Privatization and the New Medical Pluralism

Shifting Healthcare Landscapes in Maya Guatemala

Anita Chary and Peter Rohloff
Rosa, a 45-year-old Kaqchikel Maya woman from a rural community, recalls that her interest in health and healing began soon after her husband died of stomach cancer. In order to send her three young sons to school, Rosa held jobs outside the home and dedicated her nights to commissioned weaving. Slowly, and perhaps because of her life experiences and resilience, women began to approach Rosa for advice about various issues, including health concerns. Rosa was flattered, but often found herself unable to answer her confidants’ health questions. She sought out any medical training she could find, attending health education sessions sponsored by non-governmental organizations (NGOs) in a nearby town. Eventually, she stumbled on a midwifery course offered at a government health center. As a result of her excellent performance in the course, she connected with lay midwives participating in a cooperative, and she began to attend their monthly self-directed education sessions.

Rosa was not called to midwifery through dreams or a spiritual experience—the common vocational paths documented by many scholars (Lang & Elkin, 2006; Paul & Paul, 1975). Nor was her adoption of midwifery a simple matter of professional choice, which contemporary accounts suggest is increasingly common among young secular Maya midwives (Berry, 2006; Hinojosa, 2004; Maupin, 2008). Rather, Rosa’s practice grew organically out of her social position in her community. Her experience in childrearing, homemaking, and weaving—as well as the relative breadth of her medical experience—place her in confidence with all kinds
of women in her village. At the same time, through attending NGO- and government-sponsored health courses, she has become well versed in biomedical perspectives on the physiology of pregnancy and birth and has developed the skills to work with a variety of women’s health issues outside of childbirth. For example, she treats simple urinary tract infections, offers women advice about birth control methods, and refers patients to a local NGO or to the health center when there is a problem beyond her scope of practice. In these ways, Rosa simultaneously maintains strong ties with traditional Kaqchikel life and actively engages biomedical resources, on her own terms, to craft her own style of practice.

This chapter analyzes how healthcare privatization has induced changes in Guatemala’s healthcare landscape, which increasingly positions indigenous Maya midwives like Rosa to leverage multiple resources, engage with biomedicine on their own terms, and define the scope of their own practice. In Guatemalan indigenous communities, lay midwives have overseen childbirth for millennia. Lay midwives continue to play a crucial role in delivering care in Guatemala today. While Guatemalan women are, in theory, guaranteed access to free prenatal, delivery, and post-partum care through a government system of health posts, clinics, and hospitals, these facilities are underfunded and often geographically inaccessible (see this volume’s introduction). Prenatal vitamins, laboratory exams, and sterile materials for surgeries are often unavailable through the public system, with the result that impoverished women must pay for these items at private clinics. Furthermore, public health facilities are understaffed, as government-employed physicians and nurses avoid rural assignments, receive salaries only for part-time work, and earn their living primarily through private fee-for-service clinical work (see also Pezzia, this volume). These factors compound women’s cultural and religious preferences to deliver at home with a midwife (Berry, 2010). Indeed, lay midwives attend half of all births nationwide, and up to 70% of all births in rural indigenous communities (Ministerio de Salud Pública y Asistencia Social [MSPAS], 2010; United Nations Statistics Division [UNSD], 2014).

Guatemala has one of the highest rates of maternal mortality in Latin America, at 140 per 100,000 live births in 2010 (World Bank, 2014b), and this figure often doubles or triples within rural and indigenous communities (Schieber & Stanton, 2000). In attempts to reduce maternal mortality nationwide, the government of Guatemala has regulated lay midwives’ practices for many decades. As described below, this trend has only continued with healthcare privatization reforms of the 1990s. Notably, healthcare privatization in Guatemala has entailed a rapid expansion of NGOs—both those associated with a government health service contracting system and those working independently—as well as other private providers. This has promoted a greater availability of biomedical resources as well as international funding and partnerships related to lay
midwives’ work. In response to these opportunities, lay midwives are redefining their work and transforming their roles within both their communities and the national healthcare system. As they do so, they resist and subvert two disparate but paradoxically aligned discourses, which have historically circumscribed midwives’ roles. The first of these discourses is the historical perspective of anthropological literature on Guatemalan lay midwives, which situates them as “ethnomedical” practitioners by focusing on the idiosyncratic and ritualistic elements of their vocation and ignoring their contemporary multisectorial engagements. In contrast, this chapter demonstrates how indigenous midwives increasingly integrate biomedicine into their practices in creative and productive ways while still fulfilling traditional social and community-based roles. The second of these discourses is that of national public health policy and the development agenda, which have attempted to limit lay midwives’ scope of practice by insisting on their “backwardness” and inability to effectively assimilate biomedical techniques into their practice. However, Maya midwives do not let these policies define the boundaries of their practice. Rather, they readily access private and nongovernmental biomedical resources, expanding and reinforcing their central and traditional role as liaisons and arbiters between their communities and the biomedical healthcare system. Rather than passive subjects controlled by tradition, the development apparatus, and biomedicine, we argue that Maya midwives exert agency in expertly crafting their roles in contemporary society.

Ethnographic data presented here derive primarily from one year of Nora King’s (NK) participant-observation and collaboration with the Cooperativa K’alexofima’, a lay midwife cooperative in the Western highlands of Guatemala, from 2013-2014. Cooperativa K’alexofima’ is a voluntary group of about 100 members who gather monthly for educational sessions. Members also have access to discounted medications, receive practical support from the cooperative’s leadership, and can make referrals to a physician associated with the organization. Cooperativa K’alexofima’ also serves a social role, providing a safe space for lay midwives to share best practices and voice frustrations. Many participants are monolingual speakers of Mayan languages, but others are younger women who have recently begun studying midwifery. The insights presented in this chapter principally derive from NK’s work with Cooperativa K’alexofima’, including attending meetings, developing training sessions, providing clinical support, shadowing Maya midwives, and participating in social functions. Other data presented are based on site visits to NGOs involved in midwife training programs as well as a review of websites and strategic documents of such groups conducted by all authors.

This chapter begins with a historical outline of how the twin discourses of anthropology and biomedicine have circumscribed lay mid-
Chapter 8

wides’ biomedical engagements. Subsequently, it provides an overview of recent trends towards privatization and diversification of the biomedical landscape in Guatemala, which are enabling lay midwives to resist these earlier characterizations as either idiosyncratic or “backward” by leveraging biomedical resources on their own terms. Finally, it explores specific examples of how lay midwives leverage these resources through three cases, offering insight into how they are redefining their social roles through these productive and creative engagements.

LAY MIDWIVES AS ETHNOMEDICAL PRACTITIONERS: THE ANTHROPOLOGICAL DISCOURSE

Guatemalan medical anthropology has a long history, and studies of indigenous midwives feature prominently in this literature. Some of the earliest medical anthropological texts from the field were extended studies of lay indigenous midwifery practices (Adams, 1952; Valladares, 1952). These accounts were heavily influenced by Latin American indigenist ideology (indigenismo), which viewed understanding cultural difference as critical to national assimilationist projects, and which was promoted by Mexico’s National Indigenous Institute among anthropologists working in Mesoamerica. As well, in the mid-20th century, public health and research institutions regularly hired medical anthropologists to document local indigenous explanatory models and healing practices, largely for the purposes of bridging communicative gaps between biomedical practitioners and local populations and facilitating community health interventions (Barrett, 1997). In the 1970s, in particular, given the prevailing philosophy in international health of primary care for all, anthropologists sought to document ethnomedical practices in hopes of contributing towards broader efforts to integrate local healers into incipient primary care systems (S. Cosminsky, personal communication, January 1, 2015).

In this political environment of knowledge production, scholars focused on the ritualistic and spiritual elements of Maya midwifery in attempts to document and legitimize their unique knowledge. Tropes established by these early studies included accounts of Maya midwives’ receiving their vocational calling—and sometimes even their training—through spiritual means of dreams and revelations, or by falling victim to an illness with metaphorical significance, such as chronic aching in the hands, which improves following assumption of the duties of midwife (L. Paul, 1975; Paul & Paul, 1975).

Although subsequent generations of anthropologists discarded many of the assimilationist assumptions and the applied focus of these earliest studies in favor of more progressive and theoretical approaches, the scholarly focus on cultural particularity has remained relatively constant in the study of Guatemalan midwifery. For example, throughout the
1980s and 1990s, studies documented lay midwives’ use of hot-cold disease classification systems, treatment of ethnomedical illnesses such as evil eye, or practices of abdominal binding and the sweatbath (Cosminsky, 1982b; Greenberg, 1982; Lang & Elkin, 1997; Messer, 1987; Villatoro, 1986). In part, these analyses were responses to feminist critiques of the medicalization of childbirth, which led many scholars to advocate for study of cultural birthing practices as valid and coherent systems (e.g. Jordan, 1978; MacCormack, 1994; McClain, 1989; Sargent & Davis-Floyd, 1997).

Even the most recent studies of lay midwives, however, which tend to have an explicit focus on revitalizing and reasserting the public health significance and cultural authority of lay midwives, have largely recapitulated themes of indigenous cosmovision—a philosophy attributing health to cosmological, physical, spiritual, mental, and emotional balance—and vocational particularity (Eder & García Pú, 2003; Rogoff, 2011; Villatoro, 2001; Walsh, 2006). Underexplored in this literature are lay midwives’ engagements with biomedical knowledge and healthcare systems (Cosminsky, n.d.). Even as pharmacies, hospitals, birthing centers, and training programs proliferate around the country, these accounts continue to portray lay midwives as culturally conservative and operating in a sphere largely untouched by these other contemporary developments. Accounts that do detail lay midwives’ interactions with biomedical knowledge, professionals, and systems highlight power imbalances between physicians and nurses and lay midwives, biomedical providers’ and institutions’ assaults on lay midwives’ cultural identities, and lay midwives’ limited comprehension of biomedical reasoning (Acevedo & Hurtado, 1997; Berry, 2006; Cosminsky, 2001; Hurtado & Saenz de Tejada, 2001; Rogoff, 2011). Such phenomena do indeed occur regularly in Guatemala, but together, these studies suggest that biomedicine is supplanting midwifery practice. Few analyses take an alternative perspective that highlights indigenous Guatemalan midwives’ agency in complementarily using and adding biomedical practices to their repertoires (Chary, Kraemer Díaz, Henderson, & Rohloff, 2013). In general, anthropological literature about indigenous Guatemalan midwives has not followed trends in anthropological studies of midwives in other parts of the world, which explore their complex mediation of their roles, identities, and relationships with biomedical systems (Bourkeault, Benoit, & Davis-Floyd, 2004; Davis-Floyd, 2001; Hildebrand, 2012; MacDonald, 2007).

MIDWIVES AS BARRIERS TO PROGRESS: THE BIOMEDICAL DISCOURSE

In addition to the view from the anthropological lens, indigenous midwives increasingly came under the scrutiny of the emerging biomedical
Chapter 8

and public health sectors in Guatemala in the late 19th and early 20th century. As early as 1897, the Ministry of Public Education sponsored obstetrics classes for lay midwives (Carey Jr., 2014). From the 1930s onwards, the Guatemalan government increasingly formalized attempts to regulate midwifery practice through training programs and licensing requirements. Through government-sponsored training sessions, lay midwives were discouraged from using traditional therapies, such as abdominal massage and sweatbath, and were forbidden from attending certain types of high-risk deliveries (Goldman & Glei, 2000; Greenberg, 1982).

This regulation and transformation of “traditional” midwifery roles accelerated with nationwide programs following the implementation of the global Safe Motherhood Initiative (SMI) in 1987. The SMI aimed to reduce maternal mortality by strengthening community-level care, in part through more rigorous training and supervision of lay midwives (Mahler, 1987). A major documented cultural effect of these new training programs included a wave of “secular” younger lay midwives who adopted midwifery for professional reasons, but eschewed many of the more traditional vocational trappings (Hinojosa, 2004; Maupin, 2008). Nevertheless, in Guatemala and elsewhere, the SMI had minimal impact on maternal health outcomes. Hence, support for supervising and funding lay midwifery training through traditional international health sources declined, under the assumptions that lay midwives were unable to recognize danger signs and make timely referrals for obstetric emergency (Maclean, 2010).

Worldwide and in Guatemala, investment in lay midwives, by governments and intergovernmental agencies associated with the SMI, was replaced with a push for “facility-based” deliveries attended by skilled birth attendants (SBAs), a term which refers to birth attendants with biomedical training, such as nurse-midwives (Cosminsky, 2012; Kestler, Walker, Bonvecchio, Sáenz de Tejeda, & Donner, 2013; Sibley & Sipe, 2006). In Guatemala, between 1995 and 2009, the percentage of deliveries that occurred with SBAs increased from 34.8% to 51.5% (UNSD, 2014). These numbers, however, belie a difficult and controversial transition. First, despite increasing pressures for women to deliver in the hospital, many continue to deliver at home with a lay midwife, given familial and cultural expectations as well as practicalities such as transportation and finances or overt experiences of racism or discrimination at government facilities (Berry, 2010; Hurtado & Sáenz de Tejada, 2001). Second, existing “skilled” attendants are often recent medical school graduates with little experience, operating unsupported in remote health centers with very few resources. The pregnant women NK worked with emphasized safety as part of preferences to deliver at home; indeed, those who deliver in health centers are more likely to have Cesarean sections or suffer from postpartum infections (Alhabe & Belizán, 2006; Kestler & Ramirez, 2000). While it is difficult to assess whether physicians perform
Cesarean sections out of medical necessity or for their own convenience, our interlocutors roundly wished to avoid being “operated on.”

[8.14] LAY MIDWIVES AND PRIVATIZATION: A THIRD WAY

Contemporary lay midwives are situated in a complex space. On the one hand, they are reified by social scientists and many activists as the final conservateurs of endangered cultural and ethnomedical knowledge. On the other hand, they are increasingly written off as irrelevant and even dangerous by the biomedical establishment. However, as the following cases studies show, Maya midwives resist both of these characterizations. In part, they are able to do this because of the unique constellation of healthcare resources that has emerged in many rural communities following the signing of the Peace Accords and the end of the civil war in 1996. As documented in this volume’s introduction, the Peace Accords provided several specific measures designed to promote the health of indigenous communities, which have been historically underserved by the public healthcare system. At the same time, as in many other parts of the world, international lending institutions mandated health system reforms to privatize the provision of healthcare. Thus, measures to improve indigenous health were implemented under a government initiative known as the Program for the Extension of Coverage (PEC), which subcontracted basic healthcare provision in rural areas to NGOs (see Maupin, this volume). The PEC guidelines include a specific mandate to improve rural access to prenatal care, in part by providing oversight, supervision, training, and help with pregnancy referrals to lay midwives. Therefore, paradoxically, at just the moment when institutional and national health policy was otherwise shifting its interest away from lay midwives in favor of SBAs, the PEC was increasing funding and opportunities for lay midwives. Especially in the last decade, this has sparked a proliferation of new, bilateral training and funding initiatives (Berry, 2006; Chary et al., 2013; Foster et al., 2012). United Nations agencies, the US National Institutes for Health (NIH), the Pan-American Health Organization, and many international NGOs have allocated resources towards research, training, and policy development with lay midwives in Guatemala (A. Garcés, personal communication, July 20, 2012). As explored below, indigenous midwife training has also become an increasingly popular initiative for NGOs and short-term medical missions not participating in the PEC. These institutions have proliferated in recent decades, and currently thousands of NGOs operate healthcare programs in Guatemala (see the introduction, this volume). Such NGO-ization represents another important aspect of healthcare privatization that has significant effects for lay midwives. In some regions of Guatemala, NGOs—both PEC-associated and independent—have filled in the gaps where
Chapter 8

SMI funding has receded. At the same time, the private for-profit health-care market has matured considerably in recent years (United States Agency for International Development [USAID], 2008). In the towns where we work, dozens of private fee-for-service clinics and laboratories have emerged within the last decade, many of which provide exams and services unavailable in the under-resourced government health facilities. These developments create new opportunities for lay midwives who, despite being officially discounted by national and international policy-makers, increasingly reach out to and network with NGOs and private biomedical practitioners for advice, referral care and supplies. In this way, they maintain their central authoritative role as a source of traditional care for their communities while incorporating new biomedical knowledge and adapting to the changing healthcare landscape. The following vignettes examine this phenomenon in detail.

JOSEFA AND THE RENEWED INTERNATIONAL INTEREST IN LAY MIDWIVES

Josefa, a middle-aged lay midwife, stood close to her client Ofelia at her home in K’echelaj, a rural Kaqchikel village in central Guatemala. She had invited Laura, a British engineer, and myself (NK), to her client’s home to try out a newly designed prenatal monitoring device. I held the apparatus, a smartphone attached by a cable to a bubble-gum pink fetal heartrate monitor. The heartrate monitor, or Doppler ultrasound, is so ubiquitous in biomedical prenatal care in wealthy countries that Laura bought hers from an online retailer selling directly to expectant mothers for use at home with their own phones. Laura wanted to see whether indigenous midwives could find and record the fetal heartbeat, recordings of which could then be analyzed to help with early detection of fetal distress.7

Josefa and I finished explaining the function of the device to Ofelia in Kaqchikel, and she agreed to participate. She loosened her brightly colored skirt, as she had done many times before for Josefa’s prenatal check-ups, and lay down on her bed in the dim room. Laura showed Josefa how to connect the cable and use the touchscreen. I joked about Josefa’s facility with the technology, to which she replied that she had used her son’s smartphone already.

Before using the device, Josefa set it down on the bed and used her hands to feel Ofelia’s abdomen. It was large; she was just one week shy of her due date. “Útz rub’anon,” she murmured, implying that the baby was in a good position for delivery. She turned on the device and placed it on Ofelia’s abdomen. We all fell silent, listening through the static for traces of a heartbeat. Within moments, it appeared. Ofelia beamed, and Josefa looked satisfied. “There’s the heart,” she said. As we cleaned up, Josefa
Leveraging Resources in Contemporary Maya Midwifery

held the device, inspecting it again. “I would love to have one,” she said. “I think I could do a lot of good for the women I see.” Her words rang true to us; in her isolated village, early detection and referral of obstetric problems could spell the difference between life and death for mother and child.

[8.20] Lay midwives like Josefa are increasingly seeking out and incorporating biomedical and technical resources, such as Doppler ultrasounds and smartphones, into their practice. Such resources are becoming more widely available as privatization facilitates and encourages flows of humanitarians involved in research and service initiatives. Laura, for example, works with a prestigious university in England that is becoming increasingly invested in global health projects. Through a colleague with former research experience and connections in Guatemala, she contacted Cooperativa K’exeloma in hopes of finding lay midwives willing to pilot test the device for what would later be expanded into a formal small-scale clinical trial. The cooperative’s leadership enthusiastically established a partnership with Laura and her colleagues, hoping that the connection might bring in resources and equipment in the future, and arranged for Laura to conduct home visits with various lay midwives in their network over several weeks.

[8.21] These sorts of relationships between Guatemalan lay midwives and health professionals and volunteers, both local and foreign, are becoming increasingly common. A number of NGOs, religious missions, and foreign universities have established midwife training programs and midwifery schools throughout Guatemala (e.g. Midwife International, 2014; Midwives for Midwives, 2015; Saving Mothers, 2012). During visits we have conducted with such groups, administrators have spoken about their motivations to promote “women’s empowerment” and “indigenous culture” through their programs. They have showcased specially-designed birth registration notebooks, colorful educational materials illustrating common obstetric signs of danger, and basic supplies like scissors, antiseptics, and gloves that they provide to lay midwives associated with their programs. The websites of such groups feature photos of local staff, foreign volunteers, and indigenous midwives practicing skills such as auscultation and breech deliveries with mannequins (e.g., The Hope Alliance, 2014; Kitch, 2014). A number of Guatemalan physicians in Guatemala City have also organized and delivered midwife training sessions, both through local charitable foundations and institutions receiving international grants and some have proudly shown us awards they have received as a result of this work. Health professionals in these settings have described to us the ease of working with lay midwives as a group of readily identifiable community health workers, and thus an easy point of access for health interventions, as opposed to other types of local healers such as shamans or herbalists.
Chapter 8

Resources have also become increasingly available to lay midwives through nursing and midwifery schools in the Global North (Foster et al., 2012). Some of these institutions promote intercultural programs, through which trainees have opportunities to visit Guatemala and shadow lay indigenous midwives. From our interactions with such exchange students, part of their tuition money goes towards financing toolkits for local lay midwives as well as healthcare costs for their clients. In some cases, foreign students pay for homestays with lay midwives, thus making direct economic contributions towards their livelihoods. These sorts of transactional arrangements are becoming more common with the explosion of academic interest in public and global health in the last two decades and the concomitant emphasis on health professional students’ participation in service learning programs abroad (Merson & Chapman Page, 2009).8

The Doppler ultrasound Josefa pilot tested with Ofelia and Laura is part of these broader flows of biomedical resources from North America and Europe to Guatemala. By accommodating the Doppler ultrasound into her home visits with clients, Josefa demonstrates that incorporation of biomedicine into midwifery practice does not necessarily equate with the disassembly of traditional values, nor does it require absolute conformity to a facility-centered model. Josefa interacts with her client in Kaqchikel in her home, where she establishes her trust through repeated visits and receiving payment in kind. At the same time, Josefa is acutely aware of the medical consequences of obstetric emergencies. Her willingness to participate in extra-local global health initiatives in order to further opportunities for her clients demonstrates lay midwives’ capacity to expand the scope of their practice within a pluralistic and privatized medical landscape.

FLOR AND BEATRIZ: ACCESSING RESOURCES

On a Sunday morning, I (NK) received a call from Flor, a middle-aged lay midwife in the rural village of Pa Ch’ab’aq. One of her clients, Adelina, had given birth to Karina, a baby girl—her second child—two days prior at the national hospital. Adelina was healthy, but when her labor began, she bled even before the baby was born. Flor recognized this as potentially dangerous and referred her to the hospital. When Adelina arrived at the hospital with her husband, doctors closely monitored her labor. Although the labor and birth went well and the bleeding could be controlled, Flor related, Karina was born with a cleft lip and palate. Doctors in the hospital discharged Adelina and Karina home quickly with instructions to follow up at the local health post. Upon learning about the newborn’s cleft lip and palate, Flor made her way to Adelina’s house immediately. Flor is among one of the most pro-
active members of Cooperativa K’exeloma’. Despite speaking very little Spanish, she is involved with the organization’s executive board and is very influential amongst her peers—a quiet sort of leader. I spent time living with Flor’s family as I learned Kaqchikel, and during subsequent visits to her community, I was able to observe the services she provided in the community. Flor often attends home deliveries and remains with the family until everyone feels settled and safe. Whenever a baby is born in the community, whether delivered at the hospital or the home, Flor visits the family to weigh the baby with a handheld balance, gives the mother lactation advice, and prepares the sweatbath, among other services. From her previous experiences and participation in Cooperativa K’exeloma’, Flor recognized the urgency of Karina’s situation. Infants with cleft lip and palate can have trouble latching onto the nipple to breastfeed. Even those able to obtain adequate breastmilk burn more calories nursing than other infants, and therefore they are at great risk of malnutrition and dehydration if they do not receive supplemental milk formula (Reilly, Reid, Cahir, Mei, & Bunik, 2013).

Flor knew that I was a medical student involved in women’s health projects and that I was connected to another NGO, Medicina Iximulew, which had supported several people in her community with complex illnesses. She called me in hopes that I could connect Adelina and her baby to urgently needed resources—both milk formula and health education. The morning following the phone call, I met up with Flor to visit Adelina and Karina. Karina was strong and healthy and did not show signs of dehydration. I arranged for them to consult with Dr. Brown, a pediatrician working for Medicina Iximulew, the following day. This organization scheduled regular weight checks, provided the family with supplemental milk formula, and arranged for Karina to have surgery with a reputable surgical mission at nine months of age. Flor continued to visit Adelina to provide her usual postpartum care. Flor also enlisted the help of her own daughter, a community health worker, to negotiate with Adelina when she considered going to a poorer-quality surgical mission when Karina was three months old. Flor reminded Adelina that a well-done surgery would have lasting effects. Ultimately, Adelina waited to perform the surgery, which turned out successfully.

Several months later, I was talking with another lay midwife, Beatriz, at the Cooperativa K’exeloma’ office. Like Flor, 70-year-old Beatriz primarily spoke Kaqchikel and could not read or write. Beatriz was one of three lay midwives serving a very large geographical area, which included two neighboring villages: Pachimos, an indigenous Kaqchikel village where Beatriz lived, and San Pedro, a primarily Spanish-speaking village where the majority of residents are of mixed indigenous and European descent. Both villages are quite poor, and women prefer midwife-attended deliveries for cultural and economic reasons. Although Pachimos is physically close to the departmental capital, Beatriz had related
Chapter 8

stories to me about trucks getting stuck in the mud on the notoriously decrepit road. Beatriz’s clients in both villages faced economic and transportation barriers to accessing nearby health centers, and hospital births were seen as expensive, cold, impersonal, disrespectful, and even dangerous.

Recently, Beatriz related, Sara, one of her clients from San Pedro, the nonindigenous village, had given birth to a baby boy with a cleft lip and palate. Beatriz delivered the infant in the family’s house, an adobe and bamboo shelter accessible only over muddy footpaths, without incident. As she usually does, Beatriz stayed with the family until the infant was nursing well, but she was still worried. She knew the baby needed further care, which would only be available at the government health center. However, Sara was anemic and malnourished and had a domineering husband and eight other children. Because Sara was unable to leave the house, Beatriz decided to take the infant to the health center herself.

As a resident of Pachimos, Beatriz was registered as a lay midwife at the government health center of Ixcal, the majority indigenous municipality charged with providing health services for her village. She was familiar with the staff there, even though they were not on the best of terms. San Pedro, however, pertains to a different municipality, Santa Ana, and village inhabitants must attend the Santa Ana health center. Beatriz is not registered as a lay midwife at the Santa Ana health center and reported that she had only been there a handful of times. She felt that the discrimination she normally faced as an indigenous midwife in Ixcal’s health center was immensely magnified in Santa Ana. In Santa Ana, Beatriz was at least known for her long tenure and hard work as a lay midwife. In Santa Ana, her indigenous clothes and heavily accented Spanish made her seem “backwards,” a term that many lay midwives used to describe how they felt in the presence of biomedical providers.

Beatriz’s attempts to help her client Sara seek care for the newborn with cleft palate proved this point once again. “I went four times,” said Beatriz, “carrying the baby twice. They refused me each time.” When I pressed her to explain why, she admitted that her carné, a document granting permission to lay midwives to work, had expired because she had forgotten to submit her renewal paperwork. It is not uncommon for health posts to heavily emphasize bureaucratic procedures, such as documenting visits, over delivering care (see Dasgupta-Tsikinas & Wise, this volume), and staff simply refused to perform a clinical evaluation of the child. Frustrated, Beatriz told me, “We took him to Dr. Ivan.” Dr. Ivan is a locally well-known physician who runs a part-time private clinic in San Jorge. Beatriz often refers patients with general medical complaints to him, and she successfully arranged a private consultation with him for Sara and the baby. Unfortunately, by this point the child was very dehydrated and malnourished, and died shortly thereafter. The baby’s death
was a reminder that simply because lay midwives have access to diverse resources does not mean that they and their clients will be well served.

**COOPERATIVA K’EXELOMA’: DEFINING ROLES**

An elderly Maya midwife kneeled over scatterings of pine needles and colorful floral arrangements and offered a soft blessing in Kaqchikel. Cameras flashed from a large audience of about one hundred people attending the inauguration of Cooperativa K’exeloma’s new clinic. “We began on the ground,” said Cristina, the executive director of the cooperative. “No one has ever ensured that midwives have had a dignified place to work. This is a dream, and it is only the beginning.” Representatives from local health centers and supporting organizations in Guatemala City, the United States, and Europe listened on at an honorees’ table as the founding members of Cooperativa K’exeloma’ related the group’s story, which had officially begun nearly ten years before the celebration taking place that day.

In 2004, a group of Maya midwives in San Jorge grew frustrated with how they were treated at the local health center. During meetings and conversations at the Cooperativa K’exeloma’ office, midwives enumerated a number of complaints about their antagonistic relationship with biomedical providers there. First, they realized that local government providers were blaming them for maternal and infant mortality. Any adverse events, even those that occurred at a health center, were recorded as midwife-related if the woman began labor under a lay midwife’s care, making lay midwives look irresponsible. Second, the lay midwives saw little personal benefit to their participation in the required training and felt the information they received at the health center was repetitive, simplistic, and often given in incomprehensible Spanish, rather than their native language of Kaqchikel. Third, they felt that the health center granted licensure to practice arbitrarily. Maintaining one’s carnet was supposed to be contingent on attending training sessions and submitting paperwork in accordance with deadlines. However, retaining licensure meant that midwives were also required to perform humiliating tasks, such as mop the center’s buildings. They were also required to participate in health promotion activities, assist with vaccination campaigns, and record vital statistics in areas covered by the health center. Though the lay midwives recognized the value of some of these activities, they felt that the health center staff did not recognize that they were already burdened with other responsibilities, and indeed, that the health center used them as a free workforce to carry out activities in the most remote villages without compensating them for their time or transportation expenses. In a way, the lay midwives felt they had become the drones of under-resourced health centers. These problems discouraged them from
Chapter 8

seeking help at the health centers when problems arose among their clients who were in labor.

“We had to come together to defend our rights,” says Cristina, who is now the group’s executive director, “since there was no guarantee that the health center would treat us fairly.” Cristina, a middle-aged woman who had worked as a health promoter in her youth and had been a lay midwife for decades, was a natural leader and spearheaded organizational activities. She began talking with like-minded colleagues, and a small group formed. The fledgling group began to meet monthly, usually in their own homes, to talk about the treatment they received at the health center. If they were able to get a critical mass of participants, they thought, perhaps they could influence local policy towards lay midwives. At the very least, they enjoyed sharing advice and experiences. In addition, participants wanted to learn about the topics that health centers should be teaching them: complications of labor, gynecologic complaints, and basic medication use, for example. Cristina and her colleagues had no trouble finding participants. As it turned out, even the lay midwives that health center staff saw as the most “backwards”—those who were older, Kaqchikel monolingual and supposedly reluctant to give up traditional practices—were excited about the opportunity to learn more biomedicine.

Cristina quickly saw that the group was expanding beyond what she had anticipated. When participants’ homes could no longer accommodate their large meetings, she began reaching out to external resources. She led petitions to incorporate the group into San Jorge’s civil society, began to arrange meetings with NGOs in the area that might serve as allies, and performed internet searches for grants to support the group’s work. Initially, the group received sponsorship from local NGOs and government offices to rent space. With funds from an international NGO, they hired Dr. Ivan, a non-indigenous Guatemalan physician, to provide primary care to their clients and assist with hospital referrals. Working with Dr. Ivan and a second international NGO, the lay midwives began to organize their own training sessions; they also, in some cases, received scholarships from supporting NGOs to attend workshops in other towns of Guatemala and share their knowledge with other lay midwives. Soon afterwards, they began collaborating with a group of German physicians who ran a primary care clinic in Ixcal and with an international reproductive rights organization, which had a regional office in Guatemala City. Through pledges of support from these groups, Cristina and her colleagues secured funding to build a new birth center adjoining the clinic. This center was inaugurated in a public celebration, attended by health center staff, regional Ministry of Health officials, and a number of NGOs and other supporters as described above. At the celebration, an administrator of a local health center gave a public speech about how “there no longer needs to be competition between us, but collaboration,” and a
Leveraging Resources in Contemporary Maya Midwifery

leader from the regional hospital asserted that the founding of the clinic represented “a new era of collaboration between the Ministry of Health and the midwives.” International organizations continue to be instrumental in the cooperative’s day-to-day activities, such as procuring medications, providing practical training and helping with data management.

Cooperativa K’ixeloma’ demonstrates not only that successful collaboration between lay midwives and biomedical establishments is possible, but that lay midwives are eager to engage biomedical resources and forge such collaborations on their own terms. Cristina’s enterprising attitude, and her colleagues’ desire to integrate biomedicine into their practice, enabled the cooperative’s formation and success. Privatization facilitated the presence of diverse medical actors in San Jorge, including private physicians, small NGOs, foreign governments, and large international organizations.

CONCLUSION

Lay midwives remain one of the most significant healthcare resources available to rural, indigenous communities in Guatemala. They have long been subject to significant external scrutiny and analysis, both that emanating from anthropological scholarship about Guatemala as well as from public health policy at the international and national level. These analyses have tended to emphasize cultural particularities of lay midwifery while failing to appreciate its agile engagements with multiple sectors within Guatemalan society and the international community. Although originating from two disparate sites of political and theoretical engagement, anthropological portrayals of the Guatemalan midwife as “ethnomedical” practitioner and guarantor of cultural knowledge and the biomedical portrayal of the midwife as an unskilled, “backward” healthcare provider have tended to reinforce each other.

These predominant understandings of lay indigenous midwives do not capture the complexity of their contemporary practice, particularly in light of Guatemala’s privatized healthcare landscape. The rapid growth of the private healthcare sector in the years following the signing of the Peace Accords and the surge of interest among the international donors in lay midwifery have given Maya midwives new opportunities for leveraging resources. The case studies presented in this chapter demonstrate the ways in which, through access to these resources, Maya midwives gain social and financial capital that allow them to engage productively the biomedical and public health sectors on their own terms. In doing so, they also demonstrate their capacity to negotiate their public identities, which are neither exclusively ethnomedical nor exclusively biomedical. Rather, they are able to incorporate and transform key elements of the contemporary practice of biomedicine in ways that both remain “effec-
Chapter 8

tive” on biomedicine’s own terms while also reinforcing and reinvigorating their central authoritative roles as a source of traditional and local caring. As they do so, their visibility increases within biomedical establishments, the public health system, internationally-funded health projects, and among indigenous clients, many of whom prefer providers who can straddle and incorporate valuable elements from various styles of healing.

In these ways, the lay midwives of Cooperativa K’Ixeloma’ exemplify Davis-Floyd and Davis’s (1997) concept of the “postmodern midwife,” whose practices do not fall neatly into distinct categories of traditional, professional, or biomedical. Rather, they move between systems of knowledge; they integrate into their repertoires practices they see as beneficial to their clients and their own professional longevity (Davis-Floyd, Pigg, & Cosminsky, 2001; Hildebrand, 2012). Postmodern midwives are “educated, articulate, organized, political, and highly conscious of both their cultural uniqueness and their global importance” (Davis-Floyd & Davis, 1997, pp. 319-320). They actively create spaces for their own work in response to multiple processes and policies, including, for example, their marginalization from or inclusion in biomedical environments, increased availability of technological interventions in childbirth, or broader political and economic shifts (Davis-Floyd, Pigg, & Cosminsky, 2001).

In Guatemala, we suggest that what has significantly influenced the emergence of postmodern midwives is privatization, and associated flows of material and human resources from the Global North to the Global South. Lay midwives are well-poised to take advantage of these resources, given contextual factors such as limited access to high-quality birthing care, the large rural indigenous population’s ongoing dependence on lay midwives, and the global political foci of the SMI. The role of NGOs and foreign aid in driving midwives’ professionalization has similarly been documented in other parts of the world. For example, Davis-Floyd (2001) highlights how North American certified midwives make available educational and material resources that help lay midwives in Mexico organize and cast themselves as “professional midwives.” As well, Price (2014) describes how NGOs’ promotion of biomedical discourse about and among SBAs in India shapes understandings of midwives’ professional identities. In contrast to these cases, which describe professionalization of middle-class midwives or skilled birth attendants, in Guatemala, this process is occurring among indigenous women of low socioeconomic status at a grassroots level.

Our findings provide a provocative counter-example to prevailing empirical analyses of the interactions between lay midwives and biomedicine. In various countries, scholars have highlighted the ways in which biomedicine, as an institution, erodes lay midwives’ autonomy (Cosminsky, 2012; Geurts, 2001; Jenkins, 2001; Kruske & Barclay, 2004; Towghi, 2004). Often, when lay midwives interact with biomedicine on terms not
Leveraging Resources in Contemporary Maya Midwifery

their own—whether through government-imposed training courses (Torrí, 2012), co-optation into reproductive health services beyond pregnancy and childbirth (Schneider, 2006), or increased surveillance (Cosminsky, 2001; Triolo, 1994)—the results are inevitably disempowering. However, as our cases demonstrate, the flourishing of private and civil sector resources in recent years in Guatemala can change the rules of the game. Privatization has facilitated the emergence of a more autonomous and entrepreneurial lay midwife, at once ethnomedical and biomedical, who increasingly solidifies her own caregiving position both within her community and in the national healthcare landscape.

NOTES

[8.44]

1. All subjects’ names, the names of their villages, and other details, have been changed to protect identity.

2. We use the term “lay midwife” to describe women who are elsewhere called “traditional birth attendants” (TBAs) or “traditional midwives.” Commonly, in Guatemala, they are known as comadronas. In Kaqchikel, the language spoken by the women we describe, midwives are called k’ekeloma or iyoná, although comadrona is most commonly used. In this chapter, “indigenous midwife” and “Maya midwife” also refer to lay midwives. Nurse-midwives do not have a formal designation in Guatemalan biomedicine.

3. Midwives voluntarily attend the cooperative. In order to maintain the license to practice, they must attend training sessions at the local health posts and avoid government-prohibited activities (see Berry, 2006; Hinojosa, 2004).

4. A notable exception to this trend is Brigitte Jordan’s (1978) famous study of Yucatec Maya midwives in Mexico. Jordan highlights these lay midwives’ savvy in blending local and biomedical birthing practices and in creating social networks.

5. Recently, oppositional voices have emerged, arguing that midwives were not given appropriate training and tools before being judged by the SMI. For example, recent studies have shown improvements in knowledge and safe behaviors (Sibley, 2006) and impacts on perinatal and maternal mortality (Jokhio, Winter, & Cheng, 2005).

6. In contrast to the World Health Organization’s recommended Cesarean section rate of 5-10% of all pregnancies, in Guatemalan City, the Cesarean section rate is 23.8% in public hospitals and 63.9% in private practices (Alhabe & Belizán, 2006).

7. This is similar to fetal monitoring practices in the Global North, which aim to detect poor placental oxygenation and fetal acidosis, particularly during late pregnancy and delivery—harbingers of hypoxic injury and perinatal death.

8. Notably, the presence of these programs tends to be short-term, due to inadequate long-term funding mechanisms. The leadership of Cooperativa K’ekeloma was quite familiar with these issues, but generally sought to take advantage of such relationships while possible.

9. Medical care, and most midwife training sessions, are conducted in Spanish rather than indigenous languages (Berry, 2006; Chary et al., 2013; Maupin, 2008).