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Assessing UNHCR's sexual and reproductive health programme in Guatemalan refugee settlements

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List of abbreviations

MISP	Minimum Initial Service Package
NGO	Non-governmental organisation
PROSECO	Promotion of Community Services
RH	Reproductive health
SGBV	Sexual and gender-based violence
SRE	<i>Secretaría de Relaciones Exteriores</i>
STIs	Sexually transmitted infections

Glossary

<i>campesinos</i>	rural agricultural labourers
<i>maquila</i> industry	manufacturing operations in a free trade zone
<i>Secretaría de Relaciones Exteriores</i>	Ministry of Foreign Affairs

1 Introduction

The UN and other multilateral agencies in the fields of relief and development, under the premise of promoting gender equality, increasingly identify reproductive health care to displaced people as a ‘durable solution’¹ to prevent maternal mortality, complications following abortion, sexual and gender-based violence (SGBV), and sexually transmitted infections (STIs). The UNHCR response to displaced Guatemalan’s seeking asylum in Mexico is the first case where gender equality discourse was used to justify the inclusion of health interventions to respond to SGBV in its humanitarian projects. Questions remain on how gender equality discourse became institutionalised within UNHCR and its impact in shaping health interventions. What role does gender play in shaping health provision, specifically reproductive health, to refugee communities? What lessons can be gained from displaced communities in their provision of health services? To answer these questions, this paper presents findings from ethnographic research among forced migrants² living in La Gloria, the largest of the 36 original refugee camps, located in the southern state of Chiapas, Mexico.³

The paper is divided into three sections. The first section provides some historical background to the military conflict in Guatemala, the impact on indigenous communities, their exodus, resettlement and reception in Mexico. A review of the methodology used in the selection of participants in the community of La Gloria is complemented by demographic information and ethnic composition of these borderland communities. With attention to gender inequalities, the second section examines UNHCR’s free reproductive health programme in Guatemalan refugee settlement camps. I explore how discourses of reproductive health are placed by UNHCR within a gender equality framework that informs how UNHCR targets women as appropriate recipients of reproductive health interventions. The third section focuses on the experiences of Juanita and Angelina, the oldest mid-wives in La Gloria, and their unique contribution in cultivating local health practices and dismantling gender hierarchy among Guatemalan forced migrants in Mexico. A review of the literature that documents multilateral humanitarian and state institutional support to mid-wives – identified as a first line of defence in reproductive health systems infrastructure – will reveal ongoing

¹ The term ‘durable solution’ is commonly used by UNHCR in shaping its protection mandate for refugees according to: a) the 1951 UN Convention relating to the Status of Refugees b) regional legal instruments shaped through the jurisprudence of a large number of States c) issues related to underdevelopment and poverty d) secondary migration due to serious protection problems in country of putative asylum e) disparities in services provided by UNHCR in different countries f) ‘mixed movements’ that involve a smaller proportion of people who have a need for international protection and larger proportion of people who are moving for reasons unrelated to refugee status g) victims and potential victims who face or may face human rights violations experienced during trafficking (UNHCR 2007).

² Forced migration involves the ‘permanent or semi-permanent change of residence, usually across some type of [intra-state or international] administrative boundary’ (Wood 1985), commonly linked to military violence and natural disaster, but often the product of wider processes of social and economic change, processes that are normally referred to as ‘globalisation’ (Castles 2003: 16). Forced migrants are “‘ordinary people’, or ‘purposive actors,’ embedded in particular social, political and historical situations’ (Turton 2003: 1).

³ Funding for this project was provided by the University of California Institute for Mexico and the United States, and the University of California President’s Dissertation Fellowship.

marginalisation to medicalised forms of care. I conclude with a brief commentary on how reproductive health programmes in forced migrant communities can be improved to promote substantive gender equality, and argue that institutionally driven development approaches that focus only on reproductive health as a panacea miss the mark in addressing underlying sources of gender inequality in forced migrant communities.

2 Methodology and background

Military conflict in Guatemala throughout the 1980s and late 1990s, fueled by cold war politics and its aftermath, led to the forced migration of over a million people throughout Central America, Mexico, the US, and Canada. Historian María Cristina García identifies the majority of over two hundred thousand Guatemalan forced migrants that fled to Mexico as *Maya campesinos* (rural agricultural laborers), young (more than 60 percent were under the age of twenty) and with less than a quarter fluent in Spanish (2006: 45). La Gloria is one of 36 original refugee camps – with as many as 46,000 established vibrant autonomous communities – located throughout the southern state of Chiapas, Mexico. La Gloria is strategically located near one of the busiest official entry points to Central America and the interior of Mexico. An unpaved dirt road (6km) connects La Gloria to the principal Panamerican highway that serves as the main artery to travel north to the municipal head of government in Trinitaria (25km/15miles) and the city of Comitán (40km/25miles), and south to the Guatemalan border of La Mesilla (30km/19miles). La Gloria remains the largest refugee settlement in southern Mexico. As of 2007, La Gloria was comprised of 482 families and 2,300 residents, who live on 72 hectares of arid flat land with sparse amount of foliage (Ruiz Lagier 2007: 102).

In the summer of 2004, I visited La Gloria, and as a sign of my respect to community members' experiences of forced migration, I approached the all-male leaders of the community for permission to conduct fieldwork. The leaders of the community requested that I present my project to the entire community during their monthly general assembly. I presented my research in Spanish, which was also translated into Acateco, the indigenous language of the majority of La Gloria residents. Monolingual mestizos⁴ and other ethnic linguistic groups, Mam and Chuj, comprise a small minority in La Gloria. While mestizos predominantly speak Spanish, and efforts are made to integrate their language in community-wide functions, they do not maintain a visible majority nor do they control the cultural and political structures of the community, which creates tension in the form of racial and ethnic antipathy toward the majority group. Fortunately, after having discussed the research design during the general assembly, La Gloria residents overwhelmingly approved my project through a general vote.

⁴ Anthropologist Diane M. Nelson (1999) defines mestizo as a category that collapses ladino identity – an ethnically diverse category that is distinguished by people that identify as not-Indian. The mestizo category sublates racial differences that resonate with modernisation narratives, which distinguish the Indian/Indigenous category as a marker of everything backward.

Until 2007, I returned yearly to conduct observational fieldwork and recorded formal and informal interviews with teachers (n = 10), medical health practitioners (n = 5), community health promoters (n = 2), health auxiliaries (n = 2), midwives (n = 2), high school students (n = 19), and adult members of the community (n = 28). All interviews were conducted in Spanish. The majority of residents are fluent in multiple languages (particularly the younger generation of Mexican-born nationals), but when translation to Acateco was needed, a family member would usually volunteer to provide translation.

Throughout the years I spent in La Gloria, I lived with the family of Don Miguel and Doña Mikaela, which gave me the opportunity to establish rapport at a more intimate level with participants. The decision to live with community members provided the opportunity to attend religious and cultural celebrations, sporting events, school classrooms, clinics, graduations, and funeral ceremonies that would have otherwise been inaccessible. I interviewed a diverse array of community members who shared different experiences of life in La Gloria. For instance, the elder generation (between the ages of 45 to 100) shared experiences of the military conflict in Guatemala, the family ties and property they left behind, and the long and difficult years of exile. This generation survived military warfare in Guatemala, opposed UNHCR's wish to repatriate them back to Guatemala, and rejected the Mexican state's plan to relocate them to the states of Campeche and Quintana Roo. A younger generation (ages 30 to 45) shared experiences of growing up in the border area of Mexico and Guatemala, and their struggle with the Mexican state to maintain the cultural knowledge of their parents and keep a degree of autonomy alive in the community of La Gloria. Another group (ages 20 to 30) shared experiences of emigration to the US, or of a conjugal partner who received remittances for the upkeep of their family. The school aged population I interviewed (ages 17-19) shared their dreams of pursuing higher education or, due to the prohibitive cost of a college education, of migrating to the urban areas of Mexico and the US for employment. Many of these students knew family members or friends that migrated to the Mayan Riviera to seek jobs in the tourist sector, in the *maquila* industry (manufacturing operations in a free trade zone) in Tijuana, or in the US where many worked in the informal sector in the states of California, Colorado and Florida. These family ties provided a rich network that could provide resources upon arrival to the US, making migration a viable option for the younger generation to improve their socio-economic status.

To complement this rich data, I reviewed secondary sources that include conference papers, academic journals and texts that assess UNHCR's humanitarian assistance to refugees, and in particular, its response to the Guatemalan refugee crisis. The literature reveals how Cold War politics impacted UNHCR's humanitarian mandate to aid refugees, and how UNHCR utilised gender equality discourse to legitimise its newfound mission: to protect refugee women from SGBV. To accomplish this goal, UNHCR integrated a sexual and reproductive health component to its humanitarian mission in Guatemalan refugee settlements in Mexico. The following section traces the formation of gender equality policy-making in relation to development discourses, which shaped how UNHCR devised and implemented sexual and reproductive health interventions as a way to eliminate SGBV in Guatemalan refugee settlement camps. I review an independent evaluation of UNHCR's sexual and reproductive health intervention to determine its ability to further gender equality goals, and raise questions concerning its approach to health surveillance, and the cultural framework used to explain differences in fertility outcomes between refugees and citizen-nationals in Mexico.

3 UNHCR's gender mainstreaming programmes on reproductive health services in La Gloria

In the 1990s, at the end of the Cold War, many nation states redesigned immigration policies to restrict the number of asylum seekers. Increased restrictions in the reception of migrants coincided with a retrenchment in funding provided by Western states to UNHCR.⁵ These changes impacted UNHCR's ability to exercise its protection mandate of refugees, which now favoured 'assistance' in the form of repatriation over that of resettlement as a durable solution, and restricting asylum procedures in receiving Western states (ibid). Additionally, UNHCR's policy shift towards refugee women took a top-down conservative perspective on women's rights, and underpinned its gender programming that prioritised efficiency models of economic growth.

UNHCR's gender programming, shaped by discourses of development, has involved three phases within the paradigm: Women in Development (WID), Women and Development (WAD), and Gender and Development (GAD). Liberal feminists of the 1970s 'gave primacy to women's productive roles and integration into the economy as a means of improving their status' (Razavi and Miller, 1995: 2). The WID approach responded to women's invisibility and exclusion from development (Moser 1993), and aimed to 'mainstream' women as part of efficiency models of economic growth. Gender mainstreaming, under the WID paradigm, placed emphasis on what women could contribute to economic development that became synonymous with gender equity (Bhavnani et al. 2003). Similar to the WID paradigm, WAD focuses primarily on the economic agency of women, but its Marxist-feminist class-based understanding of the marginalisation faced by women shifted its focus towards investing in the agency of women rather than the influence of institutions on them (Singh 2007). None of these approaches, however, considered how to redistribute wealth while simultaneously dismantling institutionalised forms of patriarchy within humanitarian agencies and in communities targeted for aid.

The 1995 Beijing Platform for Action, adopted at the Fourth World Conference on Women, challenged the WID and WAD approaches by identifying how women's issues require an analysis of masculinity and power inequalities across gender (Baines: 2004: 54). This allowed the GAD approach to challenge economic efficiency models and class-based understandings of gender inequality on the grounds that it aims to not 'only integrate women into development, but [to] look for the potential in development initiatives to transform unequal social/gender relations and to empower women' (Bhavnani et al. 2003: 5), citing Canadian Council for International Co-Operation (CCIC 1991). Despite a shift in the feminist literature toward an analysis of gender power differentials between men and women in development programmes, UNHCR's liberal gender mainstreaming framework downplays the global inequalities between North and South that privilege cosmopolitan feminist approaches in distinguishing the best practices in promoting gender equality.

Feminist scholar, Inderpal Grewal, identifies cosmopolitan feminism as a privileged stratum that applies disciplinary liberal humanitarian knowledge to promote security *for* women in third world countries (2005). Cosmopolitan feminists, in order to distinguish themselves as

⁵ UNHCR is 'entirely dependent upon Western donor funding to carry out its protection mandate... [and] up to 98 percent of UNHCR funds comes from states' (Baines 2004: 5-6).

autonomous individuals, Grewal argues, depend on the reinforcement of ‘neocolonial racial, gendered, and classed discourses’ (2005: 162) that further ‘transnationally produced knowledge...to create the refugee [female] subject’ (ibid: 161) as victim. Cosmopolitan feminism influenced how refugee migrant women were constructed in the policy oriented field of refugee studies as *vulnerable* subjects in *need* of humanitarian assistance (Nyers 2006), in effect – lacking agency. This literature, however, contradicts migration scholars that identify women as active participants in the informal global economy and in the management of remittances that grant women some space to challenge unequal gender power norms (Kibria 1993, Hondagneu-Sotelo 1994). By naturalising refugee women as *vulnerable* victims, these discourses reinforce the labeling process that privilege policy expert knowledge about refugees and avoids an analysis of the sex/gender⁶ political apparatus used to identify appropriate and inappropriate bodies that can inhabit a nation-state.

Grewal argues that ‘transnationally connected American cultural feminism on sexual abuse as the dominant expression of the oppression of women [shaped] the paradigmatic experience in constructing the female refugee’ (2005: 162). The discourse of feminine refugee vulnerability is linked to a heterosexual complementary⁷ that frames masculine warrior men as perpetrators of violence. Indeed, female bodies are largely viewed by humanitarian aid agencies as ‘vulnerable’ to corporeal harm, while militarised ‘warrior’ men and women, due to the presumed danger they pose to human, national, regional, and international security, are viewed by states as inappropriate bodies eligible for refugee status and asylum (Nyers 2007: 102). Constructions of refugee ‘vulnerability’ are gendered: women are largely represented by international agencies as victims of state-sanctioned violence and sexual assault and in need of protection from men who are largely perceived as perpetrators of SGBV. The construction of SGBV as an issue of grave concern naturalises relations between men and women in developing countries as heteronormative and exploitative.

Ironically, UNHCR’s association of refugee women as the quintessential vulnerable subject fleeing persecution was simultaneously framed along the trope of maternal resiliency in the reproduction of the household (ibid: 46). Framing refugee women as helpless strengthened the financial position of UNHCR as a benevolent organisation that can offer developed country protection and fundraise on behalf of non-threatening ‘vulnerable’ and dependent women. While the trope of ‘vulnerability’ rendered refugee capabilities invisible, the gendered script of maternal resiliency allowed for the incorporation and participation of refugee women as agents in the planning of protection and assistance programmes. Such participation, however, follows an ‘add women and stir’ model whereby refugee women are depoliticised in redressing gender inequality in community settings and institutions, which fulfils an economic need to realise ‘cost effective’ self-sustaining camps (Forbes Martin 1992: 11). I argue that UNHCR’s ‘add women and stir’ gender mainstreaming model, and the

⁶ Rubin first introduced the concept of the sex/gender system into feminist theory. She defines it as ‘the set of arrangements by which a society transforms biological sexuality into products of human activity and in which these needs are transformed’ (1975: 159).

⁷ Butler, elaborating on the ‘heterosexual complementary’ ascribed to gender argues: ‘Gender can delineate a *unity* of experience, of sex, gender and desire, only when sex can be understood in some sense to necessitate gender. The internal coherence or unity of either gender, man or woman, thereby requires both a stable and oppositional heterosexuality. Thus we see the political reasons for substantializing gender’ (1990: 23).

heterosexual complementary discourse, combined to 'discipline' gender in refugee populations. Similarly, UNHCR's approach to redressing SGBV used reproductive health interventions for the purpose of making women's bodies legible as objects in *need* of medicalised care.

Guatemalan refugee settlements in Mexico served as a testing ground for the provision of reproductive health services, which was framed by UNHCR as a viable strategy for the reduction of SGBV. A gender mainstreaming approach informed UNHCR's programmatic response to the Guatemalan forced migration to La Gloria, which involved the following projects:

- Training for refugee workers in women's rights issues
- Training for field staff in the application of the law in condemning perpetrators of sex/gender violence
- Construction of a women's shelter to seek refuge from gender violence
- Workshops on self-esteem and human rights
- Working with men who perpetrated violence
- Information workshops on reproductive health services: infant mortality, breastfeeding, maternity, and the training of health promoters (Baines, 2004: 85).

The weaknesses of these projects were twofold. First, these projects, while quite progressive in addressing gender power inequalities by training men about the significance of women's rights, UNHCR's capacity-building strategies in refugee communities to address gender inequalities were limited because parallel work on dismantling male structures of power did not take place (Worby 1999: 36). Second, UNHCR's work with local health institutions in Mexico, provided women's health services in La Gloria as a means to affirm women's decision making power regarding reproductive matters, but unintentionally reinforced the burden of care towards women. For instance, the General Hospital of Comitán distributed contraceptives to community members that included condoms, pills, and injections, but because, as scholars have noted elsewhere, women are largely viewed as custodians of household health, male participation in reproductive health projects was overlooked.

An examination of the capital and human investment on health issues reveals how gender inequalities were reinforced through the sexual regulation of women's, and not men's, bodies. A remarkable 90 per cent of UNHCR's investment of \$1.7 million, nearly one-third of a total \$5 million US dollars allocated to respond to the displacement of Guatemalan forced migrants living in Chiapas, focused on the provision of health services for women, while allocating only 10 per cent for men. Women who learned about risk-reduction mechanisms to prevent STIs faced an increase in their burden of self-care. This risk-reduction strategy has the potential of increasing gender-based violence toward women, who are expected to share this information with their largely 'uninformed' male partners, which places them at risk of being accused of infidelity, of not trusting their partners and possible physical abuse.

Despite this lopsided sexual health education programme in La Gloria, an independent study by Laguna Morales et al. (2004) positively frames UNHCR programmes in 10 former Guatemalan refugee settlement camps in Mexico for their ability to further 'gender empowerment'. These former settlement camps were compared to four other communities in Mexico that did not receive resources provided by UNHCR. The study identified educational

workshops for men that address gender equity as vital in promoting gender empowerment. Education workshops, the report argues, reduce cases of violence within and outside the family, advise women to get a pap smear (to prevent the spread of STIs from a sexual assault), and also provide information on how to regulate fertility (ibid: 21).

Members of communities that received humanitarian assistance, the report adds, have greater knowledge of how to identify violence, particularly how to respond to cases of violent behavior, attend the doctor with greater frequency,⁸ and receive Pap smear tests in greater numbers. An increase in Pap smear tests, however, does not mean that women receive the appropriate diagnostic treatment to prevent the onset of cervical cancer and uterine cancer. A study with women in the state of Oaxaca who had a Pap test (Castañeda 1999) reveals that visual explorations rather than vaginal cytology – the official norm for this type of test – were used as a standard diagnostic tool due to lack of infrastructure.

Women in communities that received humanitarian aid, however, have higher fertility rates: up to one child more than the communities that did not receive gender equity workshops. To explain this discrepancy, Laguna Morales et al. (2004) argue that the state applies a family planning model to reproductive health, while non-governmental organisations (NGOs), prior to providing contraceptives, allow women to make educated decisions and distribute information on the regulation of their fertility. Instead of examining how humanitarian and state approaches to reproductive health may differ, the report lumps both sets of communities and identifies ethnic cultural differences, where families view having many children as important, as the underlying cause for the fertility rate to be three times the national average in Chiapas. To link higher fertility rates to cultural differences, however, ignores social science studies that identify links between poverty and fertility.

A better explanation as to why fertility rates are higher among refugee communities than Mexican nationals can be found in the prolonged delay in providing naturalisation. Mexico's *Secretaría de Relaciones Exteriores* (Ministry of Foreign Affairs, SRE) delayed the distribution of naturalisation documents by six years, formally finalised in 2006,⁹ and due to many Mexican institutions unwillingness to recognise their temporary visa status, reinforced discriminatory treatment that limited barriers to employment for more than twenty years. Indeed, barriers to naturalisation that limited employment opportunities, and not gender mainstreaming approaches underpinning humanitarian reproductive health strategies – which formally came into effect in 1997, fifteen years after the initial arrival of Guatemalan exiles, by UN institutions – can better explain why fertility rates have been higher among Guatemalan forced migrant communities over Mexican born nationals.

A 2005 study of marginalisation in Mexico provides important data that can help explain the structural reasons for the heightened fertility rate in the state of Chiapas. The study revealed that in Chiapas, 78 percent lack two minimum wage-earning heads of household, which is

⁸ Of the women interviewed in refugee settlements, only 11 percent have never seen a doctor, compared to 42 percent in other Mexican communities (Laguna Morales et al. 2004: 21).

⁹ In a 2006 interview with Juan Pablo Cordero Guillén, Municipal Director for the SRE in Comitán, he identified as many as 90 naturalisation documents that have yet to be distributed in Chiapas. To date, Cordero Guillen mentioned a total of more than 5,000 naturalisation documents have been distributed in Guatemalan refugee settlements.

three to four times greater than the industrialised border states of Baja California (14.2) and Nuevo Leon (23.5) (Anzaldo Gómez and Prado López 2005). Comparing data on the fertility rate in Chiapas and these three states, reveals that in 2000 women in Chiapas, on average, had 2.9 children, a number greater than Baja California (2.2) and double that of Nuevo Leon (2.1) (CONAPO 2000). Thus, poor families have to stretch their budgets for many family members. Ethnicity also plays a significant role in exacerbating income inequalities. For instance, figures from 2002 indicate that predominantly indigenous municipalities (more than 40 percent indigenous) incomes amounted to just 26 percent of the non-indigenous population (Ramírez 2006: 156). Indeed, an examination of ethnicity, class, and citizenship status provides a better assessment of the underlying structural reasons for the higher fertility rates in Chiapas. Discrimination and marginalisation of indigenous populations in Mexico from public health services, compounded under conditions of forced migration, combined to shape the increased fertility outcomes among Guatemalan refugees in Mexico.

In contrast to the institutionalised approaches to health provision advanced by UNHCR, the fieldwork I conducted in La Gloria with midwives reveals the important role they play in promoting culturally sensitive community health. Midwives, I argue, challenge UNHCR's ability to promote effective reproductive health programmes and redress gender inequalities, to which I now turn.

4 Prenatal and postnatal care in La Gloria



Image: Juanita and Angelia, the eldest midwives of La Gloria, sit in front of Angelina's home in La Gloria. © Manuel Gil.

Midwives play a pivotal role in both prenatal and postnatal care in La Gloria. Juanita (age 101) and Angelina (age 82), photographed by Manuel Gil in front of Juanita's home, are La Gloria's oldest midwives. Juanita and Angelina have played important roles assisting hundreds of women to give pre and post birth care. Their expertise became particularly important during the treacherous exodus from Guatemala into Mexico in the early 1980s. These two women, without immediate access to potable water or medical aid, were critical health providers. Their knowledge in prenatal and postnatal care enabled five women, who gave birth to children while traveling clandestinely to La Gloria, to survive despite the lack of basic resources.

In spite of their advanced age, both women continue to work as midwives, and through the help of a local NGO, Promotion of Community Services (PROSECO), which offers reproductive health (RH) and general health services to Guatemalan forced migrants in Mexico, provide instruction to women in neighbouring communities and throughout the state. Juanita, fluent in four languages – Chuj, Mam, Kanjobal, and Castilian – has been a midwife since age 35. During a Guatemalan military attack in the settlement of Chupadero, she suffered the loss of her adopted son. He left behind a wife and five children, who migrated north to the US. Their remittances helped pay for the construction of Juanita's home in La Gloria. Juanita emphasised that she had never experienced childbirth, and when asked how many children she helped give birth to, she quickly mentioned that the number was too large for her to remember. She also practices traditional or folk medicine to help remedy common ailments. Angelina is also trained to provide epidural injections, which she uses, when needed, to minimise the pain experienced by the birthing woman. Throughout their many years as midwives, neither Juanita nor Angelina suffered the loss of a woman's life or that of a newborn during childbirth.

An informal interview with Angelina, who has been a midwife since age 20 and organiser of La Gloria's midwives for the last 23 years, discusses the importance of providing personal prenatal care as early as the second month of pregnancy:

Ó: . . . you go see the women once they reach two months of pregnancy and for every month thereafter?

A: Yes. Midwives also...because we know...it is why we make ourselves responsible, because we have lived experience. We have to massage, to know how they [the fetus and mother] are...there are occasions that the head is located here, there are other times that it is located on the other side and there are times when the head is not here [pointing downwards to the pelvis]. If the head is here, there will be no complications during birth, but if the fetus is sideways, then we have to move ahead with an operation [cesarean-section in Comitán].

Ó: Then it is the midwives that decide when it is necessary to receive an operation?

A: Yes, when the midwife knows how to massage and straighten the fetus – we have to turn it like this, massage well – see where the head is, if the foot is here [pointing to her lower abdomen] let's place the foot here [pointing to her upper abdomen], we raise the head over here see, and it passes here, this is where the head is located, it has to be located in its rightful path. This is how one has to do it.

Ó: And have there been many occasions that an operation has been needed?

A: None [with me] here.

The expertise of midwives in providing prenatal and postnatal care provides valuable interventions in preventing neonatal and maternal mortality and morbidity.

Angelina, during the course of the interview, expressed her willingness to share her knowledge with Mexican midwives.

Ó: Do you like being a mid-wife?

A: Oh yes.

Ó: Is it nice?

A: Yes, to help the sisters. I also worked with the Mexicans.

Ó: You also help them?

A: Yes.

Ó: And they already know you? Do they come here to seek your help?

A: Yes.

Ó: And in which areas did you help Mexicans give birth?

A: Aquispala...Agua Palomas, Candelario, Zapote, many!

The lived experience and knowledge base of midwives is a cultural asset that has allowed them to engage with and provide health services to their home communities and to the Mexican host society. The ability to provide prenatal and postnatal care to neighboring Mexican communities, many with large indigenous populations, is fueled by indigenous women's historical distrust of Western-trained medical professionals, particularly men, during physical examinations. Women in La Gloria have expressed tension and insecurity when requested by health professionals to remain partially naked while wearing a medical robe or to use stirrups (the lithotomy position) during birth. Many indigenous women view this position as unnatural vis-à-vis the kneeling position used by their mothers and grandmothers. They also assert that women are not properly consulted when cesarean section is to be used. Midwives, however, are viewed by women with greater trust due to the care they provide throughout the pregnancy, and their common cultural values and shared linguistic background. Their work is particularly important considering the continued 'lack of government recognition and support for the work they do' (González Montes 2002: 19).

Midwives are identified as serving an important intermediary role between allopathic medicine and traditional medicine in rural and urban regions of Chiapas (Enciso and Manca 2000: 220). The Humanitarian Charter and Minimum Standards in Disaster Response identify midwives as a first line of defence in reproductive health systems infrastructure. These policies are activated in the early phase of a disaster, which include: 'identify[ing] an organisation(s) or individual(s) to facilitate its coordination and implementation; prevent and manage the consequences of gender-based violence, reduce HIV transmission; prevent excess neonatal and maternal mortality and morbidity; and plan for the provision of comprehensive RH [reproductive health] services' (ibid: 41). Many of these needs, however, have yet to be adequately implemented in Chiapas. Additionally, the publication identifies a Minimum Initial Service Package (MISP) for RH services, which provides 'a set of priority activities to be implemented during the early stages of an emergency (conflict or natural disaster)' (Matthews 2006: 4). MISP priority activities include 'on-the-ground staff to coordinate RH response across responding agencies; prevent and manage gender-based violence through enhancing security and providing medical and psycho-social response; reduce HIV transmission by making condoms available and assuring universal precautions in clinical settings' (Austin et al. 2008: 11-12). Midwives, while acknowledged as a first line of defence in implementing the

MISP, are limited by a lack of available resources in providing family planning, counselling, and referrals for emergency obstetric care, and reporting of gender-based violence. (Brennan 2004: 289-290).

The Inter-Agency Working Group on RH in Crisis, however, has questioned the availability of resources that would allow midwives to provide a number of the services outlined as part of the MISP (UNHCR 2004). This group conducted an evaluation based on 'a global survey of reproductive health coverage for refugee and IDP[s] [Internally Displaced Populations] in 33 countries' (Austin et al. 2008: 12). Some of the services that are not regularly offered include 'emergency obstetric care, clinical family planning methods, care for [adolescents] and survivors of gender-based violence and management of STIs' (Austin et al. 2008: 12). A more focused study of the provision of MISP has been conducted by a collaboration of groups in Mexico. Mama Maquin, an organisation active in the repatriation and education of women about their land rights in Guatemala; PROSECO; and UNHCR-Comitan reports identify cases of unsafe abortions (an option more common than contraceptives). High cases of STIs, such as gonorrhoea, have been identified, but there is a lack of reliable supplies of condoms, treatment or counselling for those that may test positive for HIV (Feingold and Jones 1998: 36-37).

Recommendations made by the Women's Commission for Refugee Women and Children call for improving reproductive health services, including counselling for those who test positive for HIV and availability of free condoms. In La Gloria, oral contraceptives are available, along with the injectable Depo Provera. Depo Provera, however, is not recommended during breastfeeding. Gender studies scholar Gonzáles Montes notes that 90 per cent of children with mothers in extreme poverty are breast-fed until nine-months old. Thus, the contraceptive options are further limited by the condition of women's lives. Alternative contraceptive choices that are financially accessible are required to ensure that the health of infants and women are not threatened.

5 Conclusion

A focus on the 'management' of refugees, who are commonly constructed as *needy*, has combined refugee and sexual rights discourse in legitimating the provision of reproductive health in UNHCR's multilateral humanitarian missions. Forced migrant women, labelled as refugees and vulnerable 'others', serve as productive bodies that legitimise the application of sexual rights as part of international human rights. The unequal application of reproductive programmes to men, however, results in men's invisibility from humanitarian health surveillance. The provision of reproductive health as a relief strategy to reduce SGBV reinforces knowledge-power inequities that add to the gendered 'circulation of discourses of rights of citizens and non-citizens' (Grewal 2005: 166). That is, women are considered appropriate while men are viewed as inappropriate beneficiaries of sexual reproductive health programmes that create different sets of challenges in eliminating gender health disparities in forced migrant communities.

My findings reaffirm anthropologists Ginsburg and Rapp's view concerning state policies aimed at controlling reproduction, in this case mediated through UNHCR,¹⁰ which they argue 'has depended directly and indirectly on defining normative families and controlling populations' (1991: 314). UNHCR's application of reproductive health care in La Gloria, with the premise of improving women's rights, views women as the appropriate bodies for reproductive health surveillance and caretakers, but by diminishing the burden of care work for men, compounds gender inequalities. The construction of refugee women as separate and subsidiary to masculine authority can help explain why UNHCR's gender mainstreaming approach to reproductive health overlooks gendered structures of power in favour of the surveillance of women's bodies. A direct consequence of UNHCR's gender mainstreaming approach to health care is the lack of institutional support and remuneration provided to La Gloria's midwives.

Indeed, the provision of reproductive health services by midwives has been severely hindered by multilateral aid agencies and government health programmes that fail to recognise and support their efforts. For midwives to be a first-line of defence in reproductive health systems infrastructure in cases of extreme disaster will require significant resources including appropriate training to provide family planning advice and emergency obstetric care, treat STIs, and counsel victims and perpetrators of sexual-based violence. Midwives, however, continue to play an important role in providing prenatal and postnatal care in La Gloria. The ability of Juanita and Angelina to provide substantial prenatal and postnatal care during the treacherous escape from Guatemala, while in exile in border communities in Chiapas, and now in La Gloria, is a testament to the resilience of these women.

¹⁰ UNHCR is 'entirely dependent upon Western donor funding to carry out its protection mandate...[and] up to 98 per cent of UNHCR funds comes from states' (Baines 2004: 5-6).

6 References

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