HIV/AIDS in Mexico’s rural and indigenous populations has become a public health problem with various psychological, social and economic consequences. To combat this epidemic, the diverse social actors that play an essential role in the communities as well as the health sector’s participation is necessary.

Throughout history, midwives have represented an important health care option for women in these areas. This is due to a variety of reasons of which the most significant include:

- Midwives pertain to the same culture thus their practices respond to the community’s symbolic order and social norms.
- Midwives are natural leaders and their privileged status allows them to work comprehensively with women from the community.
- Midwives’ care is warm and offered in solidarity and consequently their participation can contribute in an important manner to health care in general and the promotion of preventative measures related to HIV/AIDS and other sexually transmitted infections (STIs) in particular.

This study was carried out in a rural community in Morelia, Michoacan, a state that has more than 9,000 communities with less than 2,500 inhabitants, meaning that a little more than a third of the population lives in rural communities. Michoacan’s population sustains heavy migration to the United States and various indices have associated this phenomenon with an increase in the number of HIV infections. As of November 2003, 2,207 accumulated AIDS cases have been registered in the state. In 2002, 154 new cases were reported, of which 77 were asymptomatic, 51 presented symptomatology and 26 died.
Objectives

The general aim of this investigation was to analyze the role that midwives play in the prevention, detection and treatment of HIV/AIDS and other STIs. To do so, the following objectives were defined:

- Explore midwives’ knowledge, beliefs and practices for the prevention of HIV/AIDS and other STIs.
- Examine the reasons why women from the communities request midwifery services, even though the majority could access state health services if desired.
- Research the various institutional health actors (officials, doctors and community health promoters) as well as the health care users’ views on midwives’ work and their possible participation in the prevention of HIV/AIDS and other STIs, in addition to reproductive health.
- Investigate reproductive health programs’ coordination and relationships with midwives via work within the community and training courses.

A final objective, derived from the above, is to offer recommendations toward improving the relationship between midwives and official health programs, which could strengthen midwives’ role in the prevention, detection and treatment of HIV/AIDS and other STIs within communities.

Methodology

Given that many of the programmed objectives deal with the various actors involved in the health-illness cycle related to STIs in rural and indigenous areas and their knowledge, attitudes and practices, this study emphasized a qualitative focus using three distinct techniques: in-depth interviews, focus groups and direct observation.

22 interviews were carried out with institutional and community actors in March and April 2003 and a focus group was held with eight doctors from the Mexican Institute of Social Security (IMSS) Opportunities program to learn about their views regarding midwives’ work.

With the aim of understanding midwives’ knowledge on HIV/AIDS and other STIs, two focus groups were organized with members of this sector from various communities in Michoacan; one group was formed by seven midwives and the other by four. Three women who had been attended by midwives were also interviewed. Finally, observation was completed during an IMSS-Opportunities training workshop for midwives to examine the trainers’ strategies and observe midwives’ attitudes toward the session.
To analyze the information obtained from the interviews and focus groups, the transcripts were reviewed and a codification of the pertinent issues for the study was carried out. In a second phase, the relevant discourse was identified that offered a greater explanation of midwives’ role in the prevention of HIV/AIDS and other STIs along with the IMSS-Opportunities program officials, health representatives and women’s views on this same point.

Findings

The information offered by the midwives identified two risks for possible HIV/AIDS infection. The first refers to their perception of being at risk given the nature of the work they do. Midwives believe they face constant risk due to the contact they have with women’s blood, be it during the birthing process, washing up after labor or offering injections. The other perceived risk of acquiring HIV refers to the community in general. They have identified three groups of individuals that are in risk of HIV/AIDS infection: migrants and their partners, single men and men or women that have sporadic or temporary relationships with people other than their formal partners.

It was also possible to record that midwives often attend women with STIs, particularly pregnant women, although not all adopt the same attitude when facing this situation. Some treat these women with traditional remedies while others opt to refer their patients to medical doctors.

Through numerous testimonies, it was discovered that midwives face various obstacles to treat these women. Said obstacles range from women’s lack of care for their own health—becoming secondary to that of other family members—to medical negligence and women’s rejection of doctors and other health personnel. Despite these situations, midwives strongly maintain their resolution to continue participating in women’s health care.

Another of the most transcendental findings was that midwives play a central role in doctor-patient relationships, serving as a bridge of communication between women and doctors, whose worlds are so distanced and even disassociated from each other given historical and cultural elements. Nevertheless, the midwives’ presence facilitates the exchange between health personnel and women.

The above clearly can be observed when midwives care for women with HIV or AIDS, since they declared their willingness to
Midwives, HIV/AIDS and Other Sexually Transmitted Infections

accompany these women to medical centers if required. This escorting is critical in a context where women are not accustomed to attending said services, and it implies that the midwives not only escort women to the health centers but they also monitor women’s completion of the prescribed treatment and if necessary, assure that they continue to see doctors for further care. In the cases that require it, midwives play an active role during treatment participating as translators to and from indigenous tongues and medical language. Their presence ensures women’s confidence to acquiesce that doctors practice the necessary gynecological exams for diagnosis and treatment and encourages them to accept treatment with male doctors.

Midwives’ facilitation of doctor-patient relationships, which were previously quite ineffectual and even led to the squandering of services, has allowed health services to reach the female population.

Training midwives to help in the prevention and treatment of HIV/AIDS and other STIs is possible, based on their knowledge of the most common symptoms of these illnesses, their ability to share this knowledge within their community and alert the same to the risks that these place on their health. This opinion is shared by doctors who believe that midwives could be trained in HIV/AIDS and other STIs, for the following three reasons:

• because in rural and indigenous areas midwives are women’s first contact if they have a STI,

• so they learn to “protect themselves”, and

• so that the women with STIs complement medical treatment with traditional treatment.

One aspect in this study that draws attention is that some women prefer to see midwives, even if they have access to institutional health services. The reasons behind this preference are various, including a familiar tradition to seek midwifery services, women’s recognition of midwives as counselors, midwives’ orientation to resolve women’s health problems, women’s trust of midwives, and finally, women’s belief that midwives can attend them at any moment, not just during scheduled hours. These reasons also signal the need to train midwives in HIV/AIDS and other STIs to improve rural and indigenous women’s health.

Conclusions and Recommendations

Various studies have shown the importance of midwives in community health care. The data gathered in this investigation demonstrated that in addition to their contribution to women’s health care before and after birth, midwives could also play an important role in the prevention and treatment of HIV/AIDS and other STIs.

Traditionally, midwives’ responsibilities involved solely maternal-child health and other relevant areas, from health sector institutions’ point of view, such as family planning. With the rise of a reproductive health focus, other types of collaboration with midwives have been initiated, such as the prevention of breast or cervical-uterine cancer. This dynamic shows that midwives are committed to the population’s health cycle and respond knowledgeably to needs via practices that they have learned from experience, during training courses or interinstitutional exchanges and other informative measures.

However, this process has not been exempt from contradictions and resistance, on behalf of the
institutional system and midwives. Despite that midwives’ collaboration in community health care has shown great benefits, the hegemonic medical model’s discourse still subordinates and denies midwives’ knowledge and practices. This discourse appears in various arenas such as training courses and interinstitutional exchanges within the communities, since various health actors continue to believe that midwives are not prepared to carry out their activities and that the central objective of training them is “to avoid future complications”, implying a modification in their knowledge and practices.

Nevertheless, the training process itself is rather complex given that these are offered in Spanish and many midwives are not fluent in this language, hindering their understanding of the training content. While this has always been a problem for midwives, health institutions have not modified their strategies, making it appear as though the bureaucratic need to report a certain number of trainings has more weight than a true interest in ensuring a correct appropriation of the content. The midwives themselves signal that they would benefit more from the trainings if these were offered in their own language.

This study documented different views within various levels of the IMSS-Opportunities structure. While all health actors recognized, in some measure, the importance of collaborating with midwives, the recognition of their work and experience was more clear and spontaneous in the lower levels of the institution, for example from community health promoters or doctors at the rural health centers.

Although institutional medicine does not always recognize midwives’ knowledge and practices, it seeks control of their activities. These measures include various mechanisms such as the identification of midwives and the patients that visit them, or the number of births they attend and the conditions in which they do so. Health actors do not always view midwives as volunteers, but frequently believe that they should carry out institutional tasks.

The imposition of medical practices, like the use of sterilized instruments for birthing, has not altered the relationship between midwives and the health sector because midwives incorporate these practices as long as they do not affect their daily activities and
they are not mistreated by doctors or health officials. The midwives are conscious that they receive benefits through training and the inter-institutional exchange process, as well as status and knowledge that allow them to resolve more effectively the population’s health problems. Even so, many are skeptical of institutional medicine and its discourse, given that experience has taught them to be cautious; their relationships with institutions depends strongly on individual health representatives, who do not always recognize the importance of midwives’ work for the community's well being.

Throughout this process, strategies for referring patients between doctors and midwives have different meanings for each. For the first, it implies only the referral of patients, but for midwives it implies follow-up to ensure that the patients’ health problems are resolved. In many cases, midwives are not willing to only “refer” patients but also participate as escorts during medical treatment, where they act as effective communication bridges not only to interpret from indigenous languages but to also translate medical language into terms that women can understand, contributing to better relationships between doctors and patients.

The above signifies that midwives have become women’s rights defenders when they perceive medical negligence or violations of their patients’ right to health. These characteristics add important value to their work (that of defending their patients), as well as a humanitarian value to the work they carry out which distinguishes them from the medical focus, which is not always responsive to the patients’ expectations of quality and warmth.

Midwives are central health figures for their communities and it is necessary to recognize them as such, given that without their support, health institutions would only intervene in rural and indigenous areas with difficulty. In addition, midwives represent an important social network for women of rural and indigenous communities, due to their role in maternal-child care and particularly for their responsibilities related to the prevention and treatment of HIV/AIDS and other STIs.
The increase in HIV/AIDS and other STIs cases in the rural and indigenous context has implied the development of health sector programs and, for midwives, an expansion of their range of action. However, these processes have not occurred in conjunction. Midwives have been treating these illnesses via requests; they diagnosis STI symptoms and offer traditional treatment or refer patients to medical services. Nevertheless, in addition to the cultural and gender barriers they face in their communities, midwives do not have the information or the infrastructure to offer comprehensive care to their patients. Yet, in contrast they do have the sensitivity and capacity to influence prevention with women and men, since women who seek treatment with midwives have become intermediaries in their partners’ health problems, which benefits over the long term the health of the entire community.

Although health institutions have begun HIV/AIDS and STI prevention and treatment programs, they do not have the knowledge to implement these programs in rural or indigenous populations. Midwives, as natural leaders who have the community’s recognition, could be included within institutional strategies to enable these health programs to truly benefit the population. Given the midwives’ roles, they could offer an invaluable intermediary service between health personnel and the community. Given the above, if midwives are incorporated to discuss this problematic, they would contribute to:

a) counsel and orient women in the most appropriate manner;

b) opportune refer women in cases of STIs;

c) promote preventative measures not only on an inter-personal level but also reaching a larger number of individuals and specific groups such as youth, female and male adolescents.

In addition, midwives have the gender advantage, since users have more confidence in their treatment as women of these diseases. In contrast, this represents a barrier for institutions, given that a great number of doctors are men and signifies that women less frequently seek their care. If midwives accompany women, they less often reject treatment by a male doctor. As such, institutions should establish support mechanisms to facilitate midwives and their patients’ access, given that both report having faced discrimination, mistreatment and medical negligence.

In communities where doctors integrate into the community and particularly with the midwives, strategies have been developed to ensure services reach the population. Nevertheless, limitations to decreasing the prevalence of HIV/AIDS and STIs include:

a) men’s rejection of condom use,

b) women’s lack of tools to negotiate condom use with partners,

c) women’s limited control over their own bodies and their exercise of sexuality.

Influence in these aspects implies a modification of deeply rooted structures in
the rural and indigenous communities, but would be possible if we involve other social actors such as midwives.

In addition, doctors' perception of midwives' work must be modified; relationships between health personnel and midwives must be strengthened and improved and training courses must be adapted to the latter groups' context.

Institutions should offer didactic material, including photographs, in their training to allow midwives to diagnosis STIs in their patients, but better response mechanisms to the patients referred by midwives should also be established.

These actions should be complemented with minimal institutional resources to protect midwives and their patients from STIs. Midwives report a lack of basic materials such as syringes and gloves as well as disinfectant for birthing instruments.

Finally, we believe it is necessary to continue exploring midwives and health service providers’ responsibilities, as well as better understand women and men’s behavior, with the goal of breaking cultural, gender and institutional barriers that hinder the preventative actions to slow down the AIDS and STI epidemic in Mexico’s rural and indigenous communities.

---

Investigation: Silvia Esperanza Jiménez García and Silvia María Loggia Gago
Text: Rosario Taracena
Cecilia Gayet and Carlos Magis also participated.
Translation: Jennifer Paine

Thanks to the following people who contributed with photographs: Araceli Martínez and Rocío Morales.