

Las Comadronas de Guatemala:
Experiences in an Evolving World

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Abstract

The *comadrona* is arguably the most important member of the informal sector of the Guatemalan health care system. In recent years, the role of the *comadrona* has been changing, as she adapts to new challenges, both on a personal and societal scale. While the individual identity and role of the Guatemalan *comadrona* is transforming in many ways, the interplay between traditional medicine and biomedicine is also being tested. As more *comadronas* attend training programs and adapt to biomedical pressures, their relationship with their clients and the broader health care system is adjusting. Using Doña Victoriana Colop de Yac, a *comadrona* from Pachaj, Cantel as the major source of information and observation, I will look at these factors as well as how her personal experiences have shaped her view of this interplay.

Introduction

Doña Victoriana stood across from Dr. Lucy Garcia in the small room in the *Farmacia y Clinica Fundap* in the heart of Quetzaltenango. The doctor had just finished examining the second of the two women that Doña Victoriana had brought in for consultations. As the woman was fixing her *corte*, the doctor, Doña Victoriana and I went back to the adjoining office and Dr. Garcia sat down to fill out the last of the paper work. After a few moments of silence filled only by the scratching of the doctor's pen, Doña Victoriana tentatively asked the doctor if she had heard about the woman from Cantel who had just died in a hospital in Xela after giving birth to a healthy baby boy. "*No vino la placenta,*" explained Doña Victoriana, suggesting that the doctors had failed to safely remove the placenta, resulting in the death of the woman by vaginal hemorrhage (Yac, Field notes Feb 11 2008). Dr. Garcia seemed very saddened by this, shaking her head and exclaiming "*que tristeza*" many times while Doña Victoriana spoke. After Doña Victoriana had finished recounting the story and the obligatory

moments of silent mourning for the tragic situation had passed, the tone of the exchange transformed entirely. With a single drawn-out sigh, the doctor took control of the conversation. She launched into a lecture on the importance of bringing a woman to the hospital immediately if the placenta does not arrive a half hour after the baby is born. Doña Victoriana listened complacently, agreeing with everything the doctor said and answering the questions directed at her, such as: “what are some things you can do in the home to speed the arrival of the placenta after childbirth?” (Field notes, Feb 11 2008). The doctor continued her speech on the importance of midwives bringing their clients into hospitals until the patient emerged from the examining room having fixed her *corte*. There was obviously gap in understanding, I thought, as I sat listening to the doctor lecture on the helpfulness of hospitals while Doña Victoriana had just finished sharing the story of a woman who had died **in** the hospital. It was clear that these two women exist and practice medicine in entirely different worlds.

While this experience is demonstrative in many ways of the interplay between traditional and modern medicine, the extent of the relationship is not so easily summarized. Guatemalan midwives, known as *comadronas* in Spanish and *ajiyom* in K'iché, are an integral part of the informal health care system. Within the past decade, at the urging and effort of both the international health organizations and the Guatemalan National Health System, *comadronas* have become increasingly integrated into the formal sphere of public health care. As the government attempts to increase the formal training that *comadronas* receive in order to incorporate them into the biomedical world, the differences in practices and beliefs between *comadronas* and health care professionals have become apparent to both sides. Fortunately, such disparities have not been the only result of this interplay. There have also been many successes and advancements in the state of public health in Guatemala as a result of

increased coordination and cooperation. On a personal level, these changes are requiring that individual comadronas adapt to new rules, procedures, and mindsets and in some cases, that they abandon practices that have been in place for centuries.

The identity of a *comadrona* is being modified on personal and societal levels, as both she and her culture adapt to incorporate the changing role. Such is the case with Doña Victoriana, a *comadrona* from Pachaj, located in the *municipio* of Cantel. As she has attended training classes, worked alongside doctors and nurses, and continued to care for the pregnant women and infants of Pachaj, it is evident that many of her guiding principles and practices have remained constant while others have changed gradually or within the matter of days. The ways in which she is viewed and treated by her patients and their families as well as by health care professionals are testaments to the complex factors at work within the healthcare structure. Her life story and experiences are only one of many within the vast and varying world of traditional medicine practitioners, but nonetheless offers an illuminating look into the current situation and future prospects of *comadronas*.

Methodology

In conducting my field research, almost all of my interviews and activities were involving Doña Victoriana. She was both my principle interviewee as well as the coordinator of all of my outings. With Doña Victoriana, I conducted mostly informal interviews over meals or when we were walking to a destination. On two occasions, I formally asked her if I could ask her questions and take notes. These two times I asked her primarily about her personal life history. On all other occasions, I would simply ask her questions and take notes the next chance I got, usually writing down initial notes in a small notebook and formulating them into more extensive notes at the end of each day. The other individuals I spoke with concerning *comadronas* and health care in

Guatemala were a doctor, nurses, and patients that were all acquainted with Doña Victoriana. The majority of my informal interviews with Doña Victoriana took place at her home in Pachaj. Other places that I conducted informal interviews with Doña Victoriana and other people were the houses of patients, on buses, en route to visit family or patients, the Puesto de Salud Xecam, and the Fundap Clinic in Xela. All of my research interviews were conducted between February 10 and March 3, 2008.

I was fortunate enough to be living with the subject of my research. Due to this, I obtained extensive information about Doña Victoriana's life, beliefs, and activities. I therefore have a very good understanding both of her life and her beliefs about the identity of a *comadrona*. Concerning other *comadronas* and their personal views, I have significantly less information, which is an obvious hindrance to my overall understanding of their role and experiences in a community. Regarding other interview subjects, I almost always spoke to health care professionals in Doña Victoriana's presence, which may have affected the ways in which they treated me and responded to my questions. Additionally, all my interview subjects and almost all of my subjects of observation were female. The exception to this is a couple fathers of newborns that accompanied their wives on visits. This lack of male perspective could result in the fact that my findings do not encompass the view of all Guatemalans and may be tainted by gender bias. I also only spoke to indigenous women in Pachaj because the entire community consists of K'iché Mayas. On the other hand, the doctor and nurses I spoke to were either *ladinas* or foreigners. My identity as a foreigner did not seem to deter my research in any notable way. Conversely, individuals seemed excited and willing to talk to me and explain different concepts and actions to me because I was a foreigner. Furthermore, as a woman, I was very easily and eagerly accepted into the private and

intimate world of women's health in a small village. I was able to share experiences, emotions, and ideas that are universal to women, regardless of age and nationality.

Terminology

Throughout different countries and communities, there are a variety of terms used to represent the role and responsibilities of a midwife. In the English language alone, there are many terms, all used with frequency by midwives, other medical professionals, and the general public. The terminology used by different parties and individuals is extremely important in understanding the sense of authority that both midwives and health service professionals hold as well as the perceived hierarchy and control that Guatemalan health officials attempt to create over midwives. One term used with frequency is traditional birth attendant or TBA. Bailey, Szászdi, and Glover define a TBA as

an older woman, often with minimal schooling, who lives in the community and is recognized for her experience attending pregnant women, the birth itself, and caring for the mother and newborn immediately after the birth... providing certain services that the formal health system does not" (Bailey et al. 2002: 15).

While used widely in literature on the subject, this term carries a negative connotation of ignorance and incompetence on the part of midwives. It implies that they have no formal training, which is often not the case, and that they are oblivious to biomedical practices, which is also frequently not true. It is not a term that respectfully recognizes the full range of a midwife's skills, "the term 'traditional birth attendant,' used by the World Health Organization and biomedical personnel to refer to local midwives who have little or no biomedical training, is ethnocentric and medicocentric in that imposes a narrow biomedical definition on the midwife's role" (Cominsky 2001: 187). A term that has often been used in place of traditional birth attendant is traditional midwife. This term attempts to find a balance between acknowledging a midwife's extensive skills and still distinguishing her from individuals with higher training; it "respectfully

recognizes the work of these practitioners as midwifery work. The term also acknowledges the self-identity of these practitioners, while differentiating their training from a midwife who has undergone higher levels of education” (Foster et al. 2004: 5). One complaint about this term is that it is used mostly by Americans in referring to the midwives of other nations, giving an air of condescension.

While all of these terms have their merits, I chose not to use any of them in writing about my research and findings. Instead, I will use the Spanish word *comadrona*. This is because in my context of research, I was observing and learning from a self-proclaimed *comadrona*. Doña Victoriana refers to herself as a *comadrona* and consequently it is the term I believe is most respectful to her role in the community and her image of self. The nature of the word *comadrona*, coming from *comadre* or “with mother,” in itself signifies the multitude of roles that Doña Victoriana takes on, including but certainly not limited to confidant, nutritionist, masseuse, and family planning consultant. She not only delivers the baby, but she offers physical, emotional, and spiritual support to the mother and the family. I chose not to use the K’iché term *ajiyom* because although K’iché is widely spoken by the adults in Pachaj, it is not spoken by many of the biomedical professionals that Doña Victoriana and her patients come into contact with. Therefore, *comadrona* is a term that includes not only specific communities such as Pachaj, but the whole informal and formal public health system.

Background

In rural indigenous communities across Guatemala, *comadronas* constitute the majority of medical personnel. It is estimated that in indigenous communities in the rural highlands of Guatemala, 72 percent of births occur at home and are attended by a *comadrona*. For Mayan communities, this number is believed to be more than 90 percent (Hurtado et al. 2001: 216). In fact, in all of Guatemala, only 35 percent of

women give birth with a doctor or nurse present (Bailey et al. 2002: 15). There are many contributing factors as to why women do not seek professional medical care during childbirth. Both individuals and texts cite some of these reasons as fear of doctors and hospitals, lack of transportation, denial of permission from the husband or family, language barriers, and embarrassment. Compounding on these factors, hospitals in Guatemala only have the capacity to provide services for 20 percent of the women giving birth (Bailey et al. 2002: 16). Not only are women tentative to go to hospitals for childbirth in the first place, but it is clear that there are not a sufficient number of health care facilities to attend to these women if they chose to go. Therefore, it is not surprising that of the 5,110 maternal and child health care providers in the four departments of western Guatemala, 68 percent or 3,467 are *comadronas* (Hurtado et al. 2001: 214). The importance of *comadronas* as a major part of the health care system cannot be underestimated. Yet it is not only their function of assisting mothers in childbirth that solidifies the *comadronas* importance in society; it is their continually expanding roles both within their communities and as a connection between the biomedical world and the neighbors and families that trust her.

Doña Victoriana is a perfect example of this expanding and transforming role within her small rural community. Victoriana Colop García was born in the late 1940s in Estancia, an *aldea* of Cantel that lies above Pachaj higher in the foothills. Growing up in this small farming village, she had six siblings: one sister and five brothers. Only her sister, who is the youngest of the family, is still alive today; the last surviving of her brothers died on February 8, 2008, while I was living with Doña Victoriana. Doña Victoriana's mother was a *comadrona*, from whom she first learned the art of guiding women through pregnancy and childbirth. Doña Victoriana says she had never thought about becoming a *comadrona* until the age of sixteen, although she believes that her

mother knew what her daughter's future would be all along. One thing she remembers fondly from her adolescence was working alongside her mother and brother, who, inspired by his mother, had received his certification in nursing. She says the three of them worked together, consulting on difficult cases and learning from each other. Eventually, Victoriana's brother moved away to continue his training and at the age of nineteen, Victoriana married Samuel Yac Poz, a man from the neighboring Pachaj, and moved there to live with him and his family.

Although she had learned most of the skills necessary a long time before, Doña Victoriana did not actually begin working as a *comadrona* until after her children were grown. This is because her husband did not want her to work while she was raising their five children. Therefore, Doña Victoriana spent a majority of her life raising her three daughters and two sons as well as doing all the household chores, cooking, and tending to the small corn fields around their house. Thus, it was not until Doña Victoriana was well into middle age and her children were grown that she went to the *Puesto de Salud* in Cantel and began formal training. Samuel's permission to finally let her work as a *comadrona* was also due largely to the fact that he developed moderately debilitating arthritis and could no longer work in the *Fábrica* Cantel, virtually eliminating the majority of the family's income.

Training

Doña Victoriana told me very early on in my experience with her that the life of a *comadrona* is a lot easier if she is licensed. In fact, since 1945, the Guatemalan government has tried to regulate *comadronas* through the official requirement of training and licensing (Hurtado et al. 2001: 216). It is not until much later in the century, however, that these requirements actually began making an impact on the large population of *comadronas* throughout the country. In the 1980s, the Guatemalan

Ministry of Health adopted the World Health Organization model of maternal and infant health, and began requiring that the Ministry of Public Health and Social Assistance (MSPAS), “formally recognize midwives, establish a system of registration for them, grant them licenses, administer a midwife training program, and train midwives to promote the use of family planning methods” (Hurtado et al. 2001: 217). As a result of these changes, it has become both easier and bureaucratically beneficial for *comadronas* to attend training classes and receive licensing. In fact, only licensed *comadronas* can register a newborn, “the government requires a licensed midwife’s signature and official seal on the birth registration form if the baby is not born in the hospital. The midwives are given the forms and official stamps at a health center or clinic, where they are supposed to report monthly the number of births attended and outcomes” (Cosminsky 2001: 207). As a result, it is easier for both the *comadrona* and her patient if she has attended training classes. When I asked Doña Victoriana what a *comadrona* does if she is not licensed and needs to register a baby, she responded that she asks another *comadrona* to do it for her. Currently, it is estimated that 70 percent of *comadronas* in Guatemala have received some sort of formal training (Foster et al. 2004: 7).

Although training and licensing are now much more widespread, it is unclear how effective these institutions are and whether they truly benefit *comadronas* in their medical practices and sense of identity. When I asked Doña Victoriana if she enjoyed the training she received, she replied, “*me gusto pero también me dió miedo*” (Yac, Interview Feb 28 2008). Doña Victoriana’s training consisted of many parts. First, when she decided to pursue the profession, she went to the health outpost, or *Puesto de Salud*, in Cantel. Pachaj also has a *Puesto de Salud* but it is only open one day a week for half a day and offers only very basic services. The outpost in Cantel, on the other hand, is open everyday of the week and offers not only medical services but also

training opportunities for *comadronas*. She had first gone to the *Puesto de Salud* because a *comadrona* friend had advised her that she should. Doña Victoriana showed me some of their workbooks and folders that she was given during this time, in which she was required to color pictures of babies and women with risk signs. Doña Victoriana said she did not learn much from the doctor that she did not already know, but that it was good to practice certain skills because she had not helped in childbirth since her adolescence. After Doña Victoriana had spent a few months with the doctor at the *Puesto de Salud* in Cantel, the doctor suggested that she attend an eight day, official *capacitación* class in Xela.

The official *capacitación* class that Doña Victoriana attended in Xela was run by the *Comadronas Para Comadronas* (Midwives for Midwives) organization, based out of Antigua, Guatemala. It is a nonprofit organization that has been internationally hailed in recent years for its unique philosophy and methodology. These guiding principles include

the recognition and facilitation of natural processes, use of intervention only when appropriate and necessary, advocacy and education of women and their families, promotion of health care, disease prevention, and the reduction of maternal and infant mortality...the understanding of relatedness of the body and mind, mother and infant, midwife and woman, and woman and her social context. (Foster et al 2004: 9-10).

At the end of the course, the women received *maletas* containing rubber gloves, a flashlight, rubbing alcohol, and other supplies. In addition, they received a copy of Un libro para parteras: Una guía para comadronas y parteras tradicionales by Susan Klein. The book was published by the Hesperian Foundation, who is responsible for Donde no hay Doctor and related books. Doña Victoriana showed me her copy of the book, in which she had highlighted and underlined the parts that she thinks are important. The book covers a huge variety of prenatal, birthing, and postpartum issues, including chapters such as “*Cómo ayudar a las mujeres embarazadas a estar sanas*” to “*Qué hacer durante las primeras 2-6 horas después del nacimiento*” to “*Infecciones de*

los genitales y enfermedades de transmisión sexual.” This class counted as Doña Victoriana’s official training, after which she received her identification number and card. During these classes, they talked mostly about the risks during the prenatal, birthing, and postpartum stages. More briefly, they talked about and received information covering *los derechos de las mujeres* and *control de embarazo*. Doña Victoriana said she generally enjoyed the class. The one complaint she had is that they were not monetarily compensated for their travel expenses or the time they spent in the classes.

After this experience, Doña Victoriana’s official training continued beyond that of most *comadronas* in her region. Through the doctor she worked with in Cantel, she was able to shadow doctors at a hospital in Xela twice a week for six months. She accompanied the doctors as they attended pregnant women, births, and performed a number of operations. She said this experience was “*muy interesante pero tenía mucho miedo porque vi a muchas operaciones que no debemos hacer en casa*” (Yac, Interview Feb 28 2008). When I asked Doña Victoriana what she learned or took away from the overall training experience, she replied that she learned about *los riesgos* before, during, and after childbirth and “*que tenemos que llevar la mujer al hospital si tenga algún signo de riesgo*” (Yac, Interview Feb 28 1008). The training programs that Doña Victoriana attended seem to focus on indoctrinating *comadronas* with a sense that most risks and complications are beyond their control and that they need the assistance of biomedical professionals. Although the rhetoric of the Midwives for Midwives training program is very egalitarian and optimistic, from Doña Victoriana’s experiences, it seems as though they still have a long way to go before fulfilling their promises. From what Doña Victoriana shared with me, it seems as though she learned very few skills that could help her avoid or alleviate these risks on her own. It is true that many of the

complications that arise during pregnancy and birth are extremely dangerous and require advanced medical technology. However, *comadronas* should be trained to approach these situations with confidence in their actions, whether those actions are treating the woman to the best of her ability or bringing her to a hospital, instead of complete fear of anything out of the ordinary occurring.

Evaluation of Training

There have been many studies in recent years examining the effectiveness of training programs for *comadronas* in Guatemala. The conclusions have been varied. Some have found that the training of *comadronas* have led to an encouraging increase in referrals to hospitals due to risk signs, especially in the postpartum period (Bailey et al. 2002: 20). Other noted results of training programs have been “(1) change in midwives’ knowledge, attitudes, or practices (of biomedicine, especially risk factors; (2) increase in referrals by midwives to a clinic or hospital; and (3) change in maternal and infant mortality rates” (Cosminsky 2001:202). While these results are extremely encouraging, both to Guatemalan and international health officials, other studies have produced more unconvincing results. Many have found that it is difficult to evaluate the helpfulness of training programs because there are many other issues hindering the advancement of cooperation between *comadronas* and public health officials. They conclude that it is nearly impossible to analyze the effectiveness of training programs without taking other components of the Guatemalan health care system into account, such as lack of communication between *comadronas* and health officials, patients’ choices not to adhere to a *comadrona*’s advice, and many other complicating factors. In “Obstetric complications: does training traditional birth attendants make a difference?,” Bailey, Szászdi and Glover assert the “difficult of evaluating, in isolation, the effectiveness of TBAs since their potential for effectiveness is a function of the

effectiveness of the overall system within which they work” (Bailey et al 2002: 21).

This finding illustrates the difficulty in isolating the effect of training programs within the multifaceted world of *comadronas*.

Other studies have been far less optimistic in evaluating the effect that training programs have had up to this point in time. The complaints from both *comadronas* and researchers studying the outcome of training programs have focused largely on the lack of respect for the knowledge and practices of *comadronas* and the overarching sentiment of fear and incompetence that many training programs seem to instill. Many blame this on a lack of understanding on the part of training coordinators of how *comadronas* work, “many programs have been ineffective in creating respectful working relationships with midwives, learning first how midwives practice and involving them in incorporating effective evidence-based techniques into their practice” (Houston 2000: 34). Others criticize the lack of concrete skills taught in training classes and that they do “not provide learning materials, equipment, continuing education, or any professional organizing skills” (Foster et al 2004: 7). Although many faults can be found in current training programs, everyone involved in the ongoing struggle agrees that some, albeit slow, progress has been made in integrating *comadronas* into the public health care system. Additionally, many interested and concerned individuals and parties have supplied a wealth of recommendations for future training programs that will help to create more effective programs in years to come.

Contact with Biomedical World

For Doña Victoriana, these training programs have brought her into contact with individuals she would have never collaborated with in other circumstances. Dr. Lucy García of the Fundap Clinic in Xela is one of these individuals. Doña Victoriana told me she has been working with this *doctora* for about a year now. She has worked out a

special situation with the clinic in which she and her patients do not have to pay for a consultation, although it would usually cost 25 quetzals. In addition, one of Doña Victoriana's patients needed to have an ultrasound done at a hospital, and Dr. García gave her a stamped referral sheet that would allow the woman to get the ultrasound for 125 quetzals as opposed to the usual 250. As I watched the interactions at the Fundap Clinic, it was clear that Doña Victoriana had made adjustments and adopted new practices in order to acclimate to her collaboration with biomedical professionals. As opposed to the two patients whom she accompanied, Doña Victoriana seemed very calm and sure of herself when entering the clinic, waiting room, and doctor's office. She stood her ground in the unorganized line and became disgruntled when she was challenged for her place. When we were in the doctor's office, the two patients looked to Doña Victoriana every time they were directly asked a question by the doctor and she would either answer for them or give them an encouraging nod. Throughout the questioning and checkups, the women relied on Doña Victoriana as an intermediary, both for medical aspects they did not understand as well as things they felt uncomfortable about such as bowel movements and sex during pregnancy. Doña Victoriana's relative comfort and previous experience with the formal health care system obviously came in great use to both her and her patients and resulted in the successful resolution to their problems and questions.

Another individual that Doña Victoriana collaborates with on a regular basis is the *enfermera* at the *Puesto de Salud* in Xecam. Xecam is about a fifteen minute bus ride from Pachaj and Doña Victoriana says she goes there frequently because it is open everyday, while the one in Pachaj is not, and it is far less crowded than the *Puesto* in Cantel. Also, a critically important aspect of the *Puesto de Salud* in Xecam is that it has a refrigerator and therefore can distribute live-antibody vaccines. For this reason, I

went with Doña Victoriana as she accompanied a couple to get their newborn son his BCG (tuberculosis) vaccine, which is the first and mandatory vaccine that all newborns must get in order to be registered in Guatemala. During the visit, *Enfermera* Jordana almost solely communicated with the couple through Doña Victoriana. The time when the *comadrona's* understanding of the health care system was most useful was when *Enfermera* Jordana wanted to know if the parents had received their *Triple Vacuna* before, which is the measles, mumps, rubella vaccine. Not understanding what the vaccine did or why they needed it, the young couple looked to Doña Victoriana to explain, rather than the nurse. While the nurse joked at the husband for not wanting to get a shot and made fun of his misconception that the vaccine may make him sterile, Doña Victoriana explained that it would make the baby safer because then they could not give him the diseases, in addition to not falling victim themselves. *Enfermera* Jordana treated both Doña Victoriana and the parents of the newborn as children, not taking their concerns seriously and quizzing the *comadrona* on medical facts in front of patients. Although they were collaborating with the aim of accomplishing a common goal, vaccinating a newborn baby against a harmful disease, it was clear that Doña Victoriana and *Enfermera* Jordana did not share common beliefs of how to appropriately interact with patients.

These experiences reveal a great deal about the changing identity and role that a *comadrona* such as Doña Victoriana plays in her community. Her role has expanded beyond that of a health expert or medical practitioner. She now also acts as an interpreter of terms and concepts, an escort to unfamiliar places and on intimidating visits, and a pharmacist prescribing homeopathic as well as medical remedies, all this in addition to her other duties. *Comadronas* like Doña Victoriana have become the link between their communities and the biomedical world. They are

the essential connection in Guatemala between community members who need medical or obstetric care and the providers of such care... they are capable of identifying areas of concern and taking appropriate action. No matter how well trained and proactive the [*comadrona*], links with essential obstetric services in the nearest available health facility are critical for emergencies. (Foster et al 2004: 15-16).

Doña Victoriana said she does not feel like her role in Pachaj and surrounding communities has changed very much since training; she believes it is still her duty to help the women in the best way she can, now that simply involves other practices and places that she was not familiar with before. The one way in which she has changed her view of herself is in conjunction to biomedical professionals. She said often felt “asustada” in the company of doctors and was “nerviosa que ellos van a avergonzarme” (Yac, Interview Feb 28 2008). This illustrates that Doña Victoriana’s sense of identity was affected both positively and negatively by her interactions with biomedical professionals. While she felt good that she was helping her patients to get quality biomedical care, it resulted in diminished self esteem because the interactions often made her feel incapable or ashamed. This is most likely the case for many *comadronas* and their interactions with the formal health care system, “medical anthropologists have long documented the ways in which the export of western biomedical/obstetrical knowledge devalues local forms of knowledge and perpetuates hierarchies among birth attendants” (Foster et al 2004: 14).

Conclusions

The manner in which traditional medicine and biomedicine interact in Guatemala is very complex, especially within the realm of maternal and infant health. In order to examine and understand these interactions more thoroughly, it is helpful to use the ideas and terminology of syncretism that are often applied to the combining and reorganization of religions. In order to more narrowly define the type of syncretism occurring between the work of *comadronas* and the biomedical field, it is perhaps

useful to decide what types of syncretism are definitively not occurring. As has happened with many of the individuals in Pachaj who converted to Presbyterianism and no longer hold any belief in the Mayan religion, assimilation is the “replacement of traditional systems with those of another culture” (Arrieta 1992: 11). Assimilation has distinctly not occurred with traditional and biomedicine. This is illustrated by the continuing existence of *comadronas* and the high percentage of women that continue to give birth with the aid of a *comadrona*. Also, while the Guatemalan government attempts to integrate *comadronas* into the public health care system, they still allow them to practice independently, with relatively little regulation.

Another form of syncretism is compartmentalization, which is “the existence of two distinct and separate... systems, each of which contains patterns not found in the other” (Arrieta 1992: 11). While more similar to the interplay of *comadronas* and the formal health system in Guatemala, compartmentalization does not describe the interaction entirely, as seen with a few key examples. For instance, Doña Victoriana began the practice of thoroughly washing her hands and forearms after she took the *Comadronas Para Comadronas* training class, a routine that she got from the biomedical world. Additionally, some biomedical professionals have begun telling couples that they can use the natural birth control that a woman’s body produces when she is breastfeeding as a dependable form of birth control. Previously, doctors and nurses would never have encouraged it as a reliable form of avoiding pregnancy and only recommended biomedical forms of birth control.

The final two possibilities for the type of syncretism occurring are fusion and recombinant. While this distinction is much harder to make, I contend that the interplay between traditional and modern medicine in Guatemala is an example of recombinant syncretism. Fusion is the indiscriminate mixing of aspects from two systems. Yet the

amalgamation of characteristics of traditional medicine and biomedicine has not been arbitrary, as demonstrated by the pointed rejection of many biomedical features by the traditional culture. For example, Doña Victoriana contends that almost all women refuse to take prenatal vitamins because they believe that they cause abortions. Also, traditional culture and many *comadronas* reject the sanitary disposal of the placenta because it does not adhere to cultural and spiritual beliefs. Therefore, it is recombinant that best describes this interplay not simply by elimination, but because it is the optimal explanation for the selective yet important interactions. As Watanabe states, “recombinant syncretism... suggests the emergent rather than determinant nature of the cultural structure” (Watanabe 1990: 145). This means that the components of traditional medicine and biomedicine are combining in a way that produces a new cultural result, one “that continually alters the very cultural structure in which it occurs” (Watanabe 1990: 143). The purposeful rearranging of select features from the two belief systems is based on the basic needs and desires of *comadronas* and their patients as well as the biomedical health care system. Fusion, on the other hand, conveys a sense of meaningless combination as a consequence of two cultures clashing, with no purposeful results. Recombinant syncretism does not result in homogenization or culture loss but rather in new cultural elements and structures.

While the classification of the syncretism between *comadronas* and biomedicine is interesting and important to understanding the evolution of the future health care system in Guatemala, the most important aspect remains that there is interaction and dialogue occurring. Although I have focused on many of the negative results of this interplay, the positive outcomes and success stories of the collaboration between *comadronas* and biomedicine cannot be underestimated. It is crucial to keep in mind that the processes, methods of communication, and individual responsibilities are still

being developed and refined. Many suggestions and plans have been made for the future of *comadrona* training programs as well as strategies for creating healthy relationships between *comadronas* and the formal health care system. Within this evolving system, it is vital that *comadronas* continue to receive unconditional support, guidance when needed, and the utmost degree of respect.

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