Traditional Midwives & HIV/AIDS Prevention In Guatemala: Promoting New Approaches To Reproductive Health

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Public health programs in Latin America are seeking to enhance the role of traditional midwives by encouraging their participation in reproductive health, with a special focus on birth and delivery. In Guatemala, given the potential coverage of the underserved indigenous population, participation of traditional midwives has been piloted to help improve the coverage and quality of services offered to these populations to reduce maternal mortality and improve pre- and post-natal care. Nevertheless, little emphasis is placed on the role of traditional midwives in the prevention and early diagnosis of HIV/AIDS. This is quite surprising considering the fact that the number of people affected by HIV/AIDS in Guatemala has increased in the last few years. The main objective of this study is to analyze the role of traditional midwives and the challenges to the utilization of traditional medical resources such as the traditional midwives within the national health system in relation to HIV/AIDS diagnosis and prevention.

Traditional midwives have been involved in delivering babies and providing a broad range of other services for reproductive health for hundreds of years (World Health Organization, 2008). In many Latin American countries, including Guatemala, traditional midwives continue to deliver the majority of babies, especially in rural areas and represent for the local women the only option to meet their reproductive and sexual healthcare needs (Davis-Floyd, 2003; Goldman & Glei, 2003; Foster et al., 2004; Cosminsky, 2001; Bailey et al., 2005; Torres & De Vries, 2009; Walsh & Downe, 2004). Traditional midwives are not only responsible for assisting with birth, but also for providing spiritual guidance to mothers and families. Due to their role within communities,

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traditional midwives can play an important role in the prevention of HIV/AIDS, especially among women.

Guatemala accounts for nearly one-sixth of Central America’s HIV-infected population. HIV/AIDS epidemic is growing quickly and the probability of a major epidemic occurring in the near future is considered high (Ministry of Public Health and Social Welfare, 2006). There is also a concern over the progressive feminization of the HIV epidemic, considering that there are two men infected for every woman infected.

By addressing the possible interaction between the hands-on knowledge of traditional midwives and the biomedical system in Guatemala, this article examines the midwifery beliefs and practices surrounding the prevention and early diagnosis of HIV/AIDS and other sexually transmitted diseases (STDs). Particular attention will be paid to the role played by traditional midwives (comadronas) who have been trained by Centro de Educación y Recuperación Nutricional Emanuel (CERNE), a local non-governmental organization (NGO) that has been working extensively in the domain of indigenous health care in urban areas. The research questions explored in this study are as follows:

1) What is the role of traditional midwives (comadronas) in the prevention and detection of HIV/AIDS and other STDs among local indigenous populations?
2) What have been the challenges in doing so?
3) What initiatives can be promoted both by the health services or non-governmental organizations in order to promote more inclusive forms of community health prevention in the domain of HIV/AIDS and STDs?

COMMUNITY-BASED PROGRAMS, REPRODUCTIVE HEALTH & HIV/AIDS

In the last few years, there has been growing interest in alternative approaches, generated in part by the success of HIV/AIDS interventions addressed to entire communities (Alam et al., 2001; Busza and Baker, 2004; Choko et al., 2001; Dunbar et al., 2010). Community participation in prevention planning and intervention research is a growing trend in public health and there is an increasing body of literature on HIV/AIDS that illustrates how reproductive health and sexual behavior cannot be understood without a close analysis of the social context in which it occurs (Glasier et al., 2006; Miller et al., 2003; Odek et al., 2009). This interest in community-based approaches for HIV/AIDS prevention also reflects a number of additional concerns such as the demand for more
cost-effective and culturally sensitive intervention approaches (Kelly et al., 2006; Sherer et al., 2004).

In addition, community participation in HIV/AIDS prevention planning and research can help empower individuals as well as communities (Rifkin, 2009; Laverack & Wallerstein, 2001). The perceived advantages of enhancing community participation in HIV/AIDS prevention include greater buy-in from community leaders, better penetration of communities with more acceptable and culturally relevant messages, and greater sustainability of the intervention activities and effects (Stokols et al., 2003; Wei et al., 2001; Livet and Wandersman, 2005; Sherman et al., 2006).

A community approach to primary health care and prevention aims at producing specific health outcomes, as well as at expanding the community's “capacity” or “skills” (Feinberg et al., 2002) to tackle the most important health issues within the community. In the case of HIV/AIDS, the ability to adapt interventions to changing local conditions and to apply relevant skills and resources to other community health issues are all considered to be relevant.

Various process models for organizing communities are described in the literature (Dohn et al., 2004; Chinman et al., 2004; Ahmed et al., 2006) and they include varying levels of community participation in assessment, intervention planning, implementation, evaluation, and dissemination of findings (De La Cruz et al., 2009; Frith, 2007). The experience that will be analyzed in the study concerns the involvement of traditional midwives (comadronas) in HIV/AIDS testing and prevention in Guatemala. The role of the comadronas in this community-program is to motivate women, especially those who were pregnant, and possibly their husbands to check their HIV status. Another task of traditional midwives is to sensitize local communities to the possible consequences of risky behaviors in regards to HIV/AIDS and other sexually transmitted diseases, thus contributing to the prevention of these diseases. The traditional midwives also support women to adopt safer infant feeding practices and promote and support family planning.

**HIV/AIDS in Guatemala**

The HIV/AIDS epidemic is rapidly growing in Guatemala (Ministry of Public Health and Social Welfare, 2006), with a high prevalence of HIV in groups such as migrant workers (Proyecto Accion SIDA 2003). The countrywide distribution of HIV and AIDS shows the epidemic to be concentrated in the areas of greater economic development. The province's main city, Chimaltenango, is close to a major trade route that is frequented by truck drivers. This could have implications for HIV transmission as truck drivers are frequently away from home and may frequent sex workers. Other factors increasing
vulnerability to HIV/AIDS and other sexually transmitted infections (STIs) include violence, poverty, illiteracy, and social mobility (Proyecto Accion SIDA, 2003).

There are major challenges in extending both prevention and care coverage outside the capital and other main cities. Furthermore, discrimination against poor people remains a significant barrier to a more effective response to AIDS in Guatemala (UNAIDS, 2008).

The importance of traditional midwives in Guatemala for reproductive health

Among indigenous communities across Guatemala, traditional midwives\(^2\) (comadronas) constitute the majority of medical personnel. It is estimated that in indigenous communities in the highlands of Guatemala, 72 percent of births occur at home and are attended by a comadrona. For Mayan communities, this number is believed to be more than between 80\% and 90\% (Baer and Davis-Floyd, 2005). There are many contributing factors as to why women do not seek professional medical care during childbirth. Both individuals and texts cite some of these reasons as fear of doctors and hospitals, lack of transportation, denial of permission from the husband or family, language barriers, and embarrassment (Bailey et al., 2002). Compounding these factors, hospitals in Guatemala only have the capacity to provide services for 20 percent of the women giving birth (Bailey et al., 2005).

\(^2\) A point of clarification is necessary here regarding the nuances in the language of midwifery: the Guatemalan midwives that exist today are categorized in official WHO discourse as traditional birth attendants, or TBAs (WHO 1992). The acronym TBA is a category that the professional midwives of MFM have declined to adopt, because they understand it as a term to de facto diminish the role and significance of these indigenous practitioners. Additionally, the Guatemalan practitioners self-identify as midwives (comadronas in Spanish). The word *midwife* in old English means “with woman”, referring to the way women have accompanied women through childbirth. In this chapter, we refer to the indigenous Guatemalan practitioners who attend births as traditional midwives, or TMs, to distinguish them from the professional midwives, who have had formal education in western biomedical science and licensure in their respective countries either as certified nurse-midwives or certified professional midwives, categorized by WHO as skilled birth attendants (WHO 1999).
CERNE is an NGO based in San Miguel Pochuta in the Chimaltenango region that works in the domain of community health and development. The initiative of training traditional midwives for the prevention of HIV/AIDS and other STDs is part of a community-based program, which aims to increase the involvement of community members in aspects of their health that are of particular urgency. This program aims to establish links between the community and health services at the NGO and to provide health education to encourage increased testing for HIV/AIDS, enhance the accessibility to antiretrovirals and preventing mother to child transmission (PMTCT) of HIV/AIDS. Other objectives of this program have been to sensitize communities with the help of traditional midwives about HIV/AIDS by sharing information on HIV/AIDS prevention, Prevention of mother-to-child transmission (PMTCT), and the importance of HIV testing for the pregnant women and their partners. CERNE also works in partnership with a health clinic in Guatemala City, which provides free antiretrovirals to patients that are infected with HIV/AIDS. Patients affected by HIV/AIDS, and in particular women, are identified with the help of traditional midwives and are sent to the clinic for a blood test and subsequently prescribed antiretrovirals.

The fieldwork for this study was conducted in Guatemala between April and May of 2011 in San José Poaquil and San Miguel Pochuta in the Chimaltenango region. Data were collected through semi-structured and open-ended interviews, home visits, and observation in homes and at the training center of CERNE and Asociación de Servicios Comunitarios de Salud (ASECSA). Fifteen were conducted with traditional midwives (comadronas), four with nurses, and two with doctors working or collaborating with CERNE. CERNE was approached and its director introduced the researcher to traditional midwives and some patients to interview, using snowball/cascade sampling. The traditional midwives interviewed were those who had been collaborating with CERNE and who had taken part in the training sessions organized by these organizations. They were selected on the basis of parameters such as age, years of experience in traditional midwifery, and the reputation they had acquired within the community. The comadronas interviewed were aged between 43 to 78 years and all belonged to the indigenous community. The midwives interviewed had an average age of 58 years and their level of education was generally primary education. Most interviewees were experienced midwives with thirty-five to forty years of practice experience.

All the interviews (45 minutes to one hour each) were carried out in Spanish. After the subjects consented, the interviews were tape-
recorded and subsequently translated in English. Interviews data was tape recorded, and notes also were taken during each interview. Data was transcribed and translated from Spanish to English. Analysis was done by coding the information in categories based on topical questions and then compared to identify associations, patterns and themes.

An open-ended coding scheme based on dimensions observed when reading the interviews was developed to analyse the data. Information was then categorized according to underlying concepts. Initial codes were revised to check for repetitions and to reformulate codes rarely used. The categorized information was classified into five types of codes such as knowledge and misconceptions about HIV/AIDS, condom use and distribution, HIV and counselling local communities, HIV testing and disclosure, and main challenges in working in the program. Data have been summarized thematically and with illustrative quotes to capture the range of perspectives represented in the interviews.

In order to assure the privacy of the interviewees, the names have been omitted or changed. At the beginning of the interview, respondents were told of their rights to withdraw at any point and not answer questions, as well as reiterating assurances of confidentiality. Additional checks were made to ensure anonymity by not recording any real names or identifiers but instead ask the respondent to choose a pseudonym to be used in the writing up and dissemination process.

RESULTS

Knowledge & Misconceptions About HIV/AIDS of the Traditional Midwives

The evidence of different degrees of knowledge between the different categories of comadromas was shown in this study. Higher knowledge levels and a more positive attitude were reported for those midwives who had attended a formal HIV education program organized by the local NGO or by the local hospital. Those midwives who reported having adequate access to resources for obtaining current HIV information also had higher knowledge scores. Midwives who had been trained showed great enthusiasm for increasing their ability to provide higher quality care to their patients who were living with HIV. Nearly all of the participants reported interest in HIV discussion groups and training programs. All interviewees except two comadromas requested more training on recognizing HIV/AIDS symptoms and treatment.

The majority of traditional midwives who did not attend a training course with CERNE due to lack of funds or for geographic distance from the center reported inadequate access to resources for current HIV information.
Misconceptions concerning transmission existed among the group of traditional midwives who did not attend the training on HIV/AIDS: three comadronas who did not attend the training course organized by the local NGO believed insects such as mosquitoes could transmit HIV; three believed that HIV could be transmitted thought coughing or sneezing. Fear of treating an HIV-infected patient, especially during delivery, was highlighted by some traditional midwives. This aspect is delicate, as it could have a possible negative impact on patient care by reducing the willingness of traditional midwives to assist HIV/AIDS patients during the delivery. Nevertheless, traditional midwives showed in general great enthusiasm for increasing their ability to provide higher quality care to women who were living with HIV/AIDS. Nearly all of the research participants reported interest in HIV/AIDS discussion groups and in-service programs.

Condom Use & Distribution

Although the comadronas interviewed were conscious of the importance of increasing the awareness of risky behaviors regarding HIV/AIDS, some of them adamantly declared to be against its use, except in some cases:

_I can understand a married couple where the husband or the wife is infected with HIV use condoms but as a matter of principle I am against condoms because I think that they encourage people, especially the young ones, to be promiscuous._

Traditional midwives, especially those who were older (fifty-five years or older) declared that they were not feeling very comfortable taking about condom use, especially with men. A traditional midwife declared: “It’s not easy to talk to men freely about condoms and explain them how to use them... this is quite embarrassing.”

Traditional midwives were also aware of the fact that women have a very low capacity to decide whether to use condom and any other forms of contraceptive and some of them affirmed that convincing women to use condoms was not enough if men were not sensitized as well. In Guatemala, the power of women to negotiate the use of condoms within the couple, is very low. Among the most cited reasons for not using condoms, the women interviewed identified accusations of infidelity, associations with promiscuity, unnaturalness, and decreased sensation.

Thus, there is the need to educate both men and women regarding the risks of HIV/AIDS and other STDs and explain the use of condoms, even in married couples. In Guatemala, most women live in a context of profound gender inequality, with associated social and economic
dependency (Ministry of Public Health and Social Welfare, 2006). The prevailing patriarchal ideology opposes women’s autonomy in the expression of their sexuality and their health in general (Rodrıguez, 2000). As a consequence of this difficulty in addressing the topic of use of condoms in couples only six comadronas, and namely the younger ones, distributed condoms to women. These comadronas affirmed that they already had the chance to discuss this contraception and HIV/AIDS issues with the couple and that they agreed in using it. The majority of these traditional midwives (five out of six) distributed condoms to couples where the husband was already diagnosed with HIV/AIDS and where the risks of unprotected sex were thus much higher than in other cases.

**TRADITIONAL MIDWIVES, HIV/AIDS & COUNSELLING LOCAL COMMUNITIES**

**Higher capacity of traditional midwives to reach local women**

Almost all traditional midwives (i.e., twelve) declared that they approached their patients on several occasions (especially for post-natal visits) to provide them with HIV/AIDS education. They discussed sexual practices and their risks with women and on certain occasions with men. They also sensitized women about the risk of transmission between mother and child.

Culturally dictated behaviors and culturally shared beliefs, such as the concept of women’s modesty, imply that a woman does not typically talk openly about aspects linked to her sexuality. This can hinder timely diagnosis and cure of sexually transmitted diseases and other gynecological problems among this group of women (Holroyd et al., 2001).

Another important aspect that facilitates the sharing of information between local indigenous women and traditional midwives is represented by the fact that they speak the same language, i.e. Cakchiquel. As previous studies have emphasized (Smylie et al., 2004; Dodgson and Struthers, 2005; Kim-Godwin, 2003), improving the communication skills of biomedical health providers in the Cakchiquel language is very important in order to build a relationship of trust. Foster (2006) notes that, “cultural and language differences can lead to miscommunication, misdiagnoses and inappropriate treatments” (p. 28). As previous studies also emphasized (Smylie et al., 2004; Dodgson and Struthers, 2005; Kim-Godwin, 2003), improving the communication skills of biomedical health providers in the local indigenous languages is very important in order to build a relationship of trust.
However, one third of comadronas, in particular the older ones, found such discussions especially with young men in their 20s or 30s, quite difficult at times. A middle-aged comadrona affirmed:

*Every time I visit a woman after the delivery I talk about contraceptive methods and condoms ... on this occasion I also address the issue of HIV/AIDS and I explain to her the importance of reducing the risk. I always try to involve their husbands, if they are present ... this is not always easy, especially if they are young ... some of them become quite aggressive and ridicule me. They tell me: “What do you know about these things? Have you ever used them in your life?”*

**Higher capacity of traditional midwives to reach older & middle-aged people**

In addition, data from this study show that traditional midwives had a higher capacity, if compared to biomedical staff, to communicate with older or middle-aged people. Lack of trust towards biomedicine and a general reticence to discuss about sexual life with “strangers” represented the main factors that made middle-aged or older people a category that was not easily reachable. A doctor affirmed:

*The older people in this community are difficult to talk to. They are generally very reticent to discuss about their sexual life with us and they see it as a form of disrespect and invasion of their intimacy.*

**DISCUSSION**

The themes identified in this study are consistent with the issues presented in the literature. In particular, communication between traditional midwives and middle-aged and older people is important. Although HIV/AIDS continues to be perceived as a disease of young people, studies highlighted how a significant increase in transmission of HIV/AIDS among persons of fifty years of age and older often occurs (Linsk, 2000).

Comadronas, on the other hand, declared that they are generally able to approach middle-aged and older people more easily as they were perceived to be members of the community. For older traditional midwives, familiarity with local women since several generations and capacity to effectively communicate in the same language and understand cultural values and beliefs represented important factors that facilitated the communication between comadronas and the other members of the community. Because of their relative lack of specific
training, Western doctors may be slow to appreciate the nuances of various communication skills, cultural beliefs, and diversity of indigenous culture.

**Existing Challenges**

Despite the positive aspects of the involvement of comadronas in HIV/AIDS prevention and early diagnosis in terms of reaching community members, challenges still persist.

**Use of condoms and reduction of risky behaviors: Some cultural and economic factors**

When analyzing the issue of HIV/AIDS and the role of traditional midwives, it is important to keep in mind that cultural and economic factors affect sexual behavior and increase the risk of contracting HIV/AIDS and other STDs for certain groups of people, in particular women in terms of their social vulnerability. These factors should be challenged through education and larger socio-economic programs to improve the social status and livelihoods of women. It is important to identify longer-range objectives in terms of policy making that might include changing gender-role stereotypes through media and school-based education, decreasing female poverty through job training and education.

A comadrona affirmed: “Change is difficult because of cultural norms which view men’s promiscuity as normal. We need to tackle these things and design specific health education… men got drunk and then rape their wives. They think that this is ok. They have multiple partners after they got married and this is considered to be ok too… it is considered to be a way to express their masculinity… if these mentality will not change, it is difficult to reduce the pandemic of HIV/AIDS.”

Dominant constructions of femininity put women’s health at risk and pose an obstacle to acquiring accurate knowledge about sexual and reproductive health (Pan American Health Organization, 2002). Moreover, economic, cultural, and social factors exacerbate women’s vulnerability. Studies have shown how women with low incomes have less access to HIV-related information (Parker & Aggleton, 2003; Piot, 2001).

Literature on gender roles in Latin America presents a picture of a male dominance in sexual decision-making and negotiation that hinders women’s ability for self-protection (Gonzalez-Lopez, 2003). At issue here is that the public health response assumes that progress in reducing the incidence and impact of sexual health problems depends on women’s success in negotiating safe sex with their partners, and places the emphasis on strengthening behavioral capacity of women at the individual level. It is not difficult to see that an unintended repercussion
of the exclusion of male partners from health education and health promotion research and intervention projects is the establishment of yet another layer of social support to sustain the cultural constructions that guide women to assume not only the primary responsibility for sexual health protection, but also the burden of negative consequences.

Women often experience difficulty in negotiating condom use since their cultural and economic dependence on men reduces their ability to challenge their partner. Raising the cultural and economic position of women may improve their ability to negotiate safer sex, even within their marriage. In addition, a major limitation of family planning programs for HIV prevention and treatment is their continuing narrow focus on married women (Askew & Berer, 2003). Hence, family planning programs need to raise awareness of STD/HIV risk among married women.

**Comadronas & biomedical doctors: not always an easy collaboration**

The training programs which aim to reinforce the collaboration between traditional midwifery practices and biomedical medicine have often been object of criticisms (Bailey et al., 2002; Cosminsky, 2001; Goldman and Glei, 2003). Houston (2000) argues that the training program failed to take account of the cultural aspects of the traditional midwives’ knowledge and practices, to create good working relations, or to learn how traditional midwives operate as a basis for developing training material. A traditional midwife declared: “Western doctors and nurses do not trust midwives as we don’t have formal education... they think that we are not as qualified and prepared as they are... I feel intimidated by doctors.”

Mistrust and lack of understanding of each other's roles must be overcome before co-operative working can be established and these could be reduced by running joint training programs. Shadowing (accompanying a colleague during their work) could represent a means of increasing such understanding. Acknowledgement by each sector of effectiveness of treatments for various conditions can encourage appropriate referral. Traditional medicine is often mistrusted because it is not considered science-based. Yet although the formal sector is moving towards evidence-based medicine, not all western medical interventions are supported by scientific evidence but only 20% of allopathic medicine has been scientifically tested via randomized control trials (Berman et al., 2000). Evaluation of both formal and traditional medicine is important to establish the most effective methods. Different paradigms of health beliefs and practices between the two sectors do not preclude collaboration. It may be more appropriate to work towards a system of co-operation between two independent sectors, with each recognizing...
and respecting the character of the other (Hollenberg and Muzzin, 2010; Kirmayer, 2004).

The element of familiarity and respect is important in the creation of social capital, which allows the comadronas to get together with biomedical staff without feeling ‘judged’ or ‘intimidated.’ The medical staff that organizes training for comadronas have received extensive training from ASECSA regarding indigenous medicine and traditional midwifery, thus being able to understand the cultural and spiritual function of comadrona, in contrast with what happens with the medical staff working at the hospital who has not received this training.

**HIV testing & disclosure**

Data show that women interviewed cited fear of HIV testing and knowing one’s HIV status due to discrimination and stigmatization which is still present in the community. Fear of knowing one’s HIV status was an important reason for drop out from anti-retroviral services. It is thus important to extend and reinforce partnerships among different stakeholders at the health center and community levels to support education and access to health information for all women in particular and the community in general in order to prevent stigma and discrimination. HIV status disclosure may lead to improved access to HIV prevention and treatment programs, increased opportunities for risk reduction and awareness of HIV risk to untested partners, which can result in greater uptake of voluntary HIV testing and counseling, and adherence to the advice given to prevent postnatal and sexual HIV transmission (Ramirez-Valles & Brown, 2003; Olley et al., 2004).

**Improving the referral system between traditional medicine & biomedicine**

At the moment, the referral system between traditional midwives and biomedical staff at the clinic or at the hospital is still quite limited. Further training should be given to local comadronas to enable them to recognize health risks factors for their patients, especially pregnant women. AIDS-related deaths may be incidental to the pregnancy or indirect causes of maternal mortality, in which HIV infection itself, opportunistic infections, or co-infections such as tuberculosis, progress faster during pregnancy (Nachega et al., 2003). Early diagnosis and treatment of tuberculosis may prolong the quality and length of life of those with HIV as well as preventing spread of these diseases to other people and referrals from comadronas to the biomedical health sector could be an important intervention.

In addition, studies demonstrated that improved STD treatment could reduce HIV/AIDS incidence (Rottingen et al., 2001). Given the possible involvement of traditional midwives in dealing with women
affected by STDs, this may be an important area to develop collaboration and reinforce the referral system between traditional medicine and biomedicine.

CONCLUSION

Although great strides have been made in Guatemala to reduce HIV infection rates, the virus continues to have an impact on a large portion of the population. Results from this investigation illuminate the need for an increased HIV knowledge level among midwives in Guatemala. Misconceptions and gaps concerning transmission and symptoms existed amongst traditional midwives, especially those who did not attend a formal course on HIV/AIDS.

Traditional midwives’ respected positions within communities may increase their effectiveness in prevention and help them reach some groups of the community such as middle-aged or elderly people. Because of their indispensable role as health care providers in Guatemala, access to continuing education for a large number of midwives should be made available.

The participation of traditional midwives in public health programs on HIV/AIDS and other STDs should be encouraged and promoted in order to increase HIV/AIDS prevention. It is important to adopt health policies that legitimize and acknowledge the practice of comadronas and integrate them into specific health programs.

There is growing concern that interventions designed only to change health-specific attitudes and competencies can benefit highly motivated program participants but do little to address cultural, structural, or other conditions that enhance women’s vulnerability. In recognition of the context in which women make and implement their own sexual decisions, health policy interventions would also seek to change those determinants that single individuals cannot control. These include characteristics of the cultural environment, such as gender roles which define women as subordinate to men and structural environment, including opportunities for women to become economically self-sufficient. Additional intervention activities may be directed to create more opportunities for women to participate in the groups and organizations that influence their lives, as well as to increase collaboration among women-focused community groups and institutions.

There is very limited evidence-based data on the role of traditional midwives in tackling HIV/AIDS. Research in this field is needed, as traditional midwives and other community health workers could contribute to HIV/AIDS prevention in Guatemala and elsewhere. Data presented in this study may not be generalizable to the population of
traditional midwives in Guatemala due to the size of the sample studied. However, this exploratory study can be the starting point to analyze comadronas’ HIV/AIDS knowledge, attitudes, and role in HIV/AIDS prevention, thus building upon the knowledge base of health care providers.

Continued study of the knowledge and attitudes of midwives working in both the public and private sectors is necessary to build upon the results of this investigation. Qualitatively examining midwives’ barriers to increasing their HIV knowledge levels would be useful to guide health policies. Studies using educational and experiential interventions that are geared toward different learning styles would be useful in determining the types of professional development programs that would be effective in improving HIV knowledge in midwives.

REFERENCES


