this thesis on the stories and experiences of the *iloneleb'* and Q'eqchi' mothers in order to reveal the ongoing adaptation of Q'eqchi' medical knowledge and its practice in the face of social and political change in the form of ongoing biomedicalization in the region.

1.2.2 The Anthropology of Reproduction: Central America

The anthropology of reproduction represents a rich body of work that demonstrates that "birth is everywhere culturally marked and shaped" (Cheyney and Davis Floyd 2019, 2). Central America is no exception and has long served as a site of research and collaboration with communities and care providers (Berry 2006, 2008, 2010; Cosminsky 2001a, 2012, 2018; Hinojosa 2004 and 2015; Maraesa 2009, 2012, 2018a, 2018b; Rogoff 2011). Anthropological research has paid particular attention to the socially significant role of Maya midwives (Berry 2006, 2008, 2010), differing expectations of care between Maya care providers and biomedical care providers (Hinojosa 2004, 2015), the ways in which Maya practices and biomedical practices are combined or rejected to align with local values and beliefs (Cosminsky 2001a, 2018; Rogoff 2011), as well as the changing role of midwives (Jenkins 2001) and the broader implications of and challenges posed by traditional birth attendant (TBA) training programs (Maraesa 2009, 2012, 2014, 2018b). Connecting this body of research on maternal health and well-being is the impact of medicalization throughout Central America as a result of the introduction of global public health initiatives aimed at reducing maternal and infant mortality rates, of which anthropologists remain critical.

Medicalization is the process by which a once 'normal' state of being comes to be understood as a dangerous process and is "subject to the authority of medical institutions with their cadre of experts from whom we expect proper diagnosis and isolation of our health problems" (Parry 2008, 785). With medicalization, biomedical care providers adopt a position of superiority, assuming the biomedical model of care is more appropriate than all other medical systems (Waldram 2000, 606). In doing so, the longstanding experiential knowledge of Indigenous medical practitioners is often portrayed by biomedical practitioners as static, in which "[Indigenous medical practitioners] stubbornly continu[e] their practices in the face of "modern" medicine" (Cosminsky 2018, 466).

Within the medicalization of maternal health, both pregnancy and childbirth come to be viewed as an "inherently unstable period during which the health of both mother and fetus [are] at risk" (Dudgeon 2012, 19), requiring biomedical intervention in order to be deemed successful. As biomedical interventions have come to dominate maternal health, a global culture of risk avoidance has emerged surrounding pregnancy and birth (Cheyney and Davis-Floyd 2019, 6). While biomedical interventions such as cesarean sections and the use of synthetic hormones to augment labour and delivery do save lives, their routine overuse remains detrimental to both mothers and babies (Cheyney and Davis-Floyd 2019, 4). Once birth "becomes viewed as inherently risky, then it appears as if all measures must be taken to keep it safe" (Cheyney and Davis-Floyd 2019, 6). It is this fear of adverse outcomes in conjunction with global public health initiatives which have become the primary motivation for the intense medical management of pregnancy and birth.

While "therapeutic legitimacy is largely restricted to biomedically trained practitioners [reflecting] the hegemony of Western 'modern' biomedicine" (Lock and Nguyen 2010, 291), women and their families continue to engage the services of midwives during pregnancy and postpartum. These practices provide a means of comfort and serve to reinforce kinship roles and relationships within local communities (Berry 2006, 2008, 2010; Hinojosa 2004 and 2015; Obermeyer 2000; Rogoff 2011). Prior to the introduction of biomedicine, women's maternal health needs were attended to by other women within the community, who brought their personal experience as birthing mothers to their practice. As the traditional caretakers of women during pregnancy and childbirth, local midwives are the primary target for global health initiatives aimed at reducing global maternal mortality rates and providing maternal care in areas with limited access to biomedical services (Cosminsky 2018; WHO 1992).

The training of TBAs has been promoted by the World Health Organization (WHO) since the 1950s (WHO 1992, 4). This continued through the 1960s and 1970s with the attempted incorporation of Indigenous care providers in order to reach their goal of "Health to All by the Year 2000" (Cosminsky 2018, 466). Following this, the Safe Motherhood Initiative was introduced in 1987 and led to increased training of TBAs around the globe (AbouZahr 2003; MacDonald 2017) and was viewed as a way to acknowledge and incorporate Indigenous medicine and practitioners into biomedical systems in a systematic way (MacDonald 2017, 2). This further served as a way of encouraging local care providers to question the legitimacy of

their practices and experiential knowledge (Hinojosa 2004). In the 1980s and 1990s, when it was determined that maternal and infant mortality rates had not declined enough, it was local midwives, once touted as the solution to decreasing said rates, who were blamed. As a result, training programs shifted toward educating these midwives to focus on "risk factors" and refer at risk mothers (first-time mothers, teenage mothers, signs of preeclampsia, previous cesarean, bleeding, long labour) to the hospital rather than assisting them at home (Cosminsky 2018, 466).

When rates had still not decreased enough, the WHO then shifted emphasis to emergency obstetric plans. These plans incorporated the identification of risk and encouraged women and their families to plan and save for transportation to the hospital in the event of an obstetric emergency (Cosminsky 2018, 466). However, planning and saving does not guarantee that a labouring woman will be able to get to the hospital in an obstetric emergency, as unforeseen situations could arise such as vehicles breaking down or a lack of availability. The cost may also change between making arrangements and when transportation is required. By the mid-1990s, it became apparent that the Safe Motherhood Initiative would not reach its year 2000 goal of reducing global maternal mortality rates by half. As a result, the training of TBAs was deprioritized in favour of ensuring skilled birth attendants or nurse-midwives were present at all home births (AbouZahr 2003).

The WHO defines skilled birth attendants as "accredited health professionals – such as a biomedically trained midwife, doctor, or nurse – who [have] been educated and trained to proficiency in the skills needed to manage normal (i.e., uncomplicated) pregnancies, childbirth, and the immediate postnatal period" (WHO 2004, 1). Anthropologists remain critical of such a distinction as it implies that "traditional [Indigenous] midwives have no skills, as opposed to acknowledging that their skills might be different from the biomedical ones taught to 'skilled birth attendants'" (Cosminsky 2012, 84). These different skills Indigenous midwives provide include "important social, emotional, physical, and ritual support to … [a] woman and her family" (Cosminsky 2012, 81) during pregnancy, delivery, and the postpartum period. Indigenous midwives and TBAs also combine some and reject other aspects of biomedical care to align with local values and beliefs and to meet the needs of the women for whom they care (Cosminsky 2001a, 2018; Rogoff 2011). Midwives today follow practices that they have been taught in prior biomedical training programs only to be told that their practices are now incorrect. While those midwives who continue to follow local practices may find in training sessions that

these practices happen to be similar to new biomedical practices. Unaware of such changes, biomedical providers remain critical of the work of Indigenous midwives and TBAs and the experiential knowledge they bring to their practice. (Cosminsky 2018, 465).

As this body of work demonstrates, traditional birthways have been, or are in the process of being, subsumed under the global culture of industrialization and medicalization of pregnancy and birth (Cheyney and Davis-Floyd 2019, 3). Berry (2010) argues that instead of reducing vulnerability within communities, these global public health initiatives, such as the Safe Motherhood Initiative, instead further vulnerabilities, reducing maternal mortality to a "medical problem where lack of access to skilled biomedical providers dominate the agenda for making pregnancy safer" (1). When considered in terms of statistics of life and death, we lose sight of the human experiences of pregnancy and birth. It is here that critical-interpretive medical anthropology returns attention to the body and the lived experience of pregnancy, birth, and motherhood. Instead of focusing on developing global health programs and policies to reduce maternal and infant deaths, birth activists, researchers, and anthropologists have turned their attention towards questioning the "assumptions of what women and babies need to survive" (Cheyney and Davis-Floyd 2019, 4). Anthropologist Robbie Davis-Floyd has called for a humanistic model of birth in which women are treated as individuals and provided with compassionate support, in which trust in the birth process is central and support among mothers, family, and care providers is reaffirmed (Cheyney and Davis-Floyd 2019, 8).

1.2.3 Medicalization and Decision-Making

The Belizean Ministry of Health (MOH) has been training TBAs since the 1950s in line with international prioritization of maternal and child health initiatives (Maraesa 2009, 205). With funding from UNICEF, these training programs set in motion the medicalization of pregnancy and childbirth within Belize (Maraesa 2009, 205). MOH officials invited local women known to have midwifery experience and who were trusted within local communities to participate in a 6-month training program in Belize City (Maraesa 2009; De Gezelle 2014). Following the completion of their training, they were certified as birth attendants and were encouraged to view themselves as working in tandem with the MOH and to maintain contact (Maraesa 2009; De Gezelle 2014). Since training began, the number of TBAs trained in Belize

has remained small as a result of limited resources, and by 1989, training of TBAs began to dwindle (Maraesa 2014, 11).

While the MOH does continue to train TBAs, this training is in accordance with international biomedical standards of maternal and child safety and risk (Maraesa 2009). In training TBAs, biomedical knowledge is privileged over local knowledge. These training programs remain unresponsive to the practical needs of TBAs, placing a strong emphasis on pre-established guidelines instead of taking an experiential learning approach, which is the traditional form of knowledge acquisition for Maya midwives (Hinojosa 2004, 642). These pre-established guidelines discourage women from thinking "creatively and experimenting with different therapeutic techniques appropriate to their patients" (Hinojosa 2004, 642) and encourage women to question their abilities and experiential knowledge (Hinojosa 2004). Training in Belize is now limited to several months, and TBAs trained today do not come to the practice with the same foundational knowledge as those Maya midwives who were first recruited for biomedical training in the 1950s (De Gezelle 2014). Additionally, the TBAs of today are not accorded the same authority by biomedical care providers as the previous Maya midwives, and while they are trained to provide services to remote communities, access and availability of their services remain limited (Maraesa 2009 and 2014).

In 2000, with funding from UNICEF, the non-governmental organization (NGO) Giving Ideas for Tomorrow (GIFT) worked to implement a three-phase TBA training program in the Toledo District. However, not realizing it was necessary, the NGO failed to obtain permission from the MOH. Aid organizations operating within the area are already viewed with suspicion as their interventions last only as long as the funding associated with them (Maraesa 2014). As a by-product of GIFTs failure to obtain permission from the MOH, as well as further misunderstandings between local level MOH and GIFT personnel, the mistrust that developed between these organizations was extended to the TBAs trained by GIFT (Maraesa 2014, 17). Maraesa (2014) also observed MOH personnel making disparaging remarks about the GIFT trained TBAs, accusing them of endangering the lives of labouring mothers. These TBAs were further underutilized by the communities they were meant to provide care in, as women preferred to deliver at home with the assistance of their husbands and mothers-in-law, as was the practice for generations (Maraesa 2014).

In making their services available, biomedical care providers expect that health seekers will utilize them. Those patients whose health care behaviours do not conform to biomedical understandings of care are often viewed as non-cooperative and non-compliant (Harvey 2008). However, when examining healthcare availability and decision-making, it cannot be assumed that patients access and make use of only one type of medical care. Medical pluralism is "characterized by a pattern in which biomedicine exerts dominance over alternative medical systems, whether they are professionalized or not" (Baer, Singer, and Susser 2003, 332). How individuals access and make use of these multiple systems has been referred to as the hierarchy of medical resort (Romanucci-Schwartz 1969).

Within the Toledo district, the quality of biomedical services remains poor, due in part to a lack of doctors and nurses, functioning medical equipment, specialists and emergency services, and unreliable emergency vehicles (Reeser 2014, 180). With limited access to care, "medical pluralism [in the Toledo District] remains vital, in part, to fill the gaps in health care that biomedicine is unable to reach" (Reeser 2014, 17). In his research on medical pluralism in the town of Punta Gorda, Reeser (2014) finds that "virtually every household practice[s] its own unique form of medical pluralism" (Reeser 2014, 124). This includes making use of biomedical services, pharmacists, and *iloneleb'*, as well as home-based remedies passed down through multiple generations (De Gezelle 2014; Reeser 2014).

1.2.4 Risk: Perceptions and Preventions

Risk is conceptualized in relation to danger and the associated potential for negative outcomes that may result from the dangers associated with the uncertainty of future events (Browner 2012, x). Notions of risk are socially selected and constructed, encompassing both the physical and the spiritual (Douglas and Wildavsky 1983), and while the concept of risk may be considered universal, the ways in which risks are conceptualized and understood by different social actors remains variable. Notions of risk are not bounded. Instead, they are dynamic and informed by the social, political, and historical context in which they emerge. In medically plural environments, conceptions of risk are multiple, as lay discourse on risk differs considerably from biomedical risk factors (Dudgeon 2012, 32). In such cases, conflicting understandings of risk emerge, as well as competition over whose knowledge counts and when.

Biomedical risks associated with pregnancy and childbirth can be divided into personal and external risk factors (Cosminsky 2012, 88). Personal risk factors are those associated with the physical body and include a woman's age, the number of pregnancies she has had, her blood pressure, pre-eclampsia, and anemia (Cosminsky 2012, 88). External risk factors are defined by biomedical care providers as the longstanding practices used by midwives such as prenatal massage and the use of a sweat bath or vaginal steaming (Cosminsky 2012, 88). However, for local Maya women, not adhering to practices such as prenatal massage presents a greater risk to one's health and well-being than avoiding such practices. Prenatal massage plays a key role in maintaining well-being during pregnancy and ensuring the baby is in the correct position for delivery. Previous research in southern Belize by Maraesa (2012) suggests that biomedical care providers and the hospital itself may also be viewed as a greater risk than seeking care from an *ilonel,* midwife, or giving birth at home. The hospital is viewed as a site of risk and avoided: as women fear being scolded if they cry out during labour and delivery, fear the pain and possibility of a cesarean section, and have often heard stories of women dying during birth (Maraesa 2012, 224). Mothers prioritize their lived experiences of previous and current pregnancies over hypothetical biomedical risks that may or may not occur (Maraesa 2012, 220).

The ways in which risk is constructed inform how individuals conduct themselves in their day to day lives and in how they seek care. Risk within a biomedical framework "relies on a constructed objectivity to validate its superiority" (Maraesa 2012, 211). However, mothers perceive risk and make decisions based on their own embodied understandings of their health and well-being, as well as their own social and environmental realities (Maraesa 2012, 211). Therefore, local understandings of risk extend beyond the physical to encompass the spiritual, social, and environmental contexts in which they live.

1.2.5 Health and Well-being

Within a biomedical framework, health as a concept is primarily used in reference to the physical body (Mathews and Izquierdo 2010, 4) and the concept of well-being is frequently used as a synonym for health (Thin 2010, 35). While the physical body can be included in both health and well-being, one's well-being is not exclusively based on physical health alone. As a result of this strong emphasis on health, and the physical body in particular, biomedical and non-biomedical ideas and understandings of health and well-being often come into conflict with one

another (Mathews and Izquierdo 2010, 4). It is at this nexus of conflict that critical-interpretive medical anthropology pushes back against this reductionist view of the body and brings to the discussion the multitude of factors that influence one's health and well-being. Mathews and Izquierdo (2010) broadly define well-being as "an optimal state for an individual, community, society, and the world as a whole. It is conceived of, expressed, and experienced in different ways by different individuals and within the cultural contexts of different societies" (5). Well-being extends beyond that which is physical to encompass "people's own internal states of mind" (Mathews and Izquierdo 2010, 4). While broad in definition, it is possible to break the concept of well-being into smaller analytical pieces.

In approaching the study of well-being, Thin (2010, 30) suggests that well-being as a concept should be interrogated in relation to feelings, evaluative meanings, and motives. Feelings encompass not only how participants feel about themselves, but how they feel about the relationships, institutions, processes, and events that make up their everyday lived experience (Thin 2010, 30). Evaluative meaning provides insight into the ways in which meaning is constructed by participants, within their own lives as well as in relation to those around them (Thin 2010, 30). Finally, motive extends beyond the desire to feel good to include the desire to live a life that is meaningful, not only at the level of the individual but within the wider social context and in relation to the broader social principles of one's community (Thin 2010, 31). Taken together, feelings, evaluative meaning, and motive allow well-being to be understood as a process of meaning-making and interpretation of one's quality of life (Thin 2010). Situating anthropological research on well-being in such a way allows for a detailed interrogation of the nuances of participants' lived experiences and the diverse factors, interpersonal, physical, biomedical or otherwise, that contribute to well-being.

Both health and well-being are important for the Q'eqchi'. Research by Waldram (2020) finds that among the Q'eqchi' health is tied to the absence of sickness and one's ability to work. An individual who is unable to work and unable to contribute is one who is experiencing sickness. Q'eqchi' notions of well-being are conceptualized in a broad sense, encompassing feelings of goodness or contentment, and living a good and happy life (Waldram 2020). Connecting this to the work of Thin (2010), these criteria form the basis upon which community members construct meaning in relation to their well-being. Furthermore, well-being includes a social dimension in which being seen as a visible, active member of one's community indicates

that one is healthy and well. Overall, notions of well-being are tied to being content, living a good and happy life, the ability to work and to publicly fulfill one's social roles. (Waldram 2020).

1.3 Ethnographic Context

Belize is a small, diverse nation in Central America, bordered to the north by Mexico, Guatemala to the west and south, and the Caribbean Sea to the east. Belize gained independence from Britain in 1981 and is the only official English speaking country in Central America. As of 2017, the total population of Belize was 387, 879 (SIB 2017, 14) of which 40,825 are Maya, which includes Q'eqchi', Mopan, and Yucatec (SIB 2017, 17). It is estimated that 76% of the Maya population in Belize live in poverty (PAHO 2009). Belize has a diverse population that includes Creole, East Indian, East Asian, Garifuna, Mestizo, Mennonite, American, and Canadian (SIB 2013b). In Belize, Creole identity blurs ethnic distinction and refers to a mixture of any sort, rather than the official definition of descendants of African and European ancestry (Maraesa 2018b). Chinese and East Indian immigrants in Belize include those whose ancestors were indentured migrants and a more recent wave of Chinese immigrants beginning in the early 2000s, most of whom own and operate most of the small grocery stores and a number of restaurants in Punta Gorda (Maraesa 2018b). The Garifuna (descendants of shipwrecked Africans who resisted enslavement) were the first to settle along the coastal areas of Toledo and established the town of Punta Gorda, while the Mennonites immigrated as a way to maintain their religious freedoms (Maraesa 2018b). A number of expatriates from Canada and the United States who have sought early retirement also call Toledo home (Maraesa 2018b).

The Belizean economy is primarily based on tourism as well as marine and agricultural exports which include sugar, citrus, banana, and papaya (PAOH 2012). There are two main political parties in Belize, the People's United Party (PUP) and the United Democratic Party (UDP) (Maraesa 2018b). With few discernable characteristics between these parties, elections tend to switch between the PUP and UDP every few terms (Maraesa 2018b). Education in the district includes both primary and secondary school. Primary schools are predominantly Catholic (SIB 2018) and free for students to attend, while secondary school (grades 9 through 12) is not mandatory and requires families to pay tuition. As of 2018, the transition rate from Standard 6 (grade 8) to secondary school was 76% in the district (SIB 2018).

The country is divided into six administrative districts: Corozal in the north, Orange Walk to the northwest, Belize running along the coast, Cayo in the interior district, Stann Creek, and the southernmost Toledo District. As the most remote and underfunded district in the country, the Toledo district is commonly referred to as "the forgotten district" (Reeser 2014; De Gezelle 2014) and has the highest rates of poverty in the country (PAHO 2009).

The Toledo District is made up of lush, dense forest and has a population of 36,695 (SIB 2017, 12). It is connected to the rest of the country by the Southern Highway, which terminates in the district's only major town, Punta Gorda, which has a population of 6,148 (SIB 2017, 12). The remaining 30,547 individuals make up the rural population of Toledo, the majority of whom are Maya (SIB 2017, 12). The Maya are frequently referenced as a singular Indigenous group from Mesoamerica, living in modern-day Mexico, Guatemala, Belize, El Salvador, and Honduras. However, the Maya are far from a homogenous group. The Maya are linguistically diverse, with over 30 different spoken languages. It is within community and in spoken language that Maya groups find their identity (Waldram, Cal, and Maquin 2009, 38), and there has been considerable mobilization among Maya groups, including both Q'eqchi' and Mopan, to assert their cultural and linguistic differences (Medina 1998, 135). While the term Q'eqchi' previously referred only to spoken language, it has now come to represent the specific Maya group that speaks it (Wilson 1993, 126). The total Q'eqchi' population is estimated to be between 700,000 to 900,000, the majority of whom make their homes in Guatemala (De Gezelle 2014, 6). While Maya claims to Indigenous identity are not typically disputed, in Belize this has been challenged as a number of groups compete to assert their Indigenous status over the region (Medina 1998, 136). The Q'eqchi' living in Belize made their way from Guatemala in multiple waves as a means of escaping forced military service and poor labour conditions with little financial compensation (Kahn 2006, 41; Medina 1998, 143) and this may contribute to the contestation of their Indigenous status in Belize. The Maya population is mixed and includes 14,091 Q'eqchi', 4,608 Mopan, and 22 Yucatec (SIB 2010, 78) residing in approximately 30 villages scattered throughout the district (Reeser 2014). Of the six administrative districts in Belize, Toledo has the lowest population density, largest average family size, and the most limited access to electricity (De Gezelle 2014). Reeser (2014) notes that the Maya are quite often marginalized within Punta Gorda, as they tend to be viewed as "rural farmers who continue to practice traditions that to many in [Punta Gorda], seem outdated" (Reeser 2014, 81). The Toledo district also serves as a

site of continued land disputes with Guatemala, necessitating the continued patrolling of the Belize Defence Force along the border (Maraesa 2018b).

In both the Q'eqchi' and Mopan villages of southern Belize divisions of labour are along gendered lines. The men are responsible for farming activities which include preparing the fields for planting as well as the maintenance and harvesting of these crops and hunting for game animals (Baines 2016, 16). Women's roles include the preparation of crops for consumption and sale, as well as the collection and processing of wild plants and caring for domestic animals such as chickens, ducks, and pigs. Children as young as three will help with caring for domestic animals as well, stripping corn from the cob to feed chickens and ducks, and when they are a little older, they will be responsible for gathering firewood. Children will also be called on to perform errands, running to the shop for necessary items as well as to the local corn mill for the next batch of masa (Baines 2016, 16).

Indian Creek is one of the 30 Maya villages in the Toledo District. As of the 2010 census the village was comprised of 134 households with an average household size of 5.4, and a total population of approximately 721 (SIB 2013a, 69). Following Hurricane Iris in 2001, Indian Creek expanded to the southeast and now straddles the Southern Highway. The paved highway plays host to the James Bus Line which operates a dozen or so buses each day between Punta Gorda and Belize City, as well as a number of local buses which run from Indian Creek or other nearby villages to Punta Gorda several times a day. As a result, Indian Creek is well situated to access the rest of the country. However, trips to Punta Gorda or other neighbouring villages can quickly add up in cost.

The village has four churches, three women's groups, and a preschool and primary school. While primary school education is free, families are responsible for the cost of uniforms, textbooks, and report cards. High school is not required and is not free. Textbooks and uniforms are also required, and tuition fees are high; many families obtain scholarships in order to send their children to high school.

At the time of my research, Indian Creek did not have power lines leading to any homes. However, on two occasions, workers came through to survey for future installation of power lines, with no word as to when they may be installed. Many families do have solar panels connected to batteries within their homes, allowing them to power one or two lights in the evening and for charging their cellphones. The village has two sources of water: the creek and

the treated community well. Most homes have access to one or both water supplies. Treated water costs $10 BZD each month. Water from the creek is typically used for bathing and laundry, while treated water is used for drinking, cooking, and washing dishes and food. Since access to water is at times disrupted by heavy rainfall, families typically keep one or two five-gallon pails full of fresh drinking water in their kitchen area. There are three local shops in the village, which offer cold drinks, phone credit, and dry goods, as well as three family run gas-powered corn mills.

1.3.1 Maternal Heath and Biomedical Care in the Toledo District

There are a number of health issues facing Belizeans, and those in the Toledo district in particular. This includes an increase in both emerging diseases and non-communicable diseases, as well as increases in road traffic accidents and both gang and domestic violence (PAHO 2017). Emerging diseases include Zika virus, H1N1 virus, Dengue and Chikengunya, while there has been an increase in non-communicable disease such as strokes, cancer, and respiratory disease. Diabetes and heart disease are currently the largest contributors to morbidity and are quickly becoming the leading causes of death within the country (PAHO 2012, 28) along with malignant neoplasms (PAHO 2017). Relating to maternal health, complications during pregnancy, childbirth and the puerperium, particularly for those ages 15 to 19 and 20 to 29, account for approximately 70% of all hospitalizations in the country (PAHO 2017). Such numbers indicate that teen pregnancy occurs at an early age in Belize (PAHO 2017). Additionally, complications during pregnancy, childbirth, and the puerperium are also the leading cause of hospitalization for those ages 30 to 40 (PAHO 2017).

The Maternal Mortality Ratio (MMR) is an indicator used to predict the probability of maternal deaths and is calculated based on available reported maternal deaths (WHO 2015b, 27 and 30). The WHO defines maternal deaths as "the death of a woman within 42 days of termination of pregnancy, irrespective of duration… from any cause related to or aggravated by pregnancy or its management but not from accidental or incidental causes" (2019, 30). The most recent MMRs available for Belize come from 2015, 2016, and 2017. In 2015, the national rate was 107.3 per 100,000 live births; in 2016, it was 83.1; and 138.1 in 2017 (SIB 2016, 148). In 2015, the MMR for the Toledo district was higher than the national rates at 302.6 and was the highest in the country. In 2016, the Toledo district had a rate of zero with no reported maternal

deaths. It is unclear if this is an issue with the available date or if there were no maternal deaths for this year. The MMR increased to 304.9 in 2017 and the district once again had the highest rate in the country (SIB 2017, 144). From statistical data, it is unclear as to where, when, why, and how these deaths occurred and as to why the MMR fluctuated between 2016 and 2017. Since the 1990s the cause of maternal death has shifted from "direct obstetric emergencies to indirect circumstances such as heart disease or other existing conditions" (PAHO 2012, 20). As a result, the number of maternal deaths per year in the Toledo district has remained consistently at around two or fewer deaths since the 1990s onward (Maraesa 2009, 124; SIB 2013b, 81).

The Infant Mortality Rate (IMR) indicates the probability of an infant dying between birth and one year of age and is reported per 1,000 births (WHO 2015b, 27). The leading causes of death in children under the age of one have been reported as hypoxia, birth asphyxia, respiratory conditions, birth defects and other conditions originating in the perinatal period (PAHO 2017). In 2015, the Toledo district had the highest IMR in the country at 21.2 (SIB 2017, 143). The IMR dropped to 9.4 in 2016 and was the second lowest in the country, while in 2017 at 10.7 the Toledo district had the lowest IMR in the country. The IMR is unavailable for previous years, however, the number of infant deaths have been reported per district between 2002 and 2011. During this time period the number of infant deaths per year in the Toledo district ranged between 9 and 18, which is fewer than most other districts in the country (SIB 2013b, 19). Additionally, the number of infant deaths in the Toledo District has remained low compared to the rest of the districts since the early 2000s, with the lowest number of infant deaths in 2014, 2016, and 2017 (SIB 2013b; SIB 2016; SIB 2017).

Since the late 90s, Belize has been divided into four health regions, Northern, Central, Western, and Southern. The Toledo district is part of the Southern Health Region and includes 28 health posts and 20 health centres (SIB 2018), approximately 37 community health workers, five satellite clinics (Big Falls, Santa Ana, Pueblo Viejo, Santa Teresa and San Pedro Colombia), two polyclinics (San Antonio and Punta Gorda), Hillside Healthcare Centre (a private clinic near Punta Gorda), the Punta Gorda Hospital, the Southern Regional Hospital (formerly Dangriga Hospital) (SHR 2018), and several private practices. With a total of 20 beds, the Punta Gorda Hospital provides primary care, managing both common illnesses and obstetric cases that do not require any type of specialist intervention (SHR 2018). It should be noted that specialist clinics are held at the Punta Gorda Hospital by visiting specialists from the Southern Regional Hospital

(SHR 2018). The Southern Regional Hospital located in Dangriga provides both primary and secondary care and has two main wards, the general ward and the maternity ward, with a total of 52 beds (SHR 2018). Maternal health services at the Southern Regional Hospital include pre-and post-natal care, newborn care, as well as pre-and post-op care for cesarean sections (SHR 2018). In the event of complication during delivery, mothers are transferred from Punta Gorda to the Southern Regional Hospital by plane or ambulance. Alternatively, pregnant women may be referred to the Southern Regional Hospital for cesarean section if the baby is not in the correct position, or if they have previously had a cesarean section. Further specialized care (tertiary level) is available at the Karl Heusner Memorial Hospital in Belize City (MOH 2020).

Health care in Belize works on a referral system, in which health seekers are instructed to first visit their entry-level health facility, or for those in rural communities the local health post (Reeser 2014, 96). From there, patients may be referred by their community health worker to one of the satellite clinics and then from there to one of the polyclinics or to the Punta Gorda Hospital. Doctors at the Punta Gorda Hospital have the authority to refer patients to the Southern Regional Hospital, where patients may then be referred to a major hospital in Belize City, which lies 6 hours by road to the north (Reeser 2014, 96).

There are a number of significant barriers in the implementation of such a system, in particular, the staffing of these institutions. While the MOH aims to have a Community Health Worker in every village, this is not always possible, leaving some villages without coverage (Reeser 2014, 97). Additionally, the Belizean health system, and the referral system in particular, do not account for the ways in which those living in rural areas make use of transportation services and how this correlates with the ways in which they access health care. Many make use of the clinic in Punta Gorda when they are in town on market day, instead of incurring additional debt by travelling to the new, but underutilized and out of the way, San Antonio Polyclinic (Reeser 2014).

During my time in Indian Creek, there was no mention of a Community Health Worker. This may be due to the close proximity of the Big Falls satellite clinic, a 10-15 minute bus ride away. The satellite clinic, a bright green two-story building surrounded by a chain-link fence, was constructed sometime around 2006 and it is open Monday to Friday from 8:30-4:00. I passed the satellite clinic going to and from the village each day. However, it wasn't until the end of my fieldwork that I set foot in the building. Despite the regular clinic hours, there is not always a

doctor present, and even when a doctor is present, and the line may appear minimal, wait times can be long. The satellite clinic hosts a prenatal clinic every Wednesday, and women visit once a month during the early months of pregnancy, increasing to weekly visits in the last two months of pregnancy. Prenatal visits include checking the baby's heart rate, measuring the stomach, and the prescription of iron pills and prenatal vitamins. Free contraceptives are also provided at the clinic.

1.3.3 Q'eqchi' Medicine and Maternal Health in the Toledo District

Maya medicine has long been categorized as adhering to a humoral system with a strong emphasis on hot and cold (Cosminsky 2001a and 2018; De Gezelle 2014). As noted by Waldram (2020), the "humors" present in classical humoral medicine are noticeably absent. Instead, the iloneleb' employ a stripped-down version of the humoral system based on environmental, bodily, and metaphorical temperatures (Waldram 2020). Waldram (2020) instead refers to the navigation between hot and cold as the thermal principle, in which equilibrium within the body is central to health and well-being. A body that is either too hot or too cold is at risk of sickness and may be influenced by several factors including the time of year or time of day, weather, age, and one's physiological state (De Gezelle 2014, 18). An imbalance between hot and cold within the body leads to illness (Cosminsky 2001a and 2018; De Gezelle 2014; Waldram 2020). Hot conditions are treated with the application of cold medicines to cool the body, while hot medications and foods are used to warm the body. Additionally, extreme thermal changes should be avoided (Waldram 2020). If an individual is in a hot state, care must be taken to avoid exposure to cold, as the combination of two extreme temperature changes may also cause illness (Cosminsky 2018).

In Belize, while Q'eqchi' medicine remains outside of the "direct control of the state and biomedicine [it does not remain] unaffected" (Waldram 2000, 617) by either. For the Q'eqchi', healing is a syncretic practice, blending longstanding Maya knowledge and healing practices with Christian and biomedical practices (De Gezelle 2014:9; Waldram, Cal, and Maquin 2009). While Q'eqchi' medicine remains dynamic and open to change, these practices are rooted in what Waldram (2020) identifies as the four pillars of Q'eqchi' medicine: pulsing; prayer dialogue; pharmacology; and *jilok* or "massage". Reliance on one of these pillars alone is generally not enough to cure a patient, and the efficacy of Q'eqchi' medicine is intrinsically tied

to the use of these four pillars in various combinations. Q'eqchi' *iloneleb'* use pulsing and prayer dialogue as diagnostic tools (Waldram and Hatala 2016, 7; Waldram 2020), while ritual, prayer, and massage are used in conjunction with botanical medicines, which are mixed into teas or baths, in order to cure (De Gezelle 2014; Waldram, Cal, and Maquin 2009).

The Maya Healer's Association of Belize (MHAB) was formed by a group of Q'eqchi' *iloneleb'* in 1999 (at the time they were known as the Q'eqchi' Healer's Association of Belize) as a means of promoting healing activities among their own people and to preserve Q'eqchi' medical practices (Waldram, Cal, and Maquin 2009; Waldram and Hatala 2015). While membership fluctuates, there has been a core group of six *iloneleb'* who have been most active in the surrounding community (Waldram, Cal, and Maquin 2009, 38). However, upon my arrival in Belize, we learned that one of the *iloneleb'* had passed away two weeks prior. Working as an *iloneleb'* provides only a limited income, as a family who receives treatment will pay what they can afford or what they deem to be fair for the services rendered; as such, many *iloneleb'* must supplement their income through some degree of farming activity (Waldram, Cal, and Maquin 2009; De Gezelle 2014). Despite the personal cost and time incurred procuring botanical medicines and ceremonial objects, the *iloneleb'* engage with their craft "out of a commitment to use their knowledge and skills" (Waldram, Cal, and Maquin 2009, 44) and will help any who request their assistance.

There are several threats to Q'eqchi' medical practices, including pressure from evangelical missionaries, the demonization of said practices, Christian-based education in schools, as well as the loss of plant species as a direct result of development (Waldram, Cal, and Maquin 2009). As part of the MHAB's goal to revitalize and preserve knowledge, they have planted a medicinal herb garden, named *Itzamma* for the Maya god of wisdom, along the banks of Golden Stream (Waldram, Cal, and Maquin 2009; De Gezelle 2014). The MHAB is dedicated to helping those in need, and are committed to demonstrating the value of Q'eqchi' medicine not only to their local communities but to broader medical and scientific communities both within and outside of Belize (Waldram, Cal, and Maquin 2009). Additionally, the *iloneleb'* of the MHAB argue in favour of a complementary application of Q'eqchi' medicine and biomedicine, and they are not opposed to integrating biomedical ideas and technologies into their practices (Waldram, Cal, and Maquin 2009). However, Reeser (2014) notes that there appears to be little interest from the MOH in integrating Q'eqchi' medicine into the national health system (127).

While Maya midwifery persists in Guatemala, research by De Gezelle (2014) and Maraesa (2009), conducted in 2006 and 2007, suggests there is little evidence of Maya midwives practicing in the Toledo district today. De Gezelle (2014) notes that, during this time, she heard of only four Q'eqchi' midwives. However, one woman had passed away prior to her arrival, another was no longer practicing, and the other had migrated from Guatemala and was unsure of healthcare laws in Belize (102). De Gezelle attributes the decline of Maya midwifery practice in Belize to the waves of immigration from Guatemala and discouragement of practicing midwifery outside the supervision of the MOH by the Belizean government (109). De Gezelle (2014) notes that immigration disrupts familial networks, which in turn leads to a disruption of the traditional lines of knowledge transmission. Additionally, midwives form strong ties with the communities in which they practice, leading to few midwives or women with maternal care experience immigrating to Belize, and the resulting loss of transmission of longstanding maternal health knowledge and practices (De Gezelle 2014, 109). As discussed above, those individuals who do immigrate may be unfamiliar with the rules of practicing midwifery in Belize and may be reluctant to provide their services, or may be required to remain secretive in their practice, and may restrict treatment to family members (De Gezelle 2014).

1.4 Fieldwork and Methodology

Prior to entering the field, ethics approval for my research was obtained through my supervisor Dr. James. B. Waldram's ongoing research project in Belize and my research adheres to these approved guidelines. A research permit from the government of Belize is also required, and was acquired for me by Dr. Waldram prior to the beginning of my fieldwork. Primary research methods were participant observation and in-depth semi-structured interviews. Participant observation allows for the contribution and observation of daily life, and is of particular importance for understanding how this contributes to Q'eqchi' mother's well-being, while semi-structured interviews allow for the identification and exploration of topics relating to maternal health and well-being as experienced by my participants and the factors that inform their decision-making.

From the end of May to the end of August 2018, I called southern Belize home. During fieldwork, I stayed in a furnished apartment in the town of Punta Gorda, where I was treated to my very first tropical storms, 5:30 am sunrises, and an oceanfront view. Arriving in the field, I

was provided with a four-day orientation by Dr. Waldram. Our time was spent introducing me to members of the MHAB, as well as Tomas Caal and the Makin family who have been involved in Waldram's research with the *iloneleb'* since it began fifteen years ago. Tomas, the son of one of the *iloneleb'*, served as my cultural guide, interpreter, and translator for my interviews with the *iloneleb'*, while Pedro and Fercia Makin served as my cultural guides, interpreters, and translators for my interviews with Q'eqchi' mothers in Indian Creek. During my time in Belize, they welcomed me into their family, helped me learn Q'eqchi' (of which I was a slow study), shared their own stories with me, and assisted me in becoming an adequate tortilla maker.

Our arrival in Indian Creek was one of joy and excitement, but there was also sadness. Mr. Manuel Baki, an *ilonel* from the MHAB, and who had been sick for more than a year, had passed away two weeks prior to our arrival. We travelled with the Makin family to the nearby town of Big Falls to visit Mr. Baki's widow and to offer our condolences. Dr. Waldram and I also met with four of the *iloneleb'* from the MHAB, which includes Mr. Manuel Choc who lives in Indian Creek, Mr. Augustino Sho from Big Falls, Mr. Francisco Caal who lives in Punta Gorda, and his younger brother Mr. Emilio Kal, who lives in the village of Jalacte near the border with Guatemala. Following this whirlwind of introductions, I was on my own and ready to begin my research.

Each morning I would take the 45-minute bus ride to Indian Creek. Along the way, I would take in the lush, ever-changing landscape, observing the patterns of daily life of Belize's most diverse region. I looked forward to taking the bus to the village, and I never quite knew what I was going to see from day to day or the conversations I would have. Arriving in the village each morning, I would be greeted at the road with smiles and hugs from Fercia and her youngest three children. At the end of the day the bus ride home allowed me time to reflect on the day's events and organize my thoughts in preparation for writing up the day's field notes.

For the duration of my fieldwork I participated in the daily life of Indian Creek. I frequently visited the family on days when no interviews were scheduled, and family invitations to events were always extended to me. I had the opportunity to go to graduation parties, weddings, and a christening. For the first month, I was treated as a guest, and it was only with a great deal of persistence on my part that I was permitted to assist in daily activities such as cooking and helping with the clean-up after. Following that I was allowed to help knead the flour for making wheat tortillas, crush garlic for the *caldo*, and occasionally help with the dishes. I

also offered my assistance to Fercia and her sisters who run the Maya Arts Women's Group. They provide cultural experiences to guests interested in learning about Maya culture and daily life. This includes cooking lunch, and showing guests how to make tortillas, as well as cultural dances, weaving, and chocolate making demonstrations. On several occasions when they had guests coming, I was able to help with set up and clean up.

I conducted a total of 36 interviews with Q'eqchi' mothers in the Toledo district. Thirty-three of these were conducted with mothers from the community of Indian Creek, two with mothers from the nearby community of Hicatee, and one with a Latina mother who is married to a Q'eqchi' man from Indian Creek. Q'eqchi' mothers from within the community were recruited for participation by Fercia, who also served as my interpreter during interviews. As a result, I was able to interview a number of mothers within Fercia's kinship group. This provided me with valuable insight into the transmission of maternal health knowledge across generations and the ways in which the medicalization of pregnancy and birth have led to changes in decision-making between generations.

Inclusion criteria for participation was purposefully broad. Women must have given birth at least once and be able to provide informed consent; however, in the field, this was expanded to include a young woman who was expecting her first child in October of 2018. In keeping the inclusion criteria broad, I was able to interview Q'eqchi' mothers ranging in age from 21 to 65. I was able to speak with mothers who experienced pregnancy and birth prior to the introduction of biomedicine, those who became mothers during the transition to institutionalized prenatal and delivery care, and those who have become mothers following this transition. These experiences have allowed for the documentation of the shifting maternal health practices of Q'eqchi' women in Indian Creek as they respond to the change in the availability of services and in response to locally perceived changes in birth practice and policy.

I had the opportunity to interview the local Q'eqchi' midwife, Leona, who was trained in prenatal massage by another midwife from the village of Laguna. Leona was also selected by the community to partake in the TBA training funded by UNICEF in the year 2000. Leona's daughter-in-law was pregnant with her first child while I was in Indian Creek, and both kindly agreed to allow me to observe one of their treatment sessions and to be interviewed afterwards. This was the only treatment session I observed during my time in the field.

A total of six interviews were conducted with the four members of the MHAB. Two interviews were conducted with Mr. Manuel Choc and Mr. Francisco Caal, while Mr. Emilio Kal and Mr. Augustino Sho were each interviewed once. Interviews were conducted in Q'eqchi' with the assistance of Tomas Caal and Pedro Makin, with the exception of my interview with Mr. Augustino Sho, which was in English. The majority of my community interviews were conducted in Q'eqchi'. I do not speak Q'eqchi' and struggled with the words and phrases the family would teach me, often asking them to repeat words each day. Towards the end of my time in Belize, they would simply speak to me in Q'eqchi', and I became adept at inferring their meaning. Due to my deficiency in the local language, an interpreter was necessary, and a double translation system was used for all interviews conducted in Q'eqchi'.

In introducing the double translation system, Waldram (2018) makes the distinction between interpretation and translation, where interpretation occurs during interviews and translation from audio recordings is done by different individuals than those who interpreted during interviews. Interviews followed a standard question and answer format. I would ask my questions in English, which would be relayed and answered in Q'eqchi', and then translated back to English for my benefit. Additionally, the double translation system allows for the comparison of translated and interpreted answers and reveals where the interpreter has added their own knowledge of the participant or may be speaking to their own experiences in relation to the participants.

I was responsible for the transcription of interviews in English. These interviews were transcribed verbatim, with the exception of instances of 'um' and repetitions of the word 'like' which were not transcribed. Instances of 'um' were marked with an ellipsis to indicate a pause in the flow of conversation. It should be noted that while English is the national language of Belize, in the Toledo district, it is often the second or third language for those living in rural Maya communities, and Q'eqchi' is spoken almost exclusively within the home. As a result, the quotes and words of my participants that appear throughout my thesis have been edited for clarity and readability. In doing so, I have taken care to ensure that these changes are as minimal as possible and accurately represent the meaning conveyed by my participants.

1.4.1 Data Analysis

Coding and content analysis were undertaken on interview transcripts using Nvivo

software. Transcripts were divided into two categories, community interviews and ilonel interviews. Prior to coding and content analysis, community and ilonel transcripts were reviewed separately, and notes were made on potential latent and in vivo codes. These notes and lists were then used to create two codebooks, one for each data set. Rules of inclusion, also referred to as inclusion criteria (Saldana 2013, 25), were determined for latent codes and remained flexible throughout data analysis, and were expanded and refined as data analysis progressed. Two rounds of coding were applied to both sets of transcripts. During the first round of coding, a combination of lumping and splitting was used (Saldana 2013, 23). Lumping allows for the broad categorization of data while splitting is used to break the data into smaller pieces for a more detailed analysis (Saldana 2013, 23). Lumping was used primarily during the first round of coding, and was particularly useful for the initial organization of passages that did not clearly conform to the rules of inclusion or exclusion within my codebook. By lumping these codes, I was able to return to these sections during the second round of coding to refine my analysis. Splitting involves breaking the data down into smaller, more detailed codes (Saldana 2013, 23). Splitting was used in the second round of coding as it allows for a more nuanced analysis of the data. During this second round of coding I was then able to refine codes that had been lumped during the first round of coding. I also chose to make use of simultaneous coding, or co-occurrence coding. While this has been criticized as it "suggests that there is no clear or focused research purpose and thus a clear lens and filter for analyzing the data" (Saldana 2013, 81), using simultaneous coding allowed for the documentation of multiple meanings and interactions that emerged throughout my interviews. Pregnancy, birth, and the postpartum period are not isolated events or experiences, and should not be analyzed as though they occur in isolation from other life events or that in relating these stories there is only one possible meaning associated with them.

Themes emerge out of relevant repetition of particular words, phrases, and experiences that connect to one another in meaningful ways (Bernard 2011). A specific journal was kept throughout coding and content analysis. I returned to these notes when beginning my thematic analysis, drawing on them to establish broad themes which include well-being, knowledge, and decision-making. Relevant codes were then grouped within these broader themes and organized in relation to pregnancy, labour and delivery, and postpartum. Specific codes, such as "use of biomedicine during pregnancy" were then taken from Nvivo, and

participant responses were grouped based on similarity. For example, well-being during pregnancy is associated with a woman's ability to work and keep her body warm. These answers were grouped together. However, mothers disagree on the types of work and how much work should be done, dividing the category into those mothers who believe that all work should be done and those that believe heavy work should not be done during pregnancy. During this time, exemplars were selected that best-illustrated Q'eqchi' mother's notions of well-being during pregnancy. This process was repeated for each of these broad themes and form the basis of the chapters of this thesis.

1.5 Conclusion

When experiences of maternal health and well-being are reduced to numbers representing maternal and infant deaths, the everyday lived experiences of women throughout the world are lost. These numbers mask the factors that inform mothers' and their families' decision-making processes, the ways in which notions of well-being are constructed, and how practices accessed outside of biomedicine contribute to well-being during pregnancy and postpartum. This thesis aims to reveal the daily lived experience of Q'eqchi' mothers and their families in Indian Creek, providing a space for their voices and stories to be heard.

In the following chapters, I detail the persistence of Q'eqchi' medical practices, practitioners and their use during pregnancy, labour and delivery, and postpartum, from the perspective of the *iloneleb'* and the mothers of Indian Creek as they navigate the shifting landscape of care as a result of the ongoing medicalization of maternal health within the region. In chapter 2, I detail Q'eqchi' medical practices and their use from the perspective of the *iloneleb'*. In doing so I begin by focusing on the *iloneleb'* training and treatments they use to assist women who seek their services, and their perception of risks faced by mothers today. In chapter 3, I shift focus to mothers and their understandings of and the ways in which they work to maintain well-being during pregnancy, labour and delivery, and postpartum. As well as how Q'eqchi' women are educated and supported by the maternal figures in their lives as they are taught to maintain well-being during pregnancy, labour and delivery, and postpartum before, during, and after the medicalization of maternal health. In chapter 4, I discuss how mothers in Indian Creek navigate the shifting landscape of care as a result of ongoing medicalization in the region. I look at how decision-making of Q'eqchi' mothers has changed in recent years as it has

become constrained by a regionally perceived "law" requiring women to access biomedical health services during pregnancy and for labour and delivery. Finally, in chapter 5 I address the theme of change which has been brought about by increased medicalization in the Toledo district. This change is further compounded by the decline in availability of *iloneleb'* and midwives as pregnant women now turn to biomedicine as their primary form of maternal care. I conclude this thesis by providing recommendations for future reproductive health research in the region.

CHAPTER 2: Q'eqchi' Medicine – Knowledge, Practice, and Practitioners

> "When we lived in the middle of the jungle [Jalacte] it was difficult. Sometimes I was called late at night, other times it was raining and muddy. But it didn't matter, I would go and help. I have helped a lot of women, and have seen a lot of kids born."
>
> – Mr. Francisco

2.1 Introduction

Throughout Central America, midwives have traditionally held the role of maternal care providers. As a result, Maya midwives with long-standing knowledge and experience who operate in rural and remote communities, have been targeted by global public health initiatives and local governments as a way to introduce the biomedical model of care. In doing so, these midwives are trained to identify biomedical risk factors and to exercise their judgement of when to refer pregnant women to the nearest clinic or hospital for prenatal and delivery care. Yet midwives appear to be scarce within the Toledo district (De Gezelle 2014; Maraesa 2009, 2018b). For Q'eqchi' mothers in the village of Indian Creek, maternal care has traditionally been provided by the *iloneleb',* who are predominantly male. While the *iloneleb'* have long operated outside of the gaze of the MOH, their practices do not remain unaffected by medicalization in the region. The knowledge of maternal care is now held by a small number of *iloneleb'*, with few of the younger generation training and pursuing these practices today (De Gezelle 2014, 9; Waldram, Cal, and Maquin 2009).

This chapter addresses the knowledge and practice of maternal health and well-being held by four practicing members of the MHAB. I begin by introducing each of the *iloneleb'*, detailing their decisions to train, and the responsibility that comes with openly practicing as an *ilonel*. Following this, I discuss the restorative and preventive nature of Q'eqchi' medical practice (Waldram 2013). Emerging from the data are properties of sympathetic magic (Fraser 2010 [1922]), mimesis (Huggan 1998; Langford 1999; Porath 2011), and the doctrine of signatures (Bennet 2007; Durant 2017; Gelis 1991). These similarities are discussed throughout this chapter as they relate to the treatments provided by the *iloneleb'* during pregnancy, labour and delivery, and postpartum.

In focusing on the work of the *iloneleb',* I demonstrate the importance of these practices as well as the ways in which the *iloneleb'* have helped generations of Q'eqchi' mothers. I also highlight the similarities and differences between the practices of the *iloneleb'* and Maya

midwives throughout Guatemala and Mexico whose practices serve similar functions. While the *iloneleb'* have long been the sole care providers, mothers of today now rely primarily on biomedical health services for prenatal and delivery care. While the *iloneleb'* openly acknowledge that there are treatments only biomedically trained doctors and nurses can provide, some conditions can only be treated by the *iloneleb'*. Today both the *iloneleb'* and biomedical services are used in a complementary fashion to meet pregnant women's prenatal needs. The *iloneleb'* provide culturally relevant care in the form of prenatal massage, the use of botanical medicines to ease morning sickness, miscarriage prevention, assisting with prolonged labour, and the reduction of postpartum bleeding and restoration of a mother's body.

2.2 The *Iloneleb'* of the MHAB

Among the Q'eqchi' there are no formalized training schools for teaching Q'eqchi' medicine. Instead, students study under a master *ilonel* through an apprenticeship system. Those who are interested will learn the different prayer dialogues, botanical medicines and their uses, massage techniques, and pulsing. Q'eqchi' medical knowledge is passed down and "combined with the accrued empirical knowledge from many years of practice," the result of which is a "detailed body of complex but varied knowledge not distributed equally among the [*iloneleb'*]" (Waldram, Cal, and Maquin 2000, 39). *Iloneleb'* may also seek out additional training to further hone their craft, and the MHAB serves as a way for the *iloneleb'* to collaborate and compare medical practices. This apprenticeship system and the longstanding practice of working alone, account for differences in knowledge and experience among the *iloneleb'*. This statement is not meant to diminish their work, but rather to account for differences in approaches to treatment among practitioners.

The role of an *ilonel* is not restricted to specific individuals. It is possible for anyone to train as an *ilonel*, so long as they are willing to learn. The decision to become an *ilonel* cannot be made for someone. An individual must have a desire to learn. Each member of the MHAB has their reasons for training and practicing as an *ilonel*, in which the ability to care for one's own family emerges as a primary motivating factor, particularly concerning the cost of care and transportation. While the villages throughout southern Belize are better connected today than in the past, the cost of transportation and medications continues to be a concern for many families.

Today there are few *iloneleb'* practicing, yet they remain an essential resource for families who do not have the financial means to travel to Punta Gorda for care.

Mr. Francisco Caal

I first met Mr. Francisco on my second day of orientation. Dr. Waldram and I spent the morning in Indian Creek meeting with Mr. Manuel Choc, another member of the MHAB. We are driving along, just about to pass the gas station at the highway junction known as Dump when a man dashes across the road ahead of us. Dr. Waldram slows down, recognizing Francisco, commenting that you never know where you are going to run into the *iloneleb'*. Francisco is headed to the gas station to buy a snack for him and his brother Mr. Emilio. They are waiting at the bus stop for a ride to *Itzamma*, the botanical garden where they will be participating in a seminar on the botanical medicines grown there. We would meet Francisco again the following day at his home in Indianville, the Maya community at the back of Punta Gorda.

Born in Petén in Guatemala, Francisco is now 67-years-old. He is the second oldest member of the MHAB and has openly practiced as an *ilonel* for the past 45 years. Francisco began his training at the age of 18 after the death of his first wife and child. Following this tragedy, he worried that if he did not take up this practice that he may lose other people in his life. Francisco apprenticed under Mr. Lucas Chen in the village of Otoxha. He lived with Mr. Chen for a year, training with him each day. Since he began practicing, Francisco has travelled throughout Belize providing his services as an *ilonel*, from San Pedro Colombia to San Miguel, Maya Centre and Mango Creek, all the way north to the Valley of Peace and Belmopan, the capital of Belize.

Francisco and his second wife have 13 children together, and he is proud to have helped her as a husband and as an *ilonel*. When she was pregnant, they lived in a remote village and did not have access to a hospital or clinic. He and his wife delivered their 13 children at home, and he was the one to take care of her during pregnancy and postpartum, providing her with botanical medicine to help warm her back and restore her body to its pre-pregnancy state. His wife would rest for a week following each delivery before resuming her daily activities, and today, she has no complaints or pain, a testament to Francisco's care.

Mr. Emilio Kal

The day after our brief bus stop introduction, we meet with Mr. Emilio once again. Having spent the night in Punta Gorda at Francisco's home, Dr. Waldram offers to drive Emilio

home to Jalacte, a remote village near the border with Guatemala. The road to Jalacte is now paved until you get to the turnoff for the village itself, where one must contend with a dirt road filled with ruts, potholes, and steep hills.

Emilio began training as an *ilonel* at the age of 22, taking up the practice because he saw a need for Q'eqchi' medicine. Living in such a remote village Emilio worried for his children, fearing that one day they may be sick, and he would not have the financial means to obtain care. Emilio began his training with his older brother Francisco before travelling to Guatemala to further his training with another *ilonel*. Emilio began practicing as an *ilonel* by helping his wife during her pregnancies and postpartum, treating her using both botanical medicines and prayers. Following his return from Guatemala, the community learned Emilio was an *ilonel* and began coming to him for treatment. At first, he was uncertain. However, as he began to practice regularly, his confidence grew, and he continues to help many people today, both in Jalacte and the surrounding communities.

Mr. Manuel Choc

Mr. Manuel lives in Indian Creek with his wife, daughters, and granddaughters. As the oldest of the *iloneleb'*, Manuel celebrates his 81st birthday while I am in Belize. In celebration, I am invited to eat chicken *caldo* and hot corn tortillas with him and his family, of which I was happy to partake. Manuel only began practicing openly after the formation of the association in 1999. He was worried community members would call him an *obeah* man, or one who practices witchcraft (De Gezelle 2014; Maraesa 2018a). While he often thought about practicing medicine, it was not until the formation of the MHAB that he presented himself as an *iloneleb'* and has been openly practicing ever since.

Unlike Francisco and Emilio, who decided to train on their own as *iloneleb'*, Manuel was encouraged to take up the practice by his family. Born in Guatemala, when Manuel was 12-years-old, his step-father offered to train him. Manuel thought his step-father was teasing him; however, once he knew his step-father was serious, Manuel was not certain he wanted to learn. It was Manuel's mother who persuaded him to apprentice as an *ilonel*, telling him, "someday you might need it." Manuel trained with his step-father, learning the prayers, botanical medicines, and massage. Unfortunately, his step-father passed away soon after his training. Following his step-father's death, Manuel sought and received additional training from Mr. Salvadore Ac in Chacalte, to refine some of the prayers he had forgotten.

While Manuel did not openly practice as an *ilonel* until the formation of the MHAB, he did care for his wife whenever she became pregnant. While his wife suggested they go to the hospital, Manuel reassured her he would care for her at home. During pregnancy, Manuel would massage her whenever she felt cramps or pain and would provide botanical medicines to help reduce postpartum bleeding. Since practicing with the MHAB, he has treated two or three other women who have come to him for assistance during pregnancy.

Mr. Augustino Sho

Mr. Augustino, originally from the village of San Antonio, now lives in the village of Big Falls. He studies at Belize Community College and is in the process of completing his associate degree in teaching. Unlike the other *iloneleb'*, who trained prior to the formation of the MHAB, Augustino joined the association and then underwent training. When approached by the MHAB, Augustino examined his situation at home. During difficult times, money can be an issue, and Augustino worried that he may not always have the resources to care for his family. With these practices, it is possible to help his family as there is no need to worry about travel expenses and the cost of medications. After careful consideration, Augustino decided to join the MHAB, knowing there was a need for Maya medicine.

Augustino trained under the supervision of two elders from the MHAB until he had mastered the prayers and practices. While the majority of *iloneleb'* in the MHAB are Q'eqchi', Augustino is Mopan Maya. He learned the prayers in Q'eqchi' and with the help of his wife, (who is also Q'eqchi'), translated them into Mopan. As an *ilonel*, Augustino has helped women in his community as well as his wife during pregnancy and postpartum. However, he has not assisted with labour and delivery.

Wanting to deliver his children at home, Augustino spoke with the doctors at the Punta Gorda Hospital, who forbade him from doing so, insisting he bring his wife to the hospital where they would care for her. Unable to deliver his children, Augustino cared for his wife during pregnancy, providing her with massage when she struggled to walk. When it was time for his wife to deliver, he would take her to the hospital, and once they returned home postpartum, he would then provide her with massage, prayer, and botanical medicines.

2.3 Professional and Patient Responsibility

The MHAB formed as a way to promote the practice of the *iloneleb'* among their people,

as many "Q'eqchi people no longer accepted the services of the [*iloneleb'*] as effective" (Waldram, Cal, and Maquin 2009, 40). The formation of the MHAB has allowed the group to share their knowledge and learn from one another. As a by-product of the formation of the MHAB, a set of "best practices"[3] to which all members must adhere has emerged (Waldram, Cal, and Maquin 2009, 43). These "best practices" include a willingness to share one's knowledge and assist fellow members, to adhere to high standards of practice and not engage in *obeah* (witchcraft), to refrain from speaking ill of other members, and to not charge a set fee for their services (Waldram, Cal, and Maquin 2009).

With patients paying what they perceive as fair in relation to treatment, working as an *ilonel* does not provide a steady income. Instead, Q'eqchi' medicine is a part-time profession that requires supplementation through other forms of income. While not their primary source of income, the *iloneleb'* take their profession seriously, and continue to practice as part of a broader commitment to help. However, practicing Q'eqchi' medicine is not without its challenges. Following the introduction of Evangelical Christianity, some community members have come to believe the *iloneleb'* cannot help. As a result, some people will try to test their knowledge when seeking their services. To uphold his reputation, Augustino uses a verbal patient agreement with those he believes may be trying to undermine his authority and expertise. He tells those he suspects of ulterior motives, "It is you who wants me to treat you. Then you have to listen to what I have to tell you." Augustino then outlines what the patient should and should not do, to which the patient must agree. He explains that in setting this agreement if anything happens to his patient as a result of their not adhering to his recommendations he is not responsible as they have consented to follow his instructions for treatment. Similar agreements have also been observed in the Toledo district among local community health workers affiliated with the MOH (Maraesa 2018b). In each case, both the *ilonel* and the community health worker are absolved of responsibility should the patient's condition worsen as a result of not adhering to their instructions and advice.

[3] It should be noted that these best practices are designed to mimic biomedical practice and do not stem from an indigenous concept. The *iloneleb'* have done so as a way to meet the standards of acceptable practice today, and in doing so speak back to those who wish to isolate their practice in a romantic past. These best practices serve to promote the sharing of knowledge and approaches rather than limit innovation among practitioners (Waldram 2020).

The responsibility of seeking care from an *ilonel* lies with the patient. The *iloneleb'* do not advertise or recommend their services to the communities in which they live and work. Instead, their reputation is established through caring for patients, and their success as *iloneleb'* and the services they provide are spread through word of mouth. Regarding prenatal care, Augustino tells me, "I will not tell a patient, 'I need to see you.' I cannot do that. They will have to tell me 'I want help with this,' then I will be there. But for me to tell them, I don't do that." While the decision to seek care lies with the patient, if additional treatments are required, *iloneleb'* will schedule follow-up appointments.

The *iloneleb'* are also responsible for knowing how to diagnose and administer treatments, and botanical medicines in particular, correctly. Manuel is particularly reticent when it comes to giving botanical medicines to patients, retelling the story of his *compadre* (friend) who gave bitter medication to a woman without first consulting to see if she was pregnant. Following this treatment, the woman's condition worsened, and she was taken to the hospital. When she was asked by the doctor what was wrong with her, she replied that she received medication from an *ilonel*. Manuel later learned that his *compadre* was arrested and sent to jail. Manuel shared this story as a way to emphasize the professional responsibility of the *iloneleb'*. *Iloneleb'* practice with an "imperative to cure" (Waldram 2013, 200) and are ethically bound to do no harm. As Augustino says "the key is to help; I am here to help."

2.4 The Practice of Q'eqchi' Medicine

Q'eqchi' medical practices are both restorative and preventive. Restorative healing works on the basis of returning one's patient from "the liminal status inherent in sickness or disability to the psychological or physical state preceding the sickness" (Waldram 2013, 194). The effectiveness of restorative healing is evaluated by the return of a patient to their presickness state as though there had been no problem to begin with (Waldram 2013, 194). For the *iloneleb'* of the MHAB, treatment effectiveness is demonstrated by curing their patient's sickness (Waldram 2013, 200). Three forms of evidence are employed to evaluate efficacy: empirical observations, objective "clinical" proof, and subjective proofs (Waldram 2013, 200; Young 1983). Empirical observations are those changes that are observable by the *ilonel* and others, demonstrating the patient's restoration to their presickness state (Waldram 2013, 200). *Iloneleb'* are able to evaluate the patient through pulsing or massage, indicating a positive change in the

patient, and standing as objective "clinical" proof that the patient is cured. Finally, subjective proofs are those expressed by patients and their family following treatment, as they communicate the improvement of their condition (Waldram 2013, 200).

In addition to its restorative nature, Q'eqchi' medical practices used in treating maternal health issues are also preventive. By providing prenatal massage, *iloneleb'* prevent complications during labour and delivery. Postpartum the *iloneleb'* use botanical medicines to reduce postpartum bleeding, as well as a combination of prayer dialogue, massage, and abdominal binding to bring the bones back together and warm the body, reducing the chance of mothers experiencing pain in the future.

Emerging from my conversations with the *iloneleb'* about the treatments they provide were elements of the doctrine of signatures, sympathetic magic, and mimesis. While I define these concepts here, they are elaborated on in the subsequent sections which discuss the use of Q'eqchi' medicine in providing maternal care. Within Q'eqchi' medicine, the selection and use of plants for specific conditions conform to the doctrine of signatures, in which the use of a plant is associated with its physical characteristics, which are representative of its therapeutic use (Bennet 2007, 246). Therefore, a plant that resembles a lung may be used to treat respiratory issues, while a red plant may be used to treat blood-related issues (Durant 2017, 95).

Elements of sympathetic magic also emerge in relation to the use of botanical medicines when providing care to expectant and labouring women. Sympathetic magic's two governing principles are the law of similarity and the law of contact (Fraser 2010 [1922]). The law of similarity, also referred to as homeopathic magic, states that like produces like (Fraser 2010 [1922])). Comparable to the doctrine of signatures, the law of similarities moves beyond the initial identification of resemblances between a condition and its treatment to include the replication of similar properties rather than representation of them in treating patients. The law of contact stipulates that "whatever is done to a material object will affect equally the person with whom the object was once in contact, whether formed from its body parts or not" (Fraser 2010 [1922], 242). This connection is maintained, even when the person and object are separated from one another. Additionally, while Fraser (2010 [1922]) uses the term "magic" it should be noted that treatments by the *iloneleb'* are medical, rather than magical. As Langford (1999) explains, "sympathetic magic, is in fact, inherent in any medicine in that healing always involves the

reinvention and the reinscription of the body of the patient, whether through incantations or anatomical explanations" (36).

Connected to sympathetic magic is the concept of mimesis. Mimesis, also referred to as mirroring, involves replication or reproduction in order to promote healing or curing (Taussig 1993, 1 and 16). Taussig (1993) suggests that the use of replication over time leads to changes between the original and that which has been replicated, such that they are distinguishable from one another. However, this does not appear to be the case within Q'eqchi' medicine, in which mimesis is found within the prayer dialogues used by the *iloneleb'* when treating patients. In reciting these prayer dialogues, Francisco explains that aspects of nature (specific trees, flowers, mosses) and from the material world (brooms or keys) are called upon in the recitation of these prayer dialogues as a way to assist in the curing of their patients. These evocations of nature and household objects serve to mimic and disrupt the problem or sickness, but not in such a way that change is evident between the original and those properties that have been replicated.

Mimicry and the law of similarity also emerge in relation to *awas*. *Awas* has two independent meanings: a condition affecting children (De Gezelle 2014; Kahn 2006; Wilson 1995), and as a spiritual offering or sacrificial ceremony[4] (Waldram and Hatala 2016). *Awas* occurs during pregnancy when a woman breaks a social rule (Khan 2006, 213) or is repulsed by an object (usually food), animal, or person (Wilson 1995,125). As a result, the child will be born with physical features that mimic the characteristics of whatever it was that caused her to be repulsed (Wilson 1995, 125).

In my conversations with the *iloneleb'*, Manuel and Emilio both describe *awas* as something that mimics and affects an individual, particularly newborns. Emilio explains that the cause of *awas* is not necessarily easy to identify. During pregnancy, both partners must be careful not to laugh or dislike anything they see; if they do, after the baby is born, it may suffer that same condition. As a result, *Awas* can be challenging to treat. Throughout pregnancy, both parents will see many things, and may not remember what they may have disliked or laughed at. If parents remember, then *awas* is easily cured. However, if left untreated *awas* may result in the infant's death.

[4] Here *awas* is used in particularly serious sickness cases which require an offering of a small animal as a way of removing the spirit of the illness (Waldram and Hatala 2016). This use of *awas* did not come up in my research.

Treatment of *awas* involves the use of the object that is somehow related to the experience that caused the *awas.* Wilson (1995, 126) describes the treatment of *awas* as homeopathic, therefore, it also conforms to sympathetic magic's law of similarity, in which "the rite serves as both divination and cure, for if the treatment does not work, then another type of *awas* is suspected." Treatment of *awas* involves the identification and use of the object that caused or is related to the *awas*. Wilson (1995) identifies three treatment methods for *awas*, which are performed by the mother. Treatment methods involve having both mother and baby chew a piece of the item (if it is food) then spitting it out, burning a piece of it and having the baby inhale the smoke, or rubbing the object over the infected area before throwing the object away (136). Only the final method identified by Wilson (1995) was discussed by both Q'eqchi' mothers and the *iloneleb'* and was described to me in detail by my translator Pedro.

Pedro is transcribing while Fercia and I are resting after the morning's interviews. He stops writing and removes his headphones, "Krista, do you understand what *awas* is?" he asks. I tell him I have heard it spoken of several times, but could use additional clarification. I pull out my phone to types notes as Pedro and Fercia tell me of their experience with *awas* following the birth of their second child. At three months old, their son developed a rash on his scalp. Pedro and Fercia tried different medications, went to the hospital, and sought the services of an *ilonel*. Following all of these appointments and visits, they determined that their son must be suffering from *awas.* Pedro and Fercia then had to remember what they may have touched or seen while Fercia was pregnant. They tried rubbing different foods on the rash such as tortilla, fried tomato with egg, even pigtail, but nothing would work. Then Pedro remembered a day during Fercia's pregnancy where they had gone fishing with his family and some friends. They were successful and were roasting the fish over a fire when it began to rain. In a rush to move the food, Pedro touched the fish which had become slippery and sticky from the rain. While he did not remember being disgusted by the fish, he suspected this was the cause of the *awas*. Pedro then went to the market to buy fish to treat his son's *awas*. Following the treatment, the rash went away, and their son was cured.

For the Q'eqchi', the fulfilment of social roles and being polite are socially significant in ensuring the health and well-being of one's unborn child. For instance, Wilson (1995) identifies an additional source of *awas* caused by eating in front of a pregnant woman (128). If a family or community member is eating in front of a pregnant woman, they must offer her some of the

food. If she is not offered this food, she may feel unfulfilled, the result of which is a baby born with an *awas* mimicking the food that was not offered. The opposite is also true if a pregnant woman does not desire the offered food but accepts to be polite (Wilson 1995, 128). First-time mother Isabella explains that this is also applicable if she is eating and does not share her food. "Say I am eating a piece of cake, and you come by," she says, "if I do not offer you some of my cake, then my baby may come out in pieces. So, I would have to share my food with you, so my baby could be born healthy."

2.5 Maya Maternal Care

Maternal care provided by the *iloneleb'* is similar to that provided by midwives in Guatemala (Berry 2006, 2008, 2010; Cosminsky 2001a, 2001b, 2012, 2018, Hinojosa 2004, 2015), as both practitioners provide botanical medicines, prenatal and postpartum massage, abdominal binding, and make use of prayers in their treatment. Together, these practices serve as a form of risk management during pregnancy, reducing the chances of complications and promoting the restoration of well-being during pregnancy, labour and delivery, and postpartum. However, the practice of midwives in Guatemala is now constrained by restrictions placed on them by their Ministry of Health, primarily through recommendations that longstanding Maya maternal care practices such as the use of prenatal massage, the squatting birthing position, and postpartum abdominal binding not be used (Hinojosa 2004, 643). In Guatemala, midwifery licenses are provided by the Ministry of Health, and may be revoked if problems arise during a home delivery (Cosminsky 2018, 479). Midwives can be held "legally responsible and thus fined or jailed, especially if the family presses charges" (Cosminsky 2012, 95). Such regulations have not been placed on the *iloneleb'* in Belize. As such, they operate outside the purview of the Belizean MOH, allowing their practices to continue unhindered by such regulations.

Previous research indicates that there has been a history of Maya midwives practicing in southern Belize (De Gezelle 2014; Maraesa 2009), and several of my participants indicated that they had travelled to other communities (such as San Pedro Colombia and Eldridgeville) to deliver with the local midwife. Unfortunately, these midwives have since passed on. However, Maya midwifery has not disappeared altogether. In response to the medicalization of pregnancy and birth, the role of midwife has been reshaped. Instead of providing care throughout pregnancy and into the postpartum period, midwives are now used almost exclusively for prenatal care.

While the centrality of the midwife in all aspects of maternal care has decreased, it is no less important. Prenatal massage remains a central part of ensuring well-being for both mother and baby during the prenatal period, ensuring the baby is in the correct position for delivery, and in preventing the need for a cesarean section.

2.5.1 Care During Pregnancy

According to the thermal principles of Q'eqchi' medicine, pregnancy is a hot condition which affects the entire body. Augustino explains this is because the baby begins to use their mother's blood. While pregnancy affects the entire body, the *iloneleb'* explain that all women are different, some are strong and experience few difficulties or complications during pregnancy, while others are weak, and their bodies do not take to pregnancy. While women experience pregnancy in different ways, both the *iloneleb'* and mothers in Indian Creek make it clear that pregnancy is not a sickness. However, women can experience non-pregnancy related sickness. Manuel explains that sickness resides within all people from birth and may be triggered by changes in the body brought on by pregnancy. In providing treatment to a pregnant woman who is also experiencing non-pregnancy related sickness, Francisco explains that he uses two separate treatments on the patient, one for the pregnancy-related issues and one for the non-pregnancy related sickness. Augustino explains that sickness affecting a pregnant woman may lead to sickness within their unborn child, noting that she should be treated before this can occur.

During pregnancy, the *iloneleb'* provide treatment for morning sickness and preventing miscarriage, and may be called upon to position the baby within the womb or confirm the baby is already in the correct position. When the baby is not, a woman may experience cramps and pain on either the side of her abdomen, her legs, or her back and may also have trouble walking and completing her work. Each of the *iloneleb'* has been trained to provide these services, and each has their recommendations as to when and how often care should be sought.

Francisco recommends that women consult with an *ilonel* in the first few months of pregnancy, ensuring the baby is in the correct position early on. He explains that if a woman waits until five or six months of pregnancy, it becomes difficult to maneuver the baby into the correct position, which may lead to complications during labour and delivery. Francisco emphasizes the importance of early and regular visits to ensure the baby is already in or remains in the correct position. Similarly, Emilio recommends a woman begin to see an *ilonel* in her third

or fourth month of pregnancy, and that she receive prenatal massage twice a month until the time of delivery. Augustino begins treating pregnant women as early as three months until the time of delivery. However, he emphasizes the decision to seek care from him is up to her. Some women come to him to make sure the baby is in the correct position; others come when they experience pains or a problem. Recommendations for prenatal care by the *iloneleb'* are rooted in restorative and preventive care. If a woman experiences pain or discomfort during pregnancy she is then able to restore her body to its pre-pain state by accessing the services of the *iloneleb'*, provided care is sought early.

Maya women tend to seek care later in their pregnancies, waiting until they feel the baby moving as a confirmation of their pregnancy (Maraesa 2014, 2018b). However, there is some degree of difference between recommendations of prenatal care as discussed by the *iloneleb'* and the practice of older Q'eqchi' mothers. While Francisco and Emilio recommend women seek care early and receive prenatal massage monthly, older Q'eqchi' mothers explain that they would only see an *iloneleb'* three times during pregnancy, unless they experienced pain or discomfort. These women would often seek care when they were five months pregnant, which is approximately one massage a month until delivery. However, this does not align with *iloneleb'* recommendations for beginning care early. The source of difference between how Q'eqchi' women access the *iloneleb'* and the recommendations of the *iloneleb'* is unclear. Overall, recommendations made by the *iloneleb'* may be influenced by their long-standing practice, the introduction of biomedical prenatal clinics (which recommend monthly visits beginning after two missed periods), or midwifery practices in Guatemala, where regular prenatal care is central to their work (Hinojosa 2004, 643). These midwives typically visit a woman once a month during early pregnancy, increasing the frequency of visits during the last month of pregnancy (Cosminsky 2018, 469). While there are differences in the recommendations by the *iloneleb'* and accessing their services by Q'eqchi' mothers, the *iloneleb'* play a central role in mitigating risk to mother and baby and restoring well-being.

While Q'eqchi' medicine centres on balancing the body as a way to prevent future problems, the *iloneleb'* also provide recommendations for activities that should be avoided during pregnancy as they place a woman at risk. Lifting heavy objects is cautioned against as this type of work may cause the baby to change position, leading women to experience pain on their sides, backs, or legs. Resting too much during pregnancy is also discouraged. Mr. Augustino

notes the importance of women continuing to be active during pregnancy, saying "if you are a person who likes to sleep you will allow the baby to set to one side," requiring massage to reposition the baby once more. This sentiment is echoed by mothers within the community and is further discussed in detail in the following chapter on well-being.

Positioning the baby within the womb is the primary form of care provided by the *iloneleb'*. Emilio explains this process:

> The family will be expecting me. When I arrive, the husband will ask if I am here to treat his wife. I will reply that "yes, I am here to do the massage." The pregnant woman will lie down on the bed so I may do the massage. I put my hands over her and start to pray, asking *Qaawa's* [God's] blessing upon her. I will recite prayers while performing the massage to aid in positioning the baby. When I finish the treatment, her husband will ask after her. If the baby is not in the right position, I will tell him I will return in three days for another massage. If the baby is in the correct position, I will return for the next massage in one month.

As the example above demonstrates, positioning the baby within the womb combines prayer dialogue and massage. In positioning the baby Emilio uses two sets of prayer dialogue. The first prayer is for the entire body, while the second set is used specifically for pregnancy. Augustino begins healing at the head by reciting the prayer for the entire body while also massaging down the body. He then moves to the womb, where he continues with the massage and recites the pregnancy-specific prayer. While massaging the womb, the *ilonel* places a hand on either side of the abdomen and lifts slightly, allowing the baby to move into the correct position.

When massaging a woman, Francisco can feel when the baby moves, explaining that this is the baby responding to the massage and prayers. Francisco compares this to the way a hen rotates her eggs underneath her. Elaborating further, he explains that the prayer used during massage is addressed to the baby, asking it to find the correct position, preventing discomfort and ensuring it does not move out of the proper position before delivery. "When we position the baby, we call on the spirits of the flowers and their beauty, so that the baby feels good within its mother," Francisco explains. This is an example of mimesis, in which the prayers used by Francisco serve as a way to mediate between different worlds (the spirit of the flowers) and people (the baby within the mother's womb) (Huggan 1998, 94). Francisco asks the spirits of the flowers, drawing on their beauty as a way to make the space comfortable and to encourage the baby to move into, and remain in, the correct position in the womb. If the baby does not move to

the correct position following the first treatment, this process will be repeated in three days time.

The practice of positioning the baby within the womb is both restorative and preventive. Pain is alleviated once the baby is in the correct position as the woman's body is returned to its pre-pain state. This practice further serves to prevent future pain and complications that may occur during labour and delivery. In describing the treatment used, the *iloneleb'* also outline the criteria on which they judge the effectiveness of this treatment. The *iloneleb'* will feel the baby move into the correct place within the womb, responding to the prayer dialogue and massage, standing as both empirical and objective proof that the woman's body has been restored. Subjective proofs typically come later, as women communicate their well-being by speaking directly to the *ilonel* or by communicating this to the *ilonel's* wife or other family members. Augustino's wife often hears from the women in the community of Big Falls how much her husband's treatment has helped them, and she passes along news of their well-being to her husband.

Q'eqchi' mothers in Indian Creek view morning sickness as a routine part of pregnancy that they must bear, and one that is typically only an issue in the first trimester. None of the Q'eqchi' mothers I spoke with mentioned receiving treatment from an *ilonel* for morning sickness. However, the *iloneleb'* are able to treat this condition. Treating morning sickness is a restorative process in which the *iloneleb'* provide prayer dialogue, massage, and botanical medicines to cure morning sickness for the remainder of the pregnancy. As mentioned previously, while the consumption of botanical medicines is not recommended for women during pregnancy, each of the *iloneleb'* explain that they will provide women with small amounts of botanical medicines to treat morning sickness. Augustino explains this is done as a way to purge a woman's system of what is causing the morning sickness. After consuming this tea, the woman will then vomit out the cause of her morning sickness and will no longer be troubled.

Morning sickness can be experienced as either a hot or cold condition. In treating morning sickness, Francisco uses the plant *baknel kejen* (*Drymonia serrulaton*) (De Gezelle 2014,50)**,** which is used regardless of whether morning sickness is experienced as a hot or cold condition. In treating morning sickness as a hot condition, *baknel kejen* will be mixed with cool water. This will be used to cool the body by bathing with the mixture three times a day (morning, afternoon, and evening). If a woman experiences excess heat and does not receive treatment, she

may develop sores on her skin, but if an *ilonel* treats this condition, she will improve. In treating morning sickness as a cold condition, *baknel kejen* will be crushed in a small amount of hot water but is served warm. A pregnant woman will drink a small amount and then bathe with the rest, twice in the morning and once again the following morning. Emilio explains that morning sickness may be a sign a woman is at risk of a miscarriage, or that her body may not suit being pregnant.

The *iloneleb'* and mothers in Indian Creek both emphasize the individuality of women's bodies. Some women may experience miscarriages early on in pregnancy because their bodies are too weak to carry a baby, while others feel as though they are not pregnant at all.
The *iloneleb'* also identify physical signs a woman may be at risk of a miscarriage. This includes bleeding early on in pregnancy, morning sickness, and falling or dropping; the latter may shake the baby loose, causing it to sit low within the womb. If the baby is low on the womb and is not treated immediately, another fall could result in a miscarriage. In preventing miscarriage, the *iloneleb'* use a combination of prayer dialogue, massage, and botanical medicines.

If a woman is experiencing bleeding early on in her pregnancy, between the first and third month, Emilio will provide her with *puchuch* **(***piper sp*) (De Gezelle 2014, 57)**.** This plant is crushed in cool water and is then consumed. Emilio will then have the woman lay down in a hammock with her feet elevated and knock her feet together to restore the baby to the correct position. Miscarriage may also be prevented by tying the womb or backbone. To do this, Francisco uses prayers, massage, and a piece of cloth to bind the abdomen. Today, any piece of cloth can be used for this, but in the past, ribbons used in hair or a cloth belt would be used. Prayers are said over the cloth, and it is tied around the woman's abdomen. The cloth is untied after a week, and is then folded nicely and placed in the bushes. This is an example of the law of contact (Fraser 2010 [1922]). In praying over this cloth, a sympathetic link is created between it and the baby. This link continues once the cloth is removed and is the motivation behind treating the cloth with care. If the cloth is mishandled, then the baby may be affected from within the womb.

Augustino is the only *ilonel* to discuss weakness of the baby within the womb, or in his words, when the baby is tied within the womb. In situations such as this, the baby will not move enough or is unable to move. This was something his wife experienced during one of her

pregnancies. After his wife attended the clinic and was told everything was fine, Augustino took over treatment, providing botanical medicines. He massaged her to ensure the baby was in the correct position and then provided her with botanical medicines to drink. This is easier to do if the baby is small, as once a woman reaches eight or nine months of pregnancy, positioning the baby becomes much more difficult. The baby, once released, will begin to move freely as it should during pregnancy. This was also experienced by Q'eqchi' mother Augustina during her sixth pregnancy. However, she did not receive care from an *iloneleb'*. Instead, she went to the clinic and was then transferred to the hospital in Dangriga where she received treatment, after which her baby began to move as it should.

2.5.2 Labour and Delivery

Today, women in the Toledo District travel to the hospital in Punta Gorda to deliver their babies. In the past, they delivered at home in a small room constructed specifically for birth and warming the body postpartum. While the older *iloneleb'* have assisted their wives with delivery, they would, in most cases, not directly assist other women in the community with their deliveries unless complications arose. In the Maya communities of southern Belize, there is considerable stigma associated with women's genitals (Maraesa 2018b), and when delivering at home, women wear their skirts to cover themselves. While not directly involved in delivery, the *iloneleb'* could be called on to provide care during the early stages of labour, or in the event of prolonged labour or a retained placenta, both of which serve to prevent mother and baby from experiencing distress. If called upon during the early stages of labour, the *ilonel* would wait at the family's home, on standby in the event of complications. Provided labour progressed smoothly the *ilonel* would then return home.

Pregnancy is a hot condition, with the heat of a woman's body increasing just before delivery (Wilson 1995, 132). This increase in heat can contribute to complications experienced during labour and delivery. Francisco explains that the excess heat a mother experiences may cause the baby to stick to her womb. Mothers also experience complications that are not related to temperature of the body. As Emilio explains, some mother's bones will be stiff and will not want to open for delivery. When labour progresses slowly, a mother becomes weak, placing both her and her baby at risk. This is when botanical medicines are prepared to help bring on stronger contractions, aiding in quick delivery. If an *ilonel* knows a woman is going to deliver soon, he

must be prepared. Some of these plants are difficult to find in the forest, therefore, knowing a woman may deliver soon Francisco would go out and search for these plants.

If labour is progressing slowly, Emilio supplies *chupial pim* (unidentified) to bring the baby down. Here Emilio draws on the law of similarity (Fraser 2010 [1922]), using the *chupial pim* which becomes slippery and slimy when crushed to make the baby slippery and deliver quickly. This tea will be given to the labouring woman to drink. Francisco explains the medication must be ingested as it is the blood and body that are working together to push the baby out. Applying the medication topically will have no effect. When a labouring woman drinks the *chupial pim*, she should deliver within 10 minutes; the baby and the placenta will deliver at the same time. Emilio notes that some *iloneleb'* use this plant warm; however, he uses it cold. A woman is able to drink this medication cold because she has not yet delivered her baby, and she has not yet begun to warm herself. Once postpartum warming begins, she must avoid exposure to cold and wind. While an *ilonel* is not typically present in the small room during birth, there are times when their assistance is required beyond providing massage and botanical medicines. Francisco has been called on twice to assist in deliveries where the babies became stuck within the birth canal. He assisted on both of these occasions, facilitating safe deliveries of both children.

If a woman has had her womb tied to prevent miscarriage, the *ilonel* must return to release the baby, allowing for a safe delivery. Some women may also request an *ilonel* massage her during the early stages of labour as a way to help manage pain. In reciting the prayer dialogue for this treatment, the *ilonel* "draws on the power of objects" (Huggan 1998, 97), specifically plants and household items, mirroring their properties to ensure a safe delivery. When using *chupial pim,* Francisco explains that in his prayers, he calls upon the properties of the moss and the lichens to help the baby slip down quickly. He will also call on the properties of a key, which serves to unlock the way, allowing the baby to be born. In addition to this massage, botanical medicines may also be provided during the early stages of labour, whether it is progressing slowly or not. Francisco explains this is a form of preventive care which allows a woman to avoid being pierced or cut. This is indicative of the syncretism of Q'eqchi' medicine, as cesarean sections have only been taking place regularly in the region over the past 15 to 20 years. By delivering quickly, a woman avoids the need for a cesarean, which is often used by doctors when labour is progressing slowly.

It is now common practice for mothers to be referred, or even rushed, to Dangriga for a cesarean section. The *iloneleb'* express concern with biomedical personnel's decisions to refer a woman for a cesarean when labour is deemed to be progressing too slow. Francisco elaborates on this:

> A woman experiences a great deal of pain when she gives birth. Pain in her hands, in her feet, all over her body. This can cause a doctor to become frightened, especially the younger doctors. They become frightened and then send the woman to be cut right away. I am not speaking ill of doctors. They help as well. However, as *iloneleb'* we have patience. Each woman is different, so we wait, and we use massage and plant medicines when needed. This is better for a woman than being cut. She recovers within a week and does not experience additional pain.

As explained by Francisco, *iloneleb'* do not rush when a woman is in labour. Instead, they are patient and wait to see how labour progresses. Considering labour and its progression on an individual basis is also practiced by Maya midwives. Prolonged labour is not considered problematic unless accompanied by additional complications (Cosminsky 2018, 471). Additionally, birthing problems are not limited to physiological determinants; instead, midwives (and the *iloneleb'*) associate problems with each woman's unique body and situation (Berry 2006, 1965). The *iloneleb',* like the midwives in Guatemala, are in tune with their patients, attending to the specifics of each individual situation as they are guided by previous experience of caring for labouring women (Berry 2006, 1962).

2.5.3 Postpartum Care

Pregnancy affects the entire body. Francisco thinks of this as though the mother's body is "ruptured" during pregnancy. Following delivery, a mother's body enters a state of cold as a result of blood loss and the expulsion of the placenta (Cosminsky 2018, 468). To restore warmth and balance to a new mother's body, Q'eqchi' postpartum warming customs as well as the services of *iloneleb'* are used. Postpartum warming is facilitated not by the *iloneleb'* but by one's mother or mother-in-law and will be discussed in detail in the following chapters. However, the *iloneleb'* do provide postpartum care, waiting three or four days before beginning treatment. This coincides with when a mother would traditionally emerge from the small warm room she has been resting in since giving birth. Once the mother emerges and bathes an *ilonel* provides botanical medicines, massage, prayers, and will bind the new mother's abdomen. In Guatemala, midwives also perform massage immediately following birth and once again three days

postpartum as a way to relieve pain, reduce the risk of postpartum hemorrhage, and to aid in restoration of the womb (Cosminsky 2012, 88).

Botanical medicines will be made into a tea for the mother to drink. This tea is consumed to reduce postpartum bleeding as well as to warm the womb. Francisco knows four types of plants used to treat postpartum bleeding. The first is the *raq maa'us*, also called *kux sawi* (*Piper tuerckheimii C.DC.*) (De Gezelle 2014, 32). The roots and leaves of the plant are boiled together then served as a tea. Mothers will also bathe with this plant in warm water. However, *raq maa'us* is difficult to find, and the *iloneleb'* must travel a great distance to obtain it. Alternatively, an *ilonel* can use a combination of three other plants found around the house: *yut it* (*Piper peltatum)* (De Gezelle 2014, 33)*, kaq uuqub* (unidentified)*,* and *q'eq xeeb'*(unidentified). These plants are also boiled and consumed as a tea. Emilio adds that these three plants will be boiled together three times a day and consumed warm. Consumption of these botanical medicines, along with massage and tying of the backbone, work together to help stop postpartum bleeding.

During labour, a woman's bones "open up" to create space for the baby to pass through during delivery (Cosminsky 2018; Hinojosa 2004). Following delivery, abdominal binding, or "tying the backbone" as it is referred to by the *iloneleb'* and Q'eqchi' mothers, is used to bring the bones together. This practice is also used to keep organs in place as a way to prevent a fallen or prolapsed uterus (Cosminsky 2018, 476) and to restore a mother's pre-pregnancy figure (Hinojosa 2004). In tying a mother's backbone, an *ilonel* will first massage her body, then pray over the cloth used to tie the backbone before securing it around the abdomen. Emilio explains he must pray to *Qaawa* as this cloth will be used to help the mother. If he does not recite these prayers, the treatment will not be as effective, and restoration of the mother's body is not possible, leading to pain later in life. In addition to praying to *Qaawa*, Francisco also prays to the wild plum tree and the *Gumbo limbo* tree while massaging the mother's body and praying over the cloth before tying her backbone. Francisco explains that if you cut either of these trees, the bark will heal itself. The sap of these trees is also slimy and slippery, similar to the blood of a person. Here we see the law of similarity (Fraser 2010 [1922]) as these characteristics are called upon within these prayers to reproduce the properties of the tree sap to reduce postpartum bleeding and in the restoration of a mother's backbone. Following these prayers, the cloth is tied around the mothers abdomen. Francisco will leave the cloth for one week while Emilio

recommends it be left for nine days, one day for each month of pregnancy. At the end of the treatment, the *ilonel* returns and unties the cloth. Emilio will travel to the family early in the morning at 4 am and untie it. He then takes the cloth and ties it around a tree that does not die easily, which are the same trees Francisco mentions in his prayers, the *Gumbo limbo*, wild plum, or the *Madre de Cacao*. Once the cloth is tied to the tree, it will be left there and will eventually rot around the tree.

2.6 Conclusion

Today, the *iloneleb'* are primarily called on to perform prenatal massage less and less to assist with labour and delivery and postpartum, as women now deliver at the hospital in Punta Gorda. However, the *iloneleb'* continue to practice and remain available to those who seek their services. Their work is informed by their training and by their years of caring for mothers within their respective communities. The maternal health services provided by the *iloneleb'* serve to prevent complications during pregnancy, labour and delivery, and postpartum, as they work to restore mothers' bodies to their pre-pain states and prevent future pain. Their long years of work and the well-being of their wives whom they have each cared for stands as evidence of the effectiveness of Q'eqchi' medical practices. As *iloneleb'* it is their responsibility to continue to use their medical knowledge, providing care to pregnant women and mothers who seek their services for their pregnancy and postpartum needs.

CHAPTER 3: Being Seen and Unseen: Constructing Well-being During Pregnancy and Postpartum

3.1 Introduction

The sun rises at 5:30 each morning and the days begin early in the Maya villages throughout the Toledo District. There is breakfast to prepare, chickens to feed, children to mind, dishes to be done, water to haul, and a seemingly never-ending mountain of laundry to be washed by hand. Once this work is complete, there are neighbours to visit and weaving to be done, which is sold to generate additional income for the family. For Q'eqchi' women, being physically well and able to complete their daily work is central to fulfilling their social role of wife and mother. As a result, these physical and social aspects of daily life are foundational to Q'eqchi' notions of health and happiness in which it is impossible to separate work from well-being (Baines 2016; Waldram 2020). Furthermore, it is essential to an individual's well-being to be seen working and contributing to the household and the broader community, as individuals observed resting are perceived to be sick or unwell.

Well-being is a broad concept that takes on different meanings in different cultural contexts. As a result, discrepancies exist between empirical measures and local perceptions of health and well-being (Izquierdo 2005, 2010). Therefore, it is imperative in any analysis of well-being that local conceptions of both health and well-being are considered. Through his critique of the anthropological study of well-being, Thin (2010) reminds readers that "well-being matters in diverse ways that aren't just about individuals feeling well" (31). Well-being matters in ways that extend beyond simply feeling good and is linked to ideals of "happiness, which are, in themselves, embedded in notions of productivity, goodness, and maintaining harmony with one's social, physical, and spiritual environment" (Izquierdo 2010, 75).

With this in mind Thin (2010) encourages those undertaking such an analysis to consider well-being in relation to feeling(s), evaluative meaning (which I refer to henceforth as constructed meaning as it allows for a more comprehensive discussion), and motive to be well. These three aspects are considered in relation to mother's overall notions of well-being during pregnancy, labour and delivery, and postpartum. Here emphasis is placed not only on the physical body but on the social dynamics between family and community that contribute to mother's overall well-being. For first time mothers, notions of well-being are informed by the maternal figures in their lives, who educate and care for their daughters and daughters-in-law.

While this chapter is about well-being, it is also about mothers, not only the mothers of today but the mothers of the past, whose experience and knowledge has been passed from one generation to the next.

3.2 Pregnancy and Motherhood in Indian Creek

While the medicalization of maternal health has been ongoing in southern Belize since the late 1950s (De Gezelle 2014; Maraesa 2009, 2018b), the institutionalization of pregnancy and childbirth for the women of Indian Creek is relatively recent. Based on the maternal health experiences of my participants, women have only begun regularly attending prenatal clinics and delivering at the Punta Gorda hospital within the last 20 years. While women today receive biomedical care throughout pregnancy and deliver at the hospital, they do not view pregnancy through a medicalized lens. Instead, they are pragmatic in their discussions of pregnancy and motherhood. It was during my first interview that I heard the words "pregnancy is not a sickness." This became a common phrase throughout my time in Indian Creek, not only during interviews with mothers in the community but with the *iloneleb'* of the MHAB as well. Despite ongoing use of biomedical services, pregnancy is not viewed as a condition requiring intensive medical surveillance as a way to mitigate risk (Parry 2008). In the words of Nina, "pregnancy is just normal for every woman… we cannot stop it, so we just bear with it and pass through it."

Not only is pregnancy referenced by women as a "normal" physical process, but it is also central to fulfilling their social responsibility as women in relationships. Fernanda explains, "it is required of us women to become mothers. It all started in the beginning. God said that a man and woman should live together and have children." Victoria adds, "it is written in the Bible that all women are to become mothers… for me, we are just made by God to live together. A man and a woman need to have children." Motherhood as a religious requirement stands as evidence of the entrenched Christian values taken up within the community as a by-product of colonization and the ever-present evangelical missionary groups. Furthermore, in an area where women have typically had limited access to economic resources and educational opportunities, becoming a mother is simply what women do, and have done for generations.

Women who do not wish to take up the role of motherhood are somewhat of an anomaly in Indian Creek. Those who are married are expected to start a family, as Anna tells me, "if they did not want to have children, then they should not have gotten married." While some mothers

had not planned to become pregnant when they did, once pregnant, their options are limited as abortion is illegal in Belize, with some exceptions (UN Economic and Social Affairs 2014). When abortion is referenced in casual conversation, it is in hushed whispers, and the word abortion is not spoken aloud. Instead, community members refer vaguely to a sin that should not be committed before the conversation moves on to other topics. Once pregnant, women are socially and physically obligated to fulfill the role of mother.

In the past, young women in Toledo relied on their mothers and mothers-in-law to educate them on reproductive health matters. In Maya communities in Guatemala young women were not educated about pregnancy and were expected to deny any knowledge until giving birth to their first child (Rogoff 2010, 211). Today's young women learn about sexual and reproductive health in school, but for those who grew up at a time when access to formalized education was limited, the death of a maternal figure disrupted this intergenerational transmission of maternal health knowledge.

In the absence of a maternal figure, young women may not have known they were pregnant. Rosalie is a 44-year-old mother of eight, her children ranging in age from eight to 27-years-old. Her mother and father died when she was a baby, and her grandparents raised both her and her sister. Married at 15, Rosalie became pregnant with her first child when she was 17. She explains:

> Well, I didn't know when I was pregnant the first time, because no one told me about it. I didn't know about having children because when visitors would come, my grandmother would send me outside so I could not hear what they were talking about. When my husband came to engage me, my grandmother had already passed away, it was just my grandfather, and he did not tell us about married life. When I got married, I didn't know I would get pregnant. I didn't know anything.

For Rosalie, the death of both her mother and grandmother severed the transmission of knowledge, leaving her unfamiliar with reproductive health matters at the time of her marriage. There is significant shame in Maya communities surrounding discussions of women's genitals and sex in general (Maraesa 2018b), and speaking openly with non-married women about reproductive matters is taboo**.** Here we see that a woman who is not pregnant has no need for such knowledge until she herself become pregnant. Rosalie did not need this information when her grandmother was alive as she was unmarried and her grandmother did not pass this knowledge on before her death. As a result of the way this knowledge is shared, it was not until

Rosalie was expecting her first child that her husband's family told her she was pregnant and would have a baby. Rosalie explains, "from there I started to learn. I started to gain knowledge." Rosalie's mother-in-law and husband assisted her at home when it was time to deliver, and her mother-in-law continued to care for her postpartum. Rosalie has shared her knowledge and experiences with her children, including her eldest daughter Eloise, who has two small daughters of her own.

Rosalie's story demonstrates the importance of a maternal figure in educating and supporting a first-time mother during pregnancy, specifically at a time when access to formalized education was limited. Today mothers in their thirties or younger are more likely to have attended school until standard six (the Canadian equivalent of grade 8), where they receive education on reproductive health in addition to what their mothers and future mothers-in-law share with them. Although sexual health education is now part of the elementary school curriculum (Ministry of Education 2018), and the MOH does offer some prenatal classes (Maraesa 2018b), knowledge acquisition continues to occur when needed and is firmly embedded within personal experience.

3.3 Well-being during Pregnancy

Isabella and I sit inside the doorway of the family's living quarters; the cement building provides some reprieve from the warmth of the day. She is wearing a colourful skirt and a pristine white t-shirt which shows off her growing stomach. Her glossy black hair is twisted into braids and pinned up, and the warmth of the morning appears to have no effect on her. In contrast, I am sweaty and uncomfortable in my baggy pants and t-shirt. At 21, Isabella is the youngest of my participants. Having just graduated from the fourth form (grade 12 in Canada), Isabella was planning to attend sixth form classes in preparation for university when she learns she is three months pregnant.

The pregnancy was a surprise to both Isabella and her partner. She had previously been told that she would likely never have children due to polycystic ovary syndrome. Because of this, it is common for her not to see her menstruation for a month or two. After a few months of missing her period and experiencing the tell-tale signs of pregnancy, including morning sickness and fatigue, her mother, Evangelina, tells her she must be pregnant. This is confirmed following a trip to the Punta Gorda hospital. Pregnancy is difficult for Isabella and tests from the hospital

confirm that she has low iron. Isabella is prescribed iron pills in addition to the standard issue prenatal vitamins.

As her pregnancy progresses, mornings continue to be difficult. Isabella deals with fatigue and worries about how her exhaustion may affect her unborn baby. Both Isabella and her partner's families are supportive. Isabella explains that both her mother and her partner's mother, who is also the local midwife, want to care for her during pregnancy and postpartum. Evangelina wins this battle, as Isabella explains, "no one will take care of you quite like your mother." In addition to caring for her daughter during pregnancy and postpartum, it is important for Evangelina that her daughter experiences the Q'eqchi' medical practices she used during her pregnancies to maintain her well-being:

> Once we knew I was pregnant, my mother wanted to bring the traditional practices to me, so I could experience what things were like in the old days. When she found out I was three months pregnant, she talked to her *ilonel*, and he came to massage me. Because at that time, I was experiencing back pain, and sometimes my legs would get weak. I could barely do any heavy work.

Evangelina, now 56-years-old, relied on the use of an *ilonel* during her reproductive years. After experiencing two miscarriages, she was told by the *ilonel* she should not be able to have children. However, the *ilonel* was able to help Evangelina by tying her womb, preventing her from miscarrying. The *ilonel* would return prior to delivery to untie her womb, allowing her to deliver safely. With the help of an *ilonel*, Evangelina was able to carry eight pregnancies to term.

During her pregnancies, Evangelina continued with her work which included collecting and splitting firewood, going to the farm, cooking, and washing the family's laundry. This was prior to the installation of water pipes at most homes, when women would carry their laundry to the creek to wash, then haul it home to dry. Continuing to work allowed Evangelina's blood to circulate, keeping her body warm, preventing her from experiencing pain during pregnancy as well as complications during labour and delivery. Evangelina would like Isabella to be as active as she was during her pregnancies:

> My mother says your blood needs to be circulating in your veins. But when a woman feels sick, she may sleep all day. She tells me it is these women who face sickness because they are not exercising their bodies. You need to keep moving and exercising your body. My mother encourages me not to sleep. She wants me to be up and about like she was, to go to the farm, to do work. But my body does not let me do that.

Isabella compromises with her mother and does what work she can, remaining cautious. Her mother-in-law, Leona, instructs her to avoid heavy work whenever possible and provides Isabella with prenatal massage whenever she experiences any discomfort or has done too much washing. Following each massage, Isabella's mother insists she rest for three days before resuming any work, and on days when Isabella is feeling unwell and cannot work, Evangelina takes care of her washing and prepares food for her daughter's partner. Reciprocity plays a central role in Evangelina and Isabella's relationship, and on days when she feels well, Isabella repays her mother by taking her clothing to be washed at her mother-in-law's, one of the few homes in the village to have a washing machine. Following the initial surprise of the pregnancy, Isabella is pleased that she can conceive. She will take a break from school to care for her baby, after which her mother has offered to care for the baby to allow Isabella to continue with her studies.

3.3.1 Feeling(s) of Well-being During Pregnancy

Returning to Thin's (2010) criteria for well-being, feelings are defined as central to notions of happiness and well-being, in relation to how an individual feels but also in relation to those around them (30). This includes one's family and community, as well as life events, institutions, and processes individuals interact with in their daily lives (Thin 2010, 30). This definition places emphasis on the emotional aspects of feeling(s), which can also be extended to include the body and how one feels physically in particular (Izquierdo 2004 and 2010). As discussed previously, among the Q'eqchi' work, well-being, and happiness rely on one another (Waldram 2020). Philomena, a mother of six, explains "whenever I am pregnant and feel well, I am happy. But if I feel unwell, I am not happy." Feeling physically unwell during pregnancy often involves pain or cramps in the abdomen, back or sides, in addition to morning sickness and exhaustion as we see with Isabella.

Fercia, a 33-year-old mother of five and niece to Evangelina, tells me, "when you are sick you will feel very lazy, you won't want to do anything. But my mom says that if I rest or if I am not doing anything it would be bad for me. So rather it is good to do your work, to exercise your body during pregnancy." Working and warming one's body and blood leads to well-being, while sickness makes a pregnant woman lazy, which prevents her from working and being happy. However, for Isabella, her daily struggle with exhaustion and fatigue prevents her from being as

active as her mother and cousin were during their pregnancies. Fortunately, Isabella has a strong support network, something not all women have.

Anita, for instance, a mother of six who is unsure of her age (but is likely in her sixties) explains what it was like to have limited support. "You can rest for a while, but who else will do your work for you? Making food, washing dishes and clothes, sweeping your house… these are chores we do every day." This is the reality for many Q'eqchi' mothers. Often their husbands or partners are away working, and they may not live with their parents or in-laws as Isabella does. Feeling physically unwell disrupts a pregnant woman's physical well-being, which in turn disrupts her emotional well-being, as she struggles to complete her work and care for her family.

3.3.2 Constructing Meaning During Pregnancy

In defining evaluative meaning, Thin (2010) follows from moral philosophy, relying on "quality of life" and "social indicator" movements that emphasize understanding how individuals construct meaning in their lives through the evaluation of their quality of life and that of those around them (30). Thin (2010) places a strong emphasis on the ways in which meaning is constructed, as such, the term constructing meaning is used rather than evaluative meaning. This is a dynamic process in which meaning is constructed in relation to one's daily lived experience (which includes the physical body), family, and community (Thin 2010, 30) and extends to encompass both physical and social dimensions of well-being (Izquierdo 2010). Prior to medicalization, notions of well-being were based on the experiences one's mother or mother-in-law chose to share, longstanding Q'eqchi' medical practices and beliefs, one's personal experience, and local notions of risk. What is perceived of as risky was previously conveyed to expectant women by the maternal figures in their lives. Today, meaning is further constructed in relation to the care and instruction young women receive from biomedical care providers during routine prenatal clinics, including information on what is perceived of as risky. Taken together, the information provided to women as well as their own lived experience are evaluated, re-evaluated, and made meaningful in relation to their well-being.

We see this with the advice Isabella receives from her mother Evangelina and mother-in-law Leona. Evangelina did not experience any pains or discomforts during her pregnancies, which she credits to continuing her daily work and is the basis for the advice she shares with her daughter. As the local midwife, Leona is trained in prenatal massage and has also taken part in

UNICEF funded TBA training. However, her recommendations are informed first and foremost by her own experiences of pregnancy and motherhood. Leona's first pregnancy ended at seven months. Unaware she was pregnant, she was doing her washing at the creek when she slipped on the wet rocks, falling on her stomach. She wipes tears from her eyes while relaying this experience. "That's why I tell women today, you don't have to work when you are pregnant. You need to take your rest. In my days when I was pregnant, I did everything. I carried water, big buckets, everything. I could not rest. So that is why I tell women today, you shouldn't lift heavy things, you need to take your rest."

The mothers I spoke with, regardless of age, emphasized the importance of working and remaining active during pregnancy. However, as we see with the advice presented by Evangelina and Leona, mothers are divided not only on the quantity and type of work that should be done during pregnancy but the associated risks as well. The loss of Leona's first child continues to influence the care and recommendations she provides to pregnant women today. She emphasizes the need for a woman to take care of herself and her unborn child by avoiding heavy work and resting as a way to avoid unnecessary risk, reducing the chance of the baby moving out of place, or the possibility of a miscarriage.

Martha, a 31-year-old Q'eqchi' mother of six, is originally from Guatemala where her mother and father continue to live. Martha tells me "it is not good to lift-up heavy objects whenever a woman is pregnant. But I have to do it because there is no one to help me. When my husband is home, he does this work for me. But when he is not home, I do this work myself." With limited social support at home, Martha has no choice but to continue with her work regardless of the potential risk or how she is feeling on any given day. This is in contrast to notions of risk shared by Evangelina. Manuela, a 36-year-old mother of five, shares Evangelina's view and elaborates on why continuing with all work is critical to maintaining well-being and mitigating risk during pregnancy:

> Whenever I get pregnant, I don't stop lifting-up heavy objects because as the months pass and you start to do heavy work again, you may have a miscarriage. When I am pregnant, I continue to do my daily activities. It is good for you to be active to keep your body warm. If you don't stay active, this is when you will face problems.

However a woman chooses to view work during pregnancy, the risk of the baby moving out of place and causing discomfort, or the potential for miscarriage, is the same. While it

is far easier to continue with one's work as Evangelina and Manuela have done during their pregnancies, for mothers like Martha who would like to avoid heavy work the social support necessary to do so is not always available. Isabella has social support from both her mother and mother-in-law, and although their opinions and experiences differ on how best to care for oneself during pregnancy, both do so as a way to reduce risk. Isabella takes advantage of her situation, constructing her own ideas of well-being based on local notions of risk in relation to advice from her mother and mother-in-law, and prioritizing how she feels physically on a daily basis.

Connected to how a pregnant woman feels on a daily basis is the use of Q'eqchi' botanical medicines and pharmaceuticals prescribed by biomedical care providers. Plant medicines provided by *iloneleb'* are viewed by the Q'eqchi' as natural as they come from the earth, while pharmaceuticals provided by the hospital or clinic are not. However, in general, taking any medication during pregnancy is typically viewed as a risk by both mothers and *iloneleb'*. As discussed in the previous chapter, the *iloneleb'* are cautious in their use of botanical medicines during pregnancy. Pregnant women can bathe with the botanical medicines provided by an *ilonel*, but should not ingest them unless instructed to do so. In contrast, the satellite clinic in Big Falls provides prenatal vitamins and iron pills as a routine part of their prenatal clinics. Although most medications are believed to be unhealthy, there is the shifting perception that if prescribed by doctors or nurses, they are safe to take during pregnancy.

Some pregnant women take these prenatal vitamins, others do not. Anita, a 28-year-old mother expecting her sixth child, explains that these vitamins are necessary, that they keep her and her baby healthy during pregnancy. For Isabella, taking prenatal vitamins makes her feel weak. She visits a private physician (an out of pocket expense), questioning the benefits of taking prenatal vitamins for both her and her baby. The private physician informs Isabella that if she were to continue using these prenatal vitamins, when it came time to deliver she would need a cesarean. Fearing this may be the case, Isabella quits taking her prenatal vitamins. Eloise also stops taking her clinic provided prenatal vitamins after experiencing heartburn. She has her husband buy her different vitamins from town, stating these vitamins are much better than the ones provided by the clinic. Here we see that meaning is constructed in relation to the recommendations of biomedical care providers as well as with respect to how taking prenatal vitamins impacts a woman's daily well-being and the perceived risk they pose to both her and

her baby. Anita has no issues with the prenatal vitamins, stating that they are important for her daily well-being, while both Isabella and Eloise quit taking the prenatal vitamins from the clinic. For both Isabella and Eloise, this decision is based on how they feel when they take their prenatal vitamins: Isabella feels weak, and Eloise experiences heartburn. However, Isabella rejects prenatal vitamins altogether, weighing the risk of taking prenatal vitamins against the possibility of a cesarean section.

While Isabella does not take her prenatal vitamins, she does take her iron pills. Isabella describes her blood as weak and takes the prescribed iron pills to build-up (strengthen) her blood and the blood of her unborn baby. Isabella explains that her low blood level increases her risk for miscarriage. Therefore, taking the iron pills is necessary, not only for her well-being but for that of her unborn baby. Isabella's approach to taking her prescribed iron pills demonstrates the practice of medical syncretism among the Q'eqchi', in which aspects of different medical systems and beliefs are blended (Baer, Singer, and Susser 2003, 41). Blood and the pulse are used by *iloneleb'* as a diagnostic tool, listening, questioning, and feeling the blood of the patient to determine their sickness (Waldram 2020). The Q'eqchi' connect blood and its strength to good health, while in a biomedical context healthy iron levels reduce the risk of postpartum hemorrhage (a leading global cause of maternal mortality) (Maraesa 2012, 214). However, while pregnant women take up and blend aspects of Q'eqchi' medicine and biomedicine, they do not necessarily subscribe to either system in a clear-cut fashion (Baer, Singer, and Susser 2003, 41). For example, Isabella selects aspects of both biomedicine and Q'eqchi' medicine which impact her short- and long-term well-being and the well-being of her unborn child, all of which centers on her desire to ensure she has a "normal" delivery.

The likelihood of a woman having a "normal" delivery is dependent on the position of the baby within the womb. In determining the position of the baby, mothers in the past relied solely on the *iloneleb'* or local midwife, while today, they also rely on biomedical care providers. Unlike the *ilonel* or the midwife, the nurses at the satellite clinic in Big Falls are unable to reposition the baby. As discussed previously, the position of the baby within the womb impacts a woman's daily well-being, and may cause pain and discomfort that prevents her from completing her daily work. In addition to her exhaustion and fatigue, Isabella experienced pain in her leg early in her pregnancy. Evangelina quickly contacted her *ilonel* to come and reposition the baby.

While she describes the massages as painful, Isabella tells me, "if the *ilonel* hadn't cured me, I would still be facing this pain today."

By repositioning the baby within the womb, Isabella's pain and discomfort are alleviated, allowing her to move freely once more. The position of the baby within the womb is also evaluated in relation to one's due date. If the baby is not in the correct position before delivery, the nurses or doctors at the Big Falls satellite clinic refer the woman for a cesarean section. Seeking early care is viewed as a form of risk management, allowing the *ilonel* or midwife sufficient time to reposition the baby, reducing the risk of cesarean section. If the baby is in the correct position, then women do not experience any pain and have no cause for concern.

3.3.3 Motive to be Well During Pregnancy

Motive to be well combines aspects of both feelings and the construction of meaning, encompassing one's desire to feel good and to lead a good life, not only in a personal sense but also in relation to one's social responsibility governed by collective and community principles (Thin 2010, 31). For Q'eqchi' women, motive to be well is tied to maintaining their physical well-being during pregnancy, which in turn allows for the fulfillment of their role as wife and mother. This was the primary motive for the women who became mothers prior to the institutionalization of pregnancy and birth. Without access to biomedical care, they did not worry if they would be sent for a cesarean, instead relying on *iloneleb'* to assist them in the event of pain during pregnancy or complications during labour and delivery. Pregnant women and mothers today continue to be pragmatic in their approach to pregnancy, however, they are not without their worries. The risk of cesarean section is of particular concern for young women today as it extends recovery time and prevents them from following Q'eqchi' postpartum warming practices. Overall, motive to be well is perhaps best described by Anita. "If I am doing something, if my body is always being exercised, then I don't feel any pain." Motive is rooted in a woman's desire to feel well during pregnancy, her ability to carry on with her daily routine as though she is not pregnant, and the desire for a "normal" delivery.

3.4 Well-being in Relation to Labour and Delivery

Fercia and I sit around a small table, while her mother sits a short distance away in her hammock, her granddaughter asleep in her lap. We pause the interview for a moment as there is

a commotion outside among the chickens. Once things quiet down, we resume our discussion of well-being during labour and delivery. She tells me, "I didn't face any problems [when I delivered] because I continued to do my work, my body was active. If you rest too much, you will have problems. I have heard of some women who labour for a full day and night and can't give birth. But for me, anytime labour came, it didn't take long for me to give birth."

For Q'eqchi' women, working during pregnancy serves to maintain well-being while also preventing complications during labour and delivery. Elaborating on this, midwife Leona tells me if a woman rests too much on one side the baby will move to that side of the womb, requiring massage from either herself or an *ilonel* to reposition the baby. In the last few months of pregnancy, the baby should be in a "good position for birth" or head down. Today, those women whose babies are not in the correct position in time for delivery are referred, or in the event of an emergency transferred, for a cesarean section. Fercia's mother tells me: "in the past sometimes the baby was not in the correct position. Maybe it came out feet first or was sitting down in the womb. But women still delivered normally with the assistance of an *ilonel*. But today the doctors send these women to be cut." In addition to the risk of cesarean section, hospital births are viewed as more painful than home birth.

Q'eqchi' mothers who gave birth at home say they did not experience any difficulties and that labour and delivery were quick. While not altogether painless, they did not reference pain when discussing their experiences of labour and delivery as frequently as younger women who give birth at the hospital. Maraesa (2014) credits the belief that hospital births are more painful to the routine use of episiotomies for first-time mothers and the application of fundal pressure to help expel the baby. At the time of Maraesa's 2006 research the pain of hospital birth was cited as a reason to remain at home for labour and delivery, however, this is not necessarily the case today. For the Q'eqchi' mothers in Indian Creek, with limited pain management options available to them the pain of a hospital birth has been routinized. As Fernanda explains, "It is just the way it is. You just have to take the pain." While the pain of delivery is difficult to deal with it is temporary, and mothers feel relief and happiness following the birth of their children.

Women who deliver at the Punta Gorda hospital remain there for at least 48 hours before making the journey home by bus, or if the funds are available, by chartered vehicle. A hospital birth prevents a mother from beginning postpartum warming immediately following delivery as mothers who delivered at home had done for generations. This leaves mothers vulnerable to cold

and wind entering their bodies, both while in the hospital and in the time it takes to travel the 45 minutes by bus from Punta Gorda to Indian Creek. Mothers who are transferred to Dangriga for cesarean, barring further complications, also return home 48-hours later by whatever means of transportation the family can afford. This institutionalization of birth, as well as the routinization of cesarean sections has significant consequences for mother's postpartum well-being and their reproductive futures.

3.5 Postpartum Well-Being

As central as continuing to work during pregnancy is for a mother's well-being, refraining from work, resting, and remaining out of sight when warming one's body postpartum is equally important. Referred to as ancient practices by both the *iloneleb'* and Q'eqchi' mothers, postpartum warming practices have been passed from mothers to daughters for generations. These practices adhere to the thermal principles of Q'eqchi' medicine, which dictate the ideal state for an individual's body is neither too hot nor too cold; balance is key to good health (Waldram 2020). Extreme temperatures in either direction lead to ill health, the cure for which is returning equilibrium to the body. This emphasis on temperature and balance is common within Maya communities in Guatemala (Cosminsky 2018), Mexico (Groark 1997; Hinojosa 2004), and in Chinese Medicine (Holroyd et al. 2005).

Q'eqchi' postpartum warming practices focus on restoring balance and preventing future pain. Balance is restored through the application of heat, the avoidance of cold, and the consumption of warm food and drink. While Q'eqchi' postpartum warming practices are thermal in nature, an *ilonel* is not required. Instead, these warming practices are facilitated by one's mother or mother-in-law. However, as discussed in the previous chapter, *iloneleb'* may be called upon to provide postpartum massage, abdominal binding, and botanical medicines to reduce postpartum bleeding. Among the mothers I spoke with, only half had used the services of an *iloneleb'* at least once postpartum. Most of these women are in their late 30s or older. It is unclear if this decline in use is due to the loss of *iloneleb'* or as a result of the institutionalization of birth, or more than likely, a combination of both.

In the past, as labour pains began, a small room would be constructed in one corner of the family home using blankets (or more recently sheets of plastic). While this small room is reminiscent of the sweat baths used for labour and delivery in Maya communities in Guatemala

and Mexico (Hinojosa 2004; Rogoff 2011), Q'eqchi' mothers did not reference the use of water to create steam. This room is constructed as a way to provide privacy for the labouring mother, and to keep her warm as her body moves from a state of hot to cold. Mother's bodies heat up from the accumulation of blood as a result of not menstruating, and move to a state of cold from loss of blood and the expulsion of the placenta (Cosminsky 2018, 468). During a woman's first birth, she was accompanied by her mother or mother-in-law, who would teach the husband how to assist during delivery. No other family members or children were permitted to enter this room. Following delivery, the husband would pick the baby up off the floor and cut the umbilical cord. Both mother and baby were bathed in warm water before being put to rest on a special bed within this small room. Construction of this bed uses sticks about one inch in diameter. These are woven together and covered in blankets or cardboard. Hot coals are then placed beneath the bed, allowing the heat to rise and warm the mothers back. This room provides protection from the cold and wind at a time in which both mother and baby are vulnerable. If exposed to either, mothers may experience pain, cramps, and swelling.

During the time a mother spends within this small room, and in the few days and weeks that follow, a rock is set on the hearth to warm. Once warm, this rock is wrapped in a thick cloth and brought to the resting mother where it is used to massage the womb. Maria, a 56-year-old mother of four, explains how to use this hot rock: "Whenever you use the rock, you press it from side to side and downwards. You can feel whenever the blood flows down. We use this hot rock to clean the blood from our wombs." In addition, this practice also serves to dry the womb. Leona explains that by following this practice, the womb should shrink to the size of a small orange. Women in the community say it is possible to identify mothers who have not used this hot rock to cure their wombs, as they continue to look as though they are pregnant.

Once a mother emerges from this small room, the bed is removed. Fercia's mother, explains that this bed needs to be placed in a cool shaded area. When I inquire as to why this is done, she replies that this was what her mother had taught her, but she was not provided with a reason. Augustina also mentions this practice, adding that it is unhealthy for women to be around this bed postpartum. If we considered this practice in relation to the thermal principles of Q'eqchi' medicine, the bed itself may be too hot to keep within the home. Extreme temperatures pose a risk to not only the well-being of mothers but to all Q'eqchi' people (Waldram 2020).

Placing the pieces of this bed in a cool or shaded spot would provide it with time to cool down, reducing the risk it may pose to a new mother, her family, or the community.

During this warming period, new mothers may only consume warm food and drink. *Caldo* is a spicy chicken soup made with garlic, and when available, the starchy root vegetables coco and cassava are added. *Caldo* is consumed with fresh corn tortillas as a way to warm, nourish, and strengthen a new mother's body, building up her blood and assisting in the production of breast milk. *Casham*, a warm corn porridge seasoned with black pepper, is also served. During the first month postpartum, a mother's primary drink is a tea of black pepper and warm water. The health benefits of this tea include warming the body, assisting in the production of breast milk, and preventing stomach pain for both mother and baby. Cold food and drink are avoided until the warming period is over. At the end of this warming, mothers allow their bodies to cool down for a full day. If a mother were to expose herself to cold and wind so soon after warming herself, the cold may enter her body, causing pain and swelling. Once the postpartum warming period is over, mothers return to their former routine and diet.

For Q'eqchi' mothers, particularly in discussions with older mothers, postpartum warming practices not only warm and restore the body but also function as a form of birth control. Fercia's mother tells me: "if you don't use the rock, well let's say maybe just one or two months later you will have your period again. Then you will get pregnant quickly. If you use the hot rock and have the hot coals beneath your bed, it will take a year and a half to two years for you to see your menstruation again." The biomedical explanation for not seeing one's menstruation for one to two years postpartum is that mothers breastfeed during this time. Q'eqchi' mothers typically breastfeed for one to two-years, however, the association of warming the body and drying the womb as a form of birth control provides mothers with agency over their bodies, especially for those Q'eqchi' women who became mothers at a time when access to birth control was limited. Today, contraceptives are available for free at the satellite clinic in Big Falls. Women only need to pay their bus fare of $4 BZD. Free contraceptives include both short- and long-term options such as oral contraceptives, the Depo-Provera shot, intrauterine systems (IUS), and the "implant" (which I initially confused for an IUS as I had never heard of the implant. I would later find out it is not legal within Canada. The implant is a small rod injected into the upper arm that releases progestin to prevent pregnancy and is effective for three years). However, these communities are small and some young women may be embarrassed to go to the

clinic for contraceptives, particularly if they are without a partner or unmarried. It should also be noted that although the cost of transportation does not appear to amount to much, $4 BZD is sometimes the difference between being able to feed one's family or not. Additionally, about half of the mothers I spoke with, as well as the *iloneleb'*, view birth control as unhealthy for the womb and believe that taking contraceptives may lead to fertility issues.

In introducing Q'eqchi' postpartum warming practices, it should be noted that the time frames discussed above are based on my conversations with older mothers from the community who delivered at home. Even among this generation of mothers, a great deal of variation exists. Some mothers rest and warm their bodies for the three days while they remain within the small room; others continue to massage their wombs using the hot rock for up to two weeks. However, what is consistent across the generations of mothers I spoke with is that the black pepper tea should be consumed for at least a month, or even up to two months postpartum.

Postpartum well-being is influenced by how a mother's body feels physically in relation to how a mother feels following labour and delivery, as well as how her body feels while adhering to postpartum warming practices. Embedded within these discussions are mothers' perceptions of these practices and the benefits they reap as a result. Though Q'eqchi' mothers agree that labour and delivery is a painful experience, discussions of how one feels postpartum are divided. There are those mothers who do not feel any pain postpartum. Catalina, the wife of an *ilonel*, tells me, "during pregnancy, you will always feel hot and sleepy. But once you have the baby that goes away, [and] your body will feel normal again." Others describe feeling weak following labour and delivery, as detailed by Anita. "I don't feel normal after I give birth," she says, "I feel weak. If I get up before my body is warmed, then I start to feel pain." Regardless of how mothers feel postpartum (normal or weak), those who deliver vaginally typically adhere to postpartum warming practices for at least one of their pregnancies, while most follow these practices to varying degrees for subsequent births.

Q'eqchi' mothers who engage in postpartum warming with the support of a maternal figure do so as a way to exercise agency over their own their well-being. In warming their bodies, mothers control the amount of pain they experience immediately following delivery, and reduce their risk for future pain caused by cold entering and remaining within the womb. Sylvia explains, "If I did not warm myself, I would experience pain from cold entering my body. I wouldn't feel comfortable if I did not use the hot rock and black pepper. That is why I always

use these, and because of this, I don't feel any pain now." By engaging with these practices, mothers warm their bodies and reduce pain, while the rejection of these practices leaves the body vulnerable to cold and wind in the short term and leads to pain and cramps in the long-term. Leona elaborates on risk to a mother's well-being if these practices are not followed. "This is what we believe," she says. "As Q'eqchi' people, these practices are important to us. If you do these things then you don't have any pain. You don't feel dizzy, you always feel healthy and strong."

Postpartum warming practices are not possible without the care and guidance of one's mother or mother-in-law. Without this support, Q'eqchi' mothers, both young and old, say they would not have known how to warm themselves. Emphasis on restoration through the application of heat is foundational in constructing meaning associated with the use of these practices. As new mothers are guided in these practices, they are not only taught how to warm themselves, but why these practices are used and how they contribute to postpartum well-being. In following these practices, mothers further construct meaning in relation to risk to their bodies as well as the risks faced by their newborn babies. Here, risk is considered with regard to mothers' immediate well-being and the future risks they face by not warming their bodies.

Sylvia is 67-years-old and has given birth to 13 children. As we sit in the family's living quarters on overturned 5-gallon pails, she speaks of her transition to motherhood and the role her mother played. "In the past, nobody would give you advice, only your mother. It was my mother who taught me how to take care of my baby. She took care of me and taught me how to do everything. Up until now, I still remember." Sylvia was also able to care for her daughters following the birth of their children. Rosanna is one of Sylvia's daughters. She is 43-years-old and a mother of five. Speaking of postpartum warming practices, Rosanna tells me, "I wouldn't have done these practices without my mother because I would not have known what to do." This sentiment is echoed by Isabella who tells me "if my mother wasn't here to help me after I have my baby I wouldn't warn myself, because I wouldn't even know what to do or how to do it." Once again, we see that mothers play a key role in educating their daughters and daughters-in-law as they make the transition to motherhood.

When a mother feels physical discomfort postpartum, it is easy for her to diagnose what the issue is, as pain is an indication that cold or wind have entered the body. While mothers try to avoid exposure to cold and wind, this is not always possible now that mothers routinely deliver

at the hospital in Punta Gorda. Eloise, a 27-year-old mother of two, 'caught cold' following the birth of her youngest daughter on Good Friday. Eloise and her daughter were discharged at 9 am on Easter Sunday, however due to the holiday, the next available bus did not leave until 1 pm. After four hours of sitting outside, Eloise's body began to ache. Eloise's mother Rosalie had prepared *caldo*, the special bed, and had a hot rock warming on the fire for her daughters return home. Eloise had been taught of the consequences of long-term cold exposure by her mother-in-law and her mother, and to construct meaning associated with postpartum well-being in relation to hot-cold principles. As such, she rushed to warm herself using the hot coals, hot rock, and the black pepper tea. Mothers also evaluate and construct meaning in relation to warming practices with regard to the well-being of their newborns. When breastfeeding, what the mother eats is passed to the baby. If Eloise did not warm herself or consume warm foods, the cold that entered her body could transfer to her newborn, causing the baby to experience stomach pains. The baby may also be warmed further by placing hot coals under their sleeping area.

Mothers who do not adhere to postpartum warming practices leave themselves vulnerable to pain in their hands, feet, and womb. An extreme example comes from Anna. "When my sister-in-law came home from the hospital, she did not follow these practices. She began to get very sick and she almost died." Although Anna's sister-in-law initially rejected these practices, the cure was to follow postpartum warming procedures. Anna cautions against dismissing these practices: "If you don't warm yourself, it is dangerous. Just look at my sister-in-law." My interpreter, Fercia, did not follow these practices after the births of four of her five children. She now experiences pain in her abdomen. "I told an older woman of my pain. She told me the cold entered my body when I was doing my washing at the creek. That is why I am facing pain today, because I did not rest and warm myself after the birth of my younger children." Mothers who do not follow postpartum warming practices do not necessarily face pain immediately; however, it does await them in the future.

Mothers are taught and encouraged to make use of postpartum warming practices by the maternal figures in their lives. Without this guidance and support, mothers may not have the social support necessary to rest after giving birth, particularly if this is their third or fourth child. Mothers also warm themselves postpartum as a way to restore the body to its pre-pregnancy state. Fernanda explains further, "when cold enters the womb, and a mother does not warm herself the blood will not come out, it stays in there. This causes the belly to be big." However,

as we see in the case of Fercia, not all mothers take up these warming practices. Mothers are further motivated to follow these practices as a way to maintain their newborn's well-being by avoiding the consumption of cold food and drink and consuming only warm foods and drink, which also serve to provide their new baby with the nourishment they need to grow and be well. Finally, mothers are motivated to follow these practices as a way to prevent future pain.

3.6 Conclusion

Through the stories and experiences of Indian Creek mothers like Isabella, Evangelina, Leona, Rosalie, and Fercia, we can see that the body itself is central to both physical and social experiences of well-being during pregnancy, labour and delivery, and postpartum. First-time mothers are educated by their mothers and mothers-in-law. who teach them what it means to be well during pregnancy and how to maintain well-being by continuing to work, allowing one's blood to circulate, keeping the body warm and allowing the baby to sit comfortably within the womb. Mothers and mothers-in-law continue to play an essential role in facilitating postpartum warming as they care for their daughters and daughters-in-law for one week to one month following their return from the hospital. Well-being is evaluated and re-evaluated daily as mothers drawn on their lived experience, knowledge from their mothers or mothers-in-law, and information provided at prenatal clinics. Women are motivated not only by their desire to feel well, but to care for their families, prevent complications during labour and delivery, and to avoid future pain.

CHAPTER 4: Choice and Decision-Making

4.1 Introduction

During pregnancy, women around the globe decide when and where to seek prenatal care, and when the time comes, they must decide where to deliver, and if they will follow culturally significant postpartum practices. Such decisions are informed by social, structural, and biomedical factors (Berry 2008) as well as local understandings of safety and risk (Jenkins 2001). Social factors are comprised of individual and family consideration and involvement in the decision-making process. In Central America, newlyweds often find themselves living with their in-laws, allowing family members the opportunity to be involved in decision-making (Dudgeon 2012, 30), solicited or otherwise. Structural factors include the distance from a hospital or clinic as well as the cost of transportation (Berry 2008). In Belize, families living in rural and remote communities do not necessarily have ready access to transportation or the financial resources to travel to and from the hospital, despite the availability of free healthcare. Furthermore, families may not trust biomedical care providers and express concern with the quality of care they may receive (Berry 2008), as well as the perception that hospital births are more painful than home births (Maraesa 2018b). Decision-making is further informed by local perceptions of risk, which often do not align with biomedical notions of risk (Maraesa 2014). If these risk factors do not conform to womens daily lived experience then they do not "generate the same fear that will motivate women to action" (Maraesa 2014, 224). These factors, along with the health care services available (biomedical, *iloneleb'*, midwife), inform reproductive decision-making. This chapter details the decision-making of pregnant women and mothers in Indian Creek as they navigate their medically plural environment, selecting amongst prenatal care providers, location of delivery, and the use of Q'eqchi' postpartum warming practices.

Medical pluralism is characterized by the existence of multiple medical care providers and systems, and Toledo is no exception. In the past, there were many different specialists, including bonesetters, snake doctors, massage therapists, and grannie healers (De Gezelle 2014, 8). However, these highly specialized care providers are less common in the region today (De Gezelle 2014, 9), while *iloneleb'* and midwives continue to practice. Within any medically plural environment, one medical system tends to dominate over other medical systems (Baer 2011, 413). This is the case for the Toledo district and the community of Indian Creek, where over the past twenty to twenty-five years pregnancy and birth have become institutionalized. Prior to this

institutionalization, pregnant women relied solely on the *iloneleb'* for prenatal care, while family assisted during labour and delivery, and both family members and *iloneleb'* were relied upon for postpartum care. Today Q'eqchi' mothers navigate amongst the local satellite clinic in Big Falls, the hospital in Punta Gorda, and the local midwives and *iloneleb'* who continue to practice throughout the region, albeit to a lesser extent than in the past. While pregnant women continue to have multiple care options, tensions exist as they feel they do not necessarily have the agency to choose whether to seek biomedical care or not. Pregnant women feel their decision-making is constrained by external pressures to use biomedical prenatal and delivery care.

4.2 Whose Decision is it?

Among residents of the Toledo District, there is the belief that one is unable to "force the action of others against their personal will or the will of an omnipotent God" (Maraesa 2018b, 187). This belief crosses ethnic lines and is not exclusive to Maya communities (Maraesa 2018b). Among Indigenous communities this is commonly referred to as the ethic of 'non-interference', in which it is perceived of as inappropriate for one individual to tell another individual what to do (Waldram 2004). For first-time mothers, decisions relating to maternal health and well-being are understood to be her right and responsibility. In exerting authority over reproductive decision-making Maraesa (2018b) notes that women in Toledo do so through firm statements of "because I want to" or "because I didn't want to." This is extended by mothers to their daughters and daughters-in-law who typically assert that, "it is her decision". While mothers maintain their agency in decision-making, there are times in which they feel they may lack control in their lives, which is indicated by the statement "only God knows" (Maraesa 2018b, 4), a phrase I often heard during my own interviews.

Mothers and mothers-in-law provide support and educate their daughters and daughters-in-law when they become pregnant. However, they cannot make decisions for their daughters. Delia explains, "each person has their own choice to make in where [and how] they want to go to receive care. I cannot choose for anybody." The understanding that an individual is responsible for making decisions places the responsibility of the outcome on the individual. This absolves family and friends of any responsibility in the event of an undesirable outcome (death of mother or baby). Additionally, this fits with the approach both *iloneleb'* and midwives take in their

work. The *iloneleb'* and midwives do not advertise their services and do not offer care unless a patient first acknowledges that they require their assistance.

While decision-making is understood to be the responsibility of an individual, this does not mean that family members are never involved in the decision-making process. In a situation where a woman may not know what to do, particularly if she is a first-time mother or if she is in an unfamiliar situation, she may seek advice from family members such as her mother, older sister(s) or aunt(s). In such a situation, this advice is solicited, and it is appropriate for family to participate in decision-making. However, exceptions do exist. As we will see later in this chapter, there are times in which the ethic of non-interference is violated as family members step in when emergencies arise or when they cannot bear to see a family member suffering from pain or discomfort.

4.3 Times of Transition: Changes in Maternal Care

First-time mothers often find themselves living with their in-laws or in some cases, their parents. Once their family becomes established they then move to their own home. Prior to formalized sexual health education, it was one's mother-in-law who would check with her new daughter-in-law to see if she was still seeing her menstruation. If she had stopped seeing her menstruation, her mother-in-law would inform her that she was pregnant and the services of an *ilonel* would be sought to ensure the baby was in the correct position. This decision-making by an experienced woman served as part of the education process. Following a woman's first pregnancy, the responsibility was then passed to her as she made decisions about care during any subsequent pregnancies. Today, students receive sexual health education in school and enter relationships with this knowledge, which in the past was unavailable to first-time mothers. This was the case for Rosaria, whose family was one of the first to settle in Indian Creek.

Originally from Guatemala, Rosaria's family moved to Belize due to food shortages, and she spent her childhood in various villages throughout the region, eventually settling in Indian Creek. Rosaria reclines in her hammock during our interview, telling me she is unsure of her age, but appears to be in her late 60s or early 70s. Rosaria explains that because her family moved so much, she was unable to attend school, commenting, "I would have had a good life if I could have gone to school." Instead, Rosaria would marry and have six children. When asked about her six pregnancies and the care she had access to at the time Rosaria explains, "in the past, there

was no clinic for you to attend. You would just wait until it was time to give birth unless your family had an *ilonel* come and attend to you." This was the case for many of the women I spoke with in their 50s and 60s who relied solely on the services of the *iloneleb'* for maternal care. Since then there has been considerable change in the maternal care available to women in Indian Creek.

When the transition from home to hospital care began 20-30 years ago, Q'eqchi' women embraced this shift to varying degrees. Mothers were not necessarily "opposed in principle to giving birth at health facilities, but … they [did]not have reason to break from what [was] perceived as the path of least resistance" (Obermeyer 2000, 192). While some women did not see the need for the journey to the hospital or could not afford the cost of transportation, others willingly attended prenatal clinic and delivered at the hospital, happy to have someone to care for them and their newborn, while others were motivated by the need for paperwork to facilitate the registry of the birth (Maraesa 2018b). Changes such as this have occurred throughout Central America as increased access to biomedicine in conjunction with global public health initiatives have encouraged mothers to embrace these services (Jenkins 2001).

During her research in Costa Rica, Jenkins' (2001) participants (rural mothers who previously had limited access to biomedical care) told her "we were ignorant about healthcare because we thought that giving birth at home was like giving birth at the hospital" (411). These Costa Rican mothers who previously felt confident about their ability to deliver their children at home began to question whether it was safe for them to do so, prompting them to begin delivering at the hospital. This stands as an example of biomedical hegemony as policymakers, and biomedical practitioners advertise biomedicine as superior to alternative medical systems and families begin to doubt their prior experience and question their previous practices (Baer, Singer, Susser 2003). When speaking with Q'eqchi' mothers in their 50s and 60s who delivered at home, I am often told "we did not know about doctors" or "in our time we did not depend on doctors." While mothers in Indian Creek express that they were unaware of doctors, unlike Jenkins' participants, they remain steadfast in the decisions they made during their pregnancies and births, in part because there were no alternatives available to them. Following in the footsteps of their mothers, they trusted in their experience and knowledge to maintain well-being during pregnancy and in their ability to deliver normally, even when the baby was not in the correct position. However, the confidence of women giving birth at the time in which biomedical

care became available was undermined in such a way that prompted them to alter how they sought care during pregnancy and for labour and delivery. We see this with the experience of Augustina, who at 45-years-old navigated this transition over 20 years and six births.

Augustina invites Fercia and I into her home. The concrete pad on which her home is built was recently poured, and the scent of fresh lumber is in the air. The lunchtime traffic can be heard in the background, the Southern Highway visible from the window. Augustina invites me to sit in one of two hammocks suspended from the high ceiling beams. An overturned five-gallon pail sits between us. As I set up the recorder, a small boy stays close to Augustina, not quite hiding behind her Q'eqchi' skirt of purple, green, and black woven threads. She introduces us and I ask if he will start school in September; he grins and nods. At four-years-old, he is the youngest of Augustina's five children, the rest of whom range in age from 18 to 25. With this age gap between her elder and youngest child, Augustina's pregnancies have spanned a time of considerable change in maternal care in Indian Creek.

When pregnant with her three eldest children, Augustina relied on the services of the local *iloneleb'*. During her ninth month of pregnancy, an *ilonel* would provide massage and botanical medicines the week before she was due. These plants would be made into a tea which was consumed every three days until Augustina went into labour. Her eldest three children were born at home with the assistance of her grandmother and husband. She gave birth to her fourth child at home after receiving prenatal care at the hospital in Punta Gorda, and relied solely on biomedical care providers during her last two pregnancies. When pregnant with her youngest two children, Augustina did not use the services of an *ilonel*. Instead, she went to the clinic in Punta Gorda or, with her youngest to the satellite clinic in Big Falls. Augustina explains that she did not want to attend these clinics, but she did so because the nurses told her she had to attend and that she would have to deliver at the hospital. "I would have liked to stay at home with my youngest two. But with this law, they force us to deliver at the hospital. They don't want babies to be born at home anymore." Once Augustina began using biomedical services for her prenatal and delivery needs, she stopped using the services of the *iloneleb'*, instead relying on the hospital and prenatal clinic. Augustina's experiences of pregnancy and birth stand as evidence of the shift in pregnancy and birthing practices within Indian Creek. Her experiences further highlight the tensions that exist between personal agency and external pressures to use biomedical health services. In explaining why she began attending prenatal clinic and delivering at the hospital,

Augustina states that it is the "law" that all women must do so. Augustina was not the first mother to reference this "law", nor was she the last.

"It is required that every pregnant woman attend prenatal clinic because that is the law," Fercia tells me during our first interview. Having familiarized myself with anthropological research in the area, I thought I knew what to expect prior to my arrival. I had foolishly assumed that women would have limited access to maternal care and that home deliveries would be the standard. I was 10 minutes into my first interview and quickly had to set my previous assumptions aside. The hospital was accessed far more than I had assumed it would be. Reference to this "law" came up repeatedly in interviews not only with mothers but in general conversation with Q'eqchi' individuals living in the surrounding villages and Punta Gorda. *Ilonel* Augustino also discussed this "law" with me, stating "if our wives don't deliver at the hospital then we cannot register our children. You just have to find a way to get her to the hospital, because we need those papers."

Despite searches for policy documenting such a "law", and repeated emails to the MOH (which went unanswered), I was unable to find evidence that this "law" exists in any official capacity. The only government document referencing home delivery is the Registration of Births and Deaths Act. This act stipulates that any child born alive in any district, including those children born at home, must be registered within 42 days of birth, either by the parents or in their absence, the witnesses of the birth (MOH 2000, 11-12). If a family waits until after the first year of birth to register the child, they must pay the prescribed fees (MOH 2011, 11). This act was updated in 2003 to include registration fees, which are $4BZD for those registering their child within one year of birth, $25BZD for those registering their child one to five years after birth, and $50BZD for those registering their child five years or more after their birth. While this act dictates that children born at home are considered to be citizens of Belize and are eligible to be registered, the fear that one's children will be denied citizenship lingers.

Q'eqchi' families frequently refer to this "law" and express concerns over their ability to register their children as their motivation for attending prenatal clinic and delivering at the hospital. Discussions of this "law" and its origin are framed around variations of the phrase "they do not allow us to have children at home anymore" or "if you do there could be trouble", "they" being the doctors and nurses at the hospital and satellite clinic. This suggests that medical staff encourage women to attend prenatal clinic and deliver at the hospital, which is interpreted at the

local level as pregnant women being required to utilize biomedical maternal health services. While this "law" does not appear to exist in any codified way, it is real to the mothers of Indian Creek and their families, and it is impossible to ignore the profound impact it has had on pregnancy and birthing practices in the region.

Despite the hegemonic influence of biomedicine (Baer, Singer, and Susser 2003, 337), Q'eqchi' medicine persists, and families continue to seek the services of midwives and *iloneleb'*. While pregnant women today have more services to choose from than previous generations, this change has come at a cost, as there are fewer and fewer *iloneleb'* available to provide prenatal massage. As established in the previous chapter, the use of *iloneleb'* and midwives is crucial to maintaining and restoring well-being during pregnancy, and can further influence the outcome of labour and delivery (vaginal birth versus a cesarean section). As a result, they are willing to travel to access the services of an *ilonel* or midwife to correct the position of the baby. These changes are evident in Victoria's prenatal care-seeking over three pregnancies and seven years.

Victoria is a 30-year-old mother who migrated from Guatemala to Belize when she was sixteen. She has three children, ages twelve, nine, and five. In addition to prenatal clinics in Punta Gorda and later-on in Big Falls, Victoria also made use of an *ilonel* and midwives. During her first pregnancy, Victoria's mother-in-law took her to the late Mr. Lorenzo Choc, who was a member of the MHAB. She visited him when she was six months pregnant. "I was experiencing pain. When I went to the *ilonel*, he told me the baby was not in the correct position. I visited him several times, and he fixed my baby. He helped me because I didn't get cut [cesarean section]. If I hadn't gone to him, I might have been cut. This is how I know the *iloneleb'* help." By the time Victoria was expecting her second child, Mr. Lorenzo Choc had passed away. Experiencing pain once again, Victoria's mother-in-law recommended she visit a midwife in the village of San Pedro Colombia (a 30-40 minute bus ride from Indian Creek). Victoria traveled to San Pedro Colombia and spent the night with the midwife who massaged her three times throughout the night and three times the following morning. When Victoria became pregnant for a third time, she once again sought the services of a midwife. However, by this time, the midwife in San Pedro Colombia had also passed away. Victoria instead went to see Indian Creeks midwife Leona, who massaged her.

Victoria's choice of care providers was constrained by the deaths of Mr. Lorenzo and the midwife from San Pedro Colombia. While Victoria was saddened by the death of Mr. Lorenzo,

stating, “If he had not died I would have gone to him with all my children,” she did not let his death prevent her from seeking prenatal massage, and her mother-in-law assisted her in finding someone else to massage her. Victoria’s attendance at prenatal clinic also reflects the changing times in the Toledo District. When Victoria was pregnant with her eldest, she traveled to the Punta Gorda hospital for prenatal care. During her second pregnancy, she made the journey to San Pedro Colombia for prenatal care (where she also saw the midwife and already being in San Pedro Colombia may have influenced her decision to do so), and by the time she was pregnant with her third child, the satellite clinic in Big Falls was open. As biomedical prenatal care becomes more convenient, finding an *ilonel* or midwife becomes more complicated, particularly following the deaths of said care providers.

4.4 Prenatal Decision-Making

Prenatal decision-making is first and foremost informed by the time period in which a woman is pregnant. When pregnant women first began attending prenatal clinics access to reliable transportation to and from Punta Gorda was limited. Since then, the Southern Highway has been paved, and families in Indian Creek have access to multiple buses running to and from Punta Gorda each day. As a result, the women of Indian Creek have far more options available to them today than their mothers did some 20 to 30 years ago. Today almost all pregnant women make use of the prenatal clinic in Big Falls, and travel to Punta Gorda for routine blood work or when the monthly ultrasound clinic is in town. While women access the satellite clinic for prenatal care, they do continue to make use of the *iloneleb’* and midwives for prenatal massage. Nina, daughter of Leona, explains: “the doctors, *iloneleb’*, and nurses all have different training. So, the doctors and nurses do a little bit, then the *iloneleb’* do some, and the midwife too. They all work together.” The services of the *iloneleb’* and midwives, when accessed today, are used complementary to biomedical prenatal care and not in competition with it.

Throughout interviews, contradictory information as to whether or not massage was offered at prenatal clinics in Punta Gorda and Big Falls emerged. Some mothers say the clinic in Punta Gorda provided prenatal massage in the past but not today. Others tell me that the satellite clinic in Big Falls offers prenatal massage. One morning I find myself at the satellite clinic with Fercia. While she is getting her test results, I take the opportunity to inquire at the desk and am told rather firmly that prenatal massage is not a service provided. However, I continued to

receive mixed responses during interviews. While chatting with Rosalie, who has attended prenatal clinic and seen an *ilonel* during her last few pregnancies, she explains that "the nurses will just feel the position of the baby. They can tell you if the baby is in the correct position or not. But they cannot position the baby, only an *ilonel* or a midwife can do that." Having had an opportunity to observe Leona administering prenatal massage I noticed that she is quite gentle. As a result, some women may equate the nurses at the satellite clinic's use of a physical exam in which they must touch a woman's belly to determine if the baby is in the correct position with prenatal massage. It is also possible that massage was used at prenatal clinics in the past, but has fallen out of favour as biomedical care providers deem the practice to be risky (Hinojosa 2014). Regardless, massage remains a central part of prenatal care for many pregnant women.

During her first pregnancy, Fercia was living with her in-laws. As it was her first pregnancy, education and decision-making fell to her mother-in-law who arranged for an *ilonel* to massage her. Fercia's elder sister, also sought care from an *ilonel* during her first pregnancy. As we sit enjoying the breeze through her open-air kitchen, she tells me, "my mom and I were both worried. Because with the first one [pregnancy] you never really know what might happen. I read many books when I was pregnant, and I have seen that some women may need to be cut, maybe the baby's buttocks come out first, or a hand or foot. So that is why I attended an *ilonel*. He massaged me, and I had a normal delivery." Emerging alongside this is fear of the unknown that comes with a woman's first pregnancy, influencing how care is sought. Her mother encouraged her to see an *ilonel* for prenatal massage as she worried for the outcome of her daughter's first delivery. In addition, Fercia and her elder sister also attended prenatal clinic, both telling me it is required by "law". Both mothers had normal first deliveries (and subsequent deliveries); however, for these sisters, their first pregnancies were the only ones in which they used the services of the *iloneleb'*.

As Fercia and I sit around the kitchen table, I gently question why she only used an *ilonel* during her first pregnancy. "Well, we weren't living with my mother-in-law anymore. So… it's like we forgot about these practices. That is why I didn't see an *ilonel*." Without her mother-in-law to encourage her to use the *ilonel*, Fercia chose to attend prenatal clinic and did not seek any additional care. Alternatively, as Fercia's mother-in-law explains, "if everything is okay, you are not having pains or problems, then you don't have to use an *ilonel*." We also see this with Fercia's sister's decision not to see an *ilonel* for her other two pregnancies. Her first delivery was

normal. Therefore, she did not see the need for an *ilonel* during her subsequent pregnancies as she did not experience any complications during her first pregnancy.

While some women choose to attend prenatal clinic and do not make use of *iloneleb'* or midwives, others seek these services in response to the nurse's evaluation of the position of the baby within the womb. During her seventh pregnancy, Rosalie was attending a routine prenatal clinic when the nurse told her that her baby was crosswise within the womb. The nurse presented Rosalie with paperwork referring her for a cesarean section. "I was afraid. I didn't want to be cut. At that time, I had six other children at home. If I were to be cut I would have to rest for many months and who would take care of them? I have seen women who have been cut. They can't do anything, no heavy lifting, nothing." With this information and these worries for her future well-being, and the well-being of her family, Rosalie turned to her husband for advice, "I called him at work and told him about the paperwork. He was worried too. His father is an *ilonel*, but he was not living in Indian Creek anymore. So, we decided I would catch the 1:00 [afternoon] bus and go to an *ilonel* in nearby Golden Stream. This *ilonel* massaged me and told me not to worry, that I will have my baby normally. And I did." At a time of uncertainty, not knowing what she should do, Rosalie included her husband in the decision-making process. Together they considered the risk Rosalie and the family faced if she was to have a cesarean section. As Rosalie mentions above, she did not have the social support necessary to rest for an extended period following a cesarean section. Therefore, receiving care from an *ilonel* was her best chance for a normal delivery.

Martha faced a similar situation. Her eldest child was born in Guatemala when she was 15-years-old. During her first pregnancy, her family used the services of a midwife or *comadrona*, who provided Martha with prenatal, delivery, and postpartum care. Martha then came to Belize on her own, the rest of her family remaining in Guatemala, leaving her unfamiliar with the country's maternal health practices. As a result, it was her husband who advised her on when and where to seek care when she first became pregnant. During her second pregnancy, Martha was at the prenatal clinic when she was provided with paperwork referring her for a cesarean section. Bringing the paperwork home, she told her husband of her appointment, and he advised her to find someone to massage her. Martha found a midwife in Mango Creek (an hour or so by bus) and began travelling there every 5-10 days for prenatal massage. Martha even travelled to the midwife the day before her prenatal clinics. She saw this as an opportunity to

demonstrate to the nurses the effectiveness of prenatal massage. In seeking care from an *ilonel* or midwife, both Rosalie and Martha's decisions to do so are in response to the nurse's evaluation of the baby's position in the womb. Both mothers consult with their husbands when faced with unfamiliar circumstances and willingly accept their assistance and input in making a final decision**.** This advice was solicited and therefore appropriate. However, there are times when families offer unsolicited advice or may even step in and make decisions for a pregnant woman against her wishes, violating the ethic of non-interference.

This is the case for Anita, introduced in the previous chapter. When asking about where she has sought prenatal care and if she had ever relied on the services of an *ilonel*, Anita explains that she does not believe in the work that they do. She attended prenatal clinic at the hospital or satellite clinic for all of her pregnancies. During her third pregnancy, Anita did receive prenatal massage from a midwife. However, the decision to see the midwife was not hers. "I didn't decide to go," Anita tells me, sitting on an overturned five-gallon pail. Her sixth pregnancy is just visible beneath her purple shirt, with rhinestones forming three flowers around the collar, reminiscent of the lace on the traditional Q'eqchi' blouses and dresses. "I didn't really set my mind to go. They [her mother-in-law] forced me to go to the midwife. I felt like I couldn't walk when I was pregnant with that baby. I had a lot of cramps, a lot of pain. So that is why my mother-in-law forced me to go to the midwife. But in a way, I see that it works. I felt well again. Until I went to deliver, I didn't have much pain at all." At the time, Anita was living with her in-laws, which facilitated her mother-in-law's ability to persuade, or in Anita's words "force," her to receive care from a midwife. It is difficult for family members to see their loved one suffering. At such times, the ethic of non-interference is undermined in favor of restoring well-being. While Anita only saw a midwife during her third pregnancy, she has consistently attended prenatal clinic during all six of her pregnancies.

Each time I inquire as to why women attend prenatal clinic in Punta Gorda and now in Big Falls, I am met with the same answer, "because we are required to go." This alleged requirement impacts their agency to decide. For Anita, financial and locally perceived legal consequences influence her decision to seek biomedical prenatal care. Anita explains that if she were to forego attending prenatal clinic, she may have to pay a great deal of money when it comes time to deliver, as the hospital in Punta Gorda would not have her name and would not be expecting her. However, if she joins the prenatal clinic early, they will know that she is pregnant,

and when she goes to deliver, there will be no financial or legal complications. Today, personal agency in prenatal decision-making is constrained by this "law" as well as local notions of risk, blame, and liability.

4.5 Blame, Responsibility, and Liability in Decision-Making

Among the Q'eqchi' mothers of Indian Creek, discussions of the "law" serve as a link between prenatal care decision-making and where they choose to deliver. Embedded within these conversations are notions of risk in which they are concerned that if they do "not engage in the expected appropriate behaviour prenatally or during birth, [that] blame and responsibility will fall on [them]" (Smith-Oka 2012, 106) or their families. The "expected behaviour" referenced here is attending routine biomedical prenatal clinics and delivering at the hospital in Punta Gorda. There is the concern that should women or their families choose not to attend prenatal clinic or deliver at the hospital and complications arise leading to the death of mother or baby, or both, that their husbands or parents may go to jail. Here we see that notions of risk are embedded within discussions of blame, and accompanying blame are questions of accountability and responsibility (Smith-Oka 2012, 106). Such beliefs among Q'eqchi' women and their families are not unfounded.

Maraesa (2018b) was working in the Toledo district when a mother died at home following delivery. While delivery went smoothly, the placenta would not deliver, and the mother died shortly after the local TBA arrived to assist (183). Following this death, the woman's family, the TBA, and the MOH each sought a guilty party. The community blamed the husband for not seeking assistance earlier (and whose first wife died in a similar fashion). The family blamed the TBA for cutting the umbilical cord before the placenta was delivered[5]. Finally, the MOH also blamed the TBA for providing "improper care." In the end, this woman's death was understood as a home birth that resulted in death, and the decision to remain at home was determined to be hers, absolving her husband of any legal, or moral, responsibility in her death (Maraesa 2018b). This unfortunate situation, and others like it, exemplify the local belief that "individuals act according to their own free will – even if those actions result in devastating

[5] It is a common practice among the Q'eqchi' to wait until the placenta is delivered before cutting the cord, the belief being that if the cord is cut too soon, it will prevent the placenta from emerging (De Gezelle 2014; Maraesa 2018b)

consequences" (Maraesa 2018b,184). Here we see that when such an unfavourable event occurs during birth – such as the death of mother, child, or both – "blame can fall on the women, the medical staff, or circumstances beyond the control of either" (Smith-Oka 2012, 106), as was the final verdict in this situation. Ultimately, the husband did not face legal consequences for the death of his wife. However, stories of situations such as this contribute to women's fears, as they worry if this were to happen to them that their families will be blamed and perhaps face jail time.

Fear of such blame motivates women in Indian Creek to attend prenatal clinic. Fernanda is 46-years-old, and while she did not attend prenatal clinic, when her daughter Marina became pregnant with her first child, she ensured her daughter attended. "If you don't attend clinic and either the mother or the baby dies, then an investigation will be carried out. This is to find out what happened and why the woman did not attend clinic," Fernanda explains, adding, "I can't decide for my daughter. I can't force her not to attend the clinic. If something were to happen to her at home, I could be blamed for her problem. Because it is me who did not send her to the clinic. So this is why we have to send our daughters and daughters-in-law to the clinic and the hospital." Fernanda's explanation demonstrates the pervasive power of the "law" and the fear of being blamed in the event of complications. Fernanda prioritizes this fear over her own experiences of pregnancy and birth, during which time she did not attend prenatal clinic and only delivered her first of seven children at the hospital in Punta Gorda, and her seventh with a midwife in San Pedro Colombia.

Notions of blame and responsibility are further embedded in conversations surrounding shifting labour and delivery practices, primarily the Companion at Birth Policy implemented by the MOH in December of 2009. This policy is intended to provide labouring women with family support, as a way to facilitate "improved mental health/psychological health during labour and delivery and the immediate post-partum period" (MOH 2009, 1). This policy outlines steps for MOH staff providing prenatal care, requiring them to identify and obtain the contact information of a woman's companion at birth. The policy states that at least two educational sessions will be provided for the companion in preparation for providing support during labour and delivery (MOH 2009, 2). This policy is meant to "reduce tension and shorten labour, increase [their] feelings of control, decrease interventions and cesareans, enhance partner's participation, [and] improve [the] outcome for the newborn" (MOH 2009, 2). While having one's partner present

during labour and delivery is meant to reduce stress for labouring women, local perceptions of why this policy has been enacted are quite different.

During our interview with Rosalie, she tells us her thoughts on why this policy has been implemented: "Some women have died in the hospital, and their husbands were left wondering what has happened to them. I think this is why they changed that law, why they need your husband to be there with you. In case something happens to you or the baby." Thinking about this on the walk home, I ask Fercia what she thinks of this change. Fercia elaborates on Rosalie's answer, explaining that this is a way for the doctors to protect themselves from blame. With one's husband or partner there as a witness, if there are complications and the mother or baby die, then the husband can see that the doctors have done everything possible to save the mother and/or baby, and that will be the end of the matter.

As a result of this "law" and circulating discussions of who is to blame (and the fear that blame will fall on them), women take on the responsibility to attend prenatal clinics and accept that they may be required to shoulder the blame in the event of complications. When discussing this responsibility as her own Fercia explains, "it is because I am the one who did not follow the rules." By missing a prenatal clinic and not "following the rules," Fercia further explains that the nurses and doctors will not be held responsible. Women see policies, such as the Companion at Birth Policy, as a way for the hospital to absolve themselves of liability in the event of complications and not as a way to provide familial support for a labouring woman as was the standard when mothers delivered at home.

4.6 From Home to Hospital Delivery

During the transition from home to hospital delivery, the decision to remain at home was influenced by a family's physical distance to the hospital, access to transportation and financial resources, shame associated with exposing one's genitals, fear of crying out or hearing others crying out during delivery, and fear of death (Maraesa 2018b). These fears of death stem from stories of mothers whose deaths have occurred while at the hospital (Maraesa 2018b, 21). Today, all of the young mothers I spoke with attended prenatal clinic and went to or planned to go to the hospital for delivery. Families continue to be concerned with questions of citizenship, worrying that their children will be accused of being Guatemalan and denied citizenship without hospital paperwork. While there is no formal evidence of such a "law" requiring women to deliver at the

hospital, and although the Belizean Nationality Act dictates that all individuals born in the country after 1985 are citizens of Belize (Government of Belize 2011), women and their families nevertheless make decisions regarding hospital deliveries based on the fear of these perceived legal requirements.

At 42-years-old Philomena is one of the mothers whose birth experiences span the time before and after this transition. Mother to six children ranging in age from 23 to five years old, Philomena gave birth to her two eldest children at home, her third and fourth children were both delivered at the homes of midwives, while her youngest two children were born in the hospital. When discussing her decision to remain at home for the birth of her two eldest children, Philomena tells me, "I didn't know about the hospital when they were born, and we didn't have the money to travel at that time even if I had known." Once she heard that women were going to the hospital to deliver their babies, Philomena was afraid, "I heard that the hospital is rough, so I worried about going there."

Philomena traveled to the midwife in Eldridgeville and then in San Pedro Colombia for the births of her third and fourth children. However, both midwives had passed away by the time she was pregnant with her fifth child. With no one to assist her, Philomena felt her only option was to deliver at the Punta Gorda hospital. "I felt sad [about going to the hospital], I didn't know how the hospital worked," Philomena explains. Despite her initial fear, she would go on to have a normal, although painful, hospital delivery. When pregnant with her youngest, it was the rainy season, leaving the ground wet and slippery. In her seventh month, Philomena dropped (the local term for slipping and falling**)** and began bleeding. Falling, particularly on the abdomen during the second and third trimester, poses a risk to both mother and baby and may result in early labour or the separation of the placenta from the wall of the uterus. After her fall, Philomena sought advice from Leona, who explained bleeding is not something she could assist her with and instead suggested Philomena go to the satellite clinic. Philomena rushed to Big Falls, where they then transferred her to Punta Gorda. From there, health care providers took her to Dangriga, where she delivered her baby early.

When Philomena began delivering at the hospital, she felt she did not necessarily have a choice in the matter, as both midwives she had previously accessed had passed away. These midwives had been practicing for many years and were well known within the region. Their passing not only represents a shift in available care but a loss of knowledge and experience that

allowed these midwives to hold a position of trust and authority over women's reproductive health and well-being, something many of the midwives or TBAs who practice today do not necessarily have. While Leona is the village midwife and provides prenatal massage, she does not assist in delivering children. When Philomena sought advice from Leona, she was told to go to the satellite clinic or hospital immediately. In addition to her training in prenatal massage by an older midwife, Leona is also trained as a TBA. This training by GIFT included how to identify risk factors and when to refer a pregnant woman to the hospital. As such, Leona identified Philomena's bleeding as a risk factor and told her to go to the satellite clinic or hospital. Philomena complied with Leona's recommendation. However, once at the satellite clinic, Philomena was in the hands of biomedical care providers, who exercised their authority and decide the best course of action. While Philomena went on to deliver a healthy baby boy, this experience and her loss of agency contributed to her decision to stop having children.

Rosalie's situation is similar to Philomena's. Rosalie successfully delivered her six eldest children at home, assisted by her mother-in-law and husband. However, when she became pregnant with her seventh child, this changed. "By that time my mother and father-in-law were not living in Indian Creek," she explained. "I was afraid to give birth without my mother-in-law, and my husband worried too. My husband told me it is better for me to go to the hospital in case something goes wrong, because he doesn't know how to help. So, when the time came, he brought me to the hospital." Without the support of her in-laws, Rosalie and her husband decided it was safer to deliver at the hospital. Rosalie adds, "when my last baby was born, the cord was wrapped around its neck. The nurse told me that if I had taken a chance and had the baby at home, maybe me or the baby would have died," reaffirming her decision to deliver her youngest two children at the hospital. Through the introduction of biomedical health services in southern Belize and the experiences of Philomena and Rosalie, we begin to see the slow erosion of mothers' and their families' confidence in their ability to deliver their children at home.

Throughout Central America policies have been enacted as a way to bring women to the nearest clinic or hospital to receive prenatal and delivery care. Policies in Guatemala and Costa Rica required first-time mothers to attend the hospital for delivery (Cosminsky 2012**;** Jenkins 2001) as a way to introduce women, who traditionally delivered at home or with the support of family, to the biomedical model of delivery care. While I could find no evidence of such a policy in Belize, I did encounter mothers who delivered their first children at the hospital and then

remained at home for any births after. Anna is one of these mothers. At 38-years-old, she has three children, ages 21, 20, and 17. During our interview, we sit in Anna's kitchen, enjoying the breeze that finds its way through the trees, smoke occasionally blowing towards us from the hearth. Anna explains why she delivered her eldest child at the hospital. "It was my first birth, so it can be risky," she said. "If I had stayed at home, I would have died. I was lucky they took me to the hospital." While Anna's first birth was difficult (with a routine episiotomy and the application of fundal pressure to help deliver her 9lb baby!) her other two deliveries took place at home with the assistance of her mother-in-law and her mother. Anna states, "I just made up my mind to have them at home." Fernanda's first delivery was also at the hospital, and she remained at home to deliver her next five children. However, her seventh child was born in San Pedro Colombia with the midwife, stating that the "law" required her to do so. Several mothers who gave birth at this time also mention delivering with the midwife. These midwives were well known in the region and would have been practicing long before the medicalization of pregnancy and birth. As a result of their experience, they were viewed by local women as an acceptable alternative to hospital birth, and Q'eqchi' mothers hint that these midwives were accorded the authority to practice by the MOH.

At the beginning of the shift to institutionalized delivery, mothers were afraid to deliver at the hospital, unsure of the care they would receive and ashamed to "open themselves up" to strangers (Maraesa 2014, 217). Following 20 years of institutionalized birth, the narrative has shifted, as the mothers of today explain that they were afraid to give birth at home. Isabella elaborates on this, saying, "we don't really bring the traditional into our lives like my parents used to. We have already gotten used to the hospital, having the doctors and nurses tend to us. When we are in front of our parents, we are ashamed to open ourselves, but not at the hospital." As a result of this "law", the fear and shame that comes with having their parents see them in labour, and since the passing of the midwives and several *iloneleb'*, pregnant women now prefer to deliver at the hospital.

4.6.1 Cesarean Section

The World Health Organization (WHO) states that "when medically justified, a cesarean section can effectively prevent maternal and perinatal mortality and morbidity" (WHO 2015, 1). While cesarean sections are used as a way to prevent maternal and infant deaths, their routine use

is on the rise globally, often exceeding the ideal rate of 10-15% recommended by the WHO (WHO 2015, 1). In Belize, cesarean rates have climbed to 35% countrywide (Maraesa 2018b, 16), double the WHO's recommended rate. Of the 31 mothers I spoke with, only five had at least one cesarean section. However, most have a family member or friend who has had a cesarean. Based on personal experience and the experiences of family and friends, they fear being cut, and what this means for their postpartum recovery, their ability to care for their family, and their reproductive futures.

Loss of agency is associated with the use of biomedicine during pregnancy and for labour and delivery (Maraesa 2018b). In the past, when women delivered at home supported by family, they maintained their agency and autonomy over what happened to them. In moments when they were unable to do so, they trusted in their family members to assist them. Today, in going to the hospital women surrender their agency and autonomy, placing themselves in the hands of the doctors and nurses. As Manuela states, "once a young woman reaches the hospital, they [medical staff] will do what they have to do." This is the case for two young mothers, Angelina and Marina.

Angelina and I sit around the table in her family home. Her youngest is asleep in a nearby hammock, while her eldest is off playing with her cousins. She asks about my Q'eqchi', and I tell her the few words and phrases I have picked up. Angelina is wearing a denim skirt and a fuchsia shirt, her hair twisted-up and secured with a clip behind her head. At 22-years-old, she is one of the younger mothers I meet. She has two daughters, both delivered via cesarean section. "They [the doctors] told me I was past my due date. I don't know if that is true or not, but they set a date for me to go to Dangriga. I travelled there by bus the day before. Then I was cut the next day. When I was pregnant with my second, I went to the clinic. There they tell me I have had a C-section already, so they will schedule me to be cut with this one [youngest daughter] as well." Angelina does not mention if they first tried to induce her or not, although from her story, it appears this was not explored. Instead, doctors opted to send her for a cesarean section. As a result of her first cesarean, Angelina had no say during her second delivery; she was simply told she would be sent for another surgery and was provided with a date and paperwork.

Marina, Fernanda's daughter, also delivered her two children via cesarean. I find myself sitting once more in the breezeway of her parents' home. Her mother is out today, and it is just Marina, Fercia, and I, enjoying the breeze and the sound of chicks chirping. Marina's long dark

hair is down, a rare sight in the village, as women typically wear their hair up (a necessity in the hot, humid rainy season). I first learned of Marina's cesarean sections when I interviewed her mother a few weeks prior. At the time Fernanda was teasing her daughter about her "big belly" as she was unable to make use of the hot rock to clean and dry her womb:

> I had an ultrasound when I was six months pregnant. It was there the doctor told me that the baby is not in the right position. I went to my auntie, Leona. She massaged me, but the baby wouldn't move. So, the doctor wrote me a recommendation for a C-section. I didn't have to sign any paperwork, because they said there was a chance I could deliver normally. But when I was nine months, I was attending my last clinic when they rushed me to Punta Gorda. Then they flew me to Dangriga to do a C-section because my baby was dying.

Marina decided to see her aunt for prenatal massage only when she found out the baby was not in the correct position; however, she waited too long, and Leona was unable to reposition her baby. "I have learned from this. You need to go to the midwife early in your pregnancy so the baby can be in the correct position. My mom told me if I had gone to see my auntie earlier, I would have had my baby normally." Marina accepts responsibility in waiting to seek care, pointing out that she was the one who did not listen to her mother, conceding that if she had, she would have delivered normally. During her second pregnancy, Marina regularly visited her aunt for prenatal massage. When the time came for Marina to deliver, the baby was in the correct position, however, she was still referred for a cesarean. "I wanted to try for a normal delivery, but they don't let you," she tells me. Both Angelina and Marina experienced a loss of agency over what happened to their bodies when seeking biomedical care. Marina was rushed to Dangriga for both of her deliveries, allowing little room for noncompliance, while Angelina complied with the doctor's instructions to travel to Dangriga for her cesareans as she felt she has no other option.

Both Angelina and Marina experienced further loss of agency before their second cesareans. They each requested a tie-off, the local term for tubal ligation. Both mothers were denied. "They told me I was too young for a tie-off," Angelina explains as her eldest daughter comes in and sits down with her, "I begged them to do it, but they never did. They told me I had one more child to go before they would do that." Marina is told the same thing. "They didn't give me a tie-off after my second baby. I asked them to, but they wouldn't do it, not until my third baby." I repeatedly heard that women could be cut three times, then the doctors will do a tie-off, whether it was wanted or not. However, while neither wants a third child, they are not

permitted to make such a decision. Instead, they must rely on the free contraceptive options offered at the satellite clinic.

As I repeatedly hear of the increased routinization of cesarean sections for mothers in Indian Creek, I begin to question why women in the community think this is becoming so commonplace. The older generation of mothers credit this increase with younger women's rejection of prenatal massage from the *iloneleb'* and midwives. "In the past, we didn't get cut," Sylvia explains, her grandchildren peeking in through the door. "Women today are not getting massaged by *iloneleb'*, this is why they are being cut during deliveries." Fercia's mother, shares a similar view. "Today doctors and nurses are being depended upon, and the *iloneleb'* are being left behind. This is why this is happening now." As has been demonstrated, prenatal massage is essential for well-being not only during pregnancy but also impacts a woman's ability to deliver normally.

The younger generation of mothers view the increased use of cesarean section as a result of so many young girls becoming pregnant. Angelina explains, "nowadays lots of young girls are getting pregnant and having C-sections. Maybe the nurses… they get pale to see them, that's why they send them to be cut." Such situations are further attributed to the experience of doctors and nurses. Eudelia explains that there used to be many older and experienced doctors and nurses working at the hospital. While the Southern Health Region has far fewer specialized biomedical practitioners than the rest of the country (Reeser 2014), mothers attribute the routinization of cesarean section to the inexperience of younger doctors and nurses who find it easier to refer them to be cut, rather than wait patiently for labour to progress.

4.7 Postpartum Decision-Making

As established in the previous chapter, postpartum warming is essential to mothers immediate and future well-being. However, just because these practices have benefited generations of Q'eqchi' mothers does not mean these practices are immune to change. Sylvia addresses this change, stating that "today young people are not treating their bodies properly. I have explained to my daughters and daughters-in-law the importance of warming their body. Some will do it, and some won't. It is their decision to make." Once again, agency over decision-making lies with the individual. If a mother does not want to make use of these practices, then that is her decision, and she is the one who will face the consequences. While these practices are

outright rejected by some, other mother's ability to practice is determined by the degree of social support they have at home. Philomena explains, "when we come home from the hospital, we don't use these warming practices as much. This allows cold to enter our bodies. It is difficult to warm yourself when you come out of the hospital."

Victoria was living with her mother-in-law when she gave birth to her eldest child. "I rested for one month after she was born. My mother-in-law took care of me. Then after the month was over, I started to do my washing again. It felt good to rest and warm myself." Living with her mother-in-law provided Victoria with the social support necessary to rest and warm herself for a full month postpartum. However, when pregnant with her third child Victoria and her husband were no longer living with his mother. "When I came out of the hospital with my third baby, my mother-in-law had the hot rock ready for me, but then she went home. I couldn't rest as I did with my first baby because there was no one to take care of me." Lacking the support necessary to warm herself, and now caring for three small children, Victoria prioritized certain warming practices over others, making adjustments to fit with what she was able to manage on her own. She did not use the hot coals as it was too difficult. However, she did use the hot rock for a week and drank the black pepper tea for a full month. While Victoria used some warming practices, she was unable to rest for a full month. "I began moving around right away, and cramps began to affect my back. I even feel pain now because the cold entered my body."

Victoria had three normal deliveries, which at the very least allowed her the option of warming herself postpartum. For women who have a cesarean, such as Angelina and Marina, postpartum warming is not an option. Maria's daughter-in-law was also cut. Maria explains the difficulties she faced in caring for her daughter-in-law after she returned home. "You can't give them the hot rock to massage their womb or put hot coals under their bed," she said. "You can't even give them *caldo*, because if you do their cut will worsen. If a woman who is cut eats pepper or hot foods, her cut will become infected and begin to pus." In addition to being unable to warm oneself postpartum, a woman who is cut also requires extended social support. Following her first cesarean Angelina rested for a full month and did not resume any of her work for an additional two months. "My mother and mother-in-law helped me at that time because I couldn't do anything. No washing, no sweeping… nothing. I was so tired of resting." While Angelina had to rest, her extended convalescence quickly became tedious. Although she did not have the

option of warming herself postpartum, had she delivered normally she would have liked to have followed these practices. This would have been made possible based on the degree of social support she had following her two cesareans.

Half of the women I had interviewed had used an *ilonel* following the delivery of at least one of their children. Availability of social support is also a factor in whether a mother has an *ilonel* massage her postpartum. Most of these mothers are 40 years of age or older. However, not all were able to be massaged or have their bones tied postpartum. Fernanda chose not to see an *ilonel* postpartum, stating "those women who use an *ilonel* after having a baby will rest for a month. They can't do anything in that time: no washing, sweeping, baking, or cooking, only caring for their baby. I didn't have anyone to help me. That is why I didn't use a healer after having my children." Fernanda elaborates: "Those women who did use the *ilonel* do not complain of back pain," she says. "My mother used an *ilonel*, and she does not have any pain today." Catalina is in a similar situation. While she is married to an *ilonel*, she chose not to have her husband massage her or tie her backbone following the birth of their children. While he would have been able to do this, Catalina did not have the social support necessary to rest for a full month. Instead, she chose to avoid the cold and drink the black pepper tea.

4.8 Conclusion

Q'eqchi' mothers who gave birth prior to medicalization and institutionalization trusted in their ability to deliver at home with the assistance of their mothers or mothers-in-law and their husbands, and relying on *iloneleb'* in the event of complications. These mothers have taken on the role of educators, passing their knowledge and experiences to their daughters and daughters-in-law as they become mothers. However, women today do not have the same agency as their mothers and grandmothers. Decision-making by Q'eqchi' women falls within the framework of the ethic of 'non-interference', implying that an individual has the right to decide and that no other individual can or should interfere (Waldram 2004), their right to decide has become constrained by the "law" which is locally perceived by Maya communities throughout the Toledo district as requiring them to attend prenatal clinics and to deliver at the hospital. Pregnant women began routinely accessing biomedical services out of fear that if they did not their children would be denied citizenship, or if complications arose that their husbands, parents, or in-laws could be charged or face jail time. Despite the increased access to and use of biomedical

prenatal and delivery services, Q'eqchi' women do continue to access local *iloneleb'* and midwives, not in competition with but complementary to these services. However, as we see with the story of Victoria, Q'eqchi' women's access to *iloneleb'* and midwives is being impacted by the loss of these care providers and their knowledge. As I often heard throughout my time in Indian Creek, everything is changing.

CHAPTER 5: Conclusion

> In the past, we gave birth at home, but this practice no longer exists. Women go to the hospital now where they will deliver normally or they will be cut. But our Q'eqchi' practices are being left behind.
>
> - Elaina

5.1 Revisiting the Research Question(s)

In beginning this research, I posed the question "what is the state of Q'eqchi' knowledge regarding maternal health and well-being, and when and how is this knowledge accessed and put into practice?" This is a broad question. However, it provided me with space to explore the valuable maternal health knowledge held by the *iloneleb'* and Q'eqchi' mothers in Indian Creek. In constructing an answer to this question, the interrelated themes of knowledge, well-being, and decision-making have been examined. Tying these together is the theme of change, which emerged repeatedly throughout my interviews with the *iloneleb'* and Q'eqchi' mothers, regardless of their age or the number of children they have. In addressing the theme of change, I now present a vignette from one of my early interviews that perhaps best exemplifies local perceptions of change and the accompaniment of loss of knowledge and Q'eqchi' practices that for generations were central to maternal well-being during pregnancy, labour and delivery, and postpartum.

It is our second day of interviews and Fercia, and I make small talk as we make our way along the dirt road. Fercia's youngest daughter accompanies us, holding her mother's hand. As we near Sylvia's home, we begin to hear the sound of construction, the hammering of nails, the sawing of boards. They are building a new kitchen next to the family's sleeping quarters. Fercia calls out, announcing our arrival. We are ushered into the house by Sylvia, who looks to be in her late 60s or early 70s. She arranges chairs for us and finds us a small table on which to place the audio recorder at Fercia's request. Fercia's daughter runs off to play with Sylvia's grandchildren, their laughter mixing with the sound of construction, the clucking of chickens and the crowing of the rooster. Sylvia's long dark hair is streaked with grey and white, she wears a Q'eqchi' blouse in a pastel pink trimmed with white lace and is wearing a store-bought black skirt with yellow polka dots, a picture of contrast between "old" and "new." Sylvia takes her place in her hammock, and our interview begins. Sylvia has given birth to 13 children, all of whom were delivered at home with the assistance of her husband and mother. Sylvia followed

Q'eqchi' postpartum warming practices taught to her by her mother after each of her births, taking the time to rest and restore her body. Unlike the women of today, Sylvia did not use the clinic or worry whether she may be "cut."

As the construction outside subsides and our interview winds down, I ask Sylvia if there is anything she would like to share with me that I may not have asked about. Sylvia is quiet for a moment, considering her answer:

> What I have spoken about today are things that happened in my days, when I was young. But now things have changed. In my younger days, our elders had many roles in our community, and they knew a great deal. When they died, they took that knowledge with them. Many things have changed since then. I have shared with my children stories of how we lived in the past, how we cared for ourselves when we were pregnant, and after we gave birth. This was taught to us by our mothers, but this is not being practiced today. Everyone goes to the hospital. Everything is changing, and this knowledge is being lost.

Statements, such as Sylvia's, are consistent with previous findings by Waldram, Cal, and Maquin (2009) in which the younger generation is not necessarily interested in taking up the practices used by their parents and grandparents, particularly in relation to the training of younger *iloneleb'*. Today they are few in numbers, and both the *iloneleb'* as well as local midwives play a reduced role in providing maternal care. Despite older mother's best efforts to educate their daughters and daughters-in-law, the final decision lies with them. As has been demonstrated throughout this thesis some women see the benefits of the midwives and *iloneleb'* while others turn to prenatal clinics and the hospital.

First-time mothers are educated by the women in their lives. For those living at home, this is the responsibility of their mother or grandmother; for those whose parents may not be around, this responsibility then shifts to their mother-in-law. Women are taught what they should and should not do in order to maintain their well-being during pregnancy, which in turn impacts their ability to have a normal delivery and engage in and adhere to postpartum warming practices. Without the social support of a maternal figure, it is not necessarily possible to follow these practices. This knowledge, passed on by the maternal figures in their lives, is taken up, sometimes selectively, and is combined with a woman's own experiences of pregnancy, birth, and postpartum care. By continuing to be active during pregnancy, Q'eqchi' women keep their blood warm and moving, preventing complications during pregnancy and labour and delivery. Individuals who are seen resting are automatically viewed as unwell and unable to work and contribute to their family and community, upon which notions of Q'eqchi' well-being are

centralized (Waldram 2020). This shifts postpartum, when mothers are expected to remain within the home, resting and caring for themselves and their newborn under the care of their mothers or mothers-in-law. Mothers who resume their work too soon after delivery are viewed by the community as not caring for themselves and will suffer the consequences later in life, as we see with Fercia, when they begin experiencing pains in their wombs, backs, hands, and feet. While such practices contribute to a woman's well-being during pregnancy and postpartum, this does not guarantee that they will use these practices.

Q'eqchi' mothers, like Sylvia, have shared their experiences and knowledge with their daughters and daughters-in-law. However, times change, and different services become available, and the decision of when, where, and how to seek care lies with the young women of today. Embedded within this is the ethic of 'non-interference' in which individual decision-making is understood to lie within the autonomy of an individual and not necessarily the collective. This does not mean that group decision-making does not happen; it is just not as common as providing an individual with the agency to decide what happens to them and their body. However, women must now contend with external pressures to use biomedical health services as a result of medicalization in the region.

Biomedical care is now more accessible to the community of Indian Creek than in the past. Today, women seek these services as a result of popular belief that there is a "law" requiring them to use these services or they will face legal consequences in the form of being unable to register their children as citizens. As a result, medicalization has both altered and limited agency to decide what happens to their bodies and when. It is here that notions of risk and decision-making intersect, as fears of blame and liability now inform women's decision to attend prenatal clinic and deliver at the hospital.

Q'eqchi' maternal health knowledge surrounding well-being during pregnancy and the use of postpartum warming remain, for now, in the minds and hearts of those who have remained active during pregnancy, called on the *iloneleb'* and midwives, and who have had the support postpartum necessary to warm themselves. External pressures to use biomedical services combined with the deaths of local *iloneleb'* and midwives have placed constraints on women's access to Q'eqchi' medicine. Young mothers who have not made use of the *iloneleb'* or midwives are reluctant to comment on the services they provide and their intended results. There is a strong value placed on personal experience, and the presentation of hypothetical situations

are met with reserve. Mothers who have not warmed themselves postpartum are reluctant to comment on the benefits as they do not have experience engaging in such practices. This reluctance places Q'eqchi' maternal health knowledge in a precarious state, as knowledge holds the most value when accompanied by personal experience.

So, what does this mean for the future of Q'eqchi' medical knowledge used during pregnancy, birth, and postpartum? Researchers such as Adelson (2000) and Izquierdo (2010) have demonstrated the ways in which the loss of Indigenous knowledge and lifeways impacts the well-being of local communities. For the women of Indian Creek, the use of the *iloneleb'* or midwives during pregnancy serves to restore well-being and prevent complications during labour and delivery. However, as has been shown throughout this thesis, such practices are not taken up by all Q'eqchi' women. This may be due to access to care providers, not experiencing any pain at which point such treatment is viewed as unnecessary, or a preference to use the prenatal clinic. While it cannot be denied that biomedicine does save lives, the routine overuse of invasive procedures such as cesarean sections have far reaching consequences for mothers postpartum recovery and their reproductive futures. Some mothers, such as Marina, are unaware of these consequences until they experience them, but by that time it is too late to make use of Q'eqchi' warming practices to help with postpartum recovery. As communities continue to make use of biomedical services, longstanding Indigenous practices are slowly left behind.

While Q'eqchi' women continue to view pregnancy as a normal process that all women should pass through, the pervasive power of the biomedical model of care is evident, as demonstrated by shifting maternal health seeking within the region over the past 20 to 30 years. There has been a slow erosion of Q'eqchi' women's agency to decide where they deliver. As a result, pregnant women now seek biomedical prenatal and delivery care. This decision is made out of fear for the legal consequences one's family may face if complications are to arise as a result of delivering at home. When further contextualized within the decline of practicing *iloneleb'* and the increased use of biomedicine, Q'eqchi' maternal health knowledge and practices are placed in a precarious position. While it is unclear what the future holds for these practices, it is clear that for better or for worse, everything is changing.

5.2 Recommendations for Future Research

There are several areas that may benefit from further anthropological research in Indian

Creek and within the Toledo District as a whole. While inclusion criteria for this research was left open for family members, such as husbands, to participate, interviews were conducted almost exclusively with Q'eqchi' mothers. With few steady opportunities for work within the village of Indian Creek itself, many of the men were working in other towns and cities, and those who were home were often away at their plantations tending to their crops. As a result, there were few husbands or partners around at the times of my interviews. As my research focuses on maternal health, many of the mothers I spoke with did not necessarily want their husbands to be there for interviews, and I am uncertain if, or how, their answers may have changed if their husbands or partners had been present. As Fercia and I sat down for our interview with Victoria the two of them were laughing; once their laughter quieted they took a moment to let me in on the joke. Victoria's husband wanted to be there for her interview as he had participated the previous year. However, she told him we were talking about women's experiences, things he did not understand and that there was no need for him to be there for the interview. However, future research would benefit from the inclusion of husbands, partners, or boyfriends, as their voices are often absent from research on maternal health.

Also absent from this research is the voice of biomedical health care providers. Future research would benefit from such discussions in addition to participant observation during weekly prenatal clinics at the Big Falls satellite clinic, as well as at the Punta Gorda Hospital. Connected to the use of biomedical health services are the concerning rates of cesarean sections in the region, which are considerably above the recommended global rates of 10-15% (WHO 2005). While this research touches on the local level implications of the increased use of cesarean sections, there is a great deal more to learn on the subject, and it would benefit from further exploration particularly from the perspective of the MOH and biomedical practitioners in the region as well as local families. Cesarean sections not only prevent mothers from engaging in postpartum warming but impact their ability to deliver 'normally' as well as their future fertility.

Q'eqchi' health and well-being and the use of contraceptives is undoubtedly an area in which there is a great deal more for Q'eqchi' mothers to comment on. Contraceptives are now available for free at the Big Falls satellite clinic; however, while they have been taken up by some women, others view their use with suspicion. Some women in the community, as well as the *iloneleb'*, explain that the use of contraceptives can cause women to experience fertility issues, or that women's wombs may become infected as a result. Further suspicion arises around

the use of tubal ligations, as mothers worry their husbands will leave them if they have this procedure done. This opens-up additional lines of questioning as to what happens when a mother has had her three cesarean sections and receives a tie-off and how this impacts her home life and relationship with her partner or husband.

5.3 Final Comments on a Critical-Interpretive Approach

Returning to critical-interpretive medical anthropology as a lens for understanding maternal health, well-being, and decision-making it is possible to reveal "the way[s] in which all knowledge, [health], and illness is culturally constructed, negotiated, and renegotiated in a dynamic process through time and space" (Lock and Scheper-Hughes 1996:43). This is demonstrated in this thesis as we see Q'eqchi' mothers over the past 20 to 30 years respond and adapt to changes in available medical services in the Toledo district and how this has impacted access to knowledge, well-being, and how these changes have influenced the decision-making process. Through critical-interpretive medical anthropology's emphasis on the individual experience it becomes possible to understand the ways in which well-being is constructed and experienced in non-biomedical ways, and to uncover what matters most to those we work with. While as an outsider it is not for me to judge the state of Q'eqchi' maternal health knowledge, I return once more to the words of the mothers of Indian Creek and the *iloneleb'* of the MHAB when they say that 'everything is changing.' As a result, this research serves not only to demonstrate the importance of Q'eqchi' medicine in relation to maternal health, but also stands as evidence of the changes and responses to these changes that have occurred as a result of medicalization and the institutionalization of birth.

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APPENDIX A: Sample Interview Questions for Q'eqchi' Mothers

1. General Questions
    - Tell me a little bit about yourself
    - What is your age?
    - Where were you born?
    - How many children do you have?
        - Where were your children born?
        - What type of services did you access?
        - Why did you choose these services?

2. Case Study/Narrative Questions
    - Tell me about your most recent pregnancy?
        - When did you find out you were pregnant?
        - What did you do when you found out?
        - What types of care did you seek?
    - Tell me about the birth?
        - Where did you give birth?
        - Who helped you?
    - Tell me about after you gave birth?
        - How did you feel?
        - What did you do after giving birth? (Massage? Steam baths? Binding?)

3. On availability and choice of maternal health services? (biomedicine, traditional medicine, home based remedies)
    - Who can a woman see when she finds out she is carrying a baby?
    - Who do you see when you are carrying a baby?
        - When do you use these services?
        - How do you decide who to see?
            - Who is involved in making the decision?
        - What is important to you in choosing a care provider?
    - Do women prefer one type of care over another? Why or why not?
        - Do you have a preference?
    - Do you ever go to a doctor and healer at the same time? Why or why not?
        - Is this something many women do?

4. On traditional knowledge relating to maternal health
    - What traditional knowledge do women have of carrying a baby?
        - What is the source of this knowledge?
    - How is this knowledge used by women in the community?
    - What do you think of traditional medicine?
        - Do you use traditional medicine when you are carrying a baby?
            - If yes, when and how is this used?
                - Who do you see?
                - What is the source of this knowledge?

        - If no, why don't you use these services?
    - Do many women use traditional healing when they will have a baby? Why or why not?

5. On well-being
    - How do you know if a woman is healthy when carrying a baby?
        - What can she do to be healthy?
    - Tell me what it means for you to be healthy when carrying a baby?
    - How do you know if a woman is unhealthy when carrying a baby?
        - What can she do?
    - Have you ever been unhealthy when carrying a baby?
        - What did you do?

6. On risk associated with pregnancy
    - What problems might a woman have when carrying a baby? (physical or spiritual)
    - Have you experienced any of these problems?
        - If yes, what type of care have you used for this problem?
        - If no, what type of care would you use for this problem?
            - Do you know anyone who has had this problem? What did they do?
    - Are there good things about traditional medicine?
        - If yes, what are they?
        - If no, what are the bad things?
    - Are there problems with doctors?
        - If yes, what are these problems?
        - If no, why are there no problems? What are good things about doctors?

7. On treatment – following observation
    - What problem were you having?
    - Why did you choose to see a healer?
    - Have you seen this healer before?
    - How do you choose which healer to contact?
    - How do you feel after being treated?
    - Do you think the treatment helped?
    - Will you need to seek additional treatment?
        - From a healer? From a doctor? Both?

APPENDIX B: Sample Interview Questions for *Iloneleb'* of the MHAB

1. On general and maternal health knowledge
    - How long have you been practicing as a healer?
    - Can you tell me about your training?
    - Tell me about your experience caring for women before they have a baby?
        - How long have you been caring for women who will give birth?
        - Where did you learn this knowledge?

2. On providing care and patient's use of healer's services
    - What types of care do you provide to women who are carrying a baby?
    - How often do you provide these services?
    - When do you provide these services?
    - Is there a difference between what men healers do and what women healers do?
    - Have men always done this? or is this new?
        - Why or why not?

3. On healer's understanding of risk
    - What problems can women face when carrying a baby? (physical or spiritual)
        - What causes this problem?
        - What should a woman do when she has this problem?
        - Is there a treatment?
            - How do these treatments help?
    - What problems can a woman face during birth? (physical or spiritual)
        - How can the mother try and prevent this problem?
        - What should the mother do if they have this problem?
        - How would you treat this problem?
    - What about after the baby is born? (physical or spiritual)
        - How can the mother try and prevent this problem?
        - What should the mother do if they have this problem?
        - How would you treat this problem?
    - Have you ever sent a mother to a doctor?
        - If no, would you send a mother to a doctor? Why or why not?
        - If yes, when have you sent a mother to a doctor, why?
    - How do you know if a mother is healthy when carrying a baby?
        - How can she stay healthy?
        - What should she do if she is not healthy?

APPENDIX C: Research Permit

ISCR
institute for social & cultural research

PERMIT TO CONDUCT SOCIAL RESEARCH

Permit No. ISCR/H/2/73

Grantee:

This is to certify that **Dr. James Waldram** (Principal Investigator of Saskatchewan University) and **Krista Murray** (Co-Principal Investigator, Saskatchewan University) have been granted permission to conduct social research in Belize.

Research Title:

"The changing context of Q'eqchi Maya Healing"

Research Location(s):

Southern Belize

Validity:

This permit shall remain valid from **1 July, 2018 to 31 July, 2019** and shall be subjected to conditions hereunder and to the compliance by the Grantee with the NICH Act.

Conditions:

Permission has been granted by the Institute for Social and Cultural Research under the auspices of the National Institute of Culture and History (NICH) as contained in the NICH Act Chapter 331, Section 71 and 72 (a) Revised Edition 2003, of the laws of Belize. The Act requires the Institute for Social and Cultural Research to review and approve all proposed research involving humans that is conducted in the country of Belize.

Institute for Social and Cultural Research
National Institute of Culture and History
Tel: 822-3307

NICH
national institute of culture and history

APPENDIX D: Ethics Certification

UNIVERSITY OF SASKATCHEWAN

Behavioural Research Ethics Board (Beh-REB)

Certificate of Re-Approval

PRINCIPAL INVESTIGATOR	DEPARTMENT	BEH#
James Waldram	Psychology	05-131

INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT
University of Saskatchewan
Saskatoon
SK

STUDENT RESEARCHER(S)
Krista Murray, Rachel Phillips Hall

FUNDER(S)
SOCIAL SCIENCES AND HUMANITIES RESEARCH COUNCIL OF CANADA (SSHRC)

TITLE
Maya Healing in Contemporary Context

RE-APPROVED ON	EXPIRY DATE
10-Jan-2018	09-Jan-2019

Delegated Review: ☒ Full Board Meeting: ☐

CERTIFICATION
The University of Saskatchewan Behavioural Research Ethics Board (Beh-REB) is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2 2014). The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS
In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month prior to the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: http://www.usask.ca/research/ethics_review/

on behalf of the
Behavioural Research Ethics Board
University of Saskatchewan

Please send all correspondence to:

Research Services and Ethics Office
University of Saskatchewan
Room 223 – Thorvaldson Building
110 Science Place
Saskatoon, SK Canada S7N 5C9