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The changing role of indigenous lay midwives in Guatemala: New frameworks for analysis

Anita Chary, MA (Graduate Student)[a,b], Anne Kraemer Díaz, MA (Executive Director, Wuqu' Kawoq)[a,c], Brent Henderson, PhD (Assistant Professor, University of Fl)[a,d], Peter Rohloff, MD, PhD (Medical Director, Wuqu' Kawoq)[a,e,*]

[a] *Wuqu' Kawoq, 2 Calle 5-43 Zona 1, Santiago Sacatepéquez, Guatemala*
[b] *Washington University in St. Louis, Dept of Anthropology and School of Medicine, 660 S. Euclid Ave., St. Louis, MO, USA*
[c] *University of Kansas Dept of Anthropology 1415 Jayhawk Blvd., Lawrence, KS, USA*
[d] *University of Florida Dept of Linguistics, 4131 Turlington Hall, Gainesville , FL, USA*
[e] *Brigham and Women's Hospital, Dept of Medicine, 75 Francis Street, Boston, MA, USA*

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ABSTRACT

Objectives: to examine the present-day knowledge formation and practice of indigenous Kaqchikel-speaking midwives, with special attention to their interactions with the Guatemalan medical community, training models, and allopathic knowledge in general.
Design/participants: a qualitative study consisting of participant-observation in lay midwife training programs; in-depth interviews with 44 practicing indigenous midwives; and three focus groups with midwives of a local non-governmental organization.
Setting: Kaqchikel Maya-speaking communities in the Guatemalan highlands.
Findings: the cumulative undermining effects of marginalization, cultural and linguistic barriers, and poorly designed training programs contribute to the failure of lay midwife-focused initiatives in Guatemala to improve maternal–child health outcomes. Furthermore, in contrast to prevailing assumptions, Kaqchikel Maya midwives integrate allopathic obstetrical knowledge into their practice at a high level.
Conclusions and implications: as indigenous midwives in Guatemala will continue to provide a large fraction of the obstetrical services among rural populations for many years to come, maternal–child policy initiatives must take into account that: (1) Guatemalan midwife training programs can be significantly improved when instruction occurs in local languages, such as Kaqchikel, and (2) indigenous midwives' increasing allopathic repertoire may serve as a productive ground for synergistic collaborations between lay midwives and the allopathic medical community.

Introduction

Guatemala is one of the most impoverished nations in Latin America, performing consistently poorly on nearly all indicators of health, social, and economic development (MSPAS et al., 2009; UNDP, 2009). Furthermore, according to recent governmental surveys, 38% of the population of Guatemala self-identifies as indigenous Maya (MSPAS et al., 2009), a number which grossly underestimates the true proportion of the population which preserves at least some components of Maya ethnic identity, such as the use of traditional woven clothing or the speaking of 21 distinct Mayan languages (Richards, 2003). This indigenous population shoulders the brunt of the country's burden of poverty, with well-documented and wide disparities in health and economic outcomes (Gragnolati and Marini, 2003; Kestler, 1995; MSPAS et al., 2009).

Since the advent of the World Health Organization's Safe Motherhood Initiative in 1987, global health policy has focused on measurable improvements in maternal–child health outcomes in the world's poorest countries, including Guatemala. Notwithstanding, Guatemala still has one of the highest maternal mortality ratios (MMR) in the region; official statistics place the current MMR at 110 per 100,000 live births (WHO et al., 2008). Especially outside the major metropolitan areas, as many as 70% of births in Guatemala occur in the home, with lay midwives in attendance. The remainder of births occur in what the Ministry of Health (MOH) calls a 'health-care establishment,' a term which encompasses a diverse array of clinical settings, including private clinics, local Health Posts, regional Maternity Centres, and departmental or national hospitals (MSPAS et al.,

* Corresponding author at: Brigham and Women's Hospital, Dept of Medicine, 75 Francis Street, Boston, MA, USA.
E-mail address: peter@wuqukawoq.org (P. Rohloff).

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2009). In these settings, births may be attended by either physicians or nurses, although with regard to the latter, there are no formal training or licensure requirements leading to a nurse midwife or equivalent certification.

Given this configuration of the maternity workforce, with an overwhelming majority of services provided by lay midwives, it is not surprising that most policy efforts at reducing the MMR in Guatemala have historically focused on the development of lay midwife training initiatives. Indeed, the Guatemalan government's efforts in this regard considerably predate the Safe Motherhood Initiative, as formal training programs for midwives were established as early as 1955 (Goldman and Glei, 2000). Currently, the Ministry of Health (MOH) grants a license to practice as a lay midwife to individuals who demonstrate consistent attendance at continuing education activities, which are typically 1 day training sessions held on a monthly basis at regional or local Health Post facilities. Periodic 2-week classes are also offered to non-practicing applicants who wish to begin work as a lay midwife. Licensing and training requirements are enforced primarily by the refusal of local health authorities to grant a birth certificate to parents who contract with a non-licensed midwife.

Lay midwife training in Guatemala has been and continues to be provided by a large range of actors, including the MOH, large regional NGOs, and local initiatives run by religious organizations or small groups of international volunteers (Berry, 2006, 2010; Maupin, 2008, 2009, 2011; Rohloff et al., 2011). Previous literature has criticized the methodology of these programmes, principally their use of classroom pedagogies that rely heavily on advanced literacy skills and use of Spanish, a language many indigenous midwives do not speak (Greenberg, 1982; Kruske and Barclay, 2004; Lang and Elkin, 1997; Maupin, 2008). Furthermore, in both Guatemala and elsewhere in the developing world, training programmes for lay midwives and other traditional birth attendants (TBAs) have been scrutinized for their failure to clearly impact maternal–child health outcomes (Bailey et al., 2002; Kruske and Barclay, 2004). In Guatemala, the MMR has not declined statistically in over 20 years and, in fact, several independent estimates have suggested that the true MMR is much higher than official statistics purport (e.g., Schieber and Stanton, 2000), despite the intensive development of numerous lay midwife-focused interventions.

Against this background, more recent policy in Guatemala has followed global trends in emphasizing a shift away from the utilization of lay midwives and TBAs in favour of skilled birth attendants (SBAs)—namely, physicians and nurse midwives—as mandated by the United Nations' Millennium Development Goals (United Nations, 2007). In Guatemala, this policy has been implemented in two ways. First, there has been a general redirection of funding away from TBA programs and towards the improvement of emergency obstetrical services at the regional hospital level, spearheaded by the MOH, USAID, and other non-governmental partners (Berry, 2010). Second, under the auspices of the MOH's refocused rural health programme, the Sistema Integral de Atención en Salud (Integrated System for Health Service, SIAS), training programs for lay midwives have remained numerically abundant, but have been considerably scaled back in complexity. Furthermore, under SIAS, the role of the lay midwife as an autonomous rural health agent has been undercut and restricted, with a new emphasis on near-universal referral of patients to hospital-level obstetrical services (Berry, 2006, 2010; Maupin, 2008, 2009, 2011).

Criticisms of a hospital- and SBA-focused policy point to the lack of convincing data that maternal outcomes in obstetrical facilities in Guatemala are significantly improved. In one study the MMR from physician-attended births was 91.5 per 100,000 live births while the MMR from traditional midwife-attended births was only slightly higher at 96.6 per 100,000 live births (Kestler, 1995). Furthermore, death from sepsis rates for uncomplicated hospital-attended vaginal births are significantly higher than for in-home vaginal births (Kestler and Ramírez, 2000). There is also doubt about the capacity of the obstetrical system to handle an increase in demand for SBA services. Regional obstetrical centres remain universally under-staffed and under-resourced, in large part because of ongoing disparity in the rural-urban distribution of health-care resources. For example, 80% of Guatemalan physicians work exclusively in the capital city, and the poorest 40% of citizens, largely rural, account for only one-quarter of national health-care expenditure (Gragnolati and Marini, 2003).

In light of this ongoing and evolving controversy in Guatemala about the role of lay midwives in the provision of health-care services to rural women, we take up a qualitative investigation of the present-day knowledge formation and practice of indigenous Kaqchikel-speaking midwives, with special attention to their interactions with the Guatemalan medical community, with training models, and with allopathic knowledge in general. Our hypothesis is that close attention to these interactions demonstrates the ways in which the 'failure' of lay midwife-focused initiatives in Guatemala are due not to an inherent inability of the constituency to respond to societal and public health needs but, rather, to the cumulative undermining effects of marginalization, cultural and linguistic barriers, and poorly-designed programming. Findings of this investigation have important implications for the structuring of maternal–child health policy in Guatemala and for the role of lay midwives as community health agents.

Methods

This investigation was commissioned and sponsored by Wuqu' Kawoq (http://www.wuqukawoq.org), a non-profit organization working to develop rural health-care services in Guatemala, as part of a situation and needs assessment prior to the development of a new midwife training protocol. In addition to their home institutions, all authors are also current staff members or volunteers at Wuqu' Kawoq. The research protocol was reviewed Wuqu' Kawoq's own IRB and by Partners Healthcare (home institutional IRB for PR) and granted exemption under 45 CFR 46.101(b)(2) (research involving the use of educational tests, survey procedures, interview procedures or observation of public behaviour).

We present data derived from interactions with Kaqchikel-speaking midwives from the departments of Chimaltenango and Sacatepéquez. These two departments are located in the central Guatemalan highlands, a short distance west of the capital city down the Pan-American Highway. Both departments contain medium-sized urban centres of 30,000–60,000 people, such as the cities of Antigua (Sacatepéquez) and Chimaltenango (Chimaltenango), which serve as important sites of tourism and business and are typically dominated by non-indigenous political interests. However, outside these centres, the bulk of the population is indigenous, and traditional agricultural lifestyles are still common, as is the wearing of indigenous clothing and the use of Kaqchikel Maya (spoken by more than 500,000 individuals) in everyday speech.

Most of our research interactions occurred in 2008–2009 as a series of in-depth interviews with 44 practicing midwives who were recruited using snowball sampling (Coleman, 1958). These interviews focused on: educational background and nature of professional formation in midwifery; individual practice characteristics, such as use of medicinal plants or pharmaceuticals; experiences interacting with the Guatemalan medical community; experiences attending various types of midwife training sessions; and knowledge of best practices in midwifery (e.g., hospital referral for prior caesarean