

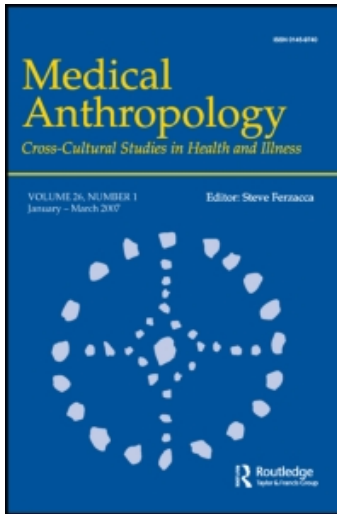
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Publisher Routledge

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Medical Anthropology

Publication details, including instructions for authors and subscription information:

<http://www.informaworld.com/smpp/title-content=t713644313>

Remaking the Guatemalan Midwife: Health Care Reform and Midwifery Training Programs in Highland Guatemala

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Online Publication Date: 01 October 2008

To cite this Article Maupin, Jonathan N.(2008)'Remaking the Guatemalan Midwife: Health Care Reform and Midwifery Training Programs in Highland Guatemala',*Medical Anthropology*,27:4,353 — 382

To link to this Article: DOI: 10.1080/01459740802427679

URL: <http://dx.doi.org/10.1080/01459740802427679>

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Remaking the Guatemalan Midwife: Health Care Reform and Midwifery Training Programs in Highland Guatemala

Jonathan N. Maupin

Midwifery practice and identity in Guatemala is constantly being transformed because midwives must negotiate their practices in response to changing international and national health care agendas and processes. Recently, the Guatemalan government implemented the *Sistema Integral de Atención en Salud* (SIAS). Framed by neoliberal processes and global reproductive health paradigms, SIAS is designed to attain the reproductive health goals outlined in the 1996 Peace Accords by reducing maternal and infant mortality rates. As the primary birthing specialists in rural areas, midwives are essential to this task. A central focus of SIAS is incorporating midwives into the national health care system through midwifery training programs. Drawing on observations of midwifery training programs and interviews with midwives in the municipality of San Martín Jilotepeque, I argue that the incorporation of midwives into SIAS is redefining the position by establishing a new model of recruitment to the role, education, and practice and authority.

Key Words: Guatemala; health care reform; Kaqchikel; midwifery

Midwifery identity and practice in Guatemala is constantly being transformed because midwives must negotiate and adapt to the pressures of medicalization from local community members, the formal health care system, and international processes. The recent international attention to

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incorporating midwives into national health care systems to address the high rates of maternal and infant mortality have exacerbated the pressures of medicalization and biomedical control over midwifery practices at the local level. In Guatemala, the national health care system has gone through a process of neoliberal reform, resulting in the creation of the *Sistema Integral de Atención en Salud* (SIAS). In addition to providing a basic package of services to the estimated 46 percent of the population who lacked access to care in 1996 (Pan-American Health Organization [PAHO] 2004), one of the primary goals of SIAS is to decrease the maternal and infant mortality rates by half the 1995 numbers (PAHO 1999). Framed by international reproductive health paradigms, SIAS is designed to improve maternal and infant health by incorporating midwives into the national health care system through midwifery training programs, a process that positions midwives as an essential extension of the formal health care system. Midwives in Guatemala are being forced to negotiate and adapt their identities and practices because they are increasingly framed at the nexus of local practice, the national health care system, and international frameworks.

In this article I analyze the effect of neoliberal health care reform, manifested in SIAS, on midwifery practice and identity in the municipality of San Martín Jilotepeque in the Department of Chimaltenango. I examine the process by which SIAS is increasing the incorporation of midwives into the national health care system through midwifery training programs. Emphasizing the articulations and contradictions between existing forms of midwifery selection, education, and practice, I examine the mechanisms through which training programs are transforming midwifery practice and identity as well as the acceptance and negotiation of these transformations by midwives themselves. This analysis is not a critique of any midwifery training program, but rather is an evaluation of the process of health care reform and the participation of midwives in training programs. Drawing from observations of midwifery training programs and interviews with midwives in San Martín Jilotepeque, I argue that by facilitating the incorporation of midwives into the formal health care system, SIAS is not only transforming the beliefs and practices of midwives but is also redefining the position by establishing a new model of recruitment to the role, education, and practice and authority.

MIDWIFERY TRAINING PROGRAMS IN GUATEMALA

Midwifery training programs and the role of midwives in Guatemala, as in most developing countries, have changed over time to reflect international trends and national agendas (Acevedo and Hurtado 1997; Asociación PIES

de Occidente [PIES] n.d.; Hurtado and Sáenz de Tejada 2001). In each successive international or national health care paradigm, governments or health organizations reconstruct the role of midwives according to their perceived ability to attain specific goals. Midwifery training programs are a medium for redefining midwifery practice and identity by incorporating midwives into the formal health care sector. Through participating in training programs, the position of midwives within the national health care system is redefined and their knowledge, practices, and authority are challenged by the biomedical model.

Midwifery training programs in Guatemala have fluctuated in response to international health paradigms over time as the national health care system has attempted to supervise and control midwifery practice. The Guatemalan government first established laws governing the practice of traditional midwives throughout the country in 1935, granting legal permission for lay midwives to work, provided they received training, were certified, and met specific demographic criteria (Acevedo and Hurtado 1997; Greenberg 1982). The Ministry of Health and Public Assistance (*Ministerio de Salud Pública y Asistencia Social* [MSPAS]) began to offer formal training in 1955 and extended certificates to traditional lay midwives after aptitude exams. The Division of Maternal and Child Health was created within the MSPAS in 1969, and midwifery training increased sharply under the new department, with roughly 6,000 midwives receiving training by 1977 (Hurtado and Sáenz de Tejada 2001: 216). Yet, few midwives maintained contact with the MSPAS after their training, and there were an additional 10,000 practicing lay midwives in Guatemala during the 1970s (Hurtado and Sáenz de Tejada 2001: 216). The inability to adequately supervise midwives after their training shows the limited control of the MSPAS over midwifery practice and its weak relationship with midwives.

The position of the midwife changed markedly in the 1980s, as Guatemala adopted the World Health Organization's (WHO) model of midwifery training and incorporation into the formal health care system. In the WHO model, the MSPAS was required to formally recognize and create a system to register and license midwives, provide training to reduce neonatal deaths and postpartum tetanus from unhygienic practices, and teach midwives to facilitate family planning methods within their communities (Leedam 1985). The MSPAS expanded its midwifery training programs and, by 1985, 6,695 midwives with some training through the MSPAS courses practiced their trade (Bossert and Del Cid Peralta 1987).

The effectiveness of midwifery training programs in Guatemala is debatable. While many studies document a marked increase in the number of referrals to the hospital or emergency centers following midwifery training programs, no strong correlation exists between biomedical training

courses and a reduction in maternal or infant mortality (Bailey et al. 2002, 2005; Goldman and Gleit 2003; Hurtado and Sáenz de Tejada 2001; Kwast 1995, 1996; O'Rourke 1995a,b). Due to the lack of improvements, the WHO (2005: 70) stated that training traditional birth attendants (TBAs), referring to local midwives with no biomedical training, is "increasingly seen as a failure." According to the WHO, TBA courses fail because of the wide variation in knowledge and practice among TBAs, the inability of the health system to adequately monitor TBA practice, and the failure of TBAs to send women with complications to the hospital. As a result, the WHO (2005) argued for increased investments into professional midwives or for health professionals with midwifery training rather than relying on TBAs.

Yet, recent neoliberal structural adjustment programs and health care reform in Guatemala have transformed the role and importance of existing midwives and have made them central to achieving national health care goals. As a part of the national restructuring process that culminated in the 1996 Peace Accords, Guatemala underwent a comprehensive health care system reform. The SIAS is touted as the medium to fulfill the social reforms outlined in the 1996 Peace Accords. Financed and largely designed by the Inter-American Development Bank, SIAS is framed by neoliberal policies that call for a decrease in government investment in health care, decentralization, and increased nongovernmental organization (NGO) participation in the delivery of health care. In SIAS, the Guatemalan government contracts NGOs to provide basic health services that consist of maternal health, infant and child care, emergency medicine and disease control, and environmental control to jurisdictions of 10,000 people each in rural areas. More specifically, SIAS is designed to accomplish the reproductive health goals outlined in the Peace Accords, which call for the reduction of the maternal and infant mortality rates by 50 percent of the 1995 rates, estimated at 190 per 100,000 and 57 per 1,000, respectively, by the year 2000 (*Instituto Nacional de Estadística* [INE] et al. 1996).

Midwives serve an essential role in the implementation of SIAS and are envisioned as the key link in fulfilling the national goals outlined in the Peace Accords. Midwives continue to serve as the primary pregnancy specialists in Guatemala, attending an estimated 47.5 percent of births nationally and an estimated 55 percent of births in rural areas (MSPAS et al. 2003). Midwives also constitute the primary source of care for Maya women, with roughly 64 percent of Maya women using midwives for deliveries, compared with only 36.2 percent of Ladinos, or non-Maya (MSPAS et al. 2003). The central role of midwives in pregnancy and delivery in Guatemala makes them an ideal medium to improve maternal and infant health. The central strategy of SIAS is thus to lower maternal and infant

mortality rates by incorporating midwives into the formal health care system through midwifery training programs.

Training courses focus largely on the Safe Motherhood paradigm, which is based on the premise that most maternal and infant mortality is preventable through skilled care at all points during pregnancy, the timely identification and referral of complications, and access to high-quality emergency care (Safe Motherhood IAG 2002; Scheiber and Stanton 2000). The primary strategy of midwifery training programs in this model is to teach midwives to recognize the signs and symptoms of obstetric and newborn complications and to emphasize the role of the midwife in referring women to the formal health care system for prenatal care and obstetric complications. SIAS training courses occur once a month and last approximately four hours each time. Courses are given by contracted medical staff and are based on standardized SIAS materials. Midwives receive roughly \$6.50 for each monthly training session they attend.

Midwifery training courses have always held the goal of lowering maternal and infant mortality rates by controlling the practices of local midwives; however, never before has there been such an intense focus on the role of the midwife to accomplish specific national health goals. While many scholars have noted the influence of biomedical training programs on midwives in Guatemala (e.g., Cosminsky 1982; Greenberg 1982; Hinojosa 2004), there is little information concerning the effect of SIAS on midwifery identity, practice, or authority. Yet SIAS is the most concerted and systematic attempt to recruit and train midwives at the national level and is significantly influencing midwifery practices throughout Guatemala. According to a SIAS national director, 8,962 midwives participated in SIAS as of May 2003. Although my research consists of a case study of the implementation of SIAS in a single municipality, it has implications for changes in midwifery practice at the national level. The intense focus of SIAS on utilizing midwives to lower maternal and infant mortality rates is transforming the Guatemalan midwife by trying to refashion the position into an extension of the biomedical system in which her function is centered on the referral of women to the formal health care system. In this respect, I argue that midwifery programs through SIAS are fostering a process of remaking the midwife along three axes: selection, education, and abilities.

METHODOLOGY

This research is based on 14 months of fieldwork conducted during 2002 and 2003 in San Martín Jilotepeque, a predominantly rural and indigenous municipality in the northeastern section of the Department of Chimaltenango.

Eighty-five percent of the 58,758 inhabitants in San Martín reside in rural areas, and 88.4 percent of the population is Kaqchikel Maya, although only 18.4 percent of the population speaks Kaqchikel (INE 2003). Reflecting the limited use of Kaqchikel, none of the midwives interviewed in this study referred to themselves as *iyom*, the Kaqchikel term for midwife, and instead all called themselves by the Spanish term, *comadrona*. During this time, I observed several midwifery training programs in San Martín Jilotepeque that were conducted by the two NGOs who were contracted through SIAS as well as one independent NGO working in the region. In addition to interacting with midwives in training courses, I interviewed midwives in their own communities over five months.

In total, I interviewed 36 midwives in 23 communities and selected midwives for interviews based on residence and availability. I used a stratified sample of communities to ensure the representation of the various geographical, demographic, and ethnic composition in which midwives live and work in San Martín. As such, I selected two communities in each of the 12 *aldeas* (rural districts) in San Martín in addition to the town center itself. Additionally, I selected communities with a health post for interviews to provide information on the relationship between midwives and the auxiliary nurse who works in the health post. Although there are seven communities with a health post in San Martín, I was not able to locate a midwife for an interview in one of the communities. Within each community, I selected midwives for interviews based on opportunity samples. Using a roster of registered midwives acquired from the government health center, I questioned residents concerning the location of midwives in the community and located at least one midwife in each community. During the course of the interview process, only one midwife declined to be interviewed. My male assistant and I conducted interviews with midwives in their homes. Interviews lasted an average of an hour and a half and were conducted in Spanish and Kaqchikel. This methodology allowed for a maximization of time by interviewing all midwives within a given community while ensuring the representation of the diverse contexts in which midwives practice.

As other male scholars have noted (Hinojosa 2004; Röst et al. 2004), it is difficult, if not impossible, for a foreign male scholar to directly observe midwifery practices. Instead, data on midwifery practices may only be gathered indirectly through conversations. This method has its limitations in that stated practices do not perfectly reflect actual behavior, and the content of what midwives say is highly contextual and depends on where and to whom they are talking (Cosminsky 2001a: 184; Jordan 1993: 183). Despite these limitations, interviews elicit important observations on midwifery practice, particularly the perceptions of and relationships with the formal health care system and training programs. Although interview narratives

do not perfectly reflect behavior, the interaction, negotiation, and conflict between traditional practices and the models presented in training courses are expressed through interviews. Narratives serve as an important medium for midwives to convey their own attempts to negotiate their position and authority within the changing social and medical landscape in San Martín.

REMAKING THE GUATEMALAN MIDWIFE

Recruitment to the Role

The MSPAS implemented SIAS in San Martín Jilotepeque in 1998, although budgetary and organizational restrictions prevented the contracted NGOs from initiating their midwifery training programs until 1999. The implementation of the SIAS maternal and neonatal program was intended to rest on the support of existing midwives working in their respective communities. Recruiting existing practitioners potentially facilitates the entrance of programs into communities and takes advantage of the fact that the health care providers are embedded within the cultural context and social networks of the communities. The implementation of SIAS into rural communities throughout San Martín followed this model of incorporating the midwives in those communities that did not have a MSPAS health post.

However, in addition to recruiting preexisting midwives, NGOs and staff contracted through SIAS also actively encouraged the selection of new midwives. In the official SIAS model, each jurisdiction of 10,000 is staffed with at least five midwives, or one for every 2,000 residents (Verdugo 2004: 60). The number of midwives in San Martín greatly exceeds this number, with an estimated 125 midwives for a total population of 58,578 in 2003, or about one for every 469 residents. However, one of the NGOs contracted by SIAS stated that there is no limit to the required number of midwives, and they would prefer to have more in each community. As one NGO director stated:

The objective of the program is to have one midwife for 50 families... But sometimes there aren't enough for this, maybe if we had more midwives. But we only have 30, no more. We should have around 40, 45.

However, directors of both SIAS-contracted NGOs noted the difficulty of recruiting midwives. As another SIAS staff member noted:

Look, with the midwives it's purely a vocation, as we say in this case. You can't elect someone if they don't want it. Many midwives... have some dream. They say "I dreamed this," and of course they have to do it. That's how they

start. Now, those who don't want it, who don't like it, who it doesn't strike their interest, it doesn't work. It is purely a personal vocation.

Yet, despite the recognition that midwifery is a sacred vocation, one SIAS staff member stated that she encourages communities without practicing midwives to elect women to the position.

Yes, we talk with some women. We teach women the importance of the midwife, that they need to elect a midwife. . . . Before there was one midwife for maybe 2,000–3,000 residents. While [she] was attending a patient, another patient giving birth could die because there was no one there.

Recruitment to the position of midwife is sanctioned by underlying cultural logics that define the social and spiritual requirements that limit potential candidates. Not all women may become midwives because the selection process is based on locally established sociocultural requirements that are derived from an understanding of the identity and role of the midwife in society. These requirements are constantly negotiated between community members, midwives themselves, and external forces. In determining the acceptance of a woman to the position, each community follows a series of social rites of passage that must be satisfied in accordance with the expectations and understandings of the midwife's role and function in the community (PIES n.d.). However, while each community has its own established norms and criteria for legitimating midwives, these systems are not static but change in response to both internal pressures and alternative models of midwifery identity, practice, and selection.

As depicted in the ethnographic literature, the most frequently reported pathways to becoming a midwife are through a divine calling, heredity, an emergency, recruitment to the role either through apprenticeship or by petitions from health personnel, and, most recently, democratic elections. The most common method of selection to midwifery practice in Guatemala, as portrayed in the ethnographic and quantitative literature, is through divine calling. As Paul (1975: 461) stated concerning midwives in San Pedro La Laguna, "midwives are born and not made." The manifestation of divinatory signs that are both visionary and physically embodied demands that a woman acquiesce and accept her destiny. If a woman fails to interpret these signs or rejects the vocation, she may be stricken with a serious illness that is only overcome when the woman accepts her destiny to serve as a midwife (Cosminsky 1982, 2001b; Paul 1975; Paul and Paul 1975). Another common method of selection to the role of midwife is through inheritance of the position. Genealogical inheritance of the position is frequently mentioned as a prime factor in a woman's vocational decision or calling to the

role (Jordan 1993: 188). Women may also be called to the position of midwifery through birthing emergencies in which they are forced to assume the position in a time of dire need. Compelled to assist with the birth, the woman is able to rise to the occasion and exhibits a natural ability or gift to assist the birth, displaying her innate capacity to undertake the position. Recruitment to midwifery may also take place through informal apprenticeships, particularly between mothers and daughters; however, I consider apprenticeship as a means of education rather than as a means of recruitment. For the purposes of this article, recruitment refers to the act of a formal request by an individual, such as a doctor, nurse, auxiliary mayor, or other midwife, that the woman undertakes the position (Villatoro 1994). The final avenue for selection to the position of midwife is through the process of democratic elections. This method is a recent construct in which women are nominated for the position during communal meetings in which all residents publicly vote for candidates by a show of hands. Women with the highest number of votes are then obligated to accept the position through popular consensus.

Midwives in San Martín Jilotepeque exemplify the heterogeneity of midwifery selection while illustrating the general sociocultural requirements and constructs that regulate ascension to the role. Midwives in San Martín also highlight the changes in the recruitment as traditional models are confronted with new forms of selection instigated by SIAS that are based on alternative criteria and underlying assumptions of the role of the midwife and the relation to society and the supernatural.

Of the 36 midwives interviewed in San Martín, the most common method of selection was through divinatory dreams. As shown in Table 1, 36 percent of the midwives interviewed stated that they had a dream or vision before assuming the role. While several midwives described dreams with symbolic elements requiring the midwife to interpret their meanings, such as white flowers, children playing, or children being baptized, other midwives reported explicit callings in which women envision themselves assisting women during delivery. One elderly Kaqchikel midwife recounted her dream in which she witnessed a laboring woman unable to deliver. Jesus

TABLE 1
Method of Selection Based on Ethnicity

<i>Ethnicity</i>	<i>Dream</i>	<i>Emergency</i>	<i>Heredity</i>	<i>Recruitment</i>	<i>Election</i>
All midwives (36 Total)	36.1% (13)	19.4% (7)	11.1% (4)	19.4% (7)	13.9% (5)
Ladina (9 Total)	11.1% (1)	44.4% (4)	11.1% (1)	11.1% (1)	22.2% (2)
Kaqchikel (27 Total)	44.4% (12)	11.1% (3)	11.1% (3)	22.2% (6)	11.1% (3)

then appeared and instructed her to assist the woman. After protesting twice due to her lack of knowledge or experience, she finally acquiesced and as soon as she knelt in front of the laboring woman, the baby came out, landing in her hands. In this case, the divinatory dream not only confirmed the woman's calling to become a midwife but also her ability to assist women during complications.

There is a large difference in the distribution of dreams between ethnic groups in San Martín. Only one of nine Ladina midwives (11 percent) stated that she was called through divinatory dreams prior to assuming the role, compared with 12 of the 27 Kaqchikel midwives (44 percent). The most common form of initiation for Ladina midwives is through emergencies, which emphasize an individual's personal ability, knowledge, and experience in solving a crisis. Unlike many Kaqchikel midwives, Ladina midwives do not adhere to the requirement of divine selection, although many still report supernatural assistance through prayer or rituals (Cosminsky 1982: 208).

While ethnic identity accounts for some of the diversity in recruitment to the position of midwife in San Martín, examining the differences in methods of selection with attention to years of experience of the practitioner highlights the fundamental changes in midwife identity. Based on years of experience, midwives in San Martín fall largely into three distinct categories. As shown in Table 2, midwives can be clustered into groups based on their experience: four or fewer years, between five to 15 years, and over 15 years. There is a large gap between these categories, as only 11 percent (4 of 36) of practicing midwives fall into the middle group of between five to 15 years of experience. The majority of midwives (61 percent) practicing in San Martín have more than 15 years of experience. Significantly, 28 percent of the midwives sampled are fairly new, having four or fewer years of experience as practicing midwives. This is highly significant because this number is directly tied to the implementation of SIAS midwifery training programs in San Martín in 1999—four years prior to this study. Thus, 28 percent of midwives sampled throughout San Martín assumed the position in the context of health care reform and the increased attempts to incorporate midwives into the national health care system.

TABLE 2
Method of Selection Based on Years of Experience

<i>Years of Experience</i>	<i>Average Age</i>	<i>Dream</i>	<i>Emergency</i>	<i>Heredity</i>	<i>Recruitment</i>	<i>Election</i>
≤ 4 (10 Total)	38	20% (2)	20% (2)	10% (1)	10% (1)	40% (4)
5≤15 (4 Total)	59	50% (2)	25% (1)	0% (0)	25% (1)	0% (0)
>15 (22 Total)	64	40.9% (9)	18.2% (4)	13.6% (3)	22.7% (5)	4.5% (1)

During interviews, many older and experienced midwives expressed their concern over the decline in the number of those women accepting the position. While several midwives stated that they had attempted to recruit women, very few were successful. Experienced midwives stated that women, even their own daughters, rejected the offer. According to these midwives, the primary reason women refuse the position is due to their husbands' objections, given that the position offers little pay and entails obligations that force them to neglect their household chores. One midwife stated that even her own children begged her not to accept the position because she would be required to be away from the house for long periods of time. Even among those few midwives who were able to recruit women to accept the role, several of the recruits quit the position due to its difficulty and their reported lack of dedication.

The increase in the number of midwives since 1999 then is significant in that it represents a dramatic resurgence of new midwives throughout San Martín. More important, the recent increase in the recruitment of midwives entails a shift in the traditional methods of selecting midwives, and in effect shows not only the imposition of a new process and set of criteria for selecting midwives but the creation of a new type of midwife altogether. By encouraging communities to elect women to the position, SIAS promotes a new process of recruitment that bypasses traditional models and is transforming the nature of midwifery in San Martín.

There are 21 midwives practicing in communities where SIAS has been implemented. Of these, five (24 percent) were recruited specifically for SIAS—they were elected or recruited specifically to participate in SIAS and were not recruited to the role based on any other method or criteria. Out of the 10 midwives formed since SIAS began training midwives in San Martín in 1999, eight (80 percent) were recruited in communities where SIAS is present. Out of these eight, five (63 percent) were specifically recruited to participate in SIAS, with four others elected and one recruited by a SIAS community health worker (CHW). Only two of these eight (25 percent) midwives stated that they had a divinatory dream that propelled them after they were nominated for election to accept the position. Thus, 50 percent (5 of 10) of all midwives sampled throughout San Martín who assumed the position since the implementation of the SIAS midwifery training program in 1999 started work as a midwife in direct response to the entrance of the program. In those communities where SIAS is active, 50 percent (four of eight) of the midwives who started in the past four years were selected based on a new model of democratic elections that supplanted traditional forms of divine election, emergency, and personal recruitment. Overall, roughly one-quarter of the midwives in communities where SIAS is currently working are new. Eighty percent of the midwives in positions created specifically for SIAS were chosen through democratic elections.

The implementation of SIAS midwifery training programs in San Martín in 1999 instigated the formation of a new cohort of young midwives whose positions are created specifically to participate in the program. Faced with the pressure of selecting and forming midwives on demand, the traditional forms and processes of recruitment to the role were insufficient to produce the number of midwives recommended by SIAS NGOs and medical staff. It is important to note, however, that SIAS did not create the process of democratic elections within communities. Democratic elections have existed as a model of selecting CHWs since the 1960s. However, midwives have not traditionally been subject to such an organized, deliberate, and public method of selection. Traditional forms of selection are individualistic, call women either at birth or at a specific point in time when their services and abilities are demanded, and are not controlled by organizational needs or public health care models that designate the presence of midwives based on population density. The forced creation of midwives to satisfy the recommendations of external health care systems required the utilization of a new form of selection and recruitment to the position (see Day 1996). Democratic elections are thus a process by which communities can produce midwives by bypassing traditional methods and criteria.

While unstated, this secularization of midwifery is part of a directed process to create a new, younger type of biomedical midwife who can both assist and replace older midwives. SIAS staff in one NGO described this process as follows:

Before the midwives were older, maybe 40 or 50 years old. Now there are midwives of maybe 20, or 25 years, much younger. These midwives are able to do more and learn more.

Additionally, several SIAS CHWs criticized traditional midwives and their practices. During a CHW training session, one SIAS CHW stated:

It's tough to work with the older ones. They don't listen to us. They think that because they are older, or rather, because of their experience, that they can do anything. . . . It's difficult to integrate their work with ours. We learn from the doctors, we take classes. . . . But they think they can do it all.

Similarly, several SIAS CHWs stated that it was easier to work with midwives who had received training. One CHW claimed:

My work is a little easier now. The old midwives are retiring, they can't work anymore. Now we have new ones, the younger ones who are receiving training. . . . [They are] easier to work with.

Numbering 1 for every 20 houses in each community (Verdugo 2004: 60), SIAS CHWs may facilitate the process of change at the local level by challenging the authority of experienced midwives and influencing communal elections by promoting a new type of midwife.

Women, particularly young women, have long been able to bypass traditional requirements for selection through participation in training courses. However, most studies show that women who do not fulfill the traditional requirements for selection to the position are generally not accepted within their communities (Cosminsky 1982; Greenberg 1982; PIES n.d.; Villatoro 1994). Yet, by promoting the election of women to train as midwives, SIAS is redefining the criteria for selection to the position throughout the municipality—a process that not only transforms the meaning of the position in terms of religious and social relations but also creates a new foundation through which midwifery training and practice are defined.

Education and Knowledge

Directly linked to the changing nature of selection, midwifery training programs are altering the process and authority of education as biomedical training programs are increasingly regarded by new midwives as the source of authoritative knowledge. Although midwives have been legally obligated to participate in training courses since 1935, these courses have primarily served as secondary forms of education (Cosminsky 2001a: 185). Women primarily learn the practice of midwifery in traditional methods based largely on their method of selection. The biomedical knowledge and practices promoted in training courses are interpreted within traditional practices and cultural logics that to a large extent determine the acceptance of new practices and beliefs (Cosminsky 1982, 2001b; Goldman and Gleit 2003; Greenberg 1982; Jordan 1993; Lang and Elkin 1997; PIES n.d.; Röst et al. 2004). However, with the increased incorporation of midwives in training programs and new forms of selection to the position in San Martín, midwifery training courses are not only providing a context in which biomedical models are given authority over traditional beliefs and practices but the participation in midwifery training programs is becoming the authoritative source of education.

The process of learning midwifery practice, and the authority of a midwife's knowledge, is intimately tied to both her own experience as well as to the ways in which women are called to the position. The most fundamental method of learning midwifery practice is through personal experience of the birthing process. Giving birth is perhaps the most basic criteria for becoming a midwife, as women must experience the process themselves in order to assist other women (Greenberg 1982: 1607; Paul and Paul

1975: 707). Through childbirth, women gain an intimate and personal knowledge of the experience. More pragmatically, as women experience birth, both personally and by observing the deliveries of female relatives, they witness the work of the midwives, which provides them with a model of midwifery practice for them to emulate.

However, personal experience and observation alone do not provide women with the ritual education or authority necessary to practice. Midwives, particularly those divinely called to the role, often learn the practice through dreams and visions that reveal the essential techniques, rituals, and meanings of midwifery practice. In some cases, the spirits of deceased midwives mentor the midwife, explaining the necessary pragmatic and ritual practices (Cosminsky 1982, 2001b; Paul and Paul 1975), while in other cases, dreams reveal instructive scenarios in which the women visualize themselves performing the acts. Women may also learn midwifery practice from experienced midwives. Jordan (1993) described the process of apprenticeship among Maya midwives in the Yucatan as the primary means of training, particularly when the position is passed through family lines. According to Jordan (1993: 188–196), the learning process is not necessarily distinct from daily life but occurs as apprentices gradually gain knowledge and practice their skills by accompanying the midwife in her work. While formal apprenticeships are not common among Maya midwives in Guatemala (Marshall 1986), inexperienced midwives may accompany older midwives during deliveries to gain experience or seek information from other maternal relatives (Villatoro 1994).

Opposed to these traditional forms of education, which emphasize personal knowledge and experience, biomedical training courses are based on a Western model of instruction in which midwives learn the practice from lectures and texts that are constructed as the authoritative knowledge. In this model, personal experience of the birthing process is not an essential criterion but, rather, formal education and mastery of technical information provides one with the expertise to serve as an instructor (Jordan 1993). Midwifery training programs follow Western pedagogical techniques and promote a biomedical model of birthing and midwifery practice that is based on theoretical models and standardized practices that may have little application to midwives' experiences (Berry 2006; Cosminsky 1982). Training programs are frequently criticized for their hierarchical structure and relationships, ethnocentrism, and pedagogical methods, which situate the midwife under the control and manipulation of the health care system. MSPAS midwifery training programs are primarily, if not exclusively, taught in Spanish, despite the fact that the majority of midwives throughout Guatemala are rural indigenous women who speak a Maya language (Cosminsky 1982; Greenberg 1982; Hinojosa

2004). In San Martín, only one training course utilized Kaqchikel instructors.

Additionally, training sessions are frequently provided in didactic form based on a Western educational format and are overly theoretical, which encourages little participation from the midwives in the course and often ignores or discounts their experiential knowledge (Cosminsky 1982, 2001b; Goldman and Glei 2003; Greenberg 1982; Hinojosa 2004; Jordan 1993). For example, during one training course, a midwife asked the doctor if it was true that midwives could prognosticate the number, sex, and spacing of a woman's future children by reading the knots on the umbilical cord. Two midwives stated that the practice was effective because their own midwives successfully predicted the number of children they would have, including a set or twins, based on the knots. The doctor replied that while she respected the midwives' beliefs:

Now we know more about these things. We know more about reproduction and women's bodies. People don't do this anymore.

As Berry (2006) argued, the conflict between theoretical knowledge presented in training courses and the empirically derived knowledge of midwives makes it unlikely that midwives will adopt biomedical models and standards. Finally, staff providing the training courses are often untrained and inexperienced in obstetrics or medical training. In San Martín, unmarried and/or childless women or men instructed all training programs. This undermines the authority of midwives by violating the gender, age, and experiential criteria that validate their own knowledge. By utilizing individuals who lack the basic criteria to justify their own knowledge of midwifery practice, training courses may create conflict over authority that potentially limits midwives' consideration or acceptance of the material presented in the course.

Since the implementation of the SIAS midwifery program in San Martín in 1999, there has been a marked transformation in the form and authority of training and education among midwives. The shift in authority from traditional knowledge and instruction to biomedical models and training courses is evident in analyzing the forms of education among experienced and new midwives. Among midwives who have more than 15 years of experience, 45 percent reported that they learned at least part of their practice from older and more experienced midwives compared with 33 percent for all midwives interviewed, while none stated that they learned the practice from training programs. In comparison, only 20 percent (2 of 10) of midwives with 4 or fewer years of experience stated that they directly learned

from other experienced midwives. Of these, one was trained by her mother, who recruited her to become a midwife. In the second case, an older, experienced midwife invited the newly elected midwife to accompany her during deliveries. The relationship lasted for two births, after which the younger midwife ended the relationship. This decrease in traditional forms of education and training is due to both the necessity of new recruits to learn the practice in unconventional ways as well as a change in the authority and legitimacy of midwifery knowledge and practice in San Martín. Rather than seek the tutelage of experienced midwives, nearly all women elected to the position largely consider training programs to be *the* vehicle for learning midwifery practice.

Although pressured by the growing dominance and supervision of the formal health care system, older midwives stress the importance and relevance of their own knowledge and experience. While all but one of the midwives in this study had attended a training course at some point in their careers, traditional midwives contextualized the importance of training programs within their own experiential knowledge and abilities. Many experienced midwives interviewed stated that they appreciated the training courses because they teach the midwives about the risks during pregnancy. As one elderly Kaqchikel midwife stated:

Before I didn't know that there were all these dangers during pregnancy or when I should send women to the hospital.

However, although experienced midwives recognize the value of the training courses, the majority of older midwives suggested that they already had a sufficient understanding of midwifery practice. For example, a Ladina midwife, who professed to only participate in training programs once a year to renew her license, said:

Training courses are good and I learn a lot when I go to them. But it is really the same work that I do here. That's why I don't go to them anymore, because they only talk about the same things that I already do.

Although there are ethnic differences in selection, practices, and authority among midwives in Guatemala (Cosminsky 1982), both Kaqchikel and Ladina midwives in San Martín emphasized the value of their own experiential knowledge over the content presented in training courses, suggesting that experience, rather than ethnicity, may be more important in perceptions of authoritative knowledge.

Rather than emphasizing their own personal experiences, new midwives who were elected to participate in the current training programs in San

Martín attribute their knowledge, ability, and legitimacy to their participation in training courses. Biomedical training courses are the primary if not sole means through which these new midwives are learning the practice. The influence of training programs on the model of midwifery practice held by new midwives is evident in interviews, as it serves as the template for their own stated practice. Recently trained and inexperienced midwives all espoused a formulaic model of midwifery practice that reflected the model taught in training courses, from the number of times they visit their patient, delivery positions, and the reasons for and timing of referrals to the hospital, to the amount they charge for their services. Yet, while new midwives espouse the model of midwifery practice presented in the training courses as their own, they might not actually follow this model in reality. Studies show that training programs have little effect on midwifery practices (Goldman and Gleit 2003; Lang and Elkin 1997). Rather, midwives might only learn how to “talk about” their work in terms that appease representatives of the formal health care system (Jordan 1993: 182–84). Additionally, few of the new SIAS midwives have actually assisted with deliveries since their training. Of the five midwives elected specifically to participate in SIAS, two (40 percent) had not attended a birth on their own in the four years since the program started, while another had only attended her sister’s delivery. Thus, because of their lack of experience, the only knowledge that new midwives have to draw on is that presented in the training course.

However, rather than just repeating the topics presented in training programs, interviews with new midwives illustrate the construction of biomedical training and practice as authoritative knowledge. During interviews, recently trained midwives repeatedly justified their ability and knowledge in terms of their participation in training programs and denied the value of the experiential knowledge of older midwives in their own communities. As a 40-year-old Kaqchikel woman elected to serve as a midwife in 2000 stated:

I was scared when I was elected because I didn’t know how I was going to do the work. But [the other midwife in the community] took me to the training course and they taught me how to do the work.

This midwife admitted that despite the presence of an older and more experienced midwife working in the community prior to the election of these two women, neither attempted to consult her concerning their work, saying that “she is too old and doesn’t work that much.” Other new midwives echoed the value of training programs. As a recently elected midwife said:

If they don’t study in the courses then they won’t know anything, they will never learn how to do the work.

More than justifying their own knowledge and abilities on participation in biomedical training programs, new midwives are actively participating in the construction of biomedical obstetrics as the authoritative knowledge of childbirth. As Jordan (1993: 169) stated, midwifery training programs are a direct attempt to construct an authoritative knowledge of childbirth, in which biomedical obstetrics is privileged above traditional beliefs and practices. In the context of training courses, inexperienced and recently recruited midwives actively participated in the denigration of traditional beliefs and practices while legitimizing biomedical knowledge. During one midwifery training course, a newly elected 26-year-old midwife, whose mother was a midwife, stated "Thank you for teaching us these things. Now we can leave behind our foolish practices (*tonterías*)." Similarly, another midwife said:

We are thankful there are so many studies now that we can learn from, so that we can learn how to do the work correctly.

Thus, younger midwives actively participate in privileging biomedicine and the instructors who control this knowledge by denigrating traditional midwifery knowledge.

However, this does not mean that the new model of midwifery is replacing the authority of experienced midwives among women in rural communities. As Rogoff (cited in Cosminsky 2001a: 185) described for San Pedro la Laguna, women may be forced to utilize midwives whose knowledge and authority stem solely from participating in training courses if older midwives with a supernatural calling are not replaced by midwives with a similar divine mandate. In San Martín, however, there are still a significant number of experienced midwives practicing in rural communities, and women have the option to choose between established midwives and the new midwives trained by SIAS. The fact that few midwives elected to participate in SIAS have attended any deliveries suggests that women prefer to utilize experienced midwives whom they trust rather than inexperienced midwives trained solely by the formal health system, a pattern found in other studies (Cosminsky 1982, Greenberg 1982; Villatoro 1994). As with previous MSPAS training programs, SIAS may fail to supplant experienced midwives if women in rural communities do not call on the newly trained midwives. Yet, while women continue to rely on experienced midwives, the required participation of midwives in SIAS training programs is strongly influencing the practices and authority of all midwives in San Martín.

Practice, Ability, and Authority

The central focus of all training programs is to change midwifery practice, either by supplanting traditional practices with biomedical models or

through delimiting traditional capabilities. The underlying logic of training programs is that maternal and infant mortality rates can be reduced by improving obstetric care and referring women with complications to emergency care in a timely manner. Training programs focus on changing those practices that are deemed to be dangerous for the mother and baby while at the same time teaching midwives basic biomedical obstetrics to recognize risk signs and to know when to refer women to a higher level of care (Cosminsky 2001b: 364). Increased participation in SIAS is pressuring midwives in San Martín to redefine their practices and authority in three areas: prenatal exams, complications and referrals, and charging for their services.

Much of midwifery practice occurs before labor and delivery, with prenatal exams comprising an essential aspect of midwifery in Guatemala. Prenatal exams serve not only as a context for physical exams of the woman and the fetus but also for social interactions between the midwife and her patients in which traditions, rituals, and the cultural meaning surrounding reproduction are passed on along with prenatal education and pragmatic advice (Acevedo and Hurtado 1997; Greenberg 1982). One of the most central practices identified in ethnographic studies of midwives in Guatemala is the practice of prenatal massage through which the midwives' knowledge is embodied and enacted (Acevedo and Hurtado 1997; Cosminsky 2001b). Through massages, midwives are able to determine fetal size and age (Acevedo and Hurtado 1997; Cosminsky 1982, 2001a; Greenberg 1982; Hinojosa 2004). Most significantly, if the fetus is determined to be in a difficult position, midwives are able to perform external cephalic versions, repositioning the fetus through abdominal massage. Not all midwives in San Martín perform massages, however, and only 16 of the 26 (61.5 percent) midwives with more than 5 years of experience routinely perform massages. In contrast, none of the midwives with less than 5 years of experience perform massages, reflecting not only the lack of experience, but also the fact that many training programs condemn massages as dangerous for the fetus (Goldman and Gleit 2003).

While midwives perform prenatal exams, providing services that are based in their own knowledge of the meaning of pregnancy in the local cultural context, the implementation of SIAS is decreasing the role and authority of midwives in prenatal care. One of the central goals of SIAS is to increase prenatal care in rural areas and the increase in the number of prenatal care visits a MSPAS performance measure for evaluating the effectiveness of NGOs contracted through SIAS (La Forgia et al. 2005). SIAS's emphasis on increasing the number of formal prenatal care visits creates a new pressure for midwives to refer their patients to formal health care providers, and many midwives are incorporating prenatal exams as a method of care supplemental to their own. Training programs are thus

encouraging midwives to relinquish their role in prenatal care and to refer their patients to the formal health care system—a process in which midwives themselves are actively participating. In fact, among many newly trained midwives, formal prenatal exams constitute the primary source of prenatal care for their patients.

Sixty-four percent (23 of 36) of midwives interviewed in San Martín stated that the most important thing for a woman's health during pregnancy is *control prenatal* (prenatal care) provided by medical professionals at health centers. All midwives interviewed said that they send their patients to their *control* every month. Even though midwives do not accompany their patients, the majority of midwives stated that it is essential that women be examined at the health center in San Martín or the nearest health post because medical personnel are able to provide tests and exams that midwives cannot, due not only to their medical knowledge but to their control over medical equipment. Doctors and nurses possess stethoscopes and blood pressure monitors to check for pre-eclampsia, scales to weigh the expectant mother, and have access to prenatal vitamins and medication. Few midwives, regardless of age or experience, contested the authority of the medical staff to perform prenatal exams due to their control of the necessary equipment. Only one midwife denied the importance of medical equipment for prenatal care, saying:

A woman told me that doctors know a lot more than the midwives. She said that midwives can't attend births correctly because they don't have the apparatuses. Only the doctors have the apparatuses and know how to use them... only doctors can attend to women correctly.

I told her, that's not true. Midwives can attend births. We know what's going on with the birth even without the apparatuses, because we can see what's going on by watching the signs, the changes in the body, and everything physical.

Yet, while this midwife argued for the experiential knowledge of midwives, she still stated that she sends all her patients to the health center in San Martín once a month for prenatal exams.

Prenatal exams performed by medical personnel in formal health centers are no longer considered supplemental but are now required by many midwives as a condition of assistance during pregnancy. Midwives throughout San Martín stated they will refuse to attend women who request assistance past their seventh month of pregnancy and have not received prenatal care from the health center or post. Although midwives stated various reasons as to why they will not accept women with no formal prenatal care, the primary reason is to protect themselves from personal responsibility and

blame by only accepting those women who pose little risk for obstetric complications (Cosminsky 2001b: 367; Hinojosa 2004: 647). As one midwife stated:

I can only attend pregnancies that are safe, that are progressing normally. If a woman comes late and has never gone to her control, you can't know if everything is normal.

Similarly, other midwives stated that if women come to them late and have not seen a doctor, there is not adequate time for them to take their prenatal vitamins, which could lead to complications. By refusing women with no formal prenatal care, midwives not only contribute to the medicalization of reproduction but limit their own authority by only accepting those cases that medical personnel have defined as safe for them to attend (Cosminsky 2001b: 365).

By denying pregnancy care to women who have not received formal prenatal care, midwives are also transforming the social relationships and obligations of the position within their communities. As Cosminsky (2001a: 189) stated, refusing to treat someone who requests her services is a violation of the midwife's divine mandate and is punishable by supernatural forces. Midwives cannot easily deny care to women who seek their assistance because they are obligated by social relations, communal obligations, and supernatural forces to attend to whoever asks the favor of them. However, only eight (22 percent) midwives, all of whom have over fifteen years of experience (36 percent), said they would accept women who come to them late in their pregnancies and have not had any prenatal care. As one midwife stated:

Sure I help them. Why not? Only I have to tell them that because they are so late, I cannot help much because I don't know how the baby is positioned or if everything is normal.

In addition to ante partum care, midwives participating in training programs are increasingly encouraged to refer women with obstetric complications to the national hospital rather than attempting to assist them. Based on the Safe Motherhood paradigm (Kwast 1995; Levitt and Minden 1995; Safe Motherhood IAG 2002), the central effort of current training programs is teaching midwives to recognize the risk signs that indicate obstetric complications and to know when they must refer women to the hospital. In interviews, the majority of midwives, including those with experience, underscored the value of the information they learned in training programs and suggested that they routinely referred women who presented any of the risk signs to biomedical health facilities. One experienced midwife stated

that although she can manipulate fetal positioning during early pregnancy, after a woman is in her eighth or ninth month, she cannot externally turn the fetus and has to send the woman to the hospital if the baby is malpositioned. Among newly elected midwives with no prior experience or training, the importance of diagnosing obstetric risk factors is essential to defining their practice within the limits presented in the courses. As one midwife elected to participate in SIAS stated:

The best thing about the training courses, they teach me when I can help women and when I need to send them to the hospital.

The act of referral to protect herself is part of a larger process in which the relationship between midwives and their patients is becoming more authoritative—a model promoted by the formal medical system. Training programs frequently encourage midwives to assume a position of authority with their patients in which they can select whom they accept and demand that women follow their orders. Constructing this hierarchical relationship allows midwives who refer their patients to deny responsibility for any adverse outcomes, and to blame shifts to either the physician or the woman and her family. Several midwives stated that when they refer women to the hospital, if the family refuses to go or if there are problems at the hospital, the midwife will not accept blame because she has fulfilled her duties. For example, one midwife stated that if the woman and her family refuse to go to the hospital, she makes them sign a release form in front of the auxiliary mayor stating that they refused to follow her advice. Whereas the divine calling of midwives used to provide the authority and protection, to some extent, from personal responsibility (Paul 1975), the fact that midwives are compelled to justify their actions to political and medical authorities is further evidence of the vulnerability of midwives to accusations of malpractice, while at the same time a sign of their increasing subordination to the formal health care system.

Despite the emphasis placed on training midwives to refer women to higher levels of care in the case of birth complications, midwives do not always refer patients, nor can they determine whether a woman will follow her advice and go to the hospital. Berry (2006) showed that the expectation of normal deliveries, the emphasis on social factors underlying problems, and a focus on empirical evidence limit referrals by midwives. Additionally, while midwives may refer women to the hospital, it is largely the women and their family members who decide whether the woman should go to the hospital based on their own interpretation of the complication, the authority and knowledge of the midwife, and their view of the hospital (Berry 2006; Glei and Goldman 2000; Glei et al. 2003; Goldman and Glei 2003; Lang and Elkin 1997: 28; Rööst et al. 2004). A common factor in non-compliance

with referrals among rural women is the refusal of the husband due to jealousy of male doctors, embarrassment, and a fear of cost (Glei and Goldman 2000; Glei et al. 2003; Greenberg 1982). Women frequently have their own aversions to giving birth in the hospital. Ethnic and social discrimination, embarrassment, language barriers, poor treatment, limited hours, fear of surgery, and a lack of information concerning procedures performed in the hospital along with a strong desire to have a normal vaginal delivery at home often prohibit women from following a midwives' suggestion for referral (Acevedo and Hurtado 1997; Berry 2006, 2008; Glei and Goldman 2000; Glei et al. 2003).

While much of the family's opposition to referrals is based on personal objections, the cost of transportation to the national hospital comprises a significant limiting factor. The majority of communities in San Martín have access to public transportation two days a week for the local market. In emergencies, families must either call the Fire Department in San Martín, which charges roughly \$6.75 for a ride and attends to only half of the communities in the municipality, or request the assistance of neighbors who have a private vehicle, and who may charge anywhere between \$2.70 to \$40, depending on distance and the time of day. Based on the average daily wage of \$3.33 for agricultural workers in the area, the cost of transportation to the hospital may prove prohibitive for many households despite the need. Few training courses or health programs take the cost of transportation into consideration in their promotion of referrals; a neglect that creates greater conflict between the demands and expectations of the midwife and the social context in which she and her patients live.

Yet, despite the personal risk, experienced midwives are often compelled to provide assistance to pregnant women even if the latter refuse to follow the recommendation for referral. During the course of interviews, several midwives recounted specific experiences in which they were forced to attend to women with complications. These narratives of problems are strategies in which midwives not only alleviate their responsibility for complications but also reaffirm their own authority based on their experiential knowledge and abilities. For example, one experienced midwife stated that during one delivery the laboring woman stated that she knew "in her soul" that she was going to die because the fetus was poorly positioned. But the midwife massaged the abdomen, repositioning the fetus, and the delivery proceeded without complication. Experienced midwives thus use narratives of obstetric complications as a medium to validate their own knowledge and practice and to contest the authority of physicians and biomedicine. However, despite the attempt to negotiate the authority of their own knowledge and practices in relation to the model presented in training courses, these experienced midwives stated that now they must refer their

patients with complications to the hospital or else they will lose their licenses.

Finally, in addition to actual practices performed during prenatal care and delivery, training programs are transforming the nature of midwifery practice by encouraging authoritative relations with patients through the cost of midwifery services. The amount that midwives charge for their services is largely determined by families and other midwives within their own communities. Although individual midwives may set their prices depending on their reputation and the specialized services that they offer, they must negotiate their own prices in relation to both the expectations and demands of the population and the standards set by other midwives within the community. Failure to adhere to these communal and collegial standards can result in harsh social critiques of personal greed by communal members and other midwives, leading to social sanctions and drop in clients (Paul and Paul 1975; PIES n.d.). The fear of being accused of overcharging is very apparent among midwives in San Martín, and all midwives interviewed felt compelled to defend the amount of they charged for their services.

Among the midwives sampled in San Martín, the average amount that midwives charged for their services was roughly Q100 (\$13.25), although the price varies from Q5 to Q300 (\$0.67 to \$40) depending on location, distance, and complication. This price includes ante partum visits, delivery, and postpartum visits. Many midwives justified their price by arguing for the increases in bus fares and the price of equipment, including candles, scissors, and gloves. Only one midwife said that she does not have a standard price, but rather only charges what the family is able to pay. Within individual communities, the price for midwifery services is largely uniform, and midwives say that they all charge the same so that there is no competition between them. However, there are individual variations in price within and between communities that cause personal conflict. In one community, two midwives interviewed critiqued a third recently elected midwife for charging for prenatal visits in addition to the agreed-on rate of Q100 for the delivery. In response, they began to tell women in the community that she was taking advantage of them and urged them to stop patronizing her.

Even though midwives varied greatly in the amount they charged for their services, a recurring theme among the interviews was the failure of families to pay for the midwife's services. Several midwives stated that families would get mad if the midwife asked for payment, and so to avoid problems they had to wait patiently for their fees. Although several midwives stated that they received little or no payment, the majority of midwives noted that they were obligated to continue the practice regardless of the personal cost or benefit. Midwifery practice, like shamanism, is often seen as a supernatural gift, and as such is not something that can be sold but rather must be shared by those

who were destined to receive the ability (Acevedo and Hurtado 1997: 304; Paul and Paul 1975: 710; PIES n.d.: 32). As an elderly Kaqchikel midwife stated, "one suffers much, but one is obligated to do the work." Another younger Ladina midwife said that the pay they asked for was only "symbolic," because while it wasn't enough to cover her time or expenses it did symbolize the gratitude of the family for her work. Other midwives denied the importance of payment at all. One evangelical midwife said that she only charges Q5 (\$0.67) for her work because God provides all the things that she needs, and so she has no concern over making money.

In contrast to this traditional model of personal obligation and locally sanctioned prices, midwifery training programs are fostering the increased commercialization of midwifery services by encouraging midwives to increase their prices. Many midwives stated that they recently increased their prices in response to suggestions made by instructors in the training courses, who encouraged the midwives to charge anywhere from Q200 to 300 (\$26.50 to \$40) for their work due to the difficulty of the job and the fact that they must buy their own equipment. Additionally, several midwives said that trainers in some programs told them that they should refuse to register newborns with the health system until they receive payment from the families, a theme documented in other training programs (Cosminsky 2001b: 362). One midwife stated that people in her community were irresponsible, and although they promised to pay her, they just kept telling her to wait. Now she refuses to register any children with the municipality or the health center until she receives her payment in full. Since she has started doing this, she noted that people have become more responsible because they realize that she is serious. By encouraging midwives to demand greater financial compensation for their work and to deny services until payments are rendered, training programs are attempting to transform the role into a profession defined by authoritative consumer relationships rather than socio-religious obligations (Cosminsky 2001a: 189; PIES n.d.: 32).

CONCLUSION

Midwifery practice in San Martín Jilotepeque is in the midst of change as national health programs reconstruct the role of the midwife to address specific health concerns that reflect international health care paradigms. In SIAS, which is based on international reproductive health care models and neoliberal agendas, midwives are the primary means of achieving the national health care goals of reducing maternal and infant mortality rates set forth in the 1996 Peace Accords. Following international paradigms and agendas, midwives are being called to solve a national crisis. The

increased international attention to reproductive health care and the Safe Motherhood Initiative, along with structural adjustment programs encouraging governmental decentralization and cost effectiveness through the use of preexisting "community volunteers" have redefined the role and potential of midwives in rural areas.

Midwives in Guatemala have interacted with the national health care system through training courses to some degree for decades. However, the implementation of SIAS in San Martín exacerbated the process of medicalization and transformation in midwifery practice and in the process has redefined the identity, practice, and authority of midwives. The attempt to incorporate midwives into the national health care system not only focused on recruiting existing midwives but also fostered an entirely new model of selection. As communities were encouraged to produce new midwives they bypassed the traditional socio-ritual criteria necessary to assume the position and utilized the process of democratic elections that was originally reserved for the selection of health promoters. Through this process a new cohort of midwives has been created based on a model devoid of the spiritual, experiential, and personal requirements that regulated acceptance of the role.

Additionally, these new midwives elected to participate in SIAS base much, if not all, of their knowledge, abilities, and authority on their participation in midwifery training programs and the biomedical model presented in them. Young midwives are directly participating in the construction of biomedicine as authoritative knowledge and midwifery practice as they denigrate their own traditional beliefs and practices. Whereas experienced midwives attempt to negotiate the authority of biomedical knowledge and practice in terms of their own knowledge and abilities, newly elected midwives espouse a model of standardized midwifery practice presented in training courses. This shift in methods of education entails a transformation of midwifery practice and identity, as a new cohort of midwives in San Martín base their knowledge, abilities, and authority on their participation in biomedical training programs.

Finally, while midwives are increasingly exposed to and adopt biomedical practices, they also must limit their own traditional practices and assume an authoritative relationship with their patients to protect themselves from personal and professional responsibility for adverse outcomes. Midwives in San Martín are participating in the medicalization of reproduction and are relinquishing some of their own abilities and authority. Along with newly recruited midwives, many experienced midwives now send their patients to prenatal exams at health centers and deny assistance to women who do not have ante-partum care to protect themselves from accusations of malpractice. However, many experienced midwives negotiate the pressures for medicalization in terms of their own experiential knowledge and obligations. Opposed to

the authoritative model of relationships promoted by the formal health care system, many experienced midwives still feel obligated to provide obstetric assistance to women, regardless of ability to pay, history of care, or potential for complications. However, as midwives increasingly participate in training programs and are placed under greater supervision by medical staff and local authorities, they are forced to limit their practices to protect themselves.

The lasting impact of SIAS on midwifery practice and identity in San Martín is uncertain and depends largely on the reaction of women in rural communities. Many attempts by the MSPAS to replace experienced midwives in Guatemala have failed because women refuse to hire inexperienced midwives who fail to satisfy established socio-religious requirements of the position. The fact that few of the midwives elected specifically to participate in SIAS in San Martín have attended a delivery shows that women continue to prefer experienced midwives who are recruited through traditional means. If women continue to reject the SIAS-elected midwives, they may have to either adapt their own practices in accordance with local models or relinquish their positions. Yet, given the large numbers of midwives participating in SIAS at the local and national levels, SIAS may play a significant role in redefining not only the nature of midwifery practice and identity in Guatemala but also local conceptions and expectations of the position.

ACKNOWLEDGMENTS

This research was funded by a Fulbright Institute for International Education Fellowship from 2002–2003. The author is grateful to Barbara Scheiber and the staff at Behrhorst Partners for Development for their assistance and support in conducting this research. He is also grateful to the three anonymous reviewers for their helpful comments and suggestions for improving this manuscript.

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