Biomedical care providers’ perception of indigenous midwives: an anthropological study in Sololá, Guatemala

Master thesis
handed in by

Ursula Wagner
Foreword

It was a large room. Full of people. All kinds. 
And they had all arrived at the same building 
at more or less the same time. (…) 
And they were all asking themselves 
the same question: 
What is behind that curtain?

Laurie Anderson: Born, never asked (1982)

Nearly one year ago I found myself in a classroom in Amsterdam together with a whole bunch of students from diverse professional and regional backgrounds to deepen my knowledge in medical anthropology. At this time it was not clear where my gaze would be directed to when the curtain, which Laurie Anderson is singing about, would be raised. However, reflecting on how this thesis came into being, and what I eventually made out of it, the red thread in my anthropological career becomes visible: power relationships fascinate me and guide me through the jungle of often unintelligible human behaviour and of possible anthropological research topics. Therefore I accepted the offer of a dear friend and colleague to do research among biomedical care providers and Mayan midwives in Guatemala without hesitation. This was the perfect opportunity to combine different interests: to follow my long-standing concern for “women’s issues”, to do another investigation on the relationship between biomedicine and so-called “traditional” medicine, to satisfy my wish to work as an “applied” but critical medical anthropologist, and to ameliorate my Spanish. Last but definitely not least I would eventually leave the (safe) armchair some friends already had assigned to me, and become a “real” anthropologist by undergoing the “rite de passage” of doing fieldwork. So it came that months later I found myself in another room – this time together with staff from health centres, midwives and NGO workers to have a look “behind the curtains” of pregnancy- and birth related care in the Guatemalan highlands. During my stay I fully enjoyed my role as curious participant observer trying to find out “what’s going on”. And although I am aware about the fact that my answer is – to use James Clifford’s expression – a “partial truth”, I would like to share in this thesis what I saw and heard.
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Amsterdam, 16th August 2004
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Abstract

This thesis is dealing with the relationship between Mayan medicine and biomedicine in the district of Sololá in the Guatemalan highlands focusing on how biomedical care providers perceive indigenous midwives’ knowledge and practices. In the first part theoretical concepts from medical anthropology are presented which deal with the complex relationship between different bodies of medical knowledge and their practitioners. Those concepts along with findings from previous anthropological studies and an outline on pregnancy- and birth related care in rural Guatemala should help to situate the findings of the field research.

The institutional framework of the field research was an NGO project from CARE Guatemala on the strengthening of Mayan medicine and the sensibilisation of biomedical care providers for aspects of Mayan cosmology and the role of indigenous midwives. Qualitative research in form of interviews, group discussions, informal talks and participant observation was mainly conducted with participants in this NGO project – biomedical care providers working in two health centres in the district of Sololá. Additional data were gathered with indigenous midwives and during visits in the hospital of Sololá.

The field research clearly shows that despite of efforts to enhance the biomedical care providers’ respect for the indigenous midwives and hence to ameliorate collaboration, they utter many complaints and allude to tensions. Regardless of their ethnic background – indigenous or Ladino – they claim authoritative knowledge over indigenous midwives and their knowledge and practices. Mostly, they legitimise this by referring to their own professional education. Thus, unlike indicated by other anthropological studies, the points of conflicts are not based on differences in ethnic background or gender, but are inherent in the relationship between biomedicine as institutionalised medical system and Mayan medicine as popular or folk medicine without clear training and standards.

Keywords: Guatemala, medical pluralism, authoritative knowledge, midwives, Mayan medicine, biomedicine.
Introduction

In a small Mayan village in the Guatemalan highlands an indigenous midwife goes to the local pharmacy: ‘A ver, hay un pastillo para el parto?’ She discovers a medicine called ‘Partosistema’ and buys it, as the Spanish word ‘parto’ means birth and she therefore assumes that it is suitable for supporting delivery. The medicine, however, actually contains chloroquine and is used for the treatment of malaria.

This small account is one of the ways how indigenous midwives are portrayed by biomedical care providers in Guatemala. It is actually meant as a joke, but reveals the conflicts which are at stake: the relationship and interchange between so-called “traditional” and biomedical practices and practitioners, the challenge how to provide good pregnancy- and birth-related care, and the question of who has the authority to decide what good health care is.

In Guatemala maternal health and the quality of health care are issues of great concern. The country has the highest infant mortality rate in the Americas and also a high maternal mortality rate. There are a number of factors contributing to it, with poverty and poor quality and limited accessibility of health services as leading causes. The country is still marked by the colonial heritage of long-standing structural inequalities between the poor and discriminated indigenous (Mayan) and the richer Ladino population. Hence, the economic and also the health care situation is worse in the rural, mostly indigenous areas of the country than in the cities.

Nowadays many governmental and non-governmental initiatives and organisations are working on improving the health situation by operating diverse programs in rural Guatemala. The international organization CARE is one of those NGOs. In two municipalities (Santa Lucía Utatlán, Nahualá) in the department of Sololá, CARE Guatemala runs the project EDUSARE (educación en salud reproductiva en Sololá) – an innovative attempt to ameliorate maternal and child health, and to strengthen women in their sexual and reproductive rights.

One Part of the project EDUSARE is the aim to bridge the gap between Mayan medicine and biomedicine, especially in the field of maternal and infant health, and to strengthen Mayan medicine within this process. The main health care providers addressed in the project are so-called “traditional” midwives on the one hand, and the biomedical care providers working in the health centres, clinics and hospitals on the other hand. They are targeted because good collaboration and communication between the two groups of health care providers are crucial for a good coverage of health care. This is due to the fact that the public health system lacks the capacity to provide pregnancy- and birth-related care for all women. CARE identified discrimination of the indigenous people, structural inequalities and differences in worldview as major obstacles for good collaboration. The midwives in mostly indigenous communities like Santa Lucía Utatlán and Nahualá are indigenous themselves and draw a big part of their knowledge and practices from Mayan worldview and cosmology. This can lead to tensions with biomedical care providers, who are socialised in biomedicine and moreover are partly Ladinos. Therefore EDUSARE offered

1 “Let’s see, is there a pill for birth?”
sensibilisation courses for both groups in order to foster mutual understanding and respect and to encourage the exchange of experiences. Within those courses, the emphasis was placed on the role of the Mayan midwife with its social, spiritual and cultural aspects.

The project EDUSARE is the framework in which the research took place – in a geographical as well as in an interpersonal sense. All research participants had participated in the sensibilisation courses of the project and are health workers in the project area. The original purpose of the field research was to find out about the actual effect of those courses on the relationship between biomedical care providers and midwives, and how it has changed over the last years. Though, considering my absence in the years before, I focused on analysing the current situation. Moreover, bearing in mind the power relationship between biomedicine and other medical practices, and that usually the “traditional” practitioners have to adapt to biomedical knowledge and to change their ideas, I got interested in focusing more on the biomedical health care providers which work in two health centres in Santa Lucía Utatlán and Nahualá. Hence, the focus of the research is their perception of and attitude towards the midwives they are working with in the communities. Their accounts on midwives’ practices, knowledge and collaboration with the public health system lie at the core of this thesis. Within this representation the following issues are addressed: the medicalisation of midwifery, the question of which role ethnicity and other markers of difference play in the perception of midwives, and finally who has to the authority to claim “truth” concerning medical knowledge and why. It is mostly to the biomedical care providers that I lend a voice in this thesis; in some cases I contrast it, however, with midwives’ perceptions or my own observations.

The thesis is divided in two main parts: in the first three chapters I present background information on maternal and child health issues and health policies in Guatemala, medical anthropological concepts, and previous research done on midwives and biomedical care providers in Guatemala. In the second half of the thesis I present my field of study, the methods and finally the results of the ethnographic research.

**Excursus: Terminology**

**Midwives**

In many studies indigenous midwives, who acquired their knowledge by apprenticeship, are called “traditional” or “empirical”. They are opposed to “professional” midwives, who were trained in institutions. However, there are no professional midwives in Guatemala (Lang & Elkin 1997), which makes the distinction irrelevant. Moreover, I consider the term “traditional” inappropriate: it is value-laden, as it implies a juxtaposition of more or less static “traditional beliefs” versus “biomedical knowledge”. In my opinion, the practices of indigenous midwives are based on knowledge as well, and their practices are constantly changing.  

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2 In a recent publication on midwifery Davis-Floyd et al. (2001) point out that the terms “midwife” and “traditional” evoke ideas, which do not fit into the present situation anymore: “They confront us with novel combinations; unexpected juxtapositions, ironies, and reversals of what was once touted as medical “progress”; and implosions of competing systems that seem surprising in relation to common Western
According to WHO guidelines, the midwives I am writing about are called “traditional birth attendants” (TBA). The definition is as follows:

_A TBA is a person who assists the mother during childbirth and initially acquired her skills by delivering babies herself or through apprenticeship to other Traditional Birth Attendants._  
(WHO 1992; in: Lefèber 1994: 4)

However, the term TBA is misleading as the midwives’ tasks include more than attending births. They accompany the pregnant woman throughout the pregnancy, assist the delivery, and often also play an important role in the postpartum period. Another aspect to consider is the social, moral and spiritual care provided by midwives. Therefore, the term “traditional birth attendant” and the role associated with it has been criticised for its “ethnocentric” and “mediocentric” shortcomings. (Cosminsky 2001a: 187-188; Lefèber 1994: 4)

Bearing in mind these discussions and the fact that in Guatemala the Spanish term “comadrona” (midwife) is common, I use the term “indigenous midwife” throughout this thesis.

**Mayan/traditional medicine – biomedicine**

Many terms are used in Guatemala to refer to the two main medical models of more or less “traditional” and popular medical practices on the one hand and biomedicine on the other hand. Traditional medicine is often called “medicina natural” (natural medicine) or “medicina maya” (Mayan medicine). Folk medicine, with its home remedies (“medicinas caseras”), is more or less subsumed under traditional/Mayan medicine. I could not find a clear definition of “Mayan medicine” (as separated from traditional medicine, which has its influences e.g. from the Spanish colonisers). As a general feature, however, emphasis is placed on the religious or spiritual component (Mayan cosmology) as characteristic for Mayan medicine and its practitioners (Ministerio de Salud Pública y Asistencia Social s.d.: 12f.). Biomedicine is usually called “medicina occidental” (Western medicine) or “medicina química” (chemical medicine). In this thesis I use the terms “traditional” medicine/Mayan medicine when I talk about not institutionalised forms of medicine, and “biomedicine” when I talk about the institutionalised public and private health system. I want to point out, though, that I am aware of the fact that these terms are problematic: they are not accurate as the boundary between “traditional” and “modern” is not clear-cut (see also chapter 2).
1 Background information on Guatemala

In the three sections of chapter I present background information on the following topics: maternal mortality as one of the major health problems, the structural inequalities between the indigenous people (Maya) and Ladinos, and Guatemalan health care policies which affect the relationship between biomedical care providers and midwives.

1.1 Reproductive health issues in Guatemala

Guatemala is one of the poorest countries in Latin America. The economic deprivation also shows its effects in the field of health and health care. Concerning reproductive health, the two main problems are high neonatal and maternal mortality rates, especially in the rural areas with a high percentage of indigenous population. The maternal mortality rate is estimated at 220 maternal deaths per 100,000 life births; for Sololá it is even considered to be 446. The government health system currently only provides biomedical assistance for 20% of all births, due to lack of capacity. Therefore local midwives are the main care providers in antenatal, delivery and postnatal care in rural Guatemala. (Hurtado & Sáenz de Tejada 2001: 212) It is estimated that good collaboration between midwives and formal care providers raises the number of referrals made from midwives to the public health system in case of high-risk pregnancy or complications during birth or in the postpartum period. Therefore, better interaction between midwives and biomedical care providers should help to lower the high neonatal, infant and maternal mortality rates in rural Guatemala. (Glei 2001)

1.2 Inequality between Ladinos and Maya

The approximately 11.5 million people living in Guatemala are divided in four main population groups: the indigenous people (Maya), the Ladinos (mestizos), the Garífuna and the Xinca. The Maya (approx. 60%) and the Ladinos (approx. 39%) form the majority of the population. (Ministerio de Salud Pública y Asistencia Social 1994: 3) To distinguish between them, though, is rather problematic. The division is not based on biology, as is often claimed, but is a social classification based on class, language, and culture. (Zur 1998: 33) This means that roughly speaking Ladinos wear Western clothes and speak Spanish, whereas the Mayan people wear traditional clothes\(^3\) and speak one of the 21 Mayan languages.\(^4\)

\(^3\) However, there is a tendency among Mayan men to wear Western clothes as well. Women, on the contrary, tend to keep wearing the traditional “huipil” (decorative blouse) and the “corte” (skirt).

\(^4\) It is important to point out that subsuming the diverse indigenous groups in Guatemala is an act of anthropological simplification: “Never before, even in pre-Hispanic times, have the Maya existed as a single, self-defined people or nation. Instead, Maya in Guatemala today speak some 20 mutually unintelligible languages and, at least since colonial times, have placed their allegiances in hundreds of local communities, each with its own style of dress, speech, and custom [...]” (Watanabe 1995: 36)
The structural inequalities between the Ladinos and the indigenous population are visible on a political, economic and sociocultural level. Since the conquest, the racist relationship between Maya and Ladinos has remained. In addition to the history of colonisation and the subsequent oppression, the Mayans have suffered from political and structural violence during the height of counterinsurgency warfare in the 1980s (Green 2002). Watanabe (1995) points out that as a common feature, the Maya are feared and subordinated at the same time. Generally speaking, the Maya are mostly poor and live in the rural areas. Currently, they are fighting for recognition of their rights as indigenous people. This process is supported by the Peace Accords which were signed in 1996 to end three decades of civil war.

1.3 Guatemalan health care policies
A central topic in anthropological research as much as in WHO policy, NGO projects and governmental interventions, is the relationship between the official health care system (usually dominated by biomedicine) and so-called “traditional” or alternative healers. In Guatemala the former government was very much interested in the so-called popular and traditional medicine and even established its own program called “Programa Nacional de Medicina Popular, Tradicional y Alternativa”. Following the Peace Accords from 1996, its aim was to pay attention to the cultural and ethnic diversity in Guatemala and to strengthen popular traditional medicine as a valuable source of health care. (Ministerio de Salud Pública y Asistencia Social s.d.) Unfortunately, with the change of government, also the policy changed and currently there is not much energy and money invested in this program.5

Additionally, Guatemala has a long history of bringing midwives closer to the public health system by offering midwife training courses6 and requiring official certification for midwives. Nowadays, the participation in a 14-day training course is a prerequisite for a midwife in order to practice legally.7 The Guatemalan Ministry of Health introduced training courses in 1955 and adopted the WHO recommendation to recognise midwives formally and to integrate them in the state health care system in the 1980s (Acevedo & Hurtado 1997). The content of those courses has changed over the years, and nowadays – also through the SIAS health program – the emphasis lies on the identification of risks in pregnancy, childbirth and the postpartum period, as well as on the referral of women and infants to the hospital (Mosquera Saravia 2002).8

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5 Personal communication with Carlos Morán and Francisco Mendéz, June 2004.

6 For an evaluation of the training courses in Guatemala see e.g. Greenberg (1982), Lang & Elkin (1997), Glei (2001); for an evaluation of training courses for Mayan midwives in Mexico see Jordan (1989).

7 Most midwives, though, start their practice before they participate in a midwife training course (Cosminsky 2001a: 185).

8 The emphasis on risk is based on the assumption that complications during birth such as prolonged labour and late referrals to biomedical providers are reasons for the high infant and maternal mortality rates in rural Guatemala. However, especially the infant mortality rate is often caused by other reasons such as diarrhoea or vomiting. (Cosminsky 2001a: 206)
The Guatemalan Ministry of Health is targeting the coverage of health services through a health reform program called SIAS (sistema integral de atención en salud). The main goals are to enlarge the basic health services and to enable better access to health care in the rural areas. Part of this is linking government health services with the diverse projects run by NGOs in the field of health and health care. The SIAS puts an emphasis on maternal and infant health. (Hurtado & Sáenz de Tejada 2001: 215-217; Mosquera Saravia 2002: 137-138). For midwives this means that they are seen as health workers on the primary level. Their tasks include: providing care in the antepartum period, during delivery and in the postpartum period; reporting information on the number of births and participation in continuous training courses. (Mosquera Saravia 2002: 137-138, 160-161).
2 Medical anthropology: key theoretical concepts

This chapter contains those concepts from cultural and medical anthropology, which guided my approach to the research topic in a theoretical way. First, I present an overview on anthropological studies of reproduction – with a focus on birth and midwifery. In the following I explain the key concepts which I employ in this thesis: medical pluralism, medicalisation, and “authoritative knowledge”. Their common feature is that they all have to do with the relationship between different medical resources and bring the question of power into the play.

2.1 Anthropology and the study of reproduction

The anthropology of birth and midwives is a subdivision of the anthropology of reproduction. An overview on anthropological approaches to human reproduction is provided by Ginsburg and Rapp (1991). One of their insights is that dispensing Western biomedical services in non-western contexts can be a double-edged sword. A more recent survey of the anthropological study of reproduction is presented in Browner and Sargent (1996). They point out that

(…) reproductive studies can provide a particularly powerful lens through which to view broader social processes. (ibid.: 219)

Pregnancy and childbirth had long been at the margins of social and cultural anthropological research and theory. If they were studied, it was mostly in hunting and gathering societies, whereas peasant societies were hardly ever the focus of research. There are two main reasons for this neglect: lack of theoretical interest and male bias. Male investigators dominated anthropology until the mid 1970s. They did not consider female reproductive matters important, claimed to have no access to women’s domains, and had no personal experience with childbirth, which all led to only a handful descriptions of reproductive issues by men. But also female ethnographers were blinded by this trend, apart from some notable exceptions: two of them are Margaret Mead with her work in the Pacific, and Phyllis Kaberry’s work on Aborigines in Australia. (McClain 1982: 37-38) In the 1960s, two movements directed attention towards reproductive matters: international public health dealing with maternal and child health, as well as the second wave of feminism (Browner & Sargent 1996: 222).

In the 1970s, two important publications appeared which shaped later research in the field of reproduction. McClain (1975) coined the term “ethno-obstetrics” for indigenous knowledge and practice around pregnancy and childbirth. And the comparative ethnographic work by Jordan (1993 [1978]) on birth in the Netherlands, Sweden, the United States and Yucatan was groundbreaking. By acknowledging that “birth is everywhere socially marked and shaped” (ibid: 1), it became clear that childbirth is worth anthropological attention and therefore inspired many researchers to conduct investigations and cross-cultural comparisons. Shortly after that, the first collection with detailed anthropological descriptions of childbirth was published (Kay 1982a), which contained an overview on the field (McClain 1982). Kay (1982b) outlines three topics that are relevant for the cross-cultural study of childbirth: social organisation, the political-economic system and medical theory. Another collection on birth in different cultures appeared in the same
year (MacCormack 1982), and gave way to numerous other publications on childbirth and midwifery in the 1980ies and 1990ies. One of the most notable works from this period is Robbie Davis-Floyd’s (1992) book on birth as a rite of passage in the United States. Another important product of the renewed interest in pregnancy- and childbirth-related topics in the last decade is the collection edited by Davis-Floyd and Sargent (1997). It covers examples of birthing practices, midwives and politics from different regions in the world. The authors in the volume draw on the concept of “authoritative knowledge” by Jordan and provide a very political view on the topic.

As an effect of the recent and renewed interest in pregnancy, births and midwives, a special issue of *Medical Anthropology* (Davis-Floyd et al. 2001) focused on midwives in different social and cultural contexts. The authors call into question the fact that midwives are blamed for high infant and mortality rates. By doing this, the root causes like socio-economic inequalities or lack of infrastructure are hidden. Hence, focusing on reproductive health issues can serve as a lens to look at the wider political, economic and social context (see quote by Browner and Sargent at the beginning of the chapter) in which they appear.

### 2.2 The concept of medical pluralism

Medical pluralism has been studied and analysed in many different settings all over the world (see e.g. Leslie 1980). For the context of Guatemala the concept was first proposed by Cosminsky and Scrimshaw (1980). Although it is already 25 years old, it is still a fruitful tool to analyse the relationship between biomedicine and other medical resources, as Mosquera Saravia (2002) points out in her recent dissertation on midwifery in rural Guatemala. The innovative aspect is that it puts so-called traditional practices in a relationship with biomedicine and shows how they are interrelated (ibid.: 78). However, two main annotations which have to be made: firstly, that the processes of continuous interchange – like the medicalisation process – challenge the dichotomy between “modern” and “traditional” (see chapter 2.3), and secondly, that medical pluralism encompasses highly political-economic and social aspects (see chapter 2.4 and 3.2).

A crucial point in the analysis of pluralistic medical settings is the way in which the relationship between the different medical resources is conceptualised. While the term “medical pluralism” implies the existence of more or less bounded, separated parts, Tedlock (1982) contests this view. She sees the concepts from Mayan cosmology and medicine and concepts derived from Western influences such as Catholicism not as oppositions, but as a “dialectical or complementary dualism” (ibid: 44). Another important point is that much of what is considered as characteristic of Latin American folk medicine, is rather a product of the multiple contacts between indigenous people, European colonisers and their descendants (Cosminsky 1994: 105; Tedlock 1987). In pluralistic medical settings the boundaries between the different medical resources are permeable and fluid. Not only do people combine different health seeking strategies at the same time (Crandon-Malamud 1991), but also practitioners themselves integrate diverse traditions in their practice (Cosminsky & Scrimshaw 1980: 275).

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9 Cosminsky (1994: 105) distinguishes the following traditions merging in contemporary Guatemala: indigenous Maya, 16th century Spanish, later European, Ladino, and biomedicine.
2.3 Medicalisation process
As outlined in chapter 2.2, medical pluralism itself has to be seen as one system with different but interrelated parts. However, in referring to “medical pluralism”, often a dichotomy between “traditional” and “modern” medicine is assumed, which is much too simplistic (Cosminsky 1994). Especially through the world-wide processes of modernisation and medicalisation, the boundaries between different medical sectors and resources are blurring. According to Cosminsky (2001a: 180) midwife training programs are one of the main forces in the medicalisation of midwives. Medicalisation can be defined as

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\text{[...] one of the processes through which biomedicine becomes accepted as the knowledge system that counts. In their contestation with biomedical knowledge, other forms of knowledge become subordinate, “muted”, and/or lost. (Cosminsky 2001b: 350)}
\]

In order to understand the process of medicalisation, the characteristics of biomedicine have to be mentioned. It is important to note that there is not a single biomedicine, but that biomedicine is practised differently according to diverse social and cultural conditions (Lock & Gordon 1988: 15). However, key characteristics such as “the ideological primacy of a scientific paradigm and faith in the idea of definitive knowledge, materialism, objectivity, and progress” (Jenkins 2001: 413) are immanent to different local versions of biomedicine. Richters (2001) depicts the “objectifying” view of biomedicine as a central characteristic.

Through the increasing importance of biomedicine, the power relationship between different forms of health care has become an issue. Due to the process of globalisation, medicalisation is now a world-wide trend (see e.g. Baer et al. 1986; Richters 2001):

\[
\text{The medical systems of complex societies are characterized by pluralism. These systems are plural rather than pluralistic in that biomedicine enjoys a dominant status over heterodox and ethnomedical practices. This dominant status is legitimized by laws which give biomedicine a monopoly over certain medical practices, and limits or prohibits the practice of other types of healers. (Baer et al. 1986: 96)}
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One marker of biomedical hegemony is the easy availability and increasing popularity of Western pharmaceuticals in developing countries. They are blurring the boundaries between “traditional” and “modern”, as they are used by formal care providers, folk healers and in the private domain alike. Also healers such as “spiritists” or “lay injectionists” do fit in none of the two categories. (Cosminsky 1994: 104-109).

2.4 Political, economic and social aspects in medical pluralism
Medical pluralism does not automatically imply a free choice for people who can make use of diverse resources. Much more, medical pluralism encompasses highly political and social aspects as well. For an analysis of medical pluralism, which includes social, political and economic factors, it is important to know “why certain forms of health care emerge or stay and others not, whose interest their existence serves, and what kind of interest that is”\textsuperscript{10} (Richters 1991: 209). People can choose between different sectors of the health care systems, and studies show that they use

\textsuperscript{10} Translated from Dutch by U.W.
them complementarily. But at the same time the multiple choices which people have are constrained by external factors and the fact that the needs of people can be manipulated. (ibid.) Both health seeking behaviour as well as the availability of different forms of health care are complex processes, informed by social, political and economic constraints and reasons. Therefore it is important to note that health care choices are not only made in a rational way to seek cure and relief or are based on certain “beliefs”, as is often depicted in older literature.

In her analysis of medical pluralism in an ethnically and culturally pluralistic town in Bolivia, Crandon-Malamud (1991) argues for a political, economic and social view on health care choice. According to her, people use medical resources for diverse means: as a tool to build social relations, to acquire access to other resources and to reconfirm or acquire a certain cultural or ethnic identity:

[…] where medical pluralism exists, the principal secondary resources for which medicine is a primary resource are social relations and material resources that permit social mobility. Medical pluralism facilitates the permeability of ethnic and religious boundaries as well as movement across class lines because, as people talk about medicine, they are also negotiating a redefinition of their own identities. (ibid: ix)

This point of view is supported by Menéndez, who in addition to social, economic and political aspects draws attention to the ideological sphere (Mosquera Saravia 2002: 80).

2.5 The concept of “authoritative knowledge”

Through control, institutionalisation and the medicalisation process, biomedicine acquired its hegemonic status. In the course of this process, other forms of knowledge are subordinated; so-called “traditional” healers and symbolic efficacy in healing are devaluated. (Mosquera Saravia 2002: 83) Consequently, biomedicine and their practitioners claim authority over other systems of knowledge. Jordan (1993, 1997) coined the term “authoritative knowledge” for this phenomenon in the analysis of different birth systems.

A consequence of the legitimation of one kind of knowing as authoritative is the devaluation, often the dismissal, of all other kinds of knowing. Those who espouse alternative knowledge systems then tend to be seen as backward, ignorant, and naïve, or worse, simply as troublemakers. (ibid: 56)

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11 “The multiple usage is the most striking characteristic of people’s health care strategies. People do not perceive a conflict among these alternatives, nor do they seem to perceive them as different systems, but rather as a variety of options [...].” (Cosminsky & Scrimshaw 1980: 275)

12 See for instance Cosminsky and Scrimshaw (1980: 276): “This pluralistic behavior is pragmatic, often based on trial and error, perceived effectiveness, uncertainty of illness causation, and expectation of quick results. [...] In addition to this empirical and pragmatic behavior, however, is the role played by faith in the supernatural or spiritual in curing.”
An important characteristic of authoritative knowledge it is “not that it is correct but that it counts” (ibid: 58). Hence this knowledge becomes the basis for decisions and also actions (Cosminsky 2001b: 350).

The devaluation of nonauthoritative knowledge systems is a general mechanism by which hierarchical knowledge structures are generated and displayed. (Jordan 1997: 56)

In reviewing Jordan’s work, Sargent and Bascope (1997) point out that “the constitution of authoritative knowledge also reflects the distribution of power within a social group.” (ibid.: 204) This means that the status of the health care providers – be it a medical doctor or a midwife – as well as discourses shape the distribution of authority among different knowledge systems. The authority of biomedicine is reinforced by the fact that it is often promoted by the state, as is the case of biomedical obstetrics in the midwife training courses. (Jordan 1989: 935; Sesia 1996: 123)
3 Pregnancy- and birth related care in rural Guatemala

The following chapter deals with the issue of pregnancy- and birth-related care in Guatemala: firstly, I describe the health resources which are available, and relate them to social and political factors which affect the provision of health care. In the following I focus on midwives as main care providers for pregnant and birthing women. I summarise findings from previous studies on the impact of medicalisation on midwifery in Guatemala, and on the midwives’ relationship with biomedical care providers. The problems in their interaction and collaboration, as well as training courses for both parties as possible solution for those problems, are the content of the last two sections.

3.1 Medical pluralism in perinatal care in rural Guatemala

Like in many other developing countries, biomedicine also acquired a hegemonic status in Guatemala (Mosquera Saravia 2002: 81). However, there are many other health care resources available, which are described by Cosminsky and Scrimshaw (1980). The authors analyse the health seeking behaviour on a Guatemalan coffee and sugar plantation and find several medical resources including and combining aspects from Mayan medicine, folk (ladino) medicine, spiritism and biomedicine. In a newer publication, Weller et al. (1997) name similar health care resources. Therefore, the heterogeneity of medical resources seems to be more or less unaffected by the medicalisation process.

Guatemalans use various medical resources stemming “from different health systems and cultural traditions” (Hurtado & Sáenz de Tejada 2001: 211), and this also applies for pregnancy- and birth-related care (Acevedo & Hurtado 1997; Cosminsky 1977, 1982a, b; Glei & Goldman 2000). However, midwives are the prime source of care in rural Guatemala. About only 20% of the births are currently assisted by health personnel from the Ministry the Health, and there are not more capacities. (Hurtado & Sáenz de Tejada 2001: 211-212) In some rural areas even over 95% of all births are assisted by midwives, the rate being especially high in indigenous communities (Cosminsky 2001a: 179). A recent survey in four departments in western Guatemala reveals that the majority of providers for maternal and child health care are midwives, followed by “others”, while physicians and nurses only play a minor role (Hurtado & Sáenz de Tejada 2001: 214).

As I pointed out in chapter 2.2., practitioners themselves often combine elements from different healing traditions. For instance, midwives have undergone a training course by the Ministry of Health and therefore integrate the biomedical knowledge in their more or less traditional practices. Moreover, many midwives have “multiple healing roles”, and are herbalists, spiritual healers or shamans at the same time. (Cosminsky 2001a, b)

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13 The resources are home remedies, curanderos, herbalists, midwives, spiritists, shamans, injectionists, stores, pharmacies, travelling vendors, private physicians, public and private clinics, and hospitals. (Cosminsky & Scrimshaw 1980)
3.2 Social and political-economic factors influencing health care

Considering the political sphere of health care, two points have to be mentioned: the impact of the armed conflict on the health services on the one hand, and the influence of ethnic relations on the other hand. In general, decades of armed conflict have caused a low coverage of health care services. Especially in the period of the early 1980ies, which is known as “La Violencia”, many health promoters – which generally are important figures in the rural health care – in the highlands were killed for their supposed collaboration with the guerrilla. Also many programs were ended in this time, and only resumed many years later. (Cosminsky 1987: 1173; Cosminsky 2001a: 202). During the time of institutionalised violence the indigenous population’s distrust in government services grew (Hurtado & Sáenz de Tejada 2001: 213).14

Medical pluralism is closely linked to ethnic pluralism in Guatemala. As mentioned above, the society is more or less equally divided in two main groups: the indigenous people (Maya) and the Ladinos. The boundaries between the two groups are blurred, and still they persist as oppositions. Concerning biomedical health care services, it is important to note, that the access is limited in remote indigenous communities in the highlands. The Ministry of Health has built health centres in the municipalities and health posts in the more remote areas, and trained volunteers as health promoters to improve this situation. 15 But still good biomedical care is not equally accessible to all inhabitants of Guatemala: “social inequity, geographical isolation, and institutional inefficiency, plus decades of political conflict” in combinations with shortage of personnel and supplies play a role in limited access (Hurtado & Sáenz de Tejada 2001: 211-214). 16 Green (2002: 124) states that there is a persisting inequality between indigenous people and Ladinos as the public health services in the highlands “have been inferior or not existent” (ibid.) Moreover, the available health services for perinatal care are oriented towards

\[...\] a Western, highly medicalized model of facility-based delivery without sufficient regard for the local cultural context and the needs of the impoverished indigenous population, especially women. (Hurtado & Sáenz de Tejada 2001: 211)17.

According to Glei and Goldman (2000: 20) indigenous people may be confronted with problems in communication with Spanish-speaking health care providers and with discrimination in public health institutions.

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14 Acevedo & Hurtado (2001: 213) admit that no research has been conducted on the impact of the political violence on the utilisation of health services. However, I was told that many people still have forceful actions like certain vaccination campaigns in their mind, and therefore are afraid of public health services. (personal communication with Javier Piu, June 2004).


16 Hurtado and Saénz de Tejada (2001: 211) claim that about half of Guatemala’s inhabitants have limited access to government health services.

17 "Concerning the practitioners of Western medicine, it seems to be valid that one is more Romanian the further one is away from Rome. The further one is away from the Western world, the more dogmatic allopathic curative medicine is applied in many cases, and the less one tries in clinical practice to make its cause-consequence-relationship transparent for lay people and to spread it.” (Richters 1991: 211) (translated from Dutch by U.W.)
3.3 The impact of medicalisation process on the practice and status of midwives

As I pointed out in chapter 2.3, medicalisation is a global process. Also midwives in Guatemala find themselves “under the twin pressure of modernization and medicalization” (Davis-Floyd et al. 2001: 123) and therefore contest the clear division between “traditional” and “modern”. The process of medicalisation becomes visible and has its effects through the implementation of training courses (Acevedo & Hurtado 1997; Lang & Elkin 1997; Goldman & Glei 2003; Hurtado & Sáenz de Tejada 2001), the subtle influence of radio advertisements (Cosminsky 1982a: 205), the recent discussion about the professionalisation of midwives in Guatemala (Mosquera 1999) as well as the widespread use of Western pharmaceuticals (Cosminsky & Scrimshaw 1980; Cosminsky 1994; Goldman & Glei 2003: 688; Cosminsky 2001a). Cosminsky (2001a: 179) defines medicalisation of midwifery as

> the application of the biomedical model of obstetrics, which views pregnancy and birth as disease or abnormal states, thus to be treated by the official medical system.

Policies and measures like the obligatory midwife training courses put an enormous pressure on midwives to adapt to biomedical standards. Additionally, midwives are subjected to a “hierarchical and authoritarian model of social relationships” (Cosminsky 2001a: 180), as the controlling function of formal care providers puts midwives in a subordinate position to them, while at the same time putting them in a dominant relationship with the pregnant and birthing women. The status of midwives differs from community to community; in some areas it is appears that women practice this more out of political, economic or social necessity, in others they are well-respected or even feared because of their supernatural powers and their knowledge about community members. The effect of training courses on the status of midwives is ambiguous. On the one hand, they can increase their status by acquiring new knowledge and using status symbols. On the other hand, their authoritative knowledge concerning local practice is undermined by biomedical staff. They get more dependent on the biomedical system and lose autonomy. (ibid: 184-187)

Through the medicalisation process midwives acquire new knowledge and adopt new practices such as aseptic procedures, horizontal position for delivery and injections (Cosminsky 2001a: 179-182).

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18 One of the first articles dealing with medicalisation in rural Guatemala is by Woods and Graves (1976). Cosminsky (1982a) published the first article on changes in midwifery in rural Guatemala.

19 Midwives are controlled by biomedical care providers as they have to report the number of births and the outcome to the health centres or health posts every month. This is also the place where the get the birth certificates and stamps for the official registration of a newborn. Additionally, they have to undergo an annual blood test. (Cosminsky 2001a: 206)

20 During the period known as “la violencia” in the 1970ies and 1980ies many indigenous people flew to the mountainous regions, and were depending on mutually supporting each other. Also women were therefore forced to help each other during birth and became midwives. Another example is that many midwives are widows and midwifery is an important source of income for them. (Cosminsky 2001a: 184-185)
180). Some biomedically inspired practices, such as oxytocin injections to speed up delivery or vaginal examinations, are even harmful and are associated with intrapartum mortality. Ironically, they are not taught in the training courses, but found their way into the midwives’ practices via the general medicalisation process. (Ibid.: 209) Another effect of the medicalisation process is that the midwives abandon techniques like abdominal massage, external version of the foetus, administration of herbs, cauterisation of the umbilical cord with a candle, use of an abdominal binder, and the use of the sweatbath. This is due to the fact that formal care providers discourage those practices. (Glei 2001: 169-170; Cosminsky 2001a: 202-203)

The medicalisation process separates the “medical” from the “social”, which becomes visible in the example of massage, which has a social as well as a physiological purpose (Glei et al. 2003: 2460). Moreover, the midwives get stripped of their sacred and ritual role and are rendered merely secularised “birth attendants” (Cosminsky 2001a: 180). At the same time, midwives counter the imposed process of medicalisation by “sacralisation”, which means that they emphasise their spiritual role (Cosminsky 2001b).

3.4 The relationship between biomedical care providers and midwives
Guatemalan women can resort to different options in prenatal, delivery and postpartum care. Among Mayan women there is a tendency to see a midwife only, but often women also go to a health centre or a health post. From the women’s perspective, there is no contradiction in making use of both systems: they seek the midwife for massage and advice, and get vitamins, vaccinations and treatment for complications in biomedical facilities. (Glei & Goldman 2000: 20) However, the question remains what characterises the relationship between the different care providers. As the communication and interaction between midwives and formal care providers has to be targeted, recent studies have shifted their attention towards their relationship (Acevedo & Hurtado 1997; Hurtado & Sáenz de Tejada 2001; Glei 2001).

Glei (2001) divides the relationship between traditional and formal care providers in two possibilities: “integration”/“collaboration” or “co-existence”. She defines collaboration by the fact if referrals are made between the providers and “that providers act out of mutual respect for the unique services that each provides” (ibid: 170). As mentioned above, training courses and the SIAS

21 The medicalisation process already dates back to the beginning of the training courses, and Paul (1975: 460) mentions that one of the midwives he got to know was “blending new procedures with the traditional”. However, this topic has only received much attention in the last years.

22 Faust (1988) describes a case of an infant death in a Mexican Maya village and the reactions of the local population to it. According to doctors she spoke to, the use of an oxytocin injection during delivery could have been the cause of death. At the same time the villagers accused the midwife of witchcraft, which they associated with the use of Western methods such as injections.

23 See for instance Paul (1975, 1978) and Paul & Paul (1975) for the ritual role of the midwife in an indigenous community in rural Guatemala. Many midwives come to their profession through “divine calling” which expresses itself through birth signs, the meaning of the birth date according to the Mayan calendar, dreams, visions, severe illness etc. Others inherit their position from women in their family, learn it by apprenticeship or may happen to assist a birth in case of emergency. (Cosminsky 2001a: 182-184) See Tedlock (1992) for the role of dreams in becoming a midwife.
puts much emphasis on the acknowledgement of danger signs in pregnancy and childbirth. In case of risk, midwives should refer women to biomedical care providers. (Hurtado & Sáenz de Tejada 2001) Glei (2001) found out that two factors influence the number of referrals in a positive way: if the midwives are trained and if also biomedical care providers (health centres, health posts) make referrals to midwives. According to Cosminsky (2001a) major obstacles for referrals are devaluation and discrimination from the side of the biomedical care providers. The reasons for the midwives’ reluctance to refer women to the hospital are:

[... ] local perceptions that the hospital is a place where people die, [...] mistreatment and scolding of patients and midwives, lack of communication and language barriers, shame of exposure in front of male doctors, fear of sterilization, and fear of surgery. This last factor has become especially relevant because of the increase in caesareans performed in the hospital. (Cosminsky 2001a: 203)

Acevedo and Hurtado (1997) conducted their research in four Ladino and indigenous communities in order to find out if services provided by midwives and by formal care providers are used complementarily or if they are in a conflicting relationship. They answer this question from the women’s as well as from the midwives’ and the formal care providers’ point of view. Indigenous women combine both types of care in the prenatal period, whereas for delivery and postpartum care they only rely on midwives. They see different qualities in both types of care and look for different treatments (e.g. massage by the midwife, vitamins by the health post). Also midwives seem to acknowledge the biomedical services as complementary, even if there are some tensions about “traditional” techniques – like the use of sweatbaths – which are discouraged by formal care providers. Still, they refer women to the health centre for prenatal check-up. On the contrary, the formal care providers feel very ambivalent about the integration of midwives in the system of care. They acknowledge that midwives provide prenatal, delivery and postpartum care, and identify risk situations. Still they perceive themselves as those who “know” and the midwives as those who “don’t know” and who “have to change their behaviour”. (ibid.: 317)

3.5 Points of conflict: hegemony, ethnicity and gender

Hurtado and Sáenz de Tejada (2001) identify the problem in the interaction between Mayan midwives and formal health care providers as twofold: on the one hand there is a tension between the “traditional” and the biomedical system of health care, and on the other hand the historical tensions and power relations between indigenous people and the Ladinos play an important role. As I pointed out in chapter 2, biomedical practices represent the “authoritative knowledge”, and other medical resources are suppressed. Automatically, the practitioners of biomedicine are in a supreme position in comparison to the midwives who handle and practice a

24 Of course, the use of the public health care services is restricted by other factors than non-referral. Women often do not comply with a referral for several reasons: “[...] women are afraid of vaccines because they think they can cause abortion or make the woman swell, and they are ashamed because they cannot speak Spanish and because of exams performed. Some women are also afraid because of rumors about sexual abuse during gynaecological exams and because of beliefs that the “pills” provided can induce abortion, function as a contraceptive, or sterilize them.” (Hurtado & Sáenz de Tejada 2001: 224) Other reasons are “problems of access, lack of economic resources, and cultural norms which make it more desirable to be attended by a midwife.” (Acevedo & Hurtado 1997: 272)
devalued system of knowledge – Mayan obstetrics and cosmology. Also Goldman and Glei (2003: 687) state that the relationship between midwives and biomedical providers is “an asymmetric one with biomedical providers occupying a privileged position within the formal health care system.” This uneven relationship is reinforced by the fact that the power relations between the Ladinos and the indigenous people are mirrored in the relationship between biomedicine and Mayan medicine.

Hurtado and Sáenz de Tejada (2001) bring into play yet another marker of difference: gender. They estimate that midwives may experience “double discrimination” for being Mayan and for being women. Most biomedical health care providers are Ladino and most physicians are male. Midwives reported disrespectful and discriminating treatment towards themselves and their patients in the government health facilities.

Therefore, not only often cited problems like language barrier, disapproval of methods like sweatbaths and massage, and the devaluation of “traditional” beliefs in general play a role (Cosminsky 1987, 2001a, 2001b), but the power relationships due medical traditions, ethnic identity, different socio-economic status and gender relations are intertwined and reinforce each other.

3.6 Future perspective: training mutual respect?

It is generally acknowledged that midwives are and will remain the main care providers during pregnancy, delivery and the postpartum period in rural Guatemala. Therefore they are key figures in the interaction with the public health system. However, Acevedo and Hurtado (1997) claim that especially in the postpartum period there is a lack of collaboration between midwives and formal care providers.

Hurtado and Sáenz de Tejada (2001) point out that the problem is due to a history of tensions between indigenous people and Ladinos, and that ethnic and gender discrimination has to be targeted in order to ameliorate communication and collaboration between midwives and formal care providers. They advocate for training courses for the health personnel including an “interethnic and intercultural relations component” (ibid.: 239) in order to make them aware of those issues and to provide knowledge on Mayan pregnancy-related care. This goes along with Jordan’s (1993) call for “mutual accommodation”. It is also supported by the policy recommendations by Glei et al. (2003) who state that training programs should be in two ways: biomedical care providers as well as local midwives should understand and respect each others beliefs, practices and the potential benefits deriving from those practices.

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25 Jordan (1993: 139) wants to put into practice the idea of “mutual accommodation”. According to her it is necessary that “the ‘upgrading’ training of traditional midwives in the direction of modern obstetrics be complemented by training of medical personnel in traditional skills and practices, thus upgrading them in the direction of the indigenous system.”
As possibilities for those training courses I want to refer to a hospital staff training project in Guatemala (O’Rourke 1995).26 The staff was taught about the practices of the local midwives, their importance for the well-being of the women, and was encouraged to be supportive and to understand the midwives as well as the women referred to the hospital. Through the course the waiting time decreased and the interaction between the hospital staff and the midwives and the women improved. The midwives made referrals earlier in case of complications. However, there was no significant decline in neonatal mortality rates, which points to the influence of sociocultural, political and economic conditions on health issues (see Cosminsky 2001b: 210).

26 Another interesting project which could serve as a role model, was conducted in Puerto Rico. Therapists and spiritists were put together in a 10-month course to learn about each other’s practices and knowledge. The goal was to bring the two medical systems closer to each other, which was apparently achieved. (Koss 1980)
4 The research

This chapter is meant to help the reader to get an idea where, under which circumstances and how I conducted the field research. I therefore present the project EDUSARE, which served as general framework in a geographical and personal sense. The sections on the research process and the methodology clarify on how I obtained my data, who were my research participants, and also which difficulties and limitations I encountered in my investigation.

4.1 The project EDUSARE

The project EDUSARE provides the framework within which the field research took place. I do not deal with the project and its effects itself, but I consider the project goals as well as the sensibilisation courses as important background information for this thesis. Knowing the aims of the project and the sensibilisation courses in particular, sheds a light on the research findings and puts them in a certain context. Moreover, I consider the courses as an innovative part of the project: they represent an aim to train “mutual respect” (see also chapter 3.6) between biomedical care providers and indigenous midwives.

4.1.1 Project data

The project EDUSARE is run by CARE Guatemala and CARE Austria. As pointed out before, EDUSARE means “educación en salud reproductivo” (education in reproductive health). The project area includes two municipalities – Santa Lucía Utatlán and Nahualá – in the department of Sololá in the Guatemalan highlands. The two municipalities are situated 2600m above sea level and belong to the “terra fria” (cold land). The area covers a population of nearly 35,000 women and men in reproductive age, living in 47 communities. The majority of the people is indigenous and belongs to the ethnic groups Quiché or Kakchiquel. About 44% of the women in reproductive age in this area have no formal education. (CARE Guatemala 2003)

Both Santa Lucía Utatlán and in Nahualá have a health centre at its disposal, with one physician, one professional nurse, auxiliary nurses, rural health technicians and administrative personnel as staff. Additionally to this, seven health posts provide primary health care in the communities. The nearest government hospital – which has its own maternity ward – is located in the city Sololá. Sololá is also the administrative centre of the whole department. Pregnancy- and birth-related care is in the hands of midwives: they assist about 80% of all births. In the project area about 260 licensed midwives carry out their work, approximately another 10% practise without training. Santa Lucía Utatlán and Nahualá are also part of the SIAS, which was implemented in the area in 1999 (see chapter 1.3). As one consequence, more efforts have been made to integrate midwives

27 The distance from the municipalities of Santa Lucía Utatlán and Nahualá to Sololá is about 35 km. As the roads are paved, this means a car ride of about 45 minutes. There are also frequent buses and pick-ups connecting the municipalities with Sololá. There is no public transport, however, from evening until the early morning.
into the public health system by offering monthly training courses. To stimulate this process, midwives in the less accessible communities nowadays receive 50 quetzales \(^{28}\) for each time they come to the midwife training course.

### 4.1.2 EDUSARE goals

The main goal of EDUSARE is to ameliorate maternal and child health in the project area, with a special focus on reducing the maternal mortality rate. This goal is approached by three objectives:

1. to raise the knowledge about reproductive rights and responsibilities of couples with an emphasis on the population aged between 14 and 34 years.
2. to bridge the cultural gap between Mayan Medicine and biomedicine, and
3. to ameliorate the quality of services for reproductive health in the municipalities Nahualá and Santa Lucía Utatlán. (CARE Guatemala 2003)

My research is dealing with the second objective, which is to bring Mayan Medicine and biomedicine closer to each other. In the long run, EDUSARE wants to achieve the acknowledgement of Mayan Medicine as part of the official health system. In order to lay the ground for this development, EDUSARE provided so-called “sensibilisation courses” (see next chapter).

### 4.1.3 The sensibilisation courses

As part of the process to bridge the gap between Mayan medicine and biomedicine, EDUSARE organised “sensibilisation courses” for biomedical care providers and midwives in the two municipalities Santa Lucía Utatlán and Nahualá. Altogether 48 persons (29 biomedical care providers, 19 midwives) took part. The courses should open a dialogue between the two groups of health care providers and should help to find ways how to work together towards a better provision of health care. The aim was to reduce discrimination between indigenous people and Ladinos, and to foster mutual respect and understanding. Special emphasis was laid on strengthening the midwives in their spiritual and social role, and also in their identity as Mayan women. The courses were planned and provided by the ‘Asociación de investigación y desarrollo integral Rex We’ (association for investigation and integral development Rex We, called ASINDI Rex We). Six modules with different contents were offered in the period between August 2001 and June 2002:

- August 2001: Sensibilisation on aspects of Mayan culture
  participants: biomedical care providers

- March 2002: The role of the traditional midwife
  participants: midwives

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\(^{28}\) 50 quetzales are about 5.50 Euro (July 2004).
• March 2002: Approaching culture and health in the rural Mayan context
  participants: biomedical care providers

• April 2002: Processes of health and illness in the rural Mayan context
  participants: biomedical care providers

• June 2002: Approaching rural health and its problems from an intercultural perspective
  participants: midwives and biomedical care providers

Two final sessions with midwives and biomedical care providers together took place in September 2003 in Santa Lucía Utatlán and Nahualá. The aim was to work together on the outcome of the courses. There, one of the conclusions from the biomedical care providers’ side was that they need more information about the practice, knowledge and resources of the indigenous midwives in order to enable a good collaboration (Asociación de investigación y desarrollo integral Rex We 2003: 15).

4.2 The research process

The field research took place in a six-week period from mid May until end of June 2004. I was living in San Pedro la Laguna, whereas the two project municipalities are situated about 1.5-hour busride up in the Guatemalan highlands on more than 2600m sea level. Apart from travelling due to this distance, I spent a lot of time in the office of EDUSARE in Santa Lucía Utatlán, in the two health centres in Santa Lucía Utatlán and Nahualá, the houses of midwives in the two municipalities, as well as in the maternity ward of the hospital in Sololá.

The first days of my research were marked by an exploration of the field – getting to know the project team, understanding the structure of the rural health care system, and making the first contacts with my research participants. As the EDUSARE team has built up an excellent relationship with the public health system and with the midwives in the project area, it was very easy for me to obtain permission to do research. Generally, I was warmly welcomed in the diverse locations of my research. Although my main research participants are all health professionals and therefore quite occupied in their daily activities, they were more than willing to take part in my study.

As outlined above, my framework and starting ground is the project EDUSARE with its sensibilisation courses and its effect on the relationship between biomedical care providers and midwives. My decision to look closer at the way how biomedical care providers perceive the local midwives they are working with was taken after the first interview (a focus group discussion with biomedical care providers). A remark on the problem of old midwives called my attention. This remark surprised me as I had supposed that the sensibilisation courses had taught the biomedical care providers to develop more respect and valuation for midwives as ritual and obstetrical specialists. Therefore, the central question in my research became the way how midwives are perceived by biomedical care providers. However, I adjusted my research in the sense that I did not focus on the effect of the courses as originally planned. I think it is difficult to make valid statements about this for a couple of reasons: First of all, I don’t know how the situation was before. Moreover, the time line “before the courses” and “after the courses” turned out to be an artificial one (and is maybe more important for CARE than for anybody else), as the midwives had
difficulties to remember the courses and the biomedical care providers had a hard time to name any clear example of change. Therefore, I limited the objective of the study to shed light on the current relationship between biomedical care providers and midwives – mostly from the biomedical care providers’ point of view. Their accounts on the working relationship with midwives, the midwives’ knowledge and practices I contrasted with experiences with the midwives themselves. The observation of prenatal care (massage), the work of midwives in the hospital in Sololá and the participation in midwives’ training courses became valuable information for me.

During the whole research I discussed my findings and insights with EDUSARE staff members, and by this I continuously reflected on the way I was perceiving and interpreting the things I heard and saw. I appreciated a lot working in a team and being part of the EDUSARE staff’s daily activities.

4.3 Methodology

4.3.1 Research participants
The main research participants are the biomedical care providers (one physician, two professional nurses, five auxiliary nurses, three rural health technicians, one administrative personnel) working in the two health centres in Santa Lucía Utatlán and Nahualá. The decision to make interviews with them was based on the aim to hear the opinions of different professions, as well as on the availability of the persons. Other research participants are physicians in the hospital of Sololá, as well as midwives from the two project municipalities. Much information was also obtained from conversations with the EDUSARE staff.

4.3.2 Data collection
The research is characterised by data triangulation (see Flick 2003). Information was gathered through

a) focus group discussions
b) semi-structured interviews
c) informal conversations
d) (participant) observation
e) field notes
f) debriefing with the EDUSARE team

Ad a) The three focus group discussions were conducted with six biomedical care providers in the health centre of St. Lucía Utatlán, five biomedical care providers in the health centre of Nahualá, and six midwives in the house of a midwife in Nahualá. The participants of the focus group discussions were those who were available at the time of the interview. However, I requested a
diversity in professional functions, which was achieved. In all focus group discussions a member of CARE was present to introduce me as a researcher. After asking consent from the research participants, the discussion was taped and later transcribed.

Ad b) The semi-structured interviews were conducted with ten biomedical care providers (five auxiliary nurses, three rural health technicians, one physician, one professional nurse) from the two health centres and three midwives in the two communities. Part of the interviews were taped and transcribed. As some research participants felt more at ease without taping, in a later stage of the research I only took notes during the interview or wrote down the interview afterwards.

Ad c) Informal conversations were conducted on a daily basis with the staff from EDUSARE. Moreover, I communicated with doctors in the hospital of Sololá, midwives working in the hospital of Sololá, a local healer in St. Lucia Utatlán, as well as with those persons who had been interviewed in a more formal way.

Ad d) A huge part of the research consisted of observation. I accompanied CARE staff to their activities in the health centres, to the communities belonging to the project area, to field visits at midwives, to reunions, to the introduction of the ‘traditional healer’ etc. While waiting for an appointment for an interview or afterwards, I stayed in the health centre to observe the daily activities, the clients coming and going. It was, however, difficult to observe the interaction between biomedical care providers and midwives in the health centre itself, as only a small number of midwives accompanies their clients to the health centre. An important part of the research was the observation in the maternity ward of the hospital. Here I could directly observe the interaction between biomedical care providers (nurses, physicians) with the midwives during a delivery, and obtain valuable information.

Moreover, I was invited by a midwife to accompany her in the sweatbath (temascal) to observe the massage for a pregnant woman and a woman with menstruation problems. I also observed the prenatal massage in the house of another midwife.

Ad e) During the entire fieldwork, I wrote up observations, reflections and new questions in my field diary.

Ad f) At the end of the research, I presented preliminary conclusions and impressions in front of the whole EDUSARE team to reflect on the findings. The remarks and comments of this session were included in the analysis of the data.
4.3.4 Data analysis
As outlined above, the focus group discussions and interviews were taped and transcribed, or written up after the interview. The main research material consists of interviews with the biomedical care providers. I analysed their content by summarising the material, breaking it up into the main topics, and finally developing my themes (Mayring 2003). During this whole process my research questions functioned as a guideline. The conclusions drawn from the interviews with the biomedical care providers I contrasted with insights from everyday conversations (with biomedical care providers, midwives, EDUSARE staff), observations and reflections with the EDUSARE team.

4.3.5 Factors influencing the research
Three main biases are caused by restrictions of the research setting and therefore have an influence on the findings of the research:

   a) the short duration of the field work
   b) my association with CARE/EDUSARE
   c) limitation in language skills and access

Ad a) Six weeks is a very short time to undertake a decent investigation and to reach a level of saturation in the answers. There was so much to be learnt for me about the country as a whole, and the structure of the health care system, the project EDUSARE itself and the project area in particular. At the same time I had to set up meetings with people, focus groups and interviews. I would have preferred to build up a good relationship with people before starting to ask sensitive questions. Again and again I heard the word ‘confianza’ (confidence) and asked myself how I could become a trustworthy person in such a short time. Especially with the midwives, I found it difficult to gain their confidence. Therefore I consider part of the data I got out of the research with them as not sufficiently valid.

The working relationship was definitely easier with the biomedical providers, who also for this reason became my main research participants. However, also with them I would have preferred more time for informal conversations. Firstly, this would have helped to free me from the role of the researcher ‘who wants to know’. And secondly, there would have been more space to go into sensitive topics like the relationship between the indigenous people and the Ladinos, or gender relations.

Ad b) I was working in the office of EDUSARE, and also introduced to many people as an anthropologist doing a research for CARE. To many interviews I was either accompanied by somebody from EDUSARE or just dropped in front of a house out of the CARE pick-up. All my intentions to show my independence as a researcher were somehow prevented by the dominance of my association with EDUSARE/CARE. Therefore, the answers I received in my interviews are certainly biased by a tendency of the people to be grateful to the efforts of CARE and to wish to please me as a supposed CARE staff member.
Ad c) All interviews were held in Spanish, which is a second language for me and also for many of my research participants. Concerning the midwives the language barrier played an even bigger role: As I neither do speak Kakchiquel nor Quiché, and the work with a translator was not successful, I could only conduct interviews with midwives who have a quite good command of Spanish. Those are certainly a different group of practitioners than those who have much less contact with the Ladino populations. Moreover, the midwives I spoke to, are those who are collaborating very well with CARE and the health centres. It would have been interesting to know the view of those midwives, who are not that collaborative and what their reasons are to do so. I could not find any problematic aspects with the midwives’ relationship with the health centre, which is questionable for me.

To conclude, my research is biased by that fact that not all people trusted me and my integrity as a researcher and did not really open up to reveal their thoughts. The effect of this is that especially for my interest in the relationship between Maya and Ladinons, the impact of gender, and for the way how midwives perceive their relationship with biomedical care providers, I could not obtain valid data. Presumably, a longer fieldwork period with the possibility to gain the people’s confidence would open the space for this.

4.3.6 Anonymity
All research participants were informed about the purpose of the research and that I will write a thesis with the information I obtained. When asked about if they preferred to be anonymous, nearly all the participants had no objections against using their real names. However, as one person did not want to be named, and as some contents may lead to tensions in the teams, I chose not to use names at all. I also prefer this as I worked with a rather big sample for a qualitative study.
5 Biomedical care providers and indigenous midwives

Santa Lucía Utatlán and Nahualá are two municipalities situated picturesquely in the Guatemalan highlands. Seeing the colourful traditional clothes of the women, even an outsider like me instantly identifies the majority of the people as indigenous. Also the midwives practising there are all Mayan women. Through the implementation of governmental policies (see chapter 1.3) and the subsequent emphasis on improving maternal health in the area, those midwives are encouraged to collaborate with the (often Ladino) biomedical care providers in the health centres, health posts and hospitals. In the course of those encounters, differences – in terms of belonging to a certain “culture”/ethnic group, religion, gender, having a particular education and of course resorting to a certain medical body of knowledge – come up. All those factors influence the way how the different health care providers perceive each other and deal with each other.

In this study I present only a part of this broad picture – the midwives’ encounters with the staff from the two health centres in Santa Lucía Utatlán and Nahualá. Taking the biomedical care providers’ accounts as point of departure, I describe where, for which reasons and how midwives and biomedical care providers interact. In the following I sketch a picture about how biomedical care providers – indigenous and Ladino colleagues alike – tend to claim “authoritative knowledge” over indigenous midwives, and perceive Mayan obstetrical practices in this light. In their aim to “medicalise” the midwives, they encounter the resistance of elderly midwives against adaptation to biomedical standards. The “good” midwife is the one who “accepts” and collaborates well; not the one who refuses to refer a woman to the hospital as she thinks that she can handle a complicated birth with her own experience and her techniques. Those and other negotiations around the power to define health, risk and good practices are the topic of this chapter.

5.1 Places of encounter

The conversations and negotiations between biomedical care providers and midwives take place in two main spaces: in the health centres and in the communities. The midwives come to the health centre either out of a certain need (help during birth, advice) or out of duty (reporting births or maternal death, receiving training). In case of complications (difficult births, postpartum infections, and maternal death) the biomedical care providers seek contact with the midwives in the communities. However, those encounters are not without conflict: although all midwives are expected to do so, only a small number accompanies their patients to the health centre or notifies births. And when staff from the health centre is called to assist a delivery, ethnicity and gender come into the play: being male and/or Ladino might be a barrier to attend a birth.

5.1.1 Health centres

The midwives come to the health centre for three main reasons: they report the deliveries they assisted, they accompany women to the prenatal control, and they attend the monthly midwife training courses. The health centres in Santa Lucia Utatlán and Nahualá are open for consultation every morning from 8 until 11. Usually, it is quite busy in the rather dark and empty buildings with
women waiting with their children for vaccinations, the administration of vitamins or other health services. As the health centre offers prenatal control, sometimes midwives accompany pregnant women for their prenatal check-up. However, only about 4 to 5 midwives come to the health centre of Santa Lucía Utatlán in company of their clients within one week; in Nahualá it is even only one on average per week. This figure is low, as about 30 to 50 pregnant women consult the health centre within one week. The staff in the health centre criticises the reluctance of midwives to accompany their clients to the health centre:

*The midwives don’t want to bring the women which they see to the health centre. They don’t bring them to us. And this should be like that, that they bring them at least one or two times. For the first control and for the last control, that we could see everything they do.* (health worker, Nahualá)

In the eyes of the biomedical care providers the presence of the midwife during prenatal control is desirable, as they can discuss the condition of the woman with the midwife who is caring for her. In some cases the midwife serves also an interpreter – in terms of language (from Spanish to Quiché or Kakchiquel) or in terms of content (from the medical language into the language of the common people) – or as a mediator. A Ladina nurse explains how the presence of a midwife functions as a bridge with the pregnant women:

*They also come because sometimes the patients are afraid to say things or to ask about doubts. Then the midwife comes and serves as a mediator, because she says “She has doubts about this” or “How is the baby?” or “She told me that she has those and those problems, she has a headache”. Thus, she also serves as a guide to offer good control for the woman. Therefore I think that it is good that they accompany the women.* (health worker, Santa Lucía Utatlán)

Although the encounter during prenatal control is meant to be an “exchange” of both opinions, the biomedical care providers tend to see themselves as those who “tell” the midwives about any indications or dangers signs.

*We evaluate their patients [...] and we give them the indications, because we tell them how the child is. If it looks good, if it is in a good position, if the foetus is good or is not good. If the woman has any danger sign, for which she has to go to the hospital. All this we discuss with the midwife. Also the indications and what the woman has to do at home, if there is any special indication.* (health worker, Nahualá)

The midwives are perceived as those who come to ask for advice, and who are provided with “knowledge” by the biomedical care providers:

*I think that the communication is very good, because the midwives who come with their patients [...] ask me for advice. Therefore, yes, there is an exchange of both opinions. As much their thoughts about the condition of their patient as ours. And that now we are exchanging so that they don’t work empirically or without knowledge.* (health worker, Santa Lucía Utatlán)

The midwives – but not all of them – also come to the health centre to report births they attended and notify the number of new-borns. Some biomedical care providers, especially the nurses, have contact with the midwives during the monthly midwife training courses. Then the midwives come together for about two hours to learn about certain topics concerning pregnancy and birth.
In Nahualá I could attend the midwife training course. The midwives gather patiently in front of the health centre and wait until they are asked to come in. There they sit down on wooden benches in a bare room, while the nurse is standing. Those who come later are welcomed friendly with “Sakari!” – the Quiché expression for greeting each other. Nowadays the midwives participate vividly, as the training courses have changed a lot: as the midwives are mostly illiterate, a lot of visual material is used and there is much space for the midwives to share their experiences. After the course, they receive a drink and a small snack. This is financed by CARE as the resources of the health centre are scarce. The midwives greatly appreciate this as a sign of respect towards them and their work. A midwife tells that it used to be different before, and that they had been treated without respect:

*Before, when we came to the reunion in the health centre, no cup of coffee, nothing. And we are thirsty. And like animals, that we have no value.* (midwife, Nahualá)

As part of the SIAS program, midwives and health promoters formed so-called health committees. In the reunions of the health committees, also staff from the health centre takes part and meet with the midwives to solve problems. For instance, when a woman does not want to come to the health centre for prenatal and postnatal control, the biomedical care providers discuss this with the midwife.

### 5.1.2 Encounters in the communities

The biomedical care providers go out into the communities for several reasons: to help when complications arise during birth or in the postpartum period and to investigate about the cause for maternal death. It happens regularly that staff from the health centre is called when a birth turns out to be complicated or takes too long. Interestingly, also male biomedical care providers – auxiliary nurses and rural health technicians – are asked to do that. However, some male biomedical care providers perceive their gender as limitation in this respect, as the midwives prefer women to work with them. One Ladino research participant complains that he cannot check if the midwives apply the knowledge from the training courses as he is not allowed to assist births together with them:

* [...] One trains the midwives and there is no adequate follow-up. [...] They don’t allow attending a birth. This is something very private for them, because they allow nobody to enter. Thus, if one trains somebody, one has to see how it is developing, what results from this training.* (health worker, Nahualá)

Apparently, confidence or “confianza” how it is called in Spanish, plays an important role. But this is not necessarily linked to ethnicity or gender. For instance, one male auxiliary nurse who has worked in a hospital for many years and is from the community, is quite popular as a “birth attendant”:

*They call me to attend births or to bring them to the hospital. The people collaborate with me because they know me. In me, they have confidence.* (health worker, Santa Lucía Utatlán)

Another example is an auxiliary nurse who is Ladina, but grew up in the community. She gave birth to her own children with the help of a midwife, and is often called for births. Her experiences with assisting births together with indigenous midwives are “excellent”:
There are moments when they have doubts. Then the husbands come to call me in the morning, in the night. And I go. (health worker, Santa Lucía Utatlán)

Thus, those biomedical care providers who are from the communities themselves, are trusted more and have easier access. Also, there are differences in this aspect in the two municipalities. In Santa Lucía Utatlán the midwives seem to be more open, while generally Nahualá was described to me as “more traditional” and that midwives would be more closed towards male care providers and Ladinos.

Maternal death is a less pleasant reason for contact between the biomedical care providers and the midwives. If a woman dies during childbirth, somebody from the health centre goes to the community and asks the midwife about the circumstances: if the woman had been to prenatal control, how the delivery was, if any complications occurred, and what happened after the birth. Together with the midwife and her memory of the birth process the biomedical care providers try to find out what caused the death of the woman. This, however, is not meant to scold or punish the midwife:

*If there is a maternal death, what we do, is going to the field. See why the woman died. What was the cause. And talk with the midwife. What she would have done. It is not to punish her, but to see what the fault was. [...] That it does not happen again.* (health worker, Nahualá)

5.2 Perception of midwives by biomedical care providers

The biomedical care providers in the health centres in Santa Lucía Utatlán and Nahualá have many things to tell about the midwives they are working with. They talk about the way they experience their relationship with them and the problems they have to deal with in the encounter with indigenous “beliefs” and “customs”. For instance, the conflict between Mayan medicine and biomedicine becomes clear when the question arises what a midwife can do or not. Frequently mentioned are the old midwives, who apparently resist the biomedical care providers’ attempts to teach them and to biomedicalise their practices. Biomedical care providers show to have considerable knowledge – which however is sometimes more based on assumptions and on hearsay than on personal experience – about Mayan obstetrics. As a general feature, they take biomedicine as the standard for granted. Consequently, this influences the judgements on the practices and knowledge, as well as the general attitude towards midwives at least as much as considering oneself to be Maya or Ladino.

5.2.1 Relationship with midwives

Generally, the biomedical care providers define the relationship with midwives as good. However, they usually refer to the professional part of their relationship – as health workers who try to ameliorate the health situation in the communities. The social part of the relationship seems to be less important, as only one health worker from Nahualá mentioned it. He talks about the fact that the midwives greet him friendly when they meet somewhere, and also he does this.
Yes, it is a good relationship in general terms. When I meet a midwife on the street they greet me very friendly. And I of course greet them in the same way, and when they come to the services, as well. (health worker, Nahualá)

In this context it is interesting to note that the social relationship is important to some midwives. For instance, one midwife stresses that she feels respected by the staff in the health centre:

They respect our hands. One midwife died and the doctor said that he was sad, because one of his right hands left. A right hand working in the rural area. It feels like a family. Together we work. One is sad if a midwife dies. (midwife, Nahualá)

The same midwife expressed the wish that midwives attend funerals from the people from the health centre and the other way round as a sign of belonging together. The midwives told me that some years ago they were treated badly in the health centre – “like animals”. But nowadays the situation is different, and they receive more respect. However, during my visits to the health centres I could observe that there was not much social interaction with the midwives when they came for the monthly training courses. The midwives sat together and waited before training, and left quite fast after finishing it. Although the staff in the health centre usually likes to chat and to make jokes, they don’t do this with the midwives.

The professional part of the relationship plays a much bigger role for the biomedical care providers than social aspects. The midwives are first of all perceived in their role health workers, as the public health system can only assist a limited number of births (see chapter 1.1).

We have respect and think that they are a useful resource for the Ministry of Health. [...] It is them who respond to the necessities of the community. While we – like the Ministry – don’t have the capacity to respond to this demand. Thus, one cannot be against midwives. (health worker, Nahualá)

All the biomedical care providers in the two health centres point out that their relationship with midwives is good. They base their valuation on the fact that midwives comply in their collaboration with the public health system, e.g. that they come to the midwife training courses, and apply the knowledge obtained in those courses. The acceptance of the biomedical knowledge is a recurrent topic in my interviews and conversations, and is seemingly of great importance for the biomedical care providers.

We are training them, so that they can chose the techniques we have. [...] Thus, there is a lot of communication from both sides. Or – there is good communication in the moment when they accept that we give advice and that we update in important topics. Thus, I don’t think that there is a barrier between midwives and us, it is good communication. (health worker, Santa Lucía Utatlán)

Along with Guatemalan health care policies (see chapter 1.3), they place special emphasis on the fact that midwives by now recognise “danger signs” in pregnancy, childbirth and the postpartum period and refer the women to the health centre or to the hospital. Within the professional relationship, the biomedical care providers clearly claim authority on knowledge, and also perceive it as their duty to act this out.

We have the obligation to reprove them and to tell them. (health worker, Santa Lucía Utatlán)
As a consequence of the SIAS program the midwives are much more under control by biomedical care providers. The regular participation in the training courses is requirement for the license to practice as midwife. According to the biomedical care providers the midwives are aware of this pressure and come more regularly than before.

*We have a list of all midwives. [...] If she does not come, then there are sanctions. Maybe telling her, that she can’t attend patients. (health worker, Nahualá)*

However, a small number of the midwives who practice in Nahualá and Santa Lucía Utatlán don’t attend the training courses and therefore don’t have their licence. One indigenous rural health technician, who has been working in the health centre for many years, relates it to the midwives’ “culture”, which makes them stay outside the public health system:

*There are always midwives who resist. They are the 10% who don’t come to the training courses. The midwives without license. They don’t want to be part of the health system. [...] It could be because of their culture. (health worker, Santa Lucía Utatlán)*

Some biomedical care providers stress that they experience the SIAS as having a positive effect on their relationship with midwives, as they come to the health centre more regularly. In the course of closer collaboration and contact, there is more space to tell the midwives when their practices don’t go along with biomedical knowledge.

*Language as crucial part of the relationship*

When asked about their relationship with midwives, many biomedical care providers instantly started talking about language: because “language is part of the communication”, as one health worker from Nahualá expressed it. Being able to command “el dialecto”, as Quiché or Kakchiquel is often referred to, is seen as an important factor in the relationship with midwives. In contrast with some years ago, nowadays the majority of the staff in the health centres is indigenous and therefore speaks Quiché or another indigenous language. Language as a barrier was a bigger problem before when nearly all biomedical care providers were Ladinos. But by now the majority of all biomedical care providers with a Ladino or non-Quiché/Kakchiquel background acquired certain knowledge of Quiché or Kakchiquel as they already work in the health centre and have lived in the community for many years. Their knowledge is sufficient for understanding each other, if the communication is not too fast. Two Ladino health workers explain:

*With communication there are no problems, because I speak the dialect a bit. ...More or less we understand each other. (health worker, Santa Lucía Utatlán)*

*It is a good relationship. Maybe a bit limited because of the language, because they only know Quiché, and I speak Quiché not 100%. Thus, when they speak fast, I lose track. Because there are words which I don’t know immediately. Therefore, I lose the rest of what they say. (health worker, Nahualá)*

The question of communication is an issue in two ways of contact: when midwives accompany their patients to the health centre, and when they come for the training courses. Those midwives who have a good relationship with the personnel in the health centres, are often those who have a relatively good command of Spanish. As I explained in the previous chapter, they sometimes function as an interpreter and explain to the women what the biomedical care providers say.
In the two midwife training courses I participated in Nahualá, the instruction language was Quiché, and the midwives participated vividly. Some years ago, the health centre staff had to organise an interpreter for the midwife training courses, as there were hardly any indigenous people working in the health centre. The majority of the staff being indigenous nowadays, the communication is easier, as an indigenous health worker states:

*We do not have problems here with communication, what makes it easier is the language. Because we can speak Quiché and we speak with them, and we reach them. And they tell their experiences.* (health worker, Nahualá)

However, some Ladino biomedical care providers still perceive it as a barrier for education that many midwives don’t speak Spanish.

*As they only speak the dialect, it costs a bit that they understand.* (health worker, Santa Lucía Utatlán)

Apart from this example, the care providers in the health centres agree that communication in terms of language functions well. Apparently, they don’t expect everybody to speak Spanish. On the contrary, they talk about their own command of Quiché or Kakchiquel. This is certainly related to the fact that both Santa Lucía Utatlán and Nahualá are populated mostly by indigenous people, and that the majority of the biomedical care providers is indigenous as well.

### 5.2.2 Old midwives

Many midwives in Guatemala start practising as a midwife when they already have their own children and are older. Additionally, according to Mayan cosmology it is not their choice to become a midwife, but it is their “calling”. The midwives I met during training courses in Nahualá, all claim to have received their “gift” or “don” – as it is called in Spanish – from God. Along with this gift they have “wisdom” (sabiduría) which enables some of them to know when a birth will take place and if it will go well. For instance, one midwife how is also a healer, told me that she had a certain feeling in her arm if she had to expect complications during birth. Nowadays, though, the age structure and way how to become a midwife is changing, though, and there are more and more young midwives – in Santa Lucía Utatlán more than in Nahualá: they don’t have the gift and practise midwifery more as a profession than as a “calling”.

The distinction between older and younger midwives has different implications for the biomedical care providers and the women in the communities. In the eyes of the biomedical care providers the older midwives are a “problem” for several reasons; on the contrary, the people in the communities have more confidence in the older midwives’ skills. This divergence becomes clear by a dilemma in the health centre in Nahualá. The staff wants to recruit and train new midwives as the older ones will die soon. At the same time, they know about the people’s preference for the old and experienced midwives. One health worker from Nahualá talks about this dilemma:

*We want new personnel. We could say, new midwives. We thought about midwives 20 years of age, 30 years of age. [...] But it is impossible. Because for us it [is] easy to select other midwives. But we have to do that for the whole population who has to deal with them. But if they prefer those who have always been working. [...] Because they have the gift. [...] But we had thought to look for new personnel. But we realise that it is not possible, because of the gift they have. And I don’t know yet how it will function, because honestly*
what is needed, are new midwives. Maybe to start to train them that they can work in the future. Because the old ones, they are near to death. (health worker, Nahualá)

For the older midwives it is clear why the women have confidence in them; one explains it with the “patience” which midwives have concerning the whole process of birth:

Many women have confidence in the midwives because the midwives have patience [...] to attend a birth. They have patience, because there are women who shout, who cry, because of the pain. The pain begins and they start crying, and the midwives [say]: “Patience, it is like that for women. Patience”. That’s what they tell her. (midwife, Nahualá)

The reasons why biomedical care providers perceive the older midwives as a problem are manifold. The main concern is that they don’t put into practice what they learn in the training courses. This is explained with the fact that they don’t want to change and are clinging stubbornly to their “beliefs”. Another explanation is that they don’t understand what they are taught or don’t pay enough attention in the training courses. Notably every biomedical care provider I spoke to made remarks – sometimes in a way to ridicule the old women. To my surprise, none of the biomedical care providers uttered respect for their many years of experience to handle pregnancy and childbirth. They rather expressed their doubts about the “gift” which the old midwives claim to have. Especially the Ladino care providers who stress that the gift is “is something which cannot be proven”, and even accuse some midwives of lying.

There are things which I don’t believe for sure. For example the midwives say that they dreamt, and that in a dream it was revealed to them that they were midwives, and that there are white flowers ... I have my reservations. I don’t say that openly that this are lies, but to me it appears that some stories are not credible. [...] I talked with the sons of a midwife. And they say: “My mother, she also has many lies”. They are sure. They say it! (health worker, Nahualá)

The biomedical care providers’ main complaint is that the older midwives don’t want to change and don’t want to learn new things as they think they are right in what they are doing and thinking. Repeatedly I heard, that they cling to their “beliefs” and don’t “accept” the biomedical knowledge propagated in the midwife training courses. A rural health technician puts it like this:

The age of the midwives plays an important role. If it is a very old midwife, she accepts no changes. She thinks that she already knows everything. (health worker, Nahualá)

The biomedical care providers criticise that the old midwives don’t put into practice what they learn in the training courses. As reasons for this they mention that the midwives show resistance, don’t pay attention and fall asleep during the training courses or because they don’t understand what they are taught. They need a lot of repetition as they forget easily what they learned. A rural health technician explains this problem:

One of the problems we have seen is that the midwives sometimes forget. For example one starts to explain: “Good, you have to do this like this. A haemorrhage is so many litres of blood. Thus, it is a danger sign, and one has to bring her to the hospital.” And one asks the midwives: “What to do with a woman with haemorrhage?” And they say: “Not know”. They forget fast. (health worker, Nahualá)

To conclude, the biomedical care providers definitely perceive the elderly midwives as a problem. There is no acknowledgement of their roles as healers or spiritual persons or their years of experience how to handle the stressful situation of pregnancy and childbirth with patience. This is
especially surprising, as it was emphasised in the sensibilisation courses by EDUSARE (see chapter 4.1) and also by the midwives themselves.

5.3.3 Attitudes towards midwives’ knowledge

Generally biomedical care providers perceive Mayan medicine as functioning because of “faith”. In the same way, they call the midwives’ knowledge, which differs from the biomedical obstetrics which is taught in the training courses, as “beliefs”. This is especially the case when they talk about the older midwives (see also previous chapter) who resist adjusting their practice to what they learn in the midwife training courses. In general, biomedical care providers are hardly ever critical about biomedical knowledge. Only some biomedical care providers do reflect on their own knowledge, like this Ladino health worker:

I can say: “This midwife does not learn, does not understand.” When I tell them that things have to be done in this way. But the midwife can think: “He is stupid, my whole life I did it like this!” (health worker, Nahualá)

The biomedical care providers more or less believe in biomedicine as absolute truth, as it is objective and can be proven. The following quote by a health worker illustrates this:

To apply natural medicine, it would need a scientific base. Western medicine has an exact dose. On the contrary, natural medicine is only something estimated. (health worker, Nahualá)

The attitude towards midwives is also influenced by the fact that the staff from the health centre works in a public institution. Although some of the biomedical care providers admit that some of the midwives’ practices are maybe not harmful at all or even beneficial, being part of an institution makes them hesitate to accept those practices.

For the same reason that we work for an institution, it is not easy that we accept certain situations. For example, the midwives make massages, they use soap, there are situations which are positive for them for attending a birth. But for us as institution we can’t share that, thus they are outside of the rules, they are outside of the norm. But is it so difficult to say until which point. Because I also sometimes have doubts, sometimes there are no scientific studies who can in fact tell us that it is not good. (health worker, Nahualá)

Apart from those minor doubts about biomedical standards, the accounts of midwives’ knowledge and practices are very contradictory. On the one hand the biomedical care providers stress that due to better methodology in the training courses and the effectiveness of the SIAS program midwives know the danger signs in pregnancy, childbirth and the postpartum period and do refer the women to the hospital. An auxiliary nurse talks about her positive experiences which means for her that midwives know the “danger signs”:

We are satisfied. Because we know, we see that the midwives put into practice what we learnt them. [...] The midwives send their patients to us, to look if there is haemorrhage. This is a danger sign. And they already know that they have to refer them immediately. [...] Last week we had a woman with swollen feet. Oedema. Thus, we draw the conclusion that they know them [the danger signs; U.W] – step by step, but more or less. At least that they know the dangers signs. (health worker, Santa Lucía Utatlán)
On the other hand the biomedical care providers seem to agree that midwives still need to learn a lot. Often, when I asked if more courses would be needed (and I was talking about sensibilisation courses) they would instantly talk about the lack of appropriate knowledge among – mostly the elderly – midwives. Some research participants stress that the low educational level and the illiteracy of midwives distinguishes them from themselves. According to them they are the reason why midwives “don’t understand everything”. A Ladina auxiliary nurse puts it like this:

*It is difficult to tell them because they don’t have much education. The majority of the midwives are illiterate.* (health worker, Nahualá)

The biomedical care providers claim that especially the old midwives forget a lot because they can’t read and review what they learned:

*The problem with the midwives is that the majority who works, they don’t know to write. Therefore, when one trains them, it is so little what they understand, the rest disappears because they can’t revise their copies, because they can’t read. And as the majority is already old, it is a problem which is at a general level.* (health worker, Santa Lucía Utatlán)

Apparently one gap in the midwives’ knowledge concerns the appropriate use of medicines. Some biomedical care providers (especially those dealing with a lot of different medicines in their profession) accuse the midwives of using medicines without knowing the effects of medicines or even what they are used for. The joke I presented in the introduction about the midwife who goes to the pharmacy and decides to buy a medicine because the name suggests it could be for birth, is an expression of how midwives’ knowledge is seen. Some biomedical care providers also brought forward that midwives don’t have the right knowledge about the anatomy of the human body and therefore about the position of the foetus. In many cases, midwives are perceived as those who “don’t know”. As I pointed out in chapter 3.4, this is a common perception among biomedical care providers.

For all those reasons, many of the research participants don’t have confidence in the midwives and prefer to give birth to their children in the hospital. One indigenous auxiliary nurse relates her distrust in midwives to differences in educational level:

*It is maybe more because of the education of the mothers. A mother, who has not been to school, has more confidence in her midwife. A mother, who has been to school, has more confidence in the doctor.* (health worker, Nahualá)

A Ladina admits that her framework is biomedicine and that she therefore would choose to give birth in the hospital. She emphasises that it has nothing to do with confidence or not, but that the hospital is better equipped in case of complications.

*What I do, if I would be pregnant? I go to the hospital. [She laughs] My branch is medicine, thus I say, I go to the doctor. I go to the hospital, and they attend my birth. [...] Maybe it is not because I don’t have confidence, but as we are more careful, because we know that there is a risk. In the moment of birth, one never knows, also if the whole pregnancy went well, in the moment of birth something happens, therefore automatically it is clear that a person will attend my birth. But automatically in the hospital there are more means than in the house of a midwife. It is not because there is no confidence, but that one sees the means which are available. Thus, first of all one is safeguarding one’s life and the life of the baby, how small the risk may be. I think, more because of this, I would go to the hospital.* (health worker, Santa Lucía Utatlán)
Hardly anybody portrayed the – maybe different – knowledge of midwives in a positive way. Among those, who did, the personal background appear to plays an important role. One auxiliary nurse – a Ladina – relates her positive attitude towards midwives with the fact that her mother was a midwife as well. She finds it important to take the midwives’ knowledge serious.

*My mother was midwife. I already learned the beliefs from my mother. There are things which are certain for traditional medicine. I respect the beliefs of the midwives. There are doctors who don’t believe them, but it is certain. [...] One has to take into consideration what the midwife says.* *(health worker, Nahualá)*

A rare example, where some biomedical care providers concede that midwives know much about, is the lunar cycle and its relationship with births. Around full moon more births are supposed to take place, and they even advised me to go to the hospital around this time if I want to observe a birth. One Ladina tells about her experience when she worked in the maternity ward of a hospital:

*I worked in a hospital. And when it was the night shift, they always told me how the moon was and said: “Today there will be so many births and you will not sleep!” And it was like this.* *(health worker, Nahualá)*

Thus, the biomedical care providers tend to see the midwives as low educated people with limited biomedical knowledge (human anatomy, effect of medicines). It is clear for them that the midwives need midwife training courses to learn about biomedical obstetrics.

### 5.3.4 Accounts of midwives’ practices

As outlined in the previous chapter, the biomedical care providers take the biomedical obstetrics as the norm and therefore disagree with many practices which belong to the “ethno-obstetrics” of Mayan midwives. The problems biomedical care providers experience with midwives, are mostly based on differences which are often referred to as “custom” or “beliefs” or explained by the low education of midwives.

Apart from the practices which lead to tensions and disagreement, only one element of Mayan ethno-obstetrics is widely accepted nowadays: the birth position. In Nahualá and Santa Lucía Utatlán, women traditionally squat or kneel on the floor or bend over (with putting their hands on the floor) for birth. Many biomedical care providers allow those positions nowadays. Even in the hospital in Sololá I was told that women could chose between giving birth in the bed, in a gynaecological chair or squatting on the floor. During my visits at the hospital, though, the women gave birth in the bed. According to the midwives, the hospital staff is not accustomed to the squatting or kneeling position. One midwife told the following story about a night shift she was doing in the hospital:

*I was at the hospital and there was a woman from here from Nahualá. [...] And there was only one nurse in the night, one nurse and one midwife. [...] Then she stayed in bed, ready, and then the baby was coming. And the nurse: “I will not attend, I will call a doctor! Uuiuii, I am afraid, I will not attend the birth, because she is bending over. I will not attend her. Doctor!!” And the nurse left to call a doctor, when the baby was born. I was prepared because [...] all Nahualans always are bent like this when the baby is born. We are accustomed to it. We are prepared to get it out from behind. When already the head of the baby came, I put out my hands and received it. Then the nurse came back: “Ay, thank you*
for attending this woman, I was afraid to attend her. I am not accustomed to this”, she told me. (midwife, Nahualá)

The biomedical care providers I spoke to are less dramatic about differing birth positions than the midwife above. One health worker put it blatantly that “the important thing is that the baby comes out well.” Most of the personnel in the health centre seem to be quite open for vertical birth positions. One Ladina explains this new acceptance among biomedical care providers with the exchange of knowledge.

When there are many problems in the moment of birth, the squatting position is used. And one only has to be squatted a bit, but not sitting on the floor. [...] It is already getting accepted, it is also exchange of knowledge from both sides. (health worker, Santa Lucía Utatlán)

Some research participants encountered “traditional” birth positions even in their biomedical trainings.

What we think we don’t have to reproach, and yes, they have maintained in the attention of birth, is the position of the woman when she is giving birth. Which is squatting or kneeling. Which is a form which is not harmful for the mother [...] I had a teacher who said that the midwives’ way of attending the birth was more physiological, was more natural than how they attend in the hospital. (health worker, Nahualá)

Although many of the care providers in the health centres see the advantage of giving birth in a more or less vertical position, there is still a tendency to perceive the horizontal position as the “correct” one. One Ladina auxiliary nurse for instance is positive about the fact that nowadays more and more indigenous women “accept” the horizontal position.

Another experience is that they are used to give birth in a position – squatting. They put their feet like this... [shows to me how the women squat on the floor]. And we in the hospital or with a Ladina in her house, we give birth in the bed, in the correct position. But they already accept this quite well. There are many who say: “I want in the bed”. Nowadays if they say “No”, we also accept it on the floor. Because we can’t oblige them. (health worker, Santa Lucía Utatlán)

Moreover, some biomedical care providers criticise that midwives don’t practice “safe clean birth” and associate giving birth on the floor with the danger of infections. Usually, the midwife puts a blanket and plastic on the floor. One indigenous care provider clearly distances himself from this “tradition” and describes it as unsafe:

It is not correct for me. For me it is possible that this is the cause for the infections in the postpartum. Because they are closer to the ground. [...] The cloth they use is old cloth. They use nylon. The house is very dirty. (health worker, Nahualá)

More controversial, but not completely rejected, is another practice which is identified as Mayan: the use of the sweatbath (temascal) for massage and sometimes also for birth. Some biomedical care providers – and only those who are indigenous – see the sweatbath as a useful tradition. But others stress a clear opposition against it. One Ladina auxiliary nurse for instance reported to me the case of a new-born baby whose hands were burnt by the hot steam of the sweatbath. On the contrary, an indigenous rural health technician who is working in the same health centre, is very positive about the sweatbath and stresses its beneficial effects:
The temascal is like a sauna. Thus, one enters, and what it does is that it relaxes the whole body of the women. [...] The midwives go with the woman, enter with her in the temascal. And control the condition of the baby, the position. They do this periodically before birth. And they can also calculate more or less when the baby will be born. And in the moment when the baby will be born, they call the midwife and she asks, if the temascal is ready. The temascal here is hot and the body of the woman expands maybe more. [...] And sometimes, when they are tired, sometimes the leave and go into the house. And then the baby is born there. Or when not, it is born in the temascal. The temascal has always been important here for birth. It is very good, the temascal. (health worker, Nahualá)

Although belonging to more to the realm of folk medicine (which is shared by Ladinos and Maya alike) than being restricted to Mayan obstetrics, the use of herbal teas (pimpinella, camomille, etc.) during birth is also a controversial topic. Some biomedical care providers think that it is beneficial.

And I have seen that in the hour of birth, they give them same teas. [...] And it serves them well. (health worker, Santa Lucía Utatlán)

This positive attitude is not shared by everybody. Many biomedical care providers have their doubts about methods which are – unlike those employed in biomedicine – not scientifically proven:

The other thing on which we don’t agree completely, but also don’t disagree, is the use of drinks. Because it is certain that some of them don’t do any harm to the patient, but are not good either. But it is something they insist on a lot. [...] Taking water, they say that it is good that the birth goes faster or that there is no haemorrhage or things like that. (health worker, Nahualá)

A very controversial topic is the fact some midwives change the position of the foetus through massage. This practice is generally not accepted by biomedical care providers, as they perceive that it puts the woman and the foetus at risk. Possible dangers are the rupture of the uterus or that the umbilical cord gets entangled around the neck of the baby.

Sometimes it is possible, but there is a risk for the woman. Maybe it does not work for all of them, only with some of them [the baby] comes out. Thus it does not work. (health worker, Nahualá)

Despite the biomedical care providers’ disapproval, I could see that midwives are still practising the massage to perform external versions and are proud of this. One midwife tells:

I rub my hands with olive oil, then I start to massage, I feel where the head is. Little by little I treat it until the head reaches its place. (midwife, Santa Lucía Utatlán)

However, not all midwives have this skill, those who do it even receive patients from distant communities. Apparently not all biomedical care providers know exactly about what midwives actually do: one Ladino research participant for expressed his relief because according to him the midwives don’t make external versions anymore:

Also that midwives dared to make external versions, to turn the child around, and this is delicate and very risky for the mother, also for the child. Those practices changed. (health worker, Nahualá)

Interestingly, there are also some “malpractices” which the biomedical care providers never saw themselves, but only heard about. One of those is that the midwives administer alcohol to the
birthing women to give them strength and to let them push harder. The biomedical care providers perceive the use of alcohol during labour as something which puts the mother and the baby at risk and therefore disapprove of this practice:

*They give them a bit of liquor before birth. This is not good for the woman and for the baby, isn’t it? Because it can lead to [...] retardation or prolonged birth. But I heard that they are few, not all of them. And they are conscious about it that it is not good, to give them this before birth.* (health worker, Nahualá)

Another story by hearsay is about midwives who use soap to make the birth canal smoother. The soap is applied in the vagina, and also administered to drink.

*Or they take soap water. I have not seen it, I only heard about it. Supposedly it is to simplify the birth.* (health worker, Nahualá)

Like the story about the wrong use of medicines, which I quoted in the introduction, the story about the use of soap is an example how midwives are portrayed as ignorant. One health worker relates the use of soap to the fact that midwives don’t know about human anatomy and therefore also don’t know that the digestive system and the reproductive organs are separated parts of the human body.

Midwives are also accused of having no sufficient knowledge of medicines and using them in a wrong way. The use of oxytocin as one of the “bad” practices is often quoted in the literature on Guatemala (see e.g. Lang & Elkin 1997). However, as it is on the decline through stricter regulations, only one research participant from Nahualá addresses it.

*Oxytocin is not a product of free sale anymore. Before oxytocin was sold in the pharmacy like you ask for an aspirin or another popular product. They sold oxytocin like this. Nowadays the use of oxytocin in the pharmacies is forbidden. Because many midwives used oxytocin as support for the women. And this put them at the risk of rupture of the uterus. And nevertheless still some get oxytocin somewhere. Not through the pharmacies, but there are persons who sell it [...]. But they are not many. Before the midwives came here to ask for oxytocin in the health centre. That we could give them support for the birth. But this has changed.* (health worker, Nahualá)

Another problem mentioned by biomedical care providers is that in their eyes midwives sometimes let the women push too early during the birthing process. One Mayan auxiliary nurse was assisted by a midwife for the birth of one of her own children because the hospital was too far away. She felt very uncomfortable because she was afraid that the midwife would let her push too early. She is plain about it that she would never like to give birth with the assistance of an indigenous midwife again. Another research participant – a Ladina nurse – also reports a similar experience, when she was called to assist a difficult birth:

*Somatics they let the woman push very early. In the training courses they are told, that no, that the patient should only walk, when she has the contractions, that she breathes deeply. And when it is really time that the baby is born, then we let her push. But I had a bad experience. When I arrived [...] the patient was exhausted, because the midwife had let her push very fast. Thus, when she really needed her strength, she did not have it anymore. Then I explained to her that this was not good.* (health worker, Santa Lucía Utatlán)
5.3.5 Collaboration of midwives with the hospital

As I outlined in chapter 3.4, the midwife training courses put an emphasis on the detection of danger signs and – if necessary – the referral of women to the health centre or hospital. By analysing the relationship between biomedical care providers and midwives, Glei (2001) identifies referrals as the main element of good collaboration. As outlined in chapter 5.3.1, the biomedical care providers are more or less content with the midwives’ collaboration with the health centre. In contrast, the midwives’ remaining reluctance to refer women to the hospital is a point of concern. The situation has improved, though, and the number of referrals has risen in the last years.

Before they did not refer their patients, even if there was danger for the woman and she could die, they did not do it. (health worker, Nahualá)

One possible reason for more referrals is a different approach in the training courses: nowadays the midwives are shown around in the hospital of Sololá to familiarise them with this surrounding and to reduce prejudices and fears. As a relatively new step since three years midwives have been doing voluntary 24-hour-shifts to assist the women in the hospital.\footnote{Sololá is the only hospital in Guatemala, where indigenous midwives are working on a voluntary basis. There are, however, problems to recruit midwives, as they only receive 100 quetzales (approx. 9 Euro) per 24-hour shift and as the work is very exhausting. As the births usually happen during the night or in the early morning, in busy nights there is no time to sleep.} In those midwives the indigenous people have confidence: they have time to care for the women in the busy everyday routine of a government hospital with little staff; they speak a Mayan language and Spanish, and therefore can function as a bridge between the hospital staff and the people. Despite those adaptations in the hospital, the biomedical care providers still talk about many reasons for non-referral. On the one hand they identify certain ideas which are subsumed under “custom” or “culture”, on the other hand they perceive lack of information or knowledge as a cause. Concerning the “custom”, the biomedical care providers are aware that the local people and therefore also the midwives perceive the hospital as a dangerous place, where people are done harm to or where they die.

It could be that going to the hospital is against their principles. It is a long-standing tradition, that they could do harm to the patient in the hospital. They prefer that the woman dies at home. (health worker, Santa Lucía Utatlán)

Although the biomedical care providers tend to put the blame on the midwives that they don’t want to refer because of own interests (like being afraid to lose money), they also admit that the resistance to referral can lie in the family. Family members might be against bringing the woman to the hospital out of “shame” or because of the costs. The midwives I spoke to even reported experiences that they had to quarrel with the family.

One research participant also assumed that the sometimes hostile and discriminatory behaviour of the hospital staff might play a role. This is supported by various accounts of the midwives on their experiences with the hospital staff, who sometimes report disrespectful behaviour. Most of the conflicts take place with the nurses, and not – as indicated by Hurtado and Sáenz de Tejada (2001; see chapter 3.5) – with the medical doctors. The midwives stress, though, that the...
situation has improved a lot. One reason is that midwives acquired a certain status through their licence and are easily allowed to enter the hospital.

*Without licence one did not enter. [...] Because in the hospital one enters with the patient. "Out of here! Out of here!" They did not receive us. As midwife one had no worth. But nowadays it changed a lot. Because with the licence I say that I am a midwife. And they let me enter, let me in.* (midwife, Santa Lucía Utatlán)

Biomedical care providers and midwives have different ideas about which situations midwives can handle at home and solve with their experience and their knowledge. According to the biomedical care providers, it is shameful for a midwife if she is not capable of assisting the birth. Then she runs danger of losing the confidence of her patients as they perceive her as a “bad” midwife.

_They have an idea which is an idea which also the community has, that a midwife who refers a patient to the hospital, is a bad midwife, who doesn’t have the capacity to solve the situations for which she is there. But there are things which she can’t solve._ (health worker, Nahualá)

Although the biomedical care providers stress proudly that the midwives accept the knowledge offered to them of training courses, concerning the referrals a contradiction arises: they talk about “lack of knowledge” or “information” among the midwives as problems. Common situations are when babies are in transverse lie, when a birth takes “too” long or when haemorrhage occurs. One auxiliary nurse for instance tells that sometimes midwives don’t recognise the risks of prolonged labour, wait too long and might cause the death of the baby:

_The midwives say: “We have to wait”. They are also told [in the midwife training courses; U.W.] that they have to wait so much until the baby is born. And they wait longer. “We have to wait more”, they say. When the babies are born, they are dead._ (16)

A recurrent topic of disagreement is when babies are in a transverse lie or breech position. Then some midwives insist on assisting the birth, and turning the baby through massage. They say: “I can work like that!” On the contrary, for the biomedical care providers a wrong positioned baby is a clear reason to send the woman to the hospital and to make a Caesarean. If the midwives resist, they are perceived as “closed” in relation to biomedical knowledge.

_Sometimes there are midwives who are a bit closed, those who say: “Yes, yes, yes”, even if it is not “yes”. There was one situation; a woman arrived here with contractions. But in the hour of birth, the baby was in breech position. And I said to the midwife that it would be better to send her to the hospital. “No”, she said, “here she will give birth”. And the truth is that she could not give birth and we had to refer her to the hospital. And she had to go and they had to make a Caesarean._ (health worker, Santa Lucía Utatlán)

Thus, the staff in the health centres knows about the variety of reasons which lead to the midwives’ reluctance to refer their patients to the hospital. Although the biomedical care providers and the midwives partly perceive the same problems (resistance of the family, disrespectful treatment by the hospital staff), the gap exists concerning which situations midwives are supposed to handle at home and which cases they have to refer to the hospital. As also in the

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30 As indicated by Cosminskey (2001a, b) the rates for Caesareans in Guatemala are very high. In the hospital for Sololá, about 30% of all births are Caesareans. (personal communication with the director of the hospital)
previous chapters, this different points of view between of the two parties exist within a context where the biomedical care providers claim “authoritative knowledge” and devalue the experience-based knowledge of the midwives as “customs” and “culture”.
6 Discussion and conclusion

Midwives are the central figures in pregnancy- and birth-related care in rural Guatemala. This fact is acknowledged widely – by health care providers, NGO workers, the government as well as the pregnant women and midwives themselves. Midwives can serve as a bridge between the community and the public health system: they follow the course of the pregnancy, birth and postpartum period, and often they are able to translate (between languages or also the “medical speak” into everyday speak) and mediate between women and biomedical care providers. Therefore, their collaboration with biomedical care providers is crucial for a good coverage of health services in the rural areas. However, in the interaction between biomedical care providers and so-called “traditional” therapists like midwives, problems can arise. In the case of biomedical care providers and indigenous midwives in rural Guatemala, previous studies identified differences in ethnic background and gender, as well as the power relationship between biomedicine (as institutionalised body of knowledge which is taught in schools) and Mayan medicine (as “traditional” medicine with apprenticeship as way of learning) as obstacles and reason for tensions.

This research dealt with the views of biomedical care providers, who in the course of an NGO project by the international organization CARE were sensibilised on aspects of Mayan medicine and cosmology. The aim of the project was to foster mutual respect and to strengthen the midwives in their social and spiritual role. However, the way how the biomedical care providers describe their experiences with midwives, supports Cosminsky’s (2001a, b) argument that they perceive themselves in a clearly hierarchical relationship – with midwives in the inferior position. By referring to their biomedical training the care providers in the two health centres under study claim what Jordan (1993, 1997) calls “authoritative knowledge” and act this out by teaching, reproving, correcting and controlling midwives. The “good midwife” is young, “accepts” the biomedical truth propagated in the training courses, and collaborates well with the public health system by referring her patients in case of complications or risks to biomedical facilities. This is not to say that biomedicine has authoritative knowledge by itself in Guatemala, but that the biomedical care providers apparently do their best to legitimise the biomedical practices: the challenge for them is to reduce the reluctance of women to come to the health centre and of midwives to refer their patients to biomedical facilities.

As stated by other anthropologists, midwives are under the pressure of medicalisation (see chapter 3.3): however, they do combine the biomedical knowledge offered to them in training courses with their own so-called “traditional” Mayan obstetrics and worldview, claim authority for their experience and practices, and sometimes also show resistance. Dealing with this, the biomedical care providers turn midwives – who often share the same indigenous background and the same gender – into “others” is by criticising their low educational level. Thus, not ethnicity or gender, but much more education appears to be the defining marker difference, and the biomedical care providers stress this by continuously referring to the importance of the (biomedicalised) midwife training courses. The complaints about old, stubborn and illiterate midwives and about non-referrals to the hospital are uttered by the indigenous and Ladino staff in the health centres alike. It is only in some aspects that belonging to an ethnic group, religion or
gender has an impact on the perception of and attitude towards midwives. Though certain Mayan obstetrical practices like the use of the sweatbath are certainly more rejected by Ladino biomedical care providers than by their indigenous colleagues, the negative attitude towards “Mayan” obstetrics or “wrong” use of biomedical products (which proves that midwives are not that “traditional” as they are sometimes portrayed) is not a discrimination based on the relationship between Ladino and Mayan people. It is their education which allows biomedical care providers to claim “authoritative knowledge” towards the midwives they are working with. In their eyes, biomedicine is the standard, something which can be empirically tested and measured, while Mayan medicine and obstetrics belong to a certain part to the realm of “beliefs” and “customs”. Subsequently, conflicts arise about which situations midwives can handle and how they do it. As indicated in previous studies, biomedical care providers perceive themselves as those “who know”, while midwives are those who “have to learn”. However, one has to take in consideration that more problems are reported about the relationship between midwives and hospitals than with health centres. Unlike in the health centres in Santa Lucía Utatlán and Nahualá, the majority of the staff in the hospital of Sololá is Ladino, and here ethnic discrimination may play a bigger role.

The medicalisation process which is acted out on midwives through midwife training courses, and which reinforces the production of biomedical knowledge, shows another effect on the attitude of biomedical care providers: despite of the sensibilisation courses offered in the project under study, there is hardly any acknowledgement of midwives as ritual and obstetrical specialists; much more they are expected to turn into well-functioning and cheap community health workers. But this strips the midwives off their spiritual and social role and does not help them to strengthen them in their identity as Mayan women.

The findings of this research support Crandon-Malamud’s argument that within a medical pluralistic setting, health care choices function to reinforce a certain identity. In the case of biomedical care providers in rural Guatemala, their critical attitude towards Mayan medicine and their practitioners appears to strengthen their own identity as educated health workers who believe in science. They do not reprove midwives on grounds of their Mayanness, but because of lack of education and because of clinging to “traditional” customs and beliefs. In the context of a country with a history of unequal relationships between the poor, uneducated, indigenous population and the economically and socially dominant class of Ladinos, this is an important insight. Therefore I claim that the missing mutual respect between biomedical care providers and midwives is not a question of ethnic or gender discrimination in the first place – certainly not in places like Santa Lucia Utatlán and Nahualá where the majority of the staff is indigenous, and where many women work in the public health system. It is the power relationship between biomedicine and a so-called “traditional” medicine which has to be targeted.

To conclude, acknowledging Mayan medicine officially as valuable body of knowledge could be a step into the direction of bridging the gap between biomedicine and Mayan medicine. At the same time, this process can support the Maya in their striving for recognition of their rights as indigenous people and strengthen Mayan midwives in their multiple roles as healers, social key figures and mediators within the complex arena of health care and health care choices in rural Guatemala.
Epilogue

When trying to think about which conclusions I can draw from this research personally, I was reminded of a quote by Linda Green, who has done much research among Mayan war widows in Guatemala: “What is at stake, it seems, are the struggles between the powerful and the powerless, and what is at issue for anthropologists, is with whom to cast their lot.” (1994: 229)
For me it is clear: I cast my lot for the Mayan midwives. They are those who gain little money with their work, who have to subject their experience to the authoritative knowledge of biomedicine, and who belong to the structurally disadvantaged part of the Guatemalan population. But it is their knowledge, experience and wisdom which have to be cherished in order to guarantee good care for pregnant and birthing women and their infants in Guatemala. I therefore hope that the insights from this thesis can help the EDUSARE team in their valuable pioneer work to strengthen Mayan medicine and its practitioners.
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Appendix: Question guides

1.1 Question guide for focus group discussion with biomedical care providers

1. Which information in the sensibilisation courses was important and/or new for you?
2. How did your knowledge or your attitude change after the courses?
3. How do you apply the knowledge in your work as health care provider?
4. What do you think about incorporating traditional therapists into public health services?
5. How can the gap between Mayan medicine and Western medicine be reduced?

1.2 Question guide for individual interviews with biomedical care providers

1. Where do you have contact with midwives?
2. How is your relationship with midwives?
3. What are the problems in your collaboration with midwives?
4. What are the differences between midwives’ practices and Western medicine?
5. How is it for you as Ladino/a (or indígena) to work with indigenous midwives?
6. What is the influence of you being a man/woman on your interaction with midwives?
7. In which respect did the courses support your ideas or knowledge about midwives?
8. In which respect was there new information about midwives in the courses?
9. Which information in the courses helped you to ameliorate your relationship with them?
10. What do you think about strengthening Mayan medicine to ameliorate maternal and child health?

1.3 Question guide for focus group discussion/interviews with midwives

1. How did your relationship with the personnel in the hospital change?
2. How did your relationship with the personnel in the health center change?
3. What do you need to ameliorate the relationship with health care providers?
4. How is it possible to work together? (Spanish: Como es posible caminar juntos?)
Curriculum Vitae

Born 23rd May 1977 in Grieskirchen, Austria

Education

2003 – 2004
“Amsterdam Master’s in Medical Anthropology”, University of Amsterdam, Netherlands; financed with the postgraduate scholarship by the Austrian Ministry of Science; graduated with honors.

1995 – 2002
Social and Cultural Anthropology Major and Combination of Subjects Minor (Gender Studies, Philosophy, Sociology, Transcultural Psychiatry) at the University of Vienna; ERASMUS exchange stay at the University of Utrecht 1999/2000; graduated with honors.

1987 – 1995

Research Experience

2002 – 2003
Researcher in the project “Organisational processes of feminist research within and outside of university”; coordinated by the ‘Association of feminist scholars’ (Verein feministischer Wissenschaftlerinnen), Austria.

Book publication


Master thesis


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