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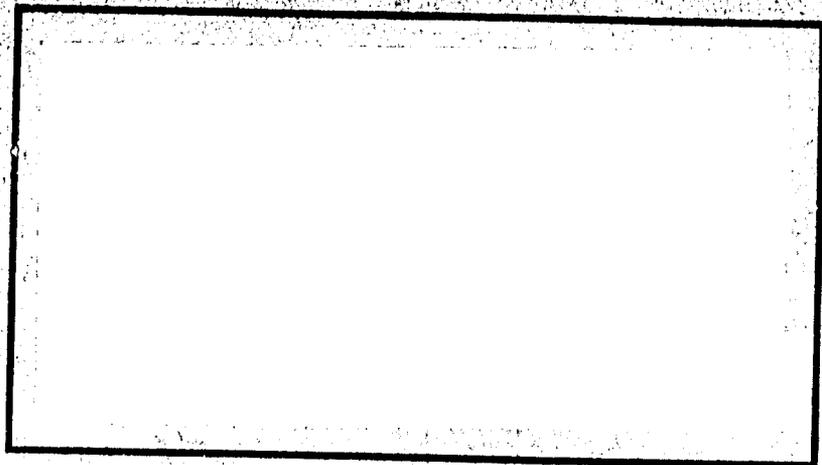
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TRAINING COURSES FOR TRADITIONAL  
MIDWIVES IN YUCATAN, MEXICO

A Report Prepared By:  
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During the Period:  
March 3-12, 1979

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(With Attachments #1, #2, #3 and #4)

## I. PROJECT BACKGROUND AND SCOPE OF WORK

On the invitation of the Instituto Nacional Indigenista (INI) and the Secretaria de Salubridad y Asistencia (SSA), Dr. Mary Elmendorf and the consultant participated in a training course in family planning methods for empirical midwives between January 29 and February 2, 1979 (see attachment #1, official letter of invitation). On the basis of our contributions to this first course, an invitation was extended to both Dr. Elmendorf and myself to participate in the second course (see attachment #2), the topic of which was perinatal management. Unfortunately for the project and to the great disappointment of the Yucatecans, funding was not obtained for Dr. Elmendorf. This report is concerned with my work in the Merida/Valladolid/Chan Kom region of Yucatan from March 3 to March 12, 1979.

According to the letter of assignment, dated February 23, 1979, the purpose of the assignment was the following:

- 1) ". . .to contribute to field report on AID-sponsored research on the empirical midwives' birthing practice and acceptability of family planning and improved maternal and child health among rural Mayan families."
- 2) ". . .to assist in a training course for empirical midwives by the National Indian Institute coordinating center with the Ministry of Health."
- 3) ". . .to prepare a brief report evaluating the training session"  
See P.10 following
- 4) ". . .to bring appropriate equipment, records, and materials to videotape applications of family planning methods for Mayan audience as developed in the training session."

(See below)\*

This was never a stated or possible goal for the training session which I attended for the present assignment, since this course was devoted to obstetric practices and not to family planning. However, the possibility of producing locally appropriate videotapes on tubal ligations and vasectomies had been a topic of discussion and a focal point of interest during the first training session, and previously in discussions between Dr. Elmendorf and medical personnel from the Ministry of Health (SSA) and the National Indian Institute (INI). I followed up on these discussions with appropriate personnel, see page 1, page 20.

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\*Persons contacted and documents reviewed concerning this assignment are listed in Appendices A and B.

It should be noted that some of my activities during the project period (e.g., home visits to graduates of the earlier training course) are concerned with follow-up on the linkages established previously. Similarly, some of the recommendations outlined later on in this report are, in part, based on information gathered during the first training course jointly with Dr. Elmendorf. In addition, my discussions with her and with Dr. Alfonso Villa Rojas allowed me to draw on their research results and extensive experience in the area. This report also draws substantially on my own research on traditional midwifery and ethno-obstetric practices in Yucatan.\*

\*Jordan, Brigitte. Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden and the United States. Montreal, Canada: Eden Press, 1978.

## II. LIST OF ACTIVITIES

- 3/3  
Sat Arrival in Merida. Negotiations with airline and customs about lost luggage. Phone calls to Dr. Gilberto Balam, Prof. Josefina Centeno, Ms. Aline Callaghan.
- 3/4  
Sun Retrieve luggage and equipment from airport. Phone contacts with Ms. Joan Andrews, Dr. Gilberto Balam's house re training course schedule, Prof. Josefina Centeno re request to speak at Instituto Tecnológico Regional de Merida at end of week.
- 3/5  
Mon Morning: meeting with Dr. Oscar Echeverria at SSA, Merida.  
Afternoon: leave for Valladolid.  
Evening: meeting with Dr. Jorge Gonzalez and staff at Instituto Nacional Indigenista, Valladolid. Discussion of audiovisual materials to be used during midwife training course in Chan Kom, 3/6 and 3/7.
- 3/6  
Tue Morning: leave for Chan Kom. In Chan Kom: pre-session discussion with staff from INI (Drs. Gonzalez and Tuz, Enf. Gloria Beatriz Soliz Rodriguez); SSA (Enfs. Silvia German, Conchita Cerveres, Lourdes Uc y Pasos); Regional Hospital of Valladolid (Enfs. Teresa Vasquez Lara and Gilma Altamirano); Elsi Cime Hu, health auxiliary of Chan Kom; and the midwives, as they arrive.  
Training Session - Part I  
Afternoon: lunch with midwives and staff, post-session conference with Enfs. Silvia German and Conchita Cerveres (SSA). Discussions of possible improvements for Training Session-Day II.  
Evening: meeting with Elsi Cime Hu, Health Auxiliary of Chan Kom. "Rounds" in Chan Kom. Discussions with local women.
- 3/7  
Wed Morning: Training Session - Part II  
Afternoon: lunch with midwives and staff. Field trip to Yaxcabah with Dr. Gonzalez. Meeting with director of Yaxcabah health center, discussion of relations of health center with midwives in the area. Follow-up visit with Sra. Anselma Rodriguez, empirical midwife, graduate of previous training course. Case discussions.  
Evening: return to Valladolid. With Dr. Gonzalez, home visit with Sra. Donaciana Torres, empirical midwife of Valladolid, also a graduate of previous training course. With Gonzalez and Torres visit to house of mother with newborn.

3/8  
Thu  
Morning: meeting with Drs. Balam and Gonzalez to discuss evaluation of training sessions and possibility of producing audiovisual materials in support of family planning, specifically videotapes of vasectomy and tubal ligation for local audiences. Also discussed videotaping a hospital birth for showing to local midwives and women.

Noon: with Drs. Balam and Gonzalez, meeting in Palacio Municipal with special emissary from the governor; Sr. Clemente Alcocer Rosado, mayor of Valladolid; and Dr. Raul Peniche, administrator of Regional Hospital of Valladolid, to organize local health committee.

Afternoon: concluding discussions with health personnel at Regional Hospital and INI. Leave for Merida.

Evening: in Merida, phone contacts with Ms. Callaghan; Enf. Silvia German (SSA); Prof. Josefina Centeno (Instituto Tecnologico). Visit from Ms. Callaghan and Prof. Georgeanna Huck, director of student exchange program, Iowa Central College.

3/9  
Fri  
Noon: lunch meeting with Enf. Silvia German (SSA). Discussion of audiovisual materials and instructional model for training courses for empirical midwives.

Afternoon: at Instituto Tecnologico, showing of videotape of a traditional, midwife-attended homebirth from consultant's research footage to personnel from SSA, professors and students from the Instituto Tecnologico, professors and students from Michigan State University (exchange program), and people from the community.

3/10  
Sat  
Isla Mujeres: no project-related work.

3/11  
Sun  
Isla Mujeres: meeting with Sr. Francisco Villa Nova, coordinator of the island health center, and two nurses, to discuss local delivery practices.

3/12  
Mon  
Merida: breakfast with Ms. Aline Callaghan and Lic. Juan Ramon Bastarrachea, Yucatecan anthropologist, to discuss status of research on traditional midwifery and ethno-obstetrics.

Return to Lansing.

### III. TRAINING COURSE FOR EMPIRICAL MIDWIVES OF THE CHAN KOM AREA

#### A. List of Participating Midwives

<u>Communities</u>	<u>Participants</u>
Chan Kom:	Marcelina Cen Un* Severiana Pat Poot* Elsi Cime Hu (a)
Kaua:	Ana Maria Tuz Chulim*
Muchucuxcah:	Francisca Mis Chay (b) Jose Asuncion Mis Chay Gregoriana (wife of Jose Mis Chay) (c)
Ticimul:	Paulina Caamal (d) Mercedes Canul (e)
Valladolid:	Antonia Poot Caamal*(f)
Xanlah:	Maria Ignacia Canul Kian
Xbojom:	Enriqueta Hau Can (g)
Xkalacoop:	Maria Tomas Noh Poot (h)

\*Did not appear for second day

#### Notes

- (a) Chan Kom Health Auxiliary
- (b) Fifty years old, illiterate. Has been working as a midwife for twenty years. Took her first course last month. Her husband, eighty years old, literate, does massage, but does not attend births. Her sister, Elisea, who is also a midwife in Muchucuxcah, is not present because she is in Can Cun. Their brother is the male midwife, Jose Mis Chay.
- (c) Gregoriana is interested in learning midwifery.
- (d) Sixty years old, illiterate. Has had no courses previously.
- (e) Is interested in being a midwife. "Goes around" with a midwife; attends births in her family only.
- (f) Sixty-two years old. Has been working as a midwife for twenty-five years. Learned from the well-known Dr. Victor, who died six years ago. Now she does only two to four births a month, and attributes this to the many birth control pills which she

distributes. Lives three blocks from the hospital and refers many cases. Works in other communities, too, and women come to her house for prenatal massages.

- (g) Fifty years old. Xbojom is a tiny place with 15 houses. She has been working as a midwife for many years, but sometimes there are only two births a year. Her mother was a midwife.
- (h) Fifty-seven years old. Has been a midwife for more than 20 years. Her mother was a midwife.

A Comment about the Situation in Muchucuxcah. Muchucuxcah is a small hamlet without electricity or piped water, located about 20 km. from Chan Kom. Several weeks before the training session under consideration, Dr. Mary Elmendorf and I had conducted interviews with the midwives of the community. At that time, we found the following: There are three practicing midwives, two female, one male, who are siblings and come from a family of midwives and shamans. They, and the women in the community, subscribe to many of the traditional practices and beliefs which are falling into disuse in less isolated areas. Thus one of the midwives told us that her knowledge came from divine inspiration; the kneeling position for birth seems to be still common in that area, and the like. What is unusual and deserving of attention is that the male midwife has some connection with a physician in Valladolid who supplies him with a variety of injections, primarily vitamin preparations, but also ampules of oxytocin. If a birth appears difficult, his sisters call him in to administer oxytocin injections. He is also known as a specialist for manual removal of the placenta, and for dealing with shoulder presentations and the like. The practices he engages in are understandable as attempts to deal with emergency situations, but are also clearly dangerous. As a consequence of our communication with health personnel, a special effort was made to assure the participation of the Muchucuxcah midwives in the present training course.

#### B. Content and Activities - Day I.

The midwives from outlying areas arrive in INI vehicles, picked up by Dr. Tuz and INI drivers. Instruction takes place in Chan Kom Casa de Salud lean-to, midwives arranged on rows of wooden chairs.

Enf. Silvia German begins by introducing the staff, pleading for cooperation between the midwives and the official health care delivery system.

First item on the agenda is an attempt to elicit the midwives' reproductive knowledge. This takes the form of giving them a sheet of paper with an outline of the female body and asking them to draw in the reproductive organs. There is much chatter and embarrassed giggling. Most of them draw some version of the uterus and Fallopian tubes, but three of them, including the two midwives from Muchucuxcah, draw a squarish circle above the navel "porque se sube la cosa cuando esta embarazada" (because the thing rises when she is pregnant). This can only refer to the tipete, the organ that in Maya ethno-anatomy acts as "the machine" that

keeps the body going. There was, however, no follow-up discussion of the significance of this, nor were the sheets identified by name for possible later follow-up.

Next, a series of slides was shown following the standard medical sequence from ovulation to conception to implantation; the development of embryo and fetus; and finally, birth. Dr. Tuz, a native Maya speaker, gave explanations in Maya which were tape-recorded for possible use during training sessions where no Maya speaking staff member is present. The midwives were politely interested. The material was heavily weighted towards the early stages of development which has no direct implications for the practice of midwifery skills. No questions or discussion were generated by this material.

Then, with chairs drawn into a circle, a discussion about danger signs during pregnancy and labor. How to recognize a diabetic. Swollen ankles. Bleeding during pregnancy. Silvia German is very effective with a blown-up plastic bag, demonstrating how the bag (which stands for the uterus) is going to rupture if the woman is made to push too early. She also warns of the dangers of oxytocic injections and of doing internal examinations. The advice in every problematic case is to take the woman to a physician or the hospital.

This is followed by a film strip on birth attendance by the empirical midwife. It includes a few photographs, but mostly consists of cartoon-type drawings. The setting depicted is unlike local settings for birth. The woman in the film strip delivers on a bed while local women have their babies in a hammock or on a chair, sometimes also kneeling on the floor or standing up. One picture shows an episiotomy which is probably not a good idea since it might be imitated.

After lunch, the midwives were returned to their home villages by INI drivers.

During the afternoon, I discussed with Enfs. Silvia German and Conchita Cerveres (SSA) ways in which Day II of the course could be improved. It should be noted that they actively solicited my suggestions and implemented them with great resourcefulness. Briefly, I proposed the following:

- 1) to check over the standard instructional sequence and remove any items that do not directly contribute to improving the delivery skills of the midwives;
- 2) to get midwives more involved by having them actually do something in order to incorporate what they are learning into routine behavioral sequences around birth;
- 3) to teach the materials not by using ideal resources (such as clamps and scissors) but by using those actually available to the midwives, either distributed through official channels or available as part of the local economy; and
- 4) to discuss the traditional practices of cauterizing the umbilical stump with a candle and of doing external cephalic versions in

case of a malpresentation. (These practices were noted specifically on the temario as undesirable from a medical point of view).

Content and Activities - Day II. The midwives again collected by INI drivers. Consonant with yesterday's discussion, the emphasis during this session is on cleanliness and adaptation of available supplies.

Handwashing: no handbrushes are available for distribution to the midwives and it turns out that only two of them own one. Consequently, the initial handwashing demonstration was done not with a handbrush but with a wad of sosquil (henequen fiber), the standard local scrubbing agent. The sosquil is actually superior to a handbrush for washing between fingers, but inferior for cleaning under fingernails. Special attention was paid to cleaning under nails, possibly with a stick, and to having nails cut short. Each midwife went through the routine with the others paying rapt attention and criticizing any lapses. Atmosphere was friendly and relaxed, with lots of jokes and laughs, as when for example, the male midwife from Muchucuxcah objected jokingly against cutting his nails, saying he was a man of the mountains, and would not be able to defend himself with short fingernails.

The question of how to conduct a birth at home under clean conditions was discussed. The midwives first watched and then participated in a demonstration of how to make sure the equipment does not get contaminated; how to boil whatever instruments they might have in a pot with tight-fitting lid. It was agreed that such a pot should only be used for birth-related items and that it was important to scrub down the chair, if the woman was to give birth on a chair, or to insist on a clean hammock, if a hammock birth is expected. (The latter is important because local custom is to use an old and often dirty hammock for the birth in anticipation of blood staining).

With the help of a rubber model, a delivery in a hammock was simulated, with Dr. Gonzalez, to everybody's delight, playing the traditional role of the husband, supporting the "woman" during contractions. Washing down the vulva was demonstrated and practiced. The birth of the baby and placenta were simulated with a doll and the need for not interfering with the expulsion of the afterbirth was emphasized. (This particular point was discussed in detail in response to information on the Muchucuxcah male midwife's habit of doing a manual extraction of the placenta if it doesn't appear in "three or five minutes.")

Care of the newborn was discussed, demonstrated and practiced with the help of a doll to which surgical gloves were affixed to simulate the navel cord. It was pointed out that umbilical clamps are not necessary (they are also not available) and that one can do a good job with sterilized cotton ties. Similarly, since the midwives do not own scissors and none were available for distribution, cutting the cord was demonstrated and practiced with a razor blade. German and Cerveres had brought ties and razor blades from Merida, and laid out a system by which supplies for one birth would be sterilized in a baby food jar at the hospital in Valladolid and be available for distribution to the midwives through Elsi Cime Hu, the Charcar health auxiliary. After each birth, the midwives will bring the jar and used razor blade back to Elsi and receive a new sterilized one.

This system has the added advantage that it is likely to lead to more valid vital statistics since Elsi can supervise filling out the statistical sheets. (Most of the midwives are illiterate).

Treatment of the umbilical stump with alcohol and merthiolate was demonstrated and practiced. The question of cauterizing it with the flame of a candle was discussed. All of the midwives admitted that they do it, after some assurance was given that it is not necessarily a bad practice. After long discussion the medical staff considered that it might actually be a beneficial practice under local conditions since the flame dries and sterilizes the wound. The midwives mentioned that in their experience cauterized navels are less likely to get infected than those only treated with alcohol and merthiolate.

Similarly, the traditional practice of doing an inversion (external cephalic version) of a malpresenting infant was not outright condemned as had been done previously. Rather the need for being extremely careful and not forcing the version was emphasized. The practice is probably beneficial if done during the eighth month or at any rate before the onset of labor. (It used to be a standard part of the U.S. obstetric repertoire before Caesarean sections became popular and is widely practiced in European obstetric systems with better pregnancy outcome statistics.)

However, it should be noted that experienced midwives in Yucatan will also attempt to turn the baby after onset of labor and the male midwife of Muchucuxcah is famous for doing it in emergency situations, as with a prolapsed arm. Given that it would be quite impossible to transport a woman in that condition it might be well to face the issue head-on and discuss ways in which this sort of inherently dangerous and traumatic procedure could at least be made somewhat less dangerous.

The use of a rubber syringe to suction the baby's airways after birth was discussed and demonstrated. The staff expressed their regrets that none were available for distribution. The suggestion was made that the midwives buy one themselves locally and price information was given.

Judging from the involvement and animation of the midwives, this part of the session was highly successful. It generated a great deal of discussion and if the distribution system for sterile ties and razor blades works, this should lead not only to a decrease in neonatal infection but also to an increased linkage to the official health care delivery system. If regular communication can be established through the health auxiliary in Chan Kom, the monitoring of pregnancies and births in the outlying areas and assisting with problems become a real possibility.

The session ended with a group discussion concerned primarily with danger signs during pregnancy for which it should be possible to bring the woman in for medical consultation even from outlying areas. In the course of this, an attempt was made to assess the transportation situation. It appears that transportation of emergency cases is almost impossible from areas like Muchucuxcah which has no resident vehicles and where a woman would have to be carried in

hammock for several hours before somewhat reliable transportation is encountered. Similar conditions obtain for the hamlets of Xanlah and Xbojom.

In summary it is worth noting that Day-II, possibly in response to the consultant's conference with Enfs. Silvia German and Conchita Cerveres on the preceding day, avoided many of the problems of the first day. Nothing was taught that was not directly relevant to improvement of midwifery skills; the midwives were involved in practicing skills rather than talking about them, which, in turn, led to animated discussions with general participation. Several of the midwives remarked that they were pleased and relieved that the instructional staff saw the benefits of turning the baby and of cauterizing the umbilical cord rather than outright condemning these traditional practices.

### C. Evaluation of Training Sessions

#### 1. Positive Aspects

Given the very real dedication of the medical staff on the one hand, and the equally real interest of the midwives in improving their skills on the other, there are several ways in which the training sessions work very well. In any re-organization, special attention should be paid to preserving these positive, well-functioning aspects.

Foremost among these is the recognition by the medical staff of the communication problems inherent in the fact that the majority of midwives speak Spanish deficiently, if at all. As a consequence, they almost always include in the training staff several Maya speakers who by and large do an excellent job of translating, explaining, giving instructions, eliciting information, and so on.

Secondly, there is a concerted effort by the staff to utilize audiovisual supports such as slides, film strips, rubber/latex models, plus a variety of locally available items, ingeniously adapted, such as the surgical gloves used for simulating the umbilical cord or the plastic bag for demonstrating effects of inappropriate pressure on the uterus. They recognize the great value of such materials in a culture where normal information acquisition takes place in the visual/demonstrative rather than the abstract/verbal mode. Increasing the use of audiovisual supports and manipulatable models should be encouraged and supported.

At this time, there is an increasing realization by the medical staff that teaching new practices has to be adapted to local conditions; that is to say, it has to be responsive to the pre-existing practices of the traditional system. For example, it is useless to advise the midwives to send a woman with a breech presentation to the physician, because the traditional system already contains an adequate solution to that problem: the external version. Failure to confront this practice where it exists will only lead to a general devaluation of the advice to seek medical help for problem conditions. The medical staff, under the leadership of Dr. Balam and Enf. German, have begun to elicit information on traditional practices. At this time, data collection is unsystematic and the content of training sessions is not yet particularly responsive to what has been learned. It is noteworthy that staff and administration are quite aware of the

importance of information about native practices. For example, Dr. Balam had asked for and received from Elmendorf and Villa Rojas their field notes on traditional medical practices and beliefs and had been keenly interested in the consultant's book on comparative obstetrics of which he was given a copy (Jordan, op. cit.). Yucatecan efforts to collect data on the indigenous system should be supported and assistance should be rendered for proper implementation of these efforts.

## 2. Discussion and Recommendations

(The following set of recommendations is specific for training courses for empirical midwives. A set of more general recommendations follows in the next section).

- a. Instructional Mode. Major portions of training courses consist of straight didactic material, brought across in mini-lecture (and sometimes maxi-lecture) format, following a kind of lesson plan where various staff members give presentations of thirty or sixty minutes duration. Any time one of these lectures begins, a series of significant behaviors is observable. As the lecturer launches into her or his spiel (e.g., the talk on the importance of cleanliness), the midwives shift into their "waiting it out posture": sitting silently, gaze far away, feet dangling, obviously tuned out. Many of them do not understand what is going on because they do not speak Spanish, but there isn't a great deal of difference between those that do and those that don't. Repeating the same lecture in Maya, which is sometimes done, doesn't produce any great changes in behavior. This kind of display stands in strong contrast to the animation and interest shown when the midwives are allowed to actually do something (like learning proper handwashing procedure through demonstration and practice).

It is important to realize that for persons with little or no formal schooling the purely verbal mode of knowledge acquisition is problematic. In everyday life, in contrast to formal education, skills are acquired by watching and imitating, with talk playing a facilitating rather than a central role. Specifically, midwives in the traditional system are accustomed to learning experientially. They are "parteras empiricas", that is to say, they have acquired their skills by paying close attention to their own birthing experiences, by "going around" with an experienced midwife, and by carefully monitoring the course and outcome of those births that they attend themselves. Talk in such situations is always closely tied to, and supportive of, action. In the traditional system to know something is to know how to do it, and only derivatively to know how to talk about it. Talk is never primary.

Given this situation, there is a real question about the transferability of knowledge acquired in the verbal mode to real-life

situations where it is likely to get washed out by previously acquired behavioral routines. There is some evidence that information learned in the verbal mode is used again in the verbal mode, in talk, and is unlikely to be translated into other behavior. What is generated, then, is a new way of talking, rather than a new way of doing. For example, one midwife (not from this group) began to refer to the uterus as the "prolapso" after she had attended a training course. It is likely that this term came from a discussion of "prolapsed uterus", but it is noteworthy that the midwife had not acquired any way of dealing with this complication. What the course had provided for her was simply a fancier and more prestigious way of talking. Every effort should be made to make sure that the training courses do not serve to provide the semblance of medical legitimization through the bits and pieces of exotic medical practice and terminology which midwives pick up without concomitant change in behavior. Clearly, the new knowledge needs to be incorporated in a behavioral repertoire; it must be behaviorally (not verbally) fixed.

It is recommended, then, that the didactic method be abandoned or at least severely curtailed; that no important point be made through abstract verbal talk alone; that the actual skill be taught experientially: by doing, by watching, and by imitating an actual performance (if possible with a real case, if not with the help of a model) in order to ensure incorporation of the new skill into the midwives' behavioral repertoire.

- b. Course Content. The course content follows the standard sequence of instruction appropriate and customary for medical curricula. It begins with ovulation, conception and implantation, treats extensively the development of the embryo and the fetus throughout the 9 months, and finally ends up with labor, delivery, and the postpartum period. The early parts of this sequence present two problems: 1) they are difficult to understand and, by virtue of the nature of the material, can be explained only through slides. The comprehensibility of this information must be exceedingly low, since the midwives have no understanding of the size proportions. They see, for example, an inch-long spermatozoon on the screen making its way towards the ovum, and since that has obviously no relationship to the "liquido" which they know to be involved in intercourse, they watch it with the same sort of interest as the exploits of Superman which they are also accustomed to seeing on the screen; 2) and more importantly, the early part of the sequence has no relationship to the tasks which midwives perform. Midwives are concerned with mother and child during pregnancy, birth, and the postpartum period. Knowing about the intricacies of ovulation and the hazards of the sperms' travel through the Fallopian tubes, etc. is not information which

contributes to their skills. (It is true that traditionally midwives have also dealt with problems of infertility and unwanted pregnancy. However, their methods, which are primarily herbal and manipulative, are not improvable by this information. A detailed explanation of the menstrual cycle would be useful in counteracting the widespread notion that the most fertile time is immediately before and after menstruation, because at that time "the uterus is open". But this is probably best left for the family planning course for midwives; at any rate, in the course described here, no such application of the information presented was attempted).

It is recommended, then, that the early parts of the instructional sequence be reviewed for relevance to midwives' skill performance. This probably means eliminating much of ovulation, conception, and embryology, and instead focusing on uterine and birth canal anatomy, and particularly the process and mechanics of labor with special attention paid to indications of abnormal developments to the extent that they are diagnosable by the midwives. For example, normal embryonic development should be taught with a view to recognizing the symptoms of extra-uterine pregnancy; normal presentation should be taught with a view to recognizing malpresentation and what to do about it, etc.

c. Responsiveness to Local Constraints.

1. Communication Network. The standard recommendation to midwives for any kind of problem, be it acute or potential, mild or life-threatening, is that they seek medical help and/or channel the woman to the hospital. This may be reasonable advice to midwives who practice in close proximity to a hospital or other medical resources. (Actually, it is not clear whether the proliferation of this recommendation has not led to widespread disregarding of it. Midwives and women express the opinion that "they want us to go to the hospital for every little thing".) In many cases, however, not seeking medical advice has less to do with ignorance or a negative attitude towards the medical establishment but rather with the simple physical impossibility of getting there. A fair proportion of traditional midwives in Yucatan practice in localities where transporting a woman to the hospital would require hours of foot travel over jungle paths, clearly not feasible once labor has started or when an emergency arises.

Of the midwives who participated in this particular training course, the group from Muchucuxcah is the one practicing in the most remote area. They stated that to get a woman to medical help would normally require carrying her in a hammock for four or five hours. It is of interest that it is precisely this group who proudly reported their expertise in emergency measures, such as manual removal of the placenta, or dealing with a prolapsed arm. (They do this by laying the woman back in her

hammock, head hanging over the posterior edge, pushing the baby's arm back in with an oiled hand, and then doing an external version. This is obviously a traumatic procedure with a range of risks from postpartum infection to uterine rupture and severe damage to the child. At the same time, it is also clear that a woman in such a condition is not likely to survive a trip to the hospital, nor will she survive if nobody does anything). The best strategy would be to discuss with midwives practicing in remote areas ways of making such emergency procedures as safe as humanly possible. The same is true for such problems as postpartum bleeding or babies in need of resuscitation.

It is recommended, then, that an analysis be made, in collaboration with the midwives, of the local communication system and the ways in which it constrains or facilitates access to medical care. Specifically, the following questions need to be answered:

- 1) What medical facilities are available in the area and, importantly, what is their reliability. This analysis should include not only the official health care delivery system but also herbalists, curers, bone-setters, shamans, and the like.

The reliability question is crucial because a pasante (intern) manning an outlying clinic might be away on business or pleasure just when his help is required. The same applies to private physicians. The most reliable facility, of course, is the hospital where there is always somebody on duty.

For those midwives who practice sufficiently close to the hospital so that emergency referral constitutes a viable option, part of the training course should be devoted to familiarizing them with the hospital and hospital procedures. Again, this should be done behaviorally, e.g., going through a simulated patient admission and, ideally, having them attend a hospital delivery. Midwives' rights, obligations, and expectations, as well as those of the medical staff are best discussed in the actual situation, i.e., while they are in the hospital.

- 2) The second question to which training courses must be responsive is: What are the local communication facilities which would allow summoning medical help. This would include investigating possible messenger service, on foot, on horseback or on bicycle; noting the closest telephone, and the like. The Valladolid hospital has an emergency vehicle that could be dispatched if summoned; INI has four-wheel drive vehicles which could be used for getting medical help to the location where it is needed. There is a new short-wave radio in Chan Kom.
- 3) The third question which training courses should take into account is: What are the local transportation facilities by which a woman

could be moved to hospital or clinic. This should include the investigation of porters, horsecarts, closest four-wheel drive vehicle, potentially available private cars, taxis and other public transportation.

If the outcome of this analysis warrants, it is also recommended that midwives who are clearly outside the range of reasonably close or reliable medical assistance be given special instruction in two areas: 1) emergency procedures - with special attention to those already contained in the indigenous system; and 2) particularly thorough instruction in the recognition of serious prenatal danger signs, while there is still time to get medical advice and assistance. Only the most common and most serious kinds of problems should be singled out, such as bleeding during pregnancy, which the traditional system does not consider particularly harmful. Conditions with which the traditional system can deal adequately, such as breech presentation, should not be included because of the danger of devaluating the recommendation to seek medical help.

In either case a joint systematic analysis of the local communication system will make medical practitioners more alert to the special problems some of these midwives face and will be helpful to the midwives in making them aware of the range of possibilities for assistance which is available to them.

2. Availability of Supplies. Typically in these training courses it is not made clear what, if anything, the midwives will receive in terms of supplies and instruments. One reason for this is that frequently the instructional staff themselves do not know whether they will have midwifery kits, scissors, clamps, brushes for hand-washing, etc. for distribution by the time the course ends. The normal instructional sequence assumes that all of these items are available, and a major proportion of course time is allocated to teaching proper management of the tools of the trade. As the midwives find out from others who have been lucky or, more relevantly, from the audio-visuals presented during the training course, that to properly attend a birth means to utilize scissors, clamps, suction bulb, etc., the gadgets become increasingly important to them, if not for their actual use, definitely as a visible and showable symbol for their expertise. Consequently, valuable time is wasted and considerable dissatisfaction is created when instruction involves instruments and supplies not available to the midwives. In the present course some of these problems were avoided because of Enf. Silvia German's immediate and practical response to the consultant's suggestions (see p. 7). It is nevertheless significant that for the closing picture of the training session the midwives were supplied with "midwifery kits" (actually crudely painted, already rusting metal boxes, which were not only hard to open, but also empty!) After the picture was taken, the boxes were returned to INI personnel.

It is recommended, then, that an availability analysis be made of all supplies and instruments whose use is discussed during the course. If not available, local substitutes should be identified and the proper use of the substitutes

should be taught in the course. It should never happen that the midwives are taught procedures which involve tools unavailable to them. As was demonstrated on day two of this course, it is possible to teach proper handwashing procedures with a wad of henequen fiber instead of a handbrush, an umbilical tie is as good as a metal clamp, and a one-time use razor blade is probably superior to an improperly sterilized pair of scissors. As long as the system cannot provide it, every effort should be made to avoid producing a deficient view of the work of the midwives by virtue of the fact that they do not have access to the medical tool kit. To teach them, explicitly or implicitly, that in order to do a proper delivery they should use resources unavailable to them, is worse than useless. It undermines their confidence that they can manage at all.

3. Information and Practices in the Traditional System. As has been mentioned before, the content of the training course follows the standard topic sequence of medical curricula. Instruction takes place, however, not in a vacuum, but against a background of prior information, attitudes and practices espoused by the midwives, namely those that make up the traditional system. As a consequence, some of the topics discussed in the course make sense to the midwives (those that correspond to the traditional system) and others don't (those noted above that the scientific view of ovulation and conception is mysterious to the midwives. On the other hand, the scientific system contains no equivalent, and, therefore, does not address, some of the concepts important in the traditional system. For example, the most important organ in Maya ethno-anatomy is the tipte. Native knowledge about the tipte powerfully influences not only attitudes towards contraception but also plays an important part in the traditional postpartum treatment of the mother. The tipte, whose functioning can be checked via the "thump, thump. . ." that can be felt if one presses a finger deep into the navel, is the "machine which makes the body work." According to the native system, the tipte is the origin of the four major blood vessels which go to the arms and legs and controls the proper functioning of all other body organs. During childbirth, the most important tasks of the traditional midwife to "fix" it (composer) during her last postpartum visit. If this is not done, the woman will suffer from headaches and loss of appetite, will become weak and thin, and will be impaired. Midwives know that doctors are ignorant of the tipte and will talk about it only after one has gained their confidence. Since the women who are their clients share this knowledge and concomitant expectations, it behooves the medical staff to be aware of it also.

In general, it is problematic to give instruction on any topic without previous assessment of native notions about that topic. In some cases the traditional practice may be harmless or actually superior to the medical practice. For example, in teaching about proper treatment of the umbilical stump, the beneficial traditional practice of sterilizing it by cauterization should be acknowledged.

In other cases the practices of the traditional system may benefit from modification. When talking about the pushing stage during birth, it would be extremely helpful for the instructional staff to know that women in the traditional system frequently push too early because of the notion that labor is "work". As a consequence, the women get exhausted long before pushing does any good, and this is part of the dynamic leading to demands for "injections of strength" (oxytocic injections) which, for example, the male midwife of Muchucuxcah specialized in. (In less remote places, private physicians are often called in to administer the oxytocin). This is a dangerous procedure for mother and child which can lead to a precipitous birth with injury to the infant and, in the extreme, can cause uterine rupture. Similarly, information about what, in the native system, is an appropriate time lapse between the birth of the infant and the birth of the placenta is important. It turns out that in some areas the placenta is expected within the span of five minutes or so, a notion that leads to dangerous and unnecessary attempts to remove the afterbirth manually.

It is recommended, therefore, that each skill or major concept taught in the training course be examined as to the correspondent practice or notion in the traditional system and that instruction be designed to specifically address areas of discrepancy. Information on traditional attitudes and practices are contained in the research reports of Elmendorf\* and Villa Rojas\*\*and in Jordan (1978)\*\*\* These should be made available in Spanish for the use of medical personnel. However, since there are important variations regionally and locally, midwives' notions about each instructional topic should be elicited during training courses before that topic is discussed in order to get access to locally specific problems.

\*Elmendorf, Mary. Changing Roles and Status of Maya Mothers and Daughters in Relation to Marriage and the Family in Yucatan. Paper presented at the Annual Meeting of the Society for Applied Anthropology, Philadelphia, Pa., March 14-17, 1979.

\*\*Villa Rojas, Alfonso. Terapeutica Indigena y Medicina Moderna entre Los Mayas de Hoy: El Proceso de Transicion en las Ultimas Decadas. Paper presented at the Annual Meeting of the Society for Applied Anthropology, Philadelphia, Pa., March 14-17, 1979.

\*\*\*op. cit.

#### IV. GENERAL RECOMMENDATIONS

(The following remarks are not specific to the midwifery training course in which the consultant participated as part of this assignment, but have to do with some of the larger issues involved in the training of traditional midwives and their relationship to the official health care delivery system. They are concerned with evaluation of the effects of existing training courses, suggestions for improvement of audiovisual supports, the question of what constitutes an appropriate conceptual model for birth in Yucatan, and, finally, a proposal to establish a School for Midwives in the area).

##### A. Evaluation of the Effects of Existing Training Courses

Beyond some casual observations and anecdotal accounts, little information exists at this point about the actual impact of training courses. Particularly crucial for improving the effectiveness of these courses is evaluation in two areas: 1) in regard to the linkage between the traditional and the official health care delivery systems; and 2) concerning the nature and extent of actual modification of traditional practices as a result of training courses. Specifically, it is recommended that data be collected to ascertain

1. changes in the extent to which trained midwives, as compared to untrained midwives, utilize the resources of the official system
  - a) for consultation with medical personnel
  - b) for channeling problematic cases to the hospital
  - c) as a source of supplies

For collecting this type of data a simple pretest/post test research design would probably be adequate.

2. In addition, data should be collected on the extent to which skills taught in training courses are actually utilized in practice; as argued earlier, the important question is the extent to which teachings are incorporated into the routine behavioral repertoire. Methodologically, simple interviewing would not be sufficient for providing this information. What is required is detailed observational records, most validly by a person who has the midwives' confidence and is allowed to accompany them on births and pre- and postnatal visits. Ideally, this would be a trained anthropologist who spends a fair amount of time living in the community.

##### B. Audiovisual Support

Given the visual and manipulative focus of the local culture, models, slides, films, and videotapes take on a crucial importance in the instructional program.

Strong emphasis should be placed on the acquisition of life-sized manipulatable rubber/latex models which would permit a three-dimensional view of the mechanics of labor and the passing of the fetus through the birth canal. Such models would be invaluable in that they allow midwives to manipulate and practice with the equivalent of an actual body in the process of labor. This would lead to a more thorough understanding of the reasons behind advocated procedures.

Course instructors and the responsible officials of SSA and INI are well aware of the importance of audiovisual aids. They face, however, two major problems:

First, good audiovisuals are in short supply. They are almost impossible to procure through official channels because of insurmountable red tape, inadequate financial resources, and most importantly, because some types are not produced by the national economy and must be imported.

It is recommended that a short-term solution to this problem be provided through the award of a grant to purchase such supplies from medical supply houses in the United States.

Second, the audiovisuals that are available for instruction in Yucatan do not properly depict the local conditions. For example, to show a filmstrip of the work of the midwife which has the woman giving birth in a bed does not contribute much to the skills of midwives whose clients deliver in a hammock or on a chair. Similarly, showing cord cutting with a pair of scissors is not useful where the most advanced feasible method is cutting with a razor blade, and so on.

It is recommended, therefore, that slide and filmstrip materials be reviewed as to their appropriateness and that, where necessary, new materials be developed which illustrate locally desirable and feasible procedures and instruments. This could be done fairly quickly and inexpensively by local personnel, who could accompany a cooperative midwife on births in the community and gain permission to take slides. The photographic collections of Jordan and Fuller on traditional birthing practices are also a possible resource.

A second major avenue for improving the quality and efficacy of audiovisual support would involve the production of moving pictures, most economically probably videotape. For midwives and the women in the community it would, for example, be extremely useful to be able to view a videotape of a hospital delivery. This would go far in dispelling the fear of the unknown in cases where actual observation of hospital births is not possible (as it probably will never be for community women).

Moving beyond childbirth, videotapes would also be extremely useful on such topics as vasectomy and tubal ligation, insertion of IUDs, and the like. In each case, these tapes should be locally produced, with expert outside advice; their major advantage would be that they would show local facilities and personnel, and Maya women and men as they undergo these procedures successfully. They would be sensitive to local fears and preoccupations and would be

designed to preclude the widespread notion that such things are all right for foreigners and Mexicans, but not for Mayans whose capacity to work might be compromised.

Dr. Mary Elmendorf had suggested the production of such tapes during earlier discussions with community women, SSA and INI personnel. These discussions were followed up by the consultant during the present assignment. Response to the idea remains enthusiastic and cooperation with such projects is assured. As a matter of fact, permission had been given by Dr. Raul Peniche, director of the regional hospital in Valladolid, to videotape a hospital birth and preliminary dry runs using the consultant's equipment were made. The project was not carried out because no suitable patient appeared in the time available.

The value of portable video equipment for the production of audiovisual materials tailored to local conditions has been widely recognized. For example, UNESCO has published a guide for the use of video in community development in developing countries.\* One question that would need to be resolved is the procurement of equipment for production and playback.

Finally, it should be noted that such equipment could be used not only for training midwives and for dispelling the fears of potential clients of the official health care delivery system, but also for sensitizing medical personnel to the practices of the traditional system. Though it may seem surprising, the vast majority of the medical and instructional staff have never seen a traditional birth as it takes place everyday in the rural communities of Yucatan. They are severely handicapped in their teaching vis-a-vis practices they know about only by hearsay, and for them to be able to appreciate the conditions under which midwives work and their clients give birth would contribute substantially to a closer mutual accommodation of the official and traditional obstetric care delivery systems.

#### C. A Conceptual Model for Birth

Medical personnel in Yucatan, as in most other places in the world, hold to the notion that birth is a medical event, appropriately managed by medical professionals with the resources of medical technology, surgery, and pharmacology. In the United States this notion is presently under attack, partially due to disappointing pregnancy outcome statistics, but also, at least in part, due to a strong consumer movement in the health care field and to changing notions about women's competencies engendered by the women's liberation movement. As a consequence, an increasing proportion of childbearing women in the U.S. are seeking out alternatives to the high-technology, surgery-prone standard hospital delivery which they see as dehumanizing. While the American system is in the process of incorporating family-centered perinatal care programs, natural

\*Atienza, Loretta; "VTR WORKSHOP: SMALL FORMAT VIDEO", UNESCO, Lausanne Switzerland 1977.

childbirth, home-like birthing rooms, and midwife-attended birth at home as well as in the hospital, policy makers in developing countries frequently still adhere to the uni-dimensional medical model of birth and attempt to institute it to whatever extent possible.

In Yucatan, official rhetoric occasionally advocates the ideal of delivering all women in hospital. This is impossible for two reasons. First, the system would be hopelessly overloaded if all women did decide to have their babies while hospitalized. Secondly, this is not likely to happen within the foreseeable future because in the local view birth is a normal life-cycle event that does not inherently require medical attention.

In spite of some of the rhetoric about delivering all women in hospital, traditional midwives and their services have been recognized as a valuable resource for health care delivery. Attempts to incorporate them into the official system have overwhelmingly taken the form of upgrading their practices in the direction of the medical model of birth, this being the only legitimate model from the point of view of medical personnel and change agents. From the point of view of midwives and their clients, the hospital-based obstetric care delivery system has its own deficiencies. It is in their view, "knife-happy", relying on surgery (particularly episiotomies and Caesarean sections) to an unreasonable extent; it separates a woman from her usual sources of support, particularly her husband and her mother; it pays no attention to preserving the woman's modesty (*vergüenza*) by exposing her private parts to male inspection and manipulation; and so on. As a consequence, the medical and the traditional system operate side-by-side, with the medical system largely unaware of the details of practice within the traditional system, while the traditional system is in the process of absorbing some medical terminology, tools, and practices. Some of these (e.g., oxytocin injections during labor) become incorporated not because they have been shown to be superior to their traditional equivalents, but largely because of the high prestige value of modern medicine.

The most important issue, then, and the one whose management is likely to have sizeable impact on maternal and child health, is the issue of mutual accommodation of the traditional and the modern medical systems. At this point the accommodation is unilateral. It is done by and to the traditional system. For a true accommodation some thought has to be given to possible changes in the official hospital-based obstetric care delivery system so that the best features of both systems may be preserved.

In this context, the question arises whether pushing for an increase in the medicalization of birth is in the best interest of mothers and children. In Yucatan, as in other areas with strong traditional family-oriented birthing systems, the medical model may be particularly inappropriate, given not only its lack of fit with traditional notions about birth, but also in view of the scarcity of medical resources which invariably leads to operational difficulties. A more appropriate blueprint might be the Dutch system of obstetric care delivery, not only because Holland has pregnancy outcome statistics which are vastly superior to those of the United States, but also because the Dutch system sees birth as a natural physiological event and relies extensively on home birth and midwives. Obviously, Holland and Yucatan are not comparable in a number of

respects, but neither are the United States and Yucatan; and the Dutch philosophy may be more in harmony with Yucatan realities than the American pathological view of birth.

It is recommended, therefore, that a distinction be drawn between abnormal, complicational deliveries on the one hand, and normal, "uneventful" births on the other. Medical resources should be reserved for the first category. For the second, which are most efficiently and beneficially handled as midwife-attended homebirths, the medical pathological model of birth should be abandoned. It is clear that this recommendation has far-reaching practical implications. It is also clear that it may run counter to national development policy. One mechanism for effecting the proposed switch is outlined in the next section.

#### D. A School for Midwives

During earlier talks with Dr. Antonio Garcia, head of the coordinated services of the Ministry of Health for the peninsula, and Dr. Gilberto Balam, head of the National Indian Institute for the area, Dr. Mary Elmendorf had proposed establishing a Yucatecan School for Midwives, possibly along the Dutch model. The Yucatecans showed great interest in the idea and the consultant has offered to act as liaison with the director of the School for Midwives in Amsterdam, Dr. Jeanette Klomp. Dr. Klomp is an internationally known obstetrician who has championed the idea of birth as a natural event managed by competent, practically trained midwives. The National Indian Institute already runs a series of training schools for indigenous people, for example, schools of carpentry, bee-keeping, and the like. It would be the logical agency under which a School for Midwives could be housed.

This is not the place for a detailed analysis of this proposal. Nevertheless, some thoughts and suggestions may be appropriate.

1. A Yucatecan School for Midwives could and should be a model for the training of traditional midwives and for maternal child health care delivery in other indigenous areas, both in Latin America and other areas of the world where a strong traditional system exists.
2. Such a school would give the midwives a territory of their own and could be instrumental in developing the manpower, attitudes, skills, and organization supportive of the physiologic management of normal birth.
3. Instruction could be designed to interface with the traditional birthing system and to take into account the kinds of local constraints discussed earlier (see pp.12 FF).
4. Training could take place under simulated home conditions, i.e., in native huts erected on the premises where women from the surrounding area could give birth assisted by husband and mother.

5. Simulated home conditions would also raise all the practical problems of perinatal management which normally do not come up when instruction is located in health center or hospital lecture rooms. Such problems as the presence of chickens, pigs, and dogs, or the difficulties of sterilizing tools when "boiling" water is carried in from an open fire in the nearby cooking hut, would become obvious and force consideration of practical solutions.
6. The School would be the reasonable agency to develop courses of instruction of varying length and content specifically designed for the particular needs of the client population (e.g., special instruction in emergency procedures for midwives working in isolated areas with it).
7. The School would also be the most reasonable agency to evaluate the efficacy of various courses of instruction and should have a research branch associated with it.
8. The School should, in addition to its own evaluation activities, provide facilities for outside researchers with the expectation that they, in turn, provide feedback on their findings in order to increase the data base for improving maternal and child health in Yucatan.

It is clear that a proposal of this sort requires a great deal of ground-work before its feasibility can be assessed. Nevertheless, its potential benefits for the health of mothers and children and, by redirecting the allocation of scarce medical resources, to the health of the population as a whole, are substantial. It is recommended, therefore, that the possibility of establishing a Yucatecan School for Midwives be pursued.

**APPENDIX A**  
**LIST OF PERSONS CONTACTED**

LIST OF PERSONS CONTACTEDSecretaria de Salubridad y Asistencia (SSA), Merida

Dr. Oscar Echeverría	Director of Maternal/Child Health and Family Planning
Enf. Silvia German	Director of Nursing and Family Planning, State Supervisor of Nurses for the Thirteen Modules of Maternal/Child Health
Enf. Conchita Cerveres	Assistant to Silvia German
Enf. Lourdes Uc y Pasos	Nurse Coordinator of Module VII (Piste-Chan Kom)
*Dr. Antonio Garcia Canul	Director of Coordinated Services of the Ministry of Health

Other, Merida

Lic. Juan Ramon Bastarrachea	Yucatecan Anthropologist
Prof. Josefina Centeno	Tecnologico Regional de Merida
Ms. Joan Andrews	Scholar and Resource Person
Ms. Aline Callaghan	Research Assistant and Resource Person
Prof. Dieter Brunnschweiler	Director of Merida Exchange Program, Michigan State University
Prof. Georgeanna Huck	Director of Merida Exchange Program, Iowa Central College
Ms. Gail Howrigan	Ph.D. Candidate, Harvard University Researcher on Neonatal Behavior in Oxkutzcab, Yucatan

\*Dr. Garcia who is in charge of the tri-state peninsula region (states of Yucatan, Campeche, Quintana Roo) was not seen on this trip, but is keenly interested in applications of anthropological research and in the use of videotapes for communicating health education issues. He was kept informed of activities through Silvia German.

Instituto Nacional Indigenista (INI), Valladolid

Dr. Gilberto Balam	Director of INI and of Servicios Coordinados de Salud
Dr. Jorge Gonzalez	Director of Health Training
Dr. Ignacio Tuz	Director of Community Health Programs
Enf. Gloria Beatriz Soliz Rodriguez	INI Nurse

Regional Hospital, Valladolid

Dr. Raul Peniche	Director of Hospital
Dr. Bonni Bandala	Hospital Director of Community Health
Enf. Gilma Alzamirano	Instructor for Midwife Training Course

Other, Valladolid

Sra. Donaciana Torres	Midwife, Valladolid
Sr. Clemente Alcocer Rosado	Mayor of Valladolid

Other

Sr. Francisco Villa Nova	Coordinator of Health Center, Isla Mujeres
Sra. Anselma Rodriguez	Midwife, Yaxcabah

**APPENDIX B**

**LIST OF DOCUMENTS AND DATA RELATED TO ASSIGNMENT**

## LIST OF DOCUMENTS AND DATA RELATED TO ASSIGNMENT

1. Oficio #3/79, official letter of invitation from Dr. Gilberto Balam, Centro Coordinador Indigenista de la Region Maya, Valladolid, Yucatan, to participate in midwife training course on family planning. Attachment #1)
2. Oficio #5/79, official letter of invitation to participate in midwife training course on perinatal management. (Attachment #2)
3. English Translation of the Garcia Report with population statistics for Yucatan (from Mary Elmendorf).
4. Organizational chart of the Instituto Nacional Indigenista (INI) (from Marta Fernandez, SFAA meetings, Philadelphia).
5. Dibujo del Cuerpo de la Mujer (used by Silvia German to elicit knowledge about reproductive organs from traditional midwives).
6. Manual para Parteras Tradicionales, published by Secretaria de Salud y Asistencia, Mexico 1975 (from Silvia German).
7. Twenty-five slides of midwife training session in Chan Kom (taken by Silvia German and consultant).
8. Notes by consultant on Days-I and II of midwife training session in Chan Kom. Includes list of participating midwives.
9. Audiotapes Yuc(9)A-1 and Yuc(9)A-2 from midwife training session in Chan Kom. Rough transcript by Eugenie Wolfson.
10. Temario for midwife training session in Chan Kom (from Silvia German). Attachment #3).
11. Clipping from Diario de Yucatan, 3/23/79, reporting on training session. (Attachment #4).



CENTRO COORDINADOR INDIGENISTA  
DE LA REGION MAYA  
KM. 2 CARRETERA VALLADOLID-CARRILLO PUERTO  
VALLADOLID, YUC.

DIRECCION

OFICIO No. 3/79

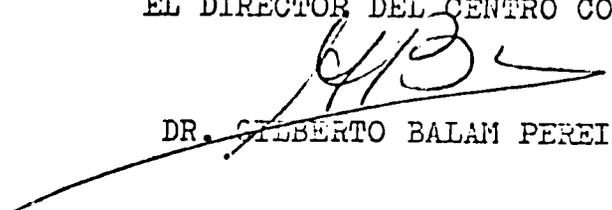
Valladolid, Yuc., a 19 de enero de 1979

ATTACHMENT #1

C. BRIGITTE JORDAN, Ph. D.  
Assistant Professor of  
Anthropology and Community Medicine  
Michigan State University  
East Lansing, Michigan 48824 U.S.A.

Durante su visita al condado de Chankom Yuc., pudimos observar su interés y gran experiencia sobre la capacitación de Parteras empíricas en México y diferentes Países, por lo que de la manera más atenta nos sería muy grato que pudiera asistir en calidad de invitada y colaboradora del próximo Curso para parteras empíricas que impartiremos conjuntamente con la S.S.A. en el mes de febrero del año en curso, por lo que le rogamos poner se en contacto con la Dra. Martha Fernández en el INI -- Av. Revolución 1,279 México 20, D. F. y con el Dr. Adalberto Cravioto Director de Servicios Coordinados de la S.S.A. Reforma Lieja de la misma C. de México.

A T E N T A M E N T E  
EL DIRECTOR DEL CENTRO COORD.

  
DR. ADALBERTO BALAM PEREIRA.

c.c.p. C. Dra. Martha Fernández, Jefa del Depto. de Mí-  
nimos de Bienestar Social, Av. Revolución 1,279-  
México 20, D. F.

c.c.p. Dr. Adalberto Cravioto.



**CENTRO COORDINADOR INDIGENISTA  
DE LA REGION MAYA**

KM. 2 CARRETERA VALLADOLID-CARRILLO PUERTO  
VALLADOLID, YUC.

DIRECCION  
OFICIO No. 5/79

Valladolid, Yuc., a 2 de febrero de 1979

ATTACHMENT #2

C. ANTROP.  
BRIGITTE JORDAN Ph. D.  
ASSISTANT PROFESSOR OF  
ANTHROPOLOGY AND COMMUNITY MEDICINE  
MICHIGAN STATE UNIVERSITY  
EAST LANSING, MICHIGAN 48824  
U. S. A.

Antetodo ruégole nos disculpe: por haber se cambiado la fecha del Curso actual para Parteras - empíricas de esta región el cual después de esta primera parte de una semana de duración, tendrá un 2o. - período de capacitación y evaluación de las mismas -- parteras provablemente en el mes de marzo.

Por el interés y la aceptación de su material audiovisual por las alumnas, así como por su interés y experiencia sobre ésta rogámosle de la manera más atenta aceptar nuestra invitación para que participe en la segunda parte del Curso, conjuntamente con la Sra. Antropóloga Mary Elmendorf.

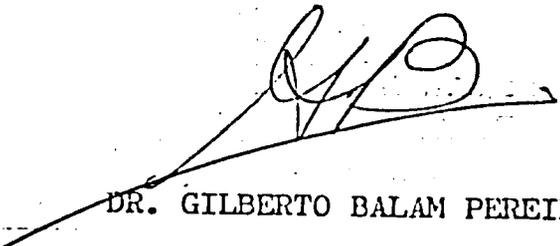


**CENTRO COORDINADOR INDIGENISTA  
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KM. 2 CARRETERA VALLADOLID-CARRILLO PUERTO  
VALLADOLID, YUC.

- 2 -

Le enviaremos oportunamente la fecha de reiniciación del curso.

A T E N T A M E N T E



DR. GILBERTO BALAM PEREIRA

- c.c.p. Antropóloga Mary Elmendorf.
- c.c.p. Dr. Adalberto Cravioto Director de Servicios -  
Coordinados de S.S.A. Reforma y Lieja México -  
D. F.
- c.c.p. Dr. Antonio Garcia Canul, Director de Servicios  
Coordinados en el Estado, Mérida Yuc.
- c.c.p. Dra. Martha Fernández, Jefa del Depto de Mínimos de Bienestar Social, Av. Revolución 1,279-  
México 20, D. F.

*Area de maternidad - Sifora*

SERVICIOS COORDINADOS DE SALUD PUBLICA EN EL ESTADO DE YUCATAN.  
PROGRAMA DE SALUD RURAL.  
JURISDICCION SANITARIA No. 2

1a. REUNION DE PARTERAS DE LA REGION DE CHANKOM.

ORGANIZACION DEL ADIESTRAMIENTO.

- I.- Duración 2 Días
- II.- Tot. Horas 10 horas
- III.- Horario 8:00 a 13:00
- IV.- Lugar donde se impartirá.- Consultorio Rural de Chankóm, Yuc.
- V.- Personal participante:-
 

Dr. Gilberto Ealam Pereira.- <i>Lf. Gloria B. Soliz Robt.</i>	Dr. Jorge González Castro Aux. Enf. Ma. Lourdes Uc y Pasos Aux. Enf. Teresa Vasquez L. Aux. de Salud Elsy Ma. Cise Uh.	Jefe de la Jurisdicción Médico del I.N.I. Resp. del Módulo de Pisté Instructora Jurisdiccional del P. Empíricas Aux. Salud de Chankóm.
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- VI.- Universo de Trabajo.- Parteras Empíricas: XEojon, Xanlah, Michucucab, Ticimul, ChanChichimilá, Chankóm (2)
- VII.- Evaluación.-
  - Se efectuará inicialmente mediante interrogatorio para conocer la forma en que las parteras Empíricas, realizan sus actividades y conocimientos relacionados con el embarazo, parto, puerperio y A.P. R.M. (atención al recién nacido)
  - Durante la reunión se evaluará la participación de las parteras y mediante interrogatorio y la realización de algunos proc. como: técnica de manejo de maletín, lavado de manos, aseo de la vulva en el módulo anatómico.
  - Al finalizar se evaluará mediante su participación en la discusión para análisis en la que las parteras empíricas indicaran los casos que deben de ser llevados a clínicas y hospital rurales, en la que las parteras que deben eliminarse por implicar riesgo para la mujer y su niño, posterior al adiestramiento, se efectuará una visita como mínimo c'tres meses para observar la aplicación de lo que se enseñó en la reunión, asimismo, se les reunirá c-3 meses por readiestramiento y aclaración de dudas.

*\* do should find out what methods of transportation they have available, i.e. cost, time necessary, etc. (communic. w. med. staff for advice?)  
 what kind of equipment they have. Give them definite idea of when they can get what from whom for how much.  
 need to eliminate temas + audiovisuales which are inappropriate - not available; i.e. stethoscope*

18 OBJETIVOS

- 1.- Detectar signos de riesgos durante <sup>embargo</sup> el parto y puerperio y referirlos oportunamente a los clínicas y Hospitales rurales.
- 2.- Establecer coordinación de las parteras empíricas con la auxiliar de salud, quien le <sup>proporcionará</sup> dotará de materiales necesarios p/mat. de partod.
- 3.- disminuir el riesgo a la promoción que atienden mediante la práctica de reglas mínimas de higiene en la atención del parto, principalmente lavado de manos., y utilización de material y equipo limpio.
- 4.- Modificar algunas prácticas del P.E. en relación con la atención del parto que ponen en peligro la salud de la madre y el producto .

- \* a) Versiones
- b) Uso de extlocica x
- c) ~~retos~~ ritos vaginales
- \* d) Corte del carbon después del alumbramiento.

5. modify some of the med. practices to make them more congruent w. the local system.

Empírico- describir- os organos cción de - hombre.	AUXILIAR DIDACTICO.	ACTIVIDAD DEL ALUMNO.	PERSONAL INSTRUCTOR	FECHA Y HORA.
		Laminas	Enf'Silvia G.	6=III-79 8:00 - 8:30
	Interrogatorio	Transparencias Laminas.		
forma sen produce- y los cam re el cuer er.	Exposición	Transparencias	Dr. Tuz	8:30 - 10:00
		Transparencias		
	Interrogatorio			

# Diario de Yucatán

MERIDA, YUCATAN, MEXICO, VIERNES 23 DE MARZO DE 1979

## El Diario en Valladolid

Concluye un curso de adiestramiento para parteras empíricas.— Concurso de declamación.— 12o. aniversario de A.A.

VALLADOLID, 22 de marzo.— El Instituto Nacional Indigenista clausuró un curso de adiestramiento a 9 parteras empíricas en Chankón en el que se abordaron los temas relacionados con el adecuado manejo de la mujer embarazada, antes, durante y después del parto.

Las pláticas tuvieron apoyo de material cinematográfico, audiovisual y anatómico y se proporcionaron maletines metálicos con equipo necesario para que las empíricas puedan desarrollar con eficiencia las actividades que aprendieron durante su adiestramiento. Se les asignaron como lugares de residencia las poblaciones de: X-bojon, Xanlah, Muchucucob, Kaua, Yokdzonot, Ticimul y Chankóm.

Impartieron los cursos por la Secretaría de Salubridad y Asistencia las enfermeras Silvia Gorman, Teresa Vázquez, Irma Altamirano y María Lourdes Uc Pasos y por el INI los Dres. Jorge González Castro e Ignacio Tuz May y la enfermera Gloria Solís Rodríguez y, como invitada, Brigitte Jordan, catedrática de la Universidad de Michigan.