Preface

These past three years I often doubted that I would ever be able to thank – in print – all those who, each in their own way, contributed to this book. The history of the book goes back a long while. It starts in 1985 when the University of Amsterdam enabled me to travel to the West Indian island of Dominica to discuss my intentions regarding fieldwork on mother-and-child health care. The Ministry of Health, in those days represented by Dr D.O.N. McIntyre and Mrs Jean Jacob, not only kindly welcomed me to the country but also arranged transport and other facilities for me to travel around and get acquainted with the island. I was issued a residence permit which later allowed me to return for my fieldwork.

After returning home from this short visit, I was confronted with the task of finding the financial and administrative means to realise my plans. With the indispensable help of Sjaak van der Geest, Humphrey Lamur, Klaas van der Veen and the other colleagues of the Department of Cultural Anthropology of the University of Amsterdam, I designed a research proposal which I presented to WOTRO, the department of NWO (Netherlands Organisation for Scientific Research), responsible for the advancement of research in tropical areas. From July 1987 to October 1991 WOTRO financed my research in Dominica. They also provided the funds for Gerald James, the Dominican counterpart, who enabled me to include a second community in my study.

WOTRO made it possible for me to spend three months in Jamaica to study the literature on West Indian and Dominican society at the libraries of the University of the West Indies. To discuss my research plans with Mervin Alleyne, Hermione McKenzie, and other members of the staff of the Department of Sociology and Social work was a stimulating experience. I received a lot of encouragement and support from the staff of ISER (Institute for Social and Economic Research) and WAND (Women and Development) of the 'Bajan' (Barbadian) campus of UWI, and from James Milette, head of the Department of History of UWI's campus in Trinidad.

The first four months of my stay in Dominica I spent learning the local 'patois'. Mrs Anita James was the most wonderful and patient teacher I could have wished for. Throughout my stay she remained my tutor in many senses of the word.

The friendship of the man, in this book called Joey, helped me through the first difficult months. Moreover, without him the information I collected during the fieldwork would probably have been of a different nature.

During the second visit my contact person at the Ministry of Health was Dr C. Etienne. Her experience and dedication were magnificent.

With the help of Mrs James and Dr Etienne I selected the research villages and found a family who offered me a place in their house and let me share in their life. I will never forget 'Pinky', who truly opened her home and hart to me. In the week-ends I retreated to a place and a bed of my own. My landlady, her husband, and their family did their utmost to make me feel at home. I will always miss the merry Christmases we passed picnicking on Dominica's beautiful beaches.

I am also indebted to the many women who generously shared their knowledge on child care with me and, when my son Jan was born, 'mothered' me with a zest that made me feel accepted and secure. I don't know how I would have fared without their friendship and guidance. It is frustrating that, to protect their privacy, I cannot thank them in a more personal way.

During the three-and-a-half years I spent in the field many people freely offered me moral, practical, and intellectual support. Anita van der Meulen, Bram Luteijn, Frederica John-Baptiste, Gregory Robin, Jeanette van der Woude, Juliana Hinterberger, Newton 'Spider' Shillingford, Phil Taalman and 'Rafa' were among them. Frederica patiently endured my attempts to get familiar with Dominican ways. The others too, became indispensable for their moral support, but they had a more critical attitude. So did Sjaak van der Geest when he came all the way to the island to discuss my work.

A very special 'mother' to me was the lady who is named Mrs Ford in this book. She took the most excellent care of Jan and me. She personally felt responsible for our well-being and we both miss her a lot.

However, our well-being did not depend on my Dominican mothers alone. My own mother came to Dominica to help me through the delivery and through the first weeks after. I believe few people have a mother as supportive and courageous as she. It is to her and my Dominican mothers that I dedicate this book.

Later, when I had returned to Holland, my mother's support became crucial for the advancement of the project once more. When I found a job at the far end of the country, she travelled 450 kilometres a week to look after Jan. In the week-ends she stayed home with my father, who never complained about having to miss her. The only comment my parents ever made was that growing old did not bring the peace and quiet they had expected.

During the first months home I had trouble to start writing. I believe that without the dedicated supervision by Sjaak van der Geest I would have got stuck in the initial phase. His comments on each draft of the book were painstakingly thorough and always to the point. Of course there were many others who commented on preliminary chapters. Anke van der Kwaak, Cor Jonker, Anne Veen, Els van Dongen, Jogien Bakker, Lia Sciortino and Ria Reis, all members of the 'promotion team' of the Medical Anthropological Section of the University

of Amsterdam encouraged me with a cheerful mixture of gossip and serious advice. Humphrey Lamur succeeded in tracing still more imperfections to add to the list of criticisms and suggestions.

I am grateful to my present colleagues as well. The staff of the Department of Health Ethics and Philosophy of the University of Limburg gave me the opportunity to finish the book. Rob de Vries contributed in particular by patiently listening to my misgivings and by offering me the opportunity to 'test' my intuitions.

Claudia Krumeich, Eustace Fontaine, Gregory Robin, Arjen Stoop, Ingrid Lathouwer, Johan Kraay, Janneke Scholten and Hanneke Kossen assisted with the technical realization of the present work. They took care of tables, figures, lay-out, the correction of the English language and many other things.

Ceriel Jacobs whose logical and patient comments on my argumentation (and my early attempts to write in English) were comforting when I needed that most. He spent a lot of time restoring my self-confidence, and he frequently reminded me, with the help of my son Jan, that there is more to life than writing a thesis.

The above proves once more that the writing of a book is teamwork. I feel that in this particular case each of the members of the team was indispensable in his or her own way. I feel therefore greatly indebted to all the people I mentioned above.

Maastricht, 12-3-1994

Introduction

Since I got involved in medical anthropology in the early eighties I was intrigued by the gap between policy (ideal) and delivery (reality) in contemporary Primary Health Care (PHC). The discovery that theoretical developments in medical anthropology had hardly touched PHC also surprised me.

PHC has been the leading policy in national and international health care planning for the last two decades. In 1978 the World Health Organisation introduced it officially at the Alma Ata conference. It was defined as 'Essential Health Care, made universally accessible to individuals and families by means acceptable to them through their full participation at a cost the community can afford' (WHO 1978a). Obviously the approach was developed for countries with a low health care budget. Like its predecessor, Basic Health Care, it focused on preventive medicine, aiming at high-risk groups (see for instance Van Ginneken & Muller 1984) in these societies (WHO 1978a & 1979). Until then it had been extremely difficult to reach the people. They hardly responded to health education and it was hard to motivate them to visit clinics or to follow medical advice (Paul 1955 & 1958, Wellin 1955 & 1966, Jelliffe 1957 and 1970). Prevention was therefore combined with 'community participation' (WHO 1981). Together they formed the heart of PHC policy. Involving the members of the community in PHC policy making, planning, delivery, and supervision would open the road to communication and give communities the chance to redefine PHC policy according to their own needs (Bryant 1969, Djuvanovic & Mach 1975, Newell 1975, WHO 1979 & 1981, Walt & Vaughan 1981). In this new perspective, health care would be based on the people's knowledge and needs, while bio-medical services would merely be offered to complement indigenous expertise.

The new approach was a response to problems of acceptance and inter-cultural communication, and to accusations of paternalism and ethnocentrism. PHC was a response also to criticism of Western health care (Walt & Vaughan 1981). Since the sixties there has been a growing concern for the de-humanizing approach of scientific medicine. It tended to separate the person from his[1] body. The humanity of a patient was ignored and the medical system took over the responsibility and management of his body. This medicalisation in the Western approach to health care was denounced most clearly in the work of Illich (1976).

PHC's answer was its emphasis on self-reliance, integration and community participation. It proposed to involve the people in planning and implementation

of modern health care,[2] to co-operate with traditional experts and to make use of local resources and expertise (WHO 1978b & 1981). Werner (1977 & 1980) and Muller (1981) tried to apply these principles to practical situations in Third World countries.

The reliance on local resources brought an additional advantage. Various authors warned against unlimited import of capital, know-how and technology, because this would give neo-colonialist and imperialistic nations new tools to gain economic power (Doyal & Pennell 1979, Elling 1981, Gish 1979, Muller 1981 & 1983, Navarro 1976 and Werner 1978). Medical aid could, according to these authors, very well be a wolf in sheep's clothes. PHC's emphasis on the use of local resources and its recognition of traditional concepts of health and illness provided an opportunity to escape from economic, and cultural dependency. Import of expensive equipment and drugs and the need for foreign knowledge and capital would be decreased.[3]

PHC's emphasis on an intersectoral approach was its response to yet another insight current in the political climate of the 1960s and 1970s (WHO 1986). Doyal & Pennell, Navarro, and many others pointed out that social and economic factors play a crucial role in health and that a successful programme has to deal with poverty, food shortages, population growth and many other problems simultaneously.

The changing political climate also gave rise to renewed optimism with respect to applied anthropology. American anthropologists have been involved in medical development projects since the 1940s and 1950s. During those early years they were occupied with cultural and social barriers obstructing implementation of health care projects (Paul, Wellin, Jelliffe, and many others). Their main task was to supply cultural knowledge to overcome these barriers. In the 1970s and 1980s, under influence of the new health care policies in PHC, the role of applied anthropology was redefined. The anthropologist as 'tamed judge', (Richters 1991:87) who paid lip-service to the dominant culture, now constituted himself as the advocate of the underdog. He identified himself with the other culture and wanted to become the bridge on the road to communication and co-operation. His role was redefined in terms of negotiator, interpreter, the link between 'us Westerners' and 'they', the people of the Third World.

Some of these anthropologists and critical doctors went further. They explored ways to use the health care system as a 'praxis of liberation' (e.g. Muller 1981 and 1983). They more or less followed the blueprints of Freire's *Pedagogy of the oppressed* (1972) and designed community health projects which were aimed at self-reliance, self-awareness and involvement (Muller, Werner). They were supported by a school of ecological anthropologists who were of the opinion that culture is an adaptive mechanism which enables a community to survive in its biological environment. Cultural practices are adaptive strategies, these authors argued. Such practices have developed empirically in the course of history

and have proven their value in the struggle for survival. With regard to health care this meant that traditional therapies were potentially effective as well (Alland 1970, Dubos 1965, Lee & DeVore 1968, Logan & Hunt 1978, McElroy & Townsend 1979).

Now, almost fifteen years after its formal introduction, we must conclude that in spite of all optimism the PHC approach has failed (Streefland & Chabot 1990). Worldwide, implementation of preventive health care is lagging behind and problems of acceptance and communication still exist (Azavedo 1991, Detmar 1991, Engelkes 1989, Lesley 1989, Rifkin 1986). There is little evidence that intersectoral imperatives are translated into practice (Rifkin 1988, WHO 1986). The promising approach of Freire, Muller and Werner seems to be forgotten and the old medico-centric approach is revived (see also Bannerji 1988, Fendall 1985 & 1987, Rifkin & Walt 1988).

Once again international agencies design top-down projects aimed at isolated illnesses. In the early 1980s selective Primary Health Care (SPHC) came into fashion (Walsh & Warren 1979) and its goal was to fight the main causes of child mortality with vertically implemented programmes. It relied on new technologies in the field of vaccination, malaria eradication and oral rehydration. The new approach was not integrative nor did it allow community participation; in many cases it overshadowed existing attempts to communicate and co-operate.[4] Moreover, as Kanji (1989) asserts, by its promotion of technologies SPHC rather benefits the industrialised world and maintains the status quo.

Medical anthropology in the 1980s defends its existence once more in terms of breaking down social and cultural barriers which obstruct implementation of modern health care (Bastien 1987, Hill 1986, Phillips 1990). Applied anthropology runs the risk to identify itself once more with the dominating forces rather than acting as the advocate of the dominated in their struggle against cultural, economic and technological imperialism (Richters 1991).

But even when attempts to co-operate with local traditional experts were the fashion, these efforts have been primarily directed at isolated aspects of their medical system, i.e. at the curative practices of local healers, and most frequently in the field of psychiatric disorders (De Jong 1987, Kakar 1988, Kiev 1974, Mullings 1984).

The relation between these local experts and modern health care officials has also remained rather one-sided. In many cases the traditional healers received some training in basic hygiene and epidemiology first. They were also obliged to refer patients if they were seriously ill.

Another group of local experts integrated in Western health care service were the traditional birth attendants (TBAs) (Cosminsky 1977, Laderman 1983, Pillsbury 1982, Ross 1986). In rural areas of several Asian and Latin American countries, TBAs were integrated in the modern system. Like the healers, they

were trained first. To diminish the risk that they would cause infection they were taught some basic hygienic measures. They learned to recognise in which cases the patient had to be referred. Western doctors or nurses were never subjected to similar training in basic traditional knowledge. Neither were they ever obliged to refer patients to their local counterparts.

A third important field of integration concerned traditional medicinal herbs. But this too, was taken over rather than integrated. A large project in Central America, for instance, studied the use of local herbs only to place the responsibility for their prescription in the hands of the staff of the clinic, but not before they had been chemically analysed in European and American laboratories (Enda Caribe 1988).

Furthermore, the motivation of many governments and development agencies to make use of local resources was opportunistic: the majority of the countries were confronted with low budgets, brain-drain and staff shortages. The use of traditional experts and medicines was merely a temporary solution until more Western-trained staff and materials were available (Foster & Anderson 1978, Kakar 1988).

If the attempts to co-operate and communicate have been limited, and integration with healers and midwives one-sided, local experts on preventive health care and first-line curative care seemed to have been overlooked altogether. Although prevention and basic curative care were presented as the foundation of PHC in underdeveloped countries, the local experts in this sector, the women – the main providers of local preventive and basic curative care and first responsible for PHC – have usually been ignored where co-operation, communication and emancipation were concerned. The majority of mother-and-child health projects never focused on the cultural and social context of mother-and-child health, nor on the development of channels for communication. Contemporary SPHC projects concerning the health of mothers and children are mainly concerned with growth monitoring, oral rehydration, breast feeding and immunization. Most of these so called GOBI approaches are based on screening and education characterised by a top-down approach. Apparently, policy makers and planners from the higher echelons of health care systems have decided what women need. The women themselves are still approached as they were in the 1940s and 1950s, when their views and customs were seen as cultural barriers to public health (Chaiken 1986, Key 1987, McCauley et al. 1990, Mtero et al. 1988, Taylor et al. 1987, WHO 1988, De Zoysa 1984 & 1991). Medical anthropologists, for their part, have seldom focused on theory or practice of interaction at the preventive level.

PHC's failure to realise its ideals with regard to its main target group, and medical anthropology's lack of interest in theoretical assessment of preventive approaches were the starting points of the fieldwork in Dominica. These issues challenged

me to study the possibilities and shortcomings of PHC and to explore medical anthropology's possibilities to fulfil the promising task of interpreter between 'Us' and the 'Other', 'our' PHC and 'their' women. By studying Dominican culture I hoped to trace views and customs with regard to motherhood, and to take a step towards the realisation of the ideal of the 1970s: an emancipated PHC.

An emancipated PHC, in which local and Western expertise are meaningfully integrated, seems to me still a goal worth striving for. In spite of the ideological and political climate of the former decades medico-centrism and medico-imperialism are still with us today. PHC never got a fair chance.
Others, too, still sympathise with the original starting points of PHC. In 1989 Nichters published his book on the co-operation between Western and Asian systems. In 1991 Nichter & Kendall edited a special issue of *Medical Anthropology Quarterly* about contemporary issues on international health, and only recently the World Bank (1993) released a report in which the bottom-up approach is propagated as the most effective investment in health. There have also been attempts to understand and remedy PHC's failure (WHO 1986, 1987a,b,c, & 1989). Many look for explanations in the economic climate of the capitalist world system, in administrative and bureaucratic failure, or in micro-level politics and economic power structures (Horn 1981, Klouda 1983, Mullen 1983, Pillsbury 1982).

Most of these authors are rather pessimistic. They feel that real improvements are only possible if international and national power structures are replaced by more democratic ones. Klouda and Pillsbury, for example, stress political factors. Politics are usually dominated by elitist classes. Doctors belong to these classes and therefore have considerable political power. Klouda shows that PHC is not attractive to them. Their belief that prestige and status depends on their professional expertise increases their fascination with technology and specialization. For prevention, PHC would rely in the first place on paramedical staff, not on highly specialised professionals and high-tech equipment.

However, these factors did not seem to play an important role in Dominica. Since the country's independence in 1978, and after hurricane David's devastating visit, which left the island in total disarray the year after, the construction of an island-wide PHC had begun. Nowadays every Dominican has easy financial and geographical access to a PHC clinic. Preventive health care is well established and over 85% of the children is completely immunized. The country is frequently seen as a model of well-functioning PHC service. Yet, although preventive and curative services are functioning properly, integrative, intersectoral and emancipatory imperatives have so far been neglected.

It was for that reason that I chose Dominica for my study. I assumed that the only chance to actually initiate these rather idealistic imperatives was to select a country that had succeeded in building up a functioning PHC service system.

I left for Dominica (formally 'The Commonwealth of Dominica') in September of 1987 and returned in December 1990. Dominica is a small island in the eastern Caribbean. It lies between the French islands Guadeloupe (in the north) and Martinique (in the south). It has approximately 80,000 inhabitants, almost all of African descent. 12,000 live in Roseau, the capital. Until 1978 the island was governed by the British. Now it is independent, but has remained member of the British Commonwealth. The official language is English, but *Kweyol*,[5] a creole based on French, is still commonly used (for more information on the island, its people and its health care system see appendix 1).

During my stay of more than three years I studied the lives of Dominican mothers. With regard to integrative, communicative and emancipatory principles I attempted to gain insight in their perceptions, practices, needs and expectations regarding health, illness and child care. Looking for clues with regard to intersectoral ideals, I explored their social and economic background, their possibilities and limitations. I combined participant observation with a variety of other ethnographic methods. Among these were open interviews, diaries (kept by the participating women), informal talks, and life-histories (appendix 2 contains further details on fieldwork activities and methodology). I also organised a seminar to discuss ways to realise emancipation. Unlike Varkevisser (1973), I focused on the physical aspects of child care alone. I realise that socialization and psychological development are equally important, but in the context of PHC physical aspects simply seemed more relevant.

While preparing for my fieldwork I was inspired by the interpretive approach designed by Arthur Kleinman. His principal concept is the 'explanatory model' (EM) through which a person gives meaning to certain experiences, in this case to experiences with regard to illness. It contains etiological and diagnostic opinions, decisions as to when and whom to consult, theories concerning effective treatment, criteria to evaluate treatment and motives to continue or terminate treatment, as well as means to realise interaction between representatives of different (medical) cultures. When a patient from one culture encounters a healer from another, their EMs clash, Kleinman argues. Anthropologists have to provide knowledge about the views of both. This knowledge is necessary for mutual understanding and consequently for the establishment of forms of communication and co-operation in which all parties involved remain equals. Like PHC supporters, Kleinman warns against ethnocentrism, paternalism and cultural imperialism. His approach provided an attractive model for my project. I planned to use his approach for the analysis of my data and as a basis for my recommendations. Thus I hoped to contribute to medical anthropological theory concerning prevention and risk.

I selected two research villages, found a research assistant to take responsibility for one of the two communities, studied the local creole, or 'patois' as Dominicans

call it, and conducted a household survey. On the basis of this survey I was able to form two groups of mothers, recruited from both villages. The first group consisted of 41 (23 and 18) mothers with children under the age of five. A total of 26 (18 and 8) older, more experienced women formed the second group. I also approached PHC nurses and local specialists working in the area.

Initially I had planned to interview all participants about topics concerning motherhood and child care and set about preparing relevant questionnaires. Towards the end of the first year, however, my position changed. I became pregnant. From that moment on the women no longer treated me as a respected outsider, but as an inexperienced young woman, a 'daughter'. It was as though I was adopted by a large number of mothers. Since I was studying motherhood, this change had a considerable effect on the information I collected: it was offered to me in a much more natural way and often was of a more confidential kind. Unfortunately it was impossible to tell exactly in what way and to what extent my material was influenced, but I believe that my experiences with pregnancy and motherhood and with the father of my child reduced the distance between me and the mothers that participated in the study. It certainly opened an avenue of communication that would otherwise have remained closed. Moreover, my new position made it possible to gather extensive autobiographies of 'my mothers'.

When I discussed this with my supervisor we decided to present two of their autobiographies in this book. Both paint lively pictures of life as a Dominican mother and combine experiences with pregnancy and confinement with information about the relation with the partner, perceptions concerning child care, health and illness and social and economic circumstances.

The most valuable ethnographic data were indeed offered to me as pieces of personal advice during my pregnancy, delivery and nurture of my son, and we felt that the best way to pass this on was to present my experiences in an autobiography as well. The three autobiographies form the first part of this book.

This part is followed by a more conventional ethnographic account in part II. Based on data provided by the two research groups, this account presents a more distant view of the mothers. It describes beliefs and practices in more general terms and offers a wider cultural context for the personal stories. It also includes information about the interaction between mothers and Dominican PHC. The personal histories, on the other hand, bring the more general accounts to life. They show how women incorporate beliefs and practices into the social and economic reality of motherhood. While the personal accounts, for instance, relate individual experiences with witchcraft and show certain social dimensions, the ethnographic part discusses general views about cause, cure, prophylaxis and treatment of witchcraft-related diseases.

The decision to include an autobiographic part in the ethnographic presentation of the field material, which in the field seemed so natural, forced me to tackle

certain methodological and epistemological problems after my return, when I was looking for a theoretical foundation for my plans.

The advantages of using life histories and (auto)biographies to present ethnographic data have been recognised for a long time. Radin's Crashing thunder for instance, was published as early as 1926. His example has since been followed by ethnographers as Casagrande (1960), Codere (1973), Lewis (1963), and countless others who used autobiographies or a combination of life histories to describe life in other cultures. In a review article discussing the use of biographic methods, Miedema (1984) mentions several specific advantages of this ethnographic genre: it can paint a lifelike picture of another culture, it does justice to the originality and the uniqueness of people, and it does all this in a natural and plausible way which makes it easier to imagine what life in the other culture is like. The popularity of the work of Lewis for example, shows that this genre can even appeal to readers who are not professionally involved in anthropology. Miedema feels these advantages are important enough to justify his own presentation of data in the form of a fictitious biography (Miedema 1983). In this respect he agrees more or less with the view of Crapanzano (1980) who combines fact and fiction to produce a lifelike picture of other cultures.

The presentation of ethnographic material through the researcher's personal account of his experiences and emotions, however, is more unusual. Most work of this nature is of a later date and those authors who actually wrote a personal account of their fieldwork experiences detached it from their ethnographic presentation (see for example Barley 1986, Bleek 1978, Bowen 1964, Cesara 1982, Chagnon 1974, Golde 1970, Warren 1988, Whitehead and Conaway 1986). Including my own autobiography could easily be perceived as pedantic and I hoped to remove this feeling by providing a theoretical foundation for our spontaneous decision.

Soon, however, my attempts to account for my autobiographic presentation forced me to re-examine Kleinman's approach as well. It would not do to take seriously possible epistemological objections and to adopt autobiographical ethnography, and yet at the same time neglect them with regard to Kleinman's approach. At first glance, his work appears subject to the very weaknesses these criticisms aim at. Therefore I had to reconsider the application of Kleinman's model as a tool to analyse possibilities for the initiation of cultural emancipation in PHC.

The conclusions of my endeavour to justify the autobiographies and my appraisal of critique of Kleinman's work are found in the eighth chapter. In chapter 7 I reflect briefly on my position as fieldworker. At first the discussions in these chapters lead away from the ethnographic line I set out in the first two parts, but in the three following chapters a linkage is effectuated. The first of these chapters, chapter 9, discusses my attempts to apply Kleinman's approach to the study of

Dominican mothers and their PHC. The second (chapter 10) examines the social and economic context of motherhood. It is motivated by the critique that was aimed at Kleinman's earlier work – many authors have reproached him for ignoring the political-economic background of health problems – and by the intersectoral principle I mentioned above.

Chapter 11 discusses recommendations regarding the interaction between mothers and PHC. It appraises the material from the autobiographic and ethnographic parts and combines it with the conclusions from the seminar, but it is based on Kleinman's extended model.

Appendix 1 contains background information about the country and its health care system, the research location, and the women who participated in the research groups. Methodological issues are discussed in appendix 2.