“I have to carry them both”:
Negotiating the Global and the Local in
Mayan Midwifery

by

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To the midwives of ACAM and to my mother
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Introduction

First, I will give a greeting. Good afternoon, it’s January 17, 2011. I, Marisol López Sánchez, have worked for thirteen, going on fourteen, years as a midwife. This is my work, being a midwife. I will share with you what I know: I cannot read or write, I don’t know about chemical medicines, I only work with natural plants. Thanks to ACAM—where we are working, who gave this space so that we could work together with our compañeras, Alba and Ángela and Juana, they are teaching me what pills cure—now I have a little experience in giving medication to people. Here at ACAM, we give treatments, if a person has a urinary tract infection, if they have diarrhea, if they are nauseous. Alba taught me which pills to give or which vitamins. We’re also receiving trainings from the Health Center here in Concepción Chiquirichapa. The doctors are giving us trainings every month, once a month, and we’re receiving these trainings and they help us a lot as midwives. I refer my patients to get vaccinated at the Health Center, so that they’ll be healthy after birth, and because doctors give them post-partum vitamins. If the patient isn’t hemorrhaging, if the patient isn’t dizzy after birth, I, Marisol, will go to bathe my patient. I watch to make sure she lactates, so she can breastfeed her baby. This is what we do here as midwives of ACAM in the area Mam. This is our work as Maya people. We will not lose our roots, our customs, here in Concepción Chiquirichapa.¹

Marisol’s greeting begins a story about training and practice, globalized biomedicine and pragmatic women. She directly addresses her audience—an unknown group of people in a country she has visited once—and describes the web of practices, biomedical and indigenous, performed within the maternity center of the Asociación de Comadronas de Area Mam (ACAM), in Concepción Chiquirichapa, Guatemala. In January 2011, I traveled to ACAM to stay with this group of midwives, gather their stories and learn how they attend to pregnant

women. In this inquiry into indigenous midwifery, I use the training of indigenous midwives as a focal point through which to discuss the intersection of global reproductive health and local practice.

Global health initiatives are framed around improving the accessibility and availability of biomedical care, materials and information. Health promotion instituted in this way, allows only one definition of “health,” that which is held in biomedicine. The World Health Organization identified midwifery as a key area for global health interventions, the fulcrum of reproductive health. Training programs aim to combat maternal mortality through the dissemination of biomedical knowledge and materials to midwives, yet also define what does, and does not, pertain to “health.” A complex negotiation occurs at the site of reproduction, where the intentions of transnational development organizations to change practice intersect with the responses of individual midwives. The nature of the care these community-based midwives deliver to childbearing women reflects both the impact of global processes and the local cultural logics employed in response to this interaction with the global.2

Every pregnant woman deserves to survive childbirth and a critique of global health strategies working to achieve this goal cannot lose sight of this shared objective. Despite this common purpose, the role that globalized biomedicine plays in reducing maternal deaths must be fundamentally reconsidered if progress towards maternal survival is to be made. We cannot

neglect the multiple layers of power and resistance interacting in these complex negotiations, nor can we fail to recognize the particularities of each locality. We must use the tools of social science to critique inherently political projects promoted as value-neutral global health initiatives, but an analysis done in this way must always work towards improving, not attacking, medicine.

Throughout this essay, I do not posit that the biomedical model is universally misapplied, nor do I idealize the local model of birth. No single model of birth, universally instituted as a complete and fixed set of practices, can accommodate the needs, desires, or cultural preferences of women—and the bodies they inhabit—worldwide. Given the nature of globalization, rigid dichotomies between ways of birthing are no longer relevant; explorations into this topic have shifted to focus on the impact of globalized biomedicine on local practice.

In trying to understand how and to what extent biomedical practices have entered indigenous midwifery, it can appear I observed the midwives to “test” them on the validity of their biomedical knowledge. I did not, nor do I argue that the correct incorporation of biomedical practices make them better midwives; I only sought to examine the multiplicity of ways in which the midwives engage biomedicine. In doing so, I ask the recurring questions of the social sciences: when does change represent progress? Who benefits? Who decides?

I situate my essay within two bodies of literature that are neither completely connected nor completely distinct. Much of my analysis builds on existing work in Science Studies (the Sociology of Science), and I draw from Michel Foucault, Donna Haraway, Annemarie Mol, Margaret Lock, and Emily Martin to frame my analysis. Second, though my work is not a cross-cultural study of birth, it does contain a comparative element in my juxtaposition of the biomedical (culturally “Western”) with the indigenous Guatemalan model of birth. I therefore continue a legacy of cross-cultural birth studies which Brigitte Jordan initiated with her seminal work Birth in Four Cultures (1973) and which continues today with the work of Faye Ginsburg and Rayna Rapp, Robbie Davis-Floyd, Nicole Berry, Sheila Cosminksy, Sarah Pinto, and Cecilia Van Hollen.

The Study of Reproduction and Childbirth

Until recent decades childbirth was regarded as a biological act and a life process universal for all women, thereby rendering it unfit for anthropological study. In the 1960s and 1970s, however, a number of anthropologists began recognizing the centrality of reproduction to social life. While early approaches analyzed what childbirth practices reflected about specific social and cultural systems, today social scientists examine reproduction in order to understand how societies re-conceptualize and re-organize the world.

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Anthropologists did not study reproduction in cross-cultural contexts, however, until the mid-twentieth century. Early work explored the discrepancy between universal and culturally-specific practice, developing the “central tenet of the anthropology of reproduction: reproduction and the management of reproductive processes are not simply biological; they are also always culturally constructed in unique ways in diverse historical contexts.” Margaret Mead and Niles Newton authored one of the earliest studies employing a cross-cultural approach, entitled “Cultural Patterning of Perinatal Behavior” (1965), in which they characterized a growing tendency to define birth as an illness. While Mead and Newton did not use this expression, they refer to a process that later came to be known as the “medicalization of birth.”

The theme of “medicalization” runs throughout my analysis, and it is a term I both employ and contest. Before I elaborate on the need to complicate the concept of “medicalization,” however, it is first necessary to define it. Initially scholars, namely Irving Zola and Peter Conrad, used the term “medicalization” to characterize a process whereby “particular social problems deemed morally problematic and often affecting the body (e.g., alcoholism, homosexuality, abortion and drug abuse) were moved from the professional jurisdiction of the law to that of medicine.” Gradually, the realm of medical jurisdiction expanded

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6 Ibid., 11.
to include life processes, including childbirth, death, menopause and contraception, further medicalizing society in the U.S. in the eyes of many. In particular, the medicalization of childbirth referred to the refiguring of a physiological life process as a pathological one that requires management by a medical professional. This process of medicalization is predicated on and paralleled by a process of individuating disease, and an emphasis on curative, rather than preventive, medicine. The institution of medicine in the U.S. privileges individual over social, economic, and environmental causes of illness, and generally directs resources towards “cures” rather than addressing preventable factors in the larger context of individuals’ lives. Many global health initiatives adopt this individuated, curative approach to health care, and my first chapter deals with the efforts of the World Health Organization’s (WHO) to combat maternal mortality by training birth attendants in the biomedical model, rather than addressing the role that malnutrition plays in maternal and infant mortality.

Some scholars argue that a process took place starting in the mid-1980s in the U.S. whereby what had formerly been called “medicalization” changed to “biomedicalization.” Where “medicalization” described the process by which behaviors and conditions previously outside medical jurisdiction came to be construed as medical problems, beginning in the mid-1980s the nature of medicalization began to change with the advent of new technoscientific innovations, material infrastructures, social forms and sociocultural discourses.

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9 Ibid.
“Biomedicalization” as this new process was labeled, “is characterized by its greater organizational and institutional reach through meso-level innovations made possible by computer and information sciences in clinical and scientific settings, including computer-based research and record-keeping.”

Biomedicalization in the United States is therefore characterized by the extension of medicalization into more areas, and a shift from an ability to control biological phenomena to an ability to transform life through increasingly technoscientific advances.

In analyzing the historical shifts in medicine within the United States, I will employ Adele Clarke’s definition of “biomedicalization” in order to remain consistent with the literature on the subject; for example, beginning the in 1970s, birth in the U.S. has been medicalized, meaning brought under the jurisdiction of medicine, while in the past decade it has become increasingly biomedicalized, meaning technological. When speaking outside of a U.S. context, however, I will use the term “biomedicine” to mean “Western medicine” and follow Celia Van Hollen’s distinction between “medical” and “biomedical” throughout my analysis. For Van Hollen, the word “medicine” encompasses “all forms of healing, of promoting and maintaining a healthy, ‘mindful body.’” “Medical” therefore refers to any form of medicine, be it indigenous or Western. “Biomedical,” when used in the context of global health, refers specifically to Western medicine and science. Within this broader definition, a non-medicalized birth indicates that no

10 Ibid., 165.
11 Van Hollen, Birth on the Threshold: Childbirth and Modernity in South India, 12.
system of medicine was employed, while a non-biomedicalized birth means the birth proceeded without the use of biomedicine (but was potentially aided by indigenous forms of medicine). In the context of the global spread of the biomedical model, the term “biomedicalization” refers to the progressive encroachment of Western medicine on local practice.

Beginning in the 1970s, second-wave feminists began to critique what they saw as the medicalization of birth in the United States, and many anthropological, sociological and historical studies sought to examine the medical model of birth. By this time, roughly 90 percent of births took place in the hospital. Second-wave feminists, including Richard and Dorothy Wertz, Judith Leavitt, Barbara Katz Rothman, and Robbie Davis-Floyd, all voiced strong opposition to this trend. While menstruation and menopause were also areas of women’s health deemed “medicalized,” feminists focused in particular on what they considered the dehumanization of the birthing experience. Childbearing women, they argued, were “processed through pregnancy and after, according to some ‘average’ pattern.” Richard W. and Dorothy C. Wertz argued that birth had become “a time of alienation from the body, from family and friends, from the community, from the community,

and even from life itself.”

The birth process became increasingly monitored and managed at every stage.

In an attempt to unravel how birth had come to such an extreme of medicalization, some feminists began to write histories of childbirth in the United States. These histories tended to focus on the shifts from home to hospital and midwife to physician as key turning points in the medicalization of birth. The narrative proceeds, more or less, as follows. Until the end of the nineteenth century, the majority of women in the U.S. typically gave birth at home, surrounded by female relatives and friends. Around the turn of the century, physicians began entering the home to attend births, though at this time social class and region largely determined whether a physician or a midwife attended a birth. These physician-attended homebirths marked a unique intermediate stage in the medicalization of childbirth. Though birth continued to take place in the home, physicians’ practices were thoroughly medical and they employed a variety of interventions, including the use of bloodletting, opiates and forceps.

Physicians, however, wanted to move birth from the home to the hospital to escape the intrusions of the birthing women’s friends and family on their practice.

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14 Wertz, Lying In: A History of Childbirth in America, 50.
15 It should be noted that the history the majority of second-wave feminists depict in their writings applied primarily to white urban women in the northeast of the U.S. Gertrude J. Fraser deals with the decline of midwifery and the rise of hospital-births within black communities in the South, chronicling a different narrative. Because the many stories of midwifery in the US are too varied to account for in this introduction, I will restrict my summary to the story most often told, while acknowledging that this is a history specific to a region and a class of women, a history most often told for reasons more to do with power and privilege than its applicability across the country.
16 Leavitt, Brought to Bed: Childbearing in America 1750-1950, 43.
not to mention the threats these relatives posed to the maintenance of aseptic technique.\textsuperscript{17}

In the period between 1900 and 1930, however, middle and upper class women began to choose to give birth in the hospital. In part, women elected to move birth from home to hospital because of an emerging understanding of germ theory and bacteria. More significantly, however, women’s friends and families could no longer support them in childbirth. Increased mobility and urbanization had strained women’s social networks in the nineteenth century, and began to dismantle them in the twentieth. The physical and psychological isolation these changes caused left women without the help they needed to deliver safely at home.\textsuperscript{18}

Consequently, for a time between 1900 and 1930 a physician-attended hospital birth was in many ways more dangerous than a midwife-attended, non-interventionist homebirths. Within the hospital physicians, unchecked by either a watchful family or professional regulations, increased interventions. Physicians had yet to master aseptic technique and infections often spread throughout maternity wards.\textsuperscript{19} The early 1930’s, however, marked a turning point as the federal government and the growing medical profession worked together to establish practice guidelines and physician qualifications. The standardization of practice, routinization of care and increased prenatal care had impressive results and from 1939-1948, maternal mortality rates in hospitals dropped by 71 percent.

\textsuperscript{17} Ibid., 105.
\textsuperscript{18} Ibid., 184.
\textsuperscript{19} Ibid., 169.
In addition to more uniform practice among physicians, the development of antibiotics and blood transfusion technology saved many lives that would have previously been lost in birth.\(^{20}\)

As mortality rates dropped, women increasingly elected for a biomedical birth. In the decade that followed these sweeping changes in hospitals, the proportion of infants born in hospitals rose (a shift less pronounced in rural and southern areas). Despite declining maternal mortality figures, interventions\(^{21}\) in birth did not decrease—physicians were simply more skilled at performing these procedures.\(^{22}\) Larger social changes were also a significant part of the drop in maternal mortality rates. Standards of living for the poor increased substantially during World War I, undoubtedly improving maternal mortality in the years following.\(^{21}\) As these rates dropped, the instances of hospital birth continued to rise. In the ten years between 1940 and 1950, the percent of US births in hospitals rose from fifty-five percent to eighty-eight percent.\(^{24}\) The Center for Disease Control (CDC) maintains even today that the drop in maternal mortality in this period is “one of the great public health success stories of the twentieth century,” and attributes the decline to the shift from home to hospital deliveries.\(^{25}\)

\(^{20}\) Ibid., 194.

\(^{21}\) Interventions, as defined in the histories of birth from which I draw this narrative, typically refer to obstetrical procedures that interfere in the process of birth. Beginning with forceps, the use of interventions in obstetrics has steadily increased over time, adding episiotomies, analgesics, IVs, fetal monitoring, and oxytocin injections to the list of standard procedures in birth.

\(^{22}\) Wertz, Lying In: A History of Childbirth in America, 165.


\(^{24}\) Leavitt, Brought to Bed: Childbearing in America 1750-1950, 171.

\(^{25}\) National Center for Chronic Disease Prevention and Health Promotion Division of Reproductive Health, CDC., "Healthier Mothers and Babies," in Morbidity and Morality Weekly Report (Atlanta: Centers for Disease Control and Prevention, 1999).
Many in the feminist movement of the 1950s and 60s first viewed a hospital birth as liberating and embraced the new technologies it offered. Giving birth in the hospital separated a woman’s “labor” from the sphere of domesticity. Some argued that the new birth technology empowered women in that it “began to give women the power to expand beyond the ‘natural order.’”\(^\text{26}\) The first wave of activism around the medicalization of childbirth, however, was mixed. “Women won the right to pain relief and compelled obstetricians to at least consider women’s preference for it; on the other hand, women arguably lost control over the process of childbirth, as well as the comforts of home and support of female relatives, friends and midwives.”\(^\text{27}\) Hospital birth and the use of pain relief became ubiquitous by the 1960s. Beginning in this time, women began to regard hospital birth more critically, giving way to the 1970s second-wave feminists who compiled these histories of birth.

The feminist-inspired anthropological, sociological and historical studies concerning birth since the 1970s mostly argue that the roots of these biomedical practices lie in Enlightenment thinking, particularly the Cartesian mind/body split of Descartes and Bacon. These scholars argue that with the rise of rationalism,\(^\text{28}\) the body was “metaphorized” as a machine, a metaphor particularly applicable to


the surgical specialty of obstetrics. Most medical literature has framed the uterus as an “involuntary” muscle, thereby making labor a process the doctor/mechanic must control. Another dimension of the metaphor of the body-as-machine is the establishment of the male body as a properly functioning machine and the female body as a defective machine. Particularly in regards to menstruation, childbirth, or menopause, the female body is continually cast as leaking, uncontrollable and unpredictable.

Second-wave feminists have thus criticized the biomedical model of birth on a number of fronts. They focus on the ways in which birth had been transformed from a routine, physiological process to a pathological event requiring intervention. In their narrative, birth has become “a technocratic service that obstetrics supplies to society,” wherein doctors are responsible for delivering babies from the wombs of (passive) mothers. The word “deliver” underscores that childbirth is an act the doctor performs as opposed to “birthing”—an action women do.

The core of second-wave feminists’ critique is biomedicine’s casting of birth as pathological, its treatment of women’s bodies as malfunctioning machines, and the unnecessary use of technology and excessive intervening in childbirth the system encourages. Second-wave feminists stressed the value of

30 Davis-Floyd, Birth as an American Rite of Passage; Simonds, Laboring On: Birth in Transition in the United States; Leavitt, Brought to Bed: Childbearing in America 1750-1950.
31 Davis-Floyd, Birth as an American Rite of Passage, 75.
alternative forms of knowledge presented in midwifery practice. Midwifery tends to focus on information and knowledge gathered from the exterior of the birthing woman—what women communicate and what midwives can feel through the use of their hands, while the medical model advocates monitoring various “interior” aspects of childbirth—for example, the fetal heart monitor, ultrasounds, and amniocentesis. Many women split from the biomedical/interventionist model of birth.

In response to the biomedical model of birth, a “natural” birth movement emerged in the 1980s.33 The “natural” model of birth is characterized by a woman-centered approach that views mother and fetus as a unit. The pregnant female body is not compared to the male body, or even the non-pregnant female body, to judge abnormalities, but instead compared to other pregnant bodies.34 In the “natural” model, childbirth takes place outside institutions and outside the medical mode. Natural childbirth underscores that women should be ‘awake and aware’ when giving birth, feel the sensations of labor, and actively push the baby out.35 Unlike in the medical model, “birth is not made to fit the routine, but the attendant to fit the birth.”36

In revisiting these feminist responses to the medicalization of childbirth with the United States, I hope to destabilize the categories of biomedical birth and

33 Barbara Katz Rothman and Wendy Simonds describe their alternative as the midwifery model (with a focus on who performs the birth) while Robbie Davis-Floyd refers to it as the holistic model (and uses “natural” to oppose “prepared” rather than “medical”). I will refer to it as the “natural” model.
35 Davis-Floyd, Birth as an American Rite of Passage, 162.
natural childbirth. The natural model of childbirth set forth in their arguments borders on essentialism—a prioritizing of a feminine approach, and an equation of the feminine and the natural. In doing so, they perpetuate rigid dichotomies and are guilty of the same processes of categorization and domaining of knowledge as biomedicine. Biomedicine cannot be cast as completely negative for women’s health, just as natural childbirth cannot be deemed completely positive. There is a pervasive assumption throughout these calls for a return to a natural childbirth that what is right for one woman is right for all, and that natural childbirth is a generalized, all-women’s response to biomedicine. Their critique, however, comes from a very specific echelon of middle-class white women of the global north, and cannot speak for the wants and needs of all women in the United States, let alone worldwide. Finally, in labeling their model “natural” feminists of the natural-birth movement imply that a woman who does not give birth in this way is not a “natural” woman. Suggesting that there are “essential” or “natural” characteristics to a woman does nothing to move practice towards a woman-centered model of birth, and may ultimately exclude more women than it empowers.

The opening decade of the twenty-first century finds women’s advocates anything but unified on what constitutes a woman-centered model of birth. Post-structuralist feminists see the natural childbirth movement as simply replacing one monolithic model with another, and argue that in engaging with the discourse of biomedicine (by existing in opposition to it) midwifery perpetuates that which it
purportedly seeks to destroy. The response from within feminist midwifery (often referred to as “modernist feminists”) to such criticisms is that simply because a practice has emerged in opposition to another does not mean it has no worth, or no “clear, cohesive and practical strategies designed to promote childbearing women’s autonomy and health.” Furthermore, they find it counter-productive to blame feminist midwives for the continued dominance of patriarchy.

The second-wave feminists deliver a critique that, though not entirely unfounded, may condemn wholesale biomedicine without taking into account positive aspects; the post-structuralist feminists do not leave much room for action when they argue that we must get outside language if we are to escape patriarchal domination. It is useful neither to demonize biomedicine in favor of “natural” childbirth, nor to argue that technology empowers without acknowledging the women it hurts. Debates within global north feminism, however, leave unanswered how women in the global south can improve their chances of having a safe and healthy birth.

Having summarized the incremental shift to a biomedical birth that has taken place in the U.S., and current debates over what constitutes a woman-centered model of birth, I now turn to the issue of the maternal survival and the global spread of biomedicine. The relationship between biomedicalization and

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birth grows exponentially more complex on a global scale. When considering transformations in childbirth outside the U.S. one must take into account the multi-institutional neocolonial alliances that “are committed to the globalization of Western biomedicine and the concomitant appropriation or destruction of indigenous healing practices, nonmedicalized healers, and indigenous knowledges.”

Expanding the discussion to include childbearing women of the global south means accounting for not only the weight of patriarchy but also the legacy of colonialism, the forces of globalization, and the multiplicity of power relationships that serve to work against women in the global south experiencing a safe and healthy birth. Numerous scholars have studied the relationship between the biomedical and indigenous models of birth in cross-cultural studies. The foundational text of such studies is Brigitte Jordan’s *Birth in Four Cultures*. This seminal work examines birth in the Yucatan, Holland, Sweden and the United States, looking at not only biomedical and non-biomedical births, but also distinctions within the biomedical model as practiced in various developed nations. Jordan employs a “biosocial” framework, treating the process of birth as “produced jointly and reflexively by (universal) biology and (particular) society.”

She argues strongly against the exportation of the biomedical model to Third

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World countries, and instead advocates a “fruitful accommodation incorporating both biomedical and indigenous systems.”

Faye D. Ginsburg and Rayna Rapp layer complexity onto Jordan’s analysis by inquiring into the varied ways the biomedical model interfaces with different localities. Biomedicalization on a global scale, they argue, does not occur in an even or consistent way. The cross-cultural perspective brought to the field by scholars such as Jordan, Ginsburg and Rapp “help[s] dispel the misconceptions embedded in those feminist studies that view all the controlling aspects of biomedicalized births as derived from a Western historical legacy of the Enlightenment and Industrial Revolution and that present a romanticized vision of holistic ‘indigenous’ birth, or ‘ethno-obstetrics,’ as egalitarian, ‘woman-centered,’ and noninterventionist.” The work of Ginsburg and Rapp frames my discussion of the biomedical model and indigenous practice in Guatemala.

I seek to explore a feminist response to the biomedical model that neither condemns biomedicine nor accepts it uncritically, and to discern whether it may be possible to incorporate aspects of the biomedical model into local practice. Perhaps because biomedical practitioners typically have little knowledge of indigenous systems, or typically disregard non-biomedical values of “health,” the aspects of biomedicine that may benefit global south communities most are usually not identified. It is exactly this area—the space that holds the potential

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41 Davis-Floyd, *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*, 3.
43 Ibid., 13; Davis-Floyd, *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*. 
for complementarity, or what Jordan calls “fruitful accommodation”—that I investigate in my analysis.

Biomedicine does not enter and affect localities in a single way; the biomedical model is incorporated, interpreted and resisted in countless ways by different individuals, groups and institutions. I cannot make claims to describe birth beyond my case study; nor can what I write here truly encompass all of the knowledge and practice at the maternity center where I stayed. My work examines how a specific group of midwives incorporate the biomedical model in a specific location—Concepción Chiquirichapa, Guatemala.

I explore “local” practice at the maternity center. My use of the word “local” indicates not only geography, specific nations, regions or communities but also “class and gender categories, namely lower class and female.” Development projects characteristically juxtapose a “naturally transcendent necessarily global institution” against “limited, fragmented, decontextualized ‘local traditions.”’ I define the global processes as those through which knowledge and power escape the communities of their creation to be imposed upon communities elsewhere, and local processes as knowledge transfers characterized by personal relationships and face-to-face interactions.

Outline of Chapters

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44 Van Hollen, *Birth on the Threshold: Childbirth and Modernity in South India.*


The structure of this work consists of four chapters that examine the training of local midwives in biomedical techniques from multiple perspectives. The first chapter, “Training Tradition,” concerns forms of top-down planning employed in global health promotion, focusing specifically on training programs for “traditional birth attendants” as a strategy to lower maternal mortality. By critiquing discourses in World Health Organization publications, I analyze the ways in which transnational health organizations exercise power over midwives and by extension the women they attend, through the lens of biopower. WHO initiatives intended to lower maternal mortality rates frame problems in a way encourage the regulation and disciplining of local midwives. Holding the power to describe and name problems, the WHO defines the limits of what is considered “health,” at the exclusion of other definitions.

Foucault’s concept of biopower describes a form of power that states and institutions exert over life. Many assert, however, that the concept of biopower cannot fully address the ways in which individuals assert control in their own lives.47 While this concept is therefore invaluable in laying bare the mechanisms of power in knowledge production and the domination of discourses in global health, we must turn to the lived experience of individuals to gain insight into the role of resistance. In contrast to Foucault’s emphasis on power and institutions, James C. Scott and other scholars stress individual agency. Scott argues that individuals possess a subjectivity that allows them to see the forces that structure

their world, and to resist and transform the institutions that exert control over
them.48

My second chapter briefly reviews the Guatemalan context to provide a
background for my case study, which I present in the third chapter. Guatemala’s
history of colonization and U.S. intervention, and the structure of its society make
it a particularly unique and complex case in which to study the layers of power
and resistance in a negotiation with what is, at its root, a symbol of modernity.
Guatemalan officials, most of whom are of the ruling ladino class, share a specific
idea of what it means to be modern, and view the indigenous Mayan communities
that make up around half of the country’s population as working against these
moves towards progress and development. Given this intersection of
colonial/neo-colonial powers, the state, and the Mayan people, Guatemala makes
for an exceedingly complex context in which to examine the integration of
biomedicine with indigenous medicine.

I then present my case study in the third chapter, “Biomedicine Without
Biopower.” Built around experiences and stories gathered at the Asociación de
Comadronas de Area Mam (ACAM), located in Concepción Chiquirichapa,
Guatemala, my case study explores a maternity center that integrates indigenous
and biomedicine. The maternity center at ACAM provides a space where
indigenous midwives can continue their practices while dictating the terms of how
biomedicine enters into their daily work. Because of the flexibility in practice the

maternity center facilities, and the social networks that remain strong in the community, the ACAM midwives have kept their practice local even while incorporating aspects of biomedicine.

Finally, in chapter four, “Rethinking ‘Biomedicalization’” I challenge the use of this term to describe a singular and uniform process in which the biomedical knowledge of developed countries systematically replaces existing indigenous medical knowledge in the developing world. Globalization does not simply “happen.” It is a force that is continually being negotiated—accommodated and resisted—by people in both the global north and the global south. Using the ACAM midwives’ narratives of their lived experiences, I challenge a concept of a cohesive process of “biomedicalization,” on the grounds that it cannot be received in a singular way nor is it disseminated by a single source; the many processes within it are “more than one and less than many.”

The global spread of biomedicine is a process that is “multiple.”

Ultimately, it is pointless to focus on “biomedicalization” as a deterministic, unstoppable process, when the process describes a vast and heterogeneous range of negotiations and interactions. Our time is better spent discerning how biomedical knowledge can be shared in ways that empower, rather than undermine, local communities. While biopower is a useful concept for analytically deconstructing the discourses in global health, it is the lived experience of the ACAM midwives that provide insight into the fault lines in these narratives.


50 Mol, *The Body Multiple: Ontology in Medical Practice*, ibid.
of globalization. The work done at ACAM reveals the shortcomings of any model of training that treats local experience and knowledge as irrelevant, and provides insight into the potential for reducing maternal deaths worldwide through expanding options for women and continually contesting development’s limited definition of “health.”
Chapter 1

Training Tradition:
The World Health Organization and the Biomedical Model of Childbirth

Assuming biomedical technologies universally improve health, many global health initiatives work to distribute these technologies worldwide. While the end-goals of such projects theoretically benefit target communities, in implementation these programs can impose changes rather than supply support. Certain campaigns to combat maternal mortal are structured around the training of global south midwives in global north forms of healthcare. Programs that seek to replace an indigenous model of birth with the biomedical model, I argue, continue a tradition of imperial and colonial interventions.

The biomedical model is the global standard—in the eyes of transnational health organizations—for a safe and healthy birth. A striking gap in maternal mortality rates between developed and developing nations provided the impetus for programs addressing childbirth. The common goal of much development work is a decline in maternal mortality rates, and the means towards achieving this goal is seen as the adoption of the biomedical model of birth. In the generalized promotion of a single model of childbirth practices, these global health

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1 The biomedical model of birth is defined here as the typical hospital birth in developed countries. In this model, birth is defined in three stages—the first, marked by regulation contractions, the second by the delivery of the baby and the third by the delivery of the placenta. This model includes a range of biomedical practices, such as the vaginal exam, the use of epidural analgesia, and the use of oxytocin. Women typically give birth in the lithotomy position, on her back but not entirely supine.

2 I define childbirth as encompassing the process of labor, birth and delivery of the placenta.
organizations make two fatal assumptions: they assume, first, that techniques and drugs developed and tested on one population can be readily exported to another and second that biomedicine is an autonomous entity—a system of knowledge that somehow developed independent of the same social, cultural, political and economic forces that produced other forms of medicine.

In my deconstruction of global health as it pertains to reproduction, I focus specifically on discourses in the World Health Organization’s publications on maternal mortality and chart the WHO’s attempts to lower maternal death rates through training what they call “traditional birth attendants (TBAs).” Using Paul Rabinow and Nikolas Rose’s interpretation of Foucault, I argue that WHO discourses around the training of traditional birth attendants constitute a form of biopower. As such these discourses define the horizon of what is considered “health,” limiting it to a biomedical conception of that value. The WHO will fall short of its goal to reduce maternal deaths so long as the recommendations it makes devalue local knowledge.

**Global Health and the Legacy of Colonialism**

Although referred to as “Western” medicine, biomedicine did not develop solely in the West. The idea that the biomedical model is “exported” to developing countries suggests that biomedicine—as a fully formed and completely separate system of knowledge and practices—is delivered intact to developing countries. Quite the contrary, the rise and growth of biomedicine are intimately

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3 “Traditional birth attendant” is a label used in international health development to refer to a wide range of people who assist in birth. It has been criticized as ethnocentric and is often understood to disregard the legitimacy of the values of health, healing and medicine held by the people it describes.
tied to the histories of imperialism and colonialism, and the system of medicine was formed through and by colonial projects.

Margaret Lock divides the history of the global spread of biomedicine into four phases: Imperial (prior to 1920), colonial (1920-1960), nationalist (1960-1980) and non-governmental (from 1980 to present). In the imperial phase—the nineteenth and early twentieth century—biomedicine was used as a tool of empire, employed to protect the health of settlers and soldiers against tropical disease. In the colonial phase, the idea that natives were “biologically commensurate” emerged in the general consciousness of colonizing countries’ populations. The focus of biomedical projects turned to containing epidemics when the recognition of a shared biology revealed disease could spread from population to population.

The shift in focus within biomedicine from tropical disease to epidemics was part of a larger trend, which moved from the imperial logic of conquest to a colonial approach to governance oriented towards maintaining order. Scientific advances during the colonial period (1920-1960) also influenced globalized biomedicine: with evidence that micro-organisms could cross borders, countries came together to address the new threats of infectious disease. While this international cooperation was initially coordinated through the League of Nations Health Office, it was formalized in 1948 with the creation of the World Health
The 1960s marked the beginning of the nationalist phase, and the use of biomedicine in developing nations began to serve as an emblem of nation-building and modernity. Finally, the fourth and ongoing stage of biomedical globalization began in the 1980s and is “carried out by development agencies, NGOs and other humanitarian efforts to improve the health of the global poor.”

Many current global health initiatives continue a legacy of intervention and control that began with the earliest imperial efforts to control tropical disease. Colonial public health projects fulfilled the dual purposes of keeping labor healthy and productive, while legitimizing the colonial project; these arguably remain two of the major forces behind many global health interventions today.

Of all areas of global health interventions, epidemics, infertility and childbirth, and famine constitute what Lock calls, “critical events,” or historical moments when both individual existence and social order are at stake. While epidemics were the earliest addressed “critical event” in global health, childbirth soon became a focus after the development of vaccinations and antibiotics ensured that most individuals survived into adulthood. Rates of maternal mortality differ vastly between developing and developed nations, and in certain parts of the world, there is a one in four chance a woman will die in childbirth over her lifetime. Birthing for women in some parts of the world continues to be

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5 Ibid., 148.
a perilous event, and complications such as obstructed labor can have grave consequences.\textsuperscript{7}

The international community first joined together to address maternal mortality in 1987 with the formation of the Safe Motherhood Initiative (SMI). This initiative began when three United Nations agencies—the United Nations Population Fund (UNFPA), the World Bank, and the WHO—organized the Nairobi Conference with the intent of creating an agenda to address maternal health on a global scale.\textsuperscript{8} These agencies, in collaboration with Planned Parenthood International and the Population Council, set a goal to decrease global maternal mortality by 50 percent by the year 2000, and made a strategic plan—which became known as the SMI—for the carrying out of this goal.\textsuperscript{9} The specific strategies the conference outlined included:

- Strengthening community-based health care by improving the skills of community health workers and traditional birth attendants, and screening high-risk pregnant women for referral for medical care;
- Improving referral-level facilities to treat complicated cases and serve as a back-up to community-level care;
- Developing an alarm and transport system to serve as a link between community and referral care.\textsuperscript{10}

A decade after the SMI agenda had been articulated, maternal mortality rates had not significantly decreased across the world. In 1997, the members of the Safe Motherhood Inter-Agency Group (IAG) met again for the Initiative’s

\textsuperscript{7} Lock, \textit{An Anthropology of Biomedicine}, 157.
\textsuperscript{8} While the founding members of the Safe Motherhood Inter-Agency Group (IAG) were the World Bank, the World Health Organization, UNFPA, United Nations Children’s Fund (UNICEF), and UNDP, this group expanded in 1987 to include the International Planned Parenthood Federation and the Population Council.
\textsuperscript{9} Berry, \textit{Unsafe Motherhood: Mayan Maternal Mortality and Subjectivity in Post-War Guatemala}, 88.
Tenth Anniversary. The group deemed two of the program interventions advocated ten years earlier “ineffective for reducing maternal mortality and not to be promoted as priority strategies.” These included the training of “traditional birth attendants” and screening for pregnant women to identify high-risk mothers likely to develop obstetric complications. Responding to what they perceived to be the failure such programs, the IAG shifted its focus to broad social, economic and political contexts. This move reflected a larger global health trend at the time as donors and governments also “began de-emphasizing large-scale training programs for traditional birth attendants and prioritizing health-sector interventions designed to increase women’s access to professional medical care, especially for life-threatening complications.”

With the arrival of the year 2000, the Safe Motherhood Initiative had not achieved its goals of reducing maternal mortality by 50 percent. Though a few countries exhibited sustained reductions in maternal mortality, a Safe Motherhood Report read, “little or no progress has been achieved in those countries with the highest levels mortality, and in some countries, it appears that they have worsened.” Coupled with the lack of “success” of the first decade, the failure to reach this mark was “basically the death knell for the Safe Motherhood Initiative.” The group has since evolved into the Partnership for Safe Motherhood and Newborn Health.

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11 Ibid., 11.
14 Berry, Unsafe Motherhood: Mayan Maternal Mortality and Subjectivity in Post-War Guatemala, 88.
That same year, 189 countries met at the UN Millennium General Assembly in New York. These countries adopted a set of international development goals called the Millennium Development Goals (MDG): “building upon the agreements and commitments made at the series of world conferences held in the 1990s, the Millennium Development Goals (MDGs) offer a blueprint for reducing poverty and hunger, and addressing poor health, gender inequality, lack of education, lack of access to clean water and environmental degradation.”

MDG-5 specifically addressed issues of maternal health and called for a reduction in maternal mortality by 75 percent by 2015.

**The WHO and the training of “traditional birth attendants”**

My focus here is on WHO publications issued between 1975 and 2010, and the discourses around training “traditional birth attendants.” I chart how this strategy was first employed and then cast aside, and I argue that the model the WHO sets forth constitutes a form of biopower. My critique is not of the biomedical model. The model itself is problematic, but the aim is not to deconstruct what it is but rather the way it is exported. Not only are parts of the biomedical model beneficial for childbirth practices, but it would also be naïve

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16 In the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, 1992 (ICD-10)*, WHO defines maternal death as: “The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.”
17 I acknowledge the discrepancy between WHO declarations and publications, and implementation. I specify that the model the WHO sets forth is policy and recommendations, and deal with the implementation of such programs in the case study that follows.
18 In collaboration with the various other development agencies that co-author some of the publications, including the International Confederation of Midwives (ICM), International Federation of Gynecologists and Obstetrics (FIGO), UNICEF, United Nations Population Fund (UNFPA), and the World Bank.
and essentialist to assume that indigenous childbirth practices could and should remain in some “pristine” pre-development state. Given our increasingly globalized world, it is inevitable that biomedicine will intersect with indigenous systems of health and healing; the question is how knowledge may be shared and practice improved, with the ultimate goal of quality care for childbearing women. The WHO’s model for training, which exhibits a unidirectional flow of information and a devaluation of indigenous forms of knowledge, constitutes a form of biopower.

In the 1970s Michel Foucault developed the concept of “biopower,” to describe a juridical form of sovereign power situated and exercised at the level of life. Biopower, and the strategies it involves for governing life, can be enacted both at the level of the individual human body and at the level of the population. Foucault traces the history of biopower, contrasting it with what he labeled “sovereign power,” which characterized the exercise of power in Europe until the seventeenth century. “Sovereign power” endowed rulers with the power to govern death, which is to say, they could kill their subjects. With the emergence of modern states, however, came the emergence of “biopower.” Those who controlled modern states now had the power to govern life. As Monica Greco explains,

Biopower is premised on the recognition that life, the life of individual bodies and the life of populations, is a fundamental political resource in a modern context increasingly characterized by inter-state competition. It is a resource in economic terms, and in military terms. From the eighteenth-century onwards, this new configuration of power is associated with the emergence of human sciences—clinical medicine among them—and with
a range of technologies designed to optimize and to capitalize on the efficiency of bodies and populations.¹⁹

Paul Rabinow and Nikolas Rose, applying Foucault’s concept of biopower to medical technologies today, argue that biopower must include three essential dimensions: knowledge, or “one or more truth discourses about the ‘vital’ character of living human beings, and an array of authorities considered competent to speak that truth;” power enacted through “strategies for intervention upon collective existence in the name of life and health;” and, third, subjectivities or “modes of subjectification, in which individuals can be brought to work on themselves, under certain forms of authority, in relation truth discourses, by means of practices of the self, in the name of individual or collective life or health.”²⁰

Instead of an understanding of biopower as exercised by a state on its population, I examine biopower as exercised by First World governments, NGOs and transnational organizations, governing life in developing countries in the form of various programs. I refer not to a form of biopower that a state exercises over its population to increase economic efficiency or military power, but a form of power that developed nations exercise over the labor and populations of post-colonial nation states.

A Foucauldian approach to global health allows us to explore the ways in which political projects are cast as objective interventions, and how those in power hold the ability to define “health” and “quality of life” for the rest of the world. In regards to the training of “traditional birth attendants,” WHO publications promote the “truth discourse” of biomedicine—the WHO frames biomedical knowledge as value-neutral, objective, and superior to local forms of medical knowledge. In order to promote this “truth discourse,” the WHO creates “strategies of intervention that enter into life processes,” in the form of training programs for traditional and skilled birth attendants. These training programs impart the responsibility of teaching childbearing women “practices of the self,” most notably, self-care and risk prevention onto local midwives. In this way, training programs function as “modes of subjectification;” the childbearing woman is taught to work on herself in the name of individual health and the health of the population.

An analysis of the WHO’s focus on maternal mortality along the axes of Rabinow and Rose’s three characteristic elements of biopower demonstrates the ways in which the World Health Organization’s efforts are not value-neutral but rather implicitly political projects. It is for this reason that we have cause to critique forms of biopower in global health, because they mask biases, intentions, perspectives and agendas behind health promotion. “If we need to be suspicious of biopower,” Greco writes, “it is because it defines the horizon of our thinking,
when it comes to articulating values and freedoms.”21 It is therefore crucial that we redefine this horizon before we examine a case study in Chapter 3.

The truth discourse of biomedicine

In the 2000 “Making Pregnancy Safer Initiative,” the WHO projected a vision for a world in 2015 with “universal coverage ensuring skilled care for every birth.” The WHO defines “skilled care” as:

The presence of a skilled attendant and other key professionals supported by an appropriate environment including policy support, access to basic supplies, drugs, transport and relevant emergency obstetric and newborn services for timely management of complications. 22

To be considered “skilled care,” a birth must take place in the presence of a professional practicing in an environment—and a larger social, political and economic context—that facilitates biomedical intervention.

This description of the key components of a safe birth emerges in opposition to what the WHO describes as unsafe traditional practices. In a 2006 report “Making a Difference in Countries: Strategic Approach to Improving Maternal and Newborn Survival and Health,” a section titled “The Need for Action” briefly reviews what the WHO considers to be the socio-cultural factors that shape traditional childbirth practices. “In many traditional societies,” the authors write, “women may be denied food during pregnancy, and pregnancy and childbirth are regarded as unclean, therefore conducted in separate often unclean

21 Greco, "Thinking Beyond Polemics: Approaching the Health Society through Foucault," 17.
area.” The label “traditional societies” is here employed to describe parts of the world as varied as Latin America, Sub-Saharan Africa and South Asia.

Moreover, the use of the word “clean”—a descriptor far more subjective than hygienic or aseptic—cuts across understandings of pollution and cleanliness, which operate both symbolically and practically, and vary considerably between cultures. The descriptions place the locus of blame for maternal mortality on the “traditional” values held in these “traditional societies,” rather than on structural issues—poverty, malnutrition, lack of transportation—or even the broader devastation that modernity and development projects have wreaked in these countries.

The report continues: “the room where the mother and baby are confined is often dark and kept warm by burning firewood. Babies who do not cry or breathe immediately after birth may be subjected to various harmful maneuvers. Various substances like turmeric powder, wood ash, talcum and animal dung are used for cord care.” Again, this description supposedly characterizes the way birth is done across the developing world. Development discourses require this essentialized idea of “traditional” to act as “the common denominator of disparate situations development can bring under control.” The key relationship is not one of the WHO to a specific locality, but rather a generalized relationship of “the modern” to “the traditional.” The distressingly simplistic description that

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24 Pigg, "Acronyms and Effacement: Traditional Medical Practitioners (Tmp) in International Health Development," 63.
the WHO provides in its report serves as the WHO’s moral impetus and justification for intervention. Not only are the biomedical practices assumed to be superior, safer, and more modern, they are part of the “truth discourse” of biomedicine which promotes more “advanced” care for women than traditional practice.

The WHO then identifies the skills that all birth attendants must possess, in effect establishing the baseline for what is considered quality care. In prenatal care, one must be able to communicate with the woman, take a detailed history, and assist the family in making a plan for birth. A birth attendant must be capable of educating women “in self-care during pregnancy, childbirth and the postnatal period.”25 The most extensive skills required, however, pertain to the labor and birth. A skilled birth attendant must be able to identify any complications (and make arrangements for a referral), perform a vaginal examination, identify the onset of labor and ensure labor progresses without delay (which warrants a referral), monitor maternal and fetal-well being, record maternal/fetal well-being on a partograph, facilitate a “normal” vaginal delivery, and manage the third stage of labor “actively”—where “actively” is defined by the use of oxytocic drugs, the clamping and cutting of the cord, and the application of controlled cord traction.26

In postnatal care, the WHO enumerates the following capabilities to be considered “skilled.” The attendant must be able to detect any conditions in the

26 Ibid.
newborn, identify any hemorrhage and/or hypertension, assist women in initiating breast-feeding, and provide advice on postpartum family planning and birth spacing. Throughout pregnancy, childbirth and the early postpartum period, the skilled birth attendant is also responsible for the “supervision” of non-skilled attendants, to ensure the care they provide is “of sound quality.”

The aforementioned skills deemed necessary for attending to the labor emerged from a thoroughly biomedical view of the body and childbirth. In emphasizing “diagnosing” the start of labor, as well as managing the various stages, the WHO promotes a linear understanding of the progression of childbirth—once labor begins, the woman is expected to move forward from the first to the third stage of labor to be considered “normal.” This is classically the view held in U.S. hospitals, where if labor is progressing too “slowly,” (often the result of analgesia) health professionals administer oxytocin to speed up labor. Biomedicine constructs childbirth, specifically the labor women perform, as factory labor—subdividing it into many stages that must be managed to optimize efficiency and productivity.

The requirement that skilled birth attendants utilize a partograph also cannot be taken as an acultural recommendation; instead, the use of partograph to monitor birth emerges from a history in Western thought of privileging the text and written forms of knowledge. Lastly, the management of a “normal” vaginal

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27 Ibid.
delivery reflects the nature of biomedicine to reduce life processes to an average “norm” and define problems as any statistical divergence from that norm.

The “active” management of the third stage of labor is perhaps the most alarming of recommendations. The use of oxytocic drugs is in no way a practice that should be universally employed without serious consideration. Most often used to counter stress-responses in Western hospital births, oxytocic drugs can require additional biomedical interventions, and often result in extremely severe and painful contractions. If administered after the birth of the baby, these drugs can stop post-partum hemorrhage with little potential for harm; if administered before, however, they can endanger the baby’s life and considerably increase the chance of infant death. Cord clamping and cutting—referenced as dangerous in the WHO’s characterization of traditional births, wherein traditional cultures place animal dung on the cord—is also a culturally specific practice. If the cord is not cut until after the placenta has descended—often the case in non-biomedical cultures—there is no need for cord clamping.

That the WHO makes recommendations is not necessarily problematic. As will be explored at length in the following chapters, the routine vaginal exam the WHO recommends proves to be an overwhelmingly helpful practice for indigenous midwives. Throughout these recommendations the WHO presents the knowledge it promotes as politically neutral and objective, without acknowledging either the cultural and political orientation of biomedicine or the WHO’s positionality as a transnational health organization. The WHO claims a “view
from nowhere,” and from this non-position, the organization (and biomedicine as a whole) declares an objective vision of the world, and claims the right to make rational knowledge claims. Donna Haraway disagrees that a position of transcendence endows anyone with the perspective to make rational knowledge claims, arguing instead, “only partial perspective promises objective vision.” The only true knowledge claims can be made from a place of “limited location and situated knowledge.” Critiquing the WHO’s claims to objectivity, however, is not an argument to replace this “truth discourse” with another. No body of knowledge can be regarded as universally objective; all knowledge comes from somewhere, and the goal of global health should be negotiating between these partial perspectives.

Elements of the biomedical approach could undoubtedly benefit childbirth practices in developing countries, and this knowledge should not be withheld. Within the transfer of this information, however, the partial perspective of each body of knowledge must be acknowledged. The danger in presenting biomedical knowledge as universal objective truth is that it eliminates other definitions of “health,” ranges of behavior, and considerations of what is considered “quality of life” across the world. Definitions of “health” remain entirely uncontested in global health discourses, yielding singular ideas of what qualifies as true health information or safe childbirth practices.

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30 Ibid., 583.
Training programs as strategies of intervention

The WHO disseminates biomedical knowledge, its “truth discourse,” to target populations through multiple strategies of intervention. In order to achieve the 2015 MDG goals, the WHO deemed it necessary that a Western-trained skilled attendant assist every birth. The call for “skilled” attendance at every birth requires further intervention from the WHO (and other international health organizations) who must then create and regulate of health care “systems” in developing countries.

Herein lies a key strategy of intervention for the promotion of biomedicine: in training midwives, the WHO creates a means to intervene in “the name of life and health upon the nation, society or pre-given communities.”

Since the inception of traditional birth attendant trainings in the 1970s, the WHO has changed who they train, and what practices they emphasize in their trainings. These alterations reveal not flexibility in policy but the opposite—a rigid adherence to the biomedical model of birth and the “truth discourse” of biomedicine. The inability of these “strategies of intervention” to accommodate other “truths” ultimately work against the WHO’s stated goal of combating maternal mortality.

In the 1970s, the many development agencies began to fit in “cultural sensitivity” into development program agendas. “Traditional birth attendants,” as the WHO labeled women whom they perceived as roughly equivalent to nurse-

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31 Rabinow, "Thoughts on the Concept of Biopower Today."
midwives in biomedicine, emerged as the appointed intermediaries in this interface between Western medicine and local cultures. The WHO developed the concept of “traditional birth attendants” without any regard to cultural particularities. In many in the developing world, most notably in parts of South East Asia, an equivalent to a nurse-midwife did not exist. The WHO attempted an approximation: traditional birth attendants “were discovered to be ‘like us’ as fellow health promoters, but crucially ‘not like us’ in that they are characterized as trusted cultural insiders who can carry development messages into the hidden heart of traditional societies.”\(^\text{32}\)

In 1975, the WHO published a guide entitled “The Traditional Birth Attendant in Maternal and Childbirth Health and Family Planning: A Guide to Her Training and Utilization” instructed how to incorporate local customs into biomedical training programs—respecting other cultures while continuing to try and control. The instances of these programs increased steadily throughout the 1970s and 1980s until 1990, when it became quantitatively evident that they were not effective in reducing maternal mortality. Maternal deaths per year numbered 585,000 worldwide—an increase of 80,000 in roughly a decade.\(^\text{33}\) In 1992, a joint coalition of the WHO, United Nations Population Fund (UNFPA), and the Maternal and Child Health division of the WHO (MCH) declared the traditional birth attendant an interim measure; the TBA was no longer to fill the role of the

\(^{32}\) Pigg, "Acronyms and Effacement: Traditional Medical Practitioners (Tmp) in International Health Development," 51.

\(^{33}\) Sue Kruske, and Lesley Barclay, "Effect of Shifting Policies on Traditional Birth Attendant Training," Journal of Midwifery and Women's Health 49, no. 4 (2004): 307. This is not to say that Western practices caused the increase, but only that trainings did not result in a marked decrease.
Western-trained midwife. Instead, the WHO would train other health workers in midwifery skills, and relegate the TBA to a role of complementary importance.

A fatal flaw in the logic of the WHO was the assumption that an equivalent profession to a Western “midwife” existed. This presumed parallel would be the best person to receive biomedical knowledge, and changing the practices of individual midwives was thought to be the best way to lower maternal mortality. In many cultures, however, there was no single person whose sole function was to attend birth, nor was there a healer whose specific purvey was childbirth. What is more, the WHO assumed the population being trained had a parallel understanding of birth. The WHO defines childbirth as a medical act while many cultures may not even associate birth with the domain of health and sickness.

Biomedicine as a system of knowledge can generally be characterized as a reductive and internally-focused approach to health. Non-western belief systems of health and healing may implicate a spectrum of concerns in birth, “spanning issues of ritual pollution, the vulnerability of pregnant women and infants to witchcraft and ritual debt.” Lastly, WHO recommendations for the training of TBAs were predicated on the idea that the cultural dimension of childbirth (the practices the TBA preserves) could be separated from the physiological aspect (the practices WHO trains the TBA to change).

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34 This is to say biomedicine tends to privilege information from the interior of bodies over that of the exterior bodies. This is visible in the institution’s emphasis on surgery, for example, or x-rays.
35 Pigg, "Acronyms and Effacement: Traditional Medical Practitioners (Tmp) in International Health Development," 57.
Within biomedicine, childbirth is framed as an event in which a universal physiological process underlies social practices that are unique to specific localities. Training programs seek to alter physiological practices, replacing “harmful” local customs with safe and hygienic practices, while keeping intact the “non-medical” cultural practices. The WHO’s first attempts to initiate TBAs into the biomedical model of childbirth reflected its expectation that TBAs would share a similar concept of childbirth as possessing discrete physiological and cultural aspects. When TBAs failed to fit into a medical model of a birth attendant—possibly because these women did not conceive of birth in the same way—rather than rethink biological/social dichotomy, the WHO chose instead to relegate TBAs to the realm of culture, excluding them from any medical aspect of birth. The conception of birth remained intact.

The domain of TBAs—as elucidated by the WHO—remains solely that of the cultural, social, ritualistic and symbolic aspects of birth. The WHO recognizes the social role of the TBA to represent a “different” form of knowledge, and grants it authority within the bounds of tradition. Labeling these other forms of knowledge as different, however, implies that TBAs’ practices are different from a biomedical norm. Non-biomedical forms of knowledge are not taken to be as “true.” While the WHO recognized that the TBAs possessed unique “knowledge” they domain this knowledge as “cultural,” and the opposite of universal, objective, and modern scientific knowledge.
After 1990, when an increase in maternal deaths indicated the failure of TBA trainings, “world policy makers assumed that practical difficulties, such as poor literacy and lack of ‘scientific knowledge,’ were preventing trained TBAs from effectively lowering the Maternal Mortality Rate (MMR) in countries that had invested in TBA training.”36 By definition, TBAs are tied to tradition—“one cannot be a true traditional birth attendant and part of institutional medicine because such inclusion removes them, by definition, from the ‘T.’”37 The WHO shifted its focus away from TBAs as the locus of intervention and seemed to hope that “the TBA would disappear as tradition atrophies and modernity progresses.”38

The WHO altered their language in 1996. Trained birth attendants were no

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**Box 1**

**Types of skilled attendants and the mix of skills and abilities**

While it is up to each country to decide on how maternity care should be organized, much depends on the availability of skilled attendants, the composite set of skills and abilities they possess and the resources available to recruit, train and retain these staff. The principal categories of skilled attendants found in many countries include:

- **Midwives (including nurse-midwives):** Persons who, having been regularly admitted to an educational programme duly recognized in the country in which it is located, have successfully completed the prescribed course of studies in midwifery and acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

- **Nurses with midwifery skills:** Nurses who have acquired midwifery knowledge and skills either as a result of midwifery being part of their nursing curricula or through special post-basic training in midwifery.

- **Doctors with midwifery skills:** Medical doctors who have acquired competency in midwifery skills through specialist education and training, either during their pre-service education or as part of a post-basic programme of studies.

- **Obstetricians:** Medical doctors who have specialized in the medical management and care of pregnancy and childbirth and in pregnancy-related complications, but not usually complications of the newly born infant. They have usually undergone additional education and clinical training to acquire these additional skills and have been certified or accredited in obstetrics.

Figure 1. The WHO’s definition for skilled attendance
longer considered sufficient; the category of “skilled birth attendant” was thus constructed to provide care in a way the “traditional birth attendant” could not. The Inter-Agency Group on Safe Motherhood declared “a skilled attendant refers exclusively to people with midwifery skills (for example doctors, midwives, nurses) trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage or refer complications.” The WHO sought to create a new class of birth attendants—completely trained in biomedical techniques, who would be present at births. One of the many tasks of the skilled birth attendant notably includes the supervision of the TBAs present. The “traditional birth attendant, on the other hand, is defined as the following:


Box 2
The role of traditional birth attendants (TBAs)

Who is a TBA?
Strictly, the term TBA refers only to traditional, independent (of the health system), non-formally trained and community-based providers of care during pregnancy, childbirth and the postnatal period.

Can TBAs provide the necessary care for women and newborns?
Because TBAs already exist in many developing country communities, it has been suggested that they could perform the role of the skilled attendant, where required with some training. Research indicates that training of TBAs has not contributed to reduction of maternal mortality. However, it is recognized that for some women TBAs are the only source of care available during pregnancy. And as experience from some countries such as Malaysia has shown, TBAs can become an important element in a country’s safe motherhood strategy and can serve as key partners for increasing the number of births at which a skilled attendant is present.

Figure 2. The WHO definition of the "traditional birth attendant"
In the latest WHO reports, the TBA is explicitly excluded from the definition of what constitutes skilled attendance at birth. These TBAs are “traditional,” and therefore a hindrance to the progress of the “modern” health systems that the WHO aims to implement. They are “non-formally trained,” where formal training is equated with acquiring knowledge of biomedical techniques.

When the strategies for intervention failed in terms of the (biomedical) measure of maternal mortality, the WHO did not attribute the failures to their general approach or to the fact that biomedicine is in itself a culturally constructed system of beliefs. Instead, they attributed the failures of the training program to the choice of the TBAs—deemed too poor or illiterate to understand the training. Maintaining the “training” of local health professionals as its general scheme, the WHO merely modified whom they sought to bring into the biomedical model. Within biopower, therefore, the fact that one strategy failed could not challenge a truth discourse. The truth discourse remained objective and true; instead the targeted populations were incapable of exhibiting “scientific knowledge.” The WHO attempted to control the practices of the TBAs.

Currently the WHO defines its task as training “modern” midwives (health workers, from that country, but typically from urban areas) in developing countries and professionalizing midwifery as part of a larger project to reorganize health care systems. The new model in the WHO is a three-pronged strategy of

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intervention, involving interventions at the level of health systems, health workers and families. The figure below, taken from a 2006 report, illustrates that, in the face of failure the WHO has not altered how it intervenes, but instead only expanded where it intervenes in the process of childbirth and at what level of collectivity.

**Figure 2: Integrated Management of Pregnancy and Childbirth (IMPAC)**

- **Policy, strategy, skilled human resources planning**
- **District level management of health services, logistics and supplies, infrastructure, cost and financing**
- **Assessment, monitoring and surveillance**
- **Programme and management guidelines for pregnancy, childbirth postpartum, newborn care and other, relevant interventions e.g., malaria, HIV/AIDS at different levels**
- **Health education and promotion, and community mobilization and support activities**
- **Improved health system response, access to and quality of essential and emergency care**
- **Training and follow up Improved skills and competencies**
- **Improved community practices and increased utilization**
- **Health system**
- **Health worker skills**

**Figure 3. The WHO's strategic plan for intervention**

The macro goal of improving the health system and the micro goal of improving education on the family level have been added on either side of the mid-level intervention—the training of health workers.

These trainings continue to assume that physiological and cultural practices can be separated. Implicitly, this opposition between physiology and culture reflects the WHO’s assumption that biomedical knowledge is acultural, asocial, and apolitical. That which pertains to physiology, i.e. biomedicine, is by
definition not part of culture. Training programs are also predicated on a larger assumption: Much in the way “truth discourses” set forth a universal model without attention to location or perspective, the WHO’s training programs (strategies for intervention) are founded in a belief in a material body that is universal and pre-social. Margaret Lock calls this the “body proper” and writes, “this body proper, the unit that supports the individual from which societies are apparently assembled, has been treated as a skin-bounded, rights-bearing, communicating, experience-collecting, biomechanical entity.”

In suggesting that a standardized biomedical model of childbirth should universally replace than whatever “medical” practices exist in those locations, the WHO makes the assumption that bodies everywhere are the same. Practices such as the administration of oxytocin are assumed to work worldwide because they work in the US. Moreover, practices like vaginal exams, which are culturally acceptable in the U.S. may be culturally inappropriate in another setting. While social practices pertaining to childbirth differ across the world, the WHO’s training is grounded in the belief that the physiological aspects are universal.

Deconstructing the “body proper” is not to say that a material body does not exist, or that biological science has no value. Obviously we all inhabit material forms, but the biological body cannot be accepted as a “universal entity that we are increasingly able to apprehend comprehensively by means of scientific

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The picture of the body that the biological sciences create—universal, asocial, ahistorical—is real but it is a partial picture. Human biology is situated in place and time, and Lock proposes “local biologies” as a more nuanced way of describing how biological processes that affect all humans (pain, aging, and, in this case, childbirth) are experienced differently due to location. There can be no standard birth, against which women worldwide are categorized as normal or abnormal. Therefore, “understanding the body as contextually situated means that we attribute variations in biology to regularities produced by temporal processes rather than to statistical laws.” Instead of teaching to a rigid and standard model of birth, the WHO must take into account local biologies in creating agendas and recommendations. A practice that is effective for white, middle-class women in the United States may not be for an indigenous woman in Guatemala unaccustomed to allopathic medicine.

Self-care as a mode of subjectification

In its latest model of Integrated Management of Pregnancy and Childbirth (IMPAC), the WHO stresses the importance of a “continuum of care.” Ensuring the best care for a pregnant woman entails educating her so that she can, first and foremost, engage in self-care: “the continuum starts with the woman and her family in the woman’s own home — i.e. self-care and prevention.” These “practices of the self,” engage third world women in “modes of subjectification,

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42 Lock, An Anthropology of Biomedicine.
43 Ibid., 90.
44 Ibid., 108.
45 WHO, “Making a Difference in Countries: Strategic Approach to Improving Maternal and Newborn Survival and Health.”
in which individuals can be brought to work on themselves, under certain forms of authority, in relation to truth discourses, by means of practices of the self, in the name of individual or collective life or health.” In this model, biomedical professionals train skilled birth attendants who subsequently train childbearing women; this transmission of biomedical knowledge constitutes a key praxis in transnational intervention, linking “pedagogy with performances of power.” Through education in biomedical practices, “local women are trained to be institutional agents;” while “TBAs’ (traditional birth attendants) are trained in ‘safe delivery.’” In calling the process “care,” the WHO obscures any intention to control populations.

Teaching practices of the self entails communicating a particular Western understanding of the self as it pertains to health. Within biomedicine, health is not a natural state, but rather one you must achieve, through eating correctly, exercising, visiting a variety of medical professionals annually, and avoiding certain substances. Our selves are constructed as objects that must be worked on and physiological processes, such as childbirth, must be constantly managed in order to optimize life. Biomedicine locates the individual as its most basic unit; promoting self-care and self-responsibility in childbirth, therefore, occurs “against the background of individualization.” Outside of Western medicine, practices of health and healing may take place on a level other than the individual—this

46 Rabinow, "Thoughts on the Concept of Biopower Today," 3.
47 Pinto, Where There Is No Midwife: Birth and Loss in Rural India, 18.
48 This is of course part of the emphasis on vitality in biopower.
distinction is particularly pronounced in regards to childbirth, where biomedicine has come to construct even the mother and fetus as separate entities. (This conception of mother and fetus as separate is visible in our use of ultrasound imaging as well as in the debates around abortion.) Finally, the management of life in biomedicine is ordered around the probability and prevention of risk—teaching practices of the self means translating this Western concept of “risk.”

Practices of the self, and self-responsibility are embedded in a rhetoric of choice, which “clearly resonates with the ethic of autonomy at the heart of advanced liberal modes of subjectification.” Locating childbirth practices in developing countries within a framework of individual responsibility and choice is profoundly problematic as it obscures the “constraining hegemonies that restrict choice[s]” for a childbearing woman. WHO recommendations make morbidity and mortality matters of private and individual concern, when maternal deaths in the developing world are overwhelmingly determined by poverty and gender status.

The IMPAC model suggests “health education and promotion, and community mobilization and support activities” will lead to “improved community practices and increased utilization.” Childbearing women, equipped with their biomedical health information, can cross from tradition (and the static

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51 Rabinow, "Thoughts on the Concept of Biopower Today," 22.
52 Pinto, *Where There Is No Midwife: Birth and Loss in Rural India*, 221.
53 Poverty and gender are also linked with economic, political and social policies that date back to colonialism. The socio-economic devastation modernity caused for older existing systems cannot be understated, and the current facts of poverty and gender inequality are a result of this process.
“traditional birth attendant”) to modernity through the choices they make.\textsuperscript{54} This sequence of events assumes that childbearing women do not utilize biomedical options because they lack “health”\textsuperscript{55} education, not because they consciously choose to seek out other models of birthing.

This choice-centered structure of health promotion exemplifies what Annemarie Mol calls “the politics of who.” In the “politics of who,” patients-as-consumers can decide in a “market-model” of health what is best for them. Optimizing care entails increasing the availability and accessibility of biomedical options, thereby placing the ultimate emphasis on who decides. In asking only “who decides?” the power biomedical authorities hold to dictate and structure options is completely unconsidered; the “facts” remained unquestioned, and the biomedical health professionals maintain their place as the sole repositories of knowledge. Within the “politics of who,” we accept biomedicine’s singular definitions of health and quality of life.

Instead of asking, “who decides?” Mol urges us to engage in a “politics of what.” She labels this a politics to underscore the need to “disrupt the ways in which medicine normalizes and promises closure through fact-finding.”\textsuperscript{56} We must ask “what to do?” in order to problematize the concepts of health and quality of life that have come to be taken as givens. The blame for infant or maternal mortality cannot be placed on the individual—mother or midwife—

\textsuperscript{54} Pinto, \textit{Where There Is No Midwife: Birth and Loss in Rural India}, 229.
\textsuperscript{55} To mean, biomedicine’s definition of health.
\textsuperscript{56} Mol, \textit{The Body Multiple: Ontology in Medical Practice}, 177.
when both are forced to chose among (potentially) flawed options. We should instead focus on expanding ways of safely giving birth through empowering alternative definitions of health and care.

Efforts by the WHO to spread biomedical knowledge are not inherently problematic. The efforts to train, regulate and control “traditional birth attendants,” however, spread biomedical knowledge in a way that devalues and undermines indigenous practice. Initiatives that aim to replace entirely indigenous practice with the biomedical model of birth constitute a form of biopower. Below, I have mapped my analysis of the ways in which the WHO spread biomedical knowledge, against what I label “local care,” an alternative to the totalizing discourse set forth by the WHO in global health promotion.

<table>
<thead>
<tr>
<th>GLOBAL HEALTH</th>
<th>LOCAL CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biomedicine as objective truth</td>
<td>Biomedicine as partial perspective</td>
</tr>
<tr>
<td>Worldwide implementation of a single model of birth through the training of midwives; belief in a universal body</td>
<td>Attention to the ways in which biologies are local and bodies are formed through biological and social processes; belief in “local biologies”</td>
</tr>
<tr>
<td>Education in practices of the self to increase utilization of biomedical care; “politics of who”</td>
<td>Emphasis on expanding options for women and calling into question the definition of “health” set forth in global health discourses; “politics of what”</td>
</tr>
</tbody>
</table>

I contest the WHO’s claims to objectivity and the ways in which these health promotion programs have sought to normalize a singular conception of “health” at the exclusion of other definitions. Until global health agendas for training midwives can be structured around empowering multiple forms of “health,”
rather than directing all resources to furthering the access and availability of one idea of “health,” attempts to lower maternal mortality will continue to have varied results.

The discourses analyzed above cannot speak to the actual implementation of WHO guidelines. The use of Foucault is invaluable for laying bare the mechanisms of power: an analysis of WHO discourses along the axes of biopower reveals that though global health initiatives may claim to be politically neutral, indisputably progressive projects, they are, in fact, profoundly problematic. Despite the utility of a Foucauldian approach to describe the power that states and institutions hold over the lives of individuals under their control, biopower has its limits. Individuals do possess the ability to transform their world, and form responses to these institutions that shape their lives. Having challenged the WHO’s policy on “improving” indigenous midwifery, I now turn to a case study of Guatemalan midwives and their lived experience of global health interventions to explore local forms of resistance.
Chapter 2:
The Guatemalan Context

Before I narrow my focus to a single group of indigenous midwives in a specific region of the country, I must review a few salient aspects of the Guatemalan context. While it is beyond the scope of this work to even attempt to paint an accurate picture of Guatemalan history and the oppression and violence that have occurred within the country, I aim to provide sufficient context for understanding the present-day relationship between the indigenous communities and the State.

Guatemala is a Central American country of about 13 million people, bordered to the north by Mexico and Belize, and to the south by Honduras and El Salvador. Indigenous communities constitute 50 to 60 percent of the population, comprise twenty-one separate language groups and are largely concentrated in the Western highlands. Small groups, including Garifuna, European and Asian immigrants, make up less than one percent of the total population. Finally, ladinos, “most easily defined as everyone else”\(^57\) comprise between 39 and 49 percent of the population, and dominate the political and economic systems in Guatemala.\(^58\)

The present day definition of ladino refers to a person who exhibits the signs of a “European” or “national” culture, most notably speaking Spanish

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\(^58\) Ibid.
language and wearing European dress. As it is not tied to a particular ethnicity or race, ladino as an identity can refer to people of mixed heritage, or people of Indian descent who have chosen to discard their indigenous dress and language in order to “ladinize.” The term ladino has changed since its inception, a history I follow below.

Throughout this essay, I use the terms “Maya,” “indio,” “Indian” and “indigenous” interchangeably to refer to ethnic/linguistic indigenous groups within Guatemala. “Maya” is a category that has been resurrected in the past twenty years as part of pan-indigenous movements and refers to a range of indigenous groups. If used to refer to a time before the pan-indigenous movements of the mid-1980s, the word “Maya” references the pre-conquest Maya civilization.

**Guatemalan history**

Prior to conquest, an estimated population of around one million inhabited what is now Guatemala. The Classic Maya (A.D. 250-900) lived around the area known as the northern lowlands, building the famous-city states still associated with Mayan civilization. Around A.D. 900, however, in the face of a

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60 I quote Diane M. Nelson at length: “Twenty years ago, the only Maya in Guatemala were on thousand-year-old glyphs and in tourism literature. Until about the mid 1980s, the word Maya was primarily used in archaeological discourses to refer to the builders of Tikal (the “Classic” Maya city, probably abandoned by the ninth century A.D.), in linguistics (referring to Maya trunk languages), and in government tourism campaigns designed to lure foreigners carrying hard currency with the promises of an exotic ancient past. Maya was not used popularly, or by those self-identifying, to refer to existing indigenous people. But in Quincentennial Guatemala, indigenous activists are redeploying the term Maya to refer to members of Guatemala’s twenty-one distinct ethnic-linguistic communities, who have traditionally identified primarily with their communities of origin, secondarily with their ethnolinguistic group, and only distantly if at all as indigenous...The new and increasingly hegemonic use of the term Maya is part of this practice of formando, making or forming this new, pan-indigenous identification.” Diane M Nelson, *A Finger in the Wound: Body Politics in Quincentennial Guatemala* (Berkeley University of California Press, 1999).
growing population, increasing environmental degradation and rising political tensions, the Maya city-states collapsed in rapid succession. In the Postclassical period that followed (A.D. 900-1200), the Toltecs repeatedly invaded from Mexico, profoundly altering the Maya population. The Spanish, therefore, did not conquer pristine, culturally untouched civilizations upon reaching Central America in the 1500s, nor did they encounter Mayan civilization at its peak.

The Spanish invaded the region in the 1520s, led by the notoriously bloodthirsty conquistador Don Pedro de Alvarado. Unlike the Spanish colonies in South America, Central America did not offer gold or vast natural resources; instead the region was home to various indigenous populations. The Spanish New Laws, established in 1541, were designed to regulate and reassert crown control over Indian labor. Specifically, the New Laws instituted the repartimiento, a system where the Crown granted a subject rights to land and labor—in the form of indigenous communities. This system institutionalized labor migrations, requiring that Indians spend part of the year on plantations, and part of the year farming plots of corn and beans. Out of the colonial period, and particularly its repartimiento system, emerged three “very distinct, mutually antagonistic sectors” within Guatemalan society: the criollos, or descendants of white immigrant Europeans, the Indians or people of the indigenous communities, and an ambiguous third category, ladinos.

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61 Fischer, "Introduction: Maya Cultural Activism in Guatemala."
62 Ibid.
64 Berry, Unsafe Motherhood: Mayan Maternal Mortality and Subjectivity in Post-War Guatemala, 133.
The origin of the term “ladino” is generally traced to the term “indio ladino” which referred to indigenous people who spoke Spanish and wore European dress yet continued to live in their indigenous communities. Under colonialism, the Spanish typically favored these indios ladinos over the non-Hispanicized Indians.66 Starting in the seventeenth century, the term “ladino” started being used to refer to castas or “mixed-race descendants of Africans, Indians, and Spaniards who were considered part of the Spanish (as opposed to Indian) republic under colonial law.”67 In the late colonial period, therefore, the categories ladino and casta were largely indistinguishable. Over the course of the nineteenth century, however, this definition changed.

Categories within society established through the repartimiento system were “meaningfully reinscribed” when the economy shifted to coffee production in the late 1800s.68 Indians and ladinos, though viewed as separate in terms of descent, did not differ in terms of class until this plantation period.69 With the establishment of coffee plantations, however, Indians became a seasonal proletariat, while rural ladinos took on the role of tenant farmers or “full-fledged proletariat” and urban ladinos became middle men in the coffee production economy. In this time, the category ladino ceased to have associations with blood, race or descent and came to refer to anyone—regardless of race or ethnicity—

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69 Smith, "Introduction: Social Relations in Guatemala over Time and Space," 25.
who displayed a European (rather than Indian) identity. Most significantly, this meant speaking Spanish, wearing European-dress and living in a non-Indian community. As the definition shifted from a biological basis for inclusion to a cultural one, it thus became possible for someone born an Indian to become a ladino if they learned Spanish, discarded Indian dress, and left their indigenous community. Lados also came to be seen as displaying “national culture,” while Indians were viewed as acting in opposition to the national project.\(^7\)

Thus, with the postcolonial period came the emergence of the “Indian problem,” defined as the question of how to become a “whole, homogeneous and functioning ‘modern nation,’” given the presence of a large indigenous population. Within this “Indian problem,” tradition and ethnicity were framed as holding nations back, “denying [these nations] the benefits of civilization and modernization.”\(^7\) Since the late 1800s, those in power have approached the “Indian problem” in Guatemala in different ways.

The Guatemalan state that formed in the postcolonial period had difficulty controlling indigenous populations, and subsequently the despotic power of the state over Indian communities increased vastly from this time on.\(^7\) This coercive state tradition continued until a coup in 1944 brought about Guatemala’s first free elections. From 1944-1954, two presidents—Juan José Arevalo and Jacobo Árbenz—headed two reform-oriented governments. The changes these two presidents instituted, most notably Árbenz’s agrarian reform in 1952, provoked

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\(^7\) Smith, "Introduction: Social Relations in Guatemala over Time and Space," 16.
constant attacks from conservative elements in society, including landowners, the church, and parts of the military.73 A coup in 1954 ended this period, and the militarized state that emerged adopted “yet another coercive response to popular resistance, reflecting the state’s inability to control the Indian population by other than violent means.”74

Guatemalan history in the second half of the twentieth century is marked by the state violence perpetrated against indigenous communities. Two waves of guerilla groups formed to counter this repression, first in the late 1960s and then the early 1970s,75 which were harshly repressed by state-sponsored “death squads.” The civil war grew increasingly violent and intense; the violence reached its height in the 1980s, when the government began committing acts of genocide against the indigenous populations. Employing a “scorched earth” policy, government forces would destroy towns—raping, pillaging, and murdering—where they found any evidence of guerilla support.76 The 1983 publication of indigenous rights activist Rigoberta Menchú’s testimonial directed international attention towards the violence. In 1986 the election of Vinicio Cerezo brought nominal civil rule, but the civil war did not end until 1996.77

74 Smith, "Introduction: Social Relations in Guatemala over Time and Space," 17.
75 Fischer, "Introduction: Maya Cultural Activism in Guatemala."
76 Berry, Unsafe Motherhood: Mayan Maternal Mortality and Subjectivity in Post-War Guatemala, 135.
77 Fischer, "Introduction: Maya Cultural Activism in Guatemala."
In 1994, The United Nations appointed the Commission on Historical Clarification (CEH) to “place on record Guatemala’s recent, bloody past.”\footnote{Guatemalan Commission for Historical Clarification, ”Guatemala Memory Silence: Tz’inil Na ’Tab’al, Report of the Commission for Historical Clarification: Conclusions and Recommendations ” Guatemalan Historical Clarification Commission, http://shr.aaas.org/guatemala/ceh/report/english/toc.html.} The Guatemalan governed justified the violence it inflicted, the report shows, by arguing that it protected the population from the threat of communism the guerilla groups posed. Any potential ally to those groups, therefore, had to be eliminated in order to ensure state security. The army perceived Mayan communities to be “natural allies of the guerillas,” and this led to the “extermination en masse of defenseless Mayan communities.”\footnote{Ibid.} The CEH has registered 626 massacres of communities and documented the countless acts of cruelty that “preceded, accompanied or occurred after the death of victims.”\footnote{Ibid.}

The CEH estimates that over 200,000 people were killed and over 1,000,000 displaced as a result of the war. Estimates also indicate that 83% of victims were Maya, while 93% of the violence was perpetrated by the state.\footnote{Berry, Unsafe Motherhood: Mayan Maternal Mortality and Subjectivity in Post-War Guatemala.} The Peace Accords signed in 1996 sought to both end the civil war, and its efforts to solve the “Indian Problem” through state-sponsored violence. The Peace Accords articulated the national problem: Guatemala’s development has been impeded by poverty, discrimination, and social and political marginalization. The solution to this problem, as determined in the Peace Accords, was that an end to social inequalities would bring an end to underdevelopment. Since this time, therefore,
the Guatemalan government has become charged with the instatement of
development policies, directed in particular towards indigenous populations.

The incorporation of Mayan communities into Guatemalan civil society is
also seen as a necessary element in becoming a “modern” nation. Carol Smith
writes that for non-Indian intellectuals, “a modern nation implies not only unity,
but the eradication of what they believe to be the very symbol of backwardness—a
group of people still rooted in the traditions of a colonial past.” The indigenous
communities, on the other hand, are more interested in justice than the possibility
of assimilation. To that end, indigenous people “wish to retain their distinctive
traditions, while taking a position of economic and political equality with others in
a modern (i.e. developing) multicultural nation.”

**The Guatemalan Health Care System**

Approximately 65 percent of Guatemala’s people live in areas considered
rural, while only 20 percent of all health services are located within rural areas.
This disproportionate distribution of services means that residents of Guatemala
City have access to almost 80 percent of the country’s health services despite
constituting 25 percent of the population. The country has a maternal mortality
rate, estimated at 248 maternal deaths per 100,000 live births by the Ministerio de
Salud Pública y Asistencia Social (MSPAS) and 220 maternal deaths per live birth by
the Demographic Health Survey. These rates are higher—sometimes double that

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of the national average—in rural areas where primarily indigenous populations live.\textsuperscript{83}

The government health care system in Guatemala is organized through the Ministry of Public Health and Social Assistance or the \textit{Ministerio de Salud Pública y Asistencia Social} (MSPAS). This body was founded in 1944, when the revolutionary government took hold of power and organized public assistance programs. The initial MSPAS consisted of three directories—public assistance, mother and child assistance, and public sanitation. As of 1993, MSPAS reported 787 health posts, including 188 type B centers (defined as without beds), 32 type A centers (some beds) and 35 hospitals. In 1999, there were an estimated 857 health posts and 254 health centers (\textit{Centros de Salud}) in the country. The majority of practitioners in the government system are ladino, and most physicians are men. A 1988 representative survey indicated that of biomedical health care providers, 89 percent were male and 15 percent could speak a Mayan language.\textsuperscript{84}

As part of the 1996 Peace Accords, Guatemala committed to a comprehensive restructuring of the health care system.\textsuperscript{85} After a 1996 report from the MSPAS indicated that 46 percent of the population did not have access to basic government health services, the government initiated a system whereby the official health system could extend coverage of basic services through


\textsuperscript{84} Ibid., 214.

subcontracts with non-governmental organizations (NGOs). This model, called the Integrated Health Care System (SIAS) added two members to what had previously been the “basic health team” stationed in each municipality. SIAS comprised only one part of larger neoliberal national restructuring programs that took place in the mid-1990s.

The Peace Accords set forth a goal of reducing maternal mortality rates by 50% by the year 2000; this initiative targets rural Mayan communities in particular, where maternal mortality rates are disproportionately higher. In order to achieve this goal, government initiatives tried to teach indigenous midwives biomedical techniques.

These required training programs not only attempt to combat maternal mortality but also function as part of a larger national project to bring indigenous communities into Guatemalan civil society. The maintenance of “traditions of a colonial past,” which include indigenous methods of attending childbirth, are seen as keeping the Mayan communities separate. While participation from all sectors of society is without a doubt a necessary component for a democracy, a hospital birth cannot be seen as a part of this participation. Training programs for midwives are therefore both an effort to ameliorate inequalities in the wake of inconceivable violence and also a project to bring indigenous communities into the national identity. These attempts to change indigenous midwifery have

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political implications, and frame indigenous midwives as not only anti-biomedical, but also anti-national and anti-modern.
Chapter 3:

Biomedicine without Biopower:
The Asociación de Comadronas de Área Mam

“I saw that the people chose me, and I said, ‘this is entirely a privilege that God has given me,’ because they always came to look for me. ‘My feet hurt,’— ‘my head hurts,’— ‘I am pregnant,’— ‘I am nauseous,’— and I told them, “Very well, I will check to see if you are pregnant,” and “you need to eat vegetables, and fruits, and all the things you like,” and I began to advise women.

Therefore, I say that this is a privilege, God has given me the gift of being a midwife, because I am not studying medicine.”

Midwives remain one of the most significant loci of knowledge in Mesoamerican communities. In rural regions in particular, midwives continue to attend the majority of births. Because of the role they hold as healers in their communities, midwives often must serve as the interface between biomedicine and indigenous medicine. While I have previously sought to examine how institutions seek to control indigenous midwives and the healing practices in which they engage, I now look to lived experience to ask how each individual negotiates her role as a midwife—a comadrona—given the influences of globalized medicine, and the accompanying pressures to change. What follows is a study of a specific group of women, who joined together with the express purpose of maintaining their practices in the face of increasing regulation. I use examples from the daily practices of midwives to deconstruct assumed dichotomies.

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between biomedical and indigenous forms of knowledge and practice, and to illustrate how the entrance of biomedicine into the work of healers and midwives in the developing world is anything but a uniform and linear process. The model of care offered at Asociación de Comadronas del Área Mam (ACAM) empowers forms of health outside the biomedical definition and, as such, expands options for indigenous mothers in Guatemala.

I compiled this case study from oral histories I conducted with seven midwives at the Asociación de Comadronas de Area Mam (ACAM), augmented with direct participant observations and stories I gathered while living and working at the center. Here, I must acknowledge my positionality as a Western intellectual: given the very limited space that Western intellectual traditions have offered those working from a subaltern position, and given the proclivity of Western intellectuals to speak for the subaltern, rather than to support subaltern voices, what can and should I say? I therefore begin my case study by acknowledging these limitations.

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3 The midwives’ names have been changed to pseudonyms.
4 I now include a story Marisol told me to underscore this point:

Yesterday, a young woman arrived who was part of the U, the university in Quetzaltenango. So she called me on Thursday. “Your name is Marisol?” she said to me, “Yes,” I told her. “Ah, good, can I ask you for a big favor?” “Why?” I told her. “I am going to come to interview you. You are a midwife, you work with medicinal plants, you’re on council of Maya-Mam.” “Me? I don’t know…” I told her. “Yes, I will come. I will pay you,” she told me. “You won’t be wasting your time,” she told me, “if we come to see you.”

And yesterday she called me, “I’m here! Where do you live?” “I live here.” “Which part?” she asked me, “ah ok.” And I went down to see them, two young women who are working in the U, so I asked them, “What are the questions?” “You are participating in the council Maya-Mam, this is you.” “Who sent you here?” I asked them. “We came representing a man who is working in el Ser Juez,” she told me, “What is his name?” “Jorge.”

“Would you give me his phone number? I am going to call him to see he ordered you to come, or it’s something else. I work in health, I don’t work in the council Maya Mam. Besides, I am not a Mayan priest, I am a midwife.” I told her. “I work here in ACAM. I am working in health, and in natural plants. I don’t participate in another organization.” I told her.

“That’s what we noticed you, we’re going to pay you for your time. I will do an interview.” They carried cameras, large ones. “No,” I told her, “I am not going to sell myself to you.” I told her, “I know my North American sisters, they help us. Not like this.”
I communicated with the midwives in Spanish, their second language after their native tongue Mam. These oral histories, which I recorded digitally, were conducted in Spanish, while the consultations and births I observed all took place in Mam.

Though practices within the center may be consistent, the lack of information from midwives outside of ACAM could mean that organization is atypical, and not generalizable to a larger Guatemalan context. However, if this study is taken to be an in-depth examination of the practices that occur at the ACAM maternity center—a location unique in the non-hospital space it provides for the intersection of biomedicine and traditional practice—then this factor, rather than limiting, merely gives my essay focus. This case study is about practices—the techniques and technologies that Guatemalan midwives use, the

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But now, many many people buy our image as Mayan people. I told them, “I cannot sell myself.”

“But why, Doña Marisol, why are you upset with us?” “I am very sorry, but I cannot give you an interview. Who knows when they’re going to pay you at the U. I, Marisol, I am illiterate, I cannot speak Spanish well, I don’t know how to read or write. Why did you come here? Go to a special doctor, over there is the hospital or [find] one working in a private hospital. Go, you all, but without me. No thank you.” I told them.

But as you are working here in ACAM, helping us in ACAM, I will give you an interview, for your work. When you return to your home country, this is the midwife that works with us. My name is Marisol. This is Marisol, here is Alba, here is Juana, here is Angela, here is Margarita, here is Augustena, here doña Santos Méndez. You know me well, and I know you. If another comes to bring my experiences outside, no. Or what do you say? Marisol López Sánchez. Interview by author. Concepción Chiquirichapa, Guatemala. January 16, 2011.

All of the midwives who staff the project speak Spanish well, but that does not mean they view communicating in Spanish and in Mam as equivalent. Their preference for Mam lies partially in comfort and the desire to speak one’s first language, but it is also a fundamentally political issue. Spanish is the language of the oppressor. While they understood that I could only communicate with them in Spanish, certain midwives would often speak to me in Mam. They expressed interest in learning English so they could “talk to me,” as if we weren’t really communicating in Spanish. The midwives would periodically quiz me on my Mam, a sort of mealtime group activity, attempting to help me master the glottal stop.

It is impossible to know what was lost in translation, but suffice it to say that the interviews quoted throughout have gone through a double translation—that of Mam to Spanish (in so far as Spanish is the midwives’ second language), and Spanish to English (in my translation of their words into English). The midwives would translate to me what was communicated in consultations and births, either in the moment or afterward.
embodied knowledge they hold in their hands, and the way they integrate biomedical and indigenous practice.

**The Asociación de Comadronas de Area Mam (ACAM)**

Posters from indigenous rights demonstrations and conferences wallpaper the front hallway of the ACAM maternity center. Though decorations elsewhere include giant framed depictions of peaceful nursing mothers, and information about fetal growth and prenatal care, the entrance serves as a statement of indigenous solidarity. These posters communicate that ACAM places the preservation of a Mayan culture and community at the forefront of its mission. Before this is a health care facility, even before it is a center for women, the Asociación de Comadronas de Area Mam offers care for *Maya* women.

**ACAM Background**

ACAM began as a network of midwives in the Quetzaltenango area. In the face of what Alba Juárez and other midwives perceived to be fundamental threats to their Mayan culture and way of life, a group of thirty midwives joined together to gain strength and to educate themselves. In 1999, when two friends who had been living in the United States since fleeing the violence of the civil war in 1982, returned to Concepción Chiquirichapa with a North American midwife, a connection was forged and the group decided to seek funds for a maternity center. ACAM received official status as an organization in Guatemala in 2000, and in 2001 the midwives’ dream of a clinic was realized when they received a donation to build the center. By June 2004, the maternity center was complete,
and since then the midwives of ACAM have been delivering care to women 24 hours a day, 365 days a year.

Eight midwives staff the center, taking 24-hour shifts in pairs. The ACAM maternidad has expanded considerably, now offering an apprenticeship program to train new midwives, as well as computer classes and a birthing simulator model\textsuperscript{7} to allow midwives to practice and teach. ACAM’s North American partners—most of whom are clinicians—raise funds, collect and send materials and provide workshops for the midwives. The center, however, is quite unique in that it is staffed and run completely by the indigenous midwives.\textsuperscript{8}

During a two-week work-study stay at ACAM, I observed the practices of eight staff midwives, and conducted oral histories with seven of those eight. Four of these seven were what I categorize as “senior midwives” (each had over a decade of experience, and were all over 40 years of age). Three of the four senior midwives, Alba Juárez, Ángela Vásquez Vásquez and Marisol López Sánchez were also founding members of ACAM. The junior midwives (mostly around 30 years of age, and all with only two years of experience, one theoretical and one practical) were Piedad Sánchez, Pilar Hernández Lorenzo, and Jimena Juárez Cabrera. All three graduated from the apprentice program at ACAM and therefore were trained entirely by the senior midwives. These eight midwives constitute the core staff, meaning they have regular shifts (turnos) at the maternity

\textsuperscript{7} This is a mechanized mannequin that gives birth.

\textsuperscript{8} In a society with deep-rooted patriarchal values, the fact that two women are permitted to work 24-hour shifts, away from responsibilities at home and sleeping in the maternity center with only another woman, is quite remarkable.
center (see schedule of midwives in appendix). A shift consists of a twenty-four hour period, typically 8 AM to 8 AM wherein two midwives stay at the maternity center, giving consultations and attending any births that arrive.

**Formal Training**

The midwives sit in rows of plastic chairs. It is the second Friday of the month—the appointed day for the monthly visits from the Ministry of Health’s Centro de Salud (Health Center)—and two female health officials stand in front of the midwives. Responsible for the midwives’ accreditation, these officials have come to give a talk, receive reports from the midwives and mark attendance on the midwives’ carnets, the licenses required to practice legally. All of the women in the ACAM network, numbering around fifty midwives in total, have come for the meeting today. The core staff calls these midwives las ancianas, the elders.

One of the health officials—a ladino woman in a grey pantsuit—paces in front of the group. “Welcome everyone,” she says, “today we’re just checking in with all of you because this is the first meeting of the year. I’ve written a list of all the dates on the board, can anyone not make these dates?” She speaks quickly and in Spanish. No one answers. “Can you understand anything I’m saying?” she quips. With the help of the core midwives, the Health Center official communicates that each midwife is to speak with her, one-on-one, to report the number of births she has attended in the past month. After the first midwife is finished, the elderly Mayan midwife stands to return to her chair. “Chjjj jjjjjjj jonte” the health official calls after her with the Mam word for “thank you,” exaggerating the glottal stop until it sounds like she is gagging.
**Midwifery Training Programs in Guatemala**

While the broader context of training “traditional birth attendants” has been addressed previously, the specifics of the Guatemalan context still must be delineated. The history of midwifery training programs in Guatemala begins in 1935, when the government first established laws to regulate the practices of midwives. These laws set forth an official mandate for the training of midwives; it specified that to practice legally, women were to be trained (within the formal health care system), hold certification and meet certain demographic criteria.\(^9\) This initial mandate aimed to orient Guatemalan midwives towards Western birthing materials, and “urban-based birthing physiology.”\(^10\) The Ministry of Public Health and Assistance (MSPAS) did not create formal training programs and certificates for midwives until 1955, and it was not until 1969 that a Division of Maternal and Child Health was created within MSPAS.

The system of training midwives changed drastically in the 1980s when the Guatemalan government adopted the WHO model for training TBAs. These new standards required a more formalized system of registering and licensing midwives and an expanded training program that encompassed general hygiene and family planning. A number of studies have look into the effectiveness of these programs, examining various factors—hospital referral rates, for instance—to assess whether training programs prepared midwives to identify a situation that

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they cannot manage. No study, however, has shown a correlation between biomedical training and a reduction in maternal or infant mortality.

The Sistema Integral de Atención en Salud (SIAS) program in Guatemala, started in 1996, is “framed by neoliberal policies that call for a decreases in governmental investment in health care, decentralization, and increased nongovernmental organization (NGO) participation in the delivery of health care.” SIAS aims to bring midwives into the formal health system through training programs. Currently, training programs carried out by the Ministry of Health typically last 15 days and are designed to teach midwives hygiene, preventive care, and risk-management—essentially when they should send the woman to the hospital. Once a midwife has received her license or “carnet” she must continue to attend monthly capacitaciones (training workshops) run by the Centro de Salud (Health Centers run by the Ministry of Health). Her carnet includes an attendance calendar as well as her photograph and information and is only valid so long as she has attended the monthly sessions.

These meetings not only provide continuing training for the midwives, they also give reason for the Ministry of Health to evaluate these women on a

13 Ibid.
14 Goldman, "Evaluation of Midwifery Care: Results from a Survey in Rural Guatemala," 688.
monthly basis. As described in the story, each midwife must meet with a representative of the Centro de Salud to report the number of pregnancies, number of births, and any complications or any emergencies she confronted in the past month. In addition, the midwife must report her plan de emergencia (plan for emergencies) to the representative.

Figure 4. The carnet of Gabriela Romero Méndez

These capacitaciones are carried out in Spanish and without a designated translator, despite most of the midwives preferring to communicate in Mam, the regional dialect of Maya spoken by roughly 250,000 in the region. With the institutionalizing of carnets, the Ministry of Health in effect created a means to professionalize indigenous midwifery. Because the midwives need their carnets not only to practice legally but also to sign birth certificates, and most Guatemalans
want a birth certificate in order to secure papers to travel, midwives must comply with government regulations in order to attract patients. Through the distribution and renewal of carnets, the government holds the power to regulate (and punish) indigenous midwifery.

Though they all hold carnets the ACAM midwives have vastly different levels of training and experience, depending on their age and their background. The junior midwives, Piedad, Pilar and Jimena, were all trained at ACAM—each has had only a year of classes and a year of practical experience. Unlike the senior midwives, none of the junior midwives began attending births before she was trained. Among the senior midwives, on the other hand, experiences varied considerably. Their stories of becoming midwives begin in the very similar ways: each first attended births for friends and family in the absence of a trained midwife or because the midwife arrived too late.

“I received the baby without equipment, only with a Gillette, I cut the umbilical cord. I washed the thread well with soap, and I tied it tightly. I didn’t know how—sweating, trembling—but, yes, at last, I finished everything.”

“As I don’t do vaginal exams, I was just watching to see if [the baby] was crowing, coming out of the mother…the mother had three contractions and out came the little baby. The baby was so cute, and I received it without equipment, without anything. I sent my uncle to bring me a flask of alcohol, and I asked him for, as we say here in Guatemala, a Gillette…I cut the umbilical

15 One Tuesday, Juana did not show up for her shift, and I observed and helped Pilar alone throughout the day. That night while upstairs in the apartment where I stayed, I suddenly heard Pilar screaming my name. A woman had come to the center to give birth and once she lay down on the bed we could both see that the baby was already crowning. Pilar asked me if I knew how to deliver a baby, I told her I didn’t, and she sent me to find gloves, scissors, buckets, towels, alcohol, and ties. The baby came out in under 10 minutes—Pilar attended the entire birth with her own daughter sleeping peacefully on her back. Afterwards Pilar told me that it was the first birth she had ever attended alone.

"I didn’t have equipment, ok… I went only with a Gillette for shaving beards, you know Gillettes? I only bought this in the store, only this Gillette. I didn’t have medical tape, I didn’t have towels, much less forceps, scissors, nothing. Only this Gillette, and with this I went. I prayed, ‘Dios mio, help me. I want everything to go well.’"18

These births the midwives attended early on highlight the need for training, whether biomedical or indigenous. After these initial common experiences, the senior midwives’ histories diverge: Graciela apprenticed herself to an experienced midwife, Ángela spent two years doing a práctica in a hospital, and Alba worked in a variety of organizations, including a hospital and another midwifery organization. Regardless of their background, the senior midwives all underwent the month-long capacitaciones required by the Health Center after the Ministry of Health’s adoption of WHO standards.19

**Daily practice at ACAM**

Women who seek care at ACAM usually come for one of three reasons: they are already pregnant, and want a consultation, they seek out a pregnancy test20 or they come to give birth. I will first describe the typical procedures for

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19 "Midwives who received certification after the mid-1990s had to attend a 4-week long training. This was last offered in 1996, according to the [Health] Center. "Hinojosa, "Authorizing Tradition: Vectors of Contention in Highland Maya Midwifery," 643.
20 These cannot be legally sold over the counter in Guatemala for fear that the woman would seek an abortion.
consultations, pregnancy tests and births and then analyze the information gathered from both my observations and my interviews.

**Prenatal Care**

Prenatal consultations (*consultas*) comprise the majority of visits to ACAM. During 2010, numbers ranged from 64 to 140 *consultas* in a given month. The procedure for performing a *consulta* is fairly standardized at the center, and consistent across the midwives. Typically, the pregnant woman enters the examining room, often accompanied by her mother, mother-in-law and/or sisters-in-law. One midwife performs the exam, while the other records any information in the record book and speaks with the family. The attending midwife

![Figure 5. The standard consultation room.](image-url)
will weigh the woman on the scale, and have her sit on the examination table. The midwife will then ask the date of her last period, and consult a pregnancy wheel to determine when she will deliver.

The woman lies down, and the midwife listens to the fetal heart rate with the fetal stethoscope. While the woman is lying down, the midwife then feels for the position of the baby. If the baby is in a good position, the midwife will begin the prenatal massage (*masaje*). This involves a series of hand movements—putting pressure around the belly with both hands, placing one hand at the top of the belly and feeling at the bottom for the baby’s head, and placing both hands, palm down, opposite each other and pressing down. If the baby is turned (something the mother usually knows when entering the *consulta*) the midwife will begin an external cephalic version, a massage that turns the baby so that its head is facing downwards. The midwife, in coordinated hand movements, incrementally applies pressure to shift the baby’s position. If the midwife cannot turn the baby, sometimes she will tell the mother to leave and return when she has not eaten. If the baby returns to its former position after the version, the woman will often come back to ACAM.

Then, the midwife takes the blood pressure. Afterwards, the woman sits up, and the mother, the midwife, and any accompanying family members typically talk following the examination. At this point, they discuss prices, complications (if

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21 “Version” is defined in medical literature as “the act of turning a child in the uterus so as to bring it into a more favorable position for delivery.”
there are any), and determine if the mother needs any medication for pain, nausea, vomiting, or headaches (the most common complaints).

**Pregnancy Tests**

Over my time at the center, I observed the administration of six pregnancy tests—three with Juana and Marisol, and one each with Ángela, Alba, and Jimena. These urine-based pregnancy tests utilize very basic technology: the woman urinates into a cup, and the test is then dipped in the urine. Two lines indicate a positive, while one line indicates a negative. Every midwife was capable of administering and reading a urine-based pregnancy test, but each differed in when and if she deferred to the biomedical technology. Some consulted the test before palpating the woman’s belly, others chose to feel for the baby first and then try a pregnancy test, and still others did not consult the test at all.

Juana and Marisol did not make definitive statements before the test itself. In one case, Juana palpated the belly before giving the test for a girl who had abdominal pain and could not recall the date of her last period. With the two other pregnancy consultations, Juana and Marisol did not perform a massage before giving the urine pregnancy test. One woman came in and reported she had not had her period in six months. The first test appeared negative, but Marisol was convinced that a second line faintly appeared. After passing the test around for almost ten minutes, the midwives decided to administer a second test. This test reported an unequivocal negative. After she left, Marisol told me the woman was taking birth control. Another time, a woman and her husband visited the
center, and requested a pregnancy test. After the test read positive, Marisol and Juana performed a full exam (weigh, heart rate, blood pressure, massage) on the woman.

Alba and Jimena performed exams with their hands first, declaring a woman to be pregnant or not, before administering a pregnancy test. First consulting their embodied knowledge—that which their hands know—Alba and Jimena then double-checked it with a urine pregnancy test. Alba fully examined a woman who entered and declared she was not pregnant before administering a urine pregnancy test, which confirmed her diagnosis. Jimena, similarly, examined the patient first before giving the pregnancy test. Seeing that the patient had the beginnings of a dark line extending from her navel downwards, Jimena estimated that the patient was pregnant. When the pregnancy test indicated negative, Jimena was confused. She gave the patient ibuprofen, acetaminophen, and amargon (dandelion) to treat her stomach pain.

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22 This is the linea nigra, a kind of hyperpigmentation that appears on the belly of a pregnant woman.
23 My role during consultations varied considerably depending on what midwife was working, and the task at hand. The older midwives would often teach me about different examination techniques—how to feel for the baby’s position, how to turn the baby etc.—or ask me to take the fetal heart rate or blood pressure. While most of the time I was in the position of an apprentice, whenever questions around biomedicine arose, I was suddenly the appointed expert. In this case, Jimena asked me why the woman had a negative pregnancy test given the fact that she was displaying the characteristic line on her belly. I told her I didn’t know.
Ángela did not use a pregnancy test. A seventeen-year-old girl came in with her mother, reporting stomach pain and nausea. After performing a full exam, Ángela determined the girl was pregnant because she could feel the uterus, and also see a dark line emerging down the middle of the stomach. Ángela prescribed a tea of three orange leaves, three onion leaves, a clove of garlic as well as pericón (Mexican tarragon) and manzanilla (chamomile). Ángela also gave the patient four pills of metoclopramide, a medication commonly used to treat heartburn that also can take away nausea. Ángela estimated that the woman was one month pregnant.

Figure 6. Diagram representing cervical dilations

**Labor and Delivery**

ACAM is equipped with three birthing rooms and plenty of instruments and materials for labor and delivery. Typically, the birthing mother chooses to give
birth in ACAM out of a desire to have her birth attended by a particular midwife, rather than an allegiance to ACAM. Women also elect to labor and deliver at ACAM if situations at their home are not well-suited for a birth. Often women arrive at the center early in their labor, return home at the suggestion of the midwives, and come back only when the contractions have increased. Family members—most often the husband and mother-in-law—accompany the woman and stay for the labor and birth.

While laboring, women typically walk or stand in the hallways, squatting only when contractions come. Women at ACAM deliver horizontally, on their back with their legs up. Often two family members stand on either side of the birthing mother holding one leg each, up and towards her head. With the exception of Marisol, all of the midwives perform vaginal examinations (el tacto) to check if a woman is fully dilated (10 cm) before telling her to push. As labor progresses, the midwives perform vaginal exams every two to four hours; they told me there is a sanitary risks in performing vaginal exams too often.

When the woman lies down to push, they place a plastic sheet below the mother and sterilize the area around her vagina before the baby crowns. As the baby crowns, the midwives typically hold a towel directly under the women’s vagina, placing two fingers below the opening to prevent tearing as the baby comes out. Once the baby is born, the midwives use a bulb stethoscope to clean out the nose and mouth. They then hold an onion (this provokes a response from the baby; the midwives refer to it as their equivalent to neonatal resuscitation)
under the nose of the baby until it cries. Through labor and delivery the midwives wear sterilized gloves.

*Cord and Placenta*

Waiting for the placenta, the midwives typically give the mother a massage, pushing down on the still contracting uterus. Typically, the umbilical cord is not cut until the placenta has descended. The midwives all use scissors to cut the cord, and elastics to tie it. They then sterilize the umbilical wound with alcohol and place the placenta in a bag for the family to take home.\(^\text{24}\)

*Postpartum*

After birth, women often enter in the *temascal* with the midwife and baby. The midwife will massage the mother, wash her with *jabón negro*—a kind of soap specific to the region. The midwives bring in various plants, including *eucalipto* (eucalyptus), *salvia santa* (*Verbenaceae*), and *manzanilla* (chamomile). The midwife bunches together several kinds—typically *chik’ jol* (*Stevia pulephala*), *chipa* (willow groundsel or *Senecio salignus*), and *sauco* (elderberry or *Sambucus Mexicana*)—and slaps the woman’s torso with the plants. The midwives emphasized the importance of cleaning the vagina, and allowing the steam to enter the woman through this opening. The midwives wash the baby with water all over, and hold the baby, bottom first, towards the coals to allow the steam to enter the baby as well. After the sweat bath, the midwives cover the mother and baby and lead

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\(^{24}\) Some sources write that the placenta is buried upside-down in a cornfield. See: Kevara Ellsworth Wilson, "Your Destiny Is to Care for Pregnant Women: Midwives and Childbirth in Naualá," in *Health Care in Maya Guatemala: Confronting Medical Pluralism in a Developing Country*, ed. Walter Randolph Adams, and John P. Hawkins (Norman: University of Oklahoma Press, 1999), 131. I did not ask questions about the placenta, so I cannot speak to specific practices in the Mam region.
them to bed. Ángela explains the process of teaching this practice to the junior midwives:

I taught them that they have to continue this practice, of bringing [the mothers] into the temascal. And some of the apprentices said, “I am not going to do the temascal because I’m not accustomed to it.” So I told them, “Well, you are going to be a midwife, and typically this is what we do.”…If there was no patient, then [the apprentices] entered with me and I taught them. “You have to do the massage, you have to massage her legs, you have to beat her feet [with the bundles of plants] so that the womb returns to its place, you have to do a massage with soap, you have to do a massage with you hands, here—in the breast, in the back, in the waist so that everything returns. And when you find the womb, you have to press so that all hemorrhage stops.”

Often, however, the mothers will not engage in the temascal while at ACAM, as they would rather enter in the temascal in their homes; women often feel woozy after a sweat bath and prefer to fall asleep in their own beds. The junior midwives (Pilar, Piedad and Jimena) were not experienced in entering the temascal with mothers, and therefore did not engage in the practice.

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Figure 7. The door to the temascal or chuj

Figure 8. The inside of the temascal
Complications

“About fifteen days ago I attended a breech birth—breeched, with all its little feet—and all at once [the baby] came, but it came quickly. [The mother] rang the doorbell, and came in, going straight to the bed. When I saw that the baby was coming breech, I did not tell the woman, I only said, “push push, because your baby’s coming!” I hardly had time to put on my gloves, and I was alone...it was only the two of us, and the husband. The baby was still inside, but pure green, it was green because it was breeched. So I received [the baby] then—I put my hand in the woman’s vagina, and I took out the little feet, and it was out to here [motions to the waist]. Then I said to the woman, “push more!” and she pushed, she pushed and it was out to here [motions to the neck], and with my two fingers, I put my two fingers in to find the mouth, and I found the mouth and I pulled, and out came the baby. It came all at once.”

Complications in labor and delivery inevitably arise, and these divergences from uncomplicated labor serve as a primary justification for the WHO’s interventions. A significant “skill” taught in Health Center capacitaciones is the identification of risks, and the creation of an emergency plan, a procedure in place to refer the woman to the hospital. Potential complications include breech or transverse presentations, prolonged labor, post-partum hemorrhage, eclampsia and obstructed labor. At ACAM, whether a breech presentation is referred to the hospital depends on the stage of labor the mother is in when she enters the maternity center. If there is sufficient time, the midwives will refer her to a hospital. If there is not time, the senior midwives—Alba, Ángela, Juana and Graciela—have had experience delivering breech, using a technique taught to

26 Graciela refers to the meconium, the earliest stool of an infant that is typically a greenish-black color. Because the baby was coming with its feet first, Graciela therefore did not see the typically black head of the crowing baby, but instead the green meconium already emerging from the baby.
them by a North American midwife. If the baby presents in the transverse position (hands first) however, the baby physically cannot descend very quickly and the mother is always sent to the hospital.

If the labor is progressing slowly, the midwives will give the women a massage and cook teas of *agua de zacate* or *pimpinela* (salad burnet or *Poterium sanguisorba*). If these methods are ineffective, they refer the woman to the hospital. The midwives also refer the woman to the hospital in the event that the placenta does not deliver within thirty minutes, which places her at a high risk for postpartum hemorrhage. In the case that that woman hemorrhages after birth, the midwives give her a tea made from *milinrama* (yarrow or *Achillea millefolium*) and sometimes a soup of *yerba morra* (“heal-all” or *Prunella vulgaris*). The midwives will massage her uterus, putting pressure around it. Ángela and Alba are trained in giving injections of oxytocin in the third stage of labor (after the baby has been born) to stop the flow of postpartum hemorrhage.

**Ritual specialists**

Various ritual aspects of birth remain in the ACAM midwives’ practices. After one birth, for example, Ángela showed me the cord and explained that the drops of blood in the cord corresponded to the number, gender, and spacing of the mother’s future children. The midwives also ascertain the sex of the baby by the appearance of the mother’s belly—if it is round and wraps more around the side of the woman, she will have a boy. If the belly is less round, and protrudes straight forward, she will deliver a girl. After birth, the midwives place salt and a
chili in the mouth of the baby, so that it will not gossip, so that it will have flavor and strength in its life, and so that it will always have tortillas and chili to eat. In the baby’s hand, the family and the midwives place 5 or 10 quetzales (bills) so that it will be a hard worker, and so that it will always have money.

**ACAM as a local organization**

Though the midwives adopt a range of biomedical practices, materials and technologies, the entrance of biomedicine into their daily lives is anything but uniform. Elements of biomedicine—sterilized latex gloves, the vaginal exam, the pregnancy test, the oxytocin injections—are incorporated as discrete elements into their existing methods of delivering care—the massage, the versions, and the temascal. The introduction of these biomedical materials is part of a “global” process, if “global” is understood to mean “those through which specific arenas of knowledge and power escape the communities of their creation to be embraced by or imposed on people beyond those communities.” Yet despite utilizing pregnancy tests, oxytocin injections, latex gloves, and other biomedical technologies, ACAM remains a fundamentally local organization, that is, “a small-scale arena in which social meanings are informed and adjusted through negotiated, face-to-face interaction.” The adoption of discrete parts of the biomedical model of childbirth has not resulted in the loss of ACAM’s local orientation.

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29 Ibid.
Practice at ACAM is not necessarily defined by the integration of two systems of medicine, but by the attention and care with which the midwives attend to the mother and family. A mother may receive the same procedure at ACAM and in a hospital—a vaginal exam, for example. The social meaning of a vaginal exam can take on vastly different connotations depending on context. If performed in a sterile clinical setting by a male physician who does not speak Mam and makes the indigenous woman remove her clothing, it could be interpreted as confusing, offensive, and disrespectful. If done at ACAM, with an indigenous Mam-speaking midwife, who asks permission to perform the exam, and who does not remove the woman’s clothing, a “global” practice is performed “locally.” The practice itself is born of a completely different conception of medicine and the body—most notably, one that emphasizes interiority—and travels to the midwives of ACAM through a transnational network. The performance of this exam continues to be situated entirely within the codes of the Mam-speaking region.

When asked what she saw as the most salient difference between giving birth at ACAM and giving birth in a hospital, Pilar clarified,

In the hospital, sometimes they don’t pay attention to the women. Sometimes the woman doesn’t receive as much attention as with a midwife...[we] give all the attention that the mother and baby require. In the hospital, when the babies are born sometimes [the doctors] don’t watch the woman, sometimes she is alone [at the time of birth]...Here, on the other hand, the midwives are always in tune with the women.30

In my role as an outside observer, acutely aware of the multitudinous ways in which the massages, medicinal plants, and sweat bath contrasted with hospital births in the U.S., it was inevitable that the initial comparison I drew was between the material differences. These more concrete distinctions, however, took a secondary importance for the midwives, who described the quality of their care as what distinguishes the experience of birthing at ACAM.

Not only do Mayan women feel neglected in hospitals, they often feeling mistreated. Studies have suggested that the roots of this conflict may have more to do with perceptions of access and exclusion, rather than shared medical beliefs or communication. This is to say that when Mayan families have a different perception of quality care than the hospital workers, and when they encounter a system that prioritizes universal ideas over local judgments, conflicts result.

Regardless of the cause—the language barrier, the differing perceptions of quality care, or the encounter between medical systems—conflicts arise. At ACAM, however, “no le regañamos,” Jimena said, “we don’t reprimand [the mother].” Another issue that arises from a different conception of “quality care” is the hospital’s treatment of individuals, rather than families. As a biomedical health professionals, doctors in hospitals focus on the woman, and not the family as a collective in the birthing process. To this end, Guatemalan hospitals offer no

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31 This moment also reflects the ingrained influence of the U.S. construction of the medical system as a marketplace and the patient as a consumer model. This approach to health care emphasizes choice between different options, for example, homeopathic vs. allopathic, medicated birth vs. non-medicated birth, etc.

lodging for families of birthing mothers—a serious problem for those who travel a long distance for a hospital delivery. At ACAM, the midwives care for the entire family. When a mother labors over the course of the night at ACAM, the midwives drag out mattresses to the waiting room, make atol\textsuperscript{33} and warm tamales for the family.

Here in ACAM, it is very nice because the families can come. The whole family comes, and they’ll say, “she is having pain, we want to see if she started labor.” They enter with us to the consultation room. We look and when we see that the labor has begun, they can stay…They can stay all day, all night…We give them a mattress and blankets so they can lie down, so they won’t be cold like they are in the hospital. In the hospital, the family gets cold because they are outside, and that’s hard for them.\textsuperscript{34}

I return now to the narrative elucidated in the introduction on the medicalization of birth in the United States, where feminist histories have argued that increasing urbanization and mobility were largely responsible for the movement of birth from the home to the hospital. With more developed means of transportation, it became easier for women to birth in hospitals than for midwives, and later physicians, to travel to homes. These larger societal shifts also removed women from their embedded female-networks of family and friends; women no longer necessarily lived near their mothers, aunts and female relatives who had experience in childbirth. Finally, as women increasingly joined the workforce, there were fewer available women to provide care at home during childbirth.

The medicalization of birth in the United States can alternatively be told as the story of the desocialization of women’s lives and the subsequent dependence

\textsuperscript{33} A corn-drink common in Mesoamerica.
\textsuperscript{34} Ángela Vásquez Vásquez. Interview by author. Concepción Chiquirichapa, Guatemala. January 18, 2011.
on a specialized profession that only gained authority in society as the twentieth century progressed. Coupled with biomedicine’s framing of the individual as the locus of health (or disease), these forces converged to create current conception of birth in the U.S. as a medical event that the woman alone experiences.

At ACAM, the midwives value collectivity. The organization is one born from an act of solidarity—as women, as midwives, as indigenous people. ACAM is a collective that treats collectives. The importance of supporting the family as a unit is simply an expression of this approach to health. Moreover, care at ACAM is delivered from Mayan women for Mayan women. At the hospital, women must change into a hospital robe. Mayan women, for whom dress is a constitutive element of their indigenous identity find this troubling. The traje, or traditional dress of Mayan women consisting of a skirt (corte) and an embroidered blouse (huipil), is more than simply cloth—it is a key element of women’s expression of ethnicity and gender. Stripping women of their traje is not only seen as violating certain understandings of modesty, it strips them of their Mayan identity during a hugely significant moment in their lives. “[Birth at ACAM] is more comfortable because the women can stay in their clothes, we don’t strip them,” Ángela said, “this is the advantage [the family] sees.”

Social networks continue to support the women who seek care at ACAM. During my time at the maternity center, not a single woman entered for a consultation, pregnancy test or labor/delivery without at least two family

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members. Often women would visit with their mothers-in-law, sisters-in-law, and husbands, if not additional family members. In including family members and regarding birth as a collective experience, ACAM challenges an individual model of health care promoted in biomedicine. ACAM allows critical aspects of home birth to carry over into birth at ACAM, a public location.

Women’s work has historically been characterized as confined to the domestic sphere, while men’s domain is public sphere. ACAM challenges this dichotomy: a formerly “domestic” practice occurs outside the home, and a woman’s work is performed in a public space. The midwives abandon their domestic obligations for their 24-hour shift at ACAM, anywhere from once to three times a week. The fact that the ACAM midwives practice outside of the home does not mean their work is no longer tied to being women. Instead, it complicates the female/domestic, male/public dichotomy.

The ACAM maternity center has successfully created a comfortable option for indigenous women who do not wish to give birth at home. At ACAM, women can speak their first language, keep on their traje, and receive the medicinal herbs, massages, and post-partum temascal to which they are accustomed. More significantly, ACAM provides an option for a safe birth that remains embedded within its social context. It seems unlikely that birth in Guatemala will incrementally shift to the hospital as it did in the U.S. for a multitude of reasons,

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36 The need for “integrative” maternity centers in Guatemala such as ACAM has not gone undocumented in the literature. Hinojosa (2004) and Replogle (2007) both cite midwives they interviewed as reporting the desire to establish their own maternity clinics. “Eva observes that ‘the conditions in which people live are pathetic’ and argues that she can control for hygiene if she centralizes her operations,” writes Hinojosa. Hinojosa, "Authorizing Tradition: Vectors of Contention in Highland Maya Midwifery," 645.
one of which being the continuing value that indigenous communities place in family networks that support birthing women. The existence of ACAM as an organization empowers a different definition of health(care), engaging in a “politics of what” through constantly challenging the dominant discourse, as set forth by the Ministry of Health, and, more broadly, the WHO.
Chapter 4:
Rethinking “Biomedicalization:"
A global process that is “more than one and less than many”

The process of the global spread of biomedicine or “biomedicalization” comprises a facet of general global trends referred to as modernization and Westernization. Regarding biomedicalization in this way, however, we must be wary of a classic narrative of globalization, which typically depicts a world gradually being made over in the image of the West, and with the assumption that all localities will ultimately reach a “Westernized” endpoint. The WHO participates in such a narrative of globalization in equating “non-biomedical” with “underdeveloped.” Certain critics of global health promotion also participate in what is perhaps too simplistic a depiction of biomedicalization. Brigitte Jordan, previously mentioned as the founder of cross-cultural birth studies, does not address the complexities within the global spread of biomedicine, referring instead to the biomedical model of birth as a monolithic structure she calls “cosmopolitical obstetrics.”1 Without undermining Jordan’s groundbreaking work, I seek to complicate her treatment of “biomedicalization.”

In regarding biomedicine solely in terms of “biomedical colonization” and “imperialism,” Jordan does not address scenarios wherein biomedicine emerges locally throughout the globe.2 While in Chapter 1, I made the case that the WHO’s training of “traditional birth attendants” continued in a legacy of colonial

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2 Van Hollen, *Birth on the Threshold: Childbirth and Modernity in South India*. 

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health interventions and constituted a form of biopower, I do not equate this process with “biomedicalization.” Rather I acknowledge that this is one means through which biomedical knowledge spreads.

Biomedicine is not a monolithic entity\(^3\), nor does it spread globally in a singular and uniform way. To this end, the WHO does not control the dissemination of biomedical knowledge, despite its self-appointed responsibility to replace “traditional” with biomedical practices. In considering “biomedicalization” we must consider the multiple layers in this process—the global organizations and state institutions that impose a biomedical model of birth, and the local ways biomedical knowledge emerges, despite the efforts of these institutions to control its spread. I propose here that we pause in lamenting the alleged disappearance of indigenous practice into the unstoppable tide of biomedicine to reconsider the term “biomedicalization.”

The lived experiences of ACAM midwives undermine a simplistic conception of “biomedicalization” defined as the exportation of the biomedical model of birth to developing countries in a singular (and uncontested) way. The various processes through which biomedical knowledge spreads, enters and emerges are diverse, and the nuances of these differences must not be lost in calling them all by the same name—biomedicalization. In recognizing difference, however, the partial connections\(^4\) of each mode must continually be acknowledged. If “biomedicalization” is neither pluralistic (composed of


\(^4\) Strathern, *Partial Connections*. 

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completely discrete modes) or unified (composed of a singular mode), how then are we to characterize the process?\(^5\) Employing Marilyn Strathern and Annemarie Mol, I call biomedicalization a process that is “more than one and less than many,”\(^6\) which is to say, *multiple.*\(^7\)

Instead of entirely opposing the singular, uniform “biomedicalization” Jordan sets forth in her “cosmopolitical obstetrics,” I instead explore its multiplicity. I deal with: biomedicalization as a constantly contested process, biomedicalization as a process within and out of which emerges an unlimited number of responses, and finally biomedicalization as a process of spreading of knowledge that proceeds not from a single source or institution but from many different nodes. The narratives of the midwives’ lived experiences illuminate these multiple ways of biomedicalization; their stories complicate a simplistic narrative of globalization.

**Biomedicine as a contested process**

When solely framed as a form of biopower, a concept of biomedicalization cannot encompass the ways in which midwives operate as active agents negotiating its expansion. Although the ACAM midwives incorporate biomedical practices—aseptic technique, the vaginal exam, urine pregnancy tests, and oxytocin injections—they resist the imposition of the biomedical model, and the attempts to replace indigenous practice. Specifically, the midwives reject the constitutive elements of biopower the WHO employs to “govern life:” that

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\(^5\) Mol, *The Body Multiple: Ontology in Medical Practice*, 82.


\(^7\) Mol, *The Body Multiple: Ontology in Medical Practice*. 

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scientific knowledge is objective truth, that a universal body exists, and that an individual/choice-centered model of health promotes the best care.

Current midwifery training programs in Guatemala are structured around the Safe Motherhood paradigm, a WHO development model “based on the premise that most maternal and infant mortality is preventable through skilled care at all points during pregnancy, the timely identification and referral of complications, and access to high-quality emergency care.” Through didactic and hierarchical teaching methods, which place the authority of texts and abstract definitions over that of personal experience, these programs aim to teach Guatemalan midwives the “correct” way to attend a birth. These trainers—often ladino health officials—act as “representatives of biomedicine, of science, of the central government and its institutions, and of progress and development,” confronting the backwards, anti-modern, and underdeveloped indigenous communities.

The ACAM midwives have all received training through these programs, and continue to attend the monthly capacitaciones the Health Center runs. Other studies on the training of Guatemalan midwives have found that, “despite the

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8 The Safe Motherhood Initiative was launched by the WHO in 1987. Since that time, it has become the Partnership for Safe Motherhood and Newborn Health, an international coalition of groups that includes the International Confederation of Midwives, the WHO, UNFPA, UNICEF, the World Bank, the Population Council, the White Ribbon Alliance (WRA), Saving Newborn Lives/Save the Children, Family Care International (FCI), the International Federation of Gynecology and Obstetrics (FIGO), the International Planned Parenthood Federation (IPPF). In Chapter 1, I analyzed discourses in the WHO’s program, “Making Pregnancy Safer,” which is part of the Safe Motherhood design.


attempt to negotiate the authority of their own knowledge and practices in
relation to the model presented in training courses, these experienced midwives
stated that now they must refer their patients with complications to the hospital
or else they will lose their licenses.”11 Perhaps because they operate within an
organization that validates their knowledge, the ACAM midwives—though they
do refer certain complications to the hospital—feel sufficiently competent to
handle most births, and do not appear to have bought into the dominant narrative
that biomedicine is universally better than the medicine they practice. In Chapter
2, I charted when and how the midwives employ certain biomedical practices and
technologies; the incorporation of certain biomedical techniques, however, has
not been accompanied by an internalized devaluation of their own knowledge.
Drawing from lived experiences, the midwives recounted stories that highlighted
the inconsistencies, misconceptions, and at times fatal mistakes that take place
within hospitals. These stories resist scientific hegemony in exposing the fallibility
of the biomedical model, but this critique does not reject wholesale biomedicine
in favor an entirely indigenous model of birth.

*A woman went to the hospital yesterday, and she said that while in the hospital the doctor told
her, “Look, ma’am, I can’t find your baby’s head. I think your baby doesn’t have a head,”
that’s what they told the woman. And when woman left she was very worried, she started to
think things. She said, “Could it be that my baby doesn’t have a head? Oh my god.” Her
mother-in-law told her, “Don’t worry, we’ll go see Alba. Alba will tell you how your baby is
doing.” That’s what her mother-in-law told her, and they came here.*

11 Maupin, “Remaking the Guatemalan Midwife: Health Care Reform and Midwifery Training Programs in
Highland Guatemala,” 375.
I began to do the massage...I didn’t try to measure [the months], I was only palpating. I felt four months, five months, six months—my hands already knew how many months along she was, and I told her, “I began to do your massage, and I felt that your baby is turned. The head is right here. That’s why they couldn’t find your baby’s head [because it was turned]. How could it be that a baby wouldn’t have a head? Don’t worry.”

And I began to do her massage, and I turned the baby and the head came down.

Now she saw. “I am not a doctor, but look here. It’s easy to find a baby’s head,” I told her.

“Thank you, Alba,” she told me, “this is why I place my trust in you.”

Alba emphasizes the doctor’s inability to perform the simple task of locating the baby’s head, and the tendency of biomedical professionals to pathologize physiological states. The doctor assumes the worst possible outcome without engaging in the most basic way with the pregnant woman—feeling her belly. The trainings sessions that Guatemalan midwives undergo teach them to identify risk, and to refer any potentially high-risk women to the hospital. In doing so, however, “health authorities tacitly and overtly encourage Maya midwives to question their own diagnostic and management abilities.” Alba has not internalized such rhetoric and remains confident in her diagnostic abilities, and critical of the haste and extreme measures of the hospital. Her embodied knowledge maintains its primacy—she did not try to mentally estimate the term, her hands knew how many months along in the pregnancy the mother was.

Ángela has witnessed the failure of the hospital to provide quality care, and like Alba, is also critical of the authority of biomedicine.

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I spent two years in the hospital, but one year was only observation. I just watched how the doctor gave care, how the nurses attended [patients], how they changed the beds, and how they tied the umbilical cord. I had many experiences in the hospital; this is why I said that not only midwives commit errors but doctors as well.

I saw a pediatrician who, when he tied the belly button of the baby, he took it off. The doctor tied it like this [she motions, pulling straight up] and when he tied it, he took the whole belly button off all at once. The baby died of pain from the navel, and the doctor told me, “You stay quiet. You’re not going to say anything. What you saw here, stays here.”

I told the doctor, “No problem, I didn’t see anything.” But I could see that doctors in hospitals make errors, not just the others—the midwives…we have errors in our work, but [doctors] make errors as well. But I told myself that I wasn’t going to tell anyone, because if I said anything they would kick me out of the hospital and I wouldn’t be able to continue watching how they attended births. There are good things and there are bad things in the hospital.

Later a nurse said to me, “why didn’t you say anything? Why did you stay quiet?”

And I said to her, “about what?”

“About the baby that the doctor killed.”

“You know, I didn’t know,” I told her.

Because if I told her that I had seen it, they would send me to the tribunals as a witness. That’s a long process, and I would also lose my midwifery license.

“I don’t know, I didn’t see anything. When I came, the doctor had already wrapped the baby in its clothing. I left to wash up, and I didn’t see it.”

“You left to wash up?” she said to me.

“Yes,” I told her, “I went to wash up.”

“You didn’t see when the doctor took off the belly button? Because he took it off from here, he ripped it off, and the baby died.” “Oh!” I said, “No, no I didn’t realize.”

Then she said to me, “well, this is something you should have seen, so that you and the midwives don’t do in your community.” And I said to her, “we don’t do it like this [she motions, pulling straight up], instead we tie it like this [she motions pulling horizontally], here.” I told her, “we put our fingers here, and pull the umbilical tie, and tie it
“up,” I told her, “we don’t tie it like this [pulls straight up]—that’s what the doctor did, like this and when he tied it, he ripped the navel.” So I told the nurse, “we don’t do it like that, it’s like this.” “Oh,” she said to me, “you mean like the doctor would have done?”

“I don’t know,” I told her, “I don’t know, I didn’t see.”

The witness to a baby’s death, Ángela saw the failure of a biomedical professional to optimize life. The doctor’s mind may have been trained in the reading of ultrasounds, or intravenous dosages, but the doctor’s hands lacked the embodied knowledge of a midwife. In the simple action of pulling up instead of out, the doctor failed to separate two lives safely into two bodies—the most fundamental act of attending births. But biomedicine retained its authority even in the face of a fatal error—the hospital nurse made sure to tell Ángela that it was good that she witnessed this terrible scene, so she would not commit the same mistake in her communities. Even when wrong, the biomedical authority clung to the power to tell the midwives what is right. For Ángela, this served as a “teaching moment” in a sense entirely the opposite—she saw cracks and limits of an institution, which claims to be the universally best way of optimizing life.

The midwives, as indigenous, as women, and as global south inhabitants, are positioned to see these cracks, limits, and false-truth claims. I quote Donna Haraway at length:

There is a premium on establishing the capacity to see from the peripheries and the depths. But here there also lies serious danger of romanticizing and/or appropriating the vision of the less powerful while

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claiming to see from their positions. To see from below is neither easily
learned nor unproblematic, even if ‘we’ ‘naturally’ inhabit the great
underground terrain of subjugated knowledges. The positionings of the
subjugated are not exempt from critical reexamination, decoding,
deconstruction, and interpretation; that is, both from semio logical and
hermeneutic modes of critical inquiry. The standpoints of the subjugated
are not ‘innocent’ positions. On the contrary, they are preferred because in principle
they are least likely to allow denial of the critical and interpretive core of all knowledge.
They are knowledgeable of modes of denial through repression, forgetting, and
disappearing acts—ways of being nowhere while claiming to see comprehensively. The
subjugated have a decent chance to be on to the god trick and all its
dazzling—and, therefore blinding—illuminations. ‘Subjugated’ standpoints
are preferred because they seem to promise more adequate, sustained,
objective, transforming accounts of the world.15 [Emphasis mine]

Ángela did not simply say she learned doctors make mistakes; she said that
midwives make errors in their work, but now she saw doctors make errors as well.
She does not place the knowledge of midwives above that of doctors; she merely
recognizes that no knowledge is exempt from error. In demonstrating to the
nurse the correct way to tie a navel, Ángela makes a “rational knowledge claim”
that is not dislocated, universal and objective. Her claims to knowledge are based
entirely in her location, positioning and situating as an indigenous midwife. These
are the “politics and epistemologies of location, positioning, and situating,” that
Haraway argues for, “where partiality and not universality is the condition of
being heard to make rational knowledge claims.” The seriousness of these claims
cannot be understated: “these are claims on people’s lives.”16

Just as knowledge claims cannot emerge from a position of universality,

15 Haraway, "Situated Knowledges: The Science Question in Feminism and the Privilege of Partial
Perspective," 584.
16 Ibid., 589.
also be treated as a partial view of reality.\textsuperscript{17} Bodies, like knowledge, must be understood in regards to their location—as contextually situated. “Local biologies,” therefore, “refers to the way in which biological and social processes are inseparably entangled over time, resulting in human biological difference.”\textsuperscript{18}

A minor digression to illustrate this point: a study of over 200 Mayan women revealed that though they reach menopause around the same average age as women in the U.S. (44.3 years of age) and appear to undergo similar endocrine changes, they do not report symptoms of hot flashes. In this way, biology differs location to location, on account of the intertwined historical processes that are at once \textit{biological}, \textit{social}, and \textit{environmental}. Lock suggests, for example, that urban migration and increased education may alter these patterns as Mayan women change dietary habits and adopt a more sedentary lifestyle.\textsuperscript{19}

The project of the WHO, by definition, rejects a view of the body as produced through biological and social factors, operating instead on the assumption of a universal biological base onto which social and cultural difference is layered. To make legitimate claims on people’s lives, global health must deny local biologies. This is profoundly problematic, as much of the evidence behind WHO recommendations for a safe birth emerges out of studies done on women in hospitals in western industrialized countries. “These women,” Brigitte Jordan writes, “in no way compare with indigenous women in terms of nutrition, health

\textsuperscript{17} Lock, \textit{An Anthropology of Biomedicine}, 109.
\textsuperscript{18} Ibid., 108.
\textsuperscript{19} Ibid., 89.
care, stress patterns, and the like, not to speak of differences in body build, blood
types, resistance to disease, tolerance of pain, response to drugs, and so on.”

In its model for the training of “traditional birth attendants,” the WHO
splits the global/biological aspects of birth, assigned to skilled attendants, from
the local/cultural, assigned to traditional birth attendants. At ACAM, the
experience of birth is not split by biological/global/biomedical vs.
cultural/local/traditional dichotomies. ACAM delivers care for Mayan women,
specifically from the Area Mam; in this model culture and biology are inextricably
linked. Prenatal care occurs within context: the midwives know the foods
available to women when making prenatal dietary recommendations and the
plants from which they make their medicinal teas grow from a land that Maya-
Mam women have inhabited for generations. Despite the incorporation of certain
biomedical practices, the ACAM midwives have not adopted biomedical belief in
a “body proper”\(^{21}\) that is universal, ahistorical and asocial.

In talking about the *temascal*, a practice positioned entirely at the
intersection of biology and culture, the midwives express a belief in local biologies
even if they do not explicitly articulate a concept of the body as produced socially
and biologically. The *temascal* is a constitutive element of Maya-Mam identity:

> If the patient is not hemorrhaging, if the patient is not nauseous after
> birth, I will go to bathe my patient…this is what we do here as midwives at
> ACAM, in the area Mam. This is what we do as Mayan people. We are not
> going to end our roots, our customs here in Concepción Chiquirichapa.

\(^{20}\) Brigitte Jordan, *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden and
\(^{21}\) Lock, *Beyond the Body Proper: Reading the Anthropology of Material Life*, 2.
This is our custom, that after birth we enter to bathe with our patient and baby.\textsuperscript{22}

These customs and cultural processes are inextricably linked with biological ones and over time result in material, embodied difference. The midwives believe that the bodies that can support the \textit{temascal} are both culturally and biologically Mayan. Ángela explains,

The ladinas cannot endure the \textit{chuj}, they faint. Therefore it is better to put them above the vapor, and afterwards wash them with this water, over their stomach with \textit{jabón negro} and after this put them to bed. On the other hand, Mayan women enter the \textit{chuj}, these woman can handle the \textit{chuj}.\textsuperscript{23}

The ideas that ladina women do not enter the \textit{temascal} because of cultural difference and that they do not enter because of physiological difference are inextricable. The post-partum practice of the entering in the \textit{temascal} cannot be placed on the WHO’s axes of physiology vs. cultural; the practice is done for physiological and “cultural” reasons simultaneously. Ladina women’s bodies have been constituted through different historical, social and biological processes, which now articulate themselves as an inability to handle the heat of the \textit{temascal}.

Founding ACAM, in and of itself, is a challenge the midwives pose to the individuation of care\textsuperscript{24} and the concomitant emphasis on a Mol’s “politics of who” that has taken place within biomedicine. Until we contest what is considered good care, the institution of biomedicine will continue to dictate the “facts,” the options, and the forms of health care deemed legitimate in a naturalizing way.

\textsuperscript{22} Marisol López Sánchez. Interview by author. Concepción Chiquirichapa, Guatemala. January 16 2011.
\textsuperscript{24} Which is to say, the emphasis on the individual in delivering care and treatment.
If the goal is to improve the quality of care\textsuperscript{25} for childbearing women, we must focus not on questioning who makes individual decisions, but on contesting “what versions of ‘health’ as a constructed reality, what range of behaviors, what moral assumptions”\textsuperscript{26} are empowered within global health. We must get outside the pressure biomedicine exerts to invalidate alternative forms of knowledge. Instead of placing the responsibility on women to choose among flawed models of birth,\textsuperscript{27} we must create new options for childbearing women.

In creating ACAM, the organization’s founders delivered their answer to the question, “what would optimize care for Mayan women?” Seeking to empower a “range of values and modes of life”\textsuperscript{28} under attack by Guatemalan health officials, the ACAM founders formed an alternative model for quality care for a group of women whose needs were not accounted for in the existing structure. This space emerged out of a critique of the totalizing effects of biomedicine, and the necessity within this institution to control and undermine any alternative systems of health and healing in order to establish authority. The role of the North American midwives in this process has been essential; not only have they supported ACAM as an organization and a model of birth, they have translated beneficial biomedical practices to the midwives, without participating in biopower.

\textsuperscript{25} I consciously state this as the goal, rather than the lowering of maternal mortality rates.
\textsuperscript{26} Greco, "Thinking Beyond Polemics: Approaching the Health Society through Foucault," 21.
\textsuperscript{27} By imperfect, I mean that for indigenous women, there may be no optimal option. Birthing in the hospital could entail receiving sub-par care, not to mention dealing with the language and cultural barriers, the disrespect indigenous women often face, and the separation the birthing woman must often endure in a hospital birth. Alternatively, if conditions at home are not optimal for birthing, the childbearing woman could be left to choose between two flawed options.
\textsuperscript{28} Greco, "Thinking Beyond Polemics: Approaching the Health Society through Foucault," 23.
The “what,” “how” and “who” of negotiating biomedical practices

When TBA training programs failed to decrease maternal morality, world policy makers blamed poor literacy and a lack of “scientific knowledge” on the part of “traditional birth attendants.” The WHO did not consider reorientating the training agenda or curriculum, nor did they take into account the potential for agency and active resistance on the part of local midwives.

Whether a midwife adopts, accommodates or resists a biomedical practice may have more to do with factors such as the practice itself, the way in which it was taught, and the personal experience of the midwife than it does her literacy rate or level of “scientific knowledge.” The multiple processes of biomedicalization may be constituted through: what is the nature of the practice—is it tactile or technological? How was this practice introduced—were the midwives trained through didactic, vertical teaching methods where they had little connection to the trainer, or through horizontal methods of knowledge sharing, where they trusted the trainer? And, finally, who is learning the practice—what has been that particular midwife’s personal experience and what is her relationship to biomedical knowledge? Considering the learning process in these terms underscores the fact that although the WHO may conceive of “traditional societies” as a single entity, there can be no single “traditional” response, either on the part of the community or the individual.

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The what

God if it is your will that decides who is to be a midwife then take my hands, my mind, my heart, and it will be you who shows me what to do and how to help people.30

Guatemalan midwives hold the knowledge of birth in their hands. A midwife’s hands—which know how to cook, weave, chop wood and harvest herbs—are the locus of her abilities. The midwives talk about their hands as feeling and knowing, as possessing embodied knowledge. It was not Alba that wanted to be a midwife, but her hands: “I went to complete my practical study at the hospital, and afterwards my hands already wanted to work, to attend births, to do massages, everything.”31 Knowledge of the pregnant woman’s body is communicated through touch—the midwives use their hands to assess the trimester and to locate the baby’s position. The hands provide treatments, in the versions the midwives perform and in the medicines they prepare from herbs they grew, chopped, ground and made into pomades, teas or soups. In this way, a midwife’s hands challenge the dichotomy between knowledge and practice by simultaneously enacting knowledge through practice—possessing embodied knowledge.

With such expert hands, the midwives easily learn biomedical practices that employ the use of touch, or dexterity of the hands. Because the midwives already posses an extensive understanding of touch, tactile biomedical practices fit easily into this existing knowledge and way of delivering care. The vaginal exam—what they refer to as el tacto or “the touch”—is the most widely used biomedical

practice among the midwives at ACAM. They understand what to feel for, and their hands now “know” when a woman is ready to push based on assessing, with their fingers, the extent to which she is dilated. The embodied knowledge of the midwives’ hands is at once knowledge and practice; their hands know and do in a single moment.

To incorporate a new practice, it must fit into the midwives’ existing understanding of health and the body. There is not a huge contrast between a massage, where the midwife uses her hands to feel the position of the baby and the hardness of the uterus, and a vaginal exam, where the midwife uses her hands to feel the size of the cervical opening. The midwives can incorporate this biomedical practice without altering greatly their existing understanding of health, and the female body. Another tactile practice the ACAM midwives have fully adopted is a procedure for delivering breech births, which entails inserting a hand into the vaginal canal, placing the pointer finger in the baby’s mouth, and guiding the shoulders and head out safely.32 Graciela, Ángela, Juana, and Alba all have experiencing delivering breech in emergency situations.

As obvious as it may seem, in order for a midwife to adopt a practice it must be relevant to her work. Though the practice of delivering breech is not widely used in the US, where most births take place in the hospital, it is of great use to midwives in rural situations. This discrepancy between the realities of birth in

32 All of the senior midwives had been taught a way to deliver breech by a North American midwife. The practice of delivering breech in this way is illegal in hospitals in the U.S. If a baby is breech, this warrants a mandatory cesarean. Many midwives, and physicians who have trained outside of the U.S. are skilled at breech deliveries, and practice them if the childbearing woman is far into her labor, or if transportation is not possible. In interviews, these senior midwives said this new skill helped their practice immensely.
developed countries and developing countries underscores the need for training programs to teach what it pragmatically useful, not what most closely approximate birth practices in the US. The physiology and complications addressed in training sessions often apply to urban, global north bodies. Rural indigenous women of the global south face another set of health concerns—common complications result from poor diet, for example. The midwives are pragmatic women; they will not incorporate a practice that has little use in their daily lives.

When the midwives do not have an existing conceptual framework for new practices, they seem to incorporate individual pieces of technology into their practice in way that make sense to their own internal and culturally informed logics. Marisol’s explanation of the pregnancy test as one line indicates the mother, and two lines indicates the mother and baby, well illustrates this point.

The how

“The enterprise of teaching and learning, whether it involves midwives, school children, or an industrial work force, is always an enterprise in the service of multiple agendas. Although it is ostensibly about the transmission of knowledge and skills, in a hierarchically organized society it is also always about the imposition, extension, and reproduction of lines of power and authority.”

Studies of Guatemalan midwives have consistently shown that midwifery-training programs have little or no ability to change how the midwives attend to women. When surveyed on their practices, trained midwives frequently display almost identical scores to untrained midwives in terms of what researchers deem

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33 Hinojosa, "Authorizing Tradition: Vectors of Contention in Highland Maya Midwifery."
both “beneficial” and “harmful” practices.\textsuperscript{35} Presented to the midwives in a Western-style, these trainings are typically organized around didactic mini-lectures and theoretical definitions, and involve minimal participation from the midwives.\textsuperscript{36} The structure of such sessions renders invisible the experiential (and culturally-influenced) knowledge that the midwives hold. Possessing neither the biomedical vocabulary nor the orientation towards \textit{talking over doing} to answer questions posed in the training session, the midwives may appear to “lack scientific knowledge.” If framed experientially rather than theoretically, the trainings could better assess what the midwives do and do not know. Jordan argues these sessions teach the midwives how to engage with biomedicine and appease the health officials through delivering “appropriate” answers, rather than valuable skills in childbirth.

Beyond the didactic method of teaching, the presentation of the material remains completely within a Western-style and biomedical understanding of the body, which may not necessarily translate to other contexts. The curriculum often proceeds, “(chrono)logically from ovulation to conception and implantation, treated extensively the development of the embryo and the fetus throughout the nine months, and finally ended up with labor, delivery, and the postpartum

\begin{footnotesize}
\textsuperscript{35} Goldman, "Evaluation of Midwifery Care: Results from a Survey in Rural Guatemala," 696.
\textsuperscript{36} Cosminsky, "Maya Midwives of Southern Mexico and Guatemala."; Goldman, "Evaluation of Midwifery Care: Results from a Survey in Rural Guatemala."; Glei, "Understanding Ethnic Variation in Pregnancy-Related Care in Rural Guatemala."; Hinojosa, "Authorizing Tradition: Vectors of Contention in Highland Maya Midwifery."; Jordan, \textit{Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States}.\end{footnotesize}
period.”37 These explanations focus on abstract principles, and often assume what Jordan calls a “Western visual literacy.” For example, to explain the workings of the uterus a trainer may show a slide of a disembodied uterus, not necessarily to scale, against a black background. While an image such as this may read to the Western eye accustomed to connecting such decontextualized representations to material corollaries, it may be completely detached from any practical application for the midwives. 38 Organized as such, the courses do not teach in ways that make content seem to matter in midwives’ lives.

That fact that the ACAM midwives have fully adopted biomedical practices relevant to their needs only further suggests that the shortcomings of the training sessions lie in the manner taught, rather than the midwives’ capabilities. The vaginal exam and breech deliveries were two procedures that the midwives learned from the North American midwives, and reported to find immensely useful. A few key differences from the training courses mark the acquisition of these skills.

The Guatemalan midwives are far more accustomed to experiential learning, not only in their work as midwives but also more generally. Having observed Juana and Ángela teach their teenage daughters skills in cooking, weaving, preparing medicinal plants, and midwifery, it became evident to me that the midwives privilege teaching by showing rather than telling across their lives. Moreover, learning is not separated from daily life as it is in trainings; Ángela

38 Ibid., 177.
would teach her daughter Candelaria skills as she performed them daily, rather than separating a skill to teach out of context.

The North American midwives visit for periods of time, and enter daily life at ACAM—attending to women along with the midwives, and sharing practices as they become relevant. Within the context of a specific situation, a North American midwife can demonstrate, with her hands, how she does a particular procedure. Moreover, the North American midwives maintain a relationship with the Guatemalan midwives: having met at a conference of midwives in Mexico in the 1990s, the two groups were introduced as peers. They connected, initially, over the discrimination and regulation that midwives face in both the United States and Guatemala, and within the organization there is no sense that the North American midwives who sit on the board have any intention of changing indigenous midwifery or regulating how birth is done at ACAM.

It follows that there is a qualitative difference between training received from a health official and the respectful, collegial training received from another midwife. North American midwives approach training with a different philosophy; they employ a non-hierarchal model of knowledge sharing, and emphasis experiential over theoretical explanations. That the North American midwives understand the centrality of experimental learning is reflected in aspects of their ongoing support of the center. One of the North American midwives, for example, worked with the ACAM midwives to gain grant money to buy a mechanical birth model. This birthing “robot” has cervix that can dilate, can birth
at different speeds, and can deliver a placenta with a variety of complications. The ACAM midwives use this mechanical birthing model—acquired through the collective efforts of the North American midwives and others to redistribute the resources of the global north—to teach vaginal exams and the management of various complications in their apprenticeship program.

While the North American midwives may teach some of the same “biomedical” practices (e.g. vaginal exam, aseptic technique) as training programs, the ideology behind teaching and learning remains fundamentally different. The context of learning these practices is situational, rather than abstract, and the North American midwives providing ongoing training and support.39

![Figure 9. Doña Juana practices on the mechanized birth model](image)

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39 The North American midwives have also helped to organize several trips to the U.S. for the ACAM midwives. These trips underscore the recognition that both sides have much to learn from each other.
The who

The structure of learning aside, ultimately it is each midwife who, on an individual level, negotiates her response to biomedicine. A multiplicity of factors inform a midwife’s relationship to various biomedical procedures, including her age, her class background, her level of education, previous experiences she may have had with biomedicine, and her personal history as a midwife. Accordingly, to conceive of a general reception to biomedicine on the part of “traditional birth attendants”—practices that Guatemalan midwives simply can or cannot pick up—completely obscures the nuances in this interface between bodies of knowledge taking place on the level of the individual midwife. The midwives are not without agency, and moreover a midwife’s response to a biomedical procedure—whether it is to adopt, accommodate or resist—depends on who she is.

Age, for example, significantly influences a midwife’s relationship with biomedicine. Because Guatemala did not adopt WHO recommendations for the training of “traditional birth attendants” until the 1980s, the senior midwives began attending births under vastly different circumstances than the junior, and were then trained after years of lived experience of being a midwife. The junior midwives, trained entirely at ACAM, learned indigenous and biomedical practices simultaneously from the senior midwives, and therefore did not undergo the experience of a western trained health official “correcting” their life’s work. While personal experiences, at hospitals, health centers, or elsewhere, undoubtedly affect
the junior midwives, I want to make clear that this generational divide has resulted in diverse experiences with biomedical knowledge.

In order to explore the complexities of how a midwife’s personal history influence her engagement with biomedical materials, I focus here on Ángela. Having spent two years in the hospital, Ángela has the most biomedical experience. Because she seemed to confront biomedical knowledge and technologies in a way distinct from the other ACAM midwives, I can only assume this is the reason. I first tell a story about her resistance to a biomedical technology, and second, a story wherein she resists and asserts biomedical knowledge in a single moment.

*Pregnancy test*

The way in which the midwives discerned whether a woman was pregnant serves as a unique and uncomplicated moment wherein the individual midwife’s decision-making process became visible. The use of the urine-based pregnancy test was an easy point of comparison between the midwives, as there is little room for variation in pregnancy test administration. The observation of the use of this simple technology revealed a moment in which an individual midwife’s ordering of biomedical and indigenous systems of knowledge became obvious. I have already spoken to the importance of a midwife’s hands. The power of the hands lies in their ability for action—they can turn a baby or stop the progress of post-partum hemorrhage. Power also lies in the hands’ embodied knowledge—a midwife’s hands can discern the stage of pregnancy, or whether a woman is
pregnant at all. The pregnancy test presents a biomedical technology that, unlike the vaginal exam, replaces an existing practice. In these moments of discerning the presence of one life or two, the midwives negotiate between the “facts” revealed through a biomedical technology and the knowledge of their hands.

While Juana and Marisol performed pregnancy tests without any massage, Alba and Jimena massaged the woman first, made an assessment, and used the urine pregnancy test as means of corroboration. While Alba’s diagnosis was corroborated by the test, Jimena’s was not and this was profoundly confusing. The knowledge held in her hands, and her experience identifying the *linea nigra* did not correspond with the technological assessment—which should she follow?\(^40\)

Despite possessing a high degree of biomedical experience and training, Ángela did not perform a pregnancy test. Clearly her time in the hospital has not encouraged a dependence on biomedical technologies, and while I can only speculate, it seem as though this previous proximity to biomedicine has made Ángela more aware of when she chooses to utilize biomedical materials, and when she deems them superfluous. Ángela does not privilege biomedical technologies simply because they are biomedical technologies; she seems to use them when they fulfill a function that she believes indigenous medicine cannot. In regards to prenatal care, Ángela her decision-making process saying,

\(^{40}\) Most likely, Jimena was searching for the *linea nigra*. Women always have a linea alba, which grows darker as a result of changing hormones to form a *linea nigra*, but typically it is the same color of the skin, and therefore not noticeable. Some women, however, always have a visible line; it is possible this was what Jimena saw. Ultimately Jimena trusted the biomedical assessment and told the woman she was not pregnant.
We have to give them plants to drink if they have high blood pressure...If
the plants don’t help, then we take them to the hospital or the Health
Center to receive a chemical treatment. But here we jump first to medical
plants, we leave [the women] for ten days and if there aren’t results, we go
to the Health Center. For example, to lower blood pressure we give them
*apiu*, *perejil*, *pepino*—the *pepino* they have to take in four pieces. We also give
them a branch of *perejil*, and then a radish, a piece of lettuce—they can
blend these and drink a glass once a day for ten days to lower blood
pressure. So first with plants, and after with the Health Center or the
hospital if the pressure doesn’t drop. First with plants, if it’s blood
pressure, we see how they are doing, and after it is with chemical
medication.

In explaining this process to me Ángela repeated the order four times: plants first,
chemical medication second.

In responses to biomedicine, enactments of resistance and accommodation
are often intertwined. I use an anecdote about Ángela again to illustrate how a
midwife’s personal experiences with biomedicine shape a complex response to
biomedical authority: one of my tasks while at ACAM was translating for a North
American nurse while she visited for a few days. Having traveled to ACAM to
observe the integration of biomedical and indigenous practices, I was suddenly a
vessel through which biomedical knowledge was to be transmitted to the
midwives. The nurse was young, unmarried and without children; these facts did
not help to establish her as an authority figure in the eyes of the midwives.41
Wishing to use her time at the center to share some of her skills and abilities, the
nurse held several workshops on how to insert IVs, which I translated. Typically,

41 While I am young, unmarried and without children as well, the midwives understood that I was not an
authority on matters of birth, but instead was there to learn from them. This meant they often treated me
like one of the apprentices, teaching me various practices as they performed *consultas* and *partos*. The only
times they did consult my knowledge were in situations that concerned biomedical technologies—reading
the pregnancy test, or distinguishing the various pills in the pharmacy. Moreover, it was almost exclusively
the junior midwives who would ask my opinion.
the workshop was presented to the two midwives on duty. The nurse’s final day, however, many of the midwives came to learn before she left.

Sitting in a semi-circle, the midwives surrounded the nurse as she began the lesson she had taught several times in the preceding days. Unlike the previous days, as the nurse explained how to find a vein (in English), Ángela turned to speak to the midwives as well, teaching a parallel lesson in Mam. She was not translating. Ángela was instructing the midwives in the techniques for inserting IVs she had learned in the hospital. The nurse, unable to communicate in either Spanish or Mam, waited for Ángela to finish talking, and then tried to begin again. As soon as she started speaking, Ángela resumed her lesson as well. The nurse’s training session was effectively brought to halt.

In the singular action of talking over the visiting nurse, Ángela simultaneously employed and resisted biomedical authority. The knowledge she holds from her time at the hospital endowed Ángela with a certain authority among her fellow midwives. In speaking over the nurse, Ángela challenged the very same privileging of biomedical authority that allowed her to address her fellow midwives from a position of power. She at once employed and refused biomedical knowledge.

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42 It should be noted as well that the nurse’s distress was largely not caused by Ángela’s interruption, but more by the fact that she believed, from the gestures Ángela was making with the practice needle, that Ángela was instructing the other midwives incorrectly. The nurse knew a precise technique for the insertion of IVs, and Ángela’s demonstration did not match this technique.
The multiple sources of biomedical knowledge

Not only can there be no single “traditional” response to biomedicalization, there is no single source of biomedical knowledge. The transmission of knowledge that descends uni-directionally from the WHO to the trained health workers and then to the people they treat constitutes merely one pathway of biomedicalization. The WHO does not control the dissemination of biomedical knowledge; various materials, technologies and practices reach the ACAM midwives from a range of sources. The sources are multiple, and information disseminated differs from source to source. Guatemalan midwives receive biomedical health information from ladino health officials, visiting nurse-midwives from the North American ACAM board, local doctors, pharmacists with whom they interact, and international NGOs. It is not clear if the midwives distinguish between these various biomedical practitioners based on their level of professional training (for example between a doctor and a nurse-midwife, as we do in the U.S.), but what seems more likely is that the midwives give authority and priority to information from trusted and respected sources of biomedical knowledge.

Often, these sources of biomedical knowledge deliver diametrically opposed pieces of advice. Guatemalan health officials have condemned four midwifery practices in particular: the prenatal massages and versions, the temascal or chuj, vaginal exams, and oxytocin injections. The various opinions on these practices, however, do not always align with a rigid biomedical/non-biomedical
dichotomy, which is to say, there is disagreement within both biomedical and non-medical groups in regards to the safety and applicability of these practices for indigenous midwifery. In focusing on four practices—two indigenous and two biomedical—the varying and conflicting perspectives on what constitutes quality care for women illustrate the futility of oversimplifications.

Scrutiny of the indigenous practices—the prenatal massage and the temascal—suggests that Guatemalan health officials, most of whom are ladino, react negatively to indigenous practices they cannot access or regulate. These practices have yet to be “proven”—that is, demonstrated in a clinical trial—to be harmful for the mother. In WHO literature, practices such as the external cephalic version and the temascal would mostly fall under the “cultural” classification, separate from the necessary medical procedures to ensure a safe birth, and under

Figure 10. Doña Juana practices el suero, the IV.
the purvey of the “traditional birth attendant.” Given the attempts since the Peace Accords to bring the indigenous population into civil society, midwifery practices that separate these communities as indigenous may be frowned upon on these grounds, rather than the prescriptions of the WHO. Regulating the Maya birth practices is a means by which the ladino state aims to control the indigenous population under the auspices of health promotion.

Massages and external cephalic versions continue to be central to practice at ACAM. The massage endangers neither the mother nor the child; the only consequence may be that baby moves again, which would simply require the mother to return. Criticism of these practices may stem from a lack of understanding and communication—“biomedical personnel in Guatemala are seldom apprised for the usefulness of prenatal massage and versions”—or from a lack of capacity to the regulate these practices “because they happen in the place to which the Center has little access: people’s homes.” The Health Center, therefore, condemns what it cannot control.

Use of the temascal is also widely criticized. Historically, Mayan and other Middle American peoples have entered the sweat bath for purposes of bathing and the practice has long been connected with midwives’ work in childbirth. Health authorities, however, condemn the temascal as unsanitary and dangerously hot for the newborn. These authorities argue that the temascal debilitates the

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44 Ibid., 644.
mother and can be potentially fatal if the woman is already weak or anemic.\textsuperscript{45} Despite these claims, studies have not proven the \textit{temascal} to be a cause of maternal or neonatal mortality. Health providers’ opposition, then, seems to be more a reaction to “a reminder of the persistence of traditional Mayan practices in the population,” than to a genuine health concern. Beginning with the Spanish colonizers, who also described the \textit{temascal} as a stove or furnace, the current condemnation of the \textit{temascal} continues a long tradition of characterizing the indigenous customs as dirty and primitive.\textsuperscript{46} Health authorities’ attempts to root out the \textit{temascal} may be tied to their view of the practice as backwards, and working against the establishment of a modern Guatemalan state.

Without empirical evidence the external cephalic version or \textit{temascal} are significantly correlated to maternal or infant mortality, a tension emerges between one perspective of biomedicine—the need for a clinical trial to establish any truth—and another, that of the Guatemalan health officials. The dangers of the improper application of vaginal exams or oxytocin injections, however, have been confirmed in studies. (It follows logically that Western science would be able to chart, measure, and assess the use of Western science). The multiple perspectives on these two practices, therefore, further complicate biomedical/non-medical lines.

\textsuperscript{45} A note: the ACAM midwives do not enter into the \textit{temascal} after birth with a mother if she appears to be weak (fainting, etc).
\textsuperscript{46} Hurtado, “Relations between Government Health Workers and Traditional Midwives in Guatemala,” 228.
Around 60 percent of Guatemalan midwives have performed a vaginal exam, and close to 40 percent do so on a routine basis. The vaginal exam has now become a routine element of the ACAM birth procedure. With the exception of Marisol, who does not perform vaginal exams, the other midwives all said it was the single most helpful practice that the North American midwives taught them. It is ironic, then, that one of the most widely adopted biomedical practices is not only not taught in programs, but also discouraged by Guatemalan health officials. Alba explains that the vaginal exam is necessary to her practice, but condemned by doctors:

The first thing I do, when the women says she already has pain…I perform a vaginal exam because it is very necessary in order to know if the uterus has started labor or not, if it has begun to open or not. The doctors, on the other hand, say that we should not do it. But for me, its necessary, so that you can know how many [dilations] she has.

In the instance of the vaginal exams, it becomes clear that biomedical practices reach the midwives in a variety of ways, yet there is not a general consensus within practitioners of biomedicine on the net benefit of performing them.

The vaginal exam is, in fact, quite a unique intersection, as responses to its use defy what would seem to be logical alliances. Guatemalan health officials generally discourage midwives from performing routine vaginal exams; if performed without proper aseptic technique, vaginal exams can increase the

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47 Goldman, "Evaluation of Midwifery Care: Results from a Survey in Rural Guatemala," 694.
48 Cosminsky, "Maya Midwives of Southern Mexico and Guatemala," 209.
mother’s infection risk substantially. The North American feminists of the woman-centered natural birth movement also tend to oppose the vaginal exam, as it privileges interiority over other legibilities of the body, and gives power to the doctor to decide when the woman is ready to push, rather than allowing the birthing mother to determine when her body is ready.

On the other hand, the WHO includes the vaginal exam in their list of abilities required to gain the title of “skilled attendant.” The North American midwives, who continue to travel down to ACAM and teach various workshops, showed the midwives how to perform the vaginal exam (hacer tacto). This practice is a low-technology technique the midwives can employ to prevent tearing of the perineum and post-partum hemorrhage.

Obviously, the North American midwives—women who, by nature of the profession they have chosen, critique the biomedical model of birth in favor of women-centered birthing—find the vaginal exam beneficial. This contested practice challenges a rigid dichotomy between biomedical and woman-centered birth. Visible here are the discrepancies between theory and practice: the theory of the woman-centered, “natural” model of birth differs from the practices that North American midwives teach, and the theory (i.e. WHO policy) behind health promotion in skilled attendance differs from what Guatemalan health officials—

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50 Though this is the current position, many of the senior midwives learned how to perform vaginal exams from trainings at the Department of Health.
51 I refer here to the second-wave feminists I referenced in my introduction, as obviously this view is not held by all North American feminists.
following that WHO model—implement. In the table below, I chart these opinions.

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<th>Vaginal Exam</th>
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<tr>
<td>Pragmatic orientation</td>
<td>Guatemalan health officials</td>
<td>North American midwives</td>
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<tr>
<td>Theoretical/Policy-based orientation</td>
<td>Global north natural-birth feminists</td>
<td>World Health Organization</td>
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The debate over the utility of vaginal exams lays bare the limits of rigid classifications, whether held in biomedicine or in feminism. The domaining of knowledge and practice in this way has little use or value to the Guatemalan midwives, who seek to employ what works. Women’s relationships with biomedicine and technology are typically grounded in pragmatism rather than considerations of whether a technology represents a form of patriarchy. “For by force of the circumstances of their lives,” writes Margaret Lock, “women have always had to learn how they may best use what is available to them. If the apparent benefits outweigh the costs to themselves, and if technology serves their own ends, then most women will avail themselves of what is offered.”

Responses to biomedicine are grounded in women’s daily, lived experiences, and the places they hold in their families and communities.

The vaginal exam exposes a juncture where the intersecting responses of ladino health officials, WHO recommendations, global north feminists, and indigenous midwives are crossed in unexpected and revealing ways. The midwives

perform vaginal exams, not because they are on the WHO’s list of requirements for skilled attendance at birth, but because it helps them decipher when a woman is ready to push. This emphasis on pragmatism and lived experience of birth align the Guatemalan midwives with the North American midwives.

An argument for pragmatism is not an argument against training. If midwives are to incorporate vaginal exams and oxytocin injections into the way they attend births, it is crucial that they do so in ways that optimize the woman’s life chances. Oxytocin in particular can present a grave danger to the mother and fetus if administered at the incorrect stage in birth, and because of this risk, Guatemalan health officials condemn the use of oxytocic drugs. Sheila Cosminsky writes, “both the practice of vaginal examinations during labor and administering oxytocin injections have been adopted inappropriately from biomedical practice and have been associated in Guatemala with intrapartum mortality.”

The use of injections has increased considerably; a study done in 1971 reported that midwives did not use drugs to precipitate or accelerate delivery. By 1986, a study reported that oxytocin injections were given in over 50% of births. The midwives each reported a range of practices to deal with a slow labor and delivery, and post-partum hemorrhage, but Ángela and Alba were the only midwives who used oxytocin injections. Unlike Cosminky’s findings, however, both Ángela and Alba use oxytocin only to speed up the delivery of the placenta and to deal with post-partum hemorrhage. The rest of the midwives said in the

53 Cosminsky, "Maya Midwives of Southern Mexico and Guatemala," 193.
54 Ibid.
case of an extremely slow labor, a placenta that did not deliver or came out in parts, and post-partum hemorrhage that did not stop after the use of milenrama, they send the woman to the hospital.

Though the administration of oxytocin during the third stage of labor (after the baby has been born) has been proven to prevent postpartum hemorrhage, it is not recommended for use before birth in developing countries. Many midwives have been trained to administer oxytocic drugs during the third stage in an attempt to lower maternal mortality, and these drugs are now freely bought in many locations. Despite WHO guidelines, however, many “traditional birth attendants” employ the use of oxytocic drugs before birth to speed up labor. This practice is extremely dangerous if done in a non-hospital setting, first because midwives typically inject oxytocin, rather than administer it intravenously, which makes dosage control hard to regulate and impossible to adapt to uterine activity. Moreover, if the woman responds in a way that necessitates a cesarean section, she may be far from a location that can perform such a procedure.\textsuperscript{55} This partial administration of biomedical technologies without immediate access to emergency biomedical care remains a serious issue.\textsuperscript{56}

The midwives at ACAM employ oxytocin solely after birth, and thus comply with WHO guidelines. Here, again, certain second-wave, “natural” birth feminists align with Guatemalan health officials in opposing oxytocin use, while WHO recommendations and the practices the North American midwives teach

\textsuperscript{56} Van Hollen, \textit{Birth on the Threshold: Childbirth and Modernity in South India}, 16.
agree in its promotion. The Ministry of Health cannot control practices that
NGOs teach, and oxytocin is readily available in most pharmacies. Rather than
outlaw its use entirely, the Health Center needs to devise a way to more effectively
teach how to administer such an injection.

The lived experiences of the ACAM midwives deny any singular concept
of “biomedicalization.” They adopt biomedical practices while resisting the
institution’s emphasis on “objective truth,” belief in a universal body, or
individuation of care, which is to say, the midwives resist the wholesale
implementation of the biomedical model of birth. In accommodating and
resisting—growing like the West and not like the West—simultaneously, the
midwives disrupt any concept of a progressive process of “biomedicalization.”
Responses to biomedicine are heterogeneous, and depend on the nature of the
discrete practices, the manner in which these practices were taught, and the
individual midwife’s own experiences and inclinations. Finally, biomedical
knowledge reaches the ACAM midwives from a number of sources—the
Guatemalan Ministry of Health, NGOs, pharmacists, visiting nurses and nurse-
midwives, and the North American midwives who sit on the board, to name only
a few.

The narratives of lived experience at ACAM reflect a process of
biomedicalization that is multiple—composed of many partially connected
processes—more than one and less than many. The process is better
characterized as a web of translation and knowledge, with countless nodes and
interactions. Given the complexity of this vast network of connections—acts of accommodation and acts of resistance—what can we say about training and the intersection of knowledge and practice? How do we balance the necessity of training with the proven futility and blatant paternalism of such a project?
Conclusion

With training—the site where indigenous midwives most directly encounter the imposition of the biomedical model—as my focal point, I have explored the complexities of this interaction. WHO publications on training birth attendants set parameters for a “safe” birth with the stated intention of lowering maternal mortality. Instead of offering recommendations that aid and empower local communities, these discourses constitute a form of biopower that limits what are considered valid health beliefs, practices, values, and legitimate health practitioners to biomedical definitions.

The lived experiences of indigenous midwives who have undergone these WHO-recommended training programs demonstrate a complexity in their negotiations with biomedicine that global health initiatives do not seem to anticipate. The assumption in WHO evaluations of training programs that if the midwife has not adopted a certain practice, she has not understood it, does not take into account an individual’s agency in that process. The ACAM midwives adopt various biomedical practices they find useful without internalizing a belief in the uncontested authority of biomedicine (as taught in trainings) or accepting a biomedical orientation towards the body.

The relationship of WHO discourses (top-down planning) to practical lived experience (bottom-up resistance) constitutes only dimension of the interaction between biomedicine and indigenous midwives. These negotiations of power and resistance occur constantly at many nodes of intersection; the
“biomedicalization” of the midwives’ practice is not a singular and deterministic process, but one complicated by individual agency, the nature of the training, and the source of the biomedical knowledge. In this critique, I aim to get outside the narratives of globalization—both the WHO’s “health promotion” and its critics’ “biomedicalization”—through narratives of lived experience which challenge the cohesiveness of both conceptions of globalized biomedicine.

I contest global health initiatives that promote a biomedical model of birth (chapter 1) without simplifying the global spread of biomedicine to a singular concept of “biomedicalization” (chapter 3). I juxtapose an analysis of the power of transnational institutions to dictate the terms of “health” with a case study of the lived experience of midwives who negotiate, accommodate and resist biomedicine daily. I complicate the WHO’s conception of training, not by discarding the strategy entirely, but asking how it may be done in a way that is meaningful for the people it seeks to empower.

In committing myself to the deconstruction of a concept of “biomedicalization,” I have hoped to counter what I believe has been an act of reification. Considerations of the global spread of biomedicine must not fall victim to the dominant narrative of globalization/modernization/Westernization, and in doing so lose sight of the complexity of interactions, negotiations, and resistances. Our challenge to hegemony cannot employ the same rigid dichotomies or domaining of knowledge as the hegemonic narrative. Biomedicine enters into the lives of individuals all around the world; I argue that this process
cannot, and must not, be considered deterministic—progressing towards an endpoint of a completely biomedical model of birth worldwide—or singular—encompassing only one of the interactions I reviewed. It must be seen as contested constantly and as multiple; more than a single interaction, yet still encompassed under the same process.

Does the global north—specifically the health professionals who call it home—have an obligation to train midwives, given the fact that it is the origin of the biomedical knowledge that now exists throughout the world? If the improper use of these technologies results in death, who is complicit in these deaths? Guatemalan pharmacies now sell oxytocin, and the decision to purchase such drugs lies with the midwife; is it better to train midwives in the safe administration of available drugs than, in the name of resisting the spread of such technologies, make no effort at all? How can a biomedical professional train indigenous midwives in a way that is respectful and effective—or should those who are thoroughly steeped in the “truth discourses” of biomedicine even act as trainers if they see no value in indigenous practice? What biomedical practices could benefit rural indigenous communities most, and how can a model for “student-centered” learning even emerge if midwives cannot request to learn techniques they do not necessarily know exist?

Given the following: biomedicine inevitably enters the lives of indigenous midwives (though an endpoint of completely “biomedicalized” is not inevitable); the use of biomedical materials requires training if these midwives are to ensure
the best care for their patients; didactic teaching methods are entirely ineffective and paternalistic; yet, finally, it is difficult for midwives to initially structure their own learning without knowledge of the range of procedures that exist within biomedicine. What are we to do?

Childbearing women of the global south must make choices within the constraints of structural inequalities that determine those choices. The task at hand is to expand options, imagine alternative modes of life, and envision different versions of what we consider quality care. In global health discourses, “that ‘health’ is a vague, subjective, and indeterminate value is, more often than not, regarded as an inconvenience and an obstacle to the construction of effective policy. An obstacle to be bypassed, or blackboxed.”¹ A Foucauldian approach helped articulate the dominance of a singular definition of “health” permeating global health discourses. This definition of “health” is uncritically accepted and the resources of global health programs are put towards improving access to one form of care and one body of knowledge. Returning to Annemarie Mol’s “politics of what,” I argue that the questions we must ask are not how we can increase the availability of this one idea of “health,” but “what forms of empowerment we might associate with health, and claim under that name.”²

We must create practices that are shared practices. ACAM has already achieved this goal in certain senses—the space it offers for integrative medicine facilitates the integration of bio- and indigenous medicine, and the relationship

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¹ Greco, "Thinking Beyond Polemics: Approaching the Health Society through Foucault," 24.
² Ibid., 25.
maintained with the North American midwives allows for a continuing dialogue. The apprenticeship program within ACAM institutionalizes the transfer of knowledge from senior to junior midwives. Though this internal structure is well established, the transmission of knowledge from outside ACAM to the midwives has yet to be formalized.

Gabriel Cámara Cervera co-directs Convivencia Educativa, a Mexican NGO that works to improve schools in rural Mexico through the establishment of what he calls “learning communities” or “comunidades de aprendizaje.” This Freirian-influenced model for learning stresses the relationship between the teacher and student, and student-centered learning. On the most basic level, the formation of these “learning communities” involves three steps: (1) the teacher and the people who want to be learners make a contract; the teacher presents what they feel comfortable teaching, and the person decides what they want to learn. (2) The person makes a commitment to work on the skill until they have mastered it. (3) Once the person feels that they are confident in the mastery of that skill, they teach someone else.3

Ironically, this model approximates the teacher/apprentice formation within the medical profession in the United States, where “see one, do one, teach one,” is the motto. Unfortunately, these horizontal teaching methods do not travel with biomedical practices to developing countries. At ACAM, however, if a biomedical professional could commit to creating a sustained relationship with

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this community of midwives and to teaching in this way, perhaps shared practices could emerge. Cámara has established 9,000 small schools across Mexico, structured as “learning communities,” which are widely successful. If the Ministry of Health in Guatemala would direct resources away from training programs that do little except make attempts to regulate the lives of indigenous midwives and further antagonism between the ladino and Maya populations, and instead turn towards placing committed health professionals in learning communities across rural areas where maternal mortality rates remain high, perhaps more women could be ensured a safe and healthy birth.

Ultimately, maternal survival will improve significantly only when the structural factors underlying malnutrition, early motherhood, and lack of transportation change. Unlike the woman-centered, natural birth movement of the U.S., the ACAM midwives critique is not of biomedicine itself, but of certain ways in which the biomedical model is imposed on them. Integration of the two belief systems is possible but the structure of training programs, and the orientation of global health initiatives on a whole, must be fundamentally rethought if any progress towards maternal survival is to be made. If the midwives can integrate both systems of medicine—embody indigenous and biomedical

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4 If a health professional from outside the Maya-Mam community were to enter to train the midwives, he or she would have to learn Mam in order to engage with the midwives in a meaningful and respectful way. This health professional does not necessarily have to be an outsider—a member of the community could also serve this role. While in previous generations the idea of an indigenous woman becoming a doctor may have been entirely unthinkable, today it may be a possibility. Many of the midwives’ children, male and female, attend various universities in the cities. Ángela’s fourteen-year-old daughter, Candelaria, is already quite knowledgeable of indigenous midwifery practices. When I asked her if she wants to be a midwife, she told me she plans to be both a doctor and a midwife.

knowledge in their hands simultaneously—can we not demand the same of global health initiatives?

Well, I follow both things. For example, when a baby is born asphyxiated, what we have in our hand is an onion, we place it below the nose. But if this does not have an effect, then we have to do what Nikki told us, we have to do this massage, pressure here. And if it does not breathe, we do mouth-to-mouth. So, this. [The two systems exist] because I cannot leave behind what is culture, nor can I leave behind [biomedical knowledge], but rather I have both.

I have to carry them both.⁶

Appendix 1: Interview Questions

Midwife's identity and characteristics

Personal information: her name, age, number of deliveries, years working as a midwife.

Personal History and Training

How long have you worked as a midwife?

Why did you decide to become a midwife?

Where did you learn your skills?

Have you taken classes at the hospital or Centro de Salud?

Have you learned new practices from the North American midwives?

Have you changed your practices since you first became a midwife? If so, which practices?

Are there things you still want to learn?

Clinical assessment: prenatal care and pregnancy

When a pregnant woman enters ACAM for a consultation, what do you do and how do you examine her? What questions do you ask? What do you do?

Labor and delivery

If a woman comes in, how do you decide she is in labor?

What do you recommend the woman do while she is laboring?

What position do you prefer during labor? Where are you and where is the woman?

What do you do if the labor is taking a long time?

How do you decide if it is time for a woman to push? What position is common to push in?

What is the position of your hands if the baby is coming out normally?
If the baby comes normally, what do you do after?

_Labor complications_

What do you do if you see the baby is coming out feet first?
What do you do if you see the baby is coming out with a hand first?
What do you do if the placenta doesn’t come out, or only part of it comes it?
What do you do if the woman doesn’t stop bleeding after the birth?


