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Medical Pluralism in a Neoliberal State: Health and Deservingness in Southern Belize

by

Douglas Carl Reeser

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy Department of Anthropology College of Arts and Sciences University of South Florida

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Keywords: ethnography, health care, traditional medicine, neglect, Caribbean, anthropology

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List of Abbreviations

BCVI – The Belize Council for the Visually Impaired

BHIS – Belize Health Information System

CHW – Community Health Worker

CSO – Central Statistical Office

GOB – Government of Belize

IDB – Inter-American Development Bank

IFI – International Financial Institution

IMF – International Monetary Fund

MOH – Ministry of Health

NGO - Non-Governmental Organization

NHDAC - National Human Development Advisory Committee

NHI - National Health Insurance

PAHO – Pan American Health Organization

P.G. – Punta Gorda

QHA - Q'eqchi' Healers Association

WHO - World Health Organization

Abstract

This ethnography explores the varied contours of a national health care system and how it is used in conjunction with traditional forms of health care in Toledo District, Belize, focused on the largest town of Punta Gorda (P.G.), In a medically plural environment, a variety of health care options are used based on a wide range of social, economic, and structural factors that shape people's choices and decisions. The convenience of and experience with low-cost home- and self-care options make these the most common first choice during an illness event in P.G., however a deeper exploration of health behavior reveals that people will exhaust all options in their quest for health. In an era when neoliberal trends have a direct effect on people's lives, including a negative impact on health and well-being, Belize stands out as an interesting case. The small Central American/Caribbean nation has taken actions that appear to be contradictory to broader neoliberal policies that encourage privatization of government services, by implementing a national health care system that provides low-cost and free health services to its citizens. While new health facilities have been opened, and health services have become more widely available throughout Belize, an analysis of how and why the health care system functions shows that such programs may actually function as mechanisms of control and surveillance, thus aligning with neoliberal aims such as decentralization and privatization of services. As it has been implemented in southern Belize, the national health care system also replicates and extends an historic trend of marginalization and neglect to the region, showing that from the perspective of the State, and by extension, the powerful and elite of the nation, the citizens of P.G. are seen

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as less deserving of the quality of health care services that are necessary to lead healthy and productive lives.

Chapter 1

Introduction: Health Services in Southern Belize



Figure 1. The Punta Gorda Polyclinic. Photo by the author.

"The clinic?" asked Emeni, a young Garifuna woman in her 30s, when I queried her about her experiences in the Polyclinic and with the State-provided health services in Punta Gorda. "Well, at least it's cleaner now!" she said laughing. "But seriously, you can go and you will stay there all day to see a doctor for three minutes. You end up just waiting and waiting. One time I went and I saw a doctor, and he treated me completely different than he does at his own private clinic. That's not right. You should get the same service – he's getting paid, right?"

She continued, "They need improvements there. With the people, the nurses, they need more PR. They're not good with people. And they need more equipment. They can't do anything here for you. If you need lab results or lab testing, you have to go there. Nowhere else does these types of things. They're iffy at the hospital. Because if I go and get a test and take it to the doctors, they have trouble reading it. You can do the same test twice, and they'll read it different each time. They're doing some of this lab work manually, and that's a big problem. And I've seen people leave the lab with some pretty serious bruises. I'm like – you got that here? That's scary – they don't really know what they're doing. Or they don't care."

"This sounds like a problem," I interrupted when Emeni paused for a breath.

She went on, "I mean, they give their medicines out in a bag. You don't know if they're expired or what, and maybe that's the point. If they're in a bag, nobody knows. Maybe they're just working with what they get, but there's other things too."

"They have no PR at all," she said, referring to the poor quality of overall service she has received at the Polyclinic. "They just treat people wrong. Half the time you can't understand what they're saying, and they act like they don't even listen to you. I just try not to go there."

At the end of our interview, I asked Emeni if she had anything else she wanted to add concerning any of the topics we covered.

She decided to drive home some of her points about the State health services. "The way they treat people is not right. They need to really work on their PR. If you're sick, you don't want to be treated like you're just there for a visit, right? You need to be there, you don't want to be there, and you want to be treated with some kind of respect. And I mean, maybe they need to

improve the training. Anyone can go get the nurse's degree, but that doesn't mean they're the right person to treat people. They need to make sure the people working there know how to treat people right – with respect."

Emeni's last statement summed up what many people I had interviewed thought about their local hospital and polyclinic: "Most of the time, people don't even want to go to the hospital, and they wait and wait, refuse to go, and they just end up dying. They don't want to go there and then their business is all over the street. There is no respect there, and it's not private, and they don't always know what they're doing."

Introduction to Punta Gorda and the Belize Health Care System

The small Central American-Caribbean nation of Belize has a national health insurance program that aims to provide "equal health for all" through a network of rural health posts, polyclinics, and hospitals. This system, the result of a complete overhaul to the national health system in 2009, provides health care services for free or low cost for Belizean citizens. The new health system builds on an earlier national health care system that was instituted at the nation's independence in 1981, which itself was an extension of the British colonial health system. Throughout the colonial period and continuing today, the government has provided the vast majority of "official" health care in Belize, with poor, limited, and inadequate care being the hallmark of government health services.

The new health system is an attempt to better organize and streamline the health care provided by the State, and by most accounts, accessibility has improved over the past few years, as some new health posts and polyclinics have been opened. Operated by the Belize Ministry of Health (MOH), the health system is well regarded internationally, however, in the southern-most

region of the country, the reputation of the State health services is more akin to those expressed in the above interview.

Situated at the far end of Punta Gorda, which most everyone calls "P.G.," the capital town of the Toledo District, at the terminal stop of the regional bus line, is the southern regional health complex. The complex of government buildings faces the Caribbean Sea, but the potentially spectacular view is blocked by a run-down cement building that houses the Red Cross. Its location next to the cemetery, an irony the builders could not have foreseen, only adds to the poor reputation, and the bright turquoise-green paint on the exterior of the utilitarian cement block buildings attempts to brighten what is generally seen as a place to avoid. With the creation of the National Health Insurance (NHI) program in 2009, existing health facilities throughout Belize have received mostly minor improvements and some new facilities have been built. The few recent renovations on what was formerly the P.G. Hospital, and an attempt to improve the effectiveness of the system have done little to change the reputation of the MOH health services: go at your own risk.

Perhaps because of the poor reputation, perhaps due to the lack of biomedical¹ alternatives, or perhaps because of the persistence and strength of local cultural traditions, residents of P.G. often turn to alternatives to the State health services. There are a handful of physicians with private practices, although all of the general practitioners in these offices are either current or past employees of the MOH. Still, if they can afford it, most people prefer the

¹ Biomedicine is used as the term to describe the medical system that originated in the West and is based on scientific theory and method. Today, biomedicine is practiced in clinics and hospitals around the globe, and in much of the world is the official form of health care supported and delivered by the State. It should be noted that despite a common origin, biomedicine takes on unique qualities in every locale in which it is practiced. Because of its roots in Western scientific thought, biomedicine is used interchangeably with Western medicine in this report (Womack 2010, Joralemon1999).

private clinics, where there is little to no wait, and the doctors reportedly offer more personal attention than is received at the Polyclinic. None of the private or State clinics offer any specialist services, which limits their utility to certain health problems. The two local pharmacies are a popular choice for medical advice and medicines when people can afford this option, however, while they are health professionals, the pharmacists are not trained physicians. Outside of the local biomedical paradigm, many people turn to traditional home remedies and local traditional healers.

In P.G., the local or traditional health practices², what residents of Toledo often call "bush medicine," is based on plant-derived medicines, mostly passed from older generations to younger generations, although some older healers have gone through intensive training in Belize and Guatemala. They take two general forms: home remedies that are often a first choice for non-emergency situations, and traditional healers, most of whom use plant-based remedies combined with some form of psycho-spiritual component in their practice³. These practices vary across ethnic groups, as Q'eqchi', Mopan, Garifuna, East Indian, and Kriol have distinct histories and traditions from which to draw. While these groups currently share P.G. in time and space, the influences of history, experience, and tradition have served to maintain somewhat distinct

² It should be recognized that "traditional" is a contested term that has been criticized for implying that something is static and from the past. In this paper, I use "traditional" to describe varied lifeways and healing methods that are not rooted directly in Western scientific and philosophic traditions. Instead, something described as "traditional" can be viewed as rooted in some specific non-Western historical trajectory that has changed and adapted over time to various local and global pressures. For instance, in the case of Belize, there are Maya, Garifuna, and East Indian (among others) traditional approaches to health care and subsistence. This term is also used by local residents to refer to their knowledge and practices, and so I use the term here.

³ In many traditional healing systems, there is a psycho-spiritual aspect to treatments. Trained healers often combine the use of herbal remedies with prayer and symbols which can add a psychological aspect to the treatment. In addition to physical ailments, traditional healers also treat psychological and spiritual problems (Womack 2010).

practices today. All of these elements, from the biomedical to the traditional, can be seen as what constitutes the health system in P.G. For most people in P.G., these various traditional practices are used in complex combinations with the multiple aspects of the available biomedical system. This research investigates how households across ethnic groups in P.G. negotiate these varied aspects of the health system.

In order to understand how people use and negotiate a given health system, the contours of that system must be defined and understood. In a sense, a health system is practiced, with each component of the system, from providers to patients, carrying out their role in an attempt to promote health. One of the first goals of this research was to understand the health system in P.G. as it is practiced by the variety of actors that comprise the medically plural system. Local doctors and other biomedical health practitioners practice health care in a way that is shaped and driven by local resources, needs, and perceptions. Herbalists and traditional healers practice health care that has roots in local cultural traditions that are a foundation for its knowledge and use. Finally, the community, the people that make P.G. and the Toledo District their home, practice health in distinct ways, driven by multiple factors, including cultural traditions, economics, health beliefs, what services are actually available to them, and more. Drawing on previous studies of medical pluralism, I show that despite limitations to most aspects of the available health system, people in P.G. exhaust all possible avenues in their quest to get healthy.

The Belize health system as a whole has many components, especially in the southernmost Toledo District; the Belizean State practices health through the MOH and its National Health Insurance (NHI) program, which manifests itself uniquely in the Toledo District. This State health system is shown to be in line with the neoliberal policies promoted by international actors such as the World Bank (Harvey 2005), which has real effects on the health

of Belizean citizens, especially in the south. Following this discussion, issues of deservingness and neglect are explored through the ways that the State provides health services to the historically marginalized populations in southern Belize.

Statement of Problem: Health Care in Southern Belize

Indigenous and rural peoples throughout Latin America and the Caribbean continue to live in marginal conditions and increasingly face disparate health problems compared to other populations in the region (Gracey and King 2009, WHO 2007, Stidsen 2006). For many groups, traditional means of subsistence and livelihood are either no longer possible or are increasingly threatened. The diverse economic pressures brought on by the many facets of globalization and neoliberal economic policies have combined to place many indigenous people in marginal spaces where health and health care are rarely available or difficult to maintain. This research investigated how the diverse population of the town of Punta Gorda (P.G.) in the Toledo District of southern Belize negotiates the multi-faceted health care system that exists in the region. I explore how factors such as ethnicity, identity, and politics shape the health system and how it is used.

The State health care system in Belize is similar to those found elsewhere throughout the world, yet it differs in important ways. The national health care system, particularly the health surveillance system run by the MOH, is internationally lauded, there has been a very limited third-sector (NGO) response to health service gaps left by the State, and traditional forms of health care remain widely used and practiced. These unique characteristics make it an ideal place to pursue research on how a diverse population manages health care in a context that intersects

with global trends toward State provided care and efforts to assure the continuity of indigenous health care practices.

While Belize has undergone neoliberal reforms (Zarger 2009), decentralization is not as pronounced as in other countries in the region, especially in the health care sector, wherein civil society organizations such as NGOs have only minimally expanded, and privatization of health services has only begun in the economic center of the country. In this context, it is thus necessary that the contours of this system be identified, with the aim of understanding the distinctive characteristics that shape the response of the State to the health care needs of the diverse population of P.G. How and why does this population utilize the various elements that make up the entirety of the health care system? What role do the State, NGOs, and other private sector service providers play in such a system? The result is a better understanding of how rural and indigenous populations manage their health in a neoliberal context, and further, an uncovering of the influence of the State on peoples' health care options and utilization.

In much of Central America, the State has historically provided health services; however, by the 1990s, State health systems throughout the region were feeling the pinch of economic struggles and reforms and, in turn, reduced funding for their services. As State-sponsored health care became increasingly difficult to obtain, a niche was opened in which NGOs could provide such services (Cardelle 2003). In fact, transnational and local NGOs have begun to fill such service gaps, especially in terms of health services, for poor and other marginalized populations, including indigenous communities. For instance, in Guatemala, USAID (2010a) reports that they help fund over 100 NGOs working with the Ministry of Health to provide health services to more than 3.5 million indigenous people throughout the country. This has become common in much of

Latin America, as health care and promotion have become one of the primary foci of NGOs that operate throughout the region.

However, the proliferation of transnational and local NGOs providing health services has not occurred equally throughout Latin America and the Caribbean. In Belize, health-related NGOs remain somewhat of a rarity, especially outside the major urban center of Belize City. The Ministry of Health (MOH) in Belize is the primary provider of health services for the country, and oversees regulation, financing and health service delivery throughout the state. Many of the efforts of the MOH have been focused on the urban centers of the country, leaving the rural districts inadequately served, a historical relic of previous national health care efforts that continues to this day. In fact, the Pan American Health Organization (PAHO 2010) specifically notes that access to health care is of particular concern in the rural southern district of Toledo. According to the Belize Ministry of Health, Belizeans living in the Toledo District, where 79 percent of the population lives in poverty, experience some of the worst health outcomes in the country (MOH Belize 2009). Besides mission-based programs that visit the district to provide some health services at various times of the year, the only NGO working in the health service sector is the Belize Council for the Visually Impaired (BCVI), which restricts its focus to eye and vision services. The Toledo district thus remains an example of the failure of not only the State, but also of the third sector, which includes NGOs, in adequately satisfying the health care needs of the population.

Related to the poor quality and limited biomedical services in P.G. and the Toledo district, many residents display an open distrust of the State health services, and continue to rely on traditional healers and other alternative treatment options, such as individual and family selfcare (e.g. generalized or non-specialist healing practices). Such traditional health services not

only supplement the poor services provided by the State, they also care for conditions that are not always treatable by biomedicine. Locally available plant-based medicines and the ability of traditional healers to address health issues that are not purely physical are among the many reasons why people continue to turn to traditional practices. Indigenous and traditional healers remain active throughout the district, and some have organized in efforts to strengthen and maintain their traditional healing knowledge (Amiguet et.al. 2005). Still, despite the presence of such healers, limits remain to the quality and type of care they can provide.

In this context, residents of P.G. and the rural Toledo district must negotiate this terrain of health care services in an effort to obtain not only the best possible care, but also the care most appropriate to their given circumstances. This "blending" of health care systems has been documented in many U.S.-based immigrant populations, and has been noted in some indigenous populations wherein biomedical clinics and hospitals provide alternatives to traditional practices (Heckler 2007, Menjivar 2002, Nigh 2002, Ito 1999, Nachman 1993). However, it remains unclear how diverse ethnic groups and indigenous people living in a zone such as the Toledo District, with reported high rates of poverty and poor health (PAHO 2010), and limited health care options, negotiate and utilize such a plural system, especially when such a system appears to be lacking in its ability to fully satisfy the health care needs of the population.

Global trends toward the expansion of neoliberal policies that often lead to the outsourcing of service provision are having a direct effect on peoples' quality of life. The effects of neoliberal policy have been shown to increase inequality within nations such that a corresponding increase in health disparities has resulted (Coburn 2003). This study aims to examine a context wherein neoliberal policy has not led to the successful growth of third sector service provision in a zone where historically marginalized populations are left to negotiate a

limited but multi-faceted health care system. The main objectives of this study were to: (1) Examine the historical roots and contemporary forms of the Belizean State health care system with a particular focus on the gaps in the provision of health services to the diverse populations of Punta Gorda Town; (2) Research the content and practice of alternative and traditional medicines in P.G. in an effort to understand the range of health services that residents utilize; (3) Understand how the various ethnic groups of P.G. experience the terrain of health services that are available, and how they perceive their interaction with such a system affects their health.

In the remaining sections of this chapter, I will introduce the key concepts that will be used to interrogate the findings of this research. Through the framework of medical pluralism, I examine how biomedicine has risen to the top of a global health hierarchy and how that placement has served to legitimate certain health systems and practices over others. Following that discussion is an introduction to theorizing about the State in general and an exploration of its historical role in providing services to citizens, particularly in Belize.

Medical Pluralism and the Hierarchy of Health Systems

As the process of globalization continues to spread the products and practices of capitalism, science, and the "developed" world to all corners of the globe, many expected an increasingly homogenous world as a result. This, of course, is not exactly what has happened (Tsing 2002). Instead, we find the growth of pluralism and creolization, wherein people incorporate global products and practices into their everyday lives in unique and novel ways such that the global becomes blended with the traditional and the local. In Belize, the Caribbean, and elsewhere around the world with colonial histories, the process or creolization has resulted in the blending of languages, religion, food, and other traditions. Despite contention, resistance, and

friction, this ongoing process continues with the increase in global flows of ideas, goods, and people (Wilk 2006, Tsing 2005).

This blending or pluralism can be seen in any number of cultural settings and activities, but has been especially prevalent (and increasingly documented) in the arena of health and health care. Crandon-Malamud offers a very simple definition of medical pluralism: "The concept of medical pluralism refers to an environment in which there is more than one medical tradition" (Crandon 1986:473). This definition, however, obscures the complexity of the concept, as well as the fact that a region, culture, or community scarcely exists, except perhaps the most isolated locations, that does not have some form of medical pluralism at play in their health system. With the implementation of the State system, and the increasing influence of globalization, societies today experience an array of medical systems that coexist in time and space, although not always complementary or equally, thus making medical pluralism the norm around the globe (Baer 2003).

Medical pluralism exists, most simply, because the means through which various cultures have addressed health and illness have varied through time and place around the globe, and innumerable distinct medical systems have arisen in various cultural contexts. Some well-known examples of alternative medical systems include Traditional Chinese Medicine, developed and utilized through much of East Asia, Ayurveda, an ancient medical system of the Indian subcontinent, not to mention the numerous traditional medicines and other ethnomedicines that exist around the globe. Ethnomedicines have been defined as medical or healing systems of any particular group that is different than Western biomedicine (Ericson 2008). However, biomedicine can also be seen as an ethnomedicine, having developed out of the specific Western scientific worldview, and out of a uniquely Western culture (Leatherman 1998, Erickson 2008).

Still, biomedicine remains unique in its domination of the rest of the world, increasingly becoming the basis of many nations' standard health system (Leslie 1980, Erickson 2008). Anthropologist Charles Leslie explains that medical systems "vary from one part of the world to another according to the family structures, religious, economic and political institutions of the regional and national societies in which they are located" (Leslie 1980:191). This holds true for biomedicine as well, as it often takes on the unique characteristics of its local context, resulting in distinctive biomedicines from region to region (Crandon-Malamud 1991). Still, a commonality that all medical systems share is the relationship between the healer, a knowledgeable expert in any given system, and the patient, who is ill, sick, or suffering in some way (Baer 2003). While biomedicine has been afforded special status around the globe, alternative medicines persist and thrive, giving rise to a largely medically plural world.

The importance of alternative medicines has long been recognized by anthropology; however, they have not always held equal status as Western scientific biomedicine. Ngokwey (1988) characterizes much of anthropological research on non-Western medical systems as rooted in evolutionism that posits Western science and biomedicine at the top. Thus, non-Western medical systems are categorized as based in religion or the supernatural and somehow less rational. Early anthropological investigations into indigenous and traditional medical systems were typically guided by an assumption that such systems were largely alike and homogenous in practice, belief, and behavior (Cosminsky 1983). They were also held to be separate from biomedicine; thus, early examinations of medical pluralism typically sought to develop a typology of systems, so as to be able to classify a health system and place it in the popular hierarchy of medical systems, which has historically held biomedicine (or Western medicine) at the top.

One example of such a hierarchical ordering is that of anthropologist Frederick Dunn (1976), who created three main categories for health systems: local, regional, and cosmopolitan. A local system is of the smallest scale, and is common in rural and indigenous communities, and contains "folk" or indigenous health systems. A regional system is present in larger geographical areas, and includes the like of Ayurvedic and Traditional Chinese Medical systems. Finally, the cosmopolitan system is present on a global scale, and consists of the multiple aspects of biomedicine. If perceived as bounded systems, Dunn's categories are adequate for most health systems around the globe. However, as noted above, health systems vary greatly by context, and within any given context, multiple medical systems exert influence on each other in unique ways (Belliard and Ramirez-Johnson 2005). Further, as will be seen, this type of categorization does not represent the way people blend and utilize multiple systems concurrently in their daily lives.

A similar typological system has been proposed to explain medical pluralism, and consists of the popular sector, the folk sector, and the professional sector (Kleinman 1980, Chrisman and Kleinman 1983). In this typology, the popular sector includes the self (for selftreatment), families, friends, and others in the social network of the sick person. The folk sector includes informal healers, including shamans, midwives, herbalists, bonesetters, and the like. The professional sector includes health systems that have been professionalized, including not only biomedicine, but also systems such as Ayurveda and Traditional Chinese Medicine. This typology remains popular across disciplines, and reflects a more patient-centered view of health systems. Such typologies, however, remain limited in their ability to explain not only how people negotiate health care options, but why, and what factors play a role in the decision making process.

Scholars have also begun to more carefully consider power and inequality when analyzing health systems (Brodwin 1996, Baer 2003), which has brought to the fore analyses of how and why biomedicine has become a dominant system around the globe. Anthropologist Charles Leslie (1980) details how nations around the world have aimed to standardize their medical systems so they are all linked to national and international standards and practices through biomedicine. "Efforts to increase the scope and to improve the quality of health care have sought to eliminate or severely restrict 'irregular practices,' so that ideally local medical systems will simply become extensions of a nationally and internationally standardized medical system" (1980:191). He notes that as of 1980, only China had incorporated a traditional medical system (Chinese Medicine) into the state sanctioned system. However, in China, as is the norm elsewhere, numerous traditional practices remained unsanctioned and outside the system, all the while maintaining high rates of utilization, epitomizing a medically plural context. Leslie's is but one example of how biomedicine remains on top of the medical hierarchy around the globe. Thirty years later, this hierarchy has remained, and perhaps become more deeply entrenched, as Baer explains: "Medical pluralism in the modern world is characterized by a pattern in which biomedicine exerts dominance over alternative medical systems" (2003:45).

However, this dominance has always remained contested, such that medical pluralism has become the norm in people's lives (see Goldstein 2004). The increase in the use of alternative medicine in the U.S. and around the globe has served to "challenge the biomedical profession's previous assumption that a single biomedical system defines our society's health care" (Kaptchuk and Eisenberg 2001:189). The biomedical profession is increasingly accepting medical pluralism, but apparently because their patients leave them no choice: "People frequently adopt multiple healing practices even when biomedicine is generally available"

(Kaptchuk and Eisenberg 2001:189). This attitude from the biomedical perspective has persisted at least in part because of the system's primary focus on the biophysical aspects of health and healing, while ignoring other more holistically-based aspects important to many patients.

Despite these more recent developments, alternative medical systems have not always held the respect of biomedical practitioners or other scholars. Ted Kaptchuk and David Eisenberg (2001), both medical doctors, describe the evolution of the U.S. medical system, including the divisive relationship between biomedicine and other medical systems that were present throughout the country's history. "Just as regular medicine often upheld dominant cultural assumptions, unorthodox healing often became a badge for social activism and religious dissent" (2001:190). They illustrate how throughout history, the medical system that one adheres to reflects a wider social identity of that person. Whether forced or welcomed is left unsaid, but the shift occurring in biomedicine is based on more of a partnership with alternative medicines, and includes university medical programs, professional journals, pharmaceutical companies, and government funding agencies. Also left unsaid is which alternative medicines are being accepted, and which are being left outside of the acceptable biomedical paradigm, likely leaving many alternative systems further marginalized.

While alternative medicines have become more accepted by some biomedical practitioners, scholars have sought to understand the reasons behind their high utilization. Leslie (1980) notes a major shortcoming within biomedicine, which may offer one explanation for the persistence of alternative medicines. He explains that biomedicine deals with the biological reality of an illness, but does not address the other social realities and experiences that accompany illness. The widespread need for the treatment of these social aspects of an illness, then, generates the need for alternatives to biomedicine. He further explains how biomedicine

does not treat certain illnesses or certain populations effectively, often due to more complex conceptions of health and illness then biomedicine accepts. Medical pluralism, then, is an essential aspect of any medical system, even those where biomedicine is most entrenched, and especially in resource poor and developing nations. "Medical pluralism is not a phenomenon of social enclaves in our own society but a structural characteristic of the whole system" (Leslie 1980:193).

Hans Baer (2003) expands on the idea that medical pluralism reflects the hierarchy present in the society being examined. "Patterns of hierarchy may be based upon class, caste, racial, ethnic, religious, and gender distinctions. Medical pluralism flourishes in all class-divided societies and tends to mirror the wider sphere of class and social relationships" (Baer 2003:44). Thus, in a context with high rates of poverty, and where biomedicine rests atop the medical hierarchy, it can be surmised that those ranks of poor not only have limited access to the biomedical system, they rely more heavily on other alternative systems that fit into the popular and folk typologies (see also Frankenberg 1981). Thus, medical pluralism remains vital, in part, to fill the gaps in health care that biomedicine is unable to reach.

An examination of specific examples of medical pluralism can reveal the hegemonic position that biomedicine has achieved for itself, even in contexts where alternative systems also thrive. Broom and colleagues (2009) examine the experiences of cancer clinicians in postcolonial India, where despite a State-sanctioned medically plural system, biomedicine remains at the top. In India, "traditional medicine and systems of knowledge may on the one hand be celebrated as indigenous forms of knowledge to be cherished and actively promoted by the State, and yet, in many Indian contexts, biomedicine has achieved hegemonic status, framing illness and determining institutional credibility" (Broom et.al. 2009:698). They further explain the role of

the State in shaping the medically plural nation: by choosing what traditions and even what aspects of those traditions are to be sanctioned, they in turn marginalize other traditional systems while helping to shape those aspects of medicine that in general should be protected or discouraged (2009:699-700). Still, as Baer notes, biomedicine has never had complete dominance over other medical systems, explaining: "The State must periodically make concessions to subordinate social groups in the interests of maintaining social order and economic productivity" (2003:46). The concessions of the State then, occasionally lend legitimacy, if not legal rights, to alternative health systems; however, biomedicine has continued to maintain its spot atop the medical hierarchy.

Deeply entrenched feelings of the superiority of biomedicine exist among practitioners as well as the State and other institutions. Broom and colleagues (2009) report that when asked about their experience with alternative medical systems, clinicians tended to tell horror stories or recall negative experiences. They concluded that the plural system in India was accepted as reflecting the variety of contemporary Indian identities; however, the traditional systems were not perceived to be working in harmony with biomedicine, and were thus somehow at fault or even ineffectual. Further, clinicians viewed patients that utilized alternative systems as uneducated and/or backwards, while, in fact, many such patients are either from more traditional rural villages or economically marginalized. "Medical pluralism, while reflecting important richness in cultural knowledge and practice, emerged as inextricably linked to forms of social inequality and suffering" (Broom et.al. 2009:704). While the plural health care system in India reflects the complexity of social life there, it also reveals the economic inequality and associated restraints that also exist. "This intermingling of identity, culture and medicine necessarily shapes hierarchies and dynamics between professional groups and systems of medicine" (Broom et.al.

2009:699). In this critical view, they conclude that the push for pluralistic medical systems in developing contexts ignores the larger social/structural problems that affect health, health care, and access to that care. In addition, by promoting a pluralistic system, the State is able to trump their inclusion and acceptance of tradition while at the same time, valorize their efforts to modernize through the biomedical system. Thus, by promoting pluralism, the official recognition of alternative medicines satisfies the need for access to care, but masks very real social and economic constraints to access that still exist.

Scholars outside of anthropology have also recognized the complexities of medical pluralism; however, biomedicine often remains framed as dominant – at least from the researchers' perspective (Hunt et.al. 2000). For example, Beliard and Ramirez-Johnson (2005), from Public Health and Psychology respectively, explain that immigrants in the U.S. resort to folk and traditional health resources mainly because of restricted access to biomedical services. They utilize Kleinman's typology (1980) in their case study of a Mexican woman in California, which they use to illustrate how a medical system is uniquely blended and individualized based on various social and economic factors. They show that the use of the popular or folk medical system satisfies health needs, and also offers a sense of cultural identity (2005:281). The primary point of their study is to reveal how immigrants who utilize a pluralistic approach to health and healing see their health care options differently than do biomedical practitioners. While comparatively less complex then other investigations on pluralism, studies such as these remain common and relevant, as biomedicine in the U.S. continues its struggle with different approaches to health.

Even if medical pluralism has been accepted as an integral part of the medical hierarchy, biomedicine has maintained its push for dominance. Wentzell and Salmeron discuss the

medicalization of impotence and the resulting clinical and public health focus on impotence "as a biological problem with a pharmaceutical solution" (2009:1760). Medicalization of conditions such as impotence "fails to account for men's lived experiences of choosing a treatment, a social act in which they weigh various options in light of their particular economic, political, cultural and interpersonal contexts" (2009:1760). Their conceptualization of treatment choice highlights the plurality of factors that go into decision-making concerning health conditions. The authors highlight the tendency of the push behind such medicalization to ignore alternative treatments, thus marginalizing not only those types of treatments, but also the patients who may choose to use them. Despite the claims of increased partnership between biomedicine and some alternatives, the association of biomedicine with the West and the elite has served to maintain its position at the top of the medical system hierarchy.

This positioning of biomedicine has been aided by critics, especially from the biomedical perspective, who have questioned the efficacy and safety of alternative and traditional medical systems (WHO 2002). Waldram (2000) addresses the issue of efficacy of traditional medicine as perceived by Western researchers, as well as the lack of a consensus of efficacy by those Western scholars. He states that there is no definitive way to determine efficacy, except when including all of the various perspectives of the actors involved in a given healing episode. The differences in perceptions of health and healing that are not acknowledged by biomedicine make comparisons weak at best, and judgments by biomedicine on efficacy to be pointless. In other words, approximations are not necessarily valid means of gauging a medical system's efficacy. He speaks of the biomedicalization of traditional medicine and how this further compounds efforts to determine efficacy, specifically noting that failure must be a part of traditional medicine in the sense that it spurs new knowledge and the perfection of the tradition.

Waldram (2000) also problematizes the concept of efficacy in terms of the time frame in which efficacy can be determined – right after a treatment, two days later, two weeks, two years? Social aspects of traditional healing raise the issue of whether healing is only about the individual, and if not (as in the case in most traditions), how can we determine efficacy of a social healing? Waldram explains the effects of biomedical hegemony in the sense that it has set the standard by which to judge the efficacy of traditional medical systems, despite the operation of these systems outside of the biomedical paradigm. Further, biomedicine has in effect, become an arm of the state and enjoys its protection and support – both institutional and financially. Such support further marginalizes traditional medical systems and puts into question the ability (or desire) of such a system as biomedicine to truly uncover efficacy.

Other scholars have also defended traditional medical systems. Alves and Rosa (2007) link traditional medicine to biodiversity and the wider biotic environment through the former's deep reliance on the surrounding environment for its pharmacopoeia. They claim that 80% of the world's population relies on traditional medicine as their primary form of health care, thus making the discussion of such links vitally important. The impacts of environmental degradation and biodiversity loss are detrimental to human health and well-being. Healthy environments can lead to better health for poor populations with ethnomedical traditions, and conversely, continued destructive changes to the natural environment are likely to result in poorer health for all. The continued transformation of ecosystems is constraining the availability of many plants and other resources commonly used in traditional medical practice. They underscore the importance of preserving ecosystems by noting that over 50% of commercial drugs have been derived from natural resources, most of which were initially used in traditional medicines. These and other studies (see for instance Balick and Mendelsohn 1992) highlight the importance and depth of

knowledge of many traditional medical systems, emphasizing the value in maintaining and revitalizing such traditions.

Still, traditional and alternative medicines remain marginalized in much of the world, and, with few exceptions, biomedicine is the system promoted by the State. Such is the case in Belize, where the MOH has yet to survey the many traditional and alternative medical practices found throughout the small country. And while the MOH aims to provide access to health care for every one of its citizens, it is a very specific health care they are advocating, which happens to be biomedical. When the State is the primary actor in the provision of health services, and those services are limited to a very specific type and system of care, there arises the need to understand what the effects of such a situation are, both on the alternative medicines that exist, and on the people who are encouraged/forced to use the system that the State is pushing.

The insights generated through this research and presented here are the result of my own relationship with P.G. that began in 2007 and continues to the present, as described in Chapter 2. My own history with this place, and with the people that call it home, played an important part of the process as did the many hours of interviews, observations, and participation in daily activities. As is the case with any ethnographic or qualitative research, it is a unique set of historical circumstances that places the researcher in the position to study particular topics in particular places. Throughout the dissertation, I consider my own positionality, along with the methods employed during the research and ethical considerations as I present my analysis.

In order to understand the effects that a particular health system has on a population in southern Belize, I examined how households in P.G. managed their own health care. In a medically plural context like that which exists in P.G., households and individuals can choose between multiple options when in need of health care. Chapter 3 explores the ethnic plurality that

exists in P.G., bringing to light how varying historical and contemporary experiences may influence how health care decisions are made. Chapter 4 details results of household interviews about how people manage their health care decisions across ethnic groups. With a clearer picture of the everyday health practices of an ethnically plural population in a medically plural environment, Chapter 5 revisits the concept of medical pluralism and shows that despite medical hegemony or quality of various treatment options, people tend to use all of the options available to them in their quest to regain health.

The State, Health, and Deservingness in Southern Belize

Following political scientist Ralph Miliband (1969) and historical sociologist Philip Abrams (1988), among others, this research is grounded in the idea that there is no entity called the State in the sense of a concrete institution that can be studied. The State is a construct that is reified so that it has a symbolic identity and creates a popular illusion in the public mind. There is, however, a state-system, and a state-idea (or ideology), that can be studied in relation to each other and other forms of power. Further, the State system is carried out and operationalized through government and government agencies. In this study the State is being analyzed through the actions and practices of one of its agencies, the Ministry of Health of Belize (MOH).

Drawing on scholars of the State such as Althusser (2006), Foucault (2006), Gramsci (2000, 2006), and Marx (in Tucker 1978), the Belizean health system as operated by the MOH, especially in P.G. and the Toledo District, can be seen as an educational apparatus of the Belizean State. The health system with its referral protocols, and as the only officially recognized medical system in the country, educates the citizens of Toledo on how to properly care for themselves. Patients must see the correct clinics in the correct order based on how they are

referred. In this system the official discourse does not include a place for traditional medicine or traditional home remedies. In this sense, by essentially ignoring alternative health practices as if they do not exist, the Belizean health system effectively promotes and reproduces the ideology of the ruling class and elite of Belize and beyond. This is ideology rooted in the historical legacy of colonialism from the days under British rule, and reflecting the more recent U.S. influences (Shoman 2000), that largely champions biomedicine as one of the great achievements of Western science, and thus at the apex of the world's many medical systems (Clarke et. al. 2010).

Additionally, the motivations and execution of the MOH health system is not limited to the Belizean population. As will be shown in Chapter 6, the ideology behind the directives of the MOH extend beyond Belize's borders, and are in fact international in scope. From the historical influences of colonialism and globalization, and through the imposition of neoliberal policies and large-scale funding from international banking institutions, the health system in Belize has become a mechanism through which a global elite has gained influence on one of the more remote populations in Central America. By funding the national health care system in Belize, and in turn the promotion of biomedicine, the international interests of International Financial Institutions (IFIs) such as the Inter-American Development Bank are promoted and reinforced, alongside of the interests of the politically-connected wealthy elite of Belizean society.

In Chapter 7, the concepts of deservingness and neglect as realized through the State health system are explored (Dorman 2007; Willen 2012). Are the people of P.G. and the Toledo District considered deserving of quality health care in the eyes of the Belizean state? I will demonstrate that the health system of the MOH is used as a mechanism that at once shows itself to be of benefit to the people, but also a means through which the people are monitored and controlled. Additionally, by showing that the population in P.G. and the Toledo District are not

seen by the State as deserving of quality health services, the substandard quality of the services that are provided are revealed as a form of neglect. This conceptualization demonstrates that the universal health care system acts as a mechanism through which the interests of the elite are reproduced, such that historical conditions of poverty and poor health remain through generations into the present day.

In the end, the practice of medical pluralism in P.G. is an everyday reality for people regardless of their economic or social standing. This research suggests that biomedical services provided by the State are substandard and specialists are lacking, leading even the most well-off in the community to travel outside of the District for many health care needs. Most people also rely on traditional forms of medicine, whether in the form of home remedies or by using the services of traditional healers, each of which have varying levels of efficacy. This complicated system of varying health approaches often leads people to exhaust all health care options that may be available. Doing whatever it takes to get healthy, regardless of one's medical preferences, is a part of everyday life in P.G. And while State health services are an attempt to address the health needs of the population, I argue that the health system is actually an extension of neoliberal policies instituted by the government of Belize in conjunction with international banks that result in the neglect of what the State views as undeserving and marginal populations, such as those in P.G. and the Toledo District.

Chapter 2

Working in P.G.: On Methodology, Ethics, and Positionality

It was a hot and sunny day in the middle of August 2012, and even after more than a year in the Belizean heat, I was already perspiring on this short five-minute walk. I was on my way to a meeting with a small group of people working on a project aimed at improving health care in P.G. at their office just down the street from my house. People around town usually try to limit their excursions during this part of the day, when the afternoon heat of the sun dries out the dirt roads, causing dust to stick to the body with the slightest breeze or passing of a car. I was a few minutes late, a locally accepted, even expected, informal custom there, when I heard someone calling from the distance in distinctive Belizean Kriol.

"Brother!"

"Hey Brother! Hey, hey man."

I stopped to turn and look down the street, and saw a muscular dread-locked guy in his 40s that I had often seen around town. He was riding up on his bicycle, and had someone following a bit behind him. "Probably a foreigner," I think, as the follower catches up. He was a slightly heavy set, white guy with burning skin, sweating profusely, and seeming unsure about being "to the back" of town and its sometimes confusing, rough dusty streets. Once they were both stopped next to me, the dread-locked guy asked me about my visa.

"Hey my brother. You're from the States, right? You're doing some missionary work?" "Well, I am from the States, but I'm not with a church or missionary group," I reply.



Figure 2. A typically rainy day in Punta Gorda. Photo by the author.

"Oh man. I thought you were working with the Church or something. What are you doing here then?" asked the dread-locked man.

I gave him a quick response, "I'm here doing research on health and the Belize health system."

"Oh man, I didn't know that. The health system has some problems man! You should talk with me about it sometime," he said, before moving on to ask how I deal with the renewal process of my visa, which he and his friend were unsure about. I explained the process that includes a \$25 US fee for the first six months, and a \$50 US fee every month after that. The quiet tourist and the confident "dread" thanked me, and we all continued on through the thick heat to our different destinations.

Interactions like this were just one variation of an experience that I had time and again throughout my work in P.G. People always attempted to make sense of my presence, and I was most commonly confused for a tourist, a missionary, a Peace Corps volunteer, and an NGO worker. Indeed, I had frequented some local spots popular with expats and tourists, and I had at least talked with each of these types of people around town. My presence in P.G. was also a frequent topic of conversation with people whom I had met just once or twice. "What made you come to Belize?" was a question I heard often. And after describing my research as my purpose, I was frequently faced with a question along these lines: "Why aren't you working in your own country? I know there are problems there too!" Whether or not people were interested in my research, most questioned why I, as a white man from the US with no clear ties to Belize, had decided to work in a country other than my own. These types of questions were not easily explained in a sentence or two, and required some serious reflection so that I could answer with honesty and clarity.

Upon reflection, ending up in Belize was due to personal reasons mixed with a bit of chance. I originally pursued anthropology as a field of study, in part, because of my interest in indigenous cultures and a desire to travel. These purely personal reasons fueled my search for an international location to conduct fieldwork for my Master's degrees (in anthropology and public health). In 2007 I stumbled across a project in Belize, and something about the place captured my attention and imagination. That first research experience was a positive one, and I continued to return, first for visits and then to assist with different projects. When I was ready to choose a place for my dissertation research, the natural choice was to return same community in Belize

where I had developed relationships that served to reinforce connections and strengthen bonds between me, the place, and the people who call it home. During the 17 months of my dissertation research, P.G. became a home to me as well. It was this process of facing the question of what I was doing in Belize that led to a more academic consideration of such issues.

Reflexivity, or the consideration of one's own influence on the research and the community within which they work (Jacobs-Huey 2002), holds a number of purposes throughout one's engagement with fieldwork. Being reflexive can aid in the understanding of one's own motives and intents, it can act as a check for the effectiveness of the questions and methods, and it can help ensure appropriate action while in the field. For these and other reasons, reflexivity is an integral part of research methodology. In this chapter I will show that the inclusion of reflection and the consideration of positionality throughout the research experience led to more valid and effective research. A review of reflexivity and positionality will inform how and why these concepts influenced my research and became an important part of my methodology.

Reflexive Positionality

Often framed as an outgrowth of a postmodern turn within anthropology (Moore 1996, Salzman 2002), the idea that positionality and subjectivity should be a vital part of any ethnography is actually not a new or recent development. In an early ethnography on Maya religion in Guatemala from 1947, Oliver La Farge tells his readers of what they are about to read:

There will be found a good deal of subjective, even opinionated writing...It is present even more because the writer believes that ethnology is an inexact science, inseparable from subjective, qualitative observations. The opinions and biases of the observer,

therefore, are essential data which should be frankly presented. The colorless objectivity

affected by many ethnologists is a deception and a suppression of data. (1947:v-vi) Where such reflective writing belongs has remained a subject of debate (Nencel 2014), and continues as a source of questions on whether cultural anthropology is a science. The use of reflexivity can serve to acknowledge that objectivity may not be fully possible when humans are studying humans. Can a reflexive science be an objective science?

While questions of objectivity may be difficult to answer, I hold that reflexivity can lead to better research in that the practice of reflexivity forces the researcher to acknowledge what potential factors may be influencing the project. Only by acknowledging such factors can one attempt to limit, or even perhaps embrace, their influence. Sociological theorist, Pierre Bourdieu (2004), posits that reflexivity can be:

...understood as the effort whereby social science, taking itself for its object, uses its own weapons to understand and check itself, it is a particularly effective means of increasing the chances of attaining truth by increasing the cross-controls and providing the principles of technical critique, which makes it possible to keep closer watch over the factors capable of biasing research (2004:89).

Acknowledging the warning that reflection can become narcissistic and unscientific, carried out with attentiveness and thoroughness, Bourdieu argues that reflexivity can lead to greater objectivity in social science research. Through reflection, I can develop a greater understanding of how my presence is met while in the field, how it affects the social reality into which I am inserting myself. How will I make sense to people on the ground?

Further, by presenting my point of view – by objectifying myself – I will situate my research more fully. My revealing my own point of view, my position vis-à-vis health, the State,

culture, and other aspects of this study helps me make sense of my research, my findings, and my conclusions. Other anthropologists and social scientists will be better able to critique and understand my research, for this study is from a particular point of view (mine), and reflexivity, both in the field and through the process of writing, can offer greater clarity into that point of view and its influence on the subjects of study. Ideally, it then follows that the research itself becomes more transparent. In keeping with Bourdieu (2004), it is only when reflection is taken up discipline-wide by the social sciences that we will be able to succeed in the production of scientific 'truth'.

Anthropologists are well known for bearing the weight of their discipline's history, which has long been tied to the colonial endeavor and the perpetuation of unequal power relations. With government and corporate positions among the most common for anthropologists outside of academia, it could be argued that these ties remain (Fiske et.al. 2010). While many in the discipline have attempted to address these issues, it was clear to me after a short time in P.G. that power and exploitation remain relevant concerns, as my presence was always questioned, sometimes even after meeting someone multiple times. How I handled and responded to these common queries was important as far as my acceptance within various circles of social groups in P.G.

In this sense, the researcher, and the subjectivity that he/she carries into the field, has tremendous influence on the research – on how the research is perceived and received. It is therefore important for researchers to somehow acknowledge that their research participants likely hold preconceived notions about them and what they are doing in the field. Further, researchers need to take responsibility for their fieldwork – to recognize that such work does disrupt and often change the lives of the participants, and to admit the asymmetrical power

relationships that often exist between the researcher and the researched. These exercises are what comprise reflexivity, and while doing so may expose the limits of fieldwork, it also allows for a potentially more open, honest, and even beneficial experience for all parties involved (England 1994).

The push for reflexivity was realized at its most concise in the 1972 edited volume, *Reinventing Anthropology* (Hymes 1972), in which the authors explained the need to take into account the multiple subjectivities that are at play during the process of fieldwork, including that of the researcher him/herself. Reflexivity, it was said, would better allow researchers to examine the biases they brought with them into the field. Such examination would also enable researchers to more accurately understand the subjective worlds of their subjects, and how those worlds are constructed and represented. "Reflexivity is self-critical sympathetic introspection and the selfconscious analytical scrutiny of the self as researcher" (England 1994:82).

An increased use of reflexivity can help to generate research that is more inclusive and flexible, while also encouraging means through which to address the unequal power relations often present during fieldwork. A reflexive approach to research also has affinities with applied anthropology in that it attempts to address a number of issues through and within research, including: "the examination of anthropologists' role in subjugation, exploitation, and exoticization of people of color throughout the world; incorporating the experiences and voices of research participants in ethnographic texts; and returning something of value to the researchers' host communities" (Jacobs-Huey 2002:792).

While earlier reflexive works do exist (such as Bowen 1954, Powdermaker 1966, Briggs 1970), the general move toward a more reflexive anthropology that came to the fore in the 1980s and 1990s led to the increased reference to the positionality of researchers (Salzman 2002).

Salzman notes that reflexive works have marked "the reflexive anthropologists as having a postmodern inclination, dedicated theoretically to epistemological relativism, perspectivism and positionality, subjectivity, and moral and political commitment" (2002:807). Positionality has remained relevant with the realization that the dichotomy of the researcher as an insider or outsider does not adequately address the complexity of fieldwork. During fieldwork, the researcher can be both an insider and outsider at varying points throughout the research, even within the same community (Merriam et.al. 2001).

The complexities of conducting research, whether from an insider's or outsider's perspective, are many, and one's positionality (gender, class, culture, race, and other factors) has been used in place of the insider/outsider status (Merriam et.al. 2001). Positionality is better suited to "understanding the dynamics of researching within and across one's culture. Positionality is thus determined by where one stands in relation to 'the other'. More importantly, these positions can shift" (Merriam et.al. 2001:411). And while the views of both insider and outsider researchers are equally valid, they are each likely to uncover different realities on the ground. In either case, the researcher must be cognizant of the power relations at hand during the fieldwork, and take efforts to balance them.

Narayan (1993) similarly argues against the native/non-native or insider/outsider dichotomies that have been put forward within anthropology. She urges anthropologists to approach our research participants "as subjects with voices, views, and dilemmas – people to whom we are bonded through ties of reciprocity and who may even be critical of our professional enterprise" (Narayan 1993:672). In this sense, the researcher must be concerned with the variable points of view that exist among and between research participants in the field. Long-term fieldwork that involves repeated visits over the course of many years can encourage

such awareness, as repeated visits can help the researcher to reconsider earlier visits and the work related to those visits, not only in reference to the academy, but also to the people with whom we work (Narayan 1993:677, Stoller 1989:6).

The question of whether the native or non-native (insider/outsider) dichotomy has salience has also directed anthropologists to consider the issue of the objectivity of the researcher. Objectivity for a social scientist has a unique quality compared to how objectivity is defined in other scientific disciplines. For example, Kanaaneh explains that objectivity in anthropological work is not "a matter of distance and non-involvement but of openness and honesty in accounting for all the factors that affect the process of anthropological production, including first and foremost the anthropologist him/herself and his/her role in producing his/her own product" (1997:4). Objectivity in the social sciences then, if it is plausible at all, is dependent on openness to the greatest extent possible.

Still, some anthropologists take issue with the increase in the use and revelation of one's positionality. "Positionality, as practiced by anthropologists, is premised on ever more specific categories of identity that can invoke a kind of cultural relativity" (Robertson 2002:789). Robertson explains that the term "positionality" is "clunky," in that in an attempt to position ourselves into a certain category, itself steeped in the politics of the academy, we obscure our own unique history and identity. Thus, taking up these increasingly common forms of positionality, especially while engaged in fieldwork, can have the effect of shielding the researcher from the learning experiences that are inherent in fieldwork.

This simplistic type of positionality can have the effect of over-emphasizing certain aspects of the researcher's background in an attempt to explain certain decisions or outcomes in the field. For example, I may position myself as a white, non-religious male from the suburban

middle-class of the northeast United States, however this actually says little about the person that I am today. For instance, my suburban background as a youth is a product of my past that I think carries less importance for my identity today than my interests in herbal medicine and traditional healing techniques, especially in the context of this research. Invoking such a simple positionality, then, can actually stifle the reflexivity that it is attempting to foster. When positionality is limited to a declaration of the researcher's general background (race, class, etc.), it does not offer any true perspective on the researcher insofar as the research is concerned. Further, a reflexive account of oneself is not necessarily a reliable or truthful account, as how well we know our own self is rarely completely clear (Salzman 2002).

Salzman argues that such reflexivity that is based on simple positionality is not a means to improve research: "The way to improve ethnographic research is, thus, not for the solitary researcher to delve within him- or herself, or to make him- or herself the subject of the account, but to replace solitary research with collaborative, team research, in which the perspectives and insights of each researcher can be challenged and tested by others" (Salzman 2002:812). Angrosino and Mays de Perez (2003) offer a similar solution while not discarding the role of positionality. They explain that the positionality of the researcher has become more salient as research is increasingly carried out in settings where the population is more likely to be educated and in some way connected to global networks of communication and knowledge generation. "Ethnographers and their collaborators do not step into fixed and fully defined positions; rather, their behaviors and expectations of each other are part of a dynamic process that continues to grow throughout the course of research projects" (Angrosino and Mays de Perez 2003:124). Some researchers have responded by utilizing a dialogic approach in which multiple voices are

participating and contributing to the various aspects of the research, in a sense, creating a more collaborative endeavor (Angrosino and Mays de Perez 2003:109-110).

Such collaborative work, however, is not without its own challenges, which are often similar to those faced by the solitary researcher. For instance, Jacobs-Huey notes: "The task of negotiating one's identity is further complicated by the fact that participants may attribute certain identities and roles to researchers for strategic purposes" (2002:793). Whether working alone for one's own purposes (such as to get a degree or to get published), or attempting to carry out a collaborative project that has multiple beneficiaries, research participants also bring their own subjectivities, needs, and motivations to the table. Choosing a more collaborative approach does not belie the fact that a number of factors play into the outcomes of fieldwork, including the participants and to whom or what they provide access, how participants perceive the researcher, and the language and communicative competence of the researcher. Further, the researcher must maintain flexibility and have the ability to adapt to the various participants and situations encountered in the field, or risk limiting the scope and depth of their research.

I would argue that anthropological research, whether intentionally or not, is always collaborative, sometimes with unseen and unknown outcomes, but always in collaboration with those who engage with us during the research process. Ryang (1997:26) has expanded this conceptualization a step further when he explains that during fieldwork, the researcher and the researched make up "mutually influencing spheres," wherein each has an effect on the other. Accepting this, one can see that during the fieldwork process, the researcher is faced with multiple participants, each with their own positionality, in turn affecting the positionality of the researcher. Thus, the researcher must remain responsive and flexible to the multitude of situations he/she encounters during the research. The anthropologist of today must have fluid and

less fixed positionalities, "which becomes a useful weapon when critically approaching what is taken for granted both in academia and the society at large" (Ryang 1997:45).

Manderson and Wilson (1998:215) explain: "Ethical, moral, and political circumstances intrude at every point in the research process. Today, relationships between study communities and researchers are negotiated on a continuing basis. Permission is granted conditionally, revisited, and re-evaluated on a regular basis." Thus, one's positionality must shift during most points along the timeline of fieldwork based on which participants the researcher is engaged with, when during the fieldwork the engagement is taking place, and what events have occurred over the course of the fieldwork. Positionality is not a static identity, but one that ebbs and flows with the experience of being in the field and interacting with the various interests that influence and comprise the research.

Further Ethical Considerations

The multiplicity of contexts for this research presented a number of challenges. In my quest to understand the health system in P.G. as it is used and as it is practiced and how this connects up with the State and concepts of medical pluralism, neglect and marginalization, my research necessarily involved a diverse cross-section of the population, including officials in the Belize Ministry of Health, doctors, nurses, and other employees of the Belizean national health system, herbalists and traditional healers from a variety of ethnic backgrounds, and a sample from the five most prominent ethnic groups in P.G. While health and health care may be a common thread that ties these diverse interests together, there nevertheless are differences in beliefs about how health and health care should be practiced. Such beliefs in P.G. are largely political beliefs with political implications, and sometimes, conflicting interests. Manderson and

Wilson explain of health research: "Our work is subject to the politics of funding and the politics of communities; the development of political identity among different communities; and the positioning of research and subject communities" (1998:216). Thus my challenge was to negotiate the political reality and the political interests as they exist around the practice of health and health care. If an outcome of this research is to be improved health and health care in P.G., then I needed to negotiate these political interests without alienating any of them. I needed to gain the trust of each of these interests so that each would speak with me of their needs, their goals, their practices. I needed to be the common subject through which these political interests could speak to each other, where such speech does not already exist.

In an attempt to address some needs of the various stakeholders that comprise my research participants, I made the effort to elicit input on how my research could be most useful to them. This approach was in keeping with Manderson and Wilson (1998), who note the rising demand of research participants that the research in some way be useful to their communities. However, the diverse nature of my research participants, from government agencies (the MOH), to university educated health providers (in State hospitals and clinics and NGO clinics), to providers and community members with a range of access to resources (traditional healers and small town communities) has made a single solution to this challenge difficult to produce. In the end, my allegiance was with the poor and traditionally marginalized of P.G. and the Toledo District, whose politics and whose voice so often remain unheard. Still, I also wanted to engage with the State employees of the Ministry of Health. Working with the State and seeking ways to communicate with them effectively and hopefully act upon my findings, is vital if health services provided by the State are to improve. At times the effort to satisfy these competing interests

created tensions in my work and relationships, and navigating this dilemma proved to be one of the more challenging aspects of my research.

I followed accepted practices for anthropological research to ensure that this research was ethical and sound from the point of view of relevant institutions in the US and Belize. My research proposal was submitted for review to a number of institutions that assured standard ethical and methodological guidelines were followed, both in view of authorities in the U.S., and Belize. The Institutional Review Board (IRB) of the University of South Florida, the Belize National Institute for Culture and History, and the Belize Ministry of Health Review Board all granted approval for this research to be carried out. This research was also guided by the Code of Ethics of the American Anthropological Association and the Society for Applied Anthropology. I acquired prior informed consent with all research participants, gave the assurance of confidentiality of my participants, and guaranteed the protection of the data that I collected. To the best of my knowledge there was no risk involved with participating in this research (Whiteford and Trotter II 2008, LeCompte and Shensul 1999).

The Research, the Methods, and Me

With this conceptualization of reflexivity and positionality in place, I can now turn to the various elements that combined to make this research happen. My first encounter with Belize, P.G. and the Toledo District occurred in 2007. I was a Master's student in a dual degree program for applied anthropology and public health looking for something and somewhere to fulfill my field research requirement. Interested in working internationally somewhere in the Americas, I was searching for a place where I could research some combination of food, plants, and

gardening among indigenous people. These were long-standing interests that at least in part, drove my decision to go to graduate school to study anthropology.

After some weeks of searching online for something to catch my interest and attention, I came across an NGO school garden project going on in southern Belize. The NGO was primarily working in indigenous Maya communities, where they would partner with primary schools to build organic food gardens. The gardens had many purposes, including the improvement of child nutrition, the use of gardens for experiential learning, school fundraising, and more. I was interested in the effects of these new gardens on local diets and gardening practices. After a few emails with the NGO's director, I had his support for my research, and found myself heading to Belize for the first time.

That first research experience in Belize proved to be a good one. I spent a little over three months in P.G., working there and in two Q'eqchi' Maya villages outside of town. Professionally, my research was successful, and resulted in my MA thesis, numerous conference papers, and a peer-reviewed journal article (Reeser 2013a). More importantly, I made some friends and important connections during my time there that have so far proved long-lasting. I continued in graduate school, pursuing my doctorate in anthropology, during which time I made a number of visits to P.G. and the Toledo District to visit friends and maintain connections. Finally, in May, 2011, I returned for more than 16 months to carry out dissertation research, with a focus on health and the Belizean health system.

But why the change to research on health and the health system? Again, my personal history plays a role. At the age of 18, I found myself for the first time without any kind of health insurance, and twenty years later, my situation remained the same. There were a few years over that period where I may have been able to afford health insurance, but by and large, the decision

was taken out of my hands for financial reasons. I've been lucky to avoid any major health issues over the years, and I credit this luck to a turn to alternative health practices. While in my 20s, I began studying herbal and natural medicines, and signed on to a degree program in alternative health with one of the early correspondence schools. This path led to an interest in traditional medical systems, like Ayurveda, Chinese Medicine, and shamanism and traditional herbalism.

I was able to connect my interests in alternative medicines during my first visit to Belize in 2007 when I interviewed a Q'eqchi' Maya healer about his homegarden. Out of the 40 Q'eqchi' homegardens that I documented, his was easily the largest and most diverse (Reeser 2008). Through our introduction, I learned of a group of male Q'eqchi' healers that had organized, and started a healing garden, where they are sharing knowledge between healers, growing many of their medicinal herbs, and offering treatments to locals and tourists. I subsequently stayed in contact with members of this group, and when it came time to develop a dissertation topic, I decided I wanted the traditional healing of southern Belize to play a role.

These personal interests in traditional and alternative medicines, my knowledge of the poor reputation of the State health system in P.G., and my familiarity with the complexity of available health services all combined to shape my research. Building on the relationships begun during previous visits to P.G., the dissertation research employed a number of ethnographic methods, including observational techniques, a variety of interviews, and archival research. Following Grenier (1998), who recommends, when possible, spending time getting to know a research community to aid in the full conceptualization of the research topic for both the researcher and participants, my previous engagement with some of the research participants aided in the development of the research. Building foundational relationships was also done

through general participant observation and informal interviews and conversations, which allowed for mutually beneficial relationships to arise within and through the research.

Tierney (2002:12) explains: "Participant observation is not just the collection of data, but a way of thinking about the people from whom one collects those data. It is also a way in which one perceives one's own position in relation to the people and the culture one is studying." The more time one spends observing a particular setting, the better understanding of what is relevant to the research ensues (Angrosino and Mays de Perez 2003:114). Thus, to immerse oneself in the social setting of the research allows for a mutual understanding of the positionality of the researcher as well as the participants, both of which develop and evolve through time. Following this, the actions of the research participants must be allowed to "make sense" on their own terms, and not necessarily conform to Western or scientific expectations or ideals, allowing for a truly beneficiary research project – one that serves the interests of all parties involved – to be developed and carried out (Angrosino and Mays de Perez 2003). Following this philosophy of fieldwork, I spent much of the first six months immersing myself in day-to-day life in P.G., which can be considered the first of a series of research phases.

Research in Phases

I arrived in P.G. in early May, 2011. My first order of business was my living arrangements, and by some good luck, I was able to return to the house where I lived in 2007. It was a small, affordable, 2-bedroom cement house, painted a distinct purple, and with an even more distinct non-functional water fountain out front (with a baby saddling a ceramic bucket on top, and also painted purple). I had rented this same house with an ethnobotanist friend in 2007, and she continued to rent it over the intervening years. Conveniently, she was finishing up her

research at about the same time I was returning to begin my own fieldwork. I took over the rent a month before I arrived, and was able to transition nicely to a well-furnished house in the dusty streets to the back of town.

My arrival in town, and in the house, went by relatively unnoticed. My friend had sublet the house to various researchers and visitors over the years, so neighbors were accustomed to seeing foreigners around. This quiet insertion into P.G. life allowed me to reengage with the town at my own pace. I began with visits to my oldest friends, and mostly tried to adjust to the slow pace of life and the intense heat. Nearly all of my conversations inevitably turned to what I was doing back in P.G., and this allowed me to start describing the many facets of my research. Within days, I had begun hearing stories ranging from different herbs and their uses, to complaints and horror stories about the State-run health clinic and hospital. My decision to return to P.G. proved useful in this sense, as my previous work and experience in town led to an easy acceptance – at least informally – of my research.

During this first phase of the research I mainly focused on revisiting and strengthening old contacts and relationships, while at the same time seeking new ones to develop. I made contact with leaders of a Q'eqchi' traditional healers group, the Q'eqchi' Healers Association, and began volunteering my time in their healer's garden. I helped to install plant identification signs throughout the garden, and helped to put up a new sign along the highway that identifies the garden. As I was spending time with the healers, I began completing semi-structured interviews with some of them, focused on their practices, the Belizean health system, and health in general. Throughout the course of my research I continued conducting interviews with traditional healers of various ethnic backgrounds, as they were not as easily identifiable as the

Q'eqchi' healers are through their organization. I pursued leads and contacts with other healers as they came up, and conducted interviews as I could.

At the same time, I began contacting local NGO staff, and leaders of the Garifuna, Maya, and East Indian ethnic councils, mainly to make introductions but also to gauge interest in my research. I also began informal interviews with people from all over town in order to gather information that would refine and structure my interview questions later in the research. Early on in the research, I made a trip to the capital city of Belmopan to meet with the director of the Institute of Social and Cultural Research (ISCR), the organization that had already approved my research in the country. I was hoping that he would be able to set up a meeting with officials at the Ministry of Health, which he did, although it took over six months. While in Belmopan I visited the Belize National Library in search of historical documents on P.G. and the Toledo District, but found little of substance. Throughout this phase of the research, I kept detailed field notes so as to better inform the interview questions and focused observations during later phases of the research (Bernard 2002, Tierney 2002).

After about ten months in the field, I felt that I was beginning to gain an understanding of the contours of the health system as it functioned in P.G. at the time. Informal discussions and interviews began to offer insight into how people used the health system, and why and when they made the decisions that they did. As the picture gained clarity, I determined that it was time to embark on the second phase of my research. By this time, the Ministry of Health had put my research up for review at their review board, and I had gained their approval, so I now had two key documents granting me permission to do this research.

At this point, I decided to embark on the task of household interviews. Through observations and informal discussions in the first phase of my research, I discovered that in the

majority of cases, women were the primary drivers behind household health decisions. I decided to interview women heads of household, however I knew that in some cases it would be difficult to obtain interviews on my own. While there are no explicit taboos about women talking to men, gossip plays an important role in the lives of people in P.G. Being seen letting a man into your home, when your neighbors know that your husband is out, may raise eyebrows, and more important, it could give people a reason to talk about you. I could have chosen to interview women in the evenings, when their families were home, but this is also the time when household activity is at its height, leaving women too busy to talk.

I was looking for an efficient approach to getting interviews, trying to avoid being turned away at every other house or worse. During the first phase of my research, I had begun working with local students from the University of Belize campus in town, basically offering informal tutoring sessions. I had been introduced to the students through my neighbor, Erika, a single mother of two teenaged boys, who was working odd jobs while putting herself through school for her Associate's degree. She had asked for my help with an assignment or two, and soon, there were a number of her classmates congregating at my house, seeking input on assignments, asking for explanations about different concepts, and asking for editing help with papers.

Erika and I continued to grow close, and became good friends. She took me to local events and family parties, let me in on local secrets about obtaining hard-to-find goods, turned me onto some new and unusual local foods, and generally aided in my acceptance around town. And as I learned more about her life, including her struggles to make ends meet, I felt the need to reciprocate her kindness and willingness to share her contacts and life in P.G. Helping her and her friends with school assignments was a start, but I was looking for a way to give back something more. When it came time to start collecting interviews, the chance to help out my

neighbor presented itself. For a small per-interview stipend, she agreed to assist me with my household interviews. After a few sessions of training on interview techniques and goals, we set out on daily interview quests.

Bringing Erika on board as a research assistant proved invaluable in many ways. Perhaps the greatest benefit in having her with me when approaching homes for interviews was that we were never turned down outright. Only two women asked us to return later, and over the course of about 2 months, we were able to conduct 60 interviews with relative ease. An unanticipated benefit also came up over the course of our interviews, and it had to do with language. English is the official language of Belize, but Kriol is the national language, the everyday language. While Kriol is an English-based creole language, it is significantly different such that it can be unintelligible to non-Kriol speakers. By this time, I understood most of the Kriol that I heard around me, however, I never began speaking it. In the social circles of P.G. that I was a part of, everyone spoke English and Kriol, and it almost felt inappropriate to speak Kriol, when English would do. However, once we were sitting with women in their homes, it became clear that some of my questions were better understood when Erika rephrased them in Kriol. We received more thoughtful and in-depth responses than I would have on my own and in English only.

The 60 household interviews, which averaged 50 minutes, but ranged from 30 minutes to two hours, were conducted in such a way as to elicit from women how they made health care decisions in the home. After collecting basic demographic information, participants were asked to recount a recent experience or two during which someone in the household needed health care, which led to some revealing stories about the quality of service provided by the State system. We also asked about the types of health services they preferred, their most common course of action during a health care event, and how they perceived the quality of health services provided by the

State. Another topic of discussion was the use of traditional health care, whether in the form of home-care or from traditional healers. These questions often provided long lists of home remedies passed down from parents or grandparents, or stories about visiting a traditional healer after visits to the hospital proved fruitless.

Once my household interviews were complete, I embarked the third phase of my research: the investigation of the public health care system, known around town as NHI. I approached the head administrators at the Punta Gorda Policlinic (an outpatient health clinic offering basic primary care) and the Punta Gorda Hospital, and after confirming that my approval from the MOH was legitimate, they each granted me permission to conduct observations in their respective facilities. They also granted me interviews, and agreed to set up interviews with clinic and hospital staff, but this promise never materialized. With my approvals from the administration in place, I first did a series of focused observations at the policlinic over a period of several weeks, designed to cover a broad sample of days and times. My goal was to document activity at the policlinic during times high, medium, and low patient volume. Each of my 12 observations lasted from 1.5 to 3 hours, during which time I sat in waiting areas and outside of doctor's offices, all the while taking detailed notes. I also engaged in observations at the hospital, although for reasons to be discussed later, less frequently.

While in the process of documenting my observations at the policlinic and hospital, I also began to set up interviews with biomedical health professionals. I procured interviews with nurses and staff employed through NHI, a number of doctors with private practices in town, local pharmacists, as well as NGO staff active in the area of health. In total, I interviewed 12 people involved with the biomedical health care system in P.G., including some of the longest-tenured doctors, nurses, and pharmacists in town. I was also sure to include a number of recently

employed health providers in an effort to record fresh perspectives on the system. My goal was to capture voices from the full spectrum of the health care system as it exists in P.G. This third phase of my research was complete after several months, at which point I had been in the field for months.

My methods followed a distinct approach throughout the research, such that the data I was collecting continually informed and refined the questions I asked in subsequent interviews. The use of semi-structured interviews allowed me to guide the interviews toward the topics I was investigating, while also allowing participants the freedom to expand on and revise the questions I asked (Bernard 2002). In my daily life, and especially in the policlinic and hospital, a focused observational approach helped to uncover the working details of the health system and how people utilize it in their daily lives. Such observational techniques allowed for the production of "a rounded account of the lives of particular people, the focus being on individuals and their ever-changing relationships rather than on the supposedly homogenous, coherent, patterned, and timeless nature of the supposed group" (Angrosino and Mays de Perez 2003:144). This approach allowed for an accurate depiction of how health care is delivered and utilized in the district, which is absent from the literature, and likely useful to the MOH, NGOs, and community leaders.

One of the primary goals of this research was to investigate health care practices across ethnic groups. Of the 60 household interviews, I split them evenly between the five major ethnic groups in P.G.: Q'eqchi, Mopan, Garifuna, Kriol, and East Indian. In order to ensure appropriate representation of the various ethnic groups I utilized quota and snowball sampling to generate my samples (Bernard 2002, LeCompte and Shensul 1999). At regular intervals throughout this time period, I engaged in systematic observation in the local hospital and State-run clinics to

better understand the services they provide, and how they are utilized by the regional population over time. Participant observation, during which informal interviews were also conducted, was a primary part of my life in P.G. These daily routines of observation were focused on understanding how people from various ethnic groups negotiate the layered health care system to which they have access. This understanding further allowed me to observe the health care activities of community members, which enhanced my interview findings (LeCompte and Shensul 1999).

Finally, in-depth interviews and participant observation (when possible) was conducted with traditional healers of various backgrounds (ethnicity, first language, location). These interviews focused on the healers' self-perceived roles in health care, and how they conceptualize the relationship between themselves (and traditional healing) and the biomedicine of the State. Participant observation with the healers aimed to discern the practices of the healers, the most common ailments treated, and the relationships healers have with their patients.

After returning from the field in October, 2012, I began the data analysis phase of my research, which included interview transcription, the analyzing of field notes for important themes, and collection of pertinent health data from online sources, all of which actually began during the early phases of the research. Data analysis focused on the generation of themes and discerning patterns out of the interview notes, field notes, and observational notes that related to my research questions (LeCompte and Shensul 1999). Using the open source software, TAMS Analyzer, I grouped, coded, and categorized the data, paying particular attention to how these data address each of the research questions. Analysis focused on understanding how people managed their health care needs, and the interrelationships between the State, NGOs, traditional

healers, and the populations that they serve. Analysis also helped to generate an understanding of how each population negotiates the health system that is available to them.

The final phase of my research primarily included the dissemination of findings. The preliminary findings of the research were presented at an annual conference put on by the National Institute of Culture and History (NICH), and ISCR, where various government officials and staff, and other researchers were present. This paper was published by NICH as part of a compilation of papers presented at the conference and is available in Belize (Reeser 2013b). Feedback from this presentation allowed for some comments to be addressed in the writing phase. I also plan to share my findings with all of the various stakeholders involved, including the MOH, hospital administrators, traditional healers, and community members. I created a brochure that graphically displays many key findings of my research. This brochure was posted online, and the link was shared with my complete list of stakeholder contacts. I also brought printed copies of the brochure to Belize in the summer of 2013, and presented them to stakeholders and community members. Continuing the reciprocal nature of the research, I will supply copies of this final write-up to the various participants of the project, deposit copies in the P.G. Library and the National Library of Belize, as well as offer condensed versions as needed. It is hoped that these presentations and information sharing will help begin the process of using the research findings for the benefit of the stakeholders involved, particularly revolving around the improvement of health services in the Toledo District.

Chapter 3

Plurality and Ethnicity: Life in Punta Gorda

"The Caribbean identity defies geography. Once you think that you've pinpointed where it happened, then the people are different...The people themselves keep changing. This is one of the things that is most beautiful about this region. We're slippery. Once you think you've gotten them, nah, then they slip away from you. Like fish. They keep moving. They keep moving from you."

– Belizean anthropologist Joseph Palacio (2013)

September 24, 2011, Independence Day in Belize.

I woke up slowly and got out of the house with a later start than I had hoped. It was the Independence holiday, and the night before I was up later than usual drinking stouts and bitters with a few Belizean friends. Socializing like this is common on most weekend nights in P.G., but it is almost expected during holiday breaks, some of which can last for a full week. Independence celebrations are especially festive, a time when all Belizeans express their pride for their country, and during which late night conversations inevitably turn to the many issues faced by Belize. One of many celebrations throughout the year, Independence Day is often cited as a favorite. A full weekend of parties, celebrations, families, and friends, it is a time that arouses intense feelings of pride and nationalism in the relatively new nation.

The morning of Independence Day, I was on my way to the small Central Park to listen to some of the pre-parade speeches. In true Belizean style, the festivities follow a fairly loose schedule, with speeches beginning sometime around 9am, to be followed by the parade, which is to start before lunch sometime. The parade begins at Central Park, the town's small central



Figure 3. The central square in Punta Gorda during the Independence Day Parade. Photo by the author.

square that is actually a sloping piece of land in the shape of a triangle. I was invited to watch the parade from the 2nd story porch at the family house of one of the friends I was drinking with the night before.

As usual, the sun was already brutally hot by the time of my mid-morning walk into town. By the time I got to Central Park, I had missed a couple of speeches, but was there in time to catch the majority of a talk by a local Maya leader, who works with one of the local NGOs. I was somewhat surprised when I stopped to listen to the speech, one that was calling for Maya people in the Toledo District to join together in their fight for the right to their ancestral lands. It struck me as somewhat out of place in the context of a nationalist holiday like Independence Day. People in the crowd seemed mostly disinterested, and with little shade in and around the park, many people were pre-occupied with fanning themselves to stay cool, and otherwise waiting impatiently for the speeches to end so they could begin the parade.

I, too, was getting bothered by the heat, so made my way to a nearby Chinese store to get myself something cold to drink. By the time I found my favorite locally produced coconut water, closing statements were being made on the stage, and people were lining up in their groups around the park for the beginning of the parade. I took a few photos, and walked over to my friend's house, where they were already out on the porch enjoying cold stouts and heated conversation, centered around the Maya speaker I had just heard.

"What is wrong with that man?! This is not the right time or place to be preaching about Maya rights!" implored James, the older brother of my friend.

"That's a lot of ras!" agreed John, using Kriol in a moment of heated exchange. "Those Maya think they're the only ones with roots around here."

James concurred, and continued, "We're indigenous to this land now too! How many generations does it take to be indigenous? My family goes way back here in P.G., and we know some of this land like nobody else. But we Kriols don't get any land given to us by the government. Where are our land rights? Those Maya aren't even from here! They just want everything given to them. My family has worked hard to get what we have. That speech was just not right. This is Independence Day – we're supposed to be coming together as Belizeans, and that kind of ras just divides us up. That man has me all vexed up!"

John and James are a part of a Kriol family, with a lineage that goes back at least three generations to the early days of P.G. Their father was a prominent figure in town, and the family still owns plots of land in and around P.G. I had become good friends with the youngest son in

the family, now in his early forties, and one of the only in his family to have remained in P.G. Most of his older sisters have been living in the U.S. for a majority of their lives, but usually visit P.G. around the Christmas holidays. He and his brother remained in P.G. as small business owners and small farmers, trying to produce income with their family properties in town, and their small holdings just outside of town. Interestingly, some of the land they currently own is a nearly 30 acre plot that they have just subdivided to sell to people looking to build. On this day, my friends miss the irony in the fact that he and his family own significant pieces of property in Belize, a place they share with Maya families who have never had the right to own the land on which they have lived and survived for generations.

This reception to an Independence Day speech exemplifies the pluricultural reality in P.G. (Watanabe and Fischer 2004). To create an ethnographic portrait of P.G., you cannot talk about people solely as Belizeans, although everyone strives to find their place as citizens. In their Belizeaness is where they share commonalities in historical experience, geography, and even certain traditions that represent a more national Belizean culture. Yet, while these similarities and commonalities exist, differences and contrasts based on social histories and experience also comprise a major part of the daily life of most Belizeans. It is then important not to let the commonalities erase the very real differences that exist between the distinct cultural groups that call the Toledo District and P.G. home.

Plurality & Pluriculturalism

For a town of just over 5000, P.G. is amazingly diverse. Kriol, Garifuna, Q'eqchi' Maya, Mopan Maya, and East Indian families each account for 9% or more of the population, and there are smaller numbers of German-descended Mennonites, Chinese immigrants, and a healthy

sample of expatriates from the U.S. and Europe (SIB 2012). Spending even a small amount of time in P.G. reveals a place that is distinctly Belizean, but also a place where families have maintained links to their unique ethnic histories and traditions. Each of the major ethnic groups in P.G. have formed ethnic councils that meet at least on a monthly basis to discuss matters important to their community members. And while there are some tensions between groups, such as the short vignette relayed above, they rarely result in overt conflict, and socializing and marriage across ethnic groups is fairly common.

The wide diversity in such a small town as P.G. feels unique in the world. People across ethnic groups are at once enamored with the latest consumer products from the global capitalist economy, intensely proud Belizeans, and firmly planted within their ethnic history and culture. It is a place where the negotiation between international, national, and traditional identities is present and ongoing. It is a place that needs to be examined through the lens of what anthropologists John Watanabe and Edward Fischer (2004) have called pluriculturalism:

"We call this approach 'pluricultural' because it pays close attention to connection across boundaries of differentiation – ethnicity, class, gender, geography, nations – that might otherwise conjure up different cultures. This approach views cultures as more accumulative and distributive than integrative. Our study of cultures must become ever more grounded in area studies of history and practices in the places (however multi-sited) where we work, not just theoretically driven or globally derived" (2004:7).

Viewed through a pluricultural lens, P.G. can be seen as a place where histories remain present, and identities are being created through an accumulative process that includes local, national, and international influences.

In this way, we can see how people of varying ethnic groups experience and negotiate their daily lives, drawing from rich cultural histories, and an ever-changing present, moving towards a wide range of possible futures. Watanabe and Fischer (2004) explain:

People themselves most often live their cultures forward in time, from self-evident presents to hoped-for (or foreboding) futures. This suggests that pluricultural ethnography should view its culture history not as a teleology of the inalterable past becoming an inevitable and already known present but as a contingent recollecting of past collective experience that conventionalizes the present into possible futures. (2004:7) In P.G. the past is often heavily drawn upon as an influence on present identity, and as an aspect of self that is deemed worthy of carrying on into the future.

However, as shown through the above vignette, such pluriculturalism can be at odds with a nationalist agenda, especially in a young nation like Belize. Along with strong affiliation to an individual's ethnic background, there comes a flip side that can serve to compromise ones Belizeaness. William Connolly (2005) explains:

Under contemporary conditions of rapid mobility within and between states, the drive to national unity itself too readily fosters marginalization of vulnerable minorities. It does so because the rapid pace of late-modern life – the rapid movement of populations, ideas, technologies, identities, and faiths across generations and territorial borders – works against the realization of the national imaginary. (7-8)

The project of creating a nation, and more important, a national identity, is a steep challenge in an era when global influences move more rapidly than at any time in history. However, in Belize, where the pride of newly won independence is still felt by most people in their 30s and

above, a national identity is one worn just below the surface, and, in many instances, can serve as a bond across ethnic divisions.

If there is anything that serves as a more overt point of division in P.G., it would appear to be economics. The economic hierarchy does not necessarily fall along ethnic lines. There is a small wealthier class primarily of families who own shops and businesses, work in finance or own transportation companies, and a small middle class, but the majority of the population in P.G. is living precariously close to or in poverty. Jealousies and tensions are more evident between those of different economic classes. However, present among all classes is a willingness to share resources, especially among friends and family, such that the social security net is truly locally based, and despite some minimal resources that are available from the national government, the use of such assistance is not very common. This system of aid and reciprocity, while evident, is unstudied, so little of certainty can be said, yet it appears to serve as an alleviation of potential tension between the economic classes, as people across economic positions rely on each other for help when they are in need.

Punta Gorda: At the Ends of the Forgotten District

At the distant end of the southern highway, situated on the coast of the Caribbean Sea, and still relatively disconnected from the rest of Belize, Punta Gorda is the end of the public bus line heading south. The most urban town in the region, P.G., as it is known locally, is still a small town in many ways. At just over 5,000 people, it is the ninth largest town in Belize, and the capital and central hub of the southernmost Toledo District (SIB 2011). Despite its larger size relative to other towns and villages in Toledo and other parts of Belize, there is a distinct small-

town feel to P.G. Many families have been in town for generations, and after spending some time there, a real sense that everyone knows each other becomes evident.

There is little written on the history of Punta Gorda. One early account of the town by John L. Stephens, an explorer and writer from the United States, offers a glimpse of what was, in 1858, the small Garifuna village:

As we approached we saw on opening on the water's edge, with a range of low houses, reminding me of a clearing in our forests at home. It was but a speck on the great line of coast; on both sides were primeval trees. Behind towered an extraordinary mountain, apparently broken into two, like the back of a two-humped camel. As the steamboat turned in, where steamboat had never been before, the whole village was in commotion: women and children were running on the banc, and four me descended to the water and came off in a canoe to meet us.

We landed at the foot of a bank about twenty feet high, and, ascending to the top, came at once, under a burning sun, into all the richness of tropical vegetation. Besides cotton and rice, the cahoon, banana, cocoanut, pineapple, orange, lemon, and plantain, with many other fruits which we did not know even by name, were growing with such luxuriance that at first their very fragrance was oppressive. (1858:27-28)

Stephens estimated that "Punta Gorda" had about 500 inhabitants, and describes the houses with thatched roofs and walls constructed of thin wood poles lashed together. Each house had a grass hammock and a figurine of the Virgin. He met an old woman, who immigrated from the island of St. Vincent, the original "homeland" of the Garifuna. With Stephens on the visit was a member of the Catholic Church, who began performing baptisms. The residents present were mostly women and children, as most of the men were either away logging mahogany or fishing. Few

present spoke much English, but most spoke Spanish. Stephens was even named as the godfather to one of the newly baptized children.

By the early 1900s, the British Crown had begun to establish some level of administrative presence in P.G., and the town became the primary colonial outpost in the south of the territory. Situated on the coast, P.G. was an ideal spot for authorities from the northern part of the country to dock and secure access to the interior of the Toledo District. The town grew slowly, partly due to its isolation, and partly due to the fact that there was little success in developing an industry in the region. Still, even with slow growth came a diversification of the population, as the various ethnic groups described above began to arrive to P.G., often for vastly different reasons.

For many Belizeans from other districts, P.G. is a place where the Belize of the past still exists, where, for instance, people still greet you in the streets with the appropriate time of day: a simple "morning", "afternoon", "evening", or "good night". Most shops are still closed on Sundays. Children roam the streets at all times of day, playing and adventuring instead of video-gaming and television-watching. Anthropologist Aminata Maraesa describes: "It is a place of familiarity, relative safety, and with a pace slower than most. 'Right now' means, 'As soon as I can get to it.' And 'soon' means anywhere from a few minutes to a few hours. Waiting is common and seldom complained about. Many Belizeans north of the Toledo District have never even visited the remote coastal district capital of Punta Gorda. Fewer have ventured out to the villages" (Maraesa 2009:30). Further, the crime that has put Belize City in international headlines and that has become ubiquitous with other parts of the country has yet to fully take hold in P.G. People walking and on bicycles is as much the norm as people in vehicles, despite the oppressive heat. It is a place where people know you before you even meet them.

Despite this friendly, open, and relatively safe environment, many Belizeans from other parts of the country often openly detest the south. When I told a colleague who grew up in Belize that I was working in P.G., she replied with surprise: "What?! P.G.?! Why are you working down there?! I would never go down there. Ew. Nope." These types of feelings are not unusual among Belizeans from other parts of the country, and it's probably due to a number of reasons. Even though it is the capital and only sizeable town in the district, P.G. is often conflated with the Toledo District as a whole, in which nearly all socio-economic and health indicators are the worst in the nation, or below the national average. Many of these statistical indicators are not available for P.G. distinctly, although as the primary center of social and economic life in the district, the conflation of P.G. with the whole of the Toledo District is filled with inaccuracies.

Considered by the State to be the primary "urban" center of the Toledo District, P.G. is hardly a city. Still, it is the district seat, where all of the government offices, banks, the market, and most businesses and stores are located. P.G. is the end of the paved road for James Busline, a locally owned bus company that is the primary one serving the entire southern half of the country. Tourists and travelers can take a small water taxi to either Livingston or Puerto Barrios in Guatemala, so it also serves as a place to pass through on the way to somewhere else. There are a number of restaurants and lodging options in town, and most of the international NGOs working throughout the District have their central office there as well. A number of village bus lines shuttle people from villages throughout the Toledo District to P.G. on market days (Monday, Wednesday, Friday, and Saturday), and at least one line recently started running six days per week. When I first began working in the Toledo District in 2007, transport by bus to the outlying villages often posed a problem, as one could take the bus from P.G. at noon, and only return on the next market day at about 6 or 6:30am. Now there are buses running on most days,

and there are even evening shuttles from P.G. to the villages. These additions to the bus schedule have made it more practical for people to get to work and school in P.G., while maintaining residence in the villages.

A Short History of Belize and the Toledo District

Belize is a relatively young nation, having only gained independence from the British in 1981, before which it was known as British Honduras (I will refer throughout to the territory as Belize, regardless of the historical period to which I am referring). It has an unusual history in Central America, which can be understood through the distinctive cultural influences found in the country. Belize is unique in that there is no other nation in the region that has this small country's mix of Latin American, Caribbean, and indigenous cultures. The territory that is now Belize was originally part of the Mayan empire that included present-day southern Mexico and the Yucatan, Guatemala, the northwest region of Honduras, and Belize. During the Classic Period of Maya civilization (between A.D. 300 and A.D. 900), the northwestern part of current-day Belize was a part of the central hub of Maya activity that was centered in the Petén area of northern Guatemala. In the tenth century A.D., shifts occurred within Maya civilization, and populations appear to have migrated away from this central hub. However, complete abandonment did not occur, as is popularly held, and some people did remain settled in the area, including in what is now known as the Toledo District (Waddell 1961).

Some authors have pointed to the fourth and final voyage of Christopher Columbus as the first sighting of Belize by a European (Stephens 1858, Setzekorn 1981). It is more widely accepted that Europeans first surveyed Belize in 1506 or 1508, when Spanish explorers sailed north along the coast from Cape Honduras to the Yucatan peninsula (Waddell 1961, Thomson

2004). From the sea, Spanish explorers reported that the territory was uninhabitable; however some expeditions that camped along the coast report engagements with local indigenous groups, who must have been inhabiting the 'uninhabitable' (Waddell 1961). After contact, Spanish settlers set up communities near to both the northern and southern edges of Belize, however each of these settlements became part of two separate Spanish jurisdictions.

It seems like Belize was left as a sort of inhospitable border land, and due to its distance from the main centers of Spanish activity, the territory was left largely unsettled by Spanish colonizers (Waddell 1961). Taking advantage of the lack of a Spanish presence, British adventurers began to set up outposts, first as bases for buccaneers who sought to exploit Spanish shipping lanes in the region, and soon thereafter to exploit the forests for the logwood trade. Peter Wallace, a British privateer of Scottish descent, spent some weeks encamped on Belizean soil in 1617, at the spot where Belize City now stands. In 1638, the remnants of Wallace's camp were re-inhabited by a different group of Englishmen, these stranded by a shipwreck. Other groups soon joined, and by the 1640s, the small settlement and an outpost on nearby St. George's Caye would be the start of what would later become British Honduras (and eventually Belize) (Setzekorn 1981).

Belize was unique also in that, unlike other British holdings in the Americas (but similar to other Caribbean islands they colonized), agricultural production was not promoted for most of the first two centuries of its history. Instead, Belize harvested a different kind of product: hardwoods (Shoman 2000). The rise in popularity of logwood dye in the mid to late 1600s began to shift interests in the settlement inland, to the vast stores of wood in the Belizean interior. The population grew slowly with the rise in the logwood trade, and included refugees and British settlers who were forcibly moved by the Spanish, battle hardened ex-pirates and buccaneers, as

well as an unreported number of indigenous Miskito, there to cut logwood. The settlement took on a reputation for hard living, debauchery, and toughness, and remained a safe-haven for pirates and other bandits of the sea. In the 1720s, the first reports of slaves of African origin appear in historical documents. They were brought from elsewhere in the British West Indies, and by the mid-1740s represented a majority of the population, outnumbering white settlers (Setzekorn 1981, Thomson 2004).

Slaves were largely used as labor in the logwood industry, and by 1803, slaves represented three-quarters of the settlement at Belize (Thomson 2004). The nature of logging work meant that groups of slaves were dispatched with one or two overseers into the depths of the Belizean jungles. According to early reports, this isolation and imbalance in numbers resulted in a high number of slave flights. Additionally, slaves in the Belize settlement were reportedly treated with less harshness and violence, and granted a greater sense of autonomy. Still, slavery meant people were owned, and problems with runaways and even revolts dot the historical record well into the 19th century. In 1838 slavery was abolished in the territory, and many exslaves stayed on as free laborers, and began to acquire land and build some wealth (Waddell 1961, Thomson 2004). While slavery was ended, however, coerced labor continued into the 1900s. This new system took the form of what Belizean author Bismark Ranguy Sr described as an "apprenticeship" system that kept workers indebted to their "trainers". Later, the indentured servitude of Chinese and East Indians who came to the colony via Jamaica and Guyana to work on the new plantations continued the legacy of coerced labor (Ranguy 1999, Maraesa 2009).

Despite numerous and ongoing disputes and skirmishes with Spain, the territory persisted, and the British eventually took possession and declared the territory the colony of British Honduras in 1862. In the roughly 100 years of British rule, Belize was similar to other

colonies in the West Indies in that the exploitation of land (hardwoods, then through agriculture) and people (through slave labor and underdevelopment) was the way of the land (Grant 1976). The British granted full self-governance in 1964, but continued to offer administrative, economic, and military assistance, until a peaceful transfer to independence in 1981. Full independence lagged over concerns about the economic viability of the young country, as well as the Guatemalan claim to the territory, which continues to be a source of controversy today. The last colony in the Americas, and now just over 30 years into its independence, Belize is one of the younger countries in the Western hemisphere (Grant 1976, Setzekorn 1981, Thomson 2004).

Named after an English merchant, and part-owner of Young, Toledo, and Company, which reportedly owned more than half of the available land in the south of the country, the Toledo District has always been known as a place at the margins of Belizean society (Ranguy 1999, Simmons 2001). Historically, from its founding as a center of logwood extraction, the southern region known as the Toledo District has had much of its economic base centered on exports. From logwood and mahogany to sugar, bananas, citrus, and oil, this export-based economy has survived to the present (Wilk 1997; Zarger 2009). In the Toledo district, most of these types of export-based ventures never met with lasting success. While logging in the district continues to this day, as in the rest of the country, it no longer represents a major economic force, and the government has recently attempted to clamp down on the illegal harvesting of rosewood for the Chinese market (7 News Belize 2013). Because it never produced the need for high numbers of laborers, logging never encouraged the growth of the population of the district. In turn, this has impacted the success of agriculture ventures there, due to a relative lack of available labor for a more labor intensive industry (Wilk 1997:56-57). By the beginning of the 20th century, most of Toledo had become British crown land due to tax defaults and lapses in

leases; much of this land was subsequently turned into government controlled reserves (Wilk 1997:62). This historical trajectory has left Toledo underdeveloped (Frank 1975), described by Wilk (1997):

Underdevelopment occurs when government fails to invest in roads, schools, communication, marketing services, or other infrastructure because it perceives the region as poor and backward. The lack of infrastructure in turn means that only extractive kinds of capitalist development are profitable or practical there, and in draining the area they further and deepen its status as backward. In the 1860s Toledo was no more backward or marginal than any other part of rural British Honduras. Today, through this cycle, it has become underdeveloped. (66)

One can see, then, that the history of underdevelopment in Toledo has contributed not only to the marginalization of the place, but also to some extent, of the people who make their life there.

Today, the Toledo district is a zone undergoing significant change, especially due to sizeable increases in tourism, and tourist-related activities. In fact, the tourist industry is one employment sector into which many indigenous people in the district have moved. Wilk has explained, "Belize has managed to keep the tourist industry at a small enough scale that local people can participate," and such holds true in the Toledo District where large-scale corporate driven tourism has yet to enter the region (2006:178). Still, besides low paying agricultural work on citrus plantations, the growth of the cacao industry, and the education sector, full-time, long term jobs are relatively scarce in the region.

Also contributing to its distinctiveness, the Toledo District is home to the largest population of indigenous people in the country, accounting for over 72 percent of the population (SIB 2013). Indigenous groups in the district include Q'eqchi' Maya, Mopan Maya and Garifuna

communities, as well as a number of immigrant groups with ties to their own traditions. Until this year, nearly all of the rural communities in the district were refused land rights, however a recent Supreme Court decision granted land and resource rights to the lands that are occupied and used by over 30 communities in Toledo (Indigenous Peoples Issues 2010). The issue of land rights has been one on which Maya communities from each of the main ethnic groups have worked together. Building the case for land rights required the solidification of Maya identity, and, in part, led to the creation of Maya councils (for more on the Maya land rights issue, see Zarger 2009, Grandia 2009, Parks 2011, and 2012). The success of the Maya councils at procuring State and even international resources was evident to others in the District, and soon, the Garifuna Council became more active, and the Kriol Council, and the East Indian Council were formed. The recent development and activity of ethnic councils in P.G. and Toledo would at first appear to be a fracturing of the region along ethnic lines, but it remains unclear what effect this will have on the economic and social conditions in the district.

Ethnicity in the Toledo District and Punta Gorda

Punta Gorda was originally a Garifuna settlement with the local name of Peini. At that point in time, in the mid-1800s, the Garifuna were still viewed as squatters with no land rights by the British Crown. Like the Maya, the Garifuna were prevented from owning their own land independently, and were instead provided with reservations through the Crown Lands Ordinance of 1872 (Bolland 1986). A Garifuna reservation currently borders the western edges of Punta Gorda, and local Garifuna people can still claim plots for homes and farms. This Garifuna legacy is still very much present, especially during "Settlement Day" celebrations in November of every year, when the community reenacts the arrival of the first Garifuna refugees to the shores of P.G. The event marks one of the most popular activities on the annual calendar for people of all ethnic groups.

By the mid-1900s, P.G. was beginning to diversify. Waddell describes Belize in the middle of the 20th century: "It is evident that at the moment contact between groups in the country is slight" and that a single British Honduran label could only be ascribed to the "Kriol majority" (1961:75). In the southern Toledo district, Waddell (1961) reports that social divisions existed between Kriols and Caribs (the Garifuna), while affinities existed between Caribs and the Maya, probably due to what he describes as similar, more traditional ways of life. Sutherland describes the ethnoscape of Belize at the end of the 20th century: "This is not a utopia of racial egalitarianism; rather, there is a general acceptance of a variety of cultures and races as the normal venue that individuals must navigate in their daily interactions" (1998:29). While there is a general tone of acceptance throughout Belize, Sutherland explains that there is also a growing move towards something like ethnic consciousness, as evidenced in development of cultural associations, or ethnic councils, or a push to reconnect with African roots by some Kriols for example (1998:80, see also Premdas 2001). Around the same time period, Barry and Vernon (1995:70) note that tensions between Kriol and Garifuna populations continue.

More recently, anthropologist Sarah Woodbury Haug reports that the government teaches a distinct form of Belizean nationalism in the primary schools that highlights the ethnic diversity in Belize, and preaches tolerance. In this State model, each ethnicity is unique, has specific characteristics, and in a sense, is bound by the ethnic label. This is contrary to life on the ground in Punta Gorda, where ethnic mixing has increased, and is perhaps becoming the norm (2002:221). Haug's research shows that children of mixed ethnicity have difficulty deciphering their own ethnic identity through the bounded categories taught at school. She notes a very

common theme of acceptance present throughout her research – acceptance of different ethnicities and of mixed ethnicities in the homes of the students of Punta Gorda (2002:222). This acceptance is how I would describe my experience in P.G., and while discussions like the one above occur every day, they do not necessarily influence how people treat others of different ethnicity on day-to-day basis.

Ethnicity in the Toledo District

The first census of Belize, in 1861, revealed between 4000 and 5000 indigenous peoples living in the territory, although mostly in the north. Other indigenous settlements were periodically reported throughout the territory; however, since much of British activity was centered on the coast, inland populations were often unnoticed (Waddell 1961:16). "It is not impossible that some remote parts of the country were occupied continuously from the fall of the Maya civilization to the nineteenth century" (Waddell 1961:18). The southern region of the territory, including what is now the Toledo district, was among these remote regions, and therefore relatively little has been recorded about historical populations in the district. Grandia (2009) reports that in the late 1600s, the Spanish military forcibly removed most of the Maya inhabitants living in what is now the Toledo District. Nothing is known of how many Maya were left in the district, but in 1886, Q'eqchi' and Mopan Maya living in the Petén in neighboring Guatemala organized and returned to the region (Grandia 2009).

Citing minimal and perhaps inaccurate data, Waddell (1961:19) notes that in the late 1800s and early 1900s, the indigenous population of the south doubled in number – mostly through immigration from Guatemala. During this time, more Garifuna and perhaps West Indian laborers also moved into the southern territory from Honduras. Still, he explains: "Lack of

information on the race of the immigrants and on the birth and death rates of different groups, as well as the vagueness of the ethnic classifications used in the census returns, make any definite statements on population movements highly dubious" (Waddell 1961:19). By the mid-20th century, Toledo represented less than nine percent of the total population of Belize (about 8,000 of a total of about 90,000) (Waddell 1961:64-65).

In the 1860s, a sizeable contingent of U.S. Confederates established a community just outside of P.G., named the Toledo Settlement. The community followed strict Methodist codes, which included limited economic activity on the Sabbath, and a mostly-followed ban on alcohol. The immigrants also sought to maintain their ideas about racial hierarchy that they brought from the southern US, which reportedly did not sit well with the local population. Simmons reports that officials in P.G. called on the colonial authorities to provide aid to guard against Confederate encroachment on to locally-held lands. "The local 'natives,' many of whom were of African descent, refused to work for the Southerners. There was apparently a great deal of animosity between the two groups" (Simmons 2001:77). However, what are now referred to as East Indians, families of Indian descent who were brought to work as indentured laborers from Jamaica and perhaps elsewhere, became workers for the Confederates.

Today, the Toledo District remains a unique region in this small Central American country of about 325,000 people (SIB 2013). The district as a whole is mostly rural and comprised of over thirty villages inhabited primarily by one of three groups: Mopan Maya, Q'eqchi' Maya or Garifuna. Some rural villages have a mixed population, with these three ethnic groups represented along with Kriol. These rural villages are home to about 25,500 people, and range in size from about 100 to 1000 residents. Overall in Toledo, there are six major ethnic

<u>+</u>	2010	2000	1991
	total # (Percent)	total # (Percent)	total # (Percent)
Total	29,885 (100)	23,117 (100)	17,486 (100)
Caucasian/White	241 (.8)	155 (0.7)	143 (0.8)
Chinese	80 (.3)	12 (0.1)	8 (0)
Kriol	1022 (3.4)	1226 (5.3)	1003 (5.7)
East Indian	1421 (4.7)	1452 (6.3)	1381 (7.9)
Garifuna	1417 (4.7)	1539 (6.7)	1751 (10)
Maya Q'eqchi'	13,691 (45.8)	10,585 (45.8)	7122 (40.7)
Maya Mopan	4507 (15.1)	4525 (19.6)	3825 (21.9)
Mennonite	239 (0.8)	125 (0.5)	15 (0.1)
<i>Mestizo</i> /Spanish	5324 (17.8)	3384 (14.6)	2080 (11.9)

Table 1. Population by Ethnicity of the Toledo District, Belize (CSO 2001:42, SIB 2013, 2011)

groups that each represent five percent or more of the population living in the district (Table 1) (SIB 2010, TMCC & TAA 1997).

Table 1 reveals significant and constant growth in the population of the district between 1991 and 2010, especially among the Q'eqchi' Maya and *Mestizo* populations. According to the Central Statistical Office (CSO), the foreign born population in Toledo in 2000 was 3,885, up from 2,491 in 1991, with about 75% coming from Guatemala in both years (CSO 2001:58). Further, Thomson has reported that much of the population growth of the country has come from refugees and economic migrants from Central America (Thomson 2004:184). Still, it must be considered that such statistics, gathered through a government sponsored census, may have underlying political motives, especially at a time when those very Maya communities that are supposedly experiencing such growth are fighting the government in court for rights to their lands based on historical land-use and residency. Further, the *Mestizo* population, which by firsthand accounts have relatively little presence in Toledo and P.G. may have inflated numbers because of mis-categorization of Spanish-speaking Maya as *Mestizo*.

Punta Gorda, with a population of about 5,300 people, is the district capital and more generally reflects the diversity found in much of the rest of Belize (SIB 2013). Haug (2002:219)

reports that in 2002, similar to the population trends found district-wide, "Punta Gorda…has six major ethnic groups that are recognized by the Belizean government, each with 7 percent or more of the population." Further, Haug, who has worked in multiple primary school classrooms in Punta Gorda, reports that 30-50 percent of the children she worked with were ethnically mixed (2002:219). In 2000, the last time that such data is available, the population in P.G. was more distributed across ethnic groups, with Kriol (14.7%), Garifuna (30.8%), Q'eqchi' and Mopan Maya (24.4%), Mestizo (19%) and East Indian (8.7%) comprising the majority of the population along with noticeable numbers of Chinese and expatriates from the U.S. and Europe, giving the small town an especially diverse feel (SIB 2009).

Regardless of the actual population numbers, P.G. and the Toledo District comprise a diverse region, and within that diversity exists a unique blend of culture and history that varies across groups. An examination of the history of these groups in Belize will allow for a better understanding of how social life is organized in Toledo, including how access to health care varies across groups.

Maya Population

The Maya in the Toledo District are mostly two distinct groups with different historical circumstances, which led to their settlement in Belize. Largely because the district is so remote, colonial authorities paid little attention to the region, leaving little in the written record. However, since the early colonial era, southern Belize has been a refuge for indigenous populations. In the late 1600s, the Spanish military forcefully relocated much of the Maya population then living in the region to the Petén in neighboring Guatemala. The two groups of Maya, the Mopan and the Q'eqchi', both migrated from Guatemala beginning around the mid to

late 1800s, and continued sporadically well into the 20th century (Grandia 2009, Wilk 1997:57-59).

More recently, the issue of land rights has brought attention to the now more than 30 Maya communities in the district. In the mid-1990s, the Belizean government awarded a half million acres in the Toledo District as an industrial logging concession. The concession cut through communities and agricultural land long-used by Maya in the district, and led to grassroots organizing, and eventually to a lawsuit to halt the logging concession and a fight to secure official rights to their lands under customary land-management. The case eventually ended up in the Belizean Supreme Court, which in 2010 ruled in favor of the Maya communities who pursued the case, effectively granting them customary rights to their lands. Still, the government continues to drag its feet in acknowledging the judgment (Grandia 2009, MLA 2010).

Mopan Maya were originally from central Belize and the Petén region of Guatemala; however, most were pushed out of Belize by the British, only to return, fleeing forced labor and taxation in Guatemala. Their return brought them back to southern Belize in the Toledo district where they founded the village of San Antonio, which continues to be the largest Mopan village (Barry and Vernon 1995:79). In flight from forced labor by German coffee growers in Guatemala, the Q'eqchi' also migrated to southern Belize starting in the 1890s. In the 1950s and 1960s, most Maya were involved in subsistence farming, and occasionally took seasonal wage labor in chicle extraction or the citrus and sugar plantations (Waddell 1961:71-72). This boom and bust export industry has a long history in the Toledo District, and both Q'eqchi' and Mopan have taken part when jobs were available, and returned to farming when the jobs left (Grandia 2006, Zarger 2009).

The taking of wage labor has increased in subsequent years and expanded into the tourist sector, and even the military. Still, many Maya households rely at least partially on their surrounding environment for subsistence – producing foods and other household products on the *milpa* and in homegardens, and collecting and hunting in the bush (Zarger 2009). A significant number of both Mopan and Q'eqchi' Maya have migrated to P.G. in recent years, lending to the expansion of the small town and the newer neighborhood's name of Indianville. The move to P.G. has been driven by a number of factors, largely the search for wage labor, to be closer to schools, and in some cases for religious reasons. Still, most Maya in P.G. retain strong ties to their families in the outlying villages, and visit often.

Garifuna Population

The Garifuna culture "is a product of Caribbean cross-fertilization over the centuries, a culture that is neither Carib nor African, yet is derived from both, with European additions" (Bolland 1986:58). The Garifuna, or Garinagu, are a unique population that primarily inhabits the Caribbean coast of Nicaragua, Honduras, Guatemala, and Belize, with origins connected to slaves from West Africa who escaped from a wrecked ship to an island near St. Vincent in 1675. They subsequently intermarried with the local indigenous, the Caribs, resulting in a unique cultural blending of West African and indigenous customs that has persisted along the relatively isolated Caribbean coast of Central America.

In his 1976 article on Carib culture on St. Vincent at the time, Gullick reports that "Black Caribs" remain on the island, describing themselves: "We are the Black Caribs. In 1675, a slaveboat sank between Bequia and St. Vincent and the Caribs looked after and married the slaves. We are their descendants" (1976:253). Some of those descendants were forcibly removed from

St. Vincent, to the coast off Honduras. By the early 1800s, the "Black Caribs", now called the Garifuna, had begun to settle in the south of the Belize, having migrated from the island of Roatan, Honduras, after being resettled there by the English from the island of St. Vincent (Chala 2006, Sutherland 1998, Setzekorn 1981). Settlements were established in the Toledo district, including in Barranco and Punta Gorda which at one time was a predominantly Garifuna village (Setzekorn 1981:63). Bolland further describes a renewed interest in the maintenance of their traditional culture by many Garifuna, especially those who have left their communities seeking work: "Some of these [Garifuna who have left Belize] feel that their old ways are now threatened and anxious that their children know what it means to be Garifuna" (1986:59). Garifuna Settlement Day is now a national holiday in Belize, and celebrates the arrival of the majority of the Garifuna population as refugees fleeing violence in Honduras in 1832.

The Garifuna make up a high percentage of the population of P.G., and two villages in the Toledo district, Barranco and Punta Negra, are principally Garifuna. As a group, they have faced challenges in Belize: they were not allowed to own land through the 1800s; they were considered squatters by the colonial government (Barry and Vernon 1995:77); and, historically, there have been hostilities between them and Kriol populations, although less so in contemporary Belize (Setzekorn 1981:23). In this way, they faced similar exploitation to Maya living in the area. Distinct from the Maya however, the Garifuna have a reserve sitting to the west of P.G. that has land available to any P.G.-born Garifuna. The reserve has historically been used for farming, but families have also built homes and moved to the reserve (Cosminsky 1977). Today, the Garifuna remain a culturally distinct group, and as communication with Garifuna communities in other countries has increased, a renewed appreciation for their culture has arisen among many Garifuna in Belize (Chala 2006:42).

East Indian Population

While slavery was abolished in Belize in the 1830s, that milestone did not erase the need for cheap labor for logging and agricultural enterprises. Throughout the Caribbean, the abolishment of slavery led to a shortage of labor in the sugar industry. In 1838, the first of approximately 500,000 indentured laborers from India were brought to the Caribbean, British Guiana specifically. The importation of indentured workers, mostly from northeast and southern India, continued in the Caribbean into the early 1900s before being abolished in 1920 (Klass 1961, Roopnarine 2003). In his study of an East Indian community in Trinidad in the late 1950s, anthropologist Morton Klass (1961) was told by elders that people were often deceived into signing contracts to work in the Caribbean by promises of high wages, but a scarcity of food, money, and work also influenced led many to leave their homes in India.

It was a British sugar company in Jamaica that first brought East Indians to Belize as indentured labor. Many East Indians in the Toledo District are descendants of East Indians who emigrated from Jamaica in the late 1800s at the founding of Seven Hills Estate, just a few miles north of Punta Gorda Town. The owners of Seven Hills Estate were from Jamaica, and had already brought many of their workers from India, and when the owners expanded into southern Belize, they brought those workers with them. The estate produced sugar and employed hundreds of people, including local Maya, Kriol, and Garifuna. In the 1860s, the Seven Hills Estate began a steady decline after the mysterious disappearance of its manager. At the same time, American confederates began to immigrate into the area and founded their own sugar mills, hiring on many of the workers from Seven Hills (Ranguy 1999). As many as 7,000 people from southern confederate states fled the U.S. in the late 1860s, some of whom settled just outside of P.G. and continued building the struggling sugar industry (Simmons 2001).

The agricultural endeavors for which East Indians were brought to work did not last long, however they remained in Toledo and still represent a significant part of the population in the region. Early East Indian immigrants were Hindu, with cultural ties to the Hindu religion in India. Some of the oldest immigrants did not speak English, and a few religious customs were followed at certain times of the year (Ranguy 1999). Today, their language, and most of their cultural and religious practices from India have been lost, however Indian heritage remains in the distinct cuisine of East Indians, including tacari, roti, dahl, and others. Ranguy (1999) reports that some of the Hindu holiday traditions were practiced by some of the early East Indians, but they have since disappeared.

Some East Indians in Belize were also brought by the British to work on sugar plantations in the north after they mutinied against the British in India, and they subsequently moved throughout the country (BNLSIS 2010, Setzekorn 1981:23). Bolland describes the experience of the East Indian population brought to Belize to work the sugar plantations: "The Indians were so few, so poor, and so isolated from their cultural heritage that most of their original culture has been lost. Apart from a few traditional foods, these people have become so integrated that they can scarcely be distinguished culturally from the Kriols" (1986:59). Overall, little is written about this population in Belize, however this research did not support Bolland's assertion that they are little different from Kriol populations, as in addition to unique foods, most East Indian households make use of a distinct and extensive array of traditional home remedies. According to the Belize National Library Service (BNLSIS 2010), East Indians remain in Toledo and are active in rice cultivation, which was also reported by Waddell (1961).

Kriol Population

The Kriol population represents the second largest ethnic group in Belize, but only makes up about 3.5% of the population in the Toledo District (SIB 2013). In P.G., Kriols are more prominent in number, likely because it is the site of government administration and the primary business center in the district (Cosminsky 1977). Kriols have played an integral part in the history of Belize, as they are a mixture of African and European ancestry, primarily from the original settlers in the country. The first African slaves were brought to Belize in the 1720s, and within 20 years, Africans outnumbered the British by about 2.5 to 1 (Gabbert 2007). Slavery in the Belizean context was unique in that logging work meant that groups of slaves were often out in the bush alone or with one or two overseers. The possibility for flight was therefore greater in Belize then in plantation settings. Bolland (1977) explains that it was custom in Belize to keep African families together during slavery so as to lessen the possibility of runaways. Due to a significant number of children born of mixed ancestry, and the ability of some slaves to buy their way out of slavery, the number of free black people in Belize grew steadily throughout the early 1800s. Free men of African and mixed-African descent, who often sought to distance themselves from slaves by taking on British customs, were able to gain wealth in influence in Belize. Over time as their numbers grew and the numbers of white settlers decreased, Kriols became increasingly prominent members of the Belizean elite, taking on the majority of government positions (Gabbert 2007).

This long history of being the majority population and having a prominent role in the governance of the country led many to declare Kriols as the "real Belizeans" upon independence in 1981 (Gabbert 2007). Research conducted by anthropologist Sheila Cosminsky (1977) revealed that in Belize, Kriols are often considered any Belizean born of African ancestry other

than the Garifuna. Both historically and today, most of the Belizean Kriol population lives in the Belize District. This historic proximity to the administrative center of the country led to many Kriols being trained by the British for administrative and political duties. Kriols became the backbone of the Belizean civil service, and moved around the country, including to P.G. to fulfill these duties (Cosminsky 1977).

Barry and Vernon (1995:73-74) further note that Kriols form a significant part of the two main political parties in Belize, and maintain high influence through the media (especially newspapers and radio). "Kriol is conceived and expressed more as a social and cultural than a biological phenomenon. The concept is used primarily to identify a non-Indian and non-*Mestizo* way of life and a set of social values derived with local adaptation, from the Anglo-Saxon countries, mainly Britain, the West Indies, and from Africa" (Grant 1976:14). Today in P.G., the creation of the Kriol Council, along with some prominent Kriol tourist ventures points to a perceived need by local Kriols that they must organize to promote and protect their interests.

Pluricultural P.G.

If Belize is viewed as a diverse nation, P.G. can be seen as the quintessential town in this respect. It was always striking that in one day in P.G., up to seven or more languages could be heard on the streets and shops of this small town. The diversity of ethnic groups, cultural events, and languages contributes to the uniqueness of the town, while making it an ideal place to study any range of topics through which diversity would be a useful lens. The incredible mix of groups from such disparate backgrounds makes P.G. a true case study in diversity in today's world.

P.G. is also a place experiencing competing influences from local, national, and international sources. A growing ethnic consciousness that has resulted in the founding of Ethnic

Councils of the major ethnic groups points to the strength of historical cultural practices and their influence on daily life in the community. As a young nation, Belize is still steadfast in its quest to reaffirm a true Belizean identity, such that through its pluricultural reality, the country can unite as one. And P.G. is a place where the global influence of capitalism and consumerism can be readily felt, as young people have the latest smart phones, lap tops and computers are becoming ubiquitous, and cable television from the U.S. is on the screens of a growing number of homes. In the end, it is perhaps the pluricultural aspect of P.G. that gives the town its truly unique character. It is through the maintenance and promotion of its many distinct cultures that will allow the community to negotiate the ever-expanding national and international influences that threaten to homogenize so many other parts of the country and globe.

These local and global influences that are so evident in P.G. are also a force in how people maintain their health. From the State-provided biomedicine, to specially trained bush doctors, and from medicines at the pharmacy to generations-old home remedies, the local and the global are at play in how people practice their health – how they negotiate the totality of the health system that is available to them. An examination of health practices in P.G. offers insight into the complexity of factors that exist when people in P.G. are faced with making a health care decision.

Chapter 4

Mapping the Contours of the Local Health Care System: Health Practice in Punta Gorda

"Some doctors believe that they know everything in their profession. This is not always true" (Ranguy 1999:66).



Figure 4. The P.G. Polyclinic on a slow afternoon. Photo by the author.

It's Monday at 8:30am, and the waiting room at the P.G. Polyclinic is full and bustling with activity. There are close to 20 people waiting in the main check-in room, at least 5 or 6 families waiting outside, and another dozen people in the doctor's waiting room. All of the seats

are taken, and many people are standing or milling around impatiently. Sitting in a corner between the rooms, I can hear a cacophony of languages: not only English and Kriol, but also Spanish, Garifuna, and at least one of the two commonly spoken Maya languages, Q'eqchi' or Mopan, and maybe both. The diversity of those in the waiting room is noticeable, and is skewed towards the elderly and mothers with a few children in tow. There are more Maya women than other ethnicities represented. Most of the Maya women present are rather reserved and quiet, mostly hushing their children or speaking in low tones with their family members. Others, particularly Garifuna and Kriol, are speaking congenially with each other about family, friends, and local gossip.

P.G. is a small town where most people know each other, and this intimacy is evident in the interactions at the clinic. Yet most of the Maya, many of whom travel from outlying villages, remain somewhat separate from those of other ethnicities in this and similar social contexts. The polyclinic in P.G. is responsible for the residents of the 28 mostly Maya villages located outside the district capital of P.G., so many Maya patients are from outside of town. Additionally, Maya are often marginalized in P.G., in many cases because they are viewed by those in town as primarily rural farmers who continue to practice traditions that, to many in P.G., seem outdated. This sense of outsider status and marginalization is present for many Maya families at the polyclinic. For others in P.G., public spaces like the polyclinic are more social and almost community-oriented in that meeting people in any public space is a chance to talk and catch up on the latest news and gossip.

As I sit quietly observing in the waiting room, I notice that some patients have with them an empty prescription medicine bottle so that they don't have to pay the clinic pharmacy for a new one. The MOH policy on refilling these bottles is that they are clean and relabeled for every

new use, but I see that's not happening today. I wonder if regular patients just know their prescription and schedule after a few cycles, and the need to re-label is reduced. Either way, the practice is unsafe, as it results in medicines of unknown type and origin being brought into people's homes and private lives.

Despite being full, the rush at the Polyclinic started earlier in the day. The clinic opens at 7am each morning, and many of the first patients come in on the early buses from the outlying villages. Others from around P.G. also arrive early in the morning, knowing the wait can be long, but most P.G. residents visit in the afternoon if they can, knowing the wait will be shorter. Today there are two doctors seeing patients, and the stream into their offices is consistent and constant. Visits, which I can witness through the open office doors, are short and concise with few if any pleasantries. Such interactions maximize the number of patients the doctors can see, but at the expense of a personable encounter for the patients. It is the interpersonal interactions that are lacking in the clinic, something I noted in my field journal at around 9am, 2 hours after the clinic opened:

A few minutes ago I noticed a pleasant looking, smiling nurse come into the waiting room from the back of the clinic. She made me realize that most of the staff are cold-faced and more serious most of the time. There is really very little emotion shown by the staff, and I can't say they come off as being pleasant. They are not mean either though – just doing their job in a somewhat mechanical way, mostly ignoring the people filling the seats in the lobby and waiting room. The patients don't seem overly annoyed though. Looking around the waiting room, many of the faces are the same as were here an hour ago or more. Some of them seem frustrated, but mostly things seem to be "business as usual," like waiting is just what you do here.

In fact, waiting in Belize is more normal than I am accustomed to in the U.S. Whether waiting for a friend to meet you for lunch, waiting for an event to start, or waiting in line at some government institution, in Belize, it is common for things to happen at their own time and pace. Thus, people wait.

At 10am, it has begun raining, and people are squeezing into the waiting rooms. There are no seats available, and the doctors and staff appear to be working quickly. A short time later, I notice more men than women waiting. By about 11:30am there are only a handful of patients left waiting to be seen by a doctor. A few more are waiting for their prescriptions to be filled, but the clinic has quieted down, and staff has begun sweeping and mopping before their lunch break. Buses start returning to the outlying villages at 11:30am, so many patients need to leave the clinic to catch the bus home. The rest of the afternoon at the polyclinic is much more quiet, and the fewer number of patients are primarily composed of residents of P.G. This was a rather typical day in the Polyclinic, with mornings busy and hectic, waits long, and not all patients receiving service, and afternoons slower and more relaxed with fewer patients.

State-Sponsored Health Care in Belize

Belize has a public health system that is primarily financed by the central government, and is composed of three main institutions: the Ministry of Health (MOH), the Social Security Board (SSB) and the National Health Insurance (NHI). NHI is the institution through which citizens receive health care, and is the purchasing arm of the MOH. However, it is housed within SSB since it is partially funded by tax dollars. For most Belizeans, the cost of care when delivered by the State is considered free, and only incurs small co-payments depending on the

services rendered (PAHO 2009). The health system is buoyed by the Belize Health Information System (BHIS), a database of citizen health records accessible throughout the country.

The health care system in Belize has been transformed over the last 10 years and has garnered international praise. This praise, however, was not always present: "Historically Belize had a health care system with service overlaps and gaps as well as poor resource distribution including drugs, medical supplies and human resources for health. Some budget lines had significant wastage" (PAHO 2010a:3). As recently as 2004, the country's health system was disorganized, poorly managed, and was characterized as "a very rudimentary, paper-based health information system," (Vital Wave Consulting 2009:65).

Today, the national health care system in Belize has fully implemented reforms, including the BHIS that is recognized by PAHO as a "best practice" system for the Caribbean and other developing nations (PAHO 2010a). Established in 2004, and operated by the Ministry of Health (MOH), the NHI program along with the BHIS make up the core structure of the government's national health system. Through the NHI and the BHIS, the MOH aims to provide universal access to health care and the just distribution of its health resources. According to the MOH, "this commitment is reflected in the elimination of financial barriers to the use of preventive and primary care services, and subsidies for in-patient care in government-run health facilities" (BZMOH 2009a:5). However, the international recognition for excellence is largely because of the BHIS and its widespread adoption across the country, and has less to do with the NHI and the actual level of services that are provided to Belizeans.

With the support of the Inter American Development Bank (IDB), funding for the reform of the health sector in Belize was secured in 1999, and comprehensive reform aimed at modernization of the organization structure, improvement in the system's operational efficiency,

and the improving health care coverage for the populace was begun in 2001 (Vital Wave Consulting 2009). By 2004, the NHI program and a pilot project BHIS was launched. However, it would be the full implementation of the BHIS in 2008 that gained the praise of organizations like the World Health Organization and the Pan American Health Organization. The BHIS was developed by the Belize MOH, which contracted Accesstec, a Canadian software developer that specializes in health, and with financial and technical assistance from the Inter American Development Bank and the Pan American Health Organization. The new health information system was designed to track every patient encounter with the Belize health care system, "while managing patient flow, monitoring infectious disease outbreaks and keeping track of supply inventories and financial and human resources" (Vital Wave Consulting 2009:65).

Closely working with the Belize MOH and Canadian health professionals, Accesstec developed a unique health information system specifically for Belize. The BHIS "incorporates elements of electronic medical records, electronic health records, patient management algorithms, health system management, supply chain management, business intelligence and analytics that uses a single graphical user interface" (Graven et.al. 2013:954). Over time, every citizen of Belize will have a personal Electronic Health Record, which will include a comprehensive medical background, history of treatment, and health status records. At its optimal operation, when a patient visits a pharmacy, a private doctor, a health outpost, a polyclinic, or a hospital, that patient's full medical records are available to the service provider. Once a patient is registered into the BHIS, they can visit any health facility in the country, and their records will be accessible.

Further, the BHIS makes treatment easier for service providers. Not only do providers have complete up-to-date health records of their patients, they have access to the BHIS diagnosis

and treatment program that categorizes health problems into eight domains and provides an "optimal" course of treatment. "Thus a clinician, at the time of a new patient encounter, has all past information available no matter where previously seen in the country. If the patient's age or problem falls within one of the eight health domains, the clinician is prompted by test menus or medication choices to make evidence based care decisions" (Graven et.al. 2013:955). In other words, service providers are provided with instructions on how to treat their patients, taking some responsibility out of the hands of health practitioners, and placing it on an electronic system. While such a system may standardize care and treatment options and decrease the time necessary for patient consultations, it has little ability to determine the complexities inherent in a person's health and well-being. A system that treats all ailments in the same manner is in danger of ignoring the particularities of the patient, thus actually raising the potential for mis-treatment of any number of health conditions.

Still, according to its supporters, there are additional aspects of the BHIS that make it an especially effective system. It has incorporated comprehensive pharmaceutical tracking that connects every pharmaceutical warehouse in Belize to every public and private distributor across the country (Vital Wave Consulting 2009:66). There are also a number of incentives that make use of the system attractive to service providers. The BHIS is designed for ease of use and has a simple learning curve, it allows for more effective time-use of the providers (see Figure 5), and with all patient information in one place, it simplifies and reduces time spent on paperwork (Graven et.al. 2013:956).

The BHIS also improves the public health efforts and responsiveness of the Ministry of Health. For example, "the benefits of the system, according to the Ministry of Health, include "better tracking and monitoring of infectious diseases such as SARS and Bird-Flu, rapid

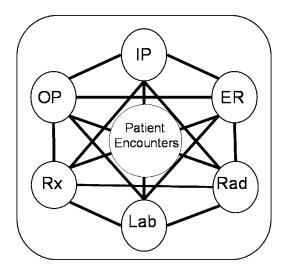


Figure 5. The interconnectedness of the BHIS as reported by Graven et al., showing that all types of patient encounters are fully integrated with the system. IP=inpatient public & private hospitals, OP=outpatient public & private clinics, Rx=public & private pharmacies, Lab=all laboratories, Rad=diagnostic imaging, ER=emergency services. Source: Graven et al. 2013:598.

identification of patients in the event of the release of unsafe medicines, country-wide prevention of mother to child transmission of HIV and better care for diabetics" (Vital Wave Consulting 2009:65). Indeed, the statistics reported in a study conducted by staff of the Belize Ministry of Health (Graven et.al. 2013) are impressive:

Within 1 year of full deployment, i.e. by July 2008, over 90% of all healthcare encounters in Belize in both the public and private sectors, in inpatient and outpatient settings, were being entered into the BHIS, with over 95% by mid-2009 with ongoing slight increases since. Thus the vast majority of health care workers had to be using the BHIS. The very small portion not entered, represents a small number of private system encounters and a tiny fraction of public system encounters scattered across the country in very rural outposts with minimal rudimentary services. (958)

Further, according to Graven et al. (2013), the MOH was able to demonstrate that the development of the eight health domains and response protocols were successful:

When the 2005 combined mortality rates for these eight domains with BHIS protocols were compared to the combined rate in 2011, a summed mortality decrease of 1.058 per 1000 was noted. In contrast, for the three domains without protocols, there was a summed increase of 0.465 per 1000 (2005 compared to 2011) over the time period. Between 2005 and 2010, the country wide crude death rate for Belize declined from 6.04/1000 to 5.00/1000 population [4,13] in keeping with the declines noted in the eight domains. (959)

It was this type of success that led, in 2009, to a regional workshop, hosted by Belize in conjunction with PAHO, during which countries from throughout the Caribbean were briefed on the BHIS and invited to draft a regional plan of action and resolution (PAHO 2010a).

This Caribbean-region workshop titled, "*Belize Health Information System: Lessons Learned to Strengthen National Health Information Systems in Barbados, Eastern Caribbean Countries, Jamaica, and Trinidad and Tobago*" was attended by officials from throughout the Caribbean and some of the world's most notable health organizations, including: Anguilla, Antigua and Barbuda, Barbados, Dominica, Jamaica, Montserrat, Saint Lucia, St. Vincent and the Grenadines, St. Kitts-Nevis, Trinidad and Tobago, Health Metrics Network, the Organization of Eastern Caribbean States, PAHO/WHO, and Accesstec Inc. (the company that helped develop the BHIS). The workshop included several presentations detailing the various aspects of the BHIS. The attendees unanimously passed a resolution, which included the recognition of the BHIS "as a best practice of an integrated country-wide electronic information system to be used as a model for the Caribbean Region" (PAHO 2010a: 23).

The resolution (PAHO 2010a) also included a critique of the health systems of other countries throughout the Caribbean:

- Cognizant that health information systems of the countries of the Caribbean are weak, fragmented and under-resourced, and that information and statistics produced are inadequate to support evidence-based planning and services; and now having viewed and appreciating that Belize has developed the first country-wide integrated electronic health information system in the world, which is a best practice model for the rest of the Region and was supported by PAHO, HMN, Inter-American Development Bank (IDB), Caribbean Development Bank (CDB), and others.

- Convinced that other countries of the Caribbean region can benefit from the outstanding achievements of the Belize Health Information System (BHIS). (22).

The health system in Belize, and specifically the BHIS (Figure 6) is now widely recognized as a success, and at what would seem like a reasonable cost. The development of the system, including hardware and programming, cost around \$4US per Belizean citizen, and annual operating and support costs are estimated at around \$3US per Belizean citizen (Graven et.al. 2013:956).

These accomplishments were made possible with significant funding and cooperation from a range of international organizations, and they grant significant prestige and pride to the Belize health system. For example, PAHO (2010a) has continued to offer praise to the BHIS:

The BHIS is not just a server designed to store health information but an adaptable system that serves many different users. The system links the Ministry of Health with the country's public and private hospitals, laboratories and clinics. It allows data to be made available to authorized users anywhere in the country almost as soon as they are entered in the system. The BHIS not only improves the efficiency of the country's health system,

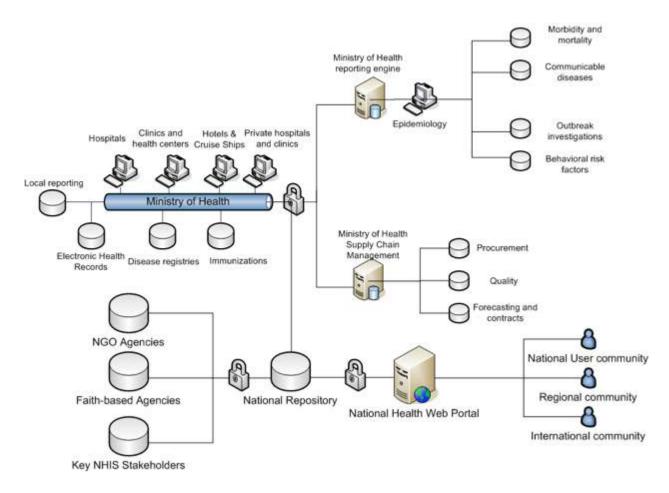


Figure 6. Final vision for the National Health Information System in Belize. Source: BZMOH 2009:13.

but also encourages a more holistic approach to diagnosis and treatment. (1) This collaborative effort to create and implement such an effective health system is impressive, and is being promoted in such a way that other developing countries are being urged to take note.

Still, the system's replicability in all but the smallest of developing nations remains in question. Factors such as population size (Belize's population is less than 350,000) and the lack of a complex system to upgrade or transform made the implementation of the health reforms in Belize more successful. Indeed, health information systems "often seem likelier to achieve success when they occur alongside a wholesale reform of a health system's structure and functioning, rather than when they are built to accommodate an existing system whose

dysfunctionality may preclude attempts to capture and integrate important data" (Vital Wave Consulting 2009:66). Such was the case in Belize, where the BHIS was introduced concurrently with complete health sector reform. And while the parties involved with the creation and institution of the new health system in Belize, namely the MOH and PAHO, have uniformly praised the new system, there remain challenges, including the continued funding of the health care system and the furthering of health infrastructure improvements. Maintaining the system as a whole, and ensuring that it is functioning properly and equitably across the nation will remain difficult tasks into the future.

Challenges for the Belizean State Health Care System

Despite being lauded for the success of the BHIS, the MOH continues to face challenges and difficulties within their overall health system, including within the BHIS itself. Challenges that are financial in nature are particularly noticeable in many of the published reviews of the health care system. In his report for the IDB, Mariano Lafuente explains: "Partially because Belize is a small state, its public administration is one of the most expensive in Central America compared to the size of its economy" (Lafuente 2013:1). According to data from the World Health Organization, the total expenditure on health per capita has steadily risen since 2001 from \$154US to \$262US in 2001 (Figure 7) (WHO 2013). In its analysis of its own health system and the BHIS, the MOH also identified financing as a weakness, specifically noting a lack of financing for monitoring and development of the public health and respective data (see Table 2).

The BHIS remains a primary focus of the Belizean State health care system, driven by the philosophy that an efficient BHIS is the best way to improve the health of all Belizeans. Still,

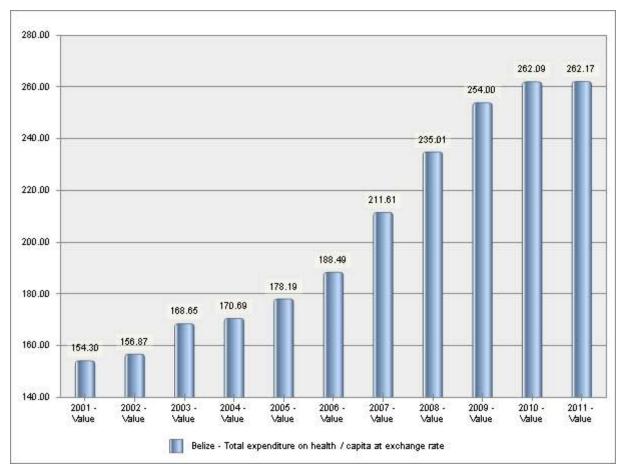


Figure 7. Belize Government Health Expenditure per Capita. Source: WHO 2013

there remain further issues that require addressing. A study by staff of the MOH points out that "Only one of the seven public hospitals, the Karl Huesner Memorial Hospital, provides tertiary care including dialysis; adult, pediatric and neonatal intensive care; and cardiac surgery" (Graven et.al. 2013:955). This lack of tertiary care options means that transport to Belize City is necessary for all patients in need of such care, no matter where they are in the country. This need for transport poses challenges for remote parts of the country like P.G. and the Toledo District, where transportation infrastructure is lacking.

PAHO (2009) also points to inadequate and insufficient health personnel and staffing as an especially key weakness in the State health system. The organization reports that keeping

Table 2. SWOT (Strength, Weakness, Opportunities, Threats) Analysis of the BHIS. S	ource:	
BZMOH 2009a:11).		

Strengths	Weaknesses	
- Comprehensive set of health indicators		
- Standardized tools and guidelines for data	- Too many indicators and reporting	
collection at health facility level	requirements – stems from different programs	
	by different partners - Inadequate financing of M&E activities,	
- Small population – facilitates coverage by	1 0 /	
EHRs Control and Pagianal Manitoring &	arising in part, from failure to budget	
- Central and Regional Monitoring & Evaluation (M&E) units within MOH	adequately for M&E activities under national programs	
- Core group of dedicated and competent	- Limited capacity for in-depth analysis on	
personnel in the MOH and stakeholder	health systems data at central and regional	
institutions	levels	
- Existence of an e-government policy	- Weak IT support, especially, at district level	
- National health statistics is published	- Poor information sharing among	
annually	government departments and with non-public	
- Political commitment to the development of	sector organizations	
the BHIS and e-Health	- Limited reporting of data by private sector	
	providers	
	- Data quality audits are not done	
	- Resistance among clinicians and managers	
	to use EHRs	
	- Managers' limited capacity to use	
	information for decision-making	
	- Lack of standards for ICT – barrier to	
	interoperability and data sharing by different	
	stakeholder organizations	
	- Limited human resources	
	- Weak legislation to support (electronic)	
	health records	
Opportunities	Threats	
- Growing awareness of need for data	- New donors with new reporting	
protection laws	requirements will use up limited capacity	
- Government e-Strategy to provide unified	- Natural disasters – Belize is prone to	
framework	hurricanes	
- Commercial sector with ICT support	- Global economic slowdown	
capabilities	- Potential for security breach higher with	
- Growing donor interest in the BHIS	web-based applications like the BHIS	
- Increasing popularity of performance-based	- Competition from private sector for IT staff	
funding (requires timely, reliable		
information)		

nurses on staff has been especially difficult:

"Nursing attrition increased from 7.7% in 2001 to 9.6% in 2006. Several factors contribute to this attrition including inadequate conditions in health facilities, shortage of medical supplies, poor state of buildings, inadequate accident and emergency services, limited availability of drugs, inappropriate ventilation, lack of support and communication from management, unconfirmed contracts, and disparity in pay for doing the same or similar job." (27)

Further, there is a difference in how health care is received between rural and urban populations: "The problematic dichotomy between health care delivery in urban and rural areas is not only reflected in inequitable distribution of medical equipment and supplies favoring urban areas but also in the number, and more importantly, the quality of health personnel. This is particularly acute for remote rural areas" (PAHO 2009: 27). This observation certainly applies to Punta Gorda and the Toledo District, where this study was carried out, as they are the most rural parts of the country, and the greatest distance from the urban center of Belize City.

Belizean National Health Care in a Local Context: Punta Gorda and the Toledo District

The very marginality of the Toledo district from the main centers of commerce and governance of the State has had a very real effect on the health and health care available to the population. This was also the case historically, as Thomson (2004:119) reports, the Maya and Garifuna villages of the Toledo district were largely self-governed until the early 1900s, leaving one to suspect that there were little to no State-provided health services available to district residents at that time. With the lack of availability of even the most basic health indicators, such as birth and death rates, little can be said about health care in the Toledo district into the mid-20th

century besides that it was largely the responsibility of the rural communities themselves (see Waddell 1961). A short document held by the digital archives of the University of Florida briefly describes a hospital in P.G in 1923 that could accommodate eight people (Anonymous n.d.). German and Irish nuns founded a small hospital in 1958, and in 1981, the year of independence, the current hospital was constructed (Maraesa 2009). 1981 was also the year the national social security system was initiated in Belize. This system was designed to provide pensions, including for injured persons, and benefits for sickness and maternity, and marked the beginning of State efforts to provide health service support (Bolland 1986:65).

Barry and Vernon (1995) report that even after independence, about half of Belize's rural population did not have easy access to health services. In an effort to address this access issue, the government began training Community Health Workers (CHWs) for each village in the Toledo District. CHWs were trained in basic first aid, blood pressure monitoring, and the distribution of over-the-counter medicines, and were to refer patients to regional health clinics or the hospital as necessary. In return for their services, the CHWs receive a small government stipend of \$100BZ (\$50 US) (Maraesa 2009). Additionally, many villages received a small, one-room cement building for CHWs and mobile services to use. At least some of these buildings were shut down or rarely used, and CHWs have not been maintained in every village. Still, they continue to provide a link from the rural villages to the State health care system (Maraesa 2009, Rebecca Zarger, personal communication, February, 2014).

For the most part, conditions in regards to health care delivery in the Toledo district remain a problem today. Belize continues to offer State-sponsored health care, although its system does not equitably satisfy the needs of all Belizeans (BZMOH 2009b). Many of the efforts of the MOH have been focused on the urban centers of the country, leaving the rural

districts inadequately served. In fact, the Pan American Health Organization (PAHO 2010b) specifically notes that access to health care is of particular concern in the Toledo District. According to the Belize MOH, those in the Toledo District, where 79 percent of the population lives in poverty (meaning the household cannot meet minimum expenditures for average food requirements), experience some of the worst health outcomes in the country (BZMOH Belize 2009b, NHDAC 2004). Along with the highest rate of poverty in the country, there exist the highest rates in Belize of undernutrition, infant mortality, infectious disease morbidity, and growth retardation (PAHO 2010b). Given the extent of these health problems, at least as reported by PAHO, it becomes evident that the national health care system of Belize is not fully meeting the needs of the communities in the Toledo district.

At first glance, the list of health service access points in the Toledo District is quite impressive. According to the MOH (BZMOH 2013), there are 19 health posts served by 37 Community Health Workers, five satellite clinics (in the rural villages of Big Falls, Santa Ana, Pueblo Viejo, Santa Teresa and San Pedro Colombia), two Polyclinics (San Antonio & Punta Gorda), one Community Hospital (Punta Gorda), 2 mobile health units, and 1 private clinic (Hillside Health Care Center) which also operates one mobile unit. This network of health facilities works on a referral system (Figure 8), and citizens are instructed to visit entry-level health facilities first. In rural villages, residents should visit the health post, and either be treated or referred to the Polyclinic, which, if it cannot treat the patient, would refer them to the Punta Gorda Hospital, which would then refer them to the Southern Regional Hospital 2 hours north in Dangriga, or to the only major tertiary care hospital in the country 6 hours north in Belize City.

In reality, there are some fairly major obstacles to the effective functioning of this network. Interviews with MOH staff, nurses, and doctors confirmed that staffing is a major issue

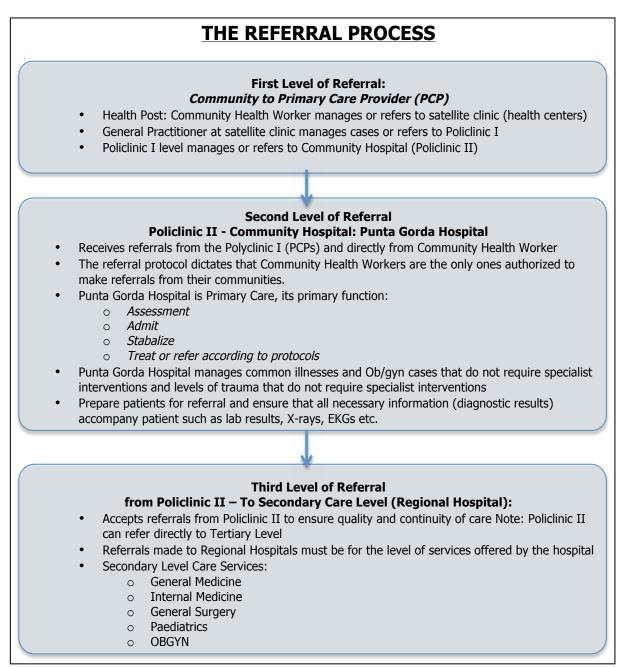


Figure 8. The official Referral Process in the National Health System of Belize as described by the MOH. Source: BZMOH 2013.

throughout the region. The MOH aims to have a Community Health Worker (CHW) trained in every village, however, they are not always present or available, and some villages remain uncovered. If a CHW is unavailable, a person in need of health services should then visit the nearest satellite clinic or Polyclinic. The 5 satellite clinics have regular opening hours 5 or 6 days per week, but are usually staffed by a rural health nurse and sometimes by a CHW. Doctors from Punta Gorda are also on rotation, and are supposed to spend a certain number of hours per week in the satellite clinics, however my interviews with MOH doctors revealed that this does not occur with any regularity because of the priority to keep the P.G. Polyclinic and hospital staffed with the limited number of doctors that are available. Further, the satellite clinics offer very basic services and medicines are usually limited to vitamins and cough syrup. Most people report that when they visit a satellite clinic there are no services provided, and they are simply referred to one of the two Polyclinics in the District.

Experiences of Health Care in Toledo District

This research explores the experiences that residents in P.G. have had with the State health system, including the Polyclinics and hospital. Services at the two Polyclinics in the District are reportedly inconsistent and confusing to many. In 2009, the MOH opened the second of the two Polyclinics in the District, a brand new facility centrally located to several rural villages. The District was split into two service regions, with the new Polyclinic to serve several rural villages, and the older Polyclinic in P.G. to serve P.G. and a number of nearby villages. In theory, and to people with little familiarity with the District, this would appear to be a good plan. However, through interviews with patients and staff at the P.G. Polyclinic, I learned that the good intentions set forth with the new Polyclinic did not come fully to fruition.

There are many factors contributing to the fact that the new Polyclinic (opened in 2009) near the village of San Antonio has not been as widely used as expected. One major obstacle is the actual location of the Polyclinic (Figure 9). The San Antonio Polyclinic was constructed on a major road that connects the Southern Highway with the border town of Jalacte. It is located at a

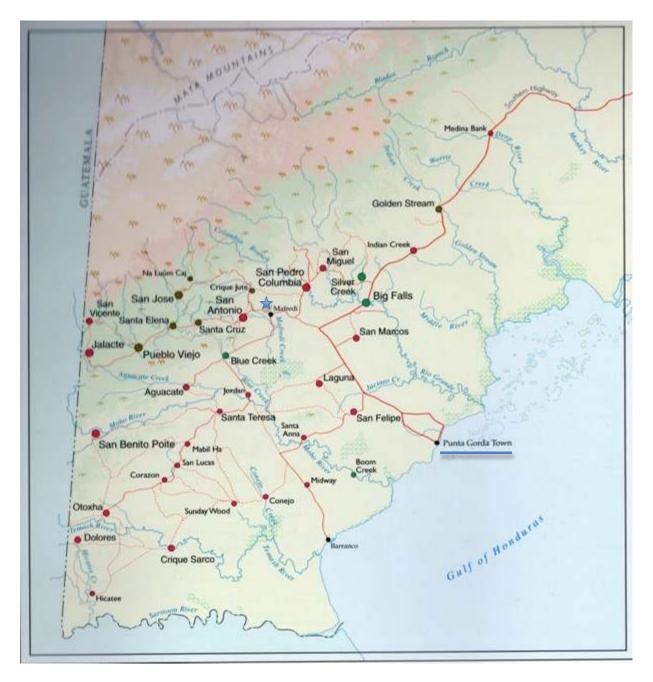


Figure 9. Close-up Map of the Toledo District. The blue star in the upper-central part of the map is the approximate location of the San Antonio Polyclinic. P.G. is underlined and on the coast. Source: TMCC & TAA 1997.

site about two to three miles past key intersections with unpaved roads that lead to over a dozen villages in its service area. In an area where people's primary mode of transportation is by bus or walking, this presented a problem. When someone needed health services, they could take the

bus (most of which usually run from villages only 4 days per week) to the intersection, where all buses make the turn towards P.G. – the opposite direction of the San Antonio Polyclinic. If someone gets off the at the intersection, they are left to walk the two-plus miles to the clinic, in many cases an impossible task for someone in need of medical attention. This factor alone caused most villagers to continue traveling the extra hour to the Polyclinic in P.G., as they had already been accustomed to doing.

The poorly conceived location of the San Antonio Polyclinic has been just one of the problems inhibiting the use of the clinic by rural residents of the District. In its review of the Belize health care system, PAHO details some of these problems: "The Southern Health Region has the least number of doctors and nurses...and serves a population that is more dispersed, have access limitations, and live in more precarious socio-economic conditions" (2009: 28). Through interviews with local staff of the MOH, I confirmed that the San Antonio Polyclinic was almost always understaffed, to the point that doctors were not always available. One MOH official explained in an interview: "That clinic has rooms full of new medical equipment, but nobody knows how to operate it. The pharmacy was often short on medications or unstocked, meaning patients had to travel to P.G. anyway to procure their medications." This poor reputation that the new Polyclinic has built in its first years of operation has driven village residents to the already understaffed, and poorly equipped P.G. Polyclinic, simply exacerbating the problems that the new clinic was supposed to help alleviate.

Political cronyism also plays a role in the inadequate functioning of the health system in the region. In an interview with another MOH official working in P.G., I was told that the administrator of the new San Antonio clinic was placed there by a family member who held a position in the higher levels of the MOH. This new administrator had no prior experience in

health or health administration, and only held a business degree, which did not aid in the efficient operation of the new clinic. A doctor working in P.G. explained: "Well the problems here are all politics. It's all politics. One [political] group gets into office, and if it's a different [political] group here, we pay the price." This political interference, poor planning, the resulting inadequate service provision have all combined to quickly give the new San Antonio a poor reputation throughout the District, leading most to still prefer traveling to P.G. for their health-service needs.

Perceptions of State Health Care Services in Punta Gorda

As the main market town and capital of the District, Punta Gorda is a definite hub of activity for residents of the Toledo District. A town of about 5,500 residents swells on the market days of Monday, Wednesday, Friday, and Saturday, when buses from villages throughout the District transport villagers to town (SIB 2012). Villagers come to P.G. to take care of numerous practical needs, including bank business, buying and selling at the market, shopping, and using government related-services, including visiting the Polyclinic, the hospital, the pharmacy, or private doctors. Many young people from Maya villages travel daily 1-3 hours by bus each way to and from P.G to attend high school. These market days are the busiest mornings of the week at the Polyclinic and Hospital, at least until around 11:30am when the buses begin leaving town to return to the villages. Tuesdays and Thursdays are quieter, and when most of the P.G. residents visit the clinic.

Before 2009, P.G. was the only place in the Toledo District for residents to access primary care on a consistent basis. The situation that persists in the outlying villages, in which staffing, supply, and equipment shortages in clinics are common, has been minimally improved in recent years. People in the Toledo District are habituated to traveling to P.G. for health services. And despite no proof that services are superior in P.G., rumors persist that the best health care comes from the clinics that are longest running – the most established. Still, the MOH has built the new Polyclinic, and has instructed staff to urge their patients to use the appropriate clinic. In fact, staff interviews revealed that villagers are disciplined for using the P.G. Polyclinic. One long-time nurse told me: "I yell at them! They are supposed to be going to San Antonio. We are already too busy here, and understaffed. That's why they built the San Antonio clinic. They have their own clinic and they should use it. After I yell though, I still give them service."

Some P.G. residents harbor resentment towards villagers using the P.G. Polyclinic as well. A number of interviewees reported that the wait at the Polyclinic is mostly due to the fact that villagers are there instead of using the San Antonio clinic. According to one Kriol mother, who repeated a common refrain: "I can't even go [to the clinic] on market days. All the villagers come in, and they're there with their whole family. I don't know why they just don't use San Antonio like they're supposed to." In P.G., the villagers being referred to are Maya, revealing that some tension – or at least frustration – exists between ethnic groups. It should also be noted that Maya living in P.G. cannot be differentiated from Maya living in the villages. Add to this the fact that the P.G. Polyclinic catchment area includes over 20 nearby villages and a population of nearly 8,000 people who live outside of P.G., and it is not at all clear who should or should not be using the services in P.G. Under the current MOH referral system, there will always be villagers using the P.G. Polyclinic. This common perception that villagers are using the wrong clinic can be seen as a thinly veiled prejudice, and is but one example of how Maya are often marginalized in P.G.

Regardless of the cause, the long wait was but one criticism of the NHI services in P.G. In interviews with 60 households across ethnic groups throughout P.G., dissatisfaction with services at the Polyclinic and hospital was common. When asked if they were satisfied with the NHI services, 83% of interviewees reported that they were unhappy with their encounters with the State health system, and they had a number of additional complaints (Figure 10). The most common complaints were: the staff is unfriendly, a responsibility of that also included descriptions such as lazy, and that they tree of the necessary transfers (48%); they need more and improved equipment (47%); the doctors and nurses are incompetent or need further training (47%); they need specialist health care provi-



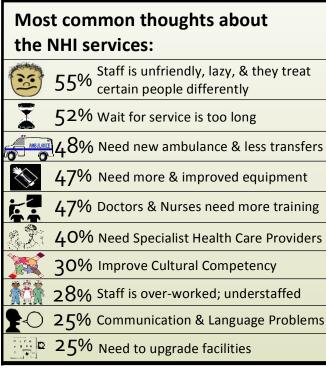


Figure 10. Interviewee responses to the question: What do you think of the NHI services?

communication and language problems (25%); they need to upgrade the facilities (25%).

Dissatisfaction with the NHI services was expressed in many ways. Sometimes explanations were short and to the point, as a Kriol mother in her 40s explained: "I will never go there! They don't listen to you, and they don't know what they're doing anyway." Others were more specific, citing examples of their past experiences. A Garifuna mother of four in her 50s told me about her experience during an overnight stay in the hospital: "It's not very comfortable to stay in the hospital. They bother you too much – now it's time for your medicines, now it's time for your bath, now it's time for this, and that. When you're sick, you just want to rest. But they keep bothering you the whole time you're there. Better off, just stay home. And they came and wanted to bathe me at 4am. Are they crazy?! You don't bathe at that time of day, not in your right mind. I told them that I would bathe when I was good and ready to do it. And for the whole week I was in there, they didn't change my sheets. Five nights with the same sheets? And you're sick. They told me they don't have any more sheets. But I change my sheets after 2 nights here at home. No sheets all week?!"

Such dissatisfaction with the NHI system in P.G., which includes the Polyclinic and the hospital, became especially evident through my interviews, as 23% of respondents said they would never use the Polyclinic except for an absolute emergency, and 45% said they only use the Polyclinic for very specific purposes like getting their blood pressure or diabetes medications. The poor reputation of the NHI services in P.G. begs the question of what people do when they need health services in non-emergency situations (Figure 11). I asked interviewees what they do in such circumstances and only 5% reported that their first course of action would be to go to the Polyclinic. 57% reported that they first try home remedies, and another 38% said they first visit the pharmacy for medicines they know or for recommendations from the pharmacist. The

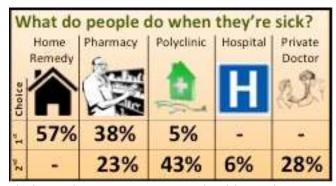


Figure 11. Interviewee choices when non-emergency health services are required.

Polyclinic was reported as the second choice by 43% of participants, making NHI services the top choice when other options don't work or are unavailable. 28% of participants said they would seek the services of a private doctor, and 23% said they would see the pharmacist as a second choice. The poor reputation of NHI services are confirmed by the fact that 1 in 3 of the households interviewed said that they travel outside of the District for health services, most commonly to Belize City or internationally to Guatemala or Mexico, and 28% of households prefer the services of a private doctor, even though they all also work within the NHI system.

The local perceptions of the NHI services available in the Polyclinic and hospital in P.G. are not necessarily far from reality. PAHO reports that some of these same shortfalls exist in the Belizean health system as well, specifically noting the lack of adequate medical equipment and supplies, the lack of and poor quality of health personnel, and the poor condition of health facilities in the Toledo District. For example, medical equipment is known as being substandard: "A large percentage of the existing medical equipment in districts have become defective and/or out of use. Advanced medical technology equipment is available only in Belize City at the private Medical Centers and KHMH" (PAHO 2009:29). My research showed this to be the case as well. During my 18 months in the field, there was never a working x-ray machine and ultrasounds were only available periodically when the equipment was brought down from the

north of the country. Early in my research, I was shown a brand new x-ray machine sitting in the corner of a storage room, reportedly donated by the Taiwanese government. However, the facilities did not have the proper electrical current to operate the machine.

Language, communication, and a lack of cultural sensitivity can also at least partially be supported by the structural reality on the ground. In other words, the health system, the structure the MOH has put in place, is not well equipped to address particular facets of local culture, such as language differences or some traditional health beliefs and practices. In some cases this lack of ability results in poor service delivery and unsatisfied patients. For example, as noted above, Belize as a whole has a shortage of health care professionals, especially doctors and nurses. PAHO explains how the MOH has attempted to address this problem: "Technical cooperation agreements exist between the Belize, Cuban and Nigerian governments, in which health personnel, mainly general practitioners are deployed to work in the rural areas" (2009:27). Toledo, and more specifically P.G., are some of the rural areas being referred to here.

During the time of my research, there were three Cuban doctors and a Nigerian doctor on staff at the Polyclinic and hospital (along with two Belizean physicians). A number of interviewees mentioned these non-Belizean doctors specifically, saying that they were short, rude, or unclear with their instructions. For the Cuban doctors, English was a second language, and none of the foreign doctors spoke Kriol or any of the indigenous languages to the area. Further, according to one Belizean doctor who had just moved to P.G., most Belizeans don't want to work in P.G. because of its isolation from the rest of the country. She described a post in P.G. or Toledo as a sort of punishment for some wrong-doing or as an initiation into the NHI system. Issues such as these and those mentioned above only contributed to the already poor reputation of the NHI services and facilities.

Non-State-Sponsored Health Providers

While the primary source of biomedical care in Punta Gorda is the MOH and its NHI program operated through the Polyclinic and hospital, there are some alternatives in town as well. There are three private practices with somewhat regular opening hours, although each of these general practitioners has ties to the MOH. At the time of my research, there were four general practitioners offering basic health services in town. All of these doctors either work or worked for the NHI system. Of the four, two have been open for more than 10 years, another for a two or three years, and the fourth, opened and closed over a period of about six months. One of the longer established practices is that of an older Belizean who is now a MOH official in the Southern Health Region, which includes P.G. The other long-standing private practice is that of a Cuban doctor who was employed by the MOH, however she no longer works with the State system.

The only other private practice currently open is that of another Cuban doctor who is currently employed by the MOH at the P.G. Polyclinic. The practice that opened and closed during the period I was conducting my research was that of a young Belizean woman who had been sent to P.G. by the MOH and ended up marrying a man from P.G. She left her NHI position to open her own practice, but was not successful in drawing enough patients to stay open. A local health professional, one of the x-ray technicians who works at the P.G. Hospital, is also attempting to open a non-profit clinic that brings in specialist practitioners throughout the year from Guatemala and the U.S., but his project has so far been limited to two health fairs during which locals could get their blood pressure checked and learn about basic health practices like nutrition and personal hygiene.

When compared to NHI services, most P.G. residents generally consider these private practices higher quality in terms of service provision. Only one of the three clinics had consistent and regular hours during my time in P.G., while the other two were open more sporadically. Despite the better reputation, for a number of reasons the demand for these private services in P.G. is not very high. Economics certainly played a part, as many households simply could not afford to pay for an office visit. Explained one East Indian mother: "Sometimes we go to a private doctor, but can't always afford that – they're expensive. But we would prefer them to the clinic or hospital." Economics in P.G. are such that many of the households that could afford the private doctor can also afford to travel out of the District – to Belize City or Guatemala – for services. One woman who travels for health care told me: "They're the same doctors as at the clinic. I don't trust them, so we just go up to Belize [City]."

In fact, they are the same doctors that could be encountered in the Polyclinic or hospital, but most people feel that the services provided in the private offices are better. One doctor hedged, but ended up confirming this perceived difference in service provision: "I give the same care no matter where I'm working. But if someone is paying me, I might give them a little better service, a little better care. My medicines are better here [at his private clinic]. But people are paying me, so I can afford to give them more attention. But I try to give the same care or service wherever I'm working." Better service, little or no wait times, and a certain prestige that comes with being able to afford private care are all factors that drive people to use the private clinics – when they can afford it.

Another common health care option for many households is the pharmacy. There are three pharmacies in P.G., and all of them are well respected around town. People use the pharmacy as a type of health care provider, best exemplified by how one Kriol woman explained

it: "Well, first I go to the pharmacy to get medicine – whatever the pharmacist recommends. If that doesn't work, I'll just go back and try something else. Because, you know, they have all kinds of different medicines for different things, so I just keep trying stuff." An interview with one of the pharmacists explained why many people choose this course of action: "I know that a lot of people come here when they should be seeing a doctor. But there are a lot of reasons for that. There is a big problem with NHI. The system is not smoothed out yet – they have some problems. People might not have their social security card with them [needed to receive care through NHI services], the wait is always too long up there, and I don't know what they do, but the medicines don't always work. They give the same medicine for just about everything, and people get frustrated and don't even want to go there." For many who cannot afford a visit to the private doctor, and for a variety of reasons, don't want to use the NHI services, the pharmacy is a type of private clinic, where they can walk in, explain their malady, and get informed advice on what to take. People can trust the quality of the medicines, and based on their long history in P.G., they can trust the pharmacists. Still, not everyone can afford to pay for their medicines, and when the services from NHI fail to work, they must find another option.

NGOs, Hillside Health International, and Medical Missionaries

There are currently no international non-governmental organizations (NGOs) offering primary health care services in P.G., and while I was not able to document specific legislation forbidding such an organization from working in the region, I was informed that the MOH is extremely hesitant to permit outside organizations to work in the country. MOH officials that I interviewed reported that the MOH takes this line in fear of the difficulties that could arise when integrating the BHIS with too many outside parties. There is one Belizean NGO working in P.G. called the Belize Council for the Visually Impaired (BCVI). BCVI treats all eye-care related problems, and works with people who are blind, losing their sight, or are otherwise visually impaired. There is also one locally-based international organization, Hillside Health Care International, in a small village about 15 minutes by vehicle outside of P.G.

Known locally as the Jericho Road Clinic (its first name from 1999) or Hillside Clinic, they are a faith-based organization that has a number of US doctors, nurses, and other service providers on staff, usually for a period of one or two years. They also bring volunteer students from the U.S. to Belize for practical experience in health services. Hillside Clinic is contracted with the MOH to provide the same health services as its other Polyclinics (like those in P.G. and San Antonio), and they provide all services free of cost to Belizeans. And while fewer than 15% of my interviewees had used the services provided at Hillside Clinic, a number of households were familiar with the services of the Hillside Clinic Mobile Unit (HCMU). The HCMU, a large white SUV with five or six young health service students from the U.S. packed in the back, is a common site around P.G. during the week. The unit visits households that have elderly or other house-bound family members to do regular check-ups and deliver prescriptions. The HCMU is widely respected around town, and gives the Hillside Clinic a reputation that far exceeds that of the NHI service providers. Those households that had visited the actual clinic also reported that the services provided were superior, that providers were friendlier, and that the medicines provided could be counted on as being of high quality.

The final source of biomedical care in the District is that provided by medical missionary groups from the U.S. These groups, two of which visited during my time in P.G., are widely talked of disparagingly by other health officials and service providers in P.G. MOH officials reported that they don't report what they are doing to the MOH, so any medications, shots,

vitamins, or services they provide are not entered into the BHIS. The lack of a connection to the BHIS has reportedly resulted in a number of problems, such as patients being given the wrong medications, or patients being taken off of medications inappropriately. Typically, such groups visit once or twice a year for about two weeks, travelling from rural village to rural village, and until recently, they represented the only biomedical care that many rural villages were able to obtain. They offer free basic services such as basic dental work, eye exams, blood sugar and blood pressure testing, and for those who cannot easily travel to one of the NHI clinics, they are still popular and convenient sources of basic care. One health official explained of the medical missionaries: "The majority don't cooperate with people like us who are here on the ground. They don't know patient histories, and they can't do any follow-up. So they're not really being helpful. They can actually cause more problems than they help. But when surgeons and dentists come, that's good. We need them, and they don't cause the same kind of problems."

Alternatives to Biomedical Care

Overall, the historic neglect of the state, poorly performing clinics and hospitals and poor health statistics, marginal, rural, and indigenous populations that are difficult to access, are all factors that combine to limit access to biomedical care in the District. Despite the fact that biomedical services are more accessible than ever, the historic isolation of the District, and the self-reliance that such isolation necessitated have led to a strong tradition of traditional medicines, including the use of traditional healers (locally referred to as bush doctors, herbalists, and snake doctors), and self-care based on herbal preparations passed down through generations and shared with family and friends. Balick and Mendelsohn have noted, "traditional practitioners provide up to 75% of the primary health care needs of rural people in Belize" (1992:128). The

use of healers is at least partially practical: "The high cost of modern pharmaceuticals, the lack of proper medical and health services and the strong practice of traditional healing in most of the rural areas of Belize is characteristic of the rural health reality" (Ellis 2001).

Traditional healers, often considered among the most informed of traditional knowledge, are numerous across the District and many live and work in P.G. as well. Among others, there is a practicing Maya herbalist and a Garifuna healer/herbalist who both live within a short walk of the NHI facilities in P.G. Other healers, of Maya, Kriol, and Garifuna descent live scattered around the outskirts of town. Traditional healers maintain a complex body of knowledge concerning the local environment and the medicinal, food, and other uses of plants found therein (Amiguet et.al. 2006). However, this source of health care in P.G. could be tenuous in the near future, as every healer I interviewed or encountered was also engaged in some sort of wage labor, most of them full time. With this time commitment to work, there are currently no young people being trained by any of the healers that I know. Even the Q'eqchi' Healers Association, to which some healers in P.G. belong, and which is actively working to preserve their traditions, has yet to find young apprentices.

People's willingness to share information about their use of home remedies and traditional healers may vary across ethnic groups, age, and church affiliation. For some, these practices are seen to carry social stigma. For example, some churches are known to actively denounce the use of herbs and traditional healers, which could not only influence whether people follow these practices, but also whether or not they discuss them. For others, the opposite holds true, and there can be a sense of cultural pride surrounding these practices. Either of these notions about such practices may skew what people are willing share, making it difficult to

generate a completely accurate picture of the extent to which home remedies and traditional healers are used.

Despite the challenge in uncovering the full extent of their use, this research shows that the use of traditional healers and traditional home remedies remains strong in households throughout P.G. Traditional home remedies, which are often based on a form of popular or generalized knowledge that does not require the consultation of a specialist such as a bush doctor, remain a first option for health care in 57% of the households I interviewed, and a second option for another 23% of the households. There were more than 70 unique remedies shared with me in interviews, with a number of specific plants most often mentioned by numerous households, including: Sorosi, Lemongrass, Lime (juice) & Honey, Aloe, Garlic, Ginger Tea, Scaganeel, Jackass Bitters, Lime Leaf, Soursop Leaf, Bissy, Oregano, and Tree of Life. Most of the women interviewed (65%) reported that they learned their remedies from their grandmother, while others related that another family member (30%) had taught them. Because women are primarily involved with the health care decisions for the household, no men were interviewed about their knowledge of home remedies for this research, which revealed that 92% of the women interviewed either made health decisions on their own (67%) or together with their husband (25%).

The use of home remedies in P.G. varied according to a number of factors. When ethnicity is considered, 92% of East Indian households use home remedies compared to only 33% of Q'eqchi' Maya households (Figure 12). Church affiliation also appears to be a factor in whether a household uses home remedies. Of those households that reported that they go to

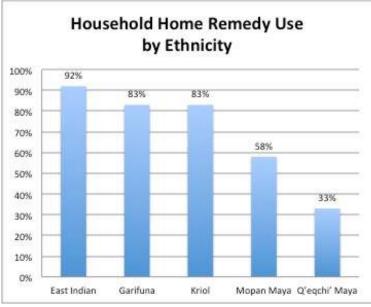


Figure 12. Household Home Remedy Use by Ethnicity of Household

church regularly (n=54), 31% do not use home remedies, with Evangelical Christians and Mennonites being the least likely to use home remedies (Table 3). Because some churches in P.G. encourage members to discontinue certain traditions, especially those associated with "the bush"–or traditionally prepared medicines derived from local flora–church attendance may be a poor indicator for the extent of the use of home remedies and traditional healers. Age of the head of the household was another factor in whether home remedies were used, with younger households less likely to be using them (Table 3).

If fewer young people are learning about and using home remedies, and if church membership is also negatively influencing the use of certain traditions, these factors may point to a change that can be expected to expand. First, the number of Evangelical Christian churches in P.G. is on the rise, and in interviews with Evangelical Christians, a common reply to whether or not they used home remedies was included a refrain about how such things were against God or of the Devil. Just as significant is the trend that younger households are not as likely to use

Home Remedies by Church Attendance		Home Remedies by Age	
No Church Regularly	5/6 (83%)	20-29	2/6 (33%)
Yes Church Regularly	37/54 (66%)	30-39	11/18 (61%)
Baptist	1/2 (50%)	40-49	9/14 (64%)
Catholic	22/27 (82%)	50-59	14/15 (93%)
Evangelical Christian	2/7 (29%)	60-69	5/6 (83%)
Garifuna Mass	1/2 (50%)	70-79	1/1 (100%)
Jehovah's Witness	3/5 (60%)		
Mennonite	0/2 (0%)		
Methodist	7/8 (88%)		

Table 3. Home Remedy Use by Church Attendance and by Age

home remedies. These households often talked of how their parents used them, but "we don't do that anymore." Another common response from younger households is that they do know some remedies but don't know where to get the plants.

While the use of home remedies remains fairly robust in P.G., the use of traditional healers is less so. For some, traditional healing is associated with superstition, so not everyone is forthright in their revealing whether they use healers or not. This hesitance was revealed to me in a number of interviews in which the interviewee would first tell me that she doesn't visit traditional healers, only to tell me a story later in the interview about having visited a healer for some ailment or problem when biomedical services didn't work. Still, only 28% of households reported in any way that they use a traditional healer for health services, and no households reported using them as a first or second option when the need for additional services arose. Perhaps a more telling question as to the popularity of traditional healers however, is when I asked what interviewees thought of traditional healers working in or with the Polyclinic in P.G. – 77% of interviewees thought this would be a good idea, many of them preferring to have the option of a more natural solution to their health problem.

Overall, the use of traditional health practices in P.G., whether with home remedies or through traditional healers, remains fairly widespread. Still, it must be noted that no households reported using only traditional medicines. In practice, people use a combination of approaches until something works. Most commonly, people will use a traditional home remedy or something from the pharmacy as a first course of action when they get sick. If the problem persists, other courses of action are taken until wellness is achieved. Nearly every household uses some combination of traditional medicine and biomedicine in their attempts to get and stay well. The factors driving these decisions vary widely, and include such personal factors as age, church affiliation, ethnicity, and income, as well as more societal factors such as the types and quality of services that are actually available.

My research shows that the use of traditional health care practices, whether through the preparation of traditional home remedies or by using the services of a traditional healer, is still widely practiced in P.G. However, there are signs that these practices may be on the decline among the younger generation. The MOH has made great strides in improving NHI services in P.G., and the ease of access, and the low cost of these public services may be steering people towards the use of biomedical services. However, as described above, there remain some serious deficits to the NHI system that result in a failing of the system to meet all of the needs of the population. Still, if there is a shift in how willing individuals are to pursue traditional health care in the face of more easily available biomedical care, the result could be the continued decline of traditional health practices. This transformation, which would result in fewer health care choices and a greater reliance on biomedicine and pharmaceutical drugs, could further widen the health care gaps that already exist in the P.G.

Chapter 5

Medical Pluralism in Southern Belize

It was a typical hot and humid afternoon in P.G. when I found myself wandering around on my old bicycle, carefully maneuvering through the muddy, puddle-laden lanes in the back of town. I was looking for a Maya home, a wood-wall, thatch-roof constructed building that, although growing increasingly rare in P.G. so it should have stood out, was proving difficult to find. I had reached a dead end, and had to stop and get off my bike to turn around. I was hopping around the puddles when I looked up to the face of a young Maya boy, not more than five or six years old, squatting on a small mound in the bushes. He was trying to go the bathroom, but I seemed to startle him, and he ran away through the bush, a remnant of the dense tropical forest that not long ago occupied this part of town.

As my gaze rose to watch him scamper away, I saw a thatch house, nestled back in the trees. A few yards away was a muddy trail leading towards the home, and I carefully made my way back. "Hello!" I called out as I approached the house with the interested eyes of about six children following my every move. My friend Anna appeared at the door holding a baby, smiled, and invited me in. I ducked beneath the low-hanging thatch roof and into the home, into a mostly bare room, slung with some hammocks, and with a washing machine and piles of laundry near the doorway. There was some activity in an adjoining room, and Anna left me for a moment.

I first met Anna when she was working with another researcher, an old friend from the U.S. who also worked in P.G. Anna was a young Q'eqchi' woman in her mid-20s, a mother of



Figure 13. A Maya healer works on a patient in P.G. Photo by the author.

three who worked part time as a primary school teacher. She was working with my friend as a translator and research assistant on a project that included interviewing Maya bush doctors when we met and offered to help me with my research as well. Anna introduced me to a few healers around P.G., and soon invited me to observe a traditional healing ceremony, to which I was headed that day.

After very brief introductions to the family of the house, Anna informed me that they were ready to start the ceremony. The children were cleared out of the room, the windows were covered, and the doors closed. I was invited into a small dark room with Anna and a small Q'eqchi' woman in her 80s, a well-known healer brought to town from a nearby village for the ceremony. The healer prepared a chair for her patient, began lightly praying in a mixture of Q'eqchi' and Spanish, and stoked a small fire burning in the corner. Someone opened the door to let in the patient, and I was surprised to see the small boy who caught my attention out by the road.

Anna had earlier explained the purpose of the ceremony: "The boy won't eat anything. He hasn't eaten for a few days now. They took him to the clinic, but they said he was fine. They didn't do anything for him. His parents have been trying to get him to eat, but nothing is working. They don't know what's wrong, but they think he may have fright⁴, so they decided to have the bush doctor come."

The ceremony happened quickly, at least partially because of the short attention span of the child. The boy was placed in the chair, his head bowed down and covered with a damp towel. The healer, always praying, placed a smoking bowl under the chair. It contained a variety of herbs, locks of the boy's hair, and a small tear of his clothing. He was made to breathe in the smoke, while the healer called for his soul to return through a small window left cracked near the ceiling. Soon, the healer dumped water to extinguish the burning material, and then bathed the boy with the water. By now he was beginning to squirm, but the ceremony was over, and he was released outside where he ran to play with his siblings, covered in the sooty water of his healing.

The ceremony took all of 20 minutes or so, and the healer had to leave so she could catch the 11:30 bus back to her village. I thanked everyone, and left with Anna so that I could ask some further questions about the ceremony and traditional healing in general. I asked if she uses the services of a bush doctor. "I don't really use them, no. I don't ever get sick, so I don't need to. And with my kids, I just take them to the clinic," she said, referring to the State-run

⁴ Fright is a folk illness caused by some startling or frightening experience. It is thought that such an experience can frighten the soul away from the body.

Polyclinic. She went on, "I just like to be sure when something's wrong with my children," referring to her perception of the reliability of the knowledge of a biomedical doctor. "I don't really believe in bush medicine," she added.

This revelation surprised me a little bit, since she was involved with researchers who worked with traditional healers, but I didn't say anything, and she continued talking unprompted. "Sometimes though, the doctors at the clinic, they don't know what's wrong. There are things that they don't know how to treat. They'll admit it too. I remember just a couple of years ago, I fell ill. I was listless and idle. I didn't want to do anything, just lay around all day. I had no energy. I went to the clinic, but they said I was fine. After a couple of weeks of this, I needed to do something, so I went to the bush doctor. He gave me a bundle of plants that I drank for about a week. Then I finally started feeling better."

In just a ten or fifteen minutes of conversation, Anna had reversed course, at first telling me she didn't believe in bush medicine, and then explaining how she had been successfully treated by a bush doctor in the recent past. Such seemingly contradictory stories became somewhat common as I talked with more and more people around town. People rarely admitted at first that they use the services of bush doctors, but in many instances, as we talked longer and as people became more comfortable, stories would come out about a particular instance when they used bush medicine. These stories exemplified the medically plural environment in P.G., where people are sometimes faced with illnesses that, for some reason, cannot be treated by the biomedicine of the State Polyclinic. For many families in P.G., bush medicine comprises one of the layers of services that they use in their efforts to maintain the health of everyone in the household.

Medical Pluralism: an Overview

Medical pluralism, a topic long explored by anthropologists, is the term used to describe contexts wherein multiple medical systems function concurrently. Largely because of the global spread of biomedicine, scarcely a place on the planet exists that is not medically plural, where more than one distinct system of medicine is practiced. P.G. is an example of such a medically plural environment, as it includes the biomedicine provided by the State, and traditional healers from at least three distinct traditions (Q'eqchi' and Mopan Maya, and Garifuna). Add to these distinct systems that require complex training for practitioners, the lay-systems of home healing that draw on Maya, Garifuna, Kriol, East Indian, and Mestizo traditions also add to the medically plural community of P.G.

Early studies of medical pluralism attempted to document the breadth of knowledge of alternative medical systems. For instance, Alfredo Mendez-Dominguez (1983) describes the two early trends in medical anthropology: (1) an anthropology for health, or the examination of folk-beliefs of causation for the purposes of health improvement or the elimination of folk-beliefs, and (2) surveys of ethnomedical⁵ traditions. His own study in the 1970s uncovered the variation that exists within traditional medicine in Guatemala, exhibiting a plural, open system that overlaps but varies geographically. Such studies began to reveal that traditional medicines are not homogenous, and instead vary greatly not only regionally, but from community to community.

Other early studies of medical pluralism also uncovered the complexities of non-Western medical systems. Anthropologist Sheila Cosminsky (1983), who worked in rural areas of Central

⁵ Erickson defines ethnomedicine as "the study of the medical systems or healing practices of a cultural group, the cross-cultural comparison of such systems, and increasingly the study of the multiple use of different medical therapies" (2008:1).

America, described pluralism as existing on two levels: on one level, there is the patients' utilization of multiple medical approaches, and on the second level there is the incorporation of various medical approaches by practitioners. Further, she revealed the holistic nature of traditional medicines in the region, which was historically ignored – first by the Spanish during the conquest and colonial periods, and then by anthropology, which both valued and highlighted the herbal treatments common to many traditional medical systems, but ignored the spiritual or religious aspects. "The separation of medicine and religion is reinforced by the domination of Western medicine, with its biomedical model, and dualism of mind and body" (Cosminsky 1983:161).

Cosminsky also found that not only were traditional systems holistic, but they were utilized in conjunction with Western medicine. "Pluralistic behavior is pragmatic, often based on trial and error, perceived effectiveness, the uncertainty of illness causation, and expectation of quick results" (1983:165). Further, pluralism is not limited to behavior and treatment, but is also evident in changing disease categories and concepts that arise out of increasing contact with other systems. She found that often, rural populations have problems utilizing Western medicines: "The choice of Western medicine, especially antibiotic and vitamin injections, frequently results in inappropriate usage with consequent ineffective treatment" (1983:168). This finding foreshadowed future work examining usually negative interactions between alternative health systems and biomedicine (see for example Hoang and Erickson 1985).

In the 30 years since Cosminsky's study, her findings hold true in the context of P.G. and Toledo. For example, a pharmacist in P.G. explained how people misuse antibiotics, despite her instructions: "People often want to buy 2 days of antibiotics, but I won't sell it to them like that. I tell them, that they have to take the full 5 days, but they don't want to listen, and right up to the

coban they go" [the coban refers to the cobañeros – typically Guatemalans who sell a variety of imported goods on or in shops near the square (the term originally referred to traveling Maya merchants from Coban in Alta Verapaz, Guatemala who carried huge bundles of goods on their backs and walked from house to house in communities throughout the region)]. Service providers also frequently told me how their patients misused or misunderstood medicines. One of the foreign doctors working in P.G. explained: "People don't know how the medicines work. They just come in and want their injection. I tell them, well you're going to need this 2 or 3 times or whatever, but they just want their one injection, and they think they'll get better." As the efforts of providers to give instructions to their patients seem to fall on deaf ears, frustration builds and they are more likely to stop giving instructions at all.

There are many examples in the literature of medical pluralism around the globe, and much of this literature examines pluralism in terms of how alternative systems interact or conflict with biomedicine (see for example McVea 1998, Ito 1999, Hunt et.al. 2000, Coreil et.al. 2004, Johannessen and Lazar 2006 and Broom et.al. 2009). A deeper understanding of alternative and traditional systems of medicine can begin to shed light on why such systems persist, despite what are often perceived as conflicts with biomedicine. Ngokwey (1988) explains how supernatural and religious explanations represent just one component of a larger non-Western etiological system. He argues that in medically pluralistic settings "social interactions are the fundamental contexts of the production and utilization of etiological knowledge. Ideas about causes of illness thus vary within each culture or community according to the specific social contexts of their articulation and use" (1988:793). He proposes a more holistic analysis of medical systems that includes the various aspects that are a part of every culture: material organization, social arrangements, and belief systems. Such an analysis is necessary in P.G., where ethnicity,

economics, religion, age, education, along with a host of other factors all play a role in the health care decisions that people make. However, in a context like P.G., where virtually every household practices its own unique form of medical pluralism, this type of analysis falls short in explaining the variation that exists. Health care decisions are made in the moment, and things like convenience, resource availability, social support, and the severity of the illness all affect those decisions.

And so, analyses of medical pluralism have continued to become more complex. Perhaps one of the most influential scholars on medical pluralism, Crandon-Malamud's work (1986, 1991) continues to impact studies on the topic (Leatherman 1998, Baer 2003). Crandon-Malamud uses the political history of Bolivia to explain social changes, and in turn, how these social changes are reflected in how people utilize western and/or traditional medicines, as well as the dialogue surrounding such choices. She explains how medical dialogue – or how people talk about illness – reflects the social, economic and political stance of the person speaking, the person being spoken about, and relations between people. "How people talk about illness is a means by which the symbolic content of ethnic identity, and consequently economic and political resources, are exchanged at the community level" (1986:464). In short, she has shown how one's social identity shapes the type of health services (and other resources) one has access to and utilizes. Further, one's identity is fluid and flexible, and changes through time and context, allowing for the use of multiple medical paradigms over time.

In P.G., social identity is reflected in not only what health services people use and have access to, but also in how they talk about it. Still, such insight provides no clear answers in terms of why people take the course of action that they do in any given situation. For instance, for some Maya, traditional healers represent an unpleasant part of their social identity, one that can

include things like stigmatization, marginalization, poverty, and a questionable faith in God. However, this connection to such negative connotations does not necessarily mean that the person identifying in this way will not use the services of a traditional healer. For other Maya, the tradition of using bush doctors is a point of pride and confidence, and shows allegiance and faith in their Mayan culture. And likewise, those that identify in a positive way with the use of bush doctors may very well visit the clinic on a regular basis for any number of ailments.

Building on the work of Crandon-Malamud, anthropologist Helle Johannessen (2007) combines two of the major threads of medical anthropology from the last 30 years: the concept of medical pluralism with subjective experiences of the body and self in the realm of health and healing. She uses the "three-perspective model" of the body (the individual body, the social body, and the body politic) and actor-networks to expand or build on studies of medical pluralism in a given locality. In this framework, a patient remains flexible in negotiating health care, but is influenced by his/her own subjectivity, the conceptions of health of his/her community, as well as the guidelines or restrictions of the State. She further explains that all of the aspects of a health system – the patients, the providers, the technologies and even the discourses – are open and fluid, and further, conditioned by each context, or each event (2007:270).

The work of Johannessen allows for the accounting of the many aspects of the self and society that affect health and decision-making. The fluidity and changeability of patients or providers allows people agency in their decisions. And recognizing the various levels of influence on an individual or household when making health care decisions more fully explains why certain decisions are made in certain circumstances. In this sense, it can be said that people do exhibit fluidity in their health care decision-making, such that every health care decision is a

unique one, informed by past experience, yet open to the needs and constraints of the moment. In P.G. and elsewhere throughout the region, biomedicine exists alongside a number of indigenous and traditional medical systems, offering people a range of options when dealing with an illness.

Medical Pluralism in Latin America

The large percentage of indigenous groups and varied migrant histories, along with high rates of social and economic inequality, have all combined to allow medical pluralism to develop into many complex and rich medical systems throughout Latin America (Pedersen and Baruffati 1985). Crandon-Malamud (1991) has gone so far to say of the region: "There is no such thing as 'Western biomedicine.' Rather, allopathic cosmopolitan medicine has become ubiquitous and hegemonic, but its form, its bureaucracy, the way it is developed, and how it articulates with other medical systems and with political, economic, and other institutions and processes, including history, varies over space and time" (1991:242). As elsewhere in the world, within a country's medical system can be seen other aspects of those societies, including cultural diversity and social stratification. "In Latin America the relationships between medical systems reveal an asymmetrical distribution of power in society; between a dominant medical system (with a marked tendency towards institutionalization and bureaucratization) and one or more subordinated medical systems" (Pedersen and Baruffati 1989:487). In most parts of the region, biomedicine has incorporated aspects of indigenous and other traditional medical systems, and vice versa. Historically, there were widespread attempts at eradicating the many traditional medical systems of the region, but more recently, attempts of collaboration with and/or the recuperation of traditional medicine has characterized much of the region (Pedersen and Baruffati 1985).

Despite this renewed interest in and respect for traditional practices, there has been little to no success in integration at the national level health systems in the region. Further, there exists no example of the merging of the multiplicity of medical paradigms that exist into one medical system. Thus, the State sanctioned medical systems of the region can be seen as biomedical or cosmopolitan in nature. Pedersen and Baruffati (1989:489) report that a review of numerous studies from Latin America shows that around 70-80% of all illness episodes are dealt with outside of the official biomedical system. Still, with the prestige associated with the backing of the State and elite sectors of society, biomedical practitioners typically treat other medical systems as something less than what biomedicine can offer patients. While some alternative health systems have suffered with the rise of biomedicine, they have not disappeared; instead they fill the gaps in health care left by biomedical care.

In fact, biomedicine appears to leave gaps no matter how entrenched and effective it is in a particular region or community. Even in the U.S., which has one of the most developed biomedical systems in the world, 38% of the population uses some form of complementary or alternative medicine (Barnes et al. 2008). Where the biomedical system is poorly or less developed, people make use of other systems of healing. For example Mary-Elizabeth Reeve (2000) has studied the health system in the Lower Amazon where high rates of poverty, and poor biomedical health infrastructure have resulted in the high utilization of and reliance on the traditional health system, such that traditional healers are consulted to determine the origin of an illness and whether traditional treatments would work. Medical doctors were usually only consulted if a traditional treatment did not work and traditional healers referred patients to them.

Even where biomedicine and traditional medicines have firm foundations, other medical systems have been shown to flourish. Anthropologist Michael Whiteford (1999) has shown that

homeopathy has experienced a growth in popularity after being introduced in the already medically plural city of Oaxaca, Mexico. He explains that city residents have a wide variety of options in terms of health care, and often refer to multiple practitioners from a variety of medical systems. Further, they typically hold multiple views on disease and illness etiology, including drawing from traditional and biomedical systems. Homeopathic practitioners occupy a special niche in Mexico, as they are formally trained in allopathic (biomedical) medical schools, but have a naturalistic approach that includes the common use of herbs and botanical remedies. Whiteford's research showed that the popularity of homeopathy appeared to be rooted in its holistic approach to health and healing.

In contexts like P.G., elsewhere in Latin America, and the world, traditional medicine has often maintained a foothold alongside of biomedicine. One reason for the resilience of traditional medicines is their holistic approach to health and illness. In her study in an indigenous community in Mexico, anthropologist Jill Fleuriet (2007) describes the distinctions between multiple levels of ill-health: disease as the organic/biological cause of an illness, illness as the individual's experience, and sickness as the social context of the illness (see also Boyd 2000). She shows how one illness can be rooted in one or more of these levels at the same time – a causal plurality. "Illness and its treatment cannot be solely accounted for by an observable, biological cause, and thus must be considered simultaneously from the standpoints of individual sufferers and the political economy" (Fleuriet 2007:158). This potential for an illness to have a plurality of causes, especially those outside of the biologically observable, is precisely where biomedicine often falls short in satisfying people's treatment needs.

And so, in P.G., as elsewhere, biomedicine is not sufficient on its own to support the health needs of the community. Its effectiveness with certain ailments and conditions, the

convenience of free services at the Polyclinic, and its general acceptance as the dominant health care service all drive people to use the biomedical services in P.G. Yet in many instances, such as in the story recounted at the start of this chapter, there remains a need for alternative health care. There are many factors that can influence people's health care decisions, including their economic situation, religious beliefs, the quality (or lack thereof) of the available biomedical services, ethnicity, age, cultural identity, and any number of day-to-day experiences that might lead to a certain decision in a certain moment. With these and other factors shown to combine to drive people's health care seeking behavior, what can an examination of that behavior reveal?

Studies of Health Behavior

As the practice of medical pluralism and the ubiquity of medically plural health systems have become widely acknowledged, there has been a turn to understand how people manage their health in such contexts. Many studies on medical pluralism focus on the behavior of patients, families or communities particularly when they make health care decisions (Weller et.al. 1997, Hueveline and Goldman 2000, Steckelenburg et.al. 2005, Cornwall 2007). These studies are largely an attempt to understand how people negotiate medically plural environments. For example, in the study mentioned previously, Fleuriet (2007) found that the indigenous community typically uses self-care as the first treatment approach, followed by biomedical care through clinics and NGO services. In another example, Weller and colleagues' (1997) research in Guatemala revealed that self-care and home remedies were utilized as a first course of action for most of the households (82%). Pharmacy, physician, and hospital visits were typically among the last treatment choices. They also found that illness severity was the best predictor of health care decision-making: the more severe the health event, the more likely a trip to the hospital would ensue. Further, they found that household economic resources were not very important relative to other factors when deciding on a course of action during a health event.

Another study examining health behavior in rural Guatemala by Hueveline and Goldman (2000) showed that biomedical services are the preferred treatment option following self-care, and traditional practitioners are sought as a last resort. Their findings point to pharmaceutical treatment as the predominant form of child treatment in rural Guatemala. "Westernization and globalization often entail the absorption of modern medical practices – particularly pharmaceuticals – into the local culture. One widespread consequence of this increasing biomedicalization is a high and often inappropriate use of modern drugs" (Hueveline and Goldman 2000:361). These findings are significant in that they point to changing patterns of health behavior; however, the study fails to reveal the underlying factors (besides the general "Westernization and globalization") that may be contributing to such changes.

In another behavioral-based study, Maria de Mello Amorozo (2004) studied rural households in Brazil that have access to multiple medical traditions. She found that over 90% of the households in her study practice some level of medical pluralism, however, fewer traditional specialists are offering services as biomedical services have become more available. Similar to other studies, Amorozo's household study found that for most illness events that were not major, the first treatment attempt was self-medication, consisting primarily of medicinal plant usage. She cites the influx of modern medical services as a driver in behavior changes that vary by context; for example, midwives have become less utilized and less necessary, but other healers that treat culturally recognized ailments remain in high demand.

Still, Amorozo shows that households generally made use of all of the health care options that were available to them. She calls this "therapeutic syncretism," and goes on to note that

patients' use of multiple approaches simultaneously can be seen as "therapeutic opportunism." This therapeutic syncretism and opportunism can be seen in P.G. as well, where households typically attempt self-care as a first course of treatment, then, if needed, they move on to whatever option is most convenient to them. Convenience is based on a number of factors, including economics, the severity of the illness, the amount of time they have available to devote to treatment, and even past experience with similar illness events and how and who treated them before.

Amorozo roots the extensive pluralism in those rural communities in Brazil to the social and economic changes occurring there. "Easy access to modern medicine, disruption of traditional knowledge transmission and change in land use, with destruction of natural vegetation, will ultimately lead to an erosion in both plant species availability and knowledge about them" (2004:151). Similar things can be said of P.G., Toledo, and even Belize in general, and similar health behaviors have resulted as well. Households in P.G. use a syncretic approach to health care, and are opportunistic to the point that the easiest, most convenient choice for health care is usually the choice most often made. As shown in the previous chapter, most people use self-care as a first option, followed by the free services provided by the State at the Polyclinic if that first treatment option fails. Still, it remains to be seen whether the changes occurring in Toledo and P.G. will result in the erosion of traditional knowledge that Amorozo claims will occur in Brazil.

Common to all of these behavioral studies, despite geographic and cultural differences, is that self-treatment is typically utilized as the first option during an illness event. Additionally, each context is going through transition, often due to the increased availability of biomedical services and treatments. In P.G., the introduction of the NHI system and the building of a new

Polyclinic for nearby rural communities are evidence of the increasing visibility and availability of biomedicine. Yet, despite this increased presence, the use of traditional home remedies remains common, and traditional healers remain a key part of the health care system, especially in cases where the biomedical services are inadequate or unsuccessful. There is therapeutic opportunism evident in P.G., and it is driven by the desire to get well. In their quest to get well, people in P.G. will do whatever they can, accepting for social, economic, spiritual, and religious factors, and do whatever it takes.

Narrowing the Focus: Medical Pluralism in the Caribbean and in Central America

Public health, that is, services provided or promoted by the State, in most of the countries in Central America and the Caribbean share a common history of neglect (Barrett 1996, Aarons 1999). Biomedicine, while holding the prestige of being the official medical system of the State in all of Central America and the Caribbean, has not been able to adequately penetrate certain demographics – generally the rural and the poor populations. Thus, medical pluralism has remained a necessity to ensure the health and well-being of people throughout the region. Medical pluralism in the region is in some ways shaped by the available health care resources, which are often consistent in kind, but variable in availability. Cosminsky (1983) explains: "The medical facilities and resources differ in their availability and accessibility in different parts of Mesoamerica, but in general include self-treatment with home remedies, and treatment by such practitioners as folk healers (shamans, herbalists, curanderos, bone setters, and midwives), spiritists, injectionists, pharmacies, traveling vendors, public and private clinics, hospitals, and physicians" (1983:162). The availability and utilization of these resources vary by population, whether along ethnic, geographical, or economic lines, and the resources themselves vary along

similar lines. Western medicine remains the primary means through which the State has attempted to address public health issues throughout the region. "The spreading of Western medicine is supported by the political and legal system, since it is the only type of medicine officially recognized by the government, supported by the Ministry of Health and promoted through the medical schools and pharmaceutical companies" (Cosminsky 1983:161).

There is little literature on health systems or medical pluralism in the Caribbean. A number of scholars have worked in Haiti (Brodwin 1996, and Farmer 1990), and Cuba⁶ can also be found in the literature, but other island nations appear relatively neglected by scholars of the topic. Still some insights can be gained from what is available. "For most of their history, Afro-Caribbean societies have operated with a bicultural system where elite and popular forms undercut each other" (Brodwin 1996:198). As in the rest of the region, the elite form of medicine, and the only one recognized by the State across the Caribbean, is biomedicine. Also, akin to neighboring States in Central America, the biomedical system has not adequately met the health needs of the island populations, which, in part, has allowed pluralism to flourish. The core difference between the pluralism in the Caribbean and that of Central America is the influence of traditional African medicines brought to the islands by slaves, as opposed to the largely indigenous traditions of Central America (Aarons 1999). The exception would be the Garifuna, an indigenous group found along the Caribbean coast of Central America (including Belize), that exhibits a blend of West African and indigenous Amerindian traditions.

Bruce Barrett (1996), an MD, PhD (anthropology) envisions Central America as a region where successfully integrated health systems could represent a positive model for other parts of

⁶ The decision was made to deliberately leave out Cuba because of the unique nature of the political and medical system in the country. Additionally, it is known for a distinctly strong biomedical culture, and widespread availability of biomedical services. I feel that the uniqueness of Cuba limits its relevance to the present study.

the globe. He notes that historically, health systems in the region have been poorly run and organized and have rarely utilized local input or collaboration with the communities they serve. These health systems have largely been modeled on the physician-dominated system of the US, "rather than by health workers interested in preventive, community, or socially-oriented care" (1996:71). However, due to the relative isolation of many rural areas in the region, ethnomedical traditions have persisted and remained available to the populace. Health care systems and experiences have varied a great deal in the region, largely related to varied governmental policies.

Barrett explains that community participation in health systems has been somewhat common throughout the region, and has evolved most recently as a result of public spending cuts due to pressures from the World Bank and IMF. The resulting increase in community input into and control of their own health systems has typically had the negative consequence of leaving those communities marginalized and under-funded. This result may be due to the possibility that "popular participation and citizen empowerment may present a real threat to certain entrenched power structures" (Barett 1996:75). By the early to mid-1990s, NGOs with health-related projects driven by local integration or participation became active in the region in efforts to counteract the neglect of State health systems. The growth of NGO involvement in health care has fulfilled a real need, and taken some pressure off of state health care systems

Integrating Traditional and Western Medicines

The recognition of traditional and alternative medical systems as vital to the health of many people around the globe has been with us for over a quarter century – since at least 1978 with declaration of the World Health Organization and UNICEF that one of their key primary

health care goals would be the integration of traditional healers into public health programs (WHO/UNICEF 1978). We have also seen the call from numerous scholars who have advocated for the integration of traditional and biomedical health systems (Harwood 1981, Akerele 1987, Green 1987, Last 1990, Reeve 2000). Further, formal integration appears likely to be accepted by the people: in describing health systems in Latin America, Whiteford notes: "For many populations, particularly those living in rural areas, no single medical worldview necessarily has been regarded as superior to others in all circumstances" (1999:69).

However, what was true in the 1980s, that in national health care systems, "little progress has been made in actually utilizing indigenous health practitioners, especially healers," (Pillsbury 1982:1825) remains true today. Despite the apparent separation that exists on the State level, medical pluralism has arisen to not only satisfy the health needs of populations around the globe, but has come to play a powerful role in their social, economic, and political lives. "Medical pluralism provides patients and their families with an array of disease concepts and treatment alternatives that may be employed not only to obtain resources like prestige, power and material resources, but also to negotiate social relations and define cultural identity" (Amorozo 2004:140). Medical pluralism as it currently exists is embedded in the very fabric of people's lives, so why do the varied systems remain separate and poorly integrated?

The integration of multiple medical systems presents challenges that, to this point, have largely prevented a fully integrated health system from being created. Anthropologist John Kennedy and nurse-midwife Karen Olsson (1996) conducted a study in rural Mexico to explore the possibility of integrating traditional with biomedical health care services while investigating health care beliefs and practices. They uncovered two core barriers to integrating health systems: one is the popularly held belief that scientific knowledge will eventually replace other

knowledge systems; the second is rooted in the differences inherent in a locally and context specific traditional knowledge versus biomedical or scientific thinking that typically aims at universality. The tension between the universality of biomedicine and the locally-specific focus of traditional medicine presents a clear challenge for any national-level health care system to overcome.

Similar to my findings in P.G., Kennedy and Olsson report that their respondents "ascribe definite limits to the healing powers of both traditional and scientific practitioners" (1996:44), and utilize each for their different strengths. The integration of different health systems remains popular from the patient perspective. Formal integration of traditional and biomedical systems in their community was favored by 77% of the respondents in my study, and nearly 80% of the respondents in Kennedy and Olsson's study (1996:44). Kennedy and Olsson conclude: "Integrated health clinics could return a measure of local control over health care, counter the hegemonic or imperialistic implications of biomedical medicine, acknowledge the validity and value of local cultures, and offer a more holistic approach to health care delivery than the present biomedically-driven approach" (1996:45). It remains to be seen whether integrating health systems would bring about such positive changes, and with the economic and political prestige (and power) behind the biomedical system, it remains in question whether those positive changes will come about.

Still, as Singer and colleagues (1998) have pointed out, traditional medical systems and the wider population in general are integrated. And as demonstrated above, as currently construed, the medically plural environment offers people flexibility in how they want to address their health needs. A more accessible biomedicine could be beneficial for some, however not at the expense of other options – as so often happens. "In today's pluralistic medical reality,

patients weave in and out of contrasting and often conflicting health systems, establishing multiple relationships with healers from different paradigms" (Belliard & Ramirez-Johnson 2005:270). A focus on improving access to and availability to all facets of this plural environment would most likely have the greatest effect on the health of populations around the world.

Medical Pluralism in Punta Gorda, Toledo District, Belize

The small coastal town of Punta Gorda (P.G.) in the southernmost Toledo District can be seen as pluralistic in many ways. In terms of health, P.G. has grown from a village reliant on the herbal and spiritual practices of Garifuna *buyeis* to the primary center of biomedical care in the southern part of the country. Alternative systems coexist with the State's biomedicine, as the Garifuna healers have been joined by Q'eqchi' and Mopan healers and herbalists, as well as a family of snake doctors (able to treat snake and other bites with herbal concoctions) of East Indian descent. Additionally, while remaining generally hidden from the public, I was told on numerous occasions that there are one or two elderly Chinese men who treat some of the Chinese immigrants with some form of Traditional Chinese Medicine.

As demonstrated in Chapter 4, households in P.G. use a plurality of services when they need health care. Decisions on what course of action to take are driven by a number of varying influences. One primary factor that may be playing a role in keeping home remedies and traditional healers a popular choice is the perception of the MOH services at the Polyclinic and Hospital. Almost one quarter (23%) of households reported that they would never use the State services, and 83% of households are not satisfied with the services provided by the MOH

facilities. Reasons varied, but one of the most common responses was similar to what one single mother explained:

I'm not satisfied with the [MOH] system. I only go [to the clinic/hospital] if I need to. There's a language issue – some of the doctors are immigrants, and some only speak Spanish. And there's a lack of compassion there. The nurses and doctors don't seem to care about you.

A number of interviewees reported problems with the medications:

They need to start properly handling the medicines. They don't have temperature control, there's no refrigeration, and it's just kind of a mess in there. They have very poor quality control of the medicines.

Another woman, a retired nurse who had worked in the U.S., explained about the medicines: I would not use the [MOH] services here given the choice. They don't label the medications well – they use a pen that just wipes off, it's not permanent ink. They charge patients for bottles [for meds]. I have even donated bottles, and then they just sell them to

the patients! Where does that money go?! Right in someone's pocket, that's where! Others reported long waits for services, the perception that the nurses and doctors are not welltrained, or need further training. Many women reported that staff at the MOH facilities treat some people differently than others, with certain people (like friends and acquaintances) receiving preferential treatment, and others (like people differing in ethnicity) left waiting and feeling neglected. There were many stories of a perceived incompetence, for instance, one grandmother explained:

This morning my daughter took her girl to the clinic for a fever. It turned out that something was wrong with her tonsils. They treated her and now she's running all over

and seems better. But, they did an incomplete check-up. They just took her temperature – not her heart rate or anything else like that. They barely looked at her and just gave us Tylenol and antibiotics – what they give for everything! And I've never seen Tylenol looking like this [she showed the bottle to reveal a thin, watery pink liquid]. It didn't even work. To me it looks all watery. Luckily I had some Tylenol here and I just gave that to her. She seems ok now.

The problem here is not necessarily whether or not the medications are being watered down, although a number of women and a local pharmacist reported this to be a problem. The larger issue, is that there is a perception among many in the community that the MOH services are generally poor, that the medicines are old, weak, or watered down, and that more than likely, whatever services one receives, they probably won't work. This negative reputation is one reason people turn to other forms of health care services.

Despite the commonality of such unfavorable perceptions of the MOH services, some people continue to find them satisfactory (17% of households), and 77% of households report that they at least occasionally use the MOH services. In fact, there are other factors driving people to use a plural approach to their health care. A number of women explained that they use herbal remedies first because they believe that the "natural cures" are better for them. There is a strain of belief across ethnic groups in P.G. that sees plants and nature as more natural and sometimes as a gift from God. This view holds that plants and herbs are there for us to use, and are in fact what we are meant to use. A 34 year old Kriol woman explained this point of view:

I prefer to try the natural things first when I get sick. Medicines come from herbs anyway

they're made from herbs, so why not just use the herbs. I think that's probably better.
Another Garifuna woman said more simply:

I like to use as much natural as I can - I think that's healthier. The plants are natural, and if they work, that's what I want to use.

Still, most people who were interviewed and expressed something like these beliefs also see there are limitations to what the plants can do. So while they would prefer to use plant and herbal remedies, they recognize the need for biomedical and pharmaceutical remedies as well.

Fewer people report using the services of a traditional healer (28%), however, over three quarters of the women interviewed (77%) felt that allowing traditional healers to practice at the Polyclinic would be a good idea. Behind this discrepancy is the idea held by many in the community that traditional healers are "back-a-bush" – something that poor and rural people do. And there are households that continue to treat themselves and their family for "folk illnesses" like fright or the evil eye. A young Mopan mother in her late 20s explained:

We visit one [a traditional healer] sometimes. We have to take the baby – sometimes she gets fright – a couple of times she's got it. We've gone to the bush doctor, and that has worked every time. The bush doctors can be good for certain things, and even better than the hospital with some things.

Still, in P.G., there is little prestige involved in admitting that you use the services of a traditional healer. Yet, with probing and in longer interviews, people would often reveal that they do sometimes use traditional healers, especially when other courses of action haven't worked. For instance, in one interview, after a little over an hour and having said that she did not use traditional healers, one Q'eqchi' woman revealed:

Yeah, I have seen one a couple of times. About 10 years ago I had to go to a bush doctor. I had something wrong, and nobody could fix it – the doctors didn't know what was wrong. So I went to the bush doctor and he was able to help me.

More in-depth research with the traditional healers in the community may shed light on how many people actually use their services. Some healers reported that they see 2 to 3 patients per day, which points to a fairly strong local demand.

There is also a fear of traditional healers present in some people in P.G.. The fear is not based on the efficacy of the herbal preparations or the knowledge of the healers, but in the belief that the healers are somehow knowledgeable about spiritual matters, and may expose patients to evil spirits or the devil. One Garifuna woman explained:

We haven't used them in a long time. I know my family and my people, we try not to use the bush doctors anymore. It you use them, you might start to rely on them too much. You get caught up in it.

Many women specifically said that a traditional healer working in the Polyclinic would be a good idea, as long as it was only the herbal preparations that were used. When asked about this idea, a 34 year old Kriol mother told me:

If it was only herbs, like an herbalist, that would be alright. But I don't think people would use it because they'll all think there's obeah⁷ going on there. But if we knew it was just the herbs, I would try it.

This fear is at once a limiting factor in how often or for what reasons people would visit a traditional healer, but it can also act as a driving factor as well, especially when other services or remedies do not work. In either case, the high number of people who felt it would be a good thing to have traditional healers working at the Polyclinic points to the respect that many in P.G. still have for such practitioners. Whether people are afraid to use traditional healers, or uneasy

⁷ Maraesa defines *obeah* in Belize as "a type of magical practice that uses supernatural powers to alter the physical world" (2011:20) that has been documented in African diaspora in the Caribbean. *Obeah* is also a term used across ethnic groups to refer to this type of practice.

about admitting they use their services, the acknowledgement that a partnership between traditional healers and the Polyclinic would be appropriate shows that the services of traditional healers remain highly regarded and needed in the community.

Moving Beyond Medical Pluralism

Studies of medical pluralism have offered much in understanding how people negotiate the use of multiple medical systems. Further, it is now understood that the pluralism studied in medical pluralism is not limited to the number of medical systems, but also in the plurality of causes and cures that an illness can have, the plurality of options that people have in treating those illnesses, and even a plurality in the ways that different people in the same communities determine how to treat the same illness. The factors that shape people's decisions are just as varied, and range from the intensely personal, such as a past experience, to the almost invisible structural influences, like the promotion by the State of biomedicine as the only legitimate medicine. What is often forgotten in these analyses is the end goal of people who are seeking health care: to get healthy.

It was only a few generations ago that people in P.G. primarily relied on the bush for their medicines. This research suggests that as more generations go by, fewer people are using the home remedies used by their ancestors, and fewer still, rely on the bush doctor for his or her expertise. Yet, an apparent decline in these traditions does not necessarily spell the end for them. In P.G., where the biomedical services of the State are of questionable quality, there is an attitude of doing whatever it takes to get well. And this attitude appears to have been rooted in tradition as well. A woman in her 50s told the story:

When I was little I fell in the creek and wasn't well. The bush doctor said I had lost my soul, and I had to burn some hair and go back to the river and do this ceremony. I got better, but my parents had taken me to the hospital at the same time, so I don't know which one made me better.

When there is no sure-fire means of getting well, people will try multiple methods to do so. In short, people just want to feel good, and get well when they're sick.

This "I'll do whatever it takes" attitude is reflected in people's practice. Families have herbal preparations that have been passed down for generations, and these are often the first line of defense in fighting an illness. They are time-tested and familiar. Assisting in their perpetuation is the poor reputation of the MOH services, despite the fact that they're free or low cost. Traditional healers fall somewhere in between the easy acceptance of home remedies and the mistrust of the biomedicine in the Polyclinic. Traditional healers are both feared and revered, but hold little prestige in an era when everyone desires the latest cell phone, and not a new pair of rubber boots to go plant hunting for remedies. Even if the best quality health services were available at the Polyclinic, it is a safe bet that traditional health practices would persist in P.G. and Toledo, not only out of tradition, but because they fill a need and are often effective.

With the practice of medical pluralism accepted as the norm around the globe, it is likely that alternative health care systems, such as the traditional medicines that exist in P.G., will continue to be used alongside biomedicine. This plural environment thrives because the varied health systems that exist are effective for different health needs, for different people, at different times. That people practice "therapeutic opportunism" is shown by the increasing amount of studies that show self-care or home remedies are the most commonly reported first course of action during an illness event. If further action is needed, people's decisions are shaped by any

number of factors that can change from day to day and illness to illness. However, it is past experience and convenience that may be the most influential factors, as people will do whatever it takes to get healthy. The "whatever it takes," however, can be limited by the same factors that influence health care decisions in the first place. Economics, age, religion, gender, and ethnicity are part of a host of social, economic, and structural factors that play a part in the choices that are available, and the choices that people make. These various factors may influence the first and subsequent courses of action that someone takes, and they may influence how people talk about their health care decisions, but in the end, this research reveals that all avenues to health will be exhausted in the quest treat an illness.

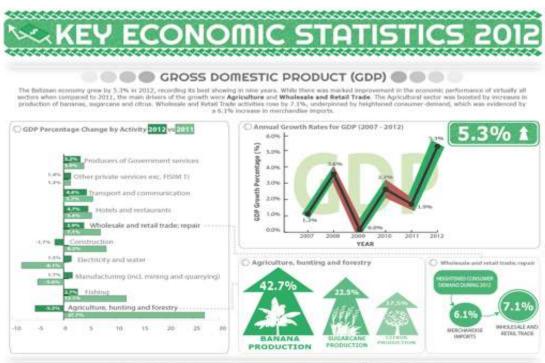
And so the concept of medical pluralism remains as more of a descriptor of the particular circumstances surrounding health and health practice in P.G. and Toledo. Attempting to move the concept beyond description or explanation, an examination of how structural injustices play a role in a medically plural context follows below. An examination of the State and neoliberal policy, and the role of the concepts of deservingness and neglect in health care provision bring the study of medical pluralism into new theoretical territory.

Chapter 6

Universal Health Care System as Agent of the Neoliberal State

I had been away for about six months, living in the U.S., teaching and beginning to make sense of the 17 months I had been in Belize, and excited for a summer in my "home away from home" back in P.G. My training as an applied anthropologist and the belief that I should make my research legible to as many people as possible, especially those in Belize, led me on a search for a unique way to share some of my preliminary findings. At the same time, I had begun noticing a trend on social media sites that I occasionally perused: the use of infographics to clearly and concisely summarize and disseminate information. I actually came across such a graphic of economic indicators published by the Statistical Institute of Belize (Figure 14), so knew such dissemination methods would be familiar there.

I set about working through my data, using the open source analysis software, TAMSAnalyzer, to come to a number of interesting findings, primarily from my household interviews (n=60). Then, over innumerable hours of painstakingly slow work in Microsoft Word, I created a tri-fold brochure containing a variety of formats of infographics presenting some of my preliminary findings in visual form. Finally, I had about 100 data brochures printed on glossy heavy stock paper, giving the final product a fairly professional glean. I emailed copies (Figure 15 and 16) to officials at the MOH and NICH. Then, on my return to Belize, I took the stack of brochures with the intention of distributing them to key stakeholders involved with my research and getting their feedback on my preliminary findings, including officials at the Ministry of



TRADE (IMPORT / EXPORT)

The value of Melion's merchandise imports gree by 6.1% to \$1.76 billion to 2017. Alimost two-thirds of this increase was due to parchases of solar panels and machinery usef, in petroleum exploration. Spending on gaseline, which rose by 10.1% to \$127.5 million, also contributed considerably to the Increase in Import epending.

soft summings were virtually incharged when compared to 2011, decreasing by a more one-tainth of a percentage point to \$681.6 million. This resulted as a sta mings from crude petroleum (136.2%) was offset by agnificant excesses in agricultural exports, most notably basaness (139.3%) and citrus concentrate (138.8 Value of Balize Imports by Section of the 5.1.T.C (2011-2012) O The % change of major exported products between 2011 and 2012. 201 d and Live Are 193.2 1 Inges and Tobaci Sude Materials Inral Fuels & Lat. AD 2 10 17.1 m Dits and Falls ALC: NO 14.2 m 46.74 card Mit 159.4 # 203.1 282.0.0 h. 8 T 213.0.0 106 4 1 106.2 # 33. 107-5 10 361.3 4 10 . Z . m 84.V.m 1.793.7 College and * Figures are represented in million dallars

2012 INFLATION RATE

The Consumer (Hot Endox (CPE) measures the severage change in the prices of a fixed basket that includes a wide range of goods and services frequently perchanged by basebolds. During 2012, a setuped inflation rate of 1.3% was recorded, driven matrix by increases in prices for "Food and Non-Alcunsic Beverages" (12.4%), "Transport" (12.3%), "Health" (14.1%), and "Recreation and Culture" (13.6%). Terms that contributed to the bacause bacadod penatry, genetice and desert, surgery two, basebiat increases bacadod penatry, genetice and desert, surgery two, basebiat contributed to the bacause bacadod penatry.



Figure 14. An infographic created and distributed by the Statistical Institute of Belize (SIB) on Key Economic Statistics for 2012. (SIB 2013)



Figure 15. Side 1 of research data brochure created by the author.



Figure 16. Side 2 of research data brochure created by the author.

Health (MOH), doctors, nurses, pharmacists, research participants, and other community members who might find my research useful or interesting.

My first stop in Belize was P.G., and I was anxious to start distributing my data brochure. How would the different stakeholders react to seeing the data? Would people find it interesting? Would it be easily understood? I began by showing the brochure to a few close friends who played key roles in assisting me with my research. Each one took their time looking over the graphics, taking in the data, mostly in silence. Slowly, their heads would begin to nod in affirmation, followed by questions or comments about certain pieces of information. Smiles and excitement emerged as we talked about the brochure, and I was encouraged to distribute it around town. They each requested additional copies as well, so they could share with people they knew.

The positive response I received from those first few friends was repeated over and over again in P.G., with doctors, pharmacists, teachers at the local university, officials with the MOH, and everyone else that I was able to share the brochure with. One of my contacts at the P.G. hospital even made copies to distribute to the rest of the staff: "Most people who do research like this don't ever bring us anything back," she said. "If they do, it's usually a report or their final paper, and not too many people ever read those," she continued with a knowing wink. A few people urged me to present the findings at a community meeting and for classes at the local branch of the university. The brochure seemed to be a success, but I was starting to run out of copies, so I kept a small stack for my upcoming trip to Belmopan, the capital city and home to the MOH and NICH (National Institute of Culture and History), both of which had given me their human subjects approval to conduct my research.

Earlier, before traveling back to Belize, I sent digital copies of the brochure to both NICH and the MOH, but received no response. Finally, about three weeks into my visit, I caught a ride to Belmopan, still nervous at the response that officials from the GOB would have to the brochure. My first stop was at NICH, where I walked in with a short stack of the brochures. The director wasn't in, but the staff there got excited when they saw the brochures and realized who I was. "Oh! We've been passing this around for weeks now – we all think this is a great way for researchers who come to Belize to share their findings. We want to urge them all to produce something like this!"

I left NICH feeling pretty good about things, and headed towards the MOH building a short ten minute walk through the summer heat. The contacts I had in the Ministry were not available when I arrived, and I was asked to wait in the small waiting area until someone could see me– who that would be was left unsaid. After about 15 minutes, I was brought in, and led to the Deputy Secretary's office – I was going to see the secretary to the Minister of Health of Belize. "Promising," I thought. When I entered, the secretary was visibly busy, and answered two different phone calls while I stood trying to explain my reason for being there. She took a handful of copies of my brochure, and just when I thought, "At least I'm trying to get this research into the hands of the MOH," she placed one of the brochures on the top of a pile of mail and documents in a metal basket. The label on that basket: "Minister of Health."

I left Belmopan that evening, and was back in P.G. later that night, feeling like my idea to produce and distribute a data brochure was a success. However, by the time I woke the next morning, I had three missed calls and two messages on my phone. A woman at the MOH requested that I call her back as soon as possible. A representative from NICH left a more detailed message: someone at the MOH had called to demand that I stop distributing the

brochure immediately. Furthermore, the MOH representative didn't know who I was, what my research was about, or that they had approved it through their own human subjects review. I was assured that I wasn't in trouble, just that I had to stop passing out the brochure.

Context is everything, and as most people in Belize knew, the MOH was currently under intense media and public scrutiny for an incredibly unfortunate series of events that had just happened at the main hospital in Belize City: 12 newborns had mysteriously died in the neo-natal unit (7 News Belize 2013a). Someone high up at the MOH, left unnamed, saw the brochure and felt that it was another source of potentially bad press at an already bad time. That official contacted NICH to ask that the brochure not be distributed.

Disappointed at the charge leveled against my brochure, I quickly took it out to try and understand how it could be seen as a potential source of bad press or otherwise put the MOH in a compromising position. My eyes quickly fell on the graphic that details the most common thoughts about the NHI system among the women heads of household that I had interviewed (Figure 17). The list was overwhelmingly negative, with the following responses comprising the "staff is unfriendly, lazy, and they treat people differently," "wait for service is too long," "need new ambulance and fewer transfers," "need more and improved equipment," and "doctors and nurses need more training." The order from the MOH to stop the distribution of my brochure appeared to be due to a case of bad timing.

I was disappointed, but I decided to follow the directive of the MOH. While it's uncertain what might have happened if I kept distributing the brochure in Belize, I did not want to put any of my future work or research in the country in jeopardy. This experience drove home just how much impact this type of research can have in a small country. Over the course of my research, I was told time and time again that my research was a good idea, but that nothing was likely to

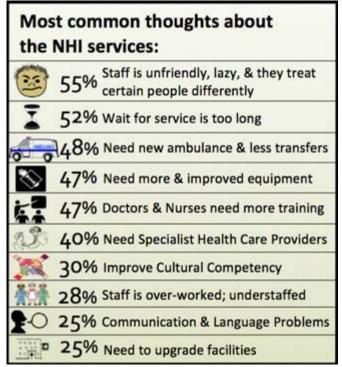


Figure 17. Infographic from the author's data brochure displaying household interview results of the most commonly held thought about the health services provided by NHI.

change because of it. I heard this message so many times that I began to internalize it, and when I dropped off the brochure at the MOH, I thought I was just doing my due diligence. However, the response that the brochure generated made it clear that the government – through the MOH – is paying attention to the research happening in the country, and more importantly, may attempt to control the messages that research sends. In one sense, I was hopeful that my research may affect change, but in another sense, State surveillance was made very real, and the efforts to shape or control public opinion were revealed.

What is the State?

The concept of the State has been much theorized and debated by scholars for generations, with much of the scholarship based on Marxist political theory. As political scientist Clyde W. Barrow (2000) has explained, due to the incomplete nature of Marx's work, the many theoretical positions with differing stances that exist are defensible due to the lack of a final complete referent from the original writings in Marx. This ongoing attention and debate about the State is perhaps due in part because the State exhibits aspects that are at once real *and* abstract. We know the State is something real when its policies affect our daily lives, when we elect officials to represent us within the State, and when we repeat our national anthems. For these very reasons however, and as Miliband (1973) observed, the State is not a "thing" – it is abstract. The State is comprised of an ongoing and ever-changing cycle of policies, politicians, and agents (employees of all types) who promote, enact, protect, and carry out its functions. Largely because of this dual nature, the State has been a common topic to theorize.

In his classic on the study of the State, historian and sociologist Philip Abrams (1988) described this dual nature of the institution and the difficulties inherent in investigating it. For Abrams, there is no state in the real sense of a concrete entity that can be studied. The State is a construct that is reified so that it has a symbolic identity and popular illusion. There is, however, a state-system, and a state-idea (or ideology), that can be studied in relation to each other and other forms of power. Further, the State system is one that is designed to legitimate domination (1988:82).

Abrams (1988) explains that one big challenge in studying the State is in understanding the relationship between the political institutions of the state and state domination, which he equates with class domination. He posits that the study of the State should not proceed in a concrete or abstract way, but instead, the *idea* of the state must be examined as a "collective misrepresentation of capitalist societies". The idea of the state is a social fact – it exists in people's minds – but it is "not a fact in nature. Social facts should not be treated as things" (Abrams 1988).

Antonio Gramsci recognized that "by 'State' should be understood not only the apparatus of government, but also the 'private' apparatus of 'hegemony' or civil society" (2006:79). Gramsci saw the State as an entity organized around the interests of the ruling classes, the wealthy elite. He saw as the objective of the State to produce a citizenry that is contributing to the progression and development of the nation in the interests of the ruling class. Gramsci went on to describe Civil Society as something apart from the State, but that is often led by people with close ties to the ruling classes, and so it operates in the interest of the State. Civil Society, then, can be seen as an extension of the State and of State interests, i.e., the interests of the ruling class (Gramsci 2006).

Drawing on Marx (in Tucker 1978) and Althusser (2006), in order for the ruling class to maintain their status, there is the need to reproduce the modes of production and just as importantly, the *relations* that allow production and reproduction to continue. In other words, relations between people, between institutions, and between institutions and people must be reproduced and/or maintained for the continuance of the ruling class. There are two aspects to the State apparatus – a repressive and an ideological characteristic – that are used to maintain and reproduce class relations. For Marx, the repressive institutions of the State include the police, army, courts, prisons, and the like, while the ideological, as defined by Althusser, are composed of private organizations like the schools, churches, media, and so on (Althusser 2006:90-94). According to instrumentalist theory, any given State makes use of each apparatus in the interests of the ruling class. Ideologically, the State is used to shape and discipline citizens through the production and promotion of its ideology – the ideology of the ruling class (Foucault 2006, Das 1996).

Others have taken this conceptualization of the State further, especially with the examination of the modern State (Trouillot 2001). The modern era can be marked by a more distinct interconnectedness of what are thought of as autonomous States. The ubiquity of neoliberal policy, a process used by States to economically privatize and open markets while more effectively controlling populations through surveillance, policing, and order, is enacted in nations across the globe (Singer 2013), coupled with a more rapid and endemic globalization in which people, goods, and ideas are parts of ever expanding networks that connect all corners of the planet. In addition, NGOs and other international organizations like the World Bank and Inter American Development Bank (IDB) are non-state actors that essentially act as state institutions. Such organizations carry out and produce projects that were at one time the sole purveyance of the State. The growth and influence of these types of organizations is an example of how state power is being diffused or readjusted, but maintains the role of producing citizens (Trouillot 2001). In such a context, that is at once expansive (global) in nature, but has the effect of shrinking or narrowing the relevance of individual nations, where does the concept of the State fit in?

Trouillot (2001) argues there are two contrasting images of the current state of the State: the State in some ways has become more visible and intrusive into daily life, and on the other hand is becoming less effective and less relevant. He expands: "The state is a set of practices and processes and their effects as much as a way to look at them, [and] we need to track down these practices, processes, and effects whether or not they coalesce around the central sites of national governments." (Trouillot 2001:131). Those practices and processes of the State are what make the idea of the State real, and it is the effects that are felt by a State's citizens.

In examining the State and its influence on citizens, Trouillot suggests a focus on the effects of the State: an isolation effect that produces a specific public that is molded for governance; an identification effect that reworks subjectivities such that they perceive themselves to be the same as others; a legibility effect that produces the language and knowledge used to regulate the public; and a specialization effect that produces the boundaries and jurisdictions of the State. The State cannot be located in any fixed space or place. It is present in its many institutions, but those institutions do not fully encapsulate the State. Thus, we can see the State as a set of processes that operate through its institutions. It has no fixity, but through its institutions it formulates and exercises processes through which to exercise its power (Trouillot 2001). There are many examples of these "effects" of the State in Belize: an isolation effect that aims to produce distinctly Belizean citizens through the education system; an identification effect that struggles to maintain a balance between a national Belizean identity and the many ethnic identities that exist there; a legibility effect that seeks, for example, to define the language and practice of health and health care through the institution of the national health care system; and a specialization effect that continues to defend its western border from Guatemalan encroachment.

The State in Belize

In most of Latin America, independence movements were driven by the desire for liberty and sovereignty. The problem of creating a national identity only came after independence was achieved, and remains an ongoing process into the 21st century. In the Latin American context, nations were not created by the majority of its would-be citizens, nations were created by the elites, i.e., the wealthy class, those with intimate connections to the colonial past, and those engaged in the global economy (Berryman 1985). As a result, the ethnic and cultural diversity of

the region has led to conflict with the drive to create nations, including contributing to the weakness of political institutions, and ongoing tensions – sometimes violent – between social groups and the State (Stevenhagen 1992). Corruption is also widespread throughout the region. In a corruption index published in 2008, the scores of 22 of 32 countries in the Americas pointed to a serious corruption problem, and 11 countries exhibited rampant corruption. Along with neighboring Nicaragua and Honduras, Belize was one of those 11 countries (Transparency International 2008).

Belize is unique in Central America, as it is the only nation in the region with a colonial history under the British as opposed to the Spanish. The legacy of British rule, which only ended in 1981, continues to this day in how the Government of Belize (GOB) functions. The GOB is based on the Westminster system of government, and is often referred to as a Caribbean nation because of its close ties to Jamaica and other island nations with a similar historical connection to the British. According to economist Michael Witter (2004), the Belizean version of the Westminster system is a continuation of colonial rule in that it controls and directs civil society by providing little opportunity for engagement or participation in governance of society besides through the elector cycle. "This structure was never designed to promote or guide sustainable development, and its culture of decision-making remains suspicious of sharing information, authority and power, particularly with popular elements within civil society" (Witter 2004: 30).

The road from colonial rule to independence was a long one in Belize. The country attained self-government in the 1964, and it wasn't until 1981 that it achieved full independence. Since independence, the country's democracy has been plagued by corruption, political patronage, and an increasingly disillusioned electorate exacerbated by an artificial polarization of the two primary political parties. The two party system, comprised of the PUP (People's United

Party) and the UDP (United Democratic Party), has alternated terms since independence [until the UDP won for a second consecutive term in 2012], which according to some scholars, points to a healthy democratic system (Nowottny 2007). Each party is highly centralized, with control in the hands of a select few at the top of their respective parties. Belizean society is deeply polarized between the two major parties, however the differences between the two have become more and more obscure. One UDP official has gone so far as to describe ideological differences between the parties as a luxury for developing nations (Nowottny 2007:8).

Nowottny (2007) cites the Guatemala claim to Belize and immigration from Central America as the two issues that have dominated Belizean politics over recent decades. The PUP is historically seen as the party catering to the Hispanic/Mestizo population, while the UDP has roots in the Kriol and Afro-Belizean population. Still, there is little to no evidence that suggests that the population votes along ethnic lines, and these distinctions between the parties do not necessarily apply readily to the Toledo district. "Nevertheless, there does remain a fear that at some future date Belizean racial divides could easily be exploited by power-hungry politicians" (Nowottny 2007: 8). The maintenance of the two party system, however, is vital to the appearance of a functioning and healthy democracy, and the deep political polarization promoted by the press, and present among the population, contributes to this appearance.

The ability to appear as a healthy democracy does not occur without critique from within Belize however, as Assad Shoman explains: "the role of the political parties, and of the party system, is to mediate between the dominators and the dominated, to give an illusion of popular autonomy, and to maintain a division of society along essentially irrelevant lines" (Shoman in Nowottny 2007:9). Corruption and abuse of power is a noted problem in the country (Transparency International 2008), and political patronage is easily observable – four of my

research participants reported being offered money for their vote in the 2012 elections. Nowottny describes three forms that political patronage takes in Belize: the dispersing of funds to allies while delaying funds to opponents, providing free food, beer, and transport for political rallies, and dispersing funds to electoral losers to better prepare for the next elections. These forms of political patronage have three general effects: voters vote based on material needs and not ideology (whoever gives them the money), social services are affected by political allegiances, and politics have become more inflammatory and potentially violent (Nowottny 2007).

Such a political environment has real effects on people's lives. With a change in the political party that is in office comes the potential for job loss (and the consequent opening of positions previously held by supporters of the opposition), the reallocation of government resources to regions, organizations, and people who supported the new party, and an overall threat to social stability that can result from such politically-motivated change. Nowottny explains, "What to outsiders appears as a politically interested electorate firmly endowed with democratic norms, under a closer cultural examination, turns out to be a population held in the grip of political parties, suspended permanently in a state of dependency" (2007:11). Indeed, a number of NHI staff who I interviewed were of the belief that Toledo was being neglected by the party in power because the district had elected representatives from the opposing party. "Oh yeah, that's just the way it is here in Belize. If you're not with the party in power, you might as well forget about it," is the way one staff member put it.

Still, the existence of corruption and political patronage does not necessarily equate with a strong, autonomous State. In his classic history of Belize that is used in most high school classrooms around the country, Belizean historian Assad Shoman explains, "The imperial system no longer depends on direct rule through colonialism, but rather uses its control of the global

economic system in order to continue to dominate the world" (2000:259). Such influence from international actors can be seen throughout the many arms and functions of the Belizean State. Sociologist Steven Brechin and environmental biologist Osmany Salas (2011) describe how in the environmental sector, the Belizean State has outsourced a majority of its management and conservation duties to third parties, primarily international NGOs. Such a shift of state services, a hallmark of neoliberalism, to third party organizations is expected to result in less bureaucracy and greater efficiency (Medina 2010).

Brechin and Salas (2011) argue that in developing countries like Belize, the State is already weak, so utilizing third party agreements actually accomplishes more than the State would otherwise be able to. From early on in the country's independence, the GOB has established an extensive system of protected areas that have been co-managed by a number of Belizean NGOs that are largely backed by international organizations and funding. This system allows for vast networks of ecosystems to be managed and protected, while reducing State bureaucracy and expenses. Co-management of natural parks and protected areas in Belize began in the 1980s, soon after independence. Since the late 1990s, conservation NGOs have expanded to encompass the entire country. NGO leaders commented on the lack of guidance and responsiveness from the government in regards to their management responsibilities. The GOB, in practice, has given most management responsibility of protected areas to NGOs, provides little oversight or engagement, and offers no financial support. In most cases, the NGOs themselves have approached the State about creating co-management partnerships. The organizations have attempted to fill the gaps of the State instead of the other way around, as is often the case in the context of developed countries (Brechin and Salas 2011).

The Belizean State uses the discourse of nationalism, development, and democracy to promote and define the Belizean nation. The development discourse promotes an increase in GDP as the measure of success, while falling under the coercive influence of international lending institutions like the IMF and World Bank. Belize pursues a policy of national development based primarily on the export of agroindustrial products like sugar, citrus, and bananas, and the now leading foreign exchange earner, the tourism sector (CIA 2013). It is primarily the export producers, however, who have used the State strategy to their own benefit, earning lines of credit, concessions for expansion, and favorable policies. Producers have enhanced the likelihood of receiving favors by providing funding for electoral campaigns. Still, producers are a fractured group as well, divided along ethnic, kin, political, and other lines that also compete within itself for political patronage (Medina 1997).

This successful development strategy is supported by the promotion of a discourse espousing Belize as a stable democracy that is attractive for international investment. The State offers tax concessions to investors, and domestically tries to keep wages low, while encouraging the use of immigrant labor. Official discourse espouses a peaceful nation with a high regard for democracy, and political parties are composed of members from all major ethnic groups. Both major parties follow the same development policy that promotes export-led development that benefits the (wealthy) producers (Medina 1997).

In summary, similar to States around the globe, Belize is a State governed by the elite, largely in the interest of the elite. A relatively small population at the top of the national economic and social hierarchy is able to take advantage of the nation's resources for the benefit and reproduction of their own interests. Belize's use of NGOs in the environmental sector is a classic example of a neoliberal shift in governance, in which the State outsources social services

and other national-level responsibilities to organizations often supported and financed by international interests. Finally, its continued reliance on loans from and debt restructuring deals with large international banks like the IMF and World Bank leaves the nation at the mercy of the global economic system. Like Shoman pointed out, Belize is deeply embedded in the new imperialist system. But is Belize truly a neoliberal State?

Is Belize a Neoliberal State?

Neoliberalism has been characterized as a global phenomenon, a geopolitical movement aimed at opening the free market around the globe, and a unique phase in the era of capitalism (Harvey 2005, Duménil and Lévy 2012, Springer 2013). The neoliberal shift has occurred in States around the globe, both in the global south and the global north. However, despite the global nature of the concept, it is important to remember that as neoliberalism has expanded globally, it has taken on characteristics unique to each locality in which it has arisen. Further, as neoliberal policy has unfolded across the globe, it has met with friction and resistance (Tsing 2005). Such contestations are rooted in the fact that neoliberalism in all of its unique forms operates to protect the interests of the entrenched elite. Further, neoliberalism has been implicated in the persistence of global inequality, poverty, authoritarian tendencies and a number of other social problems (Springer 2013, Tsing 2005, Harvey 2005).

In the global South, in places like Latin America and Belize, the neoliberal project has yet another sinister side. Springer explains, "When applied to the global South, neoliberalization proceeds as a civilizing project, operating in much the same way as colonialism did before it" (2013:159). And while social welfare programs have seen cuts throughout most of Latin America due to a neoliberal shift from public to private financing, Belize stands out as a going against the

grain. In much of the region, large international financial institutions (IFIs) such as the World Bank, the International Monetary Fund (IMF), and others, have promoted social policy reforms based on a neoliberal model that posits the free market is the most efficient way to deliver social services such as health care and education. IFIs offer large loans aimed at stabilizing national economies, promoting economic growth, among other things, and in exchange gain influence in policy making in sovereign nations, including the ability to dictate health reforms (Armada and Muntaner 2004).

In its early years, Belize built its economic base on export agriculture, specifically on sugar, which legitimated and strengthened claims for independence. The market for sugar, however, experienced serious declines in export earnings shortly after Belize gained independence in 1981, putting the new nation into debt crisis. As has been typical in much of the developing world, the IMF offered debt relief, but for a cost, which in Belize meant a diversification of its agricultural export crops. This economic restructuring led to a sharp increase in forest clearing for banana and citrus production, especially in the rural south of the country, including in the Toledo District. State lands were distributed to private interests to develop and expand the export agricultural base of the country (Medina 2010). The Belize case is a classic early example of the international spread and influence of neoliberal policy.

In other ways, however, the country has shown a steady independence from complete influence from IFIs, most recently evidenced by their threat in 2012 to default on their 'superbond' loan of about \$550 million US (Hughes 2012), which ultimately lead to a much more favorable restructuring of the payment plan (for Belize) (7 News 2013b). Belize has further bucked the neoliberal trend by nationalizing a number of prominent private companies, which goes against the key neoliberal tenet of increased privatization. In 2009, the GOB nationalized

Belize Telemedia Limited, the largest phone company in the country (7News 2009). Then in 2011, Belize Electricity Limited, the lone supplier of electric in the country, was nationalized (Channel 5 Belize 2011). The GOB continued the trend in 2013 when it nationalized two more private enterprises, Belize International Services Limited, an offshore corporate consulting firm, and the International Merchant Marine Registry of Belize (Channel 5 Belize 2013).

Similarly, it would appear, on the surface at least, that Belize has also resisted a neoliberal takeover of their health system. With funding from the IDB, they overhauled their health system, ultimately implementing the National Health Insurance system (NHI) and the Belize Health Information System (BHIS). Instead of deregulating the health care system and opening a health care "market" for private providers, as was common elsewhere in Latin America where neoliberal policy implementation took place (Williams and Maruthappu 2013, Homedes and Ugalde 2005), something different happened in Belize. The national health system was instead strengthened through an overhaul to reorganize publicly funded health service facilities into a referral system that includes local health clinics as a point of entrance into the system, all maintained and operated by the State through the MOH. These local, village-level clinics offer very basic services, but can then refer patients to regional polyclinics located in central locations throughout the country, which offer more comprehensive services. Polyclinics can then refer patients to regional hospitals, which can then continue the referral process until patients reach the largest, most comprehensive health facility in the country, located in Belize City. The goal of the restructured system is to provide universal access to health care services for all Belizeans (BZMOH 2013).

Universal Health Care as an Ally to the Neoliberal Agenda

When a nation provides its citizens with universal health care, that nation is typically seen as providing for the social good. Comprehensive State-funded health care systems, such as the one in Belize, are not often tied to the neoliberal agenda (Williams and Maruthappu 2013). Neoliberalism is known for restructuring social services like health care such that they are decentralized, publicly funded at lower rates, and outsourced to private interests. Neoliberalism has other facets as well. As described by Springer, "Neoliberalism is now regarded as a process of transformation purposely used by States to remain economically competitive in an international milieu," with a focus on surveillance, policing, and order (2013:153). Are these characteristics of neoliberalism found within the Belize health care system?

As described above, the NHI is a system that attempts to fold all Belizean citizens into the biomedical institutions primarily run by the MOH. As of 2013, there are no officially sanctioned alternatives to biomedical care recognized by the MOH, despite the persistence of the use of traditional healers and traditional and herbal remedies. It needs to be asked why the State might be hesitant to recognize traditional health practices, especially like those practiced by Maya and Garifuna who make up the majority population in Toledo. With land rights battles for 24 indigenous villages in the Toledo District still being waged (Cultural Survival 2013), the conclusion can be drawn that the Belizean State is hesitant to recognize the rights of its indigenous peoples. The recognition of traditional medicine, which is primarily practiced by indigenous peoples in Belize, as a legitimate health care service option would be a furthering of the rights of the indigenous, and potentially put the State's land rights case at risk. By officially ignoring the existence of traditional health care practices, the Belizean State maintains a consistent policy towards indigenous populations. Viewed in this light, the NHI can then be seen as a type of disciplining or policing of the population through the promotion of a national health care system (Foucault 2006). Marking biomedical health care as the only legitimate form of health care recognized by NHI, the State is attempting to control and order its citizens, legitimating who is a citizen and who is not through the health care system. NHI, with its referral system and the only officially recognized medicine in the country, educates the citizens of Toledo on how to properly care for themselves. Patients must see the correct clinics in the correct order based on how they are referred. In this system the official discourse does not include a place for bush medicine or home remedies. The official system does not include a space for indigenous or traditional practices, and by extension, for the people that practice those traditions.

Further, the BHIS can effectively be seen as a surveillance system designed not only to monitor the public health, but also to keep track of what citizens are "correctly" using the system. With MOH officials reporting in peer-reviewed journals that over 98% of patient encounters are being entered into the system, and that only people not authorized to be in the country (like immigrants who entered the country illegally) are not in the system (Graven et.al. 2013), they are effectively promoting a discourse of the "all knowing State." The message that the BHIS is all encompassing of Belizean citizens reinforces the nature of surveillance inherent in the system, and suggests an aspect of policing and control. It is in this way that the BHIS, as a system of surveillance, can be seen as a means through which the Belizean State can police not only the health of the population, but also who belongs in the country, and even determine who and what practice is Belizean. The presence of systemic surveillance and control, two hallmarks of the neoliberal State, in part, signifies that Belize practices a neoliberal agenda.

In Toledo, the functioning of the NHI and BHIS as arms of the neoliberal State are even more pronounced. In a District in which 66% of citizens are indigenous (SIB 2011), and in a context in which the State is at least hesitant to recognize the rights of those citizens, the structures and forms of coercion and repression have been maintained. In the Toledo District, the State exists, and as demonstrated through ethnographic findings, its presence is felt by its neglect. I suggest that the State health system is used to discipline the residents of the Toledo District – to forgo the use of bush doctors and traditional remedies that are essentially forms of self-reliance, and begin to rely on the State for its health care needs and become better Belizeans. Once reliance on the national health system is established, citizens are then more legible to the State and its ruling interests (Scott 1985). In short, the Belizean health system effectively promotes the ideology of the ruling class. However, along with State discipline, there is resistance, exhibited in the everyday health practices of citizens in P.G., Toledo, and the rest of Belize. The continued use of traditional home remedies and traditional medicine can be seen as a form of everyday resistance to the hegemony of the State's biomedical system (Scott 1985).

The tension between the efforts of the neoliberal State at surveillance and control and the everyday resistance practiced by much of the population is but one aspect of conflicting interests that are present in Belize. Springer has explained how neoliberalism, and the uneven development that it brings into being, has created a new form of conflict – primarily within states rather than between them – such that "particular cities and/or regions become the focal points for development and investment, while peripheral areas are largely ignored" (Springer 2013:155). The health system in Belize is a prime example of such uneven development and internal conflict. The urban areas of Belize, where the elite in the country are largely stationed, receive

the most investment and the best services and care, such that there are talks of creating a medical tourism program using the top MOH facilities in the north of the country (7 News 2012).

Meanwhile, in southern Toledo and P.G., those same health services are available, but at a severely limited level of quality and content. State health services are such that 33% of my research participants reported that they need to travel outside of the District regularly for health care. Another 23% reported that they would never use the NHI services in P.G. largely because of the lack of quality. The State is at once showing its paternal nature by providing free, albeit limited, health care services, and its power by neglecting the real needs of that same system and the people that use it. Such an approach from the State leaves many citizens marginalized, poor, and sick, especially because the poor suffer the most from such neglect. These are the very effects of the neoliberal project.

Neoliberalism, known for exacerbating inequality, is also associated with the reduction of social welfare services provided by the State. It would seem unusual that the creation of a State-funded national health care system that provides universal access to health services would be an unusual ally in the neoliberal agenda. However, as anthropologist Linwood Cousins has explained, "Social welfare polic[ies]...not only comprise inexorable power relations in terms of decisions about who gets services, why and how much, but also display how power relations are embedded in and applied through our beliefs and values about family life" (Cousins 2013:1254). Within the Belizean health care system, power relations in the country are laid bare, and we can see the values and beliefs of the elite being reproduced and even forced upon the poor, the relatively powerless, and the indigenous populations of the country's own south.

By reading the MOH and its public health system as a place where the State resides, and an institution through which it exercises its power, we can see that there can be two sides to a

universal care system. One side provides health services to the public, while the other promotes the values and interests of the State and the ruling class or elite. In the case of Belize, as is the norm around the globe, the elite is not limited to Belize, but extends to an international elite that operates through the funding of large national-scale projects. The creation of the Belize health system was funded by the IDB, the largest development bank in Latin America and the Caribbean, and noted promoter of neoliberal structural adjustment policies (Menemencioglu 2009). Thus, the NHI and BHIS must be considered as projects that reflect not only the national elite in Belize, but also an international elite, that continues to project its values and beliefs onto unsuspecting populations. Springer has noted, "As the latest incarnation of 'empire', the principles, practices, theories, and attitudes of imperialism remain intact under neoliberalism" (2013:159). Using a publicly popular institution such as a national health care system to strategically obscure the neoliberal agenda is perhaps the latest turn of the age-old imperialistic force of an international elite that has expanded around the globe.

Chapter 7

Deservingness & Neglect: On the Margins of the Welfare State



Figure 18. The front side of the P.G. Hospital. Photo by the author.

It was the middle of July in the mid-afternoon, and we were carefully avoiding mud and puddles as we walked towards our homes. We had done two interviews already that day, but it felt like we were on a roll, and my research assistant wanted to try one more house before calling it a day. Happy about the enthusiasm, I agreed, and we headed towards a part of town that we hadn't covered yet. "I'm not sure if this is the house I think it is, but it may be the home of the ambulance driver who crashed," Erika said. She was referring to a well-known accident that occurred the year before in which an ambulance drove off of a bridge on the Southern Highway while transferring a pregnant woman with complications that could not be treated in P.G. The driver and a nurse died in the crash, but the patient somehow survived. The incident was one that many people referred to when discussing the need for NHI to reduce the number of transfers.

We knocked on the door, and a kind Kriol woman answered. After explaining the purpose of our visit, a sense of excitement came over her, and she brought out some chairs and proceeded to talk with us for well over an hour. We started by talking about her experiences with the NHI services: "I go to the Polyclinic almost every night right now, so they can check my pressure. But just recently they checked and it was high, so they gave me medicine. Well then it kept going up and up and up. Luckily I had stayed there, and they gave me something else to bring it down. They make mistakes like that sometimes."

She went on: "We were just at the polyclinic yesterday too. My granddaughter here [she was holding her] had a rash – some kind of allergic reaction. It was all up and down her body – see on her face here and everything. It must have been from some plant or something. Well they took her in, and gave her an injection, and it cleared her right up. It's almost down all the way already. So they can be ok at the clinic too."

A little later in the interview, I asked her about what she thought of the overall services provided at the Polyclinic and hospital. She hesitated for a moment, then told us briefly about her husband: "They really need to train these people better. My husband was the ambulance driver here in P.G. The night of the crash, he said he didn't want to go – he had a headache. He had

high blood pressure – he wasn't feeling right. But they said, "It's your shift, so you have to drive." He didn't want to, but he had to. They gave him medicine for his pressure and sent him. The mother who survived the crash – she said he was talking to them the whole time, but that he had a bad headache. But then all of a sudden he went quiet. She yelled for him, but there was nothing."

"The next thing she knew they were in the water. He had a massive heart attack. I wonder if it was from the medicine like what happened with me? But he just went unresponsive, quiet, and that was it. He and the nurse died. Just the mother lived – she had to keep her head up out of the water. Just her head was out of the water. But when they got to her, she was ok. They took her to Dangriga, and she didn't even have the baby. She had it a few days later back down here in P.G. They didn't even need to send her!"

The story had become emotional for her, but she didn't want to stop talking, revealing that nobody had ever asked her about these issues before. She went on: "They need to fix up the hospital. It's embarrassing the way it is. They need to renovate, and give it some general maintenance. And they need better and more services. They need to have physical therapy, they need a dentist, an x-ray machine. They need to be able to give mammograms. They have an EKG machine, but nobody knows how to read it. We need to have more of these kinds of things here. We need to have more so that we don't have to go to Dangriga. We send 4 or 5 vehicles a day sometimes. We need the services here."

We had been talking for more than an hour, and I noticed that our host was starting to look uncomfortable. "Is everything ok?" I asked. She replied: "I have back problems. It seems like I hurt it when I was younger, but they couldn't fix it. They couldn't do anything here. I had to go to Belize to find out what was wrong. And I went to Guatemala for surgery, and it's still

not better. I always have pain. I can't sit. Whenever I sit for too long my legs go numb. My arms numb up. And it's really hard to stand up – painful. They don't have any kind of services for me here. There's nothing for someone with these kinds of problems. What am I supposed to do?"

This interview proved to be one of the more emotional experiences I had while talking with people about the NHI services and health care. By the end of our talk, this Kriol mother of two, widowed by the very services we were talking about, was tearing up. She actually thanked us for providing her an outlet through which to express some of these stories, and added that she hopes some real changes are in the future at the Polyclinic and hospital. "We hope so too." I replied as we hugged before leaving and heading home to process the emotionally exhausting interview.

Introduction: Deservingness and Neglect

In previous chapters we have seen that the Belize health care system, while lauded internationally, is in many ways a flawed system, especially when it concerns the residents of Punta Gorda and the Toledo District. And while health services provided through NHI vary in quality throughout the country, it is P.G. that receives the least attention. Still, with its emphasis on providing "health for all" and the attempt to provide access to primary care for every citizen, the Belize health care system would appear to be created in the interest of the public good (BZMOH 2013). In this sense, the system can be seen as part of a social welfare system, and Belize can be seen as a "welfare state," as the government has instituted programs and policies (the NHI system) that provide the nation's citizens with a type of safety net (Foucault 2006, Graham 2003). This conceptualization of the nation as a welfare state leads to the question of

what are the responsibilities of the State in terms of the public welfare? More specifically, how does the structure of the MOH reflect the construction of public welfare by the Belizean state?

In this chapter I examine Belize as a welfare state and consider how the concept of "deservingness" (Will 93, van Oorschot 2000, Willen 2012, Cousins 2013) can assist in understanding how a system that appears on the surface to promote equality actually produces and perpetuates a culture of inequality. As the nation's poorest and most indigenous region, P.G. and the Toledo District arguably have the worst health services in the nation. In any system of State-provided social medicine, those with the means, financial or otherwise, will have access to superior services. It is the marked inferior quality of the State services in P.G. and Toledo that is notable about the Belizean system. An examination of these realities through the lens of deservingness will shed light on how Belize has constructed a health system that actually favors the elite while claiming a sense of equality.

Once it is established that some regions or populations are more deserving of quality health care than others, the question of neglect becomes relevant. Can a system that provides free and low-cost health services to the public actually be seen as a system of neglect? Neglectful States have been shown to practice disengagement, exhibit clientelism, and pursue a policy of risk voidance (Dorman 2007). In Belize, it will be shown that the State, through the actions of the MOH, ignores requests from local officials in P.G., has a history of appointing people to positions based on their connections and not their qualifications, and avoids the risk that may come with complete neglect by providing State-sponsored health care services.

So, does the provision of sub-standard care, medicines, and access equate with a cycle of neglect that has defined the region for centuries? In fact, the State has created and promoted such a system to its public in P.G. and the Toledo District, such that the population largely relies on

these sub-standard State services. By creating a reliance on the system, but refusing to provide quality services, the State is perpetuating a cycled of neglect and marginalization that first gave "the Forgotten District" its epithet. One health care professional put it succinctly in our interview:

It's all political. That's right. It's politics. The Ministry knows what's wrong here. They know. They just don't want to fix things. They don't like to hear this is the "Forgotten District" anymore – that gets them mad. But it is still forgotten. We're neglected here. The Ministry will talk, but they won't do anything.

It is not an accident that there are problems with the NHI system in P.G. The problems can be seen as a strategy of neglect to a region of the country that is different from and even threatens the views of the elites of Belize.

The Welfare State

The idea that States have a responsibility towards their citizens is well accepted, however how far that responsibility goes has long been a topic for debate (Foucault 2006). The degree to which public welfare is provided has varied across time and has taken different forms in different nations. Also known as social programs or social welfare, public welfare has included such diverse social services as health care, education, unemployment insurance, child care, and housing subsidies, among other services that aid in the provision of social well-being, especially for the poor and needy. The concept of welfare has generated controversy, especially in cases where aid is reserved only for those in need. A system like the NHI in Belize, that aims to provide all citizens with health care services, avoids this critique, and in turn, generates less controversy. Still, as recent debates about state-provided health care in the U.S. have shown, any

type of public assistance is increasingly controversial in the current era of neoliberal capitalism (Horton et al. 2014).

In his classic writings on governmentality, Foucault (2006) argues that the purpose of government is the protection of the public welfare:

Government has as its purpose not the act of government itself, but the welfare of the population, the improvement of its condition, the increase of its wealth, longevity, health, etc.; and the means that the government uses to attain these ends are themselves all in some sense immanent to the population; it is the population itself on which government will act either directly through large-scale campaigns, or indirectly through techniques that will make possible, without the full awareness of the people, the stimulation of birth rates, the directing of the flow of population into certain regions or activities, etc. The population now represents more the end of government than the power of the sovereign; the population is the subject of needs, of aspirations, but it is also the object in the hands of the government, aware, vis-à-vis the government, of what it wants, but ignorant of what is being done to it. (140)

Foucault's conceptualization of government implies that through the employment of public welfare services, the government acts, not in the full interest of its citizens, but in order to more effectively control them.

Foucault continues this argument in his explanation of the concept of the "common good" which "refers to a state of affairs where all the subjects without exception obey the laws, accomplish the tasks expected of them, practice the trade to which they are assigned, and respect the established order. In other words, 'the common good' means essentially obedience to the law" (2006:136-137). Foucault then, asserts that the State, through its governance, is a means

through which a population is controlled in the interest of the State, which is the mechanism through which the elite maintain power.

This argument is supported by the earlier work of sociologist Ralph Miliband. In discussing the British introduction of its social insurance system after World War II, Miliband explains that the system was the pillar of the welfare state in that it offered services and protections beyond what had been previously offered by a western state. However this exemplary system posed no threat to the existing system of power and privilege. Miliband explains: "Those who control and determine selection and promotion at the highest level of the state service are themselves most likely to be members of the upper and middle classes…and are likely to carry in their minds a particular image of how a high-ranking civil servant…ought to think, speak, behave and react; and that image will be drawn in terms of the class to which they belong" (Miliband 1969:63-64). In other words, those officials who carry out the duties of the State through institutions such as the MOH are themselves members of the elite, and govern through those institutions in such a way that is consistent with, and in support of, their elite status.

Seen in this way, despite public welfare programs aimed at protecting and uplifting the poor, equality or democratization within the institutions of the State has not been fully realized. Instead, it is more accurate to describe a process of "bourgeoisie-ification" through which members of society from outside of the elite are recruited and transformed into a new class that adheres to the beliefs and practices of the elite, but does not have the lineage of the elite. This new class continues working in the interest of the elite even though they are of the working or middle class (Miliband 1969:64).

Such a system functions to perpetuate and foster the traditional values and interests of the elite of society. Further, the interests of the lower classes, poor, and marginalized are rarely if

ever truly represented in a system that is ultimately meant to control them. Thus, as Foucault notes, the institutions of the State, and specifically the policies of those institutions can be seen as tactics of control: "the finality of government resides in the things it manages and in the pursuit of the perfection and intensification of the processes which it directs; and the instruments of government, instead of being laws, now come to be a range of multiform tactics" (Foucault 2006:137). Through institutions like the MOH and health policy like the NHI and BHIS, the Belizean State attempts to control the health behavior of its most marginalized populations – the indigenous and poor – and thus align that behavior with those in power. These instruments of the Belizean State can be seen as an effort to homogenize and even nationalize the behavior, specifically the health behavior, of its citizens.

Neoliberalism, the Welfare State, and Deservingness

In the previous chapter I established that Belize is operating under the influence of a neoliberal model, primarily through loans from international banks to satisfy debt payments. David Harvey (2005) argues that as nations operating under the neoliberal model continue to accumulate mountains of debt, in order to right the sinking ship, the first casualties will be social welfare programs. Why then, during the precise time that the neoliberal model was taking hold in Belize, was a universal health care system instituted in the country?

By examining the way by which the Belizean health system is deployed, it becomes easier to understand how a universal health care system can at once appear to be for the public good, while also function in the interests of the elite. Springer has explained that under neoliberalism, the "constrictions of welfare provision serve to intensify the politicization of citizenship and immigration issues, as citizens and "others" come into conflict over who is

entitled who is unentitled to what little remaining protection and welfare the state provides" (2013:154). In Belize, where the premier health services are conveniently available to the nation's elite (the top hospitals and private care centers are in and around the country's seat of power), and the poorest services are provided to the poorest citizens, the conflict over who is deserving or not of the resources of the State is clearly evident. This framing of the health system also reflects colonial and post-colonial geographical distributions of power.

A nurse who works in the NHI system and has worked both in the new Polyclinic in the rural area of the Toledo District and in the hospital in P.G. detailed the conflict within the health system in Belize:

I think they totally forget about P.G. We always run out of things, and we always need things. If we do get something, it's the used things. They break too easy – they're already used, that's why they replaced them in the first place. They just don't seem to care about us down here. We're like an afterthought. We don't even have sheets in the hospital. Patients have to bring their own sheets. Believe me, we don't have lots of stuff.

A local pharmacist reiterated the lack of resources within the health system in P.G. as well: People will come here after being at the [poly]clinic for their medicines because the clinic doesn't have any. I don't know anything about them cutting the medicines [referring to the diluting of medications with water at the clinic], but I know their medicines don't always work. They give the wrong medicines out too. They give paracetamol for everything [a common pain reliever, similar to acetaminophen or Tylenol (Patient.co.uk 2013)]. People know they're just going to get paracetamol, so don't even want to waste their time going over to the clinic. They [the MOH] need more and better medicines.

Diluted or missing medications and a lack of sheets are not the only deficiencies at the Polyclinic and hospital in P.G. Locally based MOH staff reported a shortage of doctors and nurses, a lack of functioning equipment, the need for a well-running ambulance, a lack of public education on how the NHI system functions, and the inability to provide any specialist and few emergency services as ongoing problems affecting the health and well-being of the residents of P.G. and the Toledo District. These many problems related to the quality of health services that are available raise the question of whether the MOH sees Belizeans in this part of the country as deserving of the same level of care and service as are citizens in other parts of the country. And while these issues may be present for other communities throughout Belize, they are particularly acute in P.G. and the Toledo District.

Deservingness

Most of the relatively small amount of anthropological work on deservingness and health has been focused on im/migrants and the responsibility of receiving nations in providing for their health care needs (Horton 2004, Horton and Barker 2010, Goldade and Okuyemi 2012, Willen 2012). Much of the literature on deservingness deals with the concept in the context of welfare and how certain populations are taking advantage of or draining public welfare services (see Willen 2012:814). The question of deservingness in terms of health care services becomes more complicated, and has implications beyond the individual who may or may not have access to appropriate services. More broadly, asking whether a population is deserving of health care services becomes a question about human rights, government responsibility, and humanitarianism in general.

In her work with migrants in Tel Aviv, anthropologist Sarah Willen shows that when health protection is not available or inadequate, immigrants' and other workers' exploitability rises and the wages for locals are driven down. Further, treatment delays in such contexts can negatively impact individual and population level health problems. She explains: "The concept of deservingness falls into two broad camps, those that argue that im/migrants are undeserving of health services, concern, or support. On the other side, are those that frame the problem of im/migrants and health services as a human rights issue, a humanitarian issue, or an issue of the public good" (2012:813). The differing views of these two camps have yet to be reconciled, largely because in the context of State-provided health services, im/migrants are commonly seen as outsiders who may not have the same rights to State services as citizens do.

A study by anthropologist Kate Goldade and MD Kolawole Okuyemi (2012) examined providers' thoughts of deservingness to health care for migrants in Costa Rica. Like Belize, Costa Rica also has a universal care system, although it is longer established and higher functioning than is the Belize system. Theirs is one of the few studies that examines deservingness from the perspective of providers (see Castañeda 2012 for another example examining, in part, deservingness and unauthorized migrants in Germany), although it is primarily concerned with migrants' deservingness as opposed to potential differences in deservingness within a country's own population. Still, Goldade and Okuyemi found that providers were in support of migrants' access to Costa Rican State health care except in cases of occupational injuries, in which case they felt employers, whether nationally or internationallybased, are responsible. Consistent with the Hippocratic oath, providers in Costa Rica see deservingness and health care as a human rights issue. Willen (2012) posits an examination of the issues surrounding deservingness and health services leads to the relationship between two distinct issues, one about a person's formal rights to health care services, the other about moral and ethical positions on deservingness to care. The diversity of the types of people she works with, which includes political and economic refugees, victims of human trafficking, asylum seekers, seasonal workers, and the like, makes matters of health rights and deservingness especially important, as people in these positions are away from the social support networks of their home, and often have little or no legal recourse for support in their new countries of residence. However, often neglected in the conversation about health rights and deservingness are those living in poverty, in regions of limited economic opportunity, and on the margins of their own societies. Such is the case in Belize, where the State has provided a substandard quality health service system to those in the historically marginalized Toledo District.

Willen (2012) also argues that deservingness must be studied and understood from the perspective of those potentially on the receiving end of health services (in her case im/migrants), and not only from that of politicians, public health officials, and the like. She puts forward that deservingness can be seen as the "flip side" of health as a human right discourse, with human rights as universal/juridical and deservingness as moral and context-specific. For example, in Belize, the State is technically satisfying the health care as human right dictate by providing State-sponsored health services. However, the lacking quality in those services can be viewed as a moral judgment that frames citizens in the Toledo District as somehow less deserving of the level of services that are provided elsewhere in the country. Assessments of deservingness are relational in two ways: one's own sense of deservingness influences how others' deservingness is seen, and one's social connection/distance to those whose deservingness is in question.

Deservingness is also contextual in that it is often based on some real or presumed characteristics of those in question. In many ways, im/migrants and the poor share similar portrayals in efforts by interests within the media and the State to justify an undeserving status (Willen 2012).

In his work looking at children in poverty in the U.S. and their deservingness of social welfare support, anthropologist Linwood Cousins writes, "The act and privilege of determining "deservingness" involves power—power to frame and define the problem, power to decide policies to address it, and power to decide the...distribution of social welfare support" (Cousins 2013:1252). Cousins proposes that the concept of deservingness as a guiding principle in the writing of policy is harmful to children and their families, especially those living in poverty. He further argues, "Poor, working- and middle-class families matter to the social and economic well-being of children, our economy, and our society" (Cousins 2013:1253). Cousins makes the argument that it is not only a human rights issue, but that the health and well-being of all the people of a society or nation, and not just that of the elite, is what determines the health and wellbeing of that society or nation.

So how do States tend to view deservingness? In his historical study of modern welfare states, sociologist Abram de Swaan (1988) identifies three criteria for deservingness: disability, proximity, and docility. Of the three criteria, he describes disability as the most important in terms of who is deserving: if a person has the ability to make a living or provide for themselves, they lack deservingness, and those who have less control over their neediness are more deserving of State services. Proximity refers a social area of responsibility, or to the distance a needy person is from those determining their deservingness. For instance, a person in the same town or city is more deserving than a person in another state or country, who would then be the

the person or group in question is part of the "in-group", or how "like" they are to the persons responsible for them, and can include categories like ethnicity or nationality. Docility, according to de Swaan, refers to how open a person or group is with their neediness. Quiet, hidden, and docile people or groups are seen to be more deserving, whereas more openly demanding people are not seen as deserving. Other studies of deservingness (Cook 1979, Will 1993, van Oorshot 2000) have found similar or corresponding criteria for deservingness that support de Swaan's findings (van Oorschot 2000). These criteria fit in the Belizean context, where P.G. and the Toledo District are the furthest region from the country's seat of power, the most indigenous and poor (thus not part of the "in-group"), perhaps the least docile (evidenced by the Maya land rights case going to the Supreme Court), and recipients of the worst quality health services in the country.

The examination of deservingness, then, is necessarily an examination of power. Regardless of who individual citizens believe are deserving, it is those in power who have the ability to decide who is deserving. What can be gleaned from the studies above is that the higher the potential for difference a person or group holds from those deciding on deservingness, the less deserving they are. Cousins understood, "Beliefs, values and attitudes, as well as power, shape how we frame deservingness and influence who gets help and how much" (2013:1254). However, Willen countered, "Although moral conceptions of deservingness are foundational to all discussions of health-related attention, care, and investment, they remain notably understudied and, furthermore, poorly understood" (Willen 2012: 819). Power, morality, culture, and difference are all at play when the determination of deservingness is being made.

National Health Care and Deservingness in P.G. and the Toledo District

Based on the above discussion, there are a number of ways in which deservingness can be examined. Here, I am not so much interested in what individuals or citizens think about who is deserving, or not, in terms of access to health care. Instead, I am interested in how the State's actions towards specific populations or citizens can be interpreted as displaying levels of deservingness. From the State's point of view, with the MOH acting as a proxy of the State, can it be determined that some populations are more or less deserving of health care services than others? If so, how does the deservingness of some over others reflect the larger system of power that is woven into Belizean society?

A brief look at the history of the Toledo District shows that residents have always been distant from the center of power in Belize. Since the time of European contact in the region, through colonial times and into the present, the Toledo District has been a place in the margins, outside and ostensibly ignored by the national and international centers of commerce and culture. Historically, the District's slight value to the interests of the elite has been as a place for extraction of resources, and even in this, exploits have typically been unsuccessful, or when successful, relatively short-lived (Wilk 1997). In terms of proximity, residents in P.G. and the Toledo District have historically been distanced from the center of power and the elites of Belize.

It is not only by geography and economics that the region has been distanced. Ethnically, the indigenous Q'eqchi', Mopan, and Garifuna make up the majority in the Toledo District and P.G., but are the minority nationally. The percentage of indigenous people in the population of the Toledo District was 72.8% in 1991, 72.1% in 2000, and 66% in 2010, numbers primarily driven by the many Maya communities scattered across the region. P.G., a historically Garifuna town, but now more ethnically mixed, has also been a zone of indigenous majority, with 58.3%

in 1991 and 55.2% in 2000 of its population being indigenous. In a country that is composed of a majority Mestizo heritage (50% of the national population in 2010), and a historic elite comprised primarily of people of Kriol decent (21% of the national population in 2010, 40% in 1980), a geographically isolated and predominantly indigenous region of the country like the Toledo District and P.G. would be seen as different and distant from the country's elite (Woods et al. 1996, SIB 2011, SIB 2012).

The southern region further strengthened its perceived distance from the nation's elite when, in 1997, a collection of Maya groups in collaboration with academics from the U.S. released the Maya Atlas, that in part, called for the creation of a Maya Homeland that encompassed much of the Toledo District (TMCC and TAA 1997). This action was followed 10 years later when two Maya communities from the Toledo District brought the government to court to argue for ownership of their community land. While they and another 30 communities in the District won the court decision, the State has continued the appeal process, leaving land ownership in a sort of occupied limbo (Parks 2011). Needless to say, this court battle did nothing to better connect the District with the country's center, and further marked the region as something less than docile.

This history of marginalization has had a continuing and direct effect on the health and well-being of residents. It is a history of a multiplicity of groups, themselves marginalized by their own ethnicity, living in the fringes of their own country. This experience of marginalization, while it varies to some extent between groups, has direct implications on the health of the people in the district, as well as the types of health care that is accessible. And while the mission of the MOH establishes the goal of "universal access to health services of

"acceptable quality" (BZMOH 2013), the reality is that the system the MOH has instituted is unequal in its delivery of said services.

Evidence that the Belizean State views the Toledo District and P.G. as underserving of equally quality health care services became evident in a number of interviews with health care professionals both inside and out of the MOH based in P.G. An official in the MOH based in P.G. explained it this way:

I can tell you right off that they need to give the region more autonomy. The Ministry should just be advisors; they should serve as advisors or supervisors to what we do, but we should be able to make our own decisions. Right now, they meddle in our day-to-day affairs. Sometimes they'll do something, or they'll take their own sweet time. If we need to do something, we have to go through them first, and then they decide if we really need it or not.

The Ministry needs to give us more support. They get our reports and see the numbers, but then say that they don't see things that we say we need. And I only ever get a verbal response from my requests and reports. They never respond to me in writing. That allows them to do whatever they want. All I have is their verbal response to things, and that won't do anything for me. So their action is always delayed. They take their time, and act slow on the things.

I think it's the willpower of the CEO. He does things when he feels he wants to, when he's ready. Or maybe when he can. He needs to delegate more. He needs to give some authority to those people that are below him – to people that have the capacity to make those decisions. As it is, every single decision in the system is made by him. If I need something, he decides. He decides every action in the system.

Human resources are another big issue. I'm supposed to have a certain ratio of patients to doctors and nurses for example. That's written in Ministry policy. But that ratio is not being met. Especially in the summer, when people take vacation or go on leave, I'm especially short. But I'm always short something from what I'm supposed to have and from what I need. And this is a real problem. When I'm short doctors, I cannot send them out to the rural posts, so we often have no coverage in the rural areas. And this system is in place. The referral system is in place. So changes can't be made, and I don't think they will be made. We're held to the system as it is, and I don't know when or how that will change.

There are further examples of how the needs of the health system are not being met in P.G. or Toledo. A nurse who at the time of our interview was working in the P.G. Hospital, and had also worked in the new Polyclinic in rural San Antonio explained:

I think they're doing things a bit better here in town. Out there, they're short staffed, and can't really do much. They have to refer a lot of patients to us [at the hospital]. They have a pharmacy, but don't have a pharmacist. They just have an assistant pharmacist, and he's limited as to what he can give out. They have a lot of equipment just sitting there, so things aren't working that great out there.

When asked about needs at the Hospital, she replied:

What do we need? We're usually understaffed. We only have 1 doctor on most of the time. And the doctor has to cover the whole hospital. So if there's something needed in one of the wards upstairs, that's where the doctor is. But if an emergency comes in, what is the doctor supposed to do? Or if something happens in a different ward? They have to

work in too many spots all at once – too many wards, too much coverage. For the doctors and the nurses.

Discussions with other health professionals followed a similar vein, and revealed similar problems: the inability or unwillingness of the MOH to follow its own protocol in terms of allocation of resources to P.G., and a clear lack of communication between health professionals in P.G. and the MOH. The communication problems are better described as an unwillingness to listen, as it was repeatedly made known that reports are constantly sent to the MOH and they are constantly ignored.

Interviews with officials and staff of the MOH system revealed that there are definitely needs and problems with the system as it is deployed in P.G. and the Toledo District. However, is it accurate to construe these unmet needs as a sign that the region is less deserving of quality health services than others? Are these unmet needs a result of a lack of resources, or are they due to an unwillingness to meet the needs of a region deemed undeserving by a nation's elite? First, there must be a differentiation between the health system in the nation's center and the same system at the margins. The referral system itself reveals that the most comprehensive services are available in the main hospital in the country in Belize City. Interviews with MOH staff also show that there is a certain prestige associated with working in the city, with one of the primary factors being appropriate resources to provide quality health services. One doctor explained of her move to P.G.:

I wanted to stay up in Belize where the action is. There you deal with gunshot wounds, surgeries, all kinds of stuff. That's what I wanted. It's a little quieter here, but I came down, and grew to like it here. But it's hard here. There are limitations on what you can do, and there are risks. Too many people need to be sent out for simple things. It's

dangerous. It's far, and a long drive. They need to give us more resources down here, but they don't want to do it.

Another doctor reiterated the same:

I first worked in Belize City for 7 years. I loved it there – the people, the action. They have the things you need to be good at what you're doing. I think I got sent down here as punishment though, because I've asked for a transfer, but they just ignore me.

Drawing from these interviews, the structure of the referral system that sends all emergency and specialist cases to the country center, and the fact that the health system in the country's center is considered strong enough to promote medical tourism to Belize (7 News 2012), it is evident that there is a considerable difference between the services that are available to the residents of P.G. and Toledo when compared to elsewhere in the country.

These differences in the standards of care and service delivery point to a system of neglect aimed towards the south of Belize. Further, there is evidence that despite there being a system in place that decentralizes the health system, there is resistance to instituting the freedom and flexibility of autonomous decision making coming from decision makers in the MOH. As one MOH official stationed in P.G. explained:

They just won't give us any autonomy. If I have a position to fill, I'll do my duty and interview 4 or 5 of the best people, and send up my top recommendations to fill the post. I choose the person with the best qualifications, and I explain my choices by making point a, point b, and so on. But they never get hired. The CEO still has to approve my decision – so I can't really hire anybody. And even though I do my part – what I'm supposed to do – they just appoint their own people. They don't even listen to what I need or think is best. They just send us their own people. And these people, they don't

know the day-to-day issues here. They don't really know anything about the situation here. And I'll tell you – the people that they have sent down, their appointees, they are the ones that give us the most trouble. They think they're special, and they won't want to work, or they won't do their jobs. They think they're privileged because they were appointed from Belmopan. But can you imagine – they'll send us a driver that can't read or write. Or something like that. They send us the bottom of the barrel. So it's neglect, yes.

The frustrations of needs unmet and voices unheard have even the ranks of the MOH speaking out against the perceived injustice of a health system that is meant to satisfy the needs of all.

This pattern of neglect is further revealed in another example from P.G. A group of about a dozen people interested in health issues have begun meeting to formulate plans to create a clinic where specialist providers could visit and offer free and low-cost services that are otherwise not available in P.G. or Toledo. According to one of the people involved, they have met with resistance from the MOH:

I've been working in the Ministry for 20 years. I know how it works. They gave us approval to have a clinic here, but they told us to not ask for any help because we're not going to get it. No equipment. No money. Nothing. So we're on our own here. The big issue for me is that some people think we're doing this to make money, but this is for the community. We have submitted the paperwork to be a non-profit or an NGO, but they won't give it to us. Nobody takes our calls up there [at the MOH in the capital,

Belmopan]. So we haven't been able to get that status. This is for the community. Even when willing to create a means to provide for the health needs of the community with little or no help from the State, citizens are met with resistance, stalling, and even refusal. These cases

point to a pointed policy, unwritten, that aims to keep P.G. and the Toledo District on the margins in a state of poverty, ill health, and need.

Neoliberal Neglect

The Belize MOH, operating as an institution of the State, has established a universal health care system across the country. Such a system would at first glance appear more aligned with a welfare state aimed at providing services for the population, rather than a neoliberal state looking to cut public programs and increase privatization. As discussed in Chapter 7, however, the State health system furthers the colonial and neoliberal projects, whereby State institutions function to meet interests of elites, both inside and outside of Belize. By creating a health system that demands compliance of its citizens and places them under a system of surveillance, the State has effectively produced the illusion of working for the public good as perceived in its popular sense, when in reality, it has instituted a system that more effectively controls its population. This control is achieved by promoting and legitimizing biomedicine and by ignoring and marginalizing traditional medical systems, such that the population is slowly but effectively forced into the national health care system. Once engaged with the State system, the population can more easily be monitored and controlled, and traditional medical systems are further marginalized. And while traditional medicine remains relatively widely used in P.G. and Toledo, the low numbers of people who admitted as much within this research points to the marginality of the practices that exist. If such trends continue, traditional medicines may be further banished to the margins of health care practice.

This aspect of control is especially significant where the Toledo District and P.G. are concerned. They occupy a region of the country that has historically been neglected by State

interests, except where resources could be extracted. The limited success of such endeavors combined with the majority indigenous population has always left the region on the margins of State power and the concerns of the elite. This marginality has historically resulted in neglect of the District and its population, which has continued under the latest incarnation of the country's health care system. While the State has at least provided some level of health care, the low quality of that care in comparison with other parts of the country and the limited services that are provided are indications that, in the eyes of the State, the region is less deserving than other parts of the country. In the Belizean case, power (via the State) determines deservingness (Willen 2012).

While the MOH proclaims that it aims to provide a high standard of quality care to its citizens, the health system has fallen short in P.G. and Toledo. The fact that the system as instituted has little flexibility for improvement, added to the reality that requests and complaints to those in power in the MOH often fall on deaf ears, combine to reveal a pattern of neglect towards the citizens of the region. In the case of P.G. and the Toledo District, where many of the country's indigenous reside, the interests of those already marginalized are not truly represented in the health system that promotes a substandard biomedicine and ignores traditional medical practices that have been used for generations. Further, a system that views the only legitimate health care encounters as those with the national system is an attempt to coerce citizens to act in a certain way when seeking health care services. That certain way, which aims to produce a docile population willing to use the State biomedical services and leave traditional medical practices in the past, aligns with the values and interests of the Belizean elite. This research has shown that the NHI system as it currently functions in P.G., is a form of neglect and reflects the views of the State in regards to the deservingness of the population in the south of the country.

In this case, it appears that the citizens of P.G. and the Toledo District are perceived as less deserving than others in Belize of not only quality care, but the health care necessary for healthy and productive lives. Further, the neglect produced through the NHI system in P.G. and Toledo can be seen as an effort by the State to transform a largely indigenous population, pushing people away from traditions towards a more nationally and globally oriented medical system that, through continued international funding, would continue to enrich those at the top of the economic spectrum both in Belize and abroad.

Chapter 8

Conclusion: Medical Pluralism and the State



Figure 19. The Ministry of Health building in the capital city, Belmopan. Photo by the author.

It was a little before 8am in the middle of August, and I was slowly riding my bicycle to the hospital. A few days earlier I had arranged for an interview with a longtime nurse at the P.G. hospital, and was excited to talk with someone who had seen the Belizean health system go through its reforms. There are a number of nurses and other staff who have been working with the MOH since before the reforms of 2009, but I had become friendly with Nurse Julia over the last month or so, and she had already been quite open with me about what she saw as some of the problems facing the Polyclinic and hospital in P.G.

When I arrived, Nurse Julia was sitting at the emergency room computer, chatting with a two other nurses. "Oh, hello Douglas," she said when I entered. "We picked a good morning for you to come – we're not busy today! Let's take a walk." We left the other nurses to their work and found a private spot down the hall. "So what would you like to talk about today?" she asked. I started by noting that she had been a part of the health system since before the reforms, and asked if she could reflect on the changes that she has seen. She looked down and a slight frown came to her face. She started to explain:

"The system has not been working. Geographically, it's not right, it's not set right for our area. I have a map of Toledo, and if you look at the coverage areas, they're not done right. People from too many areas cannot get to the San Antonio clinic – they can't get where they're supposed to go. So they come here. They come here for many reasons. There's the market, they may be coming in to get their government assistance, or go to the bank. People come to P.G. for a lot of reasons – they need to come here – and that makes visiting this clinic more likely. Even if they can get to San Antonio, they have to spend \$8BZ or \$10BZ [\$4 or \$5 US] to get there, when they could just spend \$4BZ [\$2 US] to get to P.G. So it's also financial. It's practical and financial."

Talking about the San Antonio Polyclinic and how people from the villages are still coming into P.G. led to a comment about how indigenous people, namely the Maya, are treated in the hospital: "I know the indigenous people don't get the same treatment here. It's politics –

it's who you know. If you're so and so, you can walk right in and get whatever you want. But if you're a Maya, it doesn't work that way. I see that, and it breaks my heart. I don't like that part of the system. And I tell my nurses that we are patient advocates. We need to give the same service to everybody. But it doesn't always happen. I believe everyone should get the same care, but that's not the way our system works."

Nurse Julia spoke some more about the problems with the location, but I was also interested in the health services and how they had been affected by the reforms. She told me some specific stories, anecdotes about some of the problems she had seen. Then she spoke of a problem that may be inherent to systems like the one in Belize:

"The staff working in NHI just goes by the numbers. They only do what they're supposed to do, and if something is a little bit outside of that, they just refer the patient. They're just referring people right away, and they won't do the check-up or blood work or anything. If someone's problem is just a little bit outside of their responsibility, they just refer them right away. But we're short doctors, so that doesn't help with the work that people want to do. I only have 2 doctors on right now, and a third is on leave. So these two are working 24 hour shifts. One works 24 hours, and then goes home for 24 hours, while the other one works. They go off and on like that. We're just really understaffed. The Ministry knows it, but they're not going to give us more. Our patient rates are low – our admission rates. So they look at our numbers, and think we have enough staff, even though they're not here seeing what goes on."

We talked for a while longer about the myriad problems she has seen during her time working at the hospital. We had been talking for well over an hour, and I feared she may be called to duty at any minute. Finally, while she was explaining the problems with the ambulance, an issue I had heard about from a number of other staff, I interjected. "What do you think about

traditional healers? Do you think they could be integrated into the NHI somehow?" I asked. She didn't skip a beat:

"I think it would be great to integrate the traditional healers. I'm in full support of that. I know people use them, and the way it is now, that causes problems sometimes. A lot of the people that come in have been seeing a traditional healer already. When it doesn't work, they come in here, so things have gotten worse already. If they were integrated, we could work together – we would know what patients are doing, and could stop problems before they get started. I think it would help with a lot of the problems if they were in the system. I believe that traditional healing works. I've seen it work. I've seen patients refuse our care – they'll be told they need an amputation, or some surgery or something. They'll do a self-discharge, and go see the healer. And I've seen them come back healed. So I know that it works. So much of it is what they believe. I mean, if you believe you're going to die, you're probably going to die. If you believe you're going to live, you'll probably live. That's how it is with traditional healers. People believe in them, and they work a lot of the time. I've seen it work."

Nurse Julia never did get called away that morning, and we continued talking for another hour or so. She began to tell me stories about growing up in the Toledo District, about walking to the river to bathe and to get drinking water, and about having to rely on the plants from the bush for their medicines. As she rose to walk me out, she added one final comment: "Things are different now. The medicines, I don't think as many people know them anymore. We're losing that stuff. We're losing our traditions. People are getting more educated now, but nobody is coming back and saying that our old knowledge is important. The old ways aren't valued anymore." And so it is in P.G., where the reliance on an inadequate biomedical health system

continues to grow with the full support of the State, while the long trusted traditional medicines struggle to find their place in a changing world.

Summary and Discussion

The Complexities of Medical Pluralism in Belize

Health care is a necessity for humans, no matter their economic, political, or geographical situation. Article 25 of the Universal Declaration of Human Rights names medical care as a right to ensure "a standard of living adequate for the health and well-being of himself and of his family" (UN 2014). Following this, the Belizean State, through its proxy, the Ministry of Health, has seemingly put forth efforts at providing this human right for its citizens. However, conditions such as those described by Nurse Julia above, and elsewhere throughout these chapters, point to a marked deficiency in the quality and quantity of those health services that the State provides.

Interviews with health care practitioners employed by the MOH and working in P.G. confirm what residents largely believe about the national health care system: that it is inadequate for the needs of the community. Because of this perception/reality, we can see that people are forced to employ tactics to satisfy their health care needs. In other words, the poor reputation of the State health care services, along with other factors like ethnicity, economics, age, and religion among others, is one of the drivers in the medically plural environment that exists in P.G. Households turn to a range of options when they are in need of health care services, on one end of the spectrum, the biomedical services of the State, and on the other, the ethnomedical services provided by traditional healers. In between are the private doctors, pharmacists, herbalists, and others, and many turn to traditional home remedies as well, most often as a first choice in treating an illness. In different conditions, this combination of available services might

make for an effective health system. However, the poor quality of biomedical care, and the lack of specialists and emergency care, places undo stress on households in P.G. who are often forced to look outside of their communities for the services they may need. In this sense, a medically plural environment is in place by necessity and not necessarily by choice.

With this research I have documented that the use of traditional health care practices, primarily through the preparation and use of traditional home remedies and care provided by traditional healers, remains strong in P.G. This is likely the case throughout the Toledo district, though this study focused primarily on P.G. Based on the prevalence of medical pluralism around the globe, it may be safe to assume that these traditions are not in danger. However, with few young people training in traditional medical systems in P.G., the future of these traditions is precarious. Household interviews as well as those with employees of the MOH indicate that integrating traditional medical practitioners into the NHI system would be a popular move. It remains a question, however, if the State would have an interest in promoting the traditions of people from a region it has historically neglected and continues to do so in many ways. If such integration were to happen, it could raise the prestige and interest in such traditional practices, further enhancing their vitality. The inclusion of traditional practitioners with western biomedicine in the clinics could serve to validate and strengthen traditional medical practices and help to strengthen the overall medical system in P.G. and Toledo (Xu and Chen 2011).

If, however, Nurse Julia is correct that there has been a shift in how willing people are to pursue traditional health care in the face of more easily available biomedical care, inaction would further limit peoples' health care choices, and create a greater reliance on biomedicine and pharmaceutical drugs. Without a response from the State to address the already present health care gaps that exist in P.G., people's health could become even more compromised. Absent a

State response, grassroots organizations like the Q'eqchi' Healers Association could be another avenue through which to retain and strengthen traditional medicines. In the case of P.G., health care, and in turn the medical pluralism that exists there, can be seen as a site of friction between the State and its citizenry (Tsing 2005).

Anna Tsing reminds us that the friction created by unequal encounters, like the one between the universalizing biomedicine of the State and the locally-produced traditional medicines in P.G. and Toledo, can result in new "arrangements of culture and power" (2005:5). Applying the concept of friction to this context aids in understanding the process of change that is occurring in the overall medical system in Belize. While it is unlikely that the presence of the State biomedical system will be reduced, it is the relationship between it and traditional medical systems that will result in change. The result of that change is yet to be realized, but the resilience seen in the current traditional medical systems has the potential to challenge the power of the State biomedicine, and through this friction, create a medical system unique to P.G., Toledo, and Belize that represents the health interests and needs of all citizens (Tsing 2005).

As it is, the medical system in P.G. and the Toledo District is a complex and plural system. As discussed in Chapter 5, the ubiquity of medical pluralism around the globe signals that traditional medicines will maintain a presence alongside the State biomedical system in P.G. The multiple health systems are used because they are effective for different health needs, for different people, at different times. People in P.G. practice "therapeutic opportunism," often choosing low-cost and convenient home remedies and other self-care options as a first course of action when dealing with an illness event. Economics, age, religion, and ethnicity are among a host of social, economic, and structural factors that can influence the first and subsequent actions during an illness event, but past experience and convenience may be the most influential factors,

as people will do whatever it takes to get healthy. The "whatever it takes" approach that is revealed by this research shows that all avenues to health will be exhausted in the quest to treat an illness.

The State, Health Care, and Control

P.G. and the Toledo District have long held the reputation of a place removed from and distant from the rest of Belize. The lone highway linking the region to the rest of the country was an unpaved gravel and dirt road for stretches as recently as 2009. Its geographical distance from the main centers of Belizean economics and power, namely the capital city of Belmopan, and more so, Belize City, has played a part in its social distance. Other aspects of the region have played a role in its perceived distance too, however, namely the inability of any industry to gain a solid foothold, the composition of the majority indigenous population, along with a relatively low population density. As demonstrated by de Swan (1988), proximity, or lack thereof, has a direct influence on how deserving a person or population is in the eyes of those with power. And it is those with power, such as a country's elite, that can determine the deservingness of a community of population to any number of rights or services (Willen 2013). The social, economic, and geographical distance of P.G. and the Toledo District directly influence the State's perceptions of the region's deservingness of health services (Wainwright 2008).

Today, the region is rapidly changing, with a growing population, an increase in tourism and other job-producing activities, and an improving infrastructure that has more readily connected P.G. and the Toledo District to the technology and goods produced by global capitalism. Despite these changes, at least one thing has remained constant, the neglect of the region by the governing elite of the country. It is through this historic neglect and the resulting

marginalization, rooted in the nation's colonial history, that the State seeks to maintain a system of control and dominance over the region.

The State-sponsored health care system may appear at first glance an odd site through which to explore the concept of State neglect. However, it is through the weaknesses and deficiencies of the health care system, such as those explained by Nurse Julia above, that the neglect becomes apparent. As described in chapter 7, health professionals within the NHI system report that lines of communication between the MOH and health officials in P.G. are open, and that the many problems and needs have been reported. And while those with the power to make changes, to make the decisions necessary to improve the situation at the P.G. Polyclinic and hospital through allocation of resources, choose instead to ignore the region. Such neglect as it is perpetrated through the health system in P.G. cannot be overt, and the State must make all efforts to show that they want to improve conditions. And so help, when it comes at all, comes slowly. But by delaying their responses, holding back resources, and never fully addressing the needs of the system in P.G., the State effectively marginalizes the region. And so, it is exactly this neglectful system that has been put in place and that the State maintains, no matter what the consequences may be. A deeper examination helps to explain why.

Belize is not immune to the neoliberal shift (Harvey 2005, Springer 2013) that has occurred around much of the globe. The small nation remains under the thumb of enormous debt to an international banking system that demands internal reforms upon its leagues of indebted nations. For decades, these reforms have been neoliberal in nature, equated with a reduction of social welfare services provided by the State, and the privatization of key sectors among other related transformations. Belize's national health care system would at first glance appear to be something other than neoliberal, as it has effectively continued to provide social welfare services

that neoliberal policies often demand be eliminated. This research shows that, in fact, a national health care system such as that instituted in Belize does align with the goals of a neoliberal State. Through mechanisms of control and surveillance like the BHIS, by promoting biomedicine as the only legitimate medical system, and by funneling a population that has historically met many of its health needs through alternative health systems into an underfunded and inefficient biomedical system, the State health care system is an effective execution of a plan to make indigenous and rural populations good Belizean citizens whose self interests become more aligned with the interests of the elite (Trouillot 2001, Harvey 2005, Foucault 2006, Willen 2012, Springer 2013).

In a region as rural and removed from the centers of power as are the Toledo District and P.G., the State must maintain a presence or risk losing influence and credibility. The national health care system is one way in which the State maintains that presence. With policies restricting the entrance of outside providers, such as health service NGOs like those that have proliferated across the border in Guatemala, the State has created an effective monopoly on health care services. With virtually no other choices in P.G. or Toledo, the majority of residents must rely on the State for their biomedical health care services, a system designed to train and educate people in the use of a health system that aligns with the interests and worldview of the elite. And while the implementation of the new health system in P.G. and the Toledo District has made biomedical care more widely available, there remain significant problems and deficiencies. If people choose to seek health care beyond the region, they must invest heavily in attempts to find alternatives, whether in hospitals, clinics, or traditional healers in northern Belize, Guatemala or Mexico. In this sense, by neglecting and marginalizing the poorest region of the

country, the Belize health system, run by an institution of the State, the MOH, can be seen as a mechanism through which the power of the elite is exercised.

The power exercised through the Belize health system comes in the form of surveillance and control. As discussed in Chapter 6, the Belize Health Information System (BHIS) aims to record every health care event of every citizen, even claiming to have nearly all citizens in the system. Such statements imply that if one is not in the BHIS, one is not a citizen. Taken further, to be a proper Belizean citizen, one must use the national health care system in the correct way, including things like following the referral protocols and carrying the correct health ID card. The use of alternative health care systems falls outside of the MOH system, and thus takes on characteristics of being something other than Belizean. Through the promotion and expansion of the NHI system, the MOH has slowly guided citizens into an increased reliance on the biomedical system. Over time, by educating the population on how to successfully navigate the only sanctioned health system in the country, the State is effectively educating them on how to "be Belizean."

Such a system has an equally powerful effect on alternative systems of health care. If biomedical care, as the only sanctioned system by the State, is the system that can lay claim to Belize and being Belizean, then other systems of health care are decidedly non-Belizean. Systems of health care unique to each of the ethnic groups that reside in P.G. and Toledo take on a stigma as something other than the mainstream. In this context, fewer people are likely to take up training in traditional systems of health care, and fewer people are going to be interested in the health care that their parents or grandparents practiced at home or otherwise. Over time, the effect may be the gradual decline of alternative health care systems, which could result in worse overall health, as fewer options remain to fill the gaps of the State health care system.

This decline is significant in Belize as the majority indigenous population has long been in conflict with the State. Whether refusing to grant land rights, or refusing to recognize their medicine, the State has a history of marginalizing and neglecting the indigenous communities of the south. The institution of a national health care system can be seen as a mechanism through which the State can alter the behavior of indigenous populations – to make them more Belizean according to the standards of the elite. Forcing citizens into the State health care system, and effectively marginalizing traditional systems of health care, is a form of control. In the eyes of the State, the erosion of indigenous and local traditions could subsequently result in the erosion of indigenous and local identity. The end result would be a transformation of indigenous and local identified people into Belizeans, thus potentially ending any conflict, as conflict cannot exist with a group that does not exist.

And lest such a system would appear to have the best interests of the citizenry at its forefront, the State has been sure to flex its muscle in the south. By ignoring the needs of its own health system in P.G. and Toledo, by providing sub-standard health services, by promoting unqualified staff, and by generally neglecting the region in terms of health care, unequal relations of power that have long been present are being reproduced today. The region historically known as the "Forgotten District" remains, in the eyes of the State, forgotten. By operating such a substandard health care system, the message from the State rings loud and clear: "Citizens of P.G. and the Toledo District, you are not deserving."

It is somewhat ironic that the fact that the State continues to neglect the region as undeserving may actually contribute to the persistence of alternative forms of health care. This seemingly contradictory reality, in which the State both pulls people away from traditional medicines and indirectly fosters the persistence of those same practices, is an example of the friction that exists within the Belizean medical system and between the State and the largely indigenous, rural, and otherwise remote populations of Belize. Traditional home remedies remain widely used and shared, such that many of the plants seen growing in people's yards and homes are medicinal. And while fewer people openly admit to using their services, traditional healers remain numerous in P.G., as there are more of them then there are biomedical doctors. The resilience of these practices and the people that practice them can be seen as a form of resistance – resistance to a State that uses its health care system as a means to control its citizens. Yet the State has also had success in the expansion of its health system, such that the resistance is a source of friction that will affect the ultimate shape of the health care system in Belize in unpredictable ways (Scott 1985, Tsing 2005).

Applied Aspects of the Research

As an applied anthropologist, one of the core tenets of conducting research is that there be some pragmatic outcome beyond data analysis and publication of the research findings. As noted in previous chapters, I wanted some of my key findings to be made available to my key informants, contacts in the P.G. hospital and polyclinic, a number of prominent local figures, and on a national level, officials at NICH and the MOH. The creation of a data brochure was meant to be easily read and concise, thus reaching the largest possible audience. I was able to distribute copies to all of these parties, but as described earlier, further distribution was halted by officials at the MOH. Despite this setback, the data brochure is available online, and a summary report of my research will be shared with NICH, the MOH, and interested parties in P.G. Further, I will deposit the summary report and a copy of this dissertation in the P.G. Library and the National

Heritage Library. This will allow, at the very least, for Belizeans to have access to the results of my research.

In the final months of my time in P.G., I began working with a small group of community leaders who were attempting to start a small non-profit clinic that could host specialist health care providers and offer low-cost services that were otherwise not available. I met with them many times, and my initial findings are being used to justify the need for and development of the project. One of the leaders explained why this new clinic was so important:

"Where do people get the money when they have to leave the district for specialists? They get it. They use their savings. They borrow it. They ask friends and family. They even take bank loans. You would not believe how many people lose their land, lose their houses because of this. They took a loan for a health emergency, and then lost everything."

This clinic has the potential to limit the number of people who must travel outside of the district for health services, which can be a major expense for people with limited or no income. By demonstrating that such a need exists, this research may contribute directly to the health and well-being of the people living in P.G.

I plan to present my findings to officials at the MOH and I am unsure of how they will be received. Still, by distributing this work throughout the country, there remains a possibility that it could be useful for some future purpose. It is my hope that this research can contribute to an improvement in the relationships between officials at the MOH and those in P.G. Even slight improvements will aid in the morale and abilities of the many doctors and nurses in P.G. that take great pride in serving their community through the provision of health care services. These people work tirelessly with the limited resources they have on hand to provide the best care

possible, and many strive to improve the system every day. And while this report has been critical of the MOH and the Belizean State, it needs to be acknowledged that Belize is a country saddled in debt with very limited resources available for the MOH. If I have been too critical it is only because the health and well-being of many people are at stake, and even minor changes could save people's lives.

And while it is impossible to say what effects the results of this research may have within the institutions of Belize, there were other aspects of my research that I view as contributing to the community of P.G., and ultimately to Toledo and Belize. My many hours volunteering in healer's gardens and my hours spent tutoring local university students were tangible activities that had real benefits. While these and other activities may not have contributed directly to the narrative or theory herein, they allowed for the development of relationships in the field that were crucial to the advancement and success of this research. These are examples of some of the unique forms that applied anthropology can take.

Theoretical Contributions

The significance of this research has the potential to reach outside of Belize. It brings new concepts to existing theories of medical pluralism by moving beyond why people choose to use multiple health systems to offer an examination of the friction between health systems, Sate institutions, and citizens, and the potential conflict that can result. Studies in medical pluralism have developed to show the complexities of health systems and how people use them along with the power dynamics inherent in medical systems (Johannessen 2007, Crandon-Malamud 1986, 1991). As some research turned to health behavior, there was an increased understanding of how and why people make health care decisions (Amorozo 2004, Fleuriet 2007). This research builds

on the concepts of medical pluralism and health behavior by revealing that while complex relationships between and within health systems do affect people's health behavior, in the end, people tend to exhaust all possible treatment options, regardless of their preferences, in their quest to regain their health. In this quest for health, people are faced with the tensions present between their own agency in making their health care decisions and the efforts of the State to funnel its citizens into the national health care system, which at present in Belize, is structured to limit people's health care choices. The limits of the concept of medical pluralism are revealed in its ubiquity around the globe such that medical pluralism has become more of a descriptor then a theoretical framework. This research provides a means to move beyond medical pluralism as a descriptor by investigating how structural injustices, such as those present in the neoliberal State, and concepts such as deservingness and neglect affect how medical pluralism is practiced and contested. In this sense, the practice of medical pluralism can then be seen as a form of passive or everyday resistance against the neoliberal State (Scott 1985).

Additionally, the framing of a national health care system that provides universal care to its citizens as a mechanism of the neoliberal State is a unique contribution. By demonstrating that such a system can be used as a means of surveillance and control may be surprising to many who may wish to see similar systems put in place elsewhere around the globe. Drawing on the work of Trouillot (2001), Althusser (2006), Foucault (2006), and Marx (in Tucker 1978), this research shows that State institutions and their programs and policies, like the NHI system deployed in Belize, are used to maintain and reproduce power relations between the elite and marginalized, whether indigenous, rural, or poor. The State is able to exercise and maintain power by promoting and funneling the population into a universal care system, and then providing inadequate funding and resources to different regions of that system. The result of such uneven

funding and resources is a neglected population with inadequate health services. Further, such conditions offer insight into what segments of the national population the State deems deserving of its resources, as the differences between rural and urban health care can be seen elsewhere in Belize. Finally, this research revealed how the values of an international elite can be pushed onto unsuspecting populations even in the more remote corners of the globe through the influence of large government loans used to establish programs such as the NHI in Belize, and the effects of such loans on the policies and practices of what many citizens may deem an autonomous nation.

In the end, however, it must be remembered that what has been presented here is just one version of a story that has developed over time, and continues to develop and change. P.G. is a place where resilience has thrived, and culture and traditions remain vibrant and alive. The growing tourist industry has spawned a new interest in all things cultural, and people are beginning to find new value in maintaining cultural traditions, including traditional health practices. Connections to global movements are also evident, as many people refer to the positive aspects of things local and organic, like herbal remedies and medicines – two movements popular in the global North, and two things recognized as firmly rooted in many of the traditions based in P.G. and the Toledo District. Despite the attempts of the State to educate, control, and standardize its citizens, there will remain resistance, friction, and other unforeseen forces that work to promote, maintain, and vitalize the traditions that have persisted in the southern region of this small nation on the Caribbean Sea.

In my view, the resilience of traditional medicines in P.G. and Belize could be greatly aided by integrating traditional health systems with the NHI. In meetings with officials at the MOH, I was told that someone has been assigned to look into the state of traditional medicines in Belize, a promising development. I spoke with a doctor in P.G. whose interests and belief in a

more holistic form of health and health care enabled a candid conversation about the potential difficulties and rewards of integrating the nation's various health services.

"What do you think of the possibility of integrating traditional medicine into the NHI system?" I asked.

The doctor began by acknowledging a number of challenges: "Traditional healers are not certified in any way – there are no standards. We would need to figure that out so that we would know who were legitimate healers and who were not. We would also need to figure what they know. And different healers know different things, and treat things with different plants. People are also concerned about *obeah*, and there are people out there that practice it, and believe it. That could be a problem."

I mentioned how some of the healers I work with in the Q'echci' Healers Association know upwards of 200+ plants and plant combinations on top of that, and noted how it would be difficult to document all of what they know. The doctor countered, "Yeah, but that's like doctors. We have these lists of hundreds of drugs and combinations of drugs for people that have multiple chronic diseases – like diabetes and hypertension. We have to know and think through all of these drugs just like a traditional healer has to think through all the plants and combinations. It's not really that different. It would take time, but I think something like this could be accomplished here."

"Do you think a project like this is worthwhile?" I asked. "What benefits would there be?" The doctor praised the BHIS (Belize Health Information System) for aiding in the improvement of services that providers are able to give: "If someone is in the system, they know what they've been prescribed and what they're supposed to be taking (how much and how often). This could also be used in the implementation of traditional healing – traditional treatments

could be entered into the system so that patients are not dual-prescribed herbs and drugs at the same time. Perhaps they could begin with the most commonly accepted herbal/plant treatments, and build the database from there. Healers could also become a part of the referral service for people who would prefer natural remedies or for whom drug treatment is not effective."

This discussion with a doctor with first hand experience with the NHI system in Belize suggests that there is room for change in the health system in P.G. The social status of a doctor would lend credibility to the idea were it formally proposed to the MOH. Such a project would increase the visibility and credibility of traditional health practices more generally, while offering a means through which to better understand the form and content of these practices. Belize already has a medically plural health system, and more formally integrating that system may offer the most benefit towards the health of all its citizens.

References

7 News Belize

- 2009 Government Passes Law to Takeover Telemedia. Electronic document, http://www.7newsbelize.com/sstory.php?nid=14843, accessed February, 2014.
- 2012 Is Medical Tourism on the Menu for Belize? Electronic document, http://www.7newsbelize.com/printstory.php?func=print&nid=23112, accessed August 2012.
- 2013a 12 Newborns Die In May At The KHMH Pediatric Intensive Care Unit. Electronic document, http://www.7newsbelize.com/printstory.php?func=print&nid=25552, accessed May, 2013.
- 2013b Superbond 2.0 Gets Ready to Close Offering. Electronic Document, http://www.7newsbelize.com/printstory.php?func=print&nid=24948, accessed March 2013.
- 2013 Belize Rosewood Listed On CITES. Electronic document, http://www.7newsbelize.com/printstory.php?func=print&nid=24968, accessed March 14.

Aarons, Derrick E.

1999 Medicine and Its Alternatives: Health Care Priorities in the Caribbean. The Hastings Center Report 29(4):23-27.

Abrams, Philip

1988 Notes on the Difficulty of Studying the State (1977). Journal of Historical Sociology 1(1):58-89.

Akerele, Olayiwola

1987 The Best of Both Worlds: Bringing Traditional Medicine Up to Date. Social Science and Medicine 24(2):177-181.

Althusser, Louis

2006 Ideology and Ideological State Apparatuses (Notes toward an Investigation). *In* The Anthropology of the State: A Reader. Aradhana Sharma and Akhil Gupta, eds. Pp 86-111. Malden, MA: Blackwell Publishers.

Alves, Romulo RN, and Ierece ML Rosa

2007 Biodiversity, Traditional Medicine and Public Health: Where do they Meet? Journal of Ethnobiology and Ethnomedicine 3(14):1-9.

Amiguet, Virninie Treyvaud, John Thor Arnason, Pedro Maquin, Victor Cal, Pablo Sanchez Vindax, and Luis Poveda

2005 A Consensus Ethnobotany of the Q'eqchi' Maya of Southern Belize. Economic Botany 59(1):29-42.

Amorozo, Maria Christina de Mello

2004 Pluralistic Medical Settings and Medicinal Plant Use in Rural Communities, Mato Grosso, Brazil. Journal of Ethnobiology 24(1):139-161.

Anderson, Robert

1996 Ethical Standards for Medical Anthropologists Consulting on Ethnomedicine. Human Organization 55(4):484-487.

Angrosino, Michael V., and Kimberly A. Mays de Perez

2003 Rethinking Observation: From Method to Context. In Collecting and Interpreting Qualitative Materials 2nd ed. Norman K. Denzin and Yvonna S. Lincoln, eds. Pp. 107-154. Thousand Oaks, CA: Sage Publications.

Anonymous

n.d. Toledo's History. 6p. Digital Library of the Caribbean. Electronic Document, http://dloc.com/UF00095457/00001/pdf, Accessed January 13, 2014.

Baer, Hans A.

2003 Contributions to a Critical Analysis of Medical Pluralism: An Examination of the Work of LIbbet Crandon-Malamud. *In* Medical Pluralism in the Andes. Joan D. Koss-Chioino, Thomas Leatherman, and Christine Greenway, eds. Pp. 42-60. New York: Routledge.

Baines, Kristina

2012 Good Men Grow Corn: Ecological Heritage and Health in a Belizean Mopan Community. Ph.D. dissertation, Department of Anthropology, University of South Florida

Balick, Michael J. and Robert Mendelsohn

1992 Assessing the Economic Value of Traditional Medicines from Tropical Rain Forests. Conservation Biology 6(1):128-130.

Barry, Tom, and Dylan Vernon

1995 Inside Belize. Albuquerque, NM: Resource Center Press.

Barnes P.M., Bloom B., Nahin R.

2008 CDC National Health Statistics Report #12: Complementary and Alternative Medicine Use Among Adults and Children, United States, 2007. Washington D.C.: National Institute of Health, National Center for Complementary and Alternative Medicine.

Barrett, Bruce

1996 Integrated Local Health Systems in Central America. Social Science and Medicine 43(1):71-82.

Barrow, Clyde W.

2000 The Marx Problem in Marxian State Theory. Science and Society 64(1): 87-118.

Beliard, Joan Carlos, and Johnny Ramirez-Johnson

2005 Medical Pluralism in the Life of a Mexican Immigrant Woman. Hispanic Journal of Behavioral Sciences 27(3):267-285.

Bernard, H. Russell

2006 Research Methods in Anthropology: Qualitative and Quantitative Approaches. 4th Edition. Lanham, MD: AltaMira Press.

Berryman, Phillip

1985 Inside Central America: the Essential Facts Past and Present on El Salvador, Nicaragua, Honduras, Guatemala, and Costa Rica. New York: Pantheon Books.

BNLSIS (Belize National Library Service and Information System)

2010 Belize Research. Electronic Document, http://www.nlsbze.bz/eastindians.html, accessed July 1, 2010.

Bohmer, Richard

2011 The Four Habits of High-Value Health Care Organizations. New England Journal of Medicine 365(22):2045-2047.

Bolland, O. Nigel

- 1986 Belize: A New Nation in Central America. Boulder, CO: Westview Press.
- 1977 *The Formation of a Colonial Society. Belize, from Conquest to Crown Colony.* Baltimore: The Johns Hopkins University Press.

Bowen, Elenore Smith

1954 Return to Laughter: An Anthropological Novel. New York: Anchor Books.

Bourdieu, Pierre

2004 Science of Science and Reflexivity. Richard Nice, trans. Chicago: University of Chicago Press.

Boyd, Kenneth M.

2000 Disease, Illness, Sickness, Health, Healing, and Wholeness: Exploring Some Elusive Concepts. Medical Humanities 26:9-17.

Brechin, Steven R. and Osmany Salas

2011 Government-NGO Networks for Nature Protection in Belize, Central America: Examining the Theory of the Hollow State in a Developing Country Context. *Journal of Natural Resources Policy Research* 3(3): 263-274. Briggs, Jean L.

1970 Never in Anger: Portrait of an Eskimo Family. Cambridge, MA: Harvard University Press.

Brodwin, Paul

1996 Medicine and Morality in Haiti: the Contest for Healing Power. Cambridge: Cambridge University Press.

Broom, Alex, Assa Doron, and Philip Tovey

- 2009 The Inequalities of Medical Pluralism: Hierarchies of Health, the Politics of Tradition and the Economies of Car in Indian Oncology. Social Science and Medicine 69:698-706.
- Bruun, Henriette, and Beth Elverdam
- 2006 Los Naturistas Healers Who Integrate Traditional and Biomedical Explanations in Their Treatment in the Bolivian Health Care System. Anthropology and Medicine 13(3):273-283.

BZMOH (Ministry of Health, Belize)

- 2009a Belize: National Health Information System Strategic Plan 2010-2014. Belmopan: Belize Ministry of Health.
- 2009b Health Situation in Belize. Belize Basic Health Indicators 6:1-12.
- 2010 Ministry of Health Belize, C.A. Electronic Document, http://www.health.gov.bz/www/, accessed July 1, 2010.
- 2013 Southern Health Region: Punta Gorda Hospital. Electronic Document, http://shr.health.gov.bz/index.php?option=com_content&view=article&id=56&Itemid=2, Accessed October 1, 2013.
- 2013 The Ministry of Health, Belize, C.A. Electronic document. www.health.gov.bz, Accessed October 1, 2013.

Chala, Santiago Valencia

2006 Blacks in Central America. Niza Fabre, trans. Lewiston, NY: The Edwin Mellen Press.

Channel 5 Belize

- 2011 B.E.L. is officially state owned; government's first day as owner. Electronic document, http://edition.channel5belize.com/archives/56497, accessed February 2014.
- 2013 Another Government nationalization: another legal battle for registries. Electronic document, http://edition.channel5belize.com/archives/86554, accessed February 2014.

Chrisman, Noel J., and Arthur Kleinman

1983 Popular Health Care, Social Networks, and Cultural Meanings: The Orientation of Medical Anthropology. *In* Handbook of Health, Health Care, and Health Professions. David Mechanic, ed. Pp. 69-79. New York: Free Press.

CIA (Central Intelligence Agency)

2014 World Fact Book: Belize. Electronic Document, https://www.cia.gov/library/publications/the-world-factbook/geos/bh.html, accessed February, 2014.

Clarke, Adele, Janet Shim, Laura Mamo, Jennifer Ruth Fosket, and Jennifer Fishman

2010 Biomedicalization: Technoscientific transformations of health, illness, and US biomedicine. *In* Biomedicalization: Technoscience, health, and illness in the US. Adele Clarke, Janet Shim, Laura Mamo, Jennifer Ruth Fosket, and Jennifer Fishman, eds. Pp. 47-87. Durham, NC: Duke University Press

Coburn, David

2003 Globalization, Neoliberalism, and Health. *In* Civilising Globalization, Richard Sandbrook, ed. Pp 27-38. Albany, NY: SUNY Press.

Connolly, William E.

2005 Pluralism. Durham, NC: Duke University Press.

Cook, Fay Lomax

1979 Who Should be Helped? Public Support for Social Services. Los Angeles, CA:Sage Publications.

Coreil, Jeannine, Michael Lauzardo, and Maude Heurtelou

2004 Cultural Feasibility Assessment of Tuberculosis Control among Persons of Haitian Origin in South Florida. Journal of Immigrant Health 6(2):63-69.

Cornwall, Andrea

2007 Taking Chances, Making Choices: The Tactical Dimensions of "Reproductive Strategies" in Southwestern Nigeria. Medical Anthropology 26(3):229-254.

Cosminsky, Sheila

- 1977 Interethnic Relations in a Southern Belizean Community. Ethnicity 4:226-245.
- 1983 Medical Pluralism in Mesoamerica. *In* Heritage of Conquest: Thirty Years Later. Carl Kendall, John Hawkins, and Laurel Bossen, eds. Pp. 159-173. Albuquerque, NM: University of New Mexico Press.

Cousins, Linwood H.

2013 Deservingness, children in poverty, and collective well being. Children and Youth Services Review 35:1252-1259.

Crandon, Libbet

1986 Medical Dialogue and the Political Economy of Medical Pluralism: a Case from Highland Bolivia. American Ethnologist 13(3):463-476.

Crandon-Malamud, Libbet

1991 From the Fat of Our Souls: Social Change, Political Process, and Medical Pluralism in Bolivia. Berkeley: University of California Press.

CSO (Central Statistical Office)

2001 Population Census Major Findings: Belize. Ministry of Budget Management: Government of Belize.

Cultural Survival

2013 Campaign Update: Belize: Government Continues to Ignore Maya Land Rights Despite Court of Appeal Ruling. Electronic document, http://www.culturalsurvival.org/news/campaign-update-belize-government-continuesignore-maya-land-rights-despite-court-appeal-ruling, Accessed September 2013.

Das, Raju J.

1996 State Theories: a Critical Analysis. Science and Society 60(1):27-57.

de Swaan, Abram

1988 In Care of the State: Health Care, Education, and Welfare in Europe and the USA in the Modern Era. Oxford: Oxford University Press.

Duménil, Gérard and Dominique Lévy

2012 Neoliberalism *In* The Elgar Companion to Marxist Economics. Ben Fine, Alfredo Saad-Filho, and Marco Boffo, eds. Pp 240-245.

Dunn, Frederick

1976 Traditional Asian Medicine and Cosmopolitan Medicine in Adaptive Systems. *In* Asian Medical Systems: A Comparative Study. Charles Leslie, ed. Pp 133-158. Berkeley, Ca: University of California Press.

Dorman, W. Judson

2007 The Politics of Neglect: the Egyptian State in Cairo, 1974-98. Ph.D. dissertation, School of Oriental and African Studies, University of London.

Ellis, Lucia

2001 Traditional Medicine: an Under-utilised Resource. Paper presented at the Belize Country Conference, Beyond Walls: Multi-Disciplinary Perspectives. University Centre, Belize City, Belize. Nov 21-24.

England, Kim V. L.

1994 Getting Personal: Reflexivity, Positionality, and Feminist Research. Professional Geographer 46(1):80-89.

Erickson, Pamela I.

2008 Ethnomedicine. Long Grove, IL: Waveland Press, Inc.

Farmer, Paul

1990 Sending Sickness: Sorcery, Politics, and Changing Concepts of AIDS in Rural Haiti Medical Anthropology Quarterly, New Series 4(1):6-27.

Fiske, Shirley J., Linda A. Bennett, Patricia Ensworth, Terry Redding, and Keri Brondo

2010 The Changing Face of Anthropology: Anthropology Masters Reflect on Education, Careers, and Professional Organizations. AAA/CoPAPIA 2009 Anthropology MA Career Survey. Arlington, VA: American Anthropological Association.

Fleuriet, K. Jill

2007 Articulating Distress on Multiple Levels: Illness, History, and Culture Among the Kumiai of Baja California, Mexico. Mexican Studies/Estudios Mexicanos 23(1):155-180.

Foucault, Michel

2006 Governmentality. *In* The Anthropology of the State: A Reader. Aradhana Sharma and Akhil Gupta, eds. Pp 131-143. Malden, MA: Blackwell Publishers.

Frank, André Gunder

1975 Development and underdevelopment in the new world: Smith and Marx vs. the Weberians. Theory and Society 2(1):431-466

Frankenberg, Ronald

1981 Allopathic medicine, profession, and capitalist ideology in India. Social Science and Medicine 15(2):115-125.

Gabbert, Wolfgang

2007 In the Shadow of the Empire: The Emergence of Afro-Creole Societies in Belize and Nicaragua. Indiana 24:39-66.

Goldade, Kate, and Kolawole S. Okuyemi

2012 Deservingness to state health services for SoutheSouth migrants: A preliminary study of Costa Rican providers' views. Social Science and Medicine 74:882-886.

Goldstein, Michael S.

2004 The Persistence and Resurgence of Medical Pluralism. Journal of Health Politics, Policy and Law 29(4-5):925-945.

Graham, Mark

2003 Emotional Bureaucracies: Emotions, Civil Servants, and Immigrants in the Swedish Welfare State. Ethos 30(3): 199-226.

Gramsci, Antonio

- 2000 The Antonio Gramsci Reader: Selected Writings 1916-1935. David Forgacs, ed. New York: New York University Press.
- 2006 State and Civil Society. *In* The Anthropology of the State: A Reader. Aradhana Sharma and Akhil Gupta, eds. Pp 71-85. Malden, MA: Blackwell Publishers.

Grandia, Liza

2009 Milpa Matters: The Maya Community of Toledo versus The Government of Belize. In Waging War, Making Peace: Reparations and Human Rights. Barbara Rose Johnston and Susan Slyomovics, Eds. Walnut Creek, CA: Left Coast Press.

Grant, C.H.

1976 The Making of Modern Belize: Politics, Society and British Colonialism in Central America. London: Cambridge University Press.

Graven, Michael, Peter Allena, Ian Smitha, and Noni E. MacDonald

2013 Decline in mortality with the Belize Integrated Patient-Centered Country Wide Health Information System (BHIS) with Embedded Program Management. International Journal of Medical Informatics 82:954-963.

Green, Edward C.

1987 The Integration of Modern and Traditional Health Sectors in Swaziland. In Anthropological Praxis. Robert M. Wulff and Shirley J. Fiske, eds. Pp. 87-97. Boulder: Westview Press.

Grenier, Louise

1998 Working with Indigenous Knowledge: A Guide for Researchers. Ottawa, ON: International Development Research Centre.

Gullick, C.J.M.R.

1976 Carib Ethnicity in a Semi-plural Society. Journal of Ethnic and Migration Studies 5(3):250-258

Harvey, David

2005 A Brief History of Neoliberalism. New York: Oxford University Press.

Harwood, Alan

1981 Ethnicity and Medical Care. Cambridge: Harvard University Press.

Haug, Sarah Woodbury

2002 Ethnicity and Multi-ethnicity in the Lives of Belizean Rural Youth. Journal of Rural Studies 18:219-223.

Hoang G.N., and R.V. Erickson

1985 Cultural barriers to effective medical care among Indochinese patients. Annual Review of Medicine 36:229-239.

Homedes, Núria, and Antonio Ugalde

2005 Why neoliberal health reforms have failed in Latin America. Health Policy 71:83-96.

Horton, Sarah

2004 Different Subjects: The Health Care System's Participation in the Differential Construction of the Cultural Citizenship of Cuban Refugees and Mexican Immigrants. Medical Anthropology Quarterly 18(4): 472-489.

Horton, Sarah, and Judith C. Barker

2010 Stigmatized Biologies: Examining the Cumulative Effects of Oral Health Disparities for Mexican American Farmworker Children. Medical Anthropology Quarterly 24(2): 199-219.

Horton, Sarah, Cesar Abadia, Jessica Mulligan, and Jennifer Jo Thompson

2014 Critical Anthropology of Global Health "Takes a Stand" Statement: A Critical Medical Anthropological Approach to the U.S.'s Affordable Care Act. Medical Anthropology Quarterly, Early View, January 2014.

Hueveline, Patrick, and Noreen Goldman

2000 A description of child illness and treatment behavior in Guatemala. Social Science and Medicine 50:345-364.

Hughes, Krista

2012 Belize Votes with Financial Future at Stake. Reuters. Electronic document, http://www.reuters.com/assets/print?aid=USL2E8E788020120307, Accessed March 2012.

Hunt, L.M., N.H. Arar, and L.L. Akana

2000 Herbs, Prayer and Insulin: Use of Medical and Alternative Treatments by a Group of Mexican American Diabetes Patients. Journal of Family Practice 49(30):216-223.

Hymes, Dell, ed.

1972 Reinventing Anthropology. Ann Arbor, MI: University of Michigan Press.

Indigenous Peoples Issues

2010 Supreme Court Affirms Maya Customary Rights For All Maya Communities In Southern Belize. Electronic Document,

http://indigenouspeoplesissues.com/index.php?option=com_content&view=article&id=5 748:supreme-court-affirms-maya-customary-rights-for-all-maya-communities-in-peoples&Itemid=82, accessed June 30, 2010.

Ito, Karen L.

1999 Health Culture and the Clinical Encounter: Vietnamese Refugees' Responses to Preventive Drug Treatment of Inactive Tuberculosis. Medical Anthropology Quarterly 3(3):338-364. Jacobs-Huey, Lanita

2002 The Natives are Gazing and Talking Back: Reviewing the Problematics of Positionality, Voice, and Accountability among "Native" Anthropologists. American Anthropologist 104(3):791-804.

Johannessen, Helle, and Imre Lazar, eds.

2006 Multiple Medical Realities: Patients and Healers in Biomedical, Alternative, and Traditional Medicine. New York: Berghahn Books.

Johannessen, Helle

2007 Body Praxis and Networks of Power. Anthropology and Medicine 14(3):267-278.

Joralemon, Donald

1999 Exploring Medical Anthropology. Needham Heights, MA: Allyn and Bacon.

Kanaaneh, Moslih

1997 The "Anthropologicality" of Indigenous Anthropology. Dialectical Anthropology 22:1-21.

Kaptchuk, Ted J. and David M. Eisenberg

2001 Varieties of Healing. 1: Medical Pluralism in the United States. Annals of Internal Medicine 135:189-195.

Kennedy, John C., and Karen Olsson

1996 Health Care Seeking Behavior and Formal Integration: A Rural Mexican Case Study. Human Organization 55(1):41-46.

Klass, Morton

1961 East Indians in Trinidad: A Study of Cultural Persistence. Prospect Heights, IL: Waveland Press.

Kleinman, Arthur

1980 Patients and Healers in the Context of Culture. An Exploration of the Borderland between Anthropology, Medicine and Psychiatry. Berkeley, CA: University of California Press.

Lafuente, Mariano

2013 Public Employment and Pay Policy in Belize. IDB Technical Note No. 582. Washington D.C.: Inter-American Development Bank.

Last, Murray

1990 Professionalism of Indigenous Healers. *In* Medical Anthropology. T.M. Johnson and C.F. Sargent, eds. Pp. 349-366. New York: Greenwood Press.

Leatherman, Thomas

1998 Changing Biocultural Perspectives on Health in the Andes. Social Science and Medicine 47(8):1031-1041.

Lee, Rance P.L.

1982 Comparative Studies of Medical Systems. Social Science and Medicine 16(6):629-642.

Leslie, Charles

1980 Medical Pluralism in World Perspective. Social Science and Medicine 14B:191-195.

Manderson, Lenore, and Ruth P. Wilson

1998 Negotiating with Communities: The Politics and Ethics of Research. Human Organization 57(2):215-216.

Maraesa, Amínata

- 2009 "I No 'Fraid for That": Pregnancy, Risk, and Development in Southern Belize. Ph.D. dissertation, Department of Anthropology, New York University.
- 2011 Saving face, losing life: obeah pregnancy and reproductive impropriety in Southern Belize, Culture, Health & Sexuality iFirst:1-14.

McGill, Kenneth

2013 Discourse, Organization, and the Welfare State in the Former East Berlin. PoLAR: Political and Legal Anthropology Review 36(1): 56-74.

McVea, Christing L.S.P.

1997 Lay injection practices among migrant farmworkers in the age of AIDS: Evolution of a biomedical folk practice. Social Science and Medicine 45(1):91-98.

Medina, Laurie Kroshus

- 1997 Development policies and identity politics: class and collectivity in Belize. American Ethnologist 24(1): 148-169.
- 2010 When Government Targets "The State": Transnational NGO Government and the State in Belize. PoLAR: Political and Legal Anthropology Review 33(2): 245–263.

Mendez-Dominguez, Alfredo

1983 Illness and Medical Theory among Guatemalan Indians. *In* Heritage of Conquest: Thirty Years Later. Carl Kendall, John Hawkins and Laurel Bossen, eds. Albuquerque, NM: University of New Mexico Press.

Menemencioglu, Rifat Kerim

2009 A Critique of the Inter American Development Bank's Neoliberal Discourse of Exclusion. MSc Thesis, Department of International Relations, Middle East Technical University.

Merriam, Sharan B., Juanita Johnson-Bailey, Ming-Yeh Lee, Youngwha Kee, Gabo Ntseane, and Mazanah Muhamad

2001 Power and Positionality: Negotiating Insider/Outsider Status Within and Across Cultures. International Journal of Lifelong Education 20(5):405-416.

Miliband, Ralph

1969 The State in Capitalist Society: an Analysis of the Western System of Power. New York: Basic Books.

MLA (Maya Leaders Alliance)

2010 Supreme Court Affirms Maya Customary Rights for All Maya Communities in Southern Belize. [press release] June 29, 2010.

Moore, Henrietta

1996 The changing nature of anthropological knowledge: an Introduction. *In* The Future of Anthropological Knowledge. Henrietta L. Moore, ed. Pp 1-15. New York: Routledge.

Narayan, Kirin

1993 How Native is a "Native" Anthropologist? American Anthropologist, New Series 95(3):671-686.

Nencel, Lorraine

2014 Situating reflexivity: Voices, positionalities and representations in feminist ethnographic texts. Women's Studies International Forum 42:75-83.

Ngokwey, Ndolamb

1988 Pluralistic Etiological Systems in Their Social Context: A Brazilian Case Study. Social Science and Medicine 26(8):793-802.

Nowottny, Mark

2007 'No Tyrants Here Linger': Understandings of Democracy in Modern Belize. Masters thesis, Institute for the Study of the Americas, University of London.

NHDAC (National Human Development Advisory Committee)

2004 Belize: 2002 Poverty Assessment Report. Belmopan: Government of Belize.

PAHO (Pan American Health Organization)

- 2009 Health Systems Profile: Belize: Monitoring and Analyzing Health Systems Change/Reform. Washington, D.C.: PAHO.
- 2010a Belize Health Information System: Lessons Learned to Strengthen National Health Information Systems in Barbados, Eastern Caribbean Countries, Jamaica, Trinidad and Tobago. Final Report. Belize City, Belize: PAHO.
- 2010b PAHO Country Profiles: Belize. Electronic Document, http://www.paho.org/english/DD/AIS/cp_084.htm, accessed January 3, 2010.
- 2013 PAHO Basic Health Indicator Database: Belize. Electronic Document, http://www1.paho.org/English/DD/AIS/cp_084.htm, accessed June 13, 2013

Palacio, Joseph

2013 Beyond Extinction: Caribbean Indigeneity. Talk for the Smithsonian Latino Center, National Museum of the American Indian, Smithsonian Institution, 2012. Available at: http://www.youtube.com/watch?v=j0of211RUgg. Parks, Shoshaunna

2011 Winning Title to Land but Not to Its Past: The Toledo Maya and Sites of pre-Hispanic Heritage. International Journal of Cultural Property 18: 111-129.

Patient.co.uk

2013 Paracetamol. Electronic document, http://www.patient.co.uk/medicine/paracetamol, accessed August, 2012.

Pedersen, Duncan, and Veronica Baruffati

- 1985 Health and Traditional Medicine Cultures in Latin America and the Caribbean. Social Science and Medicine 21(1):5-12.
- 1989 Healers, Deities, Saints and Doctors: Elements for the Analysis of Medical Systems. Social Science and Medicine 29(4):487-496.

Pillsbury, Barbara L. K.

1982 Policy and Evaluation Perspectives on Traditional Health Practitioners in National Health Care Systems. Social Science and Medicine 16:1825-1834.

Powdermaker, Hortense

1966 Stranger and Friend: the Way of an Anthropologist. New York: W.W. Norton and Company Inc.

Premdas, Ralph

2001 Belize: Identity and Ethnicity in a Multi-Ethnic State. Paper presented at the Belize Country Conference, Beyond Walls: Multi-Disciplinary Perspectives. University Centre, Belize City, Belize. Nov 21-24.

Ranguy Sr., Bismark

1999 Toledo Recollections. Belmopan, BZ: National Printers.

Reeser, Douglas Carl

- 2008 Gardens at Home, Gardens at School: Diet and Food Crop Diversity in Two Q'eqchi' Communities in Southern Belize. M.A. Thesis, Department of Anthropology, University of South Florida.
- 2013a"They don't garden here": NGO constructions of Maya gardening practices in Belize. Development in Practice, 23(7):799-810.
- 2013b The Bounds of Belief: Health, Belief, and Medicine in Southern Belize. Research Reports in Belizean History and Anthropology. Volume 1, 2013, Pp 1-7. Institute for Social and Cultural Research, NICH, Belize.

Reeve, Mary-Elizabeth

2000 Concepts of Illness and Treatment Practice in a Caboclo Community of the Lower Amazon. Medical Anthropology Quarterly 14(1):96-108.

Robertson, Jennifer

2002 Reflexivity Redux: A Pithy Polemic on "Positionality". Anthropological Quarterly 75(4):785-792.

Roopnarine, Lomarsh

2003 East Indian Indentured Emigration to the Caribbean: Beyond the Push and Pull Model. Caribbean Studies 31(2): 97-134.

Ryang, Sonia

1997 Native Anthropology and Other Problems. Dialectical Anthropology 22:23-49.

Salzman, Philip Carl

2002 On Reflexivity. American Anthropologist 104(3):805-813.

Scott, James C.

1985 Weapons of the Weak: Everyday Forms of Peasant Resistance. New Haven, CT: Yale University Press.

Setzekorn, William David

1981 A Profile of the New Nation of Belize, formerly British Honduras. Athens, OH: Ohio University Press.

Shoman, Assad

2000 13 Chapters of a History of Belize. 4th Edition. Belize City, BZ: The Angelus Press Limited.

SIB (Statistical Institute of Belize)

- 2009 Abstract of Statistics Belize: 2009. Belmopan, BZ: Statistical Institute of Belize.
- 2010 Population. Electronic Document, http://www.statisticsbelize.org.bz/dms20uc/dm_browse.asp?pid=6, accessed July 1, 2010.
- 2011 Main Results of the 2010 Population and Housing Census. Electronic document, http://www.statisticsbelize.org.bz/dms20uc/dm tree.asp?pid=6, accessed June 1, 2012.
- 2012 Abstract of Statistics, Belize, 2012, Volume 1. Belmopan, BZ: Statistical Institute of Belize.
- 2013 Belize Population and Housing Census 2010, Country Report. Belmopan, BZ: Statistical Institute of Belize.
- 2013 Key Economic Statistics 2012. Electronic document, http://www.statisticsbelize.org.bz/images/sib%20release%20final.png, accessed March, 2013.

Simmons, Donald C., Jr.

2001 Confederate Settlements in British Honduras. Jefferson, NC: McFarland & Company, Inc., Publishers.

Singer, Merrill, Lani Davison, Gina Gerdes

1988 Culture, Critical Theory, and Reproductive Illness Behavior in Haiti. Medical Anthropology Quarterly, New Series 2(4):370-385.

Springer, Simon

2013 Neoliberalism. In The Ashgate Research Companion to Critical Geopolitics. Klaus Dodds, Merje Kuus, and Joanne Sharp, editors. Pp 147-164. Surrey, UK: Ashgate.

Stekelenburg, Jelle, Bastiaan E. Jager, Pascal R. Kolk, Esther H.M.N. Westen, Anke van der Kwaak, Ivan N. Wolffers

2005 Health care seeking behaviour and utilisation of traditional healers in Kalabo, Zambia. Health Policy 71:67–81.

Stephens, John L.

1858 Incidents of Travel Central America, Chiapas, and Yucatan. New York: Harper & Brothers Publishers.

Stevenhagen, Rodolfo

1992 Challenging the Nation-State in Latin America. Journal of International Affairs 45(2):421-440.

Stoller, Paul

1989 The Taste of Ethnographic Things: the Senses in Anthropology. Philadelphia: University of Pennsylvania Press.

Sutherland, Anne

1998 The Making of Belize: Globalization in the Margins. Westport, CT: Bergin and Garvey.

Thomson, P.A.B.

2004 Belize: A Concise History. Oxford: Macmillan Caribbean.

Tierney, Gerry

2002 Becoming a Participant Observer. *In* Doing Cultural Anthropology: Projects for Ethnographic Data Collection. Michael V. Angrosino, ed. Pp. 9-18. Prospect Heights, IL: Waveland Press.

TMCC & TAA (Toledo Maya Cultural Council and Toledo Alcaldes Association)

1997 Maya Atlas: The Struggle to Preserve Maya Land in Southern Belize. Berkeley, CA: North Atlantic Books.

Transparency International

2008 2008 Corruption Perceptions Index, Regional Highlights: Americas. Electronic document, http://archive.transparency.org/policy_research/surveys_indices/cpi/2008/regi onal_highlights_factsheets, accessed Oct 2013.

Trouillot, Michel-Rolph

2001 The Anthropology of the State in the Age of Globalization: Close Encounters of the Deceptive Kind. Current Anthropology 42(1):125-138

Tsing, Anna

- 2002 The Global Situation. *In* The Anthropology of Globalization: a Reader. Jonathan Xavier Inda and Renato Rosaldo, eds. 453-485. Malden, MA: Blackwell Publishers.
- 2005 Friction: an Ethnography of Global Connection. Princeton, NJ: Princeton University Press.

Tucker, Robert C., ed.

1978 The Marx-Engels Reader. 2nd Edition. New York: W.W.Norton & Co.

UN (United Nations)

2014 The Universal Declaration of Human Rights. Electronic document, http://www.un.org/en/documents/udhr/index.shtml. Accessed January, 2014.

van Oorschot, Wim

2000 Who should get what and why? On deservingness criteria and conditionality of solidarity among the public. Policy & Politics 28(1):33-48).

Vital Wave Consulting

2009 Health Information Systems in Developing Countries: a Landscape Analysis. Research paper and strategic briefing for the Bill and Melinda Gates Foundation. Palo Alto, CA: Vital Wave Consulting.

Waddell, D.A.G.

1961 British Honduras: A Historical and Contemporary Survey. Oxford: Oxford University Press.

Wainwright, Joel

2008 Decolonizing Development: Colonial Power and the Maya. Malden, MA: Blackwell Publishing.

Waldram, James B.

2000 The Efficacy of Traditional Medicine: Current Theoretical and Methodological Issues. Medical Anthropology Quarterly, New Series 14(4):603-625.

Watanabe, John M., and Edward F. Fischer

2004 Introduction: Emergent Anthropologies and Pluricultural Ethnography in Two Postcolonial Nations. *In* Pluralizing Ethnography: Comparison and Representation in Maya Cultures, Histories, and Identities. John M. Watanabe and Edward F. Fischer, eds. Pp 3-33. Santa Fe, NM: School of American Research Press. Weller, Susan C., Trenton R. Reubush II, and Robert E. Klein

1997 Predicting Treatment-Seeking Behavior in Guatemala: A Comparison of the Health Services Research and Decision-Theoretic Approaches. Medical Anthropology Quarterly 11(2):224-245.

Wentzell, Emily, and Jorge Salmeron

2009 You'll "Get Viagraed:" Mexican Men's Preference for Alternative Erectile Dysfunction Treatment. Social Science and Medicine 68:1759-1765.

Whiteford, Linda, and Robert T. Trotter II

2008 Ethics for Anthropological Research and Practice. Long Grove, IL: Waveland Press, Inc.

- Whiteford, Michael B.
- 1999 Homeopathic Medicine in the City of Oaxaca, Mexico: Patients' Perspectives and Observations. Medical Anthropology Quarterly 13(1): 69-78.

WHO (World Health Organization)

- 2002 WHO Traditional Medicine Strategy 2002-2005. Geneva: World Health Organization.
- 2013 Global Health Expenditure Database. Electronic Document, http://apps.who.int/nha/database/PreDataExplorer.aspx?d=1, Accessed October 1, 2013.

WHO/UNICEF (World Health Organization/UNICEF)

1978 Proceedings of the International Conference on Primary Health Care. Alma Ata: WHO Publications.

Wilk, Richard R.

- 1997 Household Ecology: Economic Change and Domestic Life among the Kekchi Maya in Belize. Dekalb, IL: Northern Illinois University Press.
- 2006 Home Cooking in the Global Village: Caribbean Food from Buccaneers to Ecotourists. New York: Berg.

Will, J.A.

1993 The Dimensions of Poverty: Public Perceptions of the Deserving Poor. Social Science Research 22(3): 312-332.

Willen, Sarah S.

2012 How is health-related "deservingness" reckoned? Perspectives from unauthorized im/migrants in Tel Aviv. Social Science and Medicine 74: 812-821.

Williams, Callum and Mahiben Maruthappu

2013 "Healthconomic Crises": Public Health and Neoliberal Economic Crises. American Journal of Public Health 103(1):7-9.

Witter, Michael

2004 Civil Society Participation in Governance in Jamaica and Belize. Report for CSEDNet (Caribbean Sustainable Economic Development Network), August, 2004.

Womack, Mari

2010 The Anthropology of Health and Healing. Lanham, MD: AltaMira Press.

Woods, Louis, Joseph Perry, Jeffrey Steagall, and Ronald Cossman

1996 International Migration and the Ruralization of Belize, 1970-1991. *In* Belize: Selected Proceedings from the Second Interdisciplinary Conference. Michael D. Phillips, ed. Pp 173-198. Lanham, MD: University Press of America.

Xu, Hao, and Ke-ji Chen

2011 Integrating Traditional Medicine with Biomedicine Towards a Patient-Centered Healthcare System. Chinese Journal of Integrative Medicine 17(2): 83-84.

Yach, Derek

1992 The Use and Value of Qualitative Methods in Health Research in Developing Countries. Social Science and Medicine 35(4):603-612.

Zarger, Rebecca K.

2009 Mosaics of Maya Livelihoods: Readjusting to Global and Local Food Crises. NAPA Bulletin 32: 130–151.