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**ABSTRACT**

The thesis examines patient and providers’ beliefs and perceptions of healthcare access in Santiago Atitlan, Guatemala. Drawing from ethnographic field research, this thesis explores the links among local contextual factors of Santiago Atitlan, including the configuration of social and economic class, gender and ethnic relationships, the availability of resources and technology, and historical and cultural patterns and the short- and long-term effects of capitalist penetration of health care.

In this thesis, I discuss the influence that capitalism has on the production, distribution, and consumption of health services in Guatemala and how these processes reflect the class relations of the larger society in which the Atiteco medical system functions. I argue that the medical system of Santiago Atitlan is a reflection of the hierarchical and unequal social relations based on class, ethnicity, gender, and region found in the larger society. More specifically, I argue that these hierarchical and unequal social relations are reflected in a particular pattern of medical pluralism described in the literature as a “dominative medical system.”{{7 Singer, Merrill 2007; 148}} In other words, while several different healing traditions coexist in Guatemalan society, the biomedical health tradition is most closely aligned with the dominant social groups and is the dominant healing tradition, as well.

 The thesis is presented in five sections: Introduction, Methods, Background, Findings, and Discussion. The Introduction outlines the specific aims, rationale, and significance of the research project. The Methods section discusses the ethnographic research process and includes a description of participant observation, interviews, and data management and analysis.

 The background is organized in two parts. Part One of the Background situates the theoretical importance of the research within broader medical anthropological inquiry and more specifically in the domain of political economic medical anthropology. The second part the background establishes the context of the research, both providing a historical background of Guatemala and Santiago Atitlan, as well as a literature review of previous studies on healthcare access in the country.

The findings are presented in three parts. Part One of Findings provides a description of the ethnographic setting. Part Two of Findings provides a description of the patient sample, mothers, and reports the major themes that characterized their beliefs and perceptions of healthcare access. Part Three of Findings provides a personal background for each of the providers sampled, and reports the major themes that characterize their beliefs and perceptions of healthcare access.

The final section, the Discussion, includes a discussion of the findings and attempts to draw some conclusions about healthcare access in Santiago Atitlan.

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**INTRODUCTION**

The research project discussed in this paper was part of a larger study on infant and maternal health conducted by the Guatemala Health Initiative (GHI). GHI is an interdisciplinary student organization at the University of Pennsylvania that works to strengthen clinical services and community health promotion in resource-poor communities in Guatemala. A central goal of GHI is to use the knowledge gained through participatory research and clinical and cultural experiences to develop effective, sustainable, and culturally sensitive health interventions. (See Appendix 1)

**Specific Aims**

The goal of my ethnographic research project in Santiago Atitlan was to understand patient and providers’ beliefs and perceptions of healthcare access. Based on my findings, this thesis paper connects local contextual factors of Santiago Atitlan, including the configuration of social and economic class, gender and ethnic relationships, the availability of resources and technology, and historical and cultural patterns to the short- and long-term effects of capitalist penetration of health care.

**Significance**

 In 1996, the Guatemalan government signed a peace agreement that formally ended a 36-year guerrilla war, which had left more than 100,000 people dead and had created, by some estimates, 1 million refugees. Provisions for healthcare reform were made as the country embarked on the task of rebuilding its social, economic, and political infrastructure. Despite all efforts and more than 10 years later, access to healthcare remains an urgent and unresolved problem.

While previous research has tended to focus on either micro- or macro-level analysis, this research project attempted to reconcile the relationship between macro- and micro-level explanations in order to better understand healthcare access in Santiago Atitlan. This thesis paper asserts the dominance of macrolevel structures and processes that influence healthcare access in Santiago Atitlan but also demonstrates that a thorough understanding of the issue requires analysis of microlevel phenomena, as well.Analysis of the microlevel phenomena contribute to the understanding of the perceived barriers to healthcare in Santiago Atitlan.

**Rationale**

The motivation for this research project was inspired by the paper, “Free Markets and Dead Mothers: The Social Ecology of Maternal Mortality in Post-Socialist Mongolia.”{{41 Janes,Craig R. 2004; }} Drawing on case-study ethnographic and epidemiological data, the authors explored the links between neoliberal economic reform and maternal mortality in Mongolia. This paper influenced me to investigate how both local and structural factors affect healthcare-seeking behavior in Santiago Atitlan.

**METHODS**

 Since 2005, GHI has primarily worked with the Hospitalito Atitlán to improve health in Santiago Atitlán. In response to community concerns about high infant and maternal mortality rates, GHI launched a two month ethnographic field study to better inform future initiatives that will address this issue. Nine undergraduates from the School of Arts and Sciences and the School of Nursing and one student from the School of Medicine contributed to the study with findings on various topics including, but not limited to, midwifery, social economic status, biomedicine, religion, culture, and nutrition. The project was a collaborative effort by all members on the research team and was overseen by four faculty members.

**Participant Observation**

 Participant observation included formal and informal interviews, direct observation, and participation in daily life in order to gain insight into the cultural practices in Santiago Atitlan. These insights were developed over the course of 2 months and through repeated analysis of the field site.  Field notes were recorded during and/or after participant observation. Detailed descriptions, analyses, and reflections were documented for each observation and included: date, time, and place of observation; specific facts, numbers, and details of what happened at the site; sensory impressions: sights, sounds, textures, smells, tastes; specific words, phrases, and summaries of conversations; questions about people or behaviors at the site for future investigation; and personal responses. The field notes and questionnaire responses were hand recorded at the time of the interview. Additional notes and observations were recorded during or immediately after interviews were conducted. Detailed descriptions, analyses, and reflections were documented for each observation and included: date, time, and place of observation; specific facts, numbers, and details of what happened at the site; sensory impressions: sights, sounds, textures, smells, tastes; specific words, phrases, and summaries of conversations; questions about people or behaviors for future investigation; and personal responses. The main sites for participant observation included: the Hospitalito, the Centro de Salud, schools, homes of interviewees, health-related meetings, and commercial centers of town (the marina and the market).

**Semi-Structured Interviews**

*Sample*

 Participant observation was supplemented with ethnographic interviews to provide further insight to the research question. Because the goal of the larger study aimed to understand infant and maternal health, my interview sample was restricted to mothers. Purposive sampling was employed to gain a deeper understanding of the urban-rural disparities initially observed in Santiago Atitlan. Therefore, two population sub-groups were interviewed: 1) the urban group included mothers living within cantons located in the center of town and 2) the rural group included mothers from Tzancha, a canton located in the outskirts of town. My translators were instrumental in attaining participants for the urban group. Generally, the mothers interviewed from this group included family, friends, and neighbors of the translators, but some were simply women in their yards that we happened to pass by in our travels. I gained entry to the rural group of mothers through a volunteer position I held at a pre-school in Tzancha. After making arrangements with the teacher, I asked the students to lead me to their homes so I could inquire with their mother about an interview. With the help of the teacher and my students, I secured an adequate sample pool, comprised mainly of the mothers of students. In these ways, convenience and snowball sampling was employed in addition to purposive sampling in the selection process.

 A second sample was purposively selected to interview health care providers on the topic of health care access.

*Interview Questionnaires*

 The interview questionnaire administered to mothers was composed of approximately 50 open-ended questions addressing the following topics: (i) demographics, (ii) economic status, (iii) diet, (iv) education, (v) pregnancy related health-seeking behavior (vi) politics, and (vii) general health-seeking behavior (See Appendix 2). It took approximately 30 minutes to one hour to conduct each interview. In total, over thirty interviews were conducted –at least fifteen formal interviews were conducted in each population subgroup.

 I administered the questionnaire with the assistance of two bilingual Spanish-Tz’tujil interpreters. To ensure cultural appropriateness of each question, I consulted with the interpreters over the preliminary questionnaire before we began interviews. The questionnaire was expanded throughout the course of the study in order to cover new topics that were found to be relevant.

 A second set of interviews was conducted with a sample of healthcare providers and professionals. These semi-structured interviews consisted of open-ended questions relating to the topic of healthcare access.

**Data Management**

 Data collection occurred from June to July 2007. Field notes were promptly compiled into electronic reports that were later thematically coded in preparation for qualitative analyses.

**Data analysis**

 Thematic analysis of the data followed the grounded theory approach and was aided by the use of NVivo 7.0 qualitative data software. By identifying key themes in the data and then categorizing the relationships of those themes in the context and process of the research project, it was possible to theorize an explanation for the data. As an inductive approach, grounded theory analysis facilitated a transition from a specific understanding of the data to a more general and comprehensive understanding.{{42 Strauss, A. 1990}}

**BACKGROUND**

Part I. Political Economic Medical Anthropology

This paper analyses the state of healthcare access from a political economic perspective and aims to connect the microlevel perceptions and beliefs of patients and providers of Santiago Atitlan with the macrolevel political and economic forces that have shaped the prevailing healthcare system in Guatemala today.

**Political Economic Medical Anthropology**

Political Economic Medical Anthropology (PEMA) is a theoretical and practical effort to understand health issues in light of the larger political and economic forces that influence human relationships, social behavior, and the collective experience, including forces at the institutional, national, and global level.{{14 Singer,Merrill 1986; 128}} By analyzing health through this perspective, modern anthropology can be linked to a historical understanding of the large-scale social and economic structures in which affliction is embedded.{{13 Farmer,Paul 2004; 305}}

PEMA is concerned with investigating the social origins of illness.{{14 Singer,Merrill 1986; 129}} Disease is not viewed as an uncomplicated outcome of an infectious agent or pathophysiologic disturbance. Instead, the cause of disease is viewed a variety of problems –including malnutrition, economic insecurity, occupational risks, bad housing, and lack of political power –create an underlying predisposition to disease and death" (Waitzkin 1981:98). PEMA asserts that the ultimate origin of these problems is not environmental or biological but social, specifically the existence of inherently oppressive social relationships of production and expropriation.{{14 Singer,Merrill 1986; 129}}

*Dependency Theory and World-Systems Theory*

Development theory and world-systems theory contribute to the understanding of the global economic processes and class relationships brought into existence by the growth and spread of capitalism and our comprehension of the contemporary world. In general, those who study international health from the political economic perspective accept dependency theory, the idea that the development of the advanced capitalist countries has come, to a considerable degree, at the expense of the masses of people in underdeveloped nations. Dependency theory explains development and underdevelopment as bipolar consequences capital accumulation, a process that was initially instituted by colonialism and is now perpetuated through neocolonialism.{{15 Baer,Hans A. 1982; 16}} For example, Navarro (2000) has argued that the "underdevelopment of health" in Latin America and other parts of the Third World is an inevitable consequence of the depletion of natural and human resources that accompanies imperialism.

 By locating ethnographic evidence within historical social and economic structures, anthropologists have used the framework of world-systems theory in an attempt to depict the social machinery of oppression.{{13 Farmer,Paul 2004; 312}} World-systems theory explains historical social change and the long-term trends of development based on the idea that the world system is characterized by mechanisms, which direct the redistribution of resources from the periphery to the core. The process of resource redistribution can be understood as a structural stratification system composed of economically and politically dominant core societies and dependent peripheral and semi-peripheral regions. The modern world-system originated during the 16th century when the Americas were incorporated into the expanding Western European-centered Afroeurasian system. European expansion was achieved largely by force and the surviving populations of indigenous Americans were mobilized to supply labor for a colonial economy that was repeatedly reorganized according to the changing geopolitical and economic forces emanating from the European and later North American core societies. Throughout world history some peripheral societies have improved their positions in the larger core-periphery hierarchy, but most have maintained their relative positions. The development of the modern world-system can be understood in terms of capitalist accumulation and geopolitics, in which businesses and states compete with one another for power and wealth. Competition is influenced by the dynamics of class struggle and by the resistance of peripheral peoples to domination from the core (paraphrased from Chase-Dunn, 2000).{{22 Chase-Dunn,Christopher 2000; 111}}

Bear (1982) points out that the spread of European colonialism often destroyed indigenous subsistence systems, which had previously provided these populations with a relatively well-balanced diet, and substituted cash-crop economies which limited the amount of local foods available to these people and made them more dependent on imported foodstuffs, many of limited nutritional value. He explains that the unequal exchange relationship between the developed core nations and the semi-peripheral and peripheral nations has contributed to serious health problems in the latter.

 World system and dependency theorists traditionally focus research at the macro-level, analyzing how nations at the center of the capitalist system have systematically extracted wealth from peripheral areas, thereby causing the underdevelopment now evidenced in many third world nations.{{14 Singer,Merrill 1986; 128}} However, by focusing research at the macro-level, little attention is devoted to studying these processes at the micro-level, particularlyy with respect to the micro-populations that are commonly investigated by anthropologists. Macro-level analysis neglects to consider how such populations existed before European expansion and the advent of capitalism and the manner in which their modes of existence were penetrated, subordinated, destroyed, or absorbed, first by the growing market and subsequently by industrial capitalism.{{43 Wolf, E. 1982; 23}} While much of the past research in medical anthropology has focused on micro-populations, it has not sufficiently acknowledged the role of macro-level structures and processes rendering these analyses incomplete at best, as well.{{14 Singer,Merrill 1986; 128}} Thus, the political economic approach of medical anthropology aims to reconcile the relationship between macro- and microlevels of explanation; it asserts the dominance of macrolevel structures and processes but also maintains that a thorough understanding of any issue requires analysis of microlevel phenomena as well.{{14 Singer,Merrill 1986; 128}}

*The Political Economy of Health*

 Baer (1982) explains that “the ‘political economy of health’ is in essence a critical endeavor which attempts to understand health-related issues within the context of class and imperialist relations inherent in the capitalist world-system. He divides the political economy of health into two major sub-areas: the political economy of illness, and the political economy of healthcare. The political economy of illness seeks a holistic understanding of the etiology and distribution of morbidity, mortality, and risk behaviors; whereas the political economy of healthcare focuses on the influence that capitalism has on the production, distribution, and consumption of health services and how these processes reflect the class relations of the larger societies in which medical systems function. These sub-areas are not mutually exclusive, but overlapping and interwoven.{{15 Baer,Hans A. 1982; 1-2}}

*Political Economy of Healthcare: Dominative Medical Systems*

Recognition of the importance of power relations within medicine calls attention to the existence of several levels in the healthcare systems of core capitalist and peripheral nations.{{7 Singer, Merrill 2007; 121}} As discussed previously, PEMA seeks to comprehend the relationships between such levels. This concern extends to the nature of medical pluralism, which flourishes in class-divided societies. Critical medical anthropologists have concluded that the patterns of medical pluralism found in state societies tend to reflect hierarchical and unequal social relations based on class, caste, ethnicity, region, religion, and gender found in the larger society. Concluding that biomedicine holds a dominant status over heterodox and folk medical systems, critical medical anthropologists describe national medical systems in the modern world as ‘plural’ rather than ‘pluralistic’.{{14 Singer,Merrill 1986; 129}} However, Singer and Baer (2007) argue that plural medical systems are best described as “dominative.” In a “dominative medical system” several different healing traditions coexist in the same society, but one tends to be more closely aligned with the dominant social groups in that society and tends to be the dominant healing tradition, as well.{{7 Singer, Merrill 2007; 121}}

The concept for a dominative medical system is supported by other models. Chrisman and Kleinman (1983) developed a widely used model for plural medical systems that identifies three overlapping sectors: the popular sector, the folk sector, and the professional sector. The popular sector consists of healthcare performed by patients themselves along with their families, social networks, and communities. The second level, the folk sector, includes various healers who are self-trained or undergo an apprenticeship and tend to practice independently and often out of their home and even on a quasi-legal or illegal basis. The third level, the professional sector, is made up of practitioners and bureaucratic structures, such as clinics and hospitals, which are associated with both biomedicine and professionalized medical systems. As in a dominative medical system, Chrisman and Kleinman’s model associates biomedicine with the highest level in society.

In a similar fashion, Fabrega (1997) identifies two levels of sickness and health adaptation (SH) in state societies: 1) an official, scholarly academic medical system oriented to the care of elites and 2) a wide array of less prestigious physicians and folk healers who treat subordinate segments of the society. Fabrega explains that traditionally, the state plays an increasing role in medical care by hiring practitioners for elites and providing free or nominal care for the poor. SH in modern state societies worldwide is characterized by the emergence of biomedicine as a dominant and hegemonic profession. The establishment of biomedicine is further characterized by patterns of secularization that include the decline in the role of institutional religion in public life; an increase in scientific knowledge and an acceptance of biological reductionism, which has the tendency to view disease primarily caused by biological factors; the emergence of the hospital as the center of healing and research; and the universalization of sickness categories.

The Third World model observed in many developing societies, particularly the poorest ones in which biomedicine is largely urban based and poorly funded and largely a privilege of elites and a small middle class, is reflective of a “dominative” healthcare system.{{7 Singer, Merrill 2007; 148}} While the power structure privileges biomedicine and even makes it available on a restricted basis to the masses, it tolerates a wide array of alternative medical systems consisting of, for example, local folk healers, midwives, bonesetters, who serve the majority of people.{{7 Singer, Merrill 2007; 148}}

*Structural Violence*

Paul Farmer (2004) developed the concept of “structural violence” to inform the study of such social inequalities or as he calls it, the “social machinery of oppression.” Structural violence describes the social structures characterized by poverty and steep grades of social inequality, including racism and gender inequality, and is understood as violence exerted systematically –indirectly –by everyone who belongs to a certain social order.{{13 Farmer,Paul 2004; 307}} Paul Farmer (2004) identifies these social and economic structures as the products of neoliberal economics, what he defines as “a constellation of ideas about trade and development and governance that has been internalized by many in the affluent market societies.” He explains that the ideology of competition-driven market championed by neoliberal economics is indebted to and helps replicate inequalities of power. Additionally, he points out that neoliberal thought has been the driving force behind political and economic policies of such institutions like the International Monetary Fund (IMF) and the World Bank (WB), but that these policies have strived less to repair poverty and social inequalities than to manage them.

*More on Neoliberalism*

 Other researchers, many predecessors to Farmer, support similar ideas to those behind “structural violence.” Navarro (2002) argues that Neoliberalism is a political and ideological instrument of class domination (117). He explains that since the 1970s and 1980s there has been a push for globalization of the economy. The United States government and the IMF have put pressure on Latin American countries to open up their economies, to help them integrate into the global economy and thus solve their economic and financial crises.{{45 Navarro, V. 2002; 109}}

The logic behind neoliberal policy posits that countries can participate in the welfare and well-being assumed to result from integration into the global economy only if governments create conditions favorable to the mobility of commerce, investments, and financial transactions. Such conditions are achieved by governments who ascribe to policy prescriptions based on neoliberal orthodoxy made by international agencies (see Table 1). Policies include, among other things, lowering taxes on capital investments and transactions, reducing public deficits through a decrease in public and social (including healthcare) expenditures; deregulating financial and labor markets; privatizing public enterprises and programs (as in the proposals put forward by the WB and IMF to privatize social security systems); and developing fiscal policies that favor high-income sectors of the population, which are assumed to be those most able to save and therefore invest (with the supposition that the riches will “trickle down” to the rest of the population). Such policies have been strongly supported by prominent international financial agencies such as IMF and WB and by governments of major countries, including the United States.{{45 Navarro, V. 2002; 109-110}}

 The globalization of commerce, investments, and finance has become a major force behind public policies, including health policies. Liberalization, under such policies, is facilitated by the penetration of commercial health insurance into the healthcare models across Latin American countries. A dynamic of profit maximization has become a major guiding force behind health policies and as a result long established government national health services are weakened or dismantled. The Pan-American Health Organization (PAHO), the United States Agency for International Development (USAID), and WB actively promote managed care and managed competition in Latin America today.{{45 Navarro, V. 2002; 114}}

However, Navarro argues that deregulation , liberalization, and trans-nationalization of health services negatively affects individuals at the mirco-level in countries where for-profit, insurance-driven medical care is being imposed with assistance from the IMF, WB, and WHO. He supports this arguments highlighting that fact that increasing wages and improvements in working and environmental conditions as promised by the U.S. government on signing the North American Free Trade Agreement have yet to materialize.{{45 Navarro, V. 2002; 115}}

 Navarro points out that the problem is not solely one between the North and South. This dichotomy, put forward by the governing elites in the South, ignores the fact that each country is divided into classes and that class interests are more powerful than national interests. The export of the U.S. medical care model will benefit 20 percent of the Latin American population but hurt the majority. It is the alliance of the top elites on the two continents that is responsible for that predicament.{{45 Navarro, V. 2002; 115}}

 Navarro describes globalization as a specific form of internationalization that responds to specific financial and economic interests that are articulated in the class relations of each society.{{45 Navarro, V. 2002; 114}} Looking at how health and income are generated leads to an understanding of exploitation and domination, the roots of the unjust international order.{{45 Navarro, V. 2002; 117}}

Table 1. Neoliberal Orthodoxy

|  |  |  |
| --- | --- | --- |
|  | Position  | Policy Implications |
| 1. | Public deficits are intrinsically negative because they absorb national savings, increase interest rates, and reduce investments.  | Neoliberalism calls for reducing and eliminating public deficits, freeing up resources needed for private investment, reducing interest rates, and shifting resources from the public to the private sectors. |
| 2. | State regulation of the labor market is also intrinsically negative. It adds rigidities to the labor market, hindering both economic growth and job production.  | Labor should be considered like any other commodity and thus should be unregulated, with wages determined by the forces of the international and national markets.  |
| 3. | Social protection guaranteed by the welfare state and its redistributive policies hinders economic growth. It does so by increasing collective consumption and reducing private savings, in particular, by reducing the savings ability to the wealthiest sectors of the population. The latter groups are the most negatively affected by the redistributive policies of the welfare state –and are also those that have the greatest propensity for saving.  | Based on this assumption of an inverse relationship between redistributive policies and saving and investments, the neoliberal position calls for the reduction and even, in the most extreme cases, the complete elimination of the welfare state.  |
| 4.  | The state should not intervene in regulating foreign trade or international financial markets.  | The free flow of goods, services, and financial capital is the best way of guaranteeing an efficient and equitable worldwide distribution of resources. |

Adapted from Navarro (2002)

 Kolko (1998) argues that the poorest nations have experienced economic stagnation and decline, in spite of, and on occasion because of IMF structural adjustment policies. They explain that IMF policies require many poor countries to increase exports despite the falling prices of world commodities. This has been the principal cause of economic problems in the poorest nations. IMF conditions also demand lower government expenditures that have led to large decreases in general social spending.

 Laurell and Arellano (2002) examine the World Bank’s health policy. Investing in Health is the World Bank’s plan for new health policy within the context of structural adjustment. As the “agenda for action” indicates, the implicit premises of the plan are neoliberal. Health is defined as a private good, therefore health policy is based on two complementary principles: reduction of state intervention and public responsibility, and promotion of diversity and competition (ie privatization). Under this outline, public institutions should provide a limited number of narrowly defined public goods, or cost-efficient forms of relief for the poor. All other health-related activities are considered private duties, to be resolved by the market, nongovernmental agencies, or families. The WB proposes this as a way to achieve fiscal balance, while pushing to recommodify healthcare and turn health into a terrain for capital accumulation through the selective privatization of health-related financial and “discretionary” services. The World Bank’s proposals imply a dismantaling of public institutions (albeit unequal accessibility, these are still the only institutions accessible to the majority) and reject health human need and a social right.

Banerji (2002) analyzes the changes in policies of the WHO, UNICEF, and the World Bank since the Alma-Ata Declaration and shows how these agencies have created the dominant thought in the political, economic, and academic circles of the developed world. According to Banerji, the struggles of the labor and social movements culminated in the Alma-Ata Declaration of self-reliance in health for the peoples of the world. In order to protect their commercial and political interests, First World countries responded by “invented” Selective Primary Health Care. Using WHO, UNICEF, WB, and other agencies, rich countries were able to impose numerous “international initiatives” such as global programs on immunization, AIDS, and tuberculosis on poor countries. He shows how these programs were astonishingly ineffective in concept, design, and implementation, and how the international agencies refused to take note of published criticism.

**BACKGROUND**

Part II. Guatemala

*Guatemala*

Its land area of 108,889 km2 is divided administratively into 22 departments and 331 municipalities, which in turn have a total of 20,485 communities. In 2000, the country had an estimated population of 11,433,694; 65% lived in rural area. The average density was 102 inhabitants per km2. The indigenous population represents 48% of the total. In 2000, the annual population growth rate was 2.9%. In terms of age distribution, 44% of the total population was children and adolescents under 15 years old and 5.3% were 60 or older (Figure 1). Life expectancy was 67.2 years (64.7 years for men and 69.8 years for women).

Agricultural activity accounted for 26% of GDP and generated60% of employment. In 1998, the Guatemalan economy grew 5%. In 1999 and 2000, GDP grew 3.6% and 3.3%, respectively, and per capita GDP at 1995 prices was 0.9% and 0.8%, respectively. In 1998, the net tax burden (not including returned tax credit) came to 8.9% of GDP. The internal debt as a proportion of GDP was reduced from 10.6% in 1990 to 5.2% in 1998, and the foreign debt went from 18% in 1990 to 10% in 1998. In 1998, 91.3% of the indigenous population was living below the poverty line. Open unemployment rose from 3.7% in 1995 to 5.6% in 1999. In 1999, the illiteracy rate was 31.7% (39.2% for women and 26.3% for men). In 1999, the birth rate was 34 per 1,000 population.{{11 Pan American Health Organization 2004; 8}}

*History*

After almost three centuries as a Spanish colony, Guatemala won its independence in 1821. During the second half of the 20th century, it experienced a variety of military and civilian governments, as well as a 36-year guerrilla war. In 1996, the government signed a peace agreement formally ending the conflict, which had left more than 100,000 people dead and had created, by some estimates, some 1 million refugees. (CIA)

Guatemala has been repeatedly restructured by world market forces and geopolitics. The landed colonial patricians were displaced by the agro-exporters (who ruled in alliance with the military), and these, in turn, have been partially supplanted by a new transnational elite of neoliberals who seek to link the national economies more tightly with core capital and global markets. Both liberalism and Neoliberalism in Guatemala were and are combinations of imported ideas and local adaptations that justify and facilitate new forms of exploitation and outmaneuvering of rivals struggles was a system of elite-controlled elections in which this transnational elite gained the greatest share of power.{{22 Chase-Dunn,Christopher 2000; 119}}

After the economic crisis of the 1980s and struggling with the burden of foreign debt, Guatemala saw prices for major export crops fall dramatically.{{23 Morgan,Lynn M. 1989; 229}}Guatemala was forced to renegotiate international debt and renew attention toward internal economic diversification. The state responded by reducing investments, in health services, food subsidies, and other programs that affect health status.{{23 Morgan,Lynn M. 1989; 229}} Poverty and concomitantly, social unrest increased throughout the region. Guatemala was influenced by bilateral and multilateral agencies. The IMF has offered strict prescriptions for internal financial readjustments in exchange for negotiating debt payments.{{23 Morgan,Lynn M. 1989; 229}}

In the health arena, Guatemala followed the mandates of WHO, UNICEF, and USAID in return for the funding for health programs, which helped the government deflect not only health care costs but also popular discontent. Initially, primary healthcare was one international mandate that Guatemala adopted, but by the 1990s attention shifted to other areas.{{23 Morgan,Lynn M. 1989; 229}}

However influential international organizations may have been in the shaping of Guatemalan economic, social, and health policies, Chase-Dunn (2000) points out that the neoliberal domestic elite may sometimes have interests that contradict the policies of the neoliberal international organizations, such as the World Bank and the IMF. On these issues, the domestic neoliberals may join the older landed elites in a common cause to defend Guatemalan "sovereignty" against the meddling of the international financial institutions and the UN. The significance of this consideration stems from Chase-Dunn’s argument that the strength of the neoliberal fraction is perhaps weaker in Guatemala compared to other Central American countries.

After 36-years guerrilla war and several attempts at peace talks, a formal negotiation process got under way in 1994. The Peace Accord was signed on 29 December 1996 by representatives of the Government and the guerrilla forces. The Peace Accord outlined a plan for the institutional modernization of the state with provisions for more effective implementation of social programs that would support the processes of peace and economic development. Provisions were aimed at improving efficiency and management capacity, addressing the delicate question of public finances, and implementing effective social programs that would support the processes of peace and economic development.

One of those provisions, the Health Code, was a public policy instrument intended to support health sector reform and expand coverage. In 1997, the Health Code, was approved and stipulated that the Ministry of Public Health and Social Welfare (MSPAS) was formally responsible for leadership of the health sector and constituted the legal basis for a sectoral reform. As mentioned above, the code obligates the Ministry to provide free health care to persons without means.{{18 Pan American Health Organization 1998; 298}}An important complement to these policies has been the reforms in the allocation of funds to the *municipios.* Of the amounts that the Government gives to the municipalities—namely, 8% of the national budget—at least 90% is supposed to go for programs in education, preventive health, infrastructure, and public services to improve the quality of life.{{18 Pan American Health Organization 1998; 298}}

Since health sector reform strategies were initiated in 1997, policies have been targeted at comprehensive transformation of the social health production model, including improvement of the efficiency and equity of service delivery. In addition, it has the following specific objectives: extension of basic health service coverage with emphasis on the poorest segments of the population; increased public expenditure on health and mobilization of financial resources to ensure sustainability of the sector; redirection of resource allocation; increased efficiency of the public sector in the performance of its functions and the production of services; and generation of an organized social response, with a broad base of social and community participation. Emphasis has been placed on the organization of publicly financed services to extend coverage to the rural population that currently has little or no access to health care.{{11 Pan American Health Organization 2004; 10}}

*Organization of Public Health Services*

The health system is composed of three large sectors: private for-profit, private nonprofit, and public, which in the past have functioned independently.{{11 Pan American Health Organization 2004; 10}} The head of the public sector is MSPAS, which, as pointed out earlier, is responsible for leadership of the sector and is also one of the main direct providers of services to the open population. Other public providers take care of specific groups that serve the State, including the health services of the armed forces and the national police.{{11 Pan American Health Organization 2004; 10}}The private nonprofit sector consists of some 1,100 nongovernmental organizations, 82% of them national; of those, 18% carry out preventive health activities (80%) and provide clinical services (20%). The private for-profit sector provides services through insurance programs, prepaid medical services, medical centers or hospitals.{{11 Pan American Health Organization 2004; 10}}Drugs are sold through a network of public and private pharmacies.

*Health Sector Expenditure and Financing*

In 1999, health expenditure represented 2.8% of GDP. Households were the most important source of health financing (42.9%), followed by the Government (27.3%), businesses (22%), and external cooperation (7.8%). The annual amount spent on health came to US$ 630 million.{{11 Pan American Health Organization 2004; 11}}

*Access and Coverage*

The leaders of newly independent countries and particularly the local medical professionals have generally accepted the basic nature of the health care system that they inherited from colonial governments and aspire to provide these, at least in theory, to everyone.{{15 Baer,Hans A. 1982; 15}} Guatemala accepted and instituted a biomedical healthcare model; historically, government policy and healthcare reform has been aimed, at least in theory, toward expanding coverage. For example, the 1985 Constitution of the Republic recognizes health as a fundamental right. Furthermore, as mentioned above, the health sector reform policy of 1997, obligates the Ministry of Public Health and Social Welfare (MSPAS) to provide free health care to persons without means.{{11 Pan American Health Organization 2004; 10}}

However well intentioned health policies may be at expanding coverage, access to care remains restricted in Guatemala. According to 1999 data, for every 10,000 Guatemalans there are 9 physicians, 3 professional nurses, 11 nursing aides, 20 midwives, and 1.3 dentists. Approximately 80% of physicians, 56% of professional nurses, and 50% of nursing aides are located in the metropolitan region, where there are 28 physicians and 4.9 professional nurses per 10,000 population. The rural areas, where 65% of the population lives and where the high-risk groups are concentrated, are largely covered by nursing aides, rural health technicians, midwives, and volunteer community health promoters.{{11 Pan American Health Organization 2004; 8}} The concentration of human resources in the metropolitan area and the shortage in the hospitals of physicians with the basic specialties seriously undermines decision-making capacity at the rural outpatient and hospital levels. The current distribution of human resources is a reflection of a centralized health care model that is heavily inclined toward curative medical care.{{18 Pan American Health Organization 1998; 302}}

The pattern of resource distribution in Guatemala is characteristic of many Third World countries; cosmopolitan medicine is primarily restricted to the upper and middle classes, approximately fifteen to twenty percent of the population in areas of Latin America.{{15 Baer,Hans A. 1982; 15}} Navarro (2002) maintains that the present maldistribution of health resources in the Third World is shaped by the same political, economic, and social factors that cause underdevelopment.

**BACKGROUND**

Part III. Santiago Atitlan

The Tz’utujil Maya town of Santiago Atitlán is located on the southwestern shore of Lake Atitlán, and is surrounded by three volcanoes (Volcán San Pedro, Volcán Atitlán, and Volcán Tolimán).

In the course of the last 100 years, the consolidation of the Guatemalan state has eroded the adaptive capacity of local communities, including Santiago Atitlan. Major elements in this transformation have been the expropriation of large amounts of Mayan land, and the development of the infrastructure and military apparatus necessary to protect the interests of the emergent landed class. Added to these external factors is the explosive population growth within Mayan towns. The net result for Santiago Atitlan has been increasing poverty, heightened competition for scarce resources, factionalization, and the undermining of customary subdivision.{{5 Carlsen, Robert S. 1996; 142}} Furthermore, the most recent transformations of Atiteco society have been abrupt and reflect serious sociocultural instability.{{5 Carlsen, Robert S. 1996; 141}}

 In 1990, it was reported that less than 25 per cent of Atiteco families have sufficient land to satisfy their subsistence needs .{{5 Carlsen, Robert S. 1996; 154}} “The confiscation of vast amounts of Mayan land and exploitative labor practices, coupled with debilitating population growth, have all undercut the ‘self-reproductive capacity of the indigenous peasantry at both the level of simple economics and at the sociopolitical and ideological levels as well.”{{48 McCreery, D. 1986; 113}}

*Healthcare in Santiago*

Clínica Santiaguito, the predecessor to Hospitalito Atitlán, opened in the 1960s to provide healthcare to the people of Santiago Atitlán. However, after the massacre of 13 Atitecos by the Guatemalan Army in 1990, the Clínica was abandoned, leaving the town without access to essential medical services in the midst of the political violence and economic dislocation of Guatemala’s civil war.

In 2002, six years after the signing of the Peace Accords that brought and end to the war, community leaders in Santiago Atitlán established K’aslimaal, a grassroots organization dedicated to the reconstruction of the hospital. Through their efforts, Hospitalito Atitlán re-opened on April 1, 2005.

October 5, 2005, mudslides triggered by Hurricane Stan destroyed the canton of Panabaj and parts of the aldea Tzancha, in Santiago Atitlan, killing hundreds of Atitecos. Hospitalito Atitlán was buried under eight feet of mud and the area was declared a mass grave. Hospitalito Atitlán re-opened just two weeks later in a temporary location.

**BACKGROUND**

Part IV. HEALTHCARE-SEEKING BEHAVIOR

*Ethnicity*

Ethnicity is an important social factor in Guatemala. Two main ethnic groups each comprise roughly half of the population: the indigenous people, who are descendants of Mayan and other pre-conquest groups and maintain separate cultural identities and languages, and ladinos, who are of both indigenous and European origins, speak Spanish, and view themselves as part of the mainstream Guatemalan culture.{{26 Glei,Dana A. 2003; 2449}} The ethnic distinction between ladinos and the indigenous population is cultural rather than racial or phenotypic.{{6 Glei, Dana DA 1999; 3}}After 450 years of contact, both groups share the same gene pool –mestizo; differences are primarily in terms of their distinctive cultural systems and differential access to society’s crucial resources.{{37 Warren, J. A. 1989; }} Thus, ethnic boundaries are socially constructed based on both self-perception and social perceptions of ethnic identity, with outward markers of ethnicity, such as language and dress, playing an important part in signaling group membership to others.{{6 Glei, Dana DA 1999; 3}}

*Ethnicity and class*

In Guatemala, ethnicity is closely tied to social class. The indigenous population is, with few exceptions, poor, while ladinos are members of all social classes.{{26 Glei,Dana A. 2003; 2449}} While the indigenous population is concentrated in the most disadvantaged segments of society, the upper levels of the income and education distribution are dominated by ladinos.{{38 Steele, D. 1994; }} The ethnic subordination of the indigenous population dates back to the Spanish conquest in the 16th century when ladinos gained their dominant position by acquiring major landholdings and roles as patrones fro indigenous laborers{{37 Warren, J. A. 1989; }} Ethnicity and socioeconomic status are highly correlated in Guatemala, in part because the indigenous population was intentionally deprived of land during colonization in order to guarantee a large, underemployed and exploitable workforce for plantations.{{32 Melville, M.B. 1992; }}

*Ethnicity and Region*

 Spatial distribution of the population also varies by ethnicity. While nearly half of ladinos live in urban areas, 80% of the populations live in rural areas, often in the most remote mountainous regions of Guatemala where access to health services and public infrastructure is limited.{{38 Steele, D. 1994; }}

*Health-seeking behavior*

 The health care system in Guatemala is pluralistic; traditional providers are a major source of care and coexist with biomedical services.{{6 Glei, Dana DA 1999; 2}} Research on healthcare-seeking behavior in Guatemala suggests that the use of biomedical care varies widely by ethnicity. A research paper on a study of pregnancy related healthcare in Guatemala points out that data from the 1995 Demographic and Health Survey (DHS) in Guatemala suggest that the use of biomedical care during pregnancy and birth varies widely by ethnicity.{{34 Pebley, A.R. 1996; }} Ladinas were nearly twice as likely to see a biomedical provider for prenatal care as indigenous women.{{39 Instituto Nacional de Estadistica (INE) 1996}} Compared with the 1987 DHS, use of biomedical pregnancy care has increased more among indigenous women than ladinas.{{33 Instituto de Nutricion de Centro America y Panama (INCAP) 1989}} The authors point out that like most developing countries in that births often occur at home and are typically attended by a midwife, but large ethnic differentials persist in Guatemala. Only a very small proportion of births to indigenous women occurred in a medical facility compared to a majority of births to ladinas. As compared to urban areas, use of biomedical services is particularly low in the rural areas, where about two-thirds of Guatemalans live. For normal pregnancies, traditional midwifery care may be adequate, but in the presence of complications, biomedical care and the availability of surgical delivery in a hospital can be important for improving maternal and birth outcomes. Large ethnic differences in use of biomedical services suggest that some indigenous women who need these services are not getting them.{{6 Glei, Dana DA 1999; 2}}

These results are consistent with statistics from the Pan American Health Organization. It is reported that among indigenous women and in rural areas, prenatal care was more frequently given by midwives and nurses. Physician care was most frequent among non-indigenous and urban women. In the country as a whole, 37.8% of all deliveries were attended by trained personnel (physicians, 34.1%; nurses, 3.7%). As with prenatal care, physician-attended deliveries were much more frequent in urban areas (60% of all deliveries) than in rural areas (18%).By contrast, midwives attended 53% of the rural deliveries and only 31% of urban deliveries. It is estimated that currently, of all women living in sexual unions, 69% do not use any contraceptive method. In the indigenous group only 9.6% of the women use any family planning method; in the nonindigenous group the proportion is 43.3%.{{18 Pan American Health Organization 1998; 296}}

*Explanation*

Due to their location in within the social structure, the indigenous population is likely to face numerous barriers to biomedical health services, such as limited availability, lack of transportation, and financial constraints. In Guatemala, ladinos and indigenous people have differential access to resources as well as distinctive cultures, either or both of which may account for differential behavior by ethnicity.{{6 Glei, Dana DA 1999; 2}}

One model of explanation for differential behavior focuses on large-scale social structures that constrain social processes and affect individual behavior. Because of their location within the social structure, indigenous people may be less likely to use biomedical services due to lack of access. A micro-level approach views individual choices as shaped by social and cultural context. Thus, the shared norms, values, and beliefs that define an ethnic group as a cohesive unit may influence choice of care independently of access to health services.{{6 Glei, Dana DA 1999; 4}}

 However, previous analyses have failed to explain these large ethnic differences in type of pregnancy care.{{26 Glei,Dana A. 2003; 2447}} These studies offer evidence, sometimes conflicting, for a multitude of factors that contribute to healthcare-seeking behaviors.

*Financial Factors*

 Given that health services vary in cost, financial constraints may be a key barrier to health care. Measures of income and wealth have been shown to be important predictors of use of pregnancy care (Celik & Hotchkiss, 2000). One study found that a family’s ability to afford biomedical services has little effect on the decision to use those services during pregnancy. However, the authors reasoned that the lack of an association between a family’s income and the utilization of biomedical services is likely observed because many pregnant women rely on government facilities that provide services at little or no cost.{{26 Glei,Dana A. 2003; 2459}}Another study pointed out that although services provided at government facilities are offered at a nominal charge, transportation can be expensive.{{6 Glei, Dana DA 1999; 5}}However, findings from another study indicate that midwives are usually more expensive than Heath Care Posts but their fee generally covers the entire pregnancy, including prenatal care, delivery, and postpartum care and they are still considerably cheaper than private physicians and nurses.{{34 Pebley, A.R. 1996; }}

*Availability of Resources and Services*

One plausible factor influencing healthcare-seeking behavior may be inadequate quality of biomedical care, especially in government facilities. Health posts and centers are often staffed by minimally trained personnel, offer a limited range of services, and typically lack critical supplies and medicines.{{36 Instituto de Nutricion de Centro America y Panama (INCAP) 1997}}In qualitative interviews, Guatemalan women gave various reasons for their low utilization of biomedical care, including fear of the treatments, perceptions of poor quality of care, limited hours of service, greater confidence in midwives, and lack of confidence in biomedical health services.{{31 Hurtado, E. 2001; }}

*Transportation*

Access may be further constrained by transportation. Qualitative data suggest that among rural Guatemalans who visited a health center during pregnancy, most went only once; when asked why they did not go more often, a common reply was that there was no transportation and the walk was very long.{{28 Acevedo, D. 1997}} The authors suggest that ethnic differences in use of formal prenatal care are due to problems of access.{{6 Glei, Dana DA 1999;5}} Other researchers found distance to nearest clinic inversely related to use of formal prenatal care and formal assistance at delivery. ({{34 Pebley, A.R. 1996}} On the other hand, another study found no relationship between the proximity of biomedical services and their use.{{26 Glei,Dana A. 2003; 2459}}

*Social and Cultural Factors*

Higher utilization of biomedical services among more educated women is believed to result in part from better allocation of financial and other resources, greater control over these resources, more autonomy in household decision-making, greater self-confidence, and stronger demand for satisfactory service from health practitioners. In their analysis of the Guatemala DHS, Pebley et al. (1996) demonstrate that higher levels of education are associated with increased use of biomedical care during pregnancy.

Many biomedical providers do not speak an indigenous language, even when they serve a predominately indigenous population .{{28 Acevedo, D. 1997; }}{{36 Instituto de Nutricion de Centro America y Panama (INCAP) 1997; }} Moreover, previous qualitative studies have indicated that medical staff in Guatemala may be condescending or discriminatory towards the poor, especially indigenous people.{{31 Hurtado, E. 2001; }} Unsurprisingly, it has been found that indigenous women, especially non-Spanish speakers, are much less likely to

use biomedical pregnancy care than ladinas.{{39 Instituto Nacional de Estadistica (INE) 1996; }}{{34 Pebley, A.R. 1996; }} Ethnographic studies also cite fear of medical personnel and embarrassment, because most doctors are male.{{30 Cominsky, S. 1987;}}{{31 Hurtado, E. 2001;}}

Ethnic identity may also be associated with health beliefs that influence whether care is sought and whether that care is traditional or biomedical. Traditional beliefs remain common in Guatemala,{{30 Cominsky, S. 1987; }} although biomedical beliefs may be increasing.{{49 Goldman, N. 2000; 146}} Previous research on child illness in Guatemala has revealed that women who hold biomedical beliefs related to the causes of diarrhea are much more likely to take their sick children to private doctors as compared with other women.{{49 Goldman, N. 2000; 144}}

A woman’s role in household decision-making relative to her spouse and other family members may also affect her use of health services. Decisions regarding pregnancy-related care are often heavily influenced by the spouse and other family members {{29 Cominsky, S. 2001;}}

*Obstetric Need*

 Researchers found that women with serious complications are more likely than their counterparts to visit a biomedical provider. However, even these women are more likely to rely solely on a midwife than to seek a biomedical provider.{{26 Glei,Dana A. 2003; 2460}}

**RESULTS**

Part I. Ethnographic Background

The healthcare system in Santiago Atitlan is a plural medical system composed of biomedical providers, as well as traditional providers. The biomedical side of the medical system is composed of three major health clinics or centers, a government health clinic known as Centro de Salud, a non-profit hospital known as Hospitalito Atitlan, and a private clinic called Rxiin Tinamit. In addition there are smaller government health posts called Prodesca, private physicians, private nurses, and pharmacies. The traditional side of the medical system is comprised of traditional healers, traditional midwives called comadronas, and herbalists.

*Centro de Salud*

The Centro de Salud is a government run and funded health center at the municipo level. As a type B clinic, it provides general health consultations, prenatal healthcare, contraceptives, and drugs to the community. These services are provided to individuals at no cost; however the clinic does ask patients for a small donation of 1-2 Quetzales for health consultations. Because the clinic has a very small budget to provide clinical services and few resources to provide, patients are provided with a prescription to fill at the pharmacy at their own expense. Most of the budget for the Centro de Salud is allocated toward public health and preventative programs, including a large community wide vaccination program. The Centro de Salud is headed by one doctor, who divides his time between providing consultations at the clinic and implementing public health programs throughout the town. Support is provided by nurses and auxillary nurses. The clinic is open for service during regular weekday hours, but often stops seeing patients before noon.

*Hospitalito Atitlan*

The “hospitalito” is funded by the United States based NGO, Pueblo a Pueblo. The temporary Hospitalito Atitlán features 3 outpatient examination rooms, 4 inpatient beds, 2 labor and delivery beds, an operating room, a laboratory, and a pharmacy. It provides in-patient, surgical, and 24-hour emergency care to the people of Santiago Atitlán. The hospital is staffed by a mixture of local and foreign providers and staff.

*Comadronas*

Comadronas provide pregnancy care to many women in the pueblo. They provide pre and postnatal care and assist women during the birthing process. Comadronas provide mothers massage and baths, some administer medicine, and others conduct traditional birthing ceremonies. Comadronas practice out of their own homes or door to door. Many comadronas attend midwife training sessions hosted by the larger biomedical clinics in the pueblo. Some comadronas escort their patients to the Centro de Salud for prenatal checkups.

**RESULTS**

Part II. Mothers

*PATIENT SAMPLE: MOTHERS*

 The class system within Santiago places the very poorest women living in the rural outskirts of town. A rough approximation shows that rural women have a combined daily average income of 24 Quetzales and urban women have a combined rural average of 29 Quetzales. The rural women earned about 4 Questzales daily whereas, urban women earned twice as much. Furthermore, many women in urban households did not work. The ethnic composition of the rural areas in Santiago is most likely exclusively indigenous. The majority of rural indigenous women wore traditional dress, spoke only Tz’utujil, and in general, adhered more closely with traditional culture and beliefs than their urban counterparts.

Because their homes functioned on the smallest incomes, rural women reported spending less money on food, school, and health. Many more rural women reported having no access to electricity and running water; they had higher rates of defaulting on these utility bills or simply could not get these utilities do to the rural location of their homes. Due to distance from the center of town, transportation also served as a barrier to access to many goods and services and contributed to their economic constraints. From their reports, poor rural women faced more transportation and economic barriers to accessing to healthcare.

 Poor urban mothers comprised the next level up in the class system. Poor urban women were more “ladinized”[[1]](#footnote-1) than their rural counterparts; more poor urban women were found to speak Spanish in addition to Tz’utujil. The urban locale put them in close proximity to the market, more schools, health clinics and the hospital, and provided better access to utilities. In addition, a slightly higher household income helped these women access these necessities with greater ease. Nevertheless, poor urban women reported that economic barriers constrained their access to healthcare.

 Middle-class urban mothers held the highest position in the class system. Middle-class urban were the most ladinized[[2]](#footnote-2). In general, these women and their spouses held the highest paying jobs, had the highest levels of education, and reported spending the most on food, school, and health. Middle-class urban women had the greatest access to biomedical and traditional healthcare. In many cases, this translated into the fact that they possessed the ability to exercise a choice when accessing healthcare.

*GENERAL HEALTH-SEEKING BEHAVIOR*

While women serve the role of the caregiver in the family unit, many do not make independent decisions about going to the doctor or purchasing drugs. Despite the fact that they assume the role of caregiver and carry out the act of seeking care for themselves and their family, they make health decisions under the direction of their spouse or the male at head of the household. For example, Antonia Chivili Damián, age 25, lives with two of her sisters and her son. She explained, “I once tried to take my son to the doctor, but my brother told me it was not necessary. He instructed me to just dab some alcohol on his head.”

 Respondents were asked open-ended questions about health seeking behavior. For example, they were asked what they do when their child is sick and what kinds of medical providers are sought under such circumstances. Most of the women from both geographic regions perceived biomedical care as the superior and preferred form of healthcare. Most women perceived economic reasons as the greatest limiting factor to accessing biomedical care, both in the form of services and prescription pharmaceuticals. Therefore, natural herbs and inexpensive over-the-counter medicines from tiendas served as the first line of defense for most families. Given the economic situation, the “free” government clinic, the Centro de Salud, served as the only form of primary care for many families. However, many women perceived care from this clinic as unreliable and unaffordable. Middle-class women relied solely on private doctors and the hospital for care.

*Rural*

 ECONOMIC BARRIERS: The perception of most rural women was that the hospital, Rxiin Tinamit, doctors, and the pharmacy offer better care. They explained that economic constraints make it very difficult to access biomedical care or prevent them from seeking such care altogether. Francisca Sacarías Xiquín, is a twenty-six-year-old single mother of three. Since her husband died in the mudslide, she must support her children on her own. She told me about a time when her children were sick with inflammation of the legs and hands. “I visited Prodesca when the children had inflammation but they only gave me a topical cream…I have never been to the Rxiin Tinamit. The services at Rxiin Tinamit and the Hospitalito are the best but I cannot afford them.” Finally, after five months of inflammation, she went to the Hospitalito to seek treatment. “I could not afford the bill. There was a man. He paid for my bill.” Her oldest son, in pre-school at the time, suffers from asthma. She explained, “I am very careful to watch over [him]. My family bought him an inhaler because I could not afford it.”

Many women shared experiences in which they wanted to see a doctor, but could not afford it. Chona Gomez, age 32, a weaver, told me that she has had a hernia for 11 years but that she cannot pay for the hospital.

 Rural mothers explained that because they could not afford to see a doctor or purchase drugs from the pharmacy, they either prepare natural herbal remedies or purchase inexpensive over-the-counter medicines from the tienda to care for a sick family member. Lucia Ixbalán Rabinal, age 25, beader, said that, “I prepare natural medicines for my children because I cannot afford to pay for a doctor.” Ermelinda Pablo Lorenzo, age 26, weaver, explained that when her children have a cough or diarrhea she gives them medicine bought from a tienda. “It costs 50 centavos. For a cough I also rub “balsamico” (topical menthol rub) on their shoulders. We do not purchase medicine from the pharmacy because it is very expensive.”

Most women reported buying medicine from the pharmacy or going to the Centro de Salud only if over-the-counter or natural medicines did not work. Rosaria Caníz Xicay, age 34, mother of 7, explained that when her children have diarrhea she purchases medicine from the tienda. “If they have a fever I buy Tabcin. Sometimes I visit the Centro de Salud…when the medicine from the tienda does not work. Sometimes we get medicine from the Centro, other times they give me a prescription to buy medicine from the pharmacy. The pharmacy is expensive, this is the reason why I do not go to the Centro.” Similarly, Francisca, mentioned above, explained that because of economic constraints, “I prepare natural medicine with herbs for my children when they get diarrhea. If this does not work, then I take them to the Centro de Salud.”

 One woman, Juana Lorenzo, age 44, mother of 8, reported buying medicine from the firefighters because it is less expensive than the pharmacy. She explained that when her children have diarrhea she buys pills from the tienda. “I do not visit the doctor because I do not have the money for it. I buy medicine from the bomberos…it is cheaper.”

In instances, where rural women reported seeking the attention of a biomedical provider, most rural mothers reported visiting the Centro de Salud to see a doctor. While a small number of rural women reported no visits to the Centro de Salud, most reported receiving some form of care from the clinic, either in the form of prenatal care and/or vaccines. The reported prenatal care received by mothers at the Centro de Salud varied greatly; a majority of women did not go at all or went for only one visit. Only one woman reported going at four months pregnant and then once each month throughout the duration of her the pregnancy. Interestingly, this was the only woman who reported ever using birth control in the past, and who previously lived on the finca (Ermalinda). Since the Centro de Salud has been conducting an aggressive vaccine campaign it is not certain that the women actively sought out “care” at the Centro de Salud, or if community health workers sought mothers and their families to administer vaccines.

Few women actually reported seeking routine care at the Centro de Salud, but still relied on the services like a primary care provider. However, some women did not perceive the services offered at the Centro de Salud in high regard and reported that they stopped seeking care from the clinic. The two most common reasons for discontinuing use of services included 1) the clinic no longer provided free services and/or medicines; and/or 2) the clinic only provides patients with prescriptions that women cannot afford to fill at the privately run pharmacies. Women held these perceptions as a result of personal experience or hearsay. Maria Ouieju Pablo, twenty-six-years old and a mother of two, explained that instead of going to the Centro de Salud to treat her children’s diarrhea she went to the pueblo to buy natural medicine. “Three doses are necessary, each costs 10Q. I have gone to the Centro de Salud in the past, but not anymore. I heard that they do not give medicine now, only prescriptions.”

*Urban*

 Economic barriers persisted among the poor urban mothers, whereas middle-class urban women reported seeking private doctors or the hospital for care. Many urban women identified a hierarchy of care that favored biomedical care from doctors at the hospital and the private clinic, Rxiin Tinamet, over the free government clinic and comadronas. At the same time, many urban women, like rural women, reported economic barriers to their ideal care. Nevertheless, many reported satisfaction and/or normal births with comadronas. Many women identified economic factors as a barrier to care for themselves and/or for other poor women. They sought biomedical care only “when/if they had money.” Many identified poverty as the worst health problem in Santiago.

 Many poor urban women also reported buying over-the-counter medicines at tiendas or preparing natural medicine before purchasing drugs from the pharmacy, clinic, or doctor. Buying medicine from the firefighters or discounted medicine was also an option in some circumstances. Wealthier women reported buying medicine solely from the pharmacy. The general perception of medicine from the pharmacy was one of superiority. For example, one woman explained that the tiendas do not have good medicine.

 Perceptions of the Centro de Salud varied among the urban mothers. Some women reported getting satisfactory care, either free or at a minimal cost. A greater number of women did not believe the service, or lack of service provided by the Centro de Salud was satisfactorily. These women reported that the care at the Centro de Salud was inferior to other healthcare services. They reported that they did not receive free care and/or medicine. Women of higher social economic status reported that never visiting the Centro de Salud for care and even perceived the services as substandard level of care. Health-care seeking behavior in the upper class was restricted to private doctors, the private clinic, Rxiin Tinamit, and the hospital. Poor women, who never sought care at the Centro, did not seek any other kind of biomedical care either. Beliefs and perceptions about the services available to them personally varied greatly. For example, one woman explained that although she understood that the clinic provided pre-natal care and medicine, she did not seek birth services there because she did not think they were available to residents of her canton.

 A well-off ladina in her 50s, Doña Luc told us a story about the medical system in which a woman in town cut her lower leg about two inches across. The woman was bleeding all over the ground. Doña Luc ran over to help her and they went over to Centro de Salud. The woman there told them that she could not help her until later. Doña Luc proceeded to plead saying, “Please, help us.” Her friend was bleeding all over the place and they still refused. She then offered the woman at the clinic money to help her friend. She said she had about 80 or 90Q. One of the nurses at the Centro de Salud, who Doña Luc said was a good nurse, works out of her house and was able to help the injured woman. Dona Luc explained that when the Centro closes the nurses work out of their homes and charge more for services.

She continued to remark on the state of the medical system in Santiago and Guatemala saying that it was bad. “People have to wait in long lines for help. The health centers do not have a lot of resources and so they save pills and pain medicine.” From her gestures and words it was understood that she perceived the clinic to be tight-fisted or stingy with the available resources.

*They have medicine that’s good for pain but do not like to give it out. There are good doctors and there are bad ones. There are also good health centers, but not as good as what there is in the United States.*

*PREGNANCY-RELATED HEALTH-SEEKING*

Information on the use of pregnancy-related health-seeking was indirectly collected from responses to questions on birthing experiences. The practice of using a comadrona during pregnancy and birth is widespread throughout the entire Atiteco community. Accounts of the older generation suggest that this may not have always been the case; many older women reported giving birth on their own. Only a minority of middle-class women reported that they do not use comadronas at all. In general, rural poor women exclusively use comadronas, but in the case of a complication they seek care from a doctor, economic factors permitting. In the case of a complication, the option to see a doctor is more accessible by urban women and increases with economic status.

Mothers were asked if they or someone they knew ever experienced a pregnancy related complication or emergency. Being that the overall aim of the research was focused on infant and maternal healthcare, complications during pregnancy and birth were a major point of interest in the interviews.

*Rural*

 All the rural women used a comadrona for their births. Many also went to the Centro de Salud for visits during their pregnancy. A few used a nurse or doctor in the case of a complication with a particular pregnancy. Most women used the same comadrona for all of their pregnancies. In general, a woman only changed her comadrona if she moved or if a comadrona died. One woman explained that she did not change her comadrona because it can cause problems among the comadronas.

The reported level of care received and the cost paid for these services varied among the women. Some woman reported more pre and/or post-natal visits from the comadrona than others. Some woman only received care at the time of birth. One woman explained that she used a comadrona because it was her only choice. Some women reported that the cost for a comadrona’s services was flexible, depending on what a woman could afford to pay. Only a minority of women sought help from a hospital, clinic, and/or doctor; these cots also varied greatly. Many of the women who used these services were not capable of covering the cost themselves. These women reported borrowing or relying on family to cover the costs. In a few instances, women reported receiving free or subsidized care.

In rural Santiago, the comadrona serves as a gatekeeper to biomedical care in the case of a complication, at least in some cases. Many rural women explained that if a comadrona advised a woman to go to the hospital, she follows this advice. Other women said if there is a complication, a woman goes to the hospital but did not mention the role of a comadrona in this decision. The women explained that if a woman does not have money to pay for the hospital she borrows from neighbors and family. One woman explained she had a complication but did not do anything because she did not have any money. Another woman said that if a woman does not have family to borrow money from, death results.

*Urban*

 All urban women reported seeking some form of care during their pregnancy: either a comadrona, nurse, doctor, or some combination. The majority of women reported using a comadrona to deliver their babies. Many of these women sought biomedical care in the case of a complication or difficult birth. In comparison to the rural group, a significant number of women sought only biomedical care (hospital, doctor, or Rxiin Tinamit) and asserted its superiority over traditional medical providers. Some middle-class women also used a comadrona for their birth, even if they sought only biomedical care for other health needs.

 Most women who used a comadrona for their pregnancies used the same comadrona for all births. The reported level of care received and the costs associated with these services also varied greatly among the urban mothers. Some women reported that the cost for a comadrona’s services was flexible, depending on a woman’s ability to pay. Several women reported that the comadrona provided voluntary services and paid only a minimal fee. The reported cost for hospital, clinic, doctor, and nurse services varied greatly between women. Generally, wealthier urban women reported paying higher fees. Some poorer women reported receiving free or subsidized care.

 In general, urban women also reported that in the event of a complication a woman seeks care at the hospital or sees a doctor. Some women reported seeing a comadrona first, but seeking out a doctor once they learned they had a complication. In many of those instances, the woman was referred by the comadrona.

*EQUALITY*

 After a series of questions about personal birthing experiences, the respondents were asked if access to healthcare was equal among women. Neither “access to healthcare” nor “equal” was defined. The variation in responses due to personal definitions highlights the complexity in the meaning of access to care in Santiago.

 *Rural*

 Overwhelmingly, rural mothers identified access to care as access to a comadrona. This perception of access to care appropriately corresponds with their healthcare experiences during pregnancy which, compared with the experiences of urban woman, do not frequently involve care from biomedical providers. Some rural women contradicted themselves in their responses about the equality of healthcare: they responded positively when asked directly if access was equal but shared information that indicated otherwise. Other women explicitly identified care from comadronas as unequal; they explained that level of care and access to care depends on one’s ability to pay. Overall, women’s accounts of care by comadronas and the associated costs seem to support this belief.

 *Urban*

 Urban mothers identified access to care more broadly, encompassing both traditional and biomedical providers in their definition. This perception of care appropriately corresponds with the more mixed pregnancy-related healthcare experiences of rural mothers. The responses of many urban women also contained contradictions: in response to the direct question, some mothers reported that care was equal for all women, but their accounts revealed clear inequalities in access to care based on one’s ability to pay. Despite the apparent contradictions in perceptions and the reality of access to both traditional and biomedical providers, reports reveal the perception that access to comadronas was more equal than access to biomedical providers. In other words, the general belief can be summarized as follows: all women can feasibly get care from a comadrona, and the care that all women receive from a comadrona is more or less equal, especially when compared to care from biomedical providers. Access to biomedical healthcare and the quality of care was more variable and considerably more affected by social-economic factors.

 In neither the rural nor the urban sample did poor woman identify their inaccessibility to biomedical providers as unequal; for them it was simply a matter of having money to pay for the services or not. “When there is money we go to the doctor.” However, this does not apply to situations where a pregnant mother experiences a complication or emergency where it is known that a biomedical doctor should be sought. This is addressed later. There was no mention of violation of rights, class conflict, or injustice.

 On the other hand, “middle-class” urban women did identify inequalities in access to care. Whereas these urban middle-class mothers reported using biomedical doctors more often, either exclusively or in combination with comadronas, many perceived that poor women did not have this choice because they could not afford biomedical care.

*CONTRACEPTION*

Mothers were asked if women in the community used contraception. They were then asked if they use any form of birth control.

*Rural Women*

 No rural women reported using any form of contraception at the time of the interview. Most of the rural mothers did not indicate having any knowledge about contraceptive methods. Because of the sensitive nature of the topic, there is reason to assume some women underreported using some form of birth control or having any knowledge on the subject. For example, when asked if any of the women in the community use birth control, one respondent first replied that she did not understand the question. The question was clarified by asking about Depo Provera, the most commonly administered form of contraception by the Centro de Salud. The respondent gravely answered that “No, none of the women here use Depo.” Misinformation about contraception seems to influence the decisions that at least some women make about contraception. For example, despite the recommendation from the Centro de Salud, one woman did not want to use birth control because she believed the pills cause headaches. One rural mother, who previously lived and worked on a finca, did report using birth control in the past. She could no longer afford it despite her desire to resume use. Her experience might be considered somewhat of an outlier and may be attributable to her previous life on the finca which may have provided her with different experiences than the other rural women.

*Urban Women*

 Few urban women actually reported using birth control, but many responded that there were many other women in the community that did. Overall, the urban women were more knowledgeable about contraception and spoke more freely about the topic. Marta, the translator, explained that despite their increased comfort on the topic compared to the rural women, urban women may also under report using birth control due to the personal nature of disclosing such information. Information about and access to contraception appears to have increased in recent years throughout Santiago; but based on responses this seems to be concentrated within the pueblo. For example, one older woman explained that she lacked the access to and information about birth control that exists now when she was younger, but would have liked to have liked to.

|  |
| --- |
| **Factors Influencing Accessibility of Contraception**  |
| Accessibility of knowledge | Knowledge of and access to contraception is not reaching rural women of Santiago.- Cultural taboos of contraception hinder the open discussion of contraception. - Freedom of choice: At least in some cases, it seems that women were not free to use birth control due to their spouses. |
| General accessibility of contraception | Despite the fact that women can buy contraception at a pharmacy or access it from the government clinic and/or hospital, other factors prohibit some woman from using contraception.  |
| Economic accessibility | Not all women who wish to use contraception have the financial means to do so.  |

*PRODESCA*

As mentioned before, Prodesca clinics are government funded health posts that provides a limited range of health services and information at the canton level.

*Rural*

 I asked only half of the rural mothers about Prodesca. Of those questioned, only some women ever heard of Prodesca. One woman reported that these health posts were only for people who lived nearby. This comment might indicate that she did not know there is a Prodesca clinic in Tzancha and that this clinic is considerably closer than any other biomedical provider in the pueblo. One woman reported getting medicine (topical cream) but that it did not alleviate her medical problems.

*Urban*

 A significant number of women never heard of Prodesca. Others reported that it only served to answer questions. On the other hand, a few reported getting good care.

**RESULTS**

Part III. Providers

*PROVIDER SAMPLE:CENTRO DE SALUD*

I came to develop a friendly relationship with the head doctor at the Centro de Salud, Dr. Juan Chumil Cuk. Chumil was born in a nearby Chickikel town on the lake, but two years ago, he came to Santiago to oversee the clinic. For fifteen years prior to his arrival, the clinic had not been staffed by a doctor. He was educated in the capital city and was highly revered by many in town. Dr. Chumil was from a nearby Chichikel town on Lake Atitlan. While Dr. Chumil was of indigenous descent, any onlooker would classify him as ladino. He wore western style clothing, spoke Spanish, and associated with mainstream culture.

Francisco Sojuel is an active member of the health community. He served as the director of the Centro de Salud for 15 years prior to the arrival of Dr. Chumil, a time during which the clinic was not staffed by a doctor. He currently serves on the Board of Directors for the Hospitalito Atitlan and as the director of an NGO he and his wife founded for the disabled. Francisco was also educated in the capital city and was highly respected by many in town. Although Francisco was native Atiteco, he was associated as ladino. Like Dr. Chumil, Fransico held a high ranking and respected position in the biomedical healthcare system of Santiago Atitlan.

Chunita was a nurse and community educator at the Centro de Salud. She attended nursing school in Solola, the nearby capital city of the department. Chunita also had experience working in Hospitalito Atitlan. Chunita did not occupy the same socioeconomic status as her male counterparts. She came from a modest family, her brothers worked to put her through school. Despite her educational attainment, exposure to mainstream society, and her biomedical beliefs, she identified more with the indigenous community.

*ECONOMIC BARRIERS*

 When asked to discuss how economic factors might prevent some patients from accessing care, two individuals from the biomedical healthcare community explained that economic barriers had little influence on whether or not people received care.

Dr. Chumil strongly expressed the perception that economic factors were certainly not the only or most important factor preventing people from accessing care. To support his belief, he cited a long list of other factors that he perceived to strongly influence health-seeking behavior: culture, lack of consciousness and sensibility, paternalism, poor education, resistance to new information.

In response to my inquiry about how the economic situation of an individual might affect their access to care, Dr Chumil responded:

*Santiago is a special place. There is a culture and there are certain traditions that the people keep. These aspects of life in Santiago affect how people seek healthcare. Economics is not the only factor affecting the kind of healthcare people receive. The people that do not do something when they are sick...These people are not conscious. They do not have sensibility.*

He playacted:

*‘I am sick, but I do not do anything.’ When I am sick, I do something. I go to the doctor, to the capital, and I pay for the services.*

He expressed the view that people were personally responsible for their own economic situation. He perceived that lack of work ethic and initiative were responsible for the economic hardship of most poor people.

*People with a conscience…these kinds of people look for work. They work in the morning and after this work they go to do other work. They find work with beads or as an agricultor* [working in the fields]. *But there are people who do not do this. Many times the woman is working with her beads and the man…*[he playacts by sitting back in his

chair with his hands behind his head]*…he listens to the radio or he plays soccer or* [he puts his hand up to his mouth like he is smokin*g*]*.*

Dr. Chumil pulled up the demographic statistics for Santiago on his computer and pointed out the employment rate to highlight the number of people not working to support his points about work ethic and paternalism.

Francisco Sojuel, an active member in the health community of Santiago, echoed a similar perception. Like Dr. Chumil, Francisco did not feel that economic barriers prevented people from accessing health services. He explained that the problem was not that people did not have money, but rather that they did not spend the money they did have appropriately.

*It’s not economics that stands as a barrier to health services, it’s the way people spend the money they do have. They buy Coca-Cola instead of Agua Pura* [brand of bottled water]*. They have money to give their children, but what do they buy? Coke and junk food. Another example, the people in the pueblo have chickens. They have eggs but they do not want to eat the eggs. They rather sell the eggs in the market and buy coke with the money.*

There were some biomedical providers perceived economic factors as barrier to some types of care. The nurses working at the Centro de Salud explained that while the clinic does not offer pregnancy testing women can purchase tests from the pharmacies, but that financial constraints probably prevent some women from doing so.

*“PATERNALISMO”*

“Paternalismo” or paternalism came up in several interviews with biomedical providers. The expression was often used in a negative light to convey an unwarranted attitude of expectation or entitlement. Paternalism was almost exclusively used in reference to the people of Tzancha and Panabaj, the cantons most severely affected by the mudslides in 2005. Some biomedical providers believed that the emergency relief and “free handouts” provided to mudslide victims have caused these individuals to feel entitled to medical services without making any contributions on their own part, which could be in the form of money, time, and/or travel.

Dr. Chumil perceived that “paternalism” had a strong influence on the healthcare seeking attitudes and behaviors of people in Santiago.

*If someone gets this and someone else gets something different, people are never content. They always want what they do not have, what another person has. Paternalism has made people accustomed to sitting back and having things handed out to them. People in Tzancha like to put out their hand and receive.*

Nurse Chunita, of the Centro de Salud, perceived paternalism as a barrier to health education.

*In Panabaj, if you want to make a change or teach the people something new, they expect a handout from you or else they won’t listen to your advice.*

*TRANSPORTATION BARRIERS*

Transportation in Santiago consisted of flaetas and “tuktuks.” Walking was also an option that many people utilized. Flaetas are pickup trucks that provide a form mass transportation through town. Passengers can board at multiple established stops along the main road and ride standing up in the flatbed of the truck. A person can board at any point along the route by signaling the driver to stop with a hand gesture, an extended arm pointing diagonally toward the ground. When a person reaches his or her stop, they alert the passengers standing closest to the cab, who then bang on the roof to signal the driver that a passenger wants to get off. Flaetas are owned and run as private business ventures and charge a flat price (1Q) to ride from one side of town to the other. Stops made in the most distant rural areas are considerably more infrequent than in the center of the pueblo.

“Tuktuks” are small motor taxis that prove transportation to and from specific destinations. Tuktuks mainly provide transportation throughout the urban area of the pueblo where a person can easily hail a ride with the same hand gesture used to stop a fleata. Tuktuk transportation from the rural areas of town requires a person to call a driver to be picked up. Many homes are inaccessible to tuktuks because there are few roads off the main road. Therefore, passengers must walk to the main road to wait for their ride. The passenger seat of a tuktuk is intended to fit two persons, but families of four were seen riding together. Tuktuks are also run as private business ventures. The cost for tuktuk ride (about 5Q) is considerably more expensive than a flaeta ride and depends on the distance traveled.

For a patient seeking healthcare within Santiago, walking, flaetas, and tuktuks were potential transportation options. Restricted service at night made emergency travel difficult to access. Additionally, the firefighters provided an ambulance service, but at the time of research, all the three ambulances were out of service.

 At least one provider, Dr. Chumil, did not perceive that transportation was a barrier to accessing care at the Centro de Salud. He disagreed with the mothers in Tzancha who reported that the long distance made getting care difficult since the walk was long and economic restraints prevented them from taking transportation.

*Tzancha and Panabaj are not far from the clinic. Other people walk from even further distances to get to the clinic. Those who say that distance is a barrier are not sensible.*

*LACK OF EDUCATION*

Some providers perceived that a lack of education prevented many people from accessing appropriate healthcare. Providers specifically referred to a lack of health knowledge among the population and perceived health education as an important solution to address this problem. However, providers perceived the task of educating the community about health to be a difficult task.

Dr. Chumil perceived that education and health go hand in hand, “If you have good health you can work, and if you can work you have good health.” He also affirmed that lack of health knowledge influenced health-seeking behavior. He believed that health education was a very important issue that the Centro de Salud was just beginning to address with community health educators.

*Currently the Centro has fourteen educators, one for each canton, plus the two aldeas, and the fincas. Their responsibility is to go from house to house and provide people with information about various health topics…like birth control, hygiene, and diarrhea.*

However, Dr. Chumil expressed frustration over the failed attempts to educate patients at the Centro de Salud. His perception of patients was that they did not value the education they were provided and were disinterested in information provided to them.

*When people come to the clinic for a consult they are educated and receive pamphlets. What do the people do when they walk out?* [He playacts a person crumpling up a pamphlet and throwing it on the ground] *They do not care, they are not interested.*

Francisco Sojuel similarly perceived health education to be an important issue. He said, “The people need to learn about hygiene, keeping houses clean, proper food handling and preparation. Prodesca works to educate the community, but their resources are also very limited [like the Centro de Salud].”

As a health educator for the Centro de Salud, Chunita stressed the importance of health education in the pueblo as a way to improve health and positively impact health-seeking behavior. However, she explained that educating and introducing new ideas about health is most difficult in rural areas. Her perception was that, “People in town have already been exposed to some of these ideas and are less resistant to change.”

 Chunita expressed the desire to organize a group of women who can then educate other women. She believed that such a group could provide women with the opportunity to learn about healthy pregnancies. However, she perceived that doing so was not feasible and explained that it was more of a dream, not a reality.

*MISUNDERSTANDINGS*

Dr. Chumil and Francisco Sojuel perceived that misunderstandings of the services provided at the Centro de Salud hindered patients from seeking healthcare at the clinic.

Dr. Chumil explained that the primary function of the Centro de Salud is not providing medical services, but public health. For this reason, he expressed frustration over patients who do not want to return to the clinic when they cannot be seen. He said, “People do not understand that the clinic cannot serve everyone in one day.”

Francisco perceived that because people misunderstand the role of the clinic their expectations for services are not met. He believed that this causes patients to be dissatisfied with the attention they receive and as a result many people do not like seeking care at the Centro de Salud.

*The people do not like to go to the Centro de Salud. They do not like paying for medicine when they get a prescription. They get so mad when they go for a consultation and no one is there. They do not understand that it is because the people* [providers] *are working somewhere else in the pueblo. The role of the clinic is not to dispense medical services and medicine. It is more concerned with the vaccine program. The primary responsibility of the clinic is preventative like the vaccine program. The vaccine program has been very successful. Before only ten percent of the population was vaccinated, now ninety-five percent…The people need to understand what the Centro de Salud is.*

*LACK OF RESOURCES*

 Biomedical providers, particularly those working at government funded clinics, perceived lack of resources as a constraint to healthcare delivery. Dr. Chumil stated that the services at the Centro de Salud were “free.” However, he explained, patients are asked for a 1-2Q donation for consultations.

*This money goes to fund the Centro de Salud. We have a very small budget. The budget from the Ministry of Health is small. [He pulls up a 2006 expense report and highlights the real budget] Eighty percent of the budget goes to prevention, public health. Only twenty percent goes to medical services.*

He affirmed that primary responsibility of the Centro de Salud is prevention and education. “While eighty percent is a large portion of the budget, it still only provides very little resources to work with.”

 Francisco Sojuel perceived lack of resources as the “biggest problem” faced by the Centro de Salud. “There is very little to work with in order to provide the community with education, vaccines, and medical services.”

 Nurse Chuanita offered insight as to how lack of economic resources affected access to care. She explained that often times the doctor is not in the clinic.

*Women have to show up very early in the morning to be seen by the doctor. By 8:30AM the clinic stops seeing patients, either because the doctor is not there or there are already too many patients waiting.*

Chaunita perceived this as a reason why people often do not want to go to the Centro de Salud.

*PERCEPTIONS OF COMADRONAS*

 It is the perception of the biomedical community that comadronas do not receive formal training and are ill prepared to identify and provide appropriate care in times of pregnancy-related emergencies. The biomedical community has launched a joint effort to provide training for comadronas. Some providers also perceive that comadronas discourage patients from seeking biomedical care and act as a barrier to appropriate care.

Dr. Chumil serves as the president of the Red de Salud, an organization that brings the health community of Santiago together in order to address the pueblo’s most important health issues with a concerted cooperative effort. Maternal and infant mortality is one of the seven health priorities being address by the Red de Salud. Dr. Chumil echoed the importance of addressing the four barriers, outlined by the Red de Salud, to improved maternal and infant health and healthcare. These barriers include 1) general danger signs of a risky pregnancy are not recognized, 2) lack of emergency planning by women and their families, 3) delay in seeking appropriate attention, 4) quality and culturally appropriate services. Midwife training is one strategy the Red de Salud has identified to address the first point and increase early recognition of risky pregnancies. The responsibility for midwife training was delegated to the Centro de Salud, Rxiin Tinamet, and Hospitalito Atitlan and was meant to be carried out as a cooperative effort. However, the execution of midwife training has been carried out by all three health centers, more or less independently –the centers trade-off on a monthly basis to host training sessions.

However, Chunita did not perceive comadrona trainings as an effective strategy.

*They can't read or write so they can't have classes or exams for training. So this makes it difficult for training…Many women come to the training and get paid but don’t learn anything.*

She also perceived that comadronas advised their patients against seeking biomedical care. In relaying stories in which midwives tell their patients not to go to the doctors for prenatal care she recounted a midwife in Tzanhuju who told a patient, “I’m here if you need me, whenever you need me.” Chunita perceived that some midwifes, “don’t want to take women to the hospital because they don’t want to lose money.” Chunita perceived that educating mothers in heath matters may be a better strategy than educating comadronas. She explained that an educated mother can be more proactive in the case of a stubborn comadrona who does not want to learn from the biomedical community. “If the people know more about their health, they can know when to seek care—this is what I am doing with my work.”

 In general, Chunita also perceived that comadronas lacked the necessary skills to provide adequate care. “Comadronas don't check or screen for high blood pressure. This is really important and dangerous that they don't screen.” Nevertheless, Chunita’s perception is that midwifery care is improving. She explained that last year in Chakaya there were two newborn deaths at a comadrona delivery. These deaths were made very public in hopes of improving the morbidity rates. Her perception was that the publicity did help improve care since more comadronas would be more seriously weigh the consequence of not referring patients to a doctor.

Dr. Leah, an American doctor who worked at the Hospitalito, felt that the care comadronas give pregnant mothers can sometimes be harmful. She explained that the main form of comadrona prenatal care consists of giving massages and that this can harm the baby and rupture membranes.

*PERCEPTIONS OF PATIENTS*

Biomedical providers differed in their perceptions of what prevented patients from seeking-care.

As mentioned before, Dr. Chumil perceived that patients who did not access care at the Centro de Salud were lazy, were not conscious or sensible, and some inappropriately felt entitled to free handouts. Furthermore, he perceived patients to be resistant to educational efforts made to help patients. Francisco Sojuel perceived that patients did not appropriately allocate economic resources toward healthcare. He also felt that because patients based their expectations of service on faulty information, dissatisfaction with the Centro de Salud was unwarranted.

 Chunita perceived that patients needed more health knowledge to make better informed decisions. Unlike Dr. Chumil and Francisco, she did perceive economic constraints as a barrier. Chunita also perceived fear and embarrassment as potential barriers in some situations.

RESULTS

Part IV. Summary

*Dominative Healthcare System*

The healthcare system in Santiago Atitlan is a plural medical system composed of biomedical providers, as well as traditional providers. However, the pattern of medical pluralism is reflective of a dominative healthcare system; biomedicine is more closely aligned with the dominant social groups and is the dominant healing tradition.

*Stratified Healthcare-seeking Behavior*

Healthcare-seeking behavior is stratified in Santiago Atitlan. The stratification of health-seeking behavior is, in part, ethicized. The close association ethnicity has with socioeconomic status, culture, beliefs, education, and region prohibit understanding healthcare-seeking behavior in any clear-cut manner. However, it does appear that ethnicity is closely tied to social class in Santiago Atitlan. The traditional indigenous members of the community are, with few exceptions, poorer than their ladinized counterparts who tend to occupy a high socioeconomic levels. Furthermore, the spatial distribution of the population also varies by ethnicity in Santiago Atitlan. Ladinized members of the community were more likely to be found in the urban center of town, whereas traditional indigenous community members were located in the rural outskirts of town. Therefore, the important finding to note here is that rural traditional indigenous mothers are less likely to seek biomedical healthcare than urban ladinized mothers.

DISCUSSION

It is impossible to understand healthcare-seeking behavior in Santiago today without understanding the historical social, economic, and politic context of the country it is situate in and of the town itself. Embedded within the historical context are two important threads: one provides the historical background needed to understand the structure of contemporary Guatemalan society, and the other provides the historical background need to understand the structure of the contemporary medical system. By separating these two threads it easier to understand each in its own importance, but recognizing that both are intricately interwoven and a reflection of one another facilitates a holistic understanding of healthcare-seeking behavior in Santiago Atitlan.

*Guatemalan Society*

Contemporary Guatemalan society is highly stratified. Ethnicity is highly correlated with socioeconomic class. In general the indigenous population is poor, uneducated, more heavily concentrated in rural regions of the country with less access to the necessities of life. The current pattern of ethnic stratification can be traced back to the Spanish conquest in the 16th century when ladinos gained their dominant position by acquiring major landholdings and roles as patrones fro indigenous laborers. Ethnicity and socioeconomic status are highly correlated in Guatemala, in part because the indigenous population was intentionally deprived of land during colonization in order to guarantee a large, underemployed and exploitable workforce for plantations.

The unequal exchange relationship that Guatemala was subjected to as a peripheral nation in the world system has perpetuated since conquest in the 16th century. The landed colonial patricians have since been displaced by agro-exporters, and these, in turn, have been partially displaced by new group of transnational elite neoliberals who seek to link the national economy more tightly with core capital and global markets.

The degree to which a Neoliberal doctrine has been accepted and implemented in Guatemala is a reflection of the interests of the elite ruling class, both home and abroad. Neoliberal policies have contributed to the reinforcement of stratification along ethnic-class lines first instituted with colonialism.

 *Guatemalan Medical System*

The contemporary healthcare system in Guatemala is a dominative medical system. Biomedicine is most closely aligned with the dominant social groups in society and is the dominant healing tradition. The leaders of Guatemala, like those of other newly independent countries accepted the basic nature of the health care system that they inherited from colonial governments and aspires to provide these to everyone. Government policy and healthcare reform has been aimed, at least in theory, toward expanding coverage. For example, the 1985 Constitution of the Republic recognizes health as a fundamental right and as mentioned above, the national health policy obligates the Ministry of Public Health and Social Welfare to provide free health care to persons without means.

However, resource distribution is highly stratified in the Guatemalan medical system. The concentration of human resources in the metropolitan area and the shortage in the hospitals with the basic specialties seriously undermines decision-making capacity at the rural outpatient and hospital levels. Neoliberal policy has to some degree also affected the pattern of resource distribution. In response to the economic crisis of the 1980s, the Guatemalan state accepted strict prescriptions from the IMF that reduced investments in health services, food subsidies, and other programs that affect health status and which disproportionately affected the poor.

The overlap between the historical development evidenced in these two threads help us understand how the stratification and inequalities in the healthcare system is a reflection of the stratification and inequality in Guatemalan society interwoven nature of these two threads.

A clearer understanding of the historical social, political, and economic context of Guatemala brings us back to the central questions of this study: what are the beliefs and perceptions of healthcare access and how can we explain healthcare-seeking behavior in Santiago Atitlan?

Due to their location in within the social structure, traditional indigenous mothers in Santiago face numerous barriers to biomedical health services, such lack of transportation and financial constraints. In addition to differential access to resources, ladinos and indigenous people have distinctive cultures, either or both of which may account for differential behavior by ethnicity.

One model of explanation for differential behavior focuses on large-scale social structures that constrain social processes and affect individual behavior. Because of their location within the social structure, indigenous people may be less likely to use biomedical services due to lack of access. A micro-level approach views individual choices as shaped by social and cultural context. Thus, the shared norms, values, and beliefs that define an ethnic group as a cohesive unit may influence choice of care independently of access to health services.

Behavior based on experience

**LIMITATIONS**

 Despite the thorough and in-depth understanding that qualitative research methods permit, the necessity for small samples limits the extent to which findings can be generalized to larger populations. The purpose of this study was to understand barriers to healthcare access in rural and urban communities of Santiago. However, the sample of mothers does not adequately represent the entire population of Santiago or the targeted urban and rural cantons. As mentioned in previously, respondents from the urban sample were recruited by the translator. The relationship that most of these women had to the translator presents a sample bias. Similarly, the relationship that the respondents from the rural sample had with the Pre-school in Tzancha also introduces a sample bias. Furthermore, a number of mothers declined requests for interviews, therefore the effect that non-response had on the results should also be considered.

 The sample of biomedical providers represents a limited number of individuals from the Centro de Salud. Future studies should include the perceptions of other biomedical personnel, especially from Hospitalito Atitlan as well as the voice of comadronas.

Reliance on participant self-report about past occurrences presents an opportunity for a certain degree of recall error in the responses of mothers. Despite attempts to address each point on the interview questionnaire, questions of a sensitive nature were not asked of all mothers. For example, if a mother was visibly uncomfortable answering questions about her birthing experience, the translator was instructed to discontinue probing. Another example: in instances where the translator deemed discussion on contraception inappropriate, such questions where not asked.

Another potentially significant limitation of the study was the language barrier. It is likely that the use of translators hindered accurate information exchange in some instances. Furthermore, the translators were trained for the purpose of administering the interview questionnaire and were not proficient in formal interpretation techniques.

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**APPENDIX 1**

Maternity Care in Santiago Atitlan, Guatemala

**Introduction and rationale**

The purpose of this research is to understand the experience of pregnancy and birth in Santiago Atitlan, Guatemala. This understanding will be used to develop a long term strategy to address the high rate of infant and maternal morbidity and mortality in Santiago. Our project builds upon the work of the Guatemalan Health Initiative (GHI), an interdisciplinary research, education, and service program in Santiago Atitlan that seeks to develop community initiated programs in the Western Highlands of Guatemala on Lake Atitlan.

Previous work of the GHI in Santiago Atitlan identified maternity care as an issue of high priority. We are defining maternity care as prenatal, perinatal, and one month post-natal care of the mother and infant. Based upon previous community health assessements, concerns center, in particular, upon midwifery skills and community knowledge related to maternity care. In order to understand the experience of pregnancy and birth and the high morbidity and mortality in this area, we will address the following specific aims:

1) To understand the beliefs and practices related to pregnancy and birth among childbearing women in this region. This includes: assessing family dynamics related to helpseeking related to childbirth; assessing beliefs and preferences for skilled attendants at the time of birth; assessing prenatal practices; understanding post partum beliefs and practices; and understanding general beliefs about health and children.

2) To understand the beliefs, practices, and dynamics among maternity care providers. This includes: assessing prenatal, perinatal and post natal practices; understanding the role of the comadrona (selection or calling to the role, training for the role); understanding comadronas’ healing philosophy, cataloguing comadronas’ tools and technology, understanding comadronas’ relationships with birthing mothers; understanding comadronas’ relationships with biomedical practitioners; and understanding comadronas’ relationships with religious and government.

3) To understand the biomedical infrastructure in Santiago Atitlan. This includes cataloguing the physical, educational, staffing, technological, emergency and pharmaceutical resources available to birthing women in this region. In addition, we will assess relationships among maternity care providers and relationships between maternity care providers and birthing mothers.

4) To understand the role that political and religious institutions play in the health of birthing mothers and their children.

5) To identify action items to address maternal and infant morbidity and mortality.

**APPENDIX 2**

**Mother Interview Questionnaire**

**Preguntas General**

* Nombre
* Edad
* Idioma
* Cantón
* ¿Qué iglesia asiste?
* ¿Cuántos personas viven en su casa?

**Económicas**

* ¿Qué tipo trabaja hace?
	+ ¿Cuántos Quetzales gana?
* ¿Qué tipo trabaja hace su esposo?
	+ ¿Cuántos Quetzales gana su esposo?
* ¿Qué cosas son muy difícil para ellos pagar o no se pueden pagar?
* ¿Quién hacen las decisiones económicas?
* ¿Cuantos años han vivido en su casa?
* ¿Eres propietario de su casa?
* ¿Cuánto personas viven en su casa?

**Dieta**

* ¿Qué tipo de comida preparas por su familia?
* ¿Cuánto cuesta?
* ¿Dónde compras?

**Educación**

* ¿Asististe escuela?
	+ ¿Sabe escribir? ¿Sabe leer?
* ¿Su esposo asistió escuela?
* ¿Sus hijos asisten escuela?

**Experiencia de Dio luz**

* Cuantos veces estuve embarazada?
* ¿Cuántas hijas tiene? ¿Cuántos hijos tiene?
* ¿Cuáles son las edades?
* · Me puedes contar lo que paso cuando dio luz.
* ¿Quiénes la persona la ayudo?
	+ Dígame sobre la ayudo que recibió
	+ ¿Prefiera usar una comadrona?
* ¿Usaba una comadrona?
	+ ¿Porque decidió este?
	+ ¿Por qué use esta comadrona?
		- ¿Puede describe una comadrona buena?
			* ¿Paga las comadronas? Cuantos?
* En donde han ocurrido los partos?
	+ ¿En la casa? ¿Clínica? ¿Hospitalito?
* ¿Qué otro opciones tenía?
* ¿Hubo algunos límites o restricciones de sus recursos?
* ¿Todas las mujeres de su comunidad recibieron la misma ayuda cuando dieron luz?
* ¿Qué consejo le darías a su hija con respecto a dar luz?

**Políticos**

* ¿Sabe sobre políticas en la comunidad?
* ¿Su esposo sabe sobre políticas en la comunidad?
* ¿Votaba en el pasado? ¿Va a votar en septiembre?
* ¿Qué piensas sobre el alcalde?
* ¿Sabe personas que estaba afectaba de el deslave?
	+ ¿Qué piensa sobre la ayuda que dieron a las personas de parte el gobierno?
	+ ¿Qué pienso sobre el plan se mueve estas personas?
* ¿Qué piensas sobre el aumento de precio por agua?

 **Salud**

* ¿Cuál es el peor problema de salud en Santiago Atitlan?
* ¿Hubo algunas personas en su familia que estaba enferma en los 6 meses pasados?
* ¿Qué tipos de enfermedades?
	+ ¿Gripe? ¿Tos? ¿Diarrea? ¿Asma? ¿Diabetes? ¿Vomito? ¿Fiebre?
* ¿Qué haces cuando sus hijos están enferma?
	+ ¿Van al Centro de Salud? ¿Farmacia? ¿Doctor privado? ¿Hospitalito Atitlan?
* ¿Usas control de nacimiento?
* ¿Quién hacen las decisiones sobre salud?
* ¿Quiénes en su familia han recibido vacunas?

1. Ladinization is the process by which individuals become acculturated into mainstream ladino society from a more traditional cultural background associated with the indigenous population. Markers of the process of ladinization may include, for example, cultural beliefs, dress, and language. [↑](#footnote-ref-1)
2. Traditional dress serves as a status symbol in Santiago. Even upper-class families pride themselves on being able to dress their women and young girls in the most elaborate and expensive wipels. Therefore, western dress cannot necessarily be used as a marker of “ladinization” for women. [↑](#footnote-ref-2)