

The Impact of Westernization on the Fijian Birth Model

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June 2013

Abstract

Over the past 200 years a dramatic shift in the method of birth has occurred in the world and especially in the United States. Birth has been transformed from a common event overseen by a local midwife, a process that was common and largely mysterious as it lacked any scientific understanding, to an infrequent event overwhelmingly overseen by obstetricians and scientifically dissected in attempts to maximize health outcomes. Although many countries have gone through a transition similar to this, this specific transition is unique to the culture of the United States. With the impact that US Western culture is having on so many aspects of life in foreign lands, it seems prudent to look at how Western culture has influenced methods of birth in other cultures. More specifically, this paper examines which aspects of the Western or US birth model have been adopted in Fiji, a country that has a strong cultural identity but one that has also had great exposure to the West, and explores the reasons why those aspects have been adopted.

Introduction

Birth is an essential element to life; women give birth across the globe, a pattern that has continued for countless generations. Despite their perceived simplicity, methods of birth vary a great deal from place to place as well as from one generation to the next. For much of human history women who had personal experience with birth and who typically had a personal relationship with a mother would assist her in delivery. This became formalized into the profession of midwifery, the title midwife meaning literally “accompanying women,” a role that focused on making the mother comfortable but largely allowed her body to govern the birth process, the midwife stepping in only when completely necessary. In many countries there has been a move away from this natural birth process toward a more medically managed birth process primarily assisted by a physician. In each country a unique process guides this transition from midwife to doctor.

There are many factors that determine how and when this transition takes place, including the particular cultural traits of a people, which are a powerful factor. In the United States for example, the transition was largely an economic shift perpetrated by physicians for profit. The motivation for personal profit is based upon the cultural value of individualism and emphasis on economic success. Manifest in a slander campaign against midwives, this aspect of the birth transition in the United States highlights a trend that focuses less on the general well being of mothers and infants and more on economic prosperity. Despite the origins of this system, it resulted in a plethora of medical advancements and a large reduction in preventable deaths among mothers and infants, largely deaths caused by post delivery infection. The impact of this transition in the United States was dramatic. Over 30% of women in 2005 chose to have a cesarean section, and only 1% of women gave birth outside of the hospital (Block 2007). In

addition to this an overwhelming majority of women receive extensive medical intervention during delivery such as pain medication, heart-rate monitors, induction, cesarean section, and episiotomy. Despite recent trends to return to a more natural birth model this medicalized system is still predominant. In the minds of many US citizens this birth model feels natural and necessary, but how far have these viewpoints and practices spread around the globe? During the summer of 2012 I conducted ethnographic research in Fiji with the intention of exploring how the Western birth model has impacted the country's maternal health care. I attempt to understand which aspects of the United States model Fijian women and medical policies have adopted, and for what reasons they have adopted those aspects. At the core of the question is to understand the differences in the culture of the United States and the culture of Fiji, because cultural values and beliefs influence all aspects of a person's life, including how they choose to give birth to their children. Fijians are a people that strive to maintain their culture by strongly upholding the traditional values of community and collective responsibility, values that will undoubtedly influence their decisions surrounding birth. However, they are also a people that have been greatly influenced by the West both during their colonial period and more recently by being the major hub of the South Pacific. This paper reviews perspectives on what a good birth means to various peoples and explores contemporary attitudes towards technology playing a role in birth.

During my time in Fiji conducting research I attempted to observe how Western culture has impacted Fiji in the narrow area of birth by asking Fijian women about their attitudes surrounding birth and birthing practices. I interviewed Fijian women about their opinions regarding a hospital birth versus a more traditional birth and attempted to understand the reasons behind their opinions. Looking at the influence of governmental policies, as well as the popular cultural beliefs surrounding birth to assess whether their opinions seem to be influenced by the

West or perhaps stem from traditional roots. In the overall analysis, themes emerged that illuminated influences from both the West and from traditional Fijian cultural values. It appears that some aspects of the US birth model have carried over to Fiji, but they are used sparingly and in culturally appropriate ways, focusing on the health and safety of mothers and infants. Many aspects that are predominant in the United States remain absent in Fiji. This seems to result from a combination of the attachment Fijians still have to the primal aspects of birth, the inequality of women and their lack of autonomy in the economy, and the government's control over procedures as they financially back the health care system. These and other factors play a role in accounting for the differences between the US birth model and the Fijian birth model. This research attempts to dissect some of these factors in order to better understand their origins and implications.

Literature Review

United States: Historical Setting

Knowledge of infection and anatomy was very low in the 19th century, a time that saw a great influx of hospital births but also a simultaneous influx of hospital deaths. During the 19th century records show that at times more than 30 of every 1000 hospital births resulted in death from infection (Shorter 1982). The main infection was puerperal fever, an infection that can develop in a woman's reproductive organs following childbirth (Encyclopedia 2013). In fact in the 1860s hospital births were five times as dangerous as homebirths. This is largely because doctors in hospitals were intervening more than necessary in the birth in order to speed up the process, and each intervention created a new opportunity for the transmission of infection. Even when doctors assisted in homebirths their assistance resulted in higher mortality rates. For home births without complications during the 1930s, doctors intervened over 30% of the time versus only 3% for midwives assisting low-risk deliveries (Shorter 1982). During this time infection rates were much lower for at home births; especially those assisted by midwives with rates as low as one quarter of what they were for hospitals, generally as a result of lower intervention rates. Once knowledge about preventing infections increased and became more commonly practiced, death rates drastically fell and by the 1940s deaths from infection were equal for both home and hospital births (Shorter 1982). During the early 20th century in the United States, infant and maternal mortality rates were stagnant at a relatively high rate in comparison to other industrializing countries (Lotiff 1986). There were several reasons why rates were so high. First the economic situation of the mother predicted mortality outcomes; her environment could be prolific in bacteria more likely resulting in an infection for the fetus or mother. In addition the lack of adequate prenatal care played a large role, a mother who was largely undernourished or

who was following folklore practices was more likely to birth an unhealthy infant (Shorter 1982). A third factor impacted the mother, but was outside of her control: the capability of the birth attendant. Because this was the only factor outside of the mother's control, the birth attendant was often blamed in the event of a tragedy. For example if a "monster" was born and the mother had been well behaved during pregnancy, the midwife would be accused of practicing witchcraft (Donnison 1977). Midwives were largely blamed for poor birth outcomes when in fact their practices were better suited to the times as they also supplied housecleaning services, childcare for other children, and two weeks of postnatal care (Block 2007). In addition, the midwife's fee was smaller than that of the physician's (Lotiff 1986). In fact, all records show that a midwife's job was tedious and relatively unappreciated, an inglorious occupation that required a great deal of work, low pay, and a strong stomach (Donnison 1977, Shorter 1982). In this way it is demonstrated that the transition from midwives to physicians for the vast majority of women is not a transition based solely on its practicality or benefit.

Transition to Male Physicians

Women had looked to other women to guide their birth experience for countless generations, but in the mid 18th century there began a slow demand for male midwives and doctors (Shorter 1982). Additionally, with the help of birthing tools such as forceps, practitioners who had no traditional knowledge of birth, such as male physicians, could begin to facilitate birth. Previously doctors would only be called into the birthing room for the gruesome tasks of either performing a cesarean section on the dead mother to extract the surviving infant, or to extract the fetus limb by limb when labor proved impossible (Shorter 1982). The reason male doctors wanted to enter obstetrics was largely for profit, it was a market they previously had no access to as they lacked much of the knowledge and skills needed to attend birth. In the mid

1700s forceps became publicly available but were adopted solely by male-physicians as midwives felt they had no need for tools (Hay 2002). Midwives felt that forceps provided no advantage in the majority of births that did not require any intervention (Hay 2002). However, midwives' lack of these emerging technologies contributed to a feeling that a midwife was ill equipped to handle an emergency and promoted a desire for a doctor to oversee delivery, as it was assumed that he and his tools would be able to handle any problem that might arise (Shorter 1982). Most doctors had received little to no training in what a normal birth looked like so more often than not they chose to intervene in delivery even when no intervention was required. Some of this intervention was also encouraged by the delivering mother and her family, who no longer had the patience to wait out the delivery and might pressure the doctor to do something to end the pain their loved one was enduring (Shorter 1982).

As might be expected, these interventions did not always have perfect outcomes, especially when their purveyors lacked extensive knowledge in the methods (Shorter 1982). This resulted in the physician's reputation becoming somewhat damaged (Lotiff 1986). In retaliation physicians led a campaign against midwives, slandering the profession of midwifery in order to maintain the physician's prestige. At this time, the majority of practicing midwives were immigrants from Eastern Europe, as the number of American born midwives had been decreasing with reduced popularity. Eastern European midwives came from countries where midwifery was an honorable profession, but in the United States they found it difficult to retaliate against the physicians as they largely spoke English poorly, were less economically powerful, and were not geographically united by any agency (Lotiff 1986). Once midwives lost the trust of American women, the profession could no longer regain the respect it had received in their native countries, and the rate of midwife assisted birth dropped from 50% at the beginning

of the 20th century to only 15% by 1930 (Lotiff 1986). Clearly the campaign unleashed by obstetric physicians in the early 1900s was extremely effective, as many still garner their impressions of midwives based on this campaign's slander. Since then the rates of hospital births have steadily increased over the 20th century, with numbers reaching ultimate highs in the 1970s when 99% of births took place in the hospital (Lotiff 1986). The slander campaign was the final push in a long battle between midwives and physicians over the domain of the birthing room.

Demographic Transition

During the early twentieth century a demographic transition was occurring as the US population progressed from a stage of higher birth rates to one of lower birth rates. This transition meant that birth was no longer a common, everyday occurrence but more likely a special occasion for a family, one to which special attention and care was paid (Lotiff 1986). At this time, most women felt that a hospital birth was safer and less painful than giving birth at home, despite the fact that births attended by midwives had lower rates of infant and maternal mortality (Lotiff 1986). Women became more invested in the birth of their few children as they gained more control over their fertility due to the introduction of more family planning methods. In *A History of Women's Bodies*, Edward Shorter remarks that during this demographic transition stillbirths become a tragedy rather than a blessing (1982). When women did not have the ability to control their fertility they had many children and likely struggled to feed them all, a pregnancy ending in a stillbirth was therefore one less mouth to feed, and although still an event to mourn was also often a blessing. Once pregnancies became less frequent, more resources were available for each child and a stillborn became an imagined child lost, a piece of the family that would now be forever missing, a tragedy. The perceived nature of enhanced safety made the hospital alluring for families more invested in the survival of their limited offspring, while the

hospital's bountiful access to medical interventions, pain management and surgery made the hospital more appealing for anxious women as it seemed to be the most beneficial for their own well being and for the well being of their child (Lotiff 1986).

Pain of Delivery

For centuries the pain of childbirth was “perceived, even sanctified, as the inevitable price paid by the daughters of Eve, irrespective of social class, for fulfilling the biblical mandate to ‘be fruitful and multiply’” (Hay 2002, 25). In the modern environment of the latter half of the nineteenth century, culture was moving towards secularization and an unceasing interest in defying the natural limits of the universe. To many modern women the idea of the inevitable pain of childbirth no longer held any sway. Women were anxious to rise above the agony of birth, which they associated with the moaning and writhing of animals, and the endurance of which they believed allotted them a subordinate position to men (Hay 2002). Initially physicians were hesitant to administer chloroform to women in delivery as the possible side effects remained unknown, but women demanded the anesthetic and by the 1920s the use of anesthetics was largely universal for deliveries (Shorter 1982). The demand for pain relief by women resulted in doctors having the choice of either supplying the woman pain medication or denying it and losing the patient to another doctor who would supply it (Shorter 1982). Another encouragement to the medicalization of birth was that most physicians received their clinical training for birth in facilities for the urban poor. At such locations there was an increased risk of fever and other infections, resulting in more high-risk births requiring medical interventions. This resulted in physicians coming out of their clinical training looking at birth as a generally dangerous act which quite easily and quickly could become life threatening (Hay 2002). Training for medical doctors in general was very poor at this time, and especially in the area of obstetrics. The

specialization was seen as an occupation degrading to gentlemen and was therefore not given much attention with many medical students possibly only observing one birth before being certified to take on any obstetric challenge (Shorter 1982).

With little knowledge of what a normal birth looked like standardized processes were developed that minimized infection risk and reduced the birth knowledge required of the attendant. With this standardized process further emphasis was put upon leaving the home and giving birth in a hospital, where the entire experience could be managed and regulated. In total this move to birthing in a hospital offered an efficient place for modern birth as it provided one space to hold all of the new technological equipment and to house all the medical personnel that might be called upon if the labor proved difficult (Shorter 1982). The emphasis on the hospital was because of efficiency, and “in America efficiency was a watchword of the twentieth century” (Hay 2002, 29). Along with efficiency, America was struggling to master and exploit nature, a task to which standardizing childbirth seemed to fit easily. By the 1930s both public and medical opinion believed that “some form of narcotization should be used during birth” (Hay 2002, 32), infection death rates had dropped to below 1 death per 1000 for both hospital and home births (Shorter 1982), and midwives were attending a shrinking percentage of births (Litoff 1986).

Efficiency

For the growing number of women giving birth in hospital, routines were developed that made births more efficient and expedient in order to accommodate the influx in the number of patients desiring hospital beds (Hay 2002). These routines were often for the benefit of the hospital personnel rather than the expectant mother, for the mother was only a temporary visitor to the permanent machine of the hospital (Hay 2002). Initially women welcomed the formal

assembly line-like childbirth process, but soon the level of inhumanity and sterility drew criticism. Several physicians actually began to attack the system “advocating that minimizing the use of medical intervention, particularly the use of anesthesia, [would] enhance the mother’s birth experience” (Hay 2002, 33). These and other physicians headed the “natural childbirth” movement, which began as a backlash to the medicalized birth system that had overwhelmed the previous century.

Feminism’s Role

At the rise of the feminist movement activists were initially more concerned with the integration of women into the medical field, leaving the campaign to keep midwifery alive and protected largely ignored (Lotiff 1986). During the 1970s feminism took hold and women advocated for the empowerment of all women and for broad freedoms in reproductive rights, wanting to return the power of birth back to the mother (Hay 2002). They proposed that having your baby at home maintained a women’s control while having your baby in the hospital meant you lost that control (Shorter 1982). The focus then shifted toward the right of women to control their own bodies and a recognition of the fear that choices and options could be removed by people who think they know what is best (Lotiff 1986). As with the initial move to physician assistance, this return movement was most popular among privileged and upper-class women as they had a better education and a higher “standard of living” than working-class and minority women, who still welcomed the sterility and separation the hospital provided from their responsibility-full lives (Hay 2002).

Fetus Focus

At the same time as the movement away from the standardized hospital birth came a shift in focus away from the mother’s health toward that of the fetus. Increasingly invasive procedures

were performed when the well being of the fetus was at stake (Hay 2002). Before the 1930s the wellbeing of the woman was the only concern for both the midwife and the physician, and in the case of a woman's life being at risk a birth assistant would not think twice about sacrificing the fetus's life for the mother's (Shorter 1982). Similarly, in the early 1900s doctors would recommend a strict low calorie diet in the third trimester of pregnancy in order to reduce the fetus's size, resulting in an easier delivery for the mother but often resulting in poor health for the newborn infant (Shorter 1982). However with the "discovery of the fetus" the fetus became just as important as the woman birthing it, and no intervention was thought of as unnecessary if it improved the fetus' chance of survival, even if that intervention negatively impacted the woman. Although initially there was debate about the fetus focus, by 1941 the American Gynecological Society favored the intervention in birth on behalf of the fetus (Shorter 1982). In fact, cesarean sections were thought of as the least traumatic experience for the fetus and were promoted, despite being a very traumatic procedure for the mother (Hay 2002). A case in the late 1980s demonstrates this to an extreme when a pregnant woman was denied cancer treatment that could save her life because it might harm the fetus inside her (Block 2007).

This fetus focus culminates in the desire to perfect the child through any number of intentional actions taken during birth and pregnancy to guarantee an intelligent and well-behaved child (Hay 2002). The goal to attain the perfect child collided with an already litigious society and created a greater threat of malpractice suits. This in turn further increased the level of control demanded by physicians, allowing for even less uncertainty in the delivery room. Despite all of the intervention and an emphasis on hospital births, US infant mortality rates are second highest among 33 industrialized nations and women are 70% more likely to die in childbirth in the United States than in Europe (Block 2007). Medical interventions have only increased in recent

years with the continual additions of monitors and safety checks, such as the recent addition of electrode monitors of cervical dilation (Block 2007). Americans spend more money on health care than people in any other nation, and spend more on maternal health care than any other type of hospital care, and yet still the United States has higher maternal and infant mortalities than any other industrialized nation (Amnesty 2010).

Cultural Traits of United States

The unique culture of the United States has allowed for the almost complete transition of births to hospitals and for the explosion of medical interventions to be integrated into the ‘normal’ birth ideal. One factor in the early nineteenth century that encouraged this transition to be followed so unanimously was the attempt of immigrants to dissociate themselves from the foreign languages and customs of their countries of origin by trying to integrate into the American culture and thereby become a true American. These immigrants readily participated in any activity which helped promote their American identity, one of which they found in hiring a physician instead of a midwife to guide their birth. A midwife was seen as someone who was tied to the old world and everything it stood for. Indeed, the hiring of a midwife was seen as a very un-American act (Lotiff 1986). This desire to assimilate was largely built out of concerns with the growing class differentiation between women and individuals in general. Upper-class women had begun trying to create some separation between themselves and lower-class women, and the practice of hiring a male midwife with tools and knowledge that seemed more technical and modern, in their eyes, elevated them above the women who simply let nature take its course with a “lowly” midwife (Hay 2002).

In addition to assimilation, the culture of the United States is typically very centered on the individual. An individual’s desires and beliefs are seen to be more important than the

perceived effect an action may have on the community. This prioritization of values has led to a culture that believes each person has the right to sue another if they feel they have been wronged, without concern of the repercussions for the community or later generations. Creating an environment where doctors no longer think of what would be best for the mother-to-be but of what would prevent them from the possibility of being sued, intervening much more frequently to ensure that no one calls them negligent (Block 2007). In addition, the development of hospitals and doctors into businesses requiring increasingly high insurance rates means that in order to pay such high rates health care providers must minimize their time commitment to each patient in order to quickly move on to the next patient (Block 2007). This system often results in patients not receiving the care that would be most beneficial to them. When looking at the history of the maternal health care system in the United States we can see in many instances that the impetus for change was partially motivated by individual profit and prestige. Once the hospital took over, efficiency and profit became more important than quality care, and the perceived safety of the hospital was largely created by the allure of technology and medication, and perceived sophistication and modernity. The beliefs that make malpractice suits possible are so deeply entwined in our culture that obstetricians and hospitals alone cannot be held accountable for the results of this transition.

Fiji: Country Background

The country of Fiji is comprised of a group of islands in the South Pacific Ocean with a current population of 897,00 (CIA 2013). There are over 300 hundred islands within Fiji, only 100 of which are inhabited by people. The largest island, Viti Levu, is home to over 70% of the country's population. Fiji became independent in 1970 after nearly a century of British colonial control. Throughout colonial times, workers from India were indentured as laborers on Fijian sugar plantations, and by the time of independence Indo-Fijians made up a large demographic group. There has been a history of tension between the Indo-Fijians and the indigenous Fijians over land rights and government representation, which have been at the core of the four coups that have occurred in the country over the past 20 years (Roberts 2011). With its history of colonial control, it is clear that Fiji has had a great deal of interaction with the West. Yet, it is isolated enough geographically that it has still maintained a great deal of its cultural identity. Over 57% of the Fijian population is of indigenous descent (CIA 2007). This has created a situation where the traditional culture could be maintained because of majority status. Today Indo-Fijians and indigenous Fijians are both referred to as "Fijians", but for simplicity here the term "Fijians" will reference those Fijians of indigenous descent not those originating from the Indian subcontinent. In recent years the Fijians have begun to face large contrasts in their population. For most of their history Fijians lived in villages, a woman would move to her husband's village when she married. Life took place largely in small rural based communities. In recent years a large number of Fijians have moved to urban areas for various reasons (Ravuvu 1983). Urban areas in Fiji are growing and currently 52% of the population lives in cities, a rate that is increasing yearly (CIA 2010). In the cities individuals are exposed to Western trends and ideals, which is in turn changing the culture and practices of Fiji. There is still a large portion of

Fijians living in villages throughout the country, but even a rural inhabitant cannot avoid traveling into the urban centers to participate in markets or other consumer or health based activities. Over the past decades Fiji has been a focal point for Western health and infrastructure programs as the population is typically willing to comply. This willingness to comply may stem from the country's maintenance of the colonial era government structure, making the acceptance of Western policies easier because of built-in compatibility. In addition, as a remnant of the era of chiefdoms, Fijians respect authority figures and generally have no qualms with abiding their rulings (Ford 1938). A chief would have ultimate power over his village, with the inhabitants trusting that their chief would make the right and best decision, something the Fijian people now expect of their government, which serves as their modern day equivalent to a chief. Additionally, chiefs still hold great power with political agencies, as in the Great Council of Chiefs, an agency comprised of the country's chiefs that participates in current politics (Norton 1999). With some of the tools learned from these Western initiatives, as well as other inherent cultural traits such as the desire to promote public good (Morse 1989), Fiji's health and demographics have improved in recent years and the accessibility and availability of education has also increased. For example by the year 2005, skilled health staff attended 100% of births and 13 years of schooling was expected for both males and females (CIA 2005).

Primary Health Care

As a remnant of the British colonial administration, a three-tiered health care system was established in Fiji. Although not formalized, the colonial goal was to get health care to rural and isolated inhabitants of the country. As a part of the first tier, nurses would do outreach visits to villages and educate inhabitants, as well as be a villager's first connection with the health system should they need care in the future (Roberts 2011). This primary level was the first encounter

with a health care worker, providing people with an avenue to practice preventative health care by preemptively voicing concerns or treating ailments while they were still small. The second and third tiers worked successively toward larger and more urban institutions that focused more on severe medical conditions (Negin 2010). In the 1970s the World Health Organization (WHO) initiated a program to invest further in primary health care (PHC) for all Fijians. The idea behind PHC was to create a formal avenue for individuals at the local level to enter the national health care system, which would give everyone, even those in a remote village, the opportunity to access health care in a timely manner. When PHC came to Fiji many health workers felt that the basic idea of PHC was already being practiced in Fiji, as the country had inherited a similar three-tiered system from the British. The WHO did make an impact by increasing funding for PHC, and thereby more primary level clinics and health facilities could be established. In addition a village health worker (VHW) was selected from each village and extensively trained to administer to village health needs, dispensing some medications and reporting to the regional nurse. The VHW provided a vital link between people in the village and the larger health system. Along with training VHWs the WHO funds helped focus on improving water and sanitation for villages, where water-borne diseases were a health concern. Latrines were built and monitored by monthly inspections, and the WHO provided the necessary funding for this vital leap forward. The emphasis on infectious disease contamination was applied to birth as well and expectant mothers were encouraged to give birth in their local clinics rather than in the village. During the early years of the PHC program, 1975-1986, infant mortality and maternal mortality declined dramatically. During this time maternal mortality went from over 140 deaths per 100,000 to 60 deaths per 100,000 and infant mortality went from 40 deaths per 1000 to under 20 deaths per

1000 (Negin 2010). This huge drop in mortality rates reinforced policy makers' emphasis on moving births away from the villages.

After the first decade of the PHC program, success and adherence rates began to decline. This can be attributed to several factors, the first being that more people were moving from rural village areas to urban environments and therefore were no longer using the primary care system and the first tier but instead going directly to the general outpatient departments of urban hospitals. The second reason is that village inhabitants themselves began to use the urban hospital outpatient centers preferentially rather than their local primary care facilities. In addition, funding for the PHC program had been dramatically cut by the WHO and political instability in Fiji made the already established programs break down a great deal (Negin 2010). There were fewer and fewer doctors and nurses being trained and established medical facilities did not have enough staff to function effectively. Although funding from external agencies like the WHO is now only partially supporting health care in Fiji, with the other portion supplied by taxes, adequate funding is still not being given to medical facilities and many of Fiji's local pharmacies are lacking in their supply of medications (Sharma 2003). This has encouraged the trend in which rural Fijians go directly to the urban hospitals to ensure that they receive the care they may need, when in fact the care they require is basic and could be provided at the first tier level (Sharma 2003). This has led to a breakdown in the PHC foundations of what those health centers were established to accomplish. The perceived and possibly accurate notion that these local health facilities may not be as safe as going to a larger hospital encourages people to bypass the developed level of care, leading to the top most stage being overwhelmed with patients and hindering that facility's efficiency and effectiveness.

Many of the Fijian health policies are based on recommendations and guidelines provided by Western agencies. The exposure of Western medical advancements initiated through the Primary Health Care program improved many demographic indicators in Fiji. For example, the life expectancy of Fijians has increased by more than 8 years since the 1980s, and the infant and maternal mortality ratios have dropped in the same time frame (NationMaster 2013). Fertility rates in Fiji have almost halved since the late 1960s when they began to drop (NationMaster 2013). The formal PHC only began in the late 1970s, which means that the informal health care the Fijians already had had made a significant alteration in the behaviors of the Fijian people. It cannot be known whether the changes already occurring without the formal PHC would have continued without the monetary support the WHO program provided. Either way, many rural health centers and clinics were established in the 1960s and 1970s and provided a first tier of care to many rural village inhabitants.

In the last 30 years however, Fiji has been through several coups and the resulting restructuring of power has left the health care system lacking. Also because health care is free in Fiji health care personnel are employees of the state and have only moderate incomes, resulting in the investment required to become a health care personnel not worth the benefit of being one. This has deterred many potential providers from taking the necessary training and has left the system without a full staff at many locations. This often results in rural hospitals without personnel to run their equipment or enough medication to address their patients' needs. This situation has caused many rural Fijians to lose faith in their first tier health care and again go directly to the urban hospital setting (Roberts 2011). The formal practices of primary health care initiated by the WHO are still being practiced today, as each village is visited regularly by a VHW now trained by the Fijian Ministry of Health. Financial and human resources for current

Fijian health care are supported by development partners and non-governmental organizations in addition to the state (Roberts 2011).

The maternal health care system was largely impacted by these policies as well, as women were encouraged to travel to their primary care facility (the first tier rural health center) to give birth rather than to give birth in the village. The WHO was instrumental in making sanitary conditions available for birthing, and because infectious diseases were at such high rates they strongly encouraged women to travel to hospitals for birth. As outlined the implications of this policy drastically reduced infant and maternal mortality rates. No individual or company made money off of the transition, and at the root of the transition is concern for the well being of the mother and infant. This highlights the Fijian cultural trait of looking out for the community; the well being of the community lies in the hands of all the community members (Morse 1989). This cultural value has translated to policies that are for the benefit of the whole community and provide the safety net for individuals in vulnerable situations like birth.

Paternalistic Society

Traditionally, each area of Fiji is governed or ruled over by a chief. This chief is born into his role and regardless of his personal feelings about the matter he will become chief. In the same way, a commoner in Fiji is born into his role and has no hope of ever reaching a chiefly position (Ford 1938). This is not something that creates tension between the commoner and the chief, but rather is a fact of life that all accept; everyone has different duties in life. The chief's role is one filled with responsibility, as his duty is to watch out for his entire village. The common people entrust much to the chief, following any guideline he issues as they believe that he will act with their best interests in mind at all times (Ford 1938). Fijians are accustomed to having someone watch out for them, watching and making sure that they are safe and getting

everything they need. This cultural emphasis on centralized authority has allowed the government to have a powerful effect in issuing policies, especially because Fijians are comfortable following guidance from authority figures. With the strong cohesive emphasis on the chief comes an emphasis on the village as a whole, rather than on a person or individual (Morse 1989). This village mentality means people tend to think of the well being of the whole first and only second of themselves. This cultural value is opposite to the Western cultural value that emphasizes prioritizing oneself first before others. These cultural differences between the people of Fiji and the United States have led to a very different birth transition with potentially very different outcomes.

Methods

The interviews forming this research were gathered in the village of Vuisiga in the Naitasiri Highlands of Viti Levu. Vuisiga is approximately three hours inland by bus from Suva, the capital of Fiji. The village is in close proximity to a rural hospital as established by the PHC programs of the 1960 and 70s. The hospital can provide basic care but has been impacted by staff and medicine shortages and does not function as completely as it could. However, if necessary the hospital can provide an ambulance service to the Suva hospital.

Interviews were conducted during the summer of 2012. In total, 20 women were interviewed. All research was approved by the Cal Poly Institutional Review Board (IRB) prior to trip departure. The research participants were selected in an attempt to sufficiently represent two age cohorts. The younger age cohort was pre-menopausal and represented a population who likely had no experience of living without accessible medical facilities. These women were also still fertile and so additional questions were asked about whether or not they participated in family planning and their experiences with it. The older age cohort was post-menopausal and

represented a generation who perhaps had some exposure or experience of birth before medical institutions were so participatory in the birth process. The interviews sought to discover each woman's opinions about traditional births versus hospital and physician assisted births, including where and how they themselves would prefer to give birth and for what reasons. The interviews were conducted on a one-on-one basis, with a translator present. The same series of questions was asked to each interviewee, with slight alterations made depending on whether they were part of the younger cohort or the older cohort. Interview questions were generated with the intention of prompting conversation. Questions often asked the participant "why" and "how" in order to provoke dialogue on the subject. The goal of most questions was to retain qualitative information that shone a light onto how opinions and decisions are made for Fijian women regarding birth and delivery. Comparisons were made between hospitals and the village and participants were asked to define their ideas about how they imagine a "good" birth. Participants were also asked to compare experiences throughout their lives and in relation to the lives of their children. Participants were assisted and translated by a Fijian research assistant from the village. The interview questions administered for both cohorts are included in Appendix 1.

Findings & Discussion

Data showed that many women hold similar opinions in regards to birth, pregnancy, and delivery, portraying both the strong cultural identity of Fijians as well as the power the government has in shaping public opinion. In regards to location of birth, women almost unanimously stated they would prefer to give birth in the hospital. During interviews several themes came up in response to the question of location; women repeatedly stated the need for increased safety and sanitation as elements that guided their decisions. Lacking in their reasons for preferring a hospital birth was the need for increased convenience in their delivery, a factor

that women in the United States highly prioritize as seen by the large percentage of scheduled cesarean sections.

The first theme recognized throughout the interviews was the emphasis women placed on the safety of the hospital environment. The overwhelming number of respondents stated that the hospital was safer than the village, and that if something went wrong being in a hospital meant that additional care was available. Most women expressed concern about the chance of something going wrong if they were not at the hospital, and spoke of the safety net that the hospital provided them. This is exemplified in the following excerpts from interviews.

Woman: In the hospital everything is there, there are machines and midwives are there. It would be easier because you would be well taken care of.

Woman: In the hospital you are sure that everything is well taken care of, the nurses and doctors are there and if something goes wrong they will be ready to take care of you whereas in the village you cannot be sure.

Woman: In the village you never know the baby might get infected, it is safer at the hospital.

Woman: There is no medication around [in the village] and if something happened to the baby there would not be a place to take the baby to.

For these women the hospital provides a place where everything is accessible and in any situation they will be taken care of, whereas the village would only be safe in a delivery free of any complications. Even though the majority of births are complication free women still feel better having the safety net of the hospital in the event they need it. The hospital employs many educated individuals and has the capability of transporting the mother to an urban hospital where all known medicine and procedures are available. If a woman stays in the village for delivery and encounters complications that require transportation to the urban hospital it would be difficult to get there from the village, whereas an ambulance is standing by at the hospital.

Something directly linked to the safety of the hospital is the opportunity it creates for a sanitary environment, another theme recognized throughout interviews. Access to clean water and a sanitary environment is not always guaranteed in Fijian villages, as in 2010 only 95% of rural environments in Fiji had access to improved clean water and only 71% had access to improved sanitation facilities, and this is after decades of improvement through government and foreign aid agencies (CIA 2010). Although the village of Vuisiga does have clean water and sanitation much of the rhetoric village inhabitants have heard is based on national policy, which represents statistics of the nation. This means that in many villages throughout the country inhabitants have been and are still at risk of encountering infectious diseases during their daily lives. The event of birth exposes both the delivering woman and the infant to the elements at a very vulnerable time, and infection can be a common complication after delivery (Shorter 1982). The government strategy of relocating births to the hospital guarantees access to clean sources of water and provides a sanitary environment to the mother free of charge. This change of location is a response to real health threats, and the country has seen declines in infant mortality as a result of such policy changes. In contrast, the parallel transition in the United States was not focused on any perceived health benefits of hospital births and not surprisingly was not followed by a decrease in infant mortality rates. In fact the United States' infant mortality is rated 50th in the world, despite the country's over 99% hospitalization rate for birth (Block 2007).

One of the main factors for the transition to hospital births in the United States was the convenience and efficiency that hospitals provided. Relating this to the Fijian situation we see that most Fijian women do not have the same concept of convenience as American women. To Fijians the concept of anesthetics for birth is foreign, there are no demands for pain management and the hospital does not even provide such services. In most respects the care the hospital staff

offers is more comparable to that of an American midwife. During my interviews no woman mentioned anything about desiring pain medication for her delivery. In addition to the lack of pain medication, most of the other medical interventions common in the United States are not offered at the rural Fijian health centers either. This lack of intervention does not indicate a lack of educated staff, as staff members are licensed doctors and nurses. However, it does indicate a cultural difference between women in the United States and Fiji, in the sense that Fijian women do not desire to intervene in the birth process and alter the natural progression of their birth.

They do not attempt to remove the pain from their delivery and pain during birth is something that every woman expects (Morse 1989). This more prominent acceptance of delivery pain is not an indication of the Fijian woman's lack of pain during childbirth; they certainly find birth just as painful as do women in the United States. In fact "pain" is what most women used in reference to 'contractions'. Each of these different women addressed her contractions as the beginning of 'the pains' demonstrating what an important role pain still plays in delivery,

Woman: I was 21 years old. I had pains and then I went to the hospital and gave birth there.

Woman: With my first child I felt the pain and then went by taxi.

Woman: When I first had pains it took me one whole week.

Woman: It was easy to give birth to the first daughter but for the other 3 it was much harder and they were all boys.

It is also clear from this last statement that there are cultural beliefs about the different sexes causing more or less pain during delivery, but through such remarks it is clear that women have no illusions about birth being painless. In regards to gender, throughout my interviews I heard no preference of one gender. There were lingering ideas as seen above about the pain or experience

of birthing either a boy or a girl, but there seemed to be no preference for one. One woman explained this difference in her experience,

Woman: ...there is a difference when I am about to give birth to a boy of a girl, if I have this pain and I am about to give birth and I see blood coming out then I know it is going to be a baby boy but if no blood then it is going to be a girl.

Fiji as a culture is very pro-natal and being a mother is still a core part of being a Fijian woman. Having children is a common occurrence and most women desire to have multiple births throughout their lives. Although the average number of births has been decreasing in recent decades (NationMaster 2013). This is visible even at the small scale of my sample, with the younger cohort having on average 2 fewer children than the older cohort. Although these women desired fewer children, still no one I interviewed stated they desired no children, a difference when compared to the United States. While families in the United States expect fewer births and give each birth more significance, Fijians still relate to childbirth as a more common day-to-day event. This is not saying that they are bored by birth but that its occurrence is common; someone in the village is always pregnant. The pains of childbirth are just another fact of life for Fijian women, something as guaranteed as the preparation of the evening's meal.

This acceptance of pain can be seen as a positive for Fijian women; they are still in touch with the natural processes of their bodies and do not desire to disguise or eliminate those processes by means of medications. Women in the United States and many other Western nations have associated birth pains as a savage thing that animals endure and in turn something to get as far away from as possible. They also think of birth pains as something that the practitioner can control, an experience external from their bodies (Block 2007). Birth and being a mother are still somewhat linked to traditional ways of life, ways of life still tied to strict gender

roles. In countries like the United States, where women have more economic autonomy and more gender equality, strict gender roles are not as enforced and in effect more women are choosing occupations besides or in addition to being a mother. If we compare the United States to Fiji in this respect, we can see that gender inequality in Fiji remains high. The gender inequality index measures gender inequality in three dimensions, reproductive health, empowerment, and the labor market. This index gives Fiji a rating of 0.391 (UNHDR 2005, 1 representing total inequality and 0 total equality). In comparison, the United States rates at 0.256, a lower score than Fiji but still not comparable to European nations, some of which have ratings below 0.1 (UNHDR 2012). Gender inequality in Fiji is still prominent in the workforce, with women representing only 49.4% of the workforce, compared to 82% in the United States (UNHDR 2011).

Considering these aspects we can see that there are positives and negatives to each birth model. Fijian women are more in touch with the unique aspects of being a woman and revel in their power to give birth and endure the pain of those births. Perhaps though, it is the resilient gender inequality present in the country that prevents women from separating themselves from their reproductive cycles. I wonder if it is possible to retain this connection to the natural reproduction while also increasing gender equality and promoting female autonomy. Consider also that Fiji's birth model is not decided upon purely by Fijian women regardless of their personal autonomy, the health care system of Fiji is entirely paid for by the state, meaning that ultimately the Fijian state has a great deal of sway over the policies relating to birth. However, the participants of the health care system can choose whether to use the system as it was intended or to use it otherwise.

Breakdown of Primary Health Care

Many Fijians are now redirecting themselves to the main urban hospitals and breaking down the system put in place decades ago in which all patients first go to their local health centers. At these local health center patients would be treated for minor ailments and if necessary be redirected to the larger urban hospitals. In recent years many of these rural centers became inadequately staffed or ill equipped to treat all of a patient's needs. Probably as a result of this many pregnant women are again skipping the intermediate steps and going directly to the regional health centers in urban areas such as Suva.

Interviewer: How do you feel about giving birth in the village with a trained midwife?

Woman: If there was a trained midwife I still wouldn't like to give birth here I would prefer to go to Suva, because you will end up there with complications anyway so why not just start there.

This attitude makes sense thinking practically, if something goes wrong at the rural health center then a mother in delivery will need to be transported to Suva, a time delay that could potentially be dangerous. Even though the rural center has this backup built-in, many mothers would prefer to be in the adequately staffed and better-equipped facility. This is understandable, as everyone wants the best care possible, but since complications are unlikely for most low-risk pregnancies, a low-risk woman being in the Suva hospital simply clogs up the medical system and denies someone who may have a severe complication from receiving the care they depend on. We can also see that over the past generation Fijians have come to rely more on modern techniques than traditional birth knowledge, for example one Vuisiga woman described how her birth experience was different than that of her daughters:

Woman: It is more the same, they all have birth at the hospital and I see that whatever happened to me also happens to my children. The only difference is the c-section. Before the nurse would put her hand in you and move it around and make it birth but now if you can't deliver your own baby you have to go to Suva immediately. Before if you couldn't give birth, they had much more knowledge of childbirth and if the baby is inside they can

change the baby position. Then the mother could deliver.

This is an example of how the Western model has taken hold; with the enthusiasm of the introduction of Western birth techniques most of the women possessing knowledge of natural birth died without passing it on. I heard many times that there is simply no one left who knows how to traditionally birth a child, in particular how to help when something is wrong. This lack of traditional knowledge has made Fijian women even more resistant to giving birth in the village. I heard time and again that the women were scared because no one in the village would know what to do in the event that something went wrong. If the baby were in the wrong position for example, a woman with traditional knowledge would know how to reposition it. However, many would observe this lack of knowledge as a positive as it might not be safe to manually change the position of the baby, especially if sanitation is poor and infection prevalent.

When we look to how Fiji has responded to its exposure to the Western health care model we can see that the country has adopted many practices of the West. We can also see that they have left out many practices common in the United States. It seems that Fiji has extracted the policies and procedures that they find beneficial and applicable to their system. For example, because of the issue of sanitation in the rural areas Fiji has adopted a policy of strongly encouraging hospital births. However, because Fijian women do not prioritize convenience or pain management, the hospital largely provides the type of care that midwives in the West do. The hospital also provides a safety net if medically necessary with the ability to perform cesarean sections, with an ambulance standing by to transport any woman in need to the Suva hospital. These are all staples of the Western birth model but in Fiji they are used sparingly and in culturally appropriate ways. These policies are mindful of the rural status in Fiji, with many women living in remote areas. The Fijian Ministry of Health works to provide these women with

access to safe and sanitary birthing rooms, using Western models for these aspects but largely ignoring the use of many medical interventions that Fiji finds unnecessary at this point. Although Fiji has incorporated the cesarean section into their health management they do not offer the surgery electively but solely in medically necessary situations. Again Fiji Ministry of Health has adopted the cesarean section but has not followed the way in which the United States, for example, uses the procedure. The Fijian government has stepped in not out of liability or lobbying but in order to watch out for the greater good of the citizens. This tendency is rooted in the culture of Fiji and reflects a community focus and a sense of group responsibility.

When taking a step back, the Fijian birth model itself is very different from the United States birth model. Fijian health care uses Western procedures but uses them sparingly and in culturally appropriate ways. Although it is apparent that Fiji has been inspired by medical procedures of the West there has not been the same abundance of use. It is hard to determine the reasons for this discrepancy but surely there is basis in the differing cultures and values of the United States and Fiji. Likewise, the status of women plays a large role in how powerful they feel in regards to their own delivery. The privatization of health care in the United States has led to health care being treated as a commodity to be sold on the market, whereas in Fiji health care is universal for all. These and likely many more factors play a role in the development of maternal and infant health care programs and effect how they change throughout time. This paper attempted to illuminate the expansion of the Western birth model into international territories but also to point out how the individual culture of each country plays a large role in determining how a birth model develops.

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Appendix 1

Interview Questions

Older Cohort

1. Could you tell me about the births of your children?
When did you give birth to your first child?
How old were you?
What do you remember about it?
2. How do you feel about these experiences?
Would you change anything?
3. How and where would you give birth if you were pregnant again?
4. What can you remember about births during your childhood in your village?
5. What is your idea of a good birth?
6. How was your birth experience different than your daughter/granddaughter/niece?
7. How have practices changed since you gave birth to your first child?
8. How and where would you like your daughter to give birth today?
9. How do you feel about giving birth in the village with a trained midwife?
10. How do you feel about giving birth in the hospital?
11. Why do you think women no longer give birth in the village?
12. What ceremonies are there for when a baby is born?
13. Do you still practice these rituals? Roqoroqo?
14. How has the prevalence of these rituals changed over your life?

Younger Cohort

1. Could you tell me about the births of your children?
When did you give birth to your first child?
How old were you?
What do you remember about it?
2. How do you feel about these experiences? Would you change anything?
3. How and where would you give birth if you were pregnant again?
4. Did you breastfeed your children and for how long did you breastfeed each of your children?
5. How many children would you like to have?
6. How many children would your mother like you to have?
7. How many children would your husband like you to have?
8. How will you prevent pregnancy?
9. How do you feel about giving birth in the village with a trained midwife?
10. How do you feel about giving birth in the hospital?
11. Why do you think women no longer give birth in the village?
12. What ceremonies are there for when a baby is born?
13. Do you still practice these rituals? Roqoroqo?
14. Do you think it is important to keep these rituals alive?