



5-1-2009

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Arthur Kleinman noted that “a model of medicine as a cultural system will be valuable if it can [. . .] provide a terminology that is not limited to biomedicine, but through which biomedicine can be related to other professional, as well as popular and folk, healing traditions.”¹ This view is especially important in terms of pregnancy and birth in the Tzutujil Maya community of Santiago Atitlán – a town of 20,000 people in the Western Highlands of Guatemala, in which biomedicine was only recently introduced to the community. In Atitlán, the popular and folk practice of using *comadronas*, or midwives, is a deeply rooted cultural tradition. This cultural system, and resultant medical system, is “a symbolic system built out of meanings, values, behavioral norms and the like,” which are consequently “attached to particular social relationships and institutional settings.”² With the increase in globalization that is creating new job opportunities in the community, exposing the Tzutujil Maya to new cultural influences and importing new products to the region, there is also an opening for the improvement of health outcomes with medical advancement. Already signs of institutional change are apparent, with the establishment of specific medical spaces, such as the local small-scale hospital, called the *Hospitalito*, and its local health center, the *Centro de Salud*, among others. However, the biomedical model that is being introduced to Santiago Atitlán must consider the traditional health system and values already in place in order to be culturally sensitive. While there are many ways for biomedicine to intervene in the health practices and the beliefs of communities, only some are considerate of deeply rooted indigenous values, and will therefore prove more effective in serving the Santiago Atitlán community.

In this paper, I will draw primarily from unpublished field notes collected in Santiago Atitlán, Guatemala in Summer 2008 by student researchers of the University of Pennsylvania’s Guatemala Health Initiative (GHI). Ten researchers conducted ethnographic fieldwork over the course of ten weeks, and their notes on participant-observation and semi-structured interviews were both coded using QSR NVIVO 8 software. GHI’s research aims in 2008 included understanding the culture surrounding pregnancy and birth among the Tzutujil Maya in order to evaluate how a culturally-sensitive maternal health intervention could take place in the community.

Although Santiago Atitlán’s practitioners for pregnancy and birth fall into two main groups – *comadronas* and biomedical doctors with assistants – those members of the community who supply advice to women regarding maternity and childbirth can be found in all social categories. Kleinman notes that “most health care systems contain three social arenas within which sickness is experienced and reacted to.”³ These consist of a) *the popular*, comprising “the family context of sickness and care” and including the “social network and community activities,” b) *the folk*, “consist[ing] of non-professional healing specialists,” and c) *the professional*, “consist[ing] of professional scientific medicine and professionalized indigenous healing traditions.”⁴ People in the popular category include mothers, cousins and friends who have had pregnancy experiences and often suggest a type of healer for a pregnant woman to go to, whether it is a *comadrona* or a

biomedical doctor. For example, one woman “chose the *comadrona* with the help of her mother,” while another “decided to [go] to the Hospitalito [. . .] because her husband’s sister-in-law had a baby [there], and it went well [,] so she recommended that [the] couple [go] there.”⁵ While the *comadronas* can be considered professional in that they are specialized and have specific knowledge about birth that allows them to help others, they belong to the folk arena in that they are local healers specializing in birth and motherhood. Here, the category of professional instead describes the medical community that “talk[s] about sickness in a sector-specific language of biological functions and behavior.”⁶ However, one scholar on childbirth suggests that “whatever the details of a given birthing system [,] its practitioners will tend to see it as the best way, the right way, indeed *the way* to bring a child into the world.”⁷ Thus, there is conflict when more than one system exists in a given community.

Nevertheless, both the interactions between *comadronas* and patients, and between doctors and patients, are somewhat scripted, whether by culture or by education, as they take place through biomedical intervention in the community. As Jordan notes, “childbirth is an intimate and complex transaction whose topic is physiological and whose language is cultural.”⁸ In the case of the *comadronas*, patient and practitioner expect the same things as dictated by tradition. For example, the midwives provide prenatal massages for the women to help them to relax, to feel the baby, and to change the orientation of the baby if the head is not downwards. Massages are sometimes also done post-birth. The massages are cited by several interviewees as a reason why *comadronas* are better than doctors, but are then cited by some as an example of the dangerous work the midwives do. In addition, midwives conduct home visits, whereas doctors require the patients to travel to the medical space, hospital or clinic, for check-ups. Kleinman notes that healing occurs when “there is a ‘fit’ between expectations, beliefs, behavior and evaluations of outcome.”⁹

As there is a traditional duty ascribed to the *comadronas*, which is part of the local culture, there is an expectation among the people of what type of interaction will occur. Although individual opinion varies, there are examples in the data where midwives are also described as being more personal: one woman, who has had birth experience with both types of birth attendant, explained that “the *comadrona*, in her experience, does a much better job” because she “always gave massages, whereas the doctor never did,” and that “the *comadrona* ask[ed] her lots of questions about how she felt and how the baby felt.”¹⁰ Other interviews mention rituals, such as the bathing ceremony. In this ceremony, the baby is washed with soap in a small tub of warm water with pink flower petals, towed off, dressed, and named.¹¹ *Comadronas* also know from experience what types of herbs and natural medicines will help the mother; in one interview, a midwife explained the ritual use of incense during birth, it “burn[s] so that the smoke goes in between the delivering woman’s legs,” a ritual “that ‘God helps receive the baby.’”¹² According to another interviewee, “the *comadrona* always prepares [the medicine], always natural. And if something’s wrong with her patient, then she can tell the patient to go to the doctor to receive other medicines, but without chemicals. [So the] medicine for the mother won’t cause a miscarriage.”¹³ It is unclear from the data whether the herbs supplied by the midwives are specific ones that are common among the practitioners themselves, or whether there is evidence of the herbs’ success, but it seems that many midwives have certain herbs that they know to use. Lastly, spiritual beliefs play a role in the lives of *comadronas* and their patients. Some *comadronas* are called

to the occupation through dreams, whereas others became midwives because they were successful at delivering their first time. Culturally, these dreams are seen as spiritual messages telling the women what they should do with their skills. One man “likes the *comadronas* much better than the hospital. He says they are very experienced. Not formally taught, but powerful because the women receive messages from God.”¹⁴

In stark contrast, other people prefer biomedical doctors and nurses for their specific training. Professionals in biomedicine are taught what to do through schooling that is regulated by an international standard and a shared scientific knowledge. This education then scripts their interactions with patients and strictly delineates what types of questions are asked, what symptoms to look for, and what treatments to proceed with. For example, during prenatal consults, the doctor conducts laboratory tests, ultrasounds, and provides prenatal vitamins.¹⁵ Another service includes “measur[ing] the circumference of the woman’s arm to assess if she is malnutrition[ed].”¹⁶ Women who decide to give birth with a *comadrona* often are encouraged to go the doctor anyway for check-ups, but those who prefer the hospital or clinics do so because the doctor “can give [. . .] medicine for the pain during labor” while *comadronas* cannot.¹⁷ Moreover, doctors are better equipped to handle emergencies during labor because they have access to more technology and medical techniques, such as the ability to perform a caesarean section, which were developed specifically to combat those problems. In light of this, many midwives bring their patients to the *Hospitalito* if they recognize an emergency. Therefore, in this context, “birth is overwhelmingly seen as a medical event” in which “technical competence [. . .] is defined as professional medical expertise.”¹⁸ As the patient is most likely not qualified to evaluate the professional’s ability, he or she “is expected to have confidence and trust in the physician.”¹⁹ This trust is expected in all situations; biomedical professionals, unlike the *comadronas* whose expertise is narrower, are associated with all types of care for many health problems, and can understandably be seen by some as more knowledgeable, even though midwives specialize in birth. As one doctor describes the medical system in Guatemala:

There are three levels of care. The first, which provides the most basic services, are the *Puestos de Salud*. The *Puestos de Salud* focus on preventing and controlling illness. Then, come the *Centros de Salud* which provide more services including educational programs. The third tier of healthcare includes hospitals which provide the highest level of care.²⁰

Other institutions present in Santiago Atitlán include *Rxiiñ Tnamet* and *Prodesca*. In terms of pregnancy and birth, these various types of clinics provide information on family planning, in addition to providing methods of birth control such as “birth control pills, Depo-Provera injections, tubal ligation, IUD, and condoms”²¹ Further, some help deliver, while the hospital conducts surgeries. Because doctors treat a variety of issues, people may associate doctors with a sense of reliability and thus feel that doctors and nurses are safer as birth assistants. More data need to be collected to determine conclusively whether this is a perceived correlation. Ultimately, the doctors’ main advantage is having extensive biomedical expertise; while the *comadronas*’ main advantage is their traditional association and reputation as more natural.

Given these characteristics, perceptions concerning which birth practitioner is preferable vary greatly among members of the community, as do the reasons why people choose one over

the other. The main considerations illustrated by the data include cost, distance, education, level of comfort, culture, advice given by friends or family, gender of the birth assistant, and language. Many women interviewed who choose to give birth with a *comadrona* over a biomedical doctor cite money as a barrier to accessing services at the hospital and clinics. These women also mention that they like that the *comadronas* give massages, so cost does not seem to be the only deciding factor. It appears many women feel that if they can successfully deliver their babies with midwives and without complications, then there is no need to pay for hospital care, especially if the family is low on resources. However, many midwives also refer their patients to doctors for prenatal check-ups or bring their patients to the hospital in case of emergency. Regardless, many patients who receive check-ups do not deliver with the doctor, choosing to remain with the *comadrona*. Distance is also a central issue; the *comadrona* will visit the pregnant woman at her house and assist there during the birth, so the family will not need to worry about traveling to the hospital or clinic when labor begins. Travel also costs money, an added burden – especially if the family lives in a canton far from the *Hospitalito*, *Centro de Salud*, or *Rxün Tnamet* where doctors help deliver, it is much more convenient to have the *comadrona* come to them.

Jordan notes that “birthing systems overwhelmingly prescribe an appropriate place for giving birth” which can be “relatively marked and specialized,” such as a hospital bed, “or unmarked and within the woman’s normal sphere” in the home.²² She suggests that “whatever the stresses and anxieties of childbirth are for [the mother], having her child at home provides the kind of security that marks the event as a normal part of family life.”²³ This description contrasts with the medicalization of birth in the biomedical sphere, in which the process occurs in an unfamiliar but specialized space. Several interviewees echo this view, giving opinions such as “*comadronas* are comfortable and natural” and that “the only natural way to give birth is in the home.”²⁴

According to some of the doctors interviewed, another reason why people choose traditional healers is that “people turn to other beliefs when medicine does not cure them quickly.”²⁵ One interviewee describes how “most people now rely on the *Hospitalito* or pharmacies in town when they are sick,” but they do not understand “the difference, for example, between an infection which may need treatment and a virus which just needs time for the person to get well,” making the “job of doctors very difficult” when they cannot deliver what the patient expects.²⁶ Some people “don’t believe in medicine” altogether and “instead [. . .] go see *curanderos* [. . .] or ascribe to *brujería*,” or witchcraft.²⁷ Others still choose not to go to the hospital because “they don’t think it’s necessary.”²⁸ “These people [. . .] believe in God and believe that God decides everything about their health,” and so reason that ‘God made [them] sick’ or ‘God wants them to die.’”²⁹ Such beliefs reflect the indigenous culture and its traditional folk healers, the healers who were considered most knowledgeable and specialized before the influx of biomedicine. Many of the people in Santiago Atitlán have been using “medicinal plants” and herbs for generations, and many still seek out healers in the community.³⁰ These folk practitioners, Kleinman suggests, use the “popular cultural idiom” that is accepted in the community, so “indigenous folk healers do not disappear when modernization creates modern professional medical systems.”³¹ They are familiar to the local people and already a normal part of the social networks that comprise the popular or folk arena described by Kleinman. As one doctor said, “perhaps you grew up in a

neighborhood where the hospital was known, the doctor was known, then you're familiar with certain people," which "doesn't mean that [someone else] wouldn't be as capable to give services, but if you're familiar [with] certain people, you go there."³² Additionally, in accordance with the machismo present in the culture, the gender of the birth attendant is consequential. "Some men don't allow their wives to seek medical attention," or they "have to accompany their wives."³³ In other cases, "women feel uncomfortable with male doctors [as] usually there are no men in the room during a birth"; "birth is still a woman's thing,"³⁴ one interviewee stated.

Lastly, language and education prove to be large barriers for people seeking biomedical attention. Kleinman writes that "communication has shown itself to be a major determinant of patient compliance, satisfaction, and appropriate use of health facilities."³⁵ Whereas the *comadronas* are members of the indigenous community, most of the professionals are not; they are doctors, nurses, medical students, and volunteers from other parts of Guatemala or from other countries. Midwives are thus well versed in Tz'utujil, while the biomedical practitioners rely on translators or speak in Spanish to communicate with their patients. However, some practitioners have learned the language, and a small minority comes from the community. In general, patients have more difficulty understanding the doctors than the *comadronas*, and doctors sometimes do not describe what is happening altogether. For example, one woman described how "the nurses and doctors didn't tell her the diagnosis" for her daughter's symptoms, only telling her "that they had to operate on her."³⁶ People "worry that they won't be able to communicate with the doctors in the hospital because they [the patients] may only speak Tz'utujil."³⁷ Nevertheless, others praise the translators at the hospital. The language barrier also relates to the problems of illiteracy and the lack of education, which are both contributed to by poverty. People who are uneducated are less likely to understand the basic tenets of biomedicine because they have not been exposed to scientific knowledge and research. Without health education, they also are not aware of when they should seek help for symptoms. In one doctor's opinion, these people "are just not conscious or sensible when it [comes] to health."³⁸ He expressed his frustration at how some "patients threw away the pamphlets [about health] they were given," but this problem is inherently related to education. If the patients are illiterate, they do not read and probably do not speak Spanish, so they would "therefore have no use for a pamphlet," and this should be taken into consideration when communicating with them.³⁹ Nevertheless, with an increase in education for the younger generation, people are starting to understand the importance of treatment and are encouraging family members to seek it. Thus, a conflict between traditional and modern emerges; "what is necessarily, naturally and common-sensically appropriate in one system may be entirely inappropriate and without justification in another," and the community faces difficulties in integrating the two.⁴⁰

Furthermore, there are members of the community who criticize both the *comadrona* system and the biomedical system. One privately practicing doctor suggests that the caregivers at the hospital are "medical students and residents [who] work at the *Hospitalito* without proper knowledge [and] play with people's lives as they learn."⁴¹ Others interviewed also complained of the short duration that some doctors spend in the Santiago Atitlán community. These are sometimes specialists who come and spend a week seeing patients before moving on, and often, due to the limited time frame not all the patients receive the attention they require. Similarly,

many volunteers, nurses, and students who work at the *Hospitalito* are temporary; they rotate through periodically. These “professionals,” who may or may not have adequate training to perform the functions that they are required, gain a poor reputation among some in the community, regardless of whether the practitioners are good at what they do. People are worried that they become tools for the training of the medical students who come and go frequently. This may or may not be true, but it is a common perception as suggested by the data. Other perceptions include that the hospital staff has “no compassion for the people” or that there are not enough doctors.⁴² Also, because the doctors are on rotation, patients may not see the same doctor every time; although this may be a cause for concern, it is not brought up as a problem in the data.

As for the *comadronas*, the main perceptions are that their practices may not be sanitary and that they handle emergencies poorly. This could involve not recognizing a dangerous situation for the mother and child or refusing to bring a patient to the hospital for fear of losing pay. While midwives are improving the cleanliness of their practices, aided by the supplies given out at training sessions, they still employ practices that are unclean by biomedical standards. The home is a comfortable environment for most women, so improving the cleanliness of homes or at least the birthing room is a possible solution. However, in situations of poverty, it is hard to demand this type of standard. Most midwives and patients interviewed acknowledge that it is important to go to the hospital in case of emergency. Thus, both positive and negative views exist of both main categories of birth attendants.

Jordan notes that “at the present time, traditional birthing systems are beginning to change under the influence of Western medicine” and that “it is overwhelmingly the high-prestige medical model that provides the standard template for change.”⁴³ Similarly, changes in the “traditional way of life,” “the society’s subsistence base, [the] social structure, and political ideology” are also occurring.⁴⁴ In Santiago Atitlán, these changes are being implemented through the integration of biomedical concepts in traditional midwife practices as well as through institutional changes. The *Hospitalito*, *Centro de Salud*, and *Prodesca* implement *capacitaciones*, paid training sessions, in order to teach the midwives sanitary practice techniques and signs of complications during birth. For example, during one session, the topic was “Clean and Healthy Birth Practices”; nurses emphasized that a clean environment, clean tools, and washing hands were important for the *comadronas*.⁴⁵ Moreover, the session discussed how to be prepared and formulate an emergency plan when certain symptoms, such as retained placenta, shallow breathing, fever, or seeing a hand or foot first during birth, mean that the midwife should take her patient to the hospital. Other training topics include: “Signs and Symptoms of Danger,” “Characteristics of a good *comadrona*: What you need to learn, and what you need to teach,” “Complications During Pregnancy,” “The Cross of Death and Family Planning,” “Attention of the nurse,” “Prenatal Care,” “Fetal positions” “Complications During Birth,” and “Use of Comadrona Supplies.”⁴⁶ Biomedicine is clearly considered the standard for change.

From the vantage point of the change agent, the lay midwives on whom most traditional systems rely for their functioning appear in need of training. This training typically consists of “upgrading” in the direction of biomedicine and not [. . .] of “continuing education workshops on indigenous obstetric skills.”⁴⁷ Jordan also notes that usually there is no reciprocal program to “sensitize medical personnel” to cultural practices and community perceptions.⁴⁸ The change

agents are mostly the doctors, nurses, medical students, and volunteers who have been educated elsewhere, whether in Guatemala or abroad, so they are less familiar with the values and traditions of the indigenous community. Thus, they thus teach in a manner that may not be effective; most of the midwives, if not all, have learned their trade through experience—by shadowing and doing—rather than through formal education. Jordan notes that “the abstract and formal methods by which modern training courses attempt to impart new skills to traditional midwives stand in fundamental contrast to the pragmatic and experiential methods of skill acquisition to which they are accustomed.”⁴⁹ One woman interviewed, a nurse and a midwife, believes that “the main reason *comadronas* don’t do what they are taught is because they’re too old and too accustomed to their way of delivering babies.”⁵⁰ For the older generation of midwives, the *capacitaciones* seem like a time to meet up with the other midwives and also a way to make a little bit of money. In this interview, she also mentions that usually a smaller number of midwives come to the clinic *capacitaciones* rather than the hospital ones because those “at the *Hospitalito* are strongly reinforced by a lot of the medical staff” in contrast to the few nurses running them at *Rxiin Tnamet*.⁵¹ She also cites the “payment difference between the clinic and the *Hospitalito*” as a possible reason, suggesting that the *comadronas* are more likely to go when attendance is strictly recorded and more money is offered as compensation for their time, reasons that have little to do with valuing biomedical knowledge.⁵² A doctor at the *Centro de Salud* points out that “they avoid making the trainings lecture-like because the older *comadronas* have a tendency to fall asleep.”⁵³ However, some data suggest that this is not entirely the case – sometimes even though the activities are more stimulating, they are ineffective. For example, during a training session on HIV, the *comadronas* were asked to classify images of actions as leading to HIV transmission or not, and while they had just learned the information, many of them had taped their pictures incorrectly. Nevertheless, this type of activity is still outside the realm of empirical training. The midwives are not practicing specific methods. As such, the *comadronas* may have difficulty retaining information because they are older, set in their ways, or having difficulty understanding what is happening during the *capacitaciones*.

In general, one of the main ideas that “the *Centro de Salud*, *Hospitalito*, *Prodesca*, and *Rxiin Tnamet* staff try to teach midwives [is] that their work is not a cultural[ly] unique job, but a health profession that many other people can perform.”⁵⁴ Theoretically, this suggests that “they’re not trying to impose biomedical practices [. . .] but that they just want to make the midwives more aware of safer ways to deliver a baby,” especially because maternal and infant mortality was identified by the community as an issue, but there is little education for the biomedical staff about midwife techniques.⁵⁵ Thus, the trainings, as described by the data, tend to give emphasis to biomedicine without discussion of traditional methods.

Institutional changes are also occurring in the types of medical spaces that are available to the people. A new center, CAP, specifically devoted to birth was established by the *Centro de Salud*, but whether it is successful in increasing the safety and sanitation of births is to be determined. One midwife said “she was happy [that] women were finally going to have a safe place to deliver their babies for free,” but she is unsure whether all the other midwives share her opinion.⁵⁶ At least some do. Another midwife, who is also a nurse, agreed adding that “all the *comadronas* will be able to go there and deliver babies too. Patients choose whether they want the *comadrona* or the doctor to deliver. If the *comadrona* delivers [,] she gets paid. If the doctor delivers the *comadrona*

doesn't get paid."⁵⁷ Here, conflict emerges again between the two categories of birth attendants; midwives are unlikely to bring their patients to the new birth center if there is a high possibility of them losing their pay to the biomedical doctors, who are already intruding upon their traditional job in the community. Subsequently, they are probably less inclined to perform their rituals and procedures in the presence of doctors who are their competition. As one interviewee noted:

The *comadrona* works for the woman but won't teach the doctors her medicine, because if the doctors learn, they'll earn more money than her. For this reason, *comadronas* don't want to give the recipe of their natural medicines to the doctors. So the result [is that they] wouldn't be able to earn anything and they would be poor.⁵⁸

Some midwives may also want to keep their secrets from other midwives, but this is not mentioned in the data. In a community where the majority of *comadronas* are older, they are hopefully passing their knowledge on to the younger generation of midwives, as many of those interviewed have said they are doing. Moreover, one doctor suggests that "from what [she] sees at the *comadrona capacitaciones*, most likely they won't like the idea of coming to [the] Centro de Salud to deliver."⁵⁹ In evaluating CAP, the opinions of the women giving birth should be given attention as well. As some women prefer the home environment, it is questionable whether they would agree to travel to the Centro de Salud to give birth, even in a space designed for them. Therefore, more data should be collected to examine this question.

With the above data, examples, and analyses in mind, the last question to consider is whether "the spread of the biomedical disease model in the popular culture is transforming the health-care-related beliefs and expectations of the sector."⁶⁰ First, it is important to note that the introduction of the biomedical model and its availability to the community has already changed beliefs, and there are now more possible providers than previously, when there were only *comadronas*. Now, the indigenous people have the opportunity to choose between the traditional and the modern scientific, though some are forced to pick based on certain factors such as cost and distance as described above. Jordan writes that "the implementation of scientific medicine constitutes an important part of all development programs," influencing beliefs in the folk sector and subsequently the popular sector.⁶¹ Some *comadronas* do utilize what they have learned from the medical community when they interact with patients. In one instance, a new mother asked whether the "belief [. . .] that, if you take a cold shower in the months after giving birth, you won't produce breast milk and your face will become swollen" was true.⁶² The midwife responded that it was not true; "when she worked in a hospital in Sololá, [. . .] they didn't have hot water [. . .] and the women produced ample breast milk and their faces did not swell."⁶³ However, it is unclear whether other midwives also pass on the information from their experiences with biomedical professionals; this is the only specific example in the data. There is a gradual effect on the community as information is passed from the professional to the folk to the popular arenas, but it is nevertheless difficult to change deeply rooted traditional beliefs. Consequently, Jordan suggests that "regardless of the kinds of policy decisions that finally have to be made, [. . .] the serious evaluation of medical practices according to the standards of the traditional system will sensitize medical personnel to the obstacles" that indigenous women have to overcome in seeking professional attention.⁶⁴ It remains to be seen whether the spread of scientific knowledge causes

more women and families to forgo the traditional, cultural use of *comadronas* as birth attendants in favor of the biomedical practitioners more recently introduced into the community, given all the reasons that they have for resisting the change at the present.

For all the above analyses, more research is needed to substantiate the claims presented. This paper mainly aims to summarize the current data concerning birthing systems and to suggest directions for future exploration. Most of the data used have been pulled from interviews with the healers themselves, the *comadronas* and doctors, and there is less specific information of popular opinion in terms of why they prefer one type of birth attendant to the other. It is also unclear which geographic locations and social classes are represented, as the data used were comprised mainly of excerpts, but it is logical to suggest that the lower classes, which are more economically restricted, have more difficulty overcoming the cost barrier of seeking medical treatment, while those who live farther from the *Hospitalito* and clinics find it more of a burden to go to the doctors. Research should be conducted to determine whether education correlates to an increased probability of choosing biomedicine as well as to clearly track the evolution in popular and folk belief with the spreading scientific knowledge in the community. In conclusion, the birthing system is currently a combination of the traditional and biomedical models, with patients choosing between them, but it appears to be moving towards a hybrid model; reducing the gap between the two will lead to further improvement of the current system.

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Sharon was a student researcher with the Guatemala Health Initiative in Summer 2008.

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