“HEALTH IS A BUSINESS FOR EVERYONE AND IS NOT A RIGHT TO ANYONE”: NEOLIBERAL HEALTH CARE PROVISION IN RURAL GUATEMALA

By

Clarice Fernandes da Cunha Loureiro Amorim

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Dr. Brent E. Metz, Chairperson

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Dr. Jane W. Gibson

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Dr. Kathryn A. Rhine

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The Thesis Committee for Clarice Fernandes da Cunha Loureiro Amorim certifies that this is the approved version of the following thesis:

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Dr. Brent E. Metz, Chairperson

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ABSTRACT

Clarice Amorim
Department of Anthropology
University of Kansas
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Guatemala caught the attention of the international community as it emerged from its civil war. The stabilization offered by the Peace Accords of 1996 allowed the World Bank and the Inter-American Development Bank to urge the Guatemalan government to reduce health disparities. These organizations used their economic power as leverage to promote neoliberal reforms in health care, focusing on decentralization and privatization. In this thesis, I explore the intended and unintended consequences of these reforms as perceived by health care providers practicing in four rural communities in the state of Suchitepéquez. I focus on the perspectives of health care workers because they play a significant role in the delivery of health services. They translate health policy into health practice; yet, few studies attempt to understand how policies affect their professional and social lives. I assess the challenges faced by governmental and private health care providers as they attempt to mediate between national policies and the needs of rural communities. I examine how decentralization and privatization have undermined the motivation of rural health care workers and subverted their trust in each other. I argue that health provision in rural Guatemala is fragmented, underfunded, and uncoordinated; health care workers are dispirited, mistrustful of each other, and torn between profiteering, attracting "clients," and serving "patients." I conclude that neoliberal restructuring has failed to significantly diminish health care disparities and significantly improve health care access; in reality, it has widened the gap between rural communities and their urban counterparts. Neoliberal health care reforms in Guatemala equated to cuts in state services, poorer regulation efforts, gains for private providers, and poor health care for the most vulnerable communities.

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CHAPTER 1

Introduction

In the summer of 2010, I worked for a US- and Guatemala-based non-profit organization whose mission includes, among other things, the expansion of health care to Kaqchikel and K'iche' Maya communities. In this thesis, I will call this organization Raxnaqil to protect the privacy of my informants, and I have changed the names of all people, organizations, and communities mentioned herein. The Executive Director of Raxnaqil placed me in a small rural town in the Guatemalan state of Suchitepéquez, where I worked for six weeks alongside two Guatemalan social workers and a medical student from California.

The fieldwork that I had originally envisioned was exploratory in nature. I had never been to Guatemala before, and while I was interested on health disparities, it was still unclear to me what would constitute a good research project on this particular region. However, soon after my arrival to Suchitepéquez, the staff of Raxnaqil decided that they needed to investigate more about the local health care providers, both governmental and private. They asked for my help in conducting a collaborative research project. Understanding the perspectives of health care workers is important because these individuals play a significant role in the delivery of health services; they are the ones that translate health policy into health practice. Yet, as pointed by Kyaddondo and Whyte (2003), most studies of health services focus either on the political and administrative levels or on the impact of policies on patients. They assert that few studies attempt to understand how health policies – such as decentralization and privatization of health care – affect the professional and social lives of health care providers (Kyaddondo and Whyte 2003). In scholarly research, health care providers are seldom analyzed as social actors involved in

decision-making regarding health services; instead, I have found that most research focuses on the macro-level of policy makers, or the micro-level of care recipients.

This research is exploratory but not comprehensive. It focuses on analyzing health care providers as key players in Guatemalan health care that are often overlooked in scholarly literature. It is important to note that the term "health care provider," as defined in this study, consists of more than simply doctors and nurses. I also incorporated other professionals that offer health advice and provide treatment. For the purposes of this study, pharmacy owners and clerks, non-profit staff, social workers, and health advocates were also considered as "health care providers" because they perform functions similar to those of doctors and nurses in the communities here analyzed. In this impoverished rural region, all of these professionals have to mediate between the economic decisions made by policy-makers and the needs of a very economically disadvantaged population.

I utilized a variety of methodological strategies to learn about rural health care providers in Guatemala. Through interviews with staff in governmental and non-governmental health care facilities, I uncovered the functions that different providers performed in health centers, health posts, and non-profit clinics. I also learned about these staff members' perceptions of their own work and of their patients. By visiting facilities during working hours, I was able to assess what services governmental facilities can realistically provide to communities. Through conversations with pharmacy owners and clerks, I came to appreciate the reasons why many people have chosen to own pharmacies as a business, and why pharmacies operated as they did. I also gained insight into why people visit pharmacies more often than other facilities. My observations allowed me to ascertain the networks through which health care providers and patients alike have to navigate in order to offer and access health care in a place where services are very fragmented.

The provision of health care to disadvantaged populations in Guatemala is of particular interest because this country has been under the gaze of the international community for the last fifteen years. Guatemala endured a 36-year long civil war, a bloody conflict that started in 1960 between an extreme-right military government and leftist guerrilla groups. During most of the conflict, the outside world was largely unaware of the living conditions in the country. International agencies became more directly involved in Guatemalan politics in the early1990s, toward the end of the civil war and when claims of genocide against indigenous peoples became impossible to ignore. International agencies such as the United Nations, the World Bank, the Inter-American Development Bank (IDB), and the World Health Organization (WHO) offered aid in exchange for peace, and were key players in implementing the Guatemalan Peace Accords, a document that the government and the guerrilla movements signed in 1996 (IDB 2005). Among other things, the Peace Accords promised to significantly improve the health of the populations most at risk – rural, indigenous, poor Guatemalans (MSPAS 2001). Over a decade later, however, significant barriers still prevent the efficient delivery of quality health care to these people. I was made aware of these barriers through the acute health needs of a 5-year-old girl. Her story exemplifies several common issues with rural health care in Guatemala. I recorded these interactions toward the end of my stay in Suchitepéquez, in the summer of 2010, and they drew my attention sharply to the importance of understanding the role of providers in issues of health care access among the poor in Guatemala. Here follows my account of Nina's story.

I first saw Nina during one of the monthly health clinics held by Raxnaqil in Tinamit, a community of about 500 people. Nina was tiny in comparison to her peers; in a community where almost all of the children present some degree of stunting, anemia, and malnutrition, her small stature was particularly striking. She was five but was the size of a small three-year-old,

and was afflicted by a persistent case of diarrhea. When laboratory results ordered by Raxnaqil confirmed that Nina had amoebas, I accompanied social worker Cora as she delivered the medicine to her family. “It is a good thing we can provide them with this,” said Cora, “antibiotics that are strong like this can get really expensive.” In a community of poor people, Nina’s family seemed to be among the poorest. Her extended family inhabited a set of three partially constructed brick houses by the side of the road, which had no access to sanitary services or electricity. Their houses were also located away from the three main hubs where most families from Tinamit resided. In addition, unlike some of the other residents, Nina’s family did not own the land or the structures they inhabited; they rented them. There was smoke around from the wood fires, and dark water stood in a ditch in front of the house, over which was a small, improvised, wooden “bridge.” The affordability of health care is crucial for families such as Nina’s, to whom money is a very scarce resource. In this case, the non-profit Raxnaqil paid for the treatment, which was key in guaranteeing Nina’s access to life-saving antibiotics.

As we delivered the medicine, Nina’s mother told Cora that her diarrhea had gotten worse, that the girl cried a lot, and that she could not eat anything. The social worker was concerned, and tried to convince the mother to take the child to the hospital in Mazatenango where Cora had worked before and where she still had professional contacts. “I cannot go today; it is already too late, I will miss the bus and not be able to come back,” said the mother, and we left with the promise that they would go the next morning. The next morning came, and another after that, and Nina still had not been taken to the hospital. I asked Cora why the mother would not comply; after all, we had provided a solution to each problem posed by her. When she said that she could not go because she had no transportation, we offered to have a driver affiliated with the non-profit take her. When she said that she could not go alone and that her husband had

to work, we offered to go along with her. The situation just did not make sense to me – both of the parents knew, as we did, that Nina's life could be in danger. "It is really hard here," said Cora, disillusioned after several failed attempts to convince Nina's parents of the gravity of the situation. "People think that when they go to the hospital, they go there to die," she said. Cora's statement reflected the common mistrust of governmental health care providers shared by the strata of poor people in the communities where we worked. Her assertion was also similar to remarks made by other health care providers active in the region, who in spite of their efforts, often failed to treat their patients. In the next chapters, I will demonstrate how nurses, particularly, are disillusioned at their ability to perform their work, how non-profit staff have low opinions of other health care providers, and how pharmacists sometimes claim to be the only ones who care about patients.

It was becoming clear to me – based on my experiences in the field – that the issues faced by Nina's family as patients and by Cora as a health care provider were common in this rural region of Guatemala. A recent study about health resources in Uganda by Meinert (2004) indicates that sometimes what outsiders perceive as "irrational" or "foolish" decision-making when seeking health care is actually the consequence of the availability of local resources and of individual's ability to mobilize these resources in an effective manner. In this case, decisions stem from the fact that access to health care is the product of several different factors: location, affordability, culture, and trust. Access to health care is a consequence of the precise location of health facilities in rural regions. Are health facilities located in urban centers or rural outskirts? How far do people have to travel to visit a health facility? And, more importantly, how much does it cost to travel in order to see a doctor? In the poorest, most isolated communities, transportation is neither readily available nor reliable, which makes it very time consuming to

travel even short distances. Time lost on the road detracts from work, which detracts from income. Besides, travelling via public transportation adds to the costs of health care. This brings us to the second point: access to health care is a product of affordability. The ability to pay (for transportation, consultation, and treatment) determines whether people seek treatment and defines what kinds of treatment they seek. Finally, two abstract components of access to health care – culture and trust – have to do with how patients and health care providers interact with, perceive, and understand each other. Culture is certainly a factor at play when seeking and providing health care. The fact that Nina's mother refused to take the child to the hospital without the father's presence makes sense once one understands rural Guatemalan culture. While *machismo* and the prominent role of males as decision-makers in rural Guatemala may be a factor, Carter (2002) has also argued that rural Guatemalan women see their husband's involvement in maternal and child health care as a sign of "love" and may be embarrassed when husbands are not present. Are health care providers in rural Guatemala culturally appropriate? Do they understand how rural individuals seek health care and why they do so in particular ways? Culturally appropriate health provision enhances trust; the opposite subverts it. In addition, Berry (2008) argued that lack of trust in the quality of care and a perceived powerlessness on the part of patients contributes significantly to people's reluctance to seek and comply with biomedical health care. Stories like Nina's illuminate the fact that several gaps remain as far as the provision of health care in rural Guatemala is concerned. These episodes are also evidence that the right to control one's health is meaningless in the absence of adequate resources to do so (Roberts and Reich 2002).

This project explores the intended and unintended consequences of health care reform as perceived by health care providers in rural Guatemala. This analysis included examples provided

by professionals practicing in four rural communities located in the state of Suchitepéquez. The following research questions emerged as part of my exploratory study in rural Guatemala. I followed an inductive, not deductive process: my questions emerged from my experiences on the field, and were not developed prior to my arrival. As I interviewed health care providers in rural Suchitepéquez, the following issues caught my attention. What challenges do Guatemalan health care providers face as they try to mediate between policies made at the national (and global) level and the needs of vulnerable people living in rural areas? What significant barriers remain which prevent poor, indigenous, and rural Guatemalans from accessing adequate health care? How do local health care providers understand and negotiate their patients' life circumstances and the limitations in their available medical treatment? How do health care providers enhance or subvert trust, both from their patients and from their colleagues? While Raxnaqil was interested on some of my questions and perceived them as relevant to their work, the research questions around which this thesis revolves resulted from my own scholarly curiosity. In answering such questions, this research hopes to contribute to the larger body of research that explores the perceptions of frontline health care experts, as distinct from policy-makers at the macro level and recipients at the micro level. Through this research, I wish to add to the understanding of health provision in rural Guatemala by taking from and going beyond the analysis offered by economic theorists and international politics.

I start answering these questions in chapter two, where I provide key background information on the historical events that precipitated neoliberal health care reforms in Guatemala in the aftermath of its civil war. Chapter two explores the role of international agencies such as the World Bank and the Inter-American Development Bank (IDB) in defining economic policy in developing nations. I define neoliberalism as an economic strategy, and explain how four rural

communities in Suchitepéquez experienced neoliberal policies that pushed for decentralization and privatization of health care. In addition, I provide the historical, social, and economic background of the state of Suchitepéquez, as well as the current health care situation of the four communities where I conducted research. Finally, in chapter two I provide the fine points on my methodology as well as its ethical implications for the communities I studied.

Chapters three and four contain my description and analysis of the information provided by health professionals employed in a variety of settings. Chapter three describes the current state of health care in the communities I studied by focusing on the challenges faced by doctors and nurses working in the governmental health facilities, and explains how decentralization has affected their motivation and professional identity by limiting their ability to provide adequate care. This chapter also includes observations made by one non-governmental health care provider that has been "filling the gap" left by state institutions for several decades. Chapter four, on the other hand, analyzes how decentralization and privatization efforts have allowed pharmacies to emerge as desirable primary health care providers. Privatization makes it easier for patients to bypass doctors and nurses and go straight to the pharmacy to meet their health needs; it has fundamentally changed the social relationships of health care provision, transforming patients into customers and health care providers into businesspeople. Finally, I discuss my conclusions and the implications of my work for current and future research on chapter five.

CHAPTER 2

Literature Review and Methodology

Understanding issues of health care in Guatemala after the neoliberal reforms requires an interdisciplinary undertaking. Current literature regarding the challenges faced by health care providers, as well as policy-makers and patients, comes from many fields: economics, social sciences, global health, and public policy, to name a few. In this chapter, I draw mostly from historical and economic analyses to provide key background information on neoliberal health care reforms in Guatemala. This literature describes the rationale used by international funding agencies to promote neoliberal reforms in developing countries, defines how international economists envisioned health care reforms in Guatemala, and explains how efforts of decentralization and privatization were implemented there. Studies in the social sciences add to the understanding of how international players shape policies because they pay particular attention to the consequences of policies at the local level. Research in anthropology, sociology, and public health analyzes how economic policy translates into action and offers insightful critiques of unanticipated problems. A multidisciplinary analysis allows for a more holistic understanding of how health policy affects health care providers in rural Guatemala.

This chapter also introduces the research setting where this investigation was conducted. Here, I describe the ethnic composition of Suchitepéquez's population, explain the prevalence of poverty in the region, and paint a picture of what health care looks like in rural Guatemala. By comparing the state of Suchitepéquez with Guatemala as a whole, I can explain why this state offers a good site for research concerning neoliberal health care reforms and their impacts on

health care delivery. Finally, I detail in this chapter the methodology through which I collected the data that allowed me to approach and answer my research questions.

Socio-Historical Context of Neoliberal Health Care Reforms in Guatemala

In the mid-1990s, as Guatemala emerged from its 36-year long civil war, it caught the attention of both international organizations and national governments. With the stabilization and political legitimacy offered by the Peace Accords, the global community could finally attend to the blatant levels of health disparities in this Central American country. By 1996, when the Peace Accords that ended the civil war were signed, rural communities displayed health indicators that were significantly worse than those of their urban counterparts: high levels of infant and maternal mortality, low vaccination rates, and very high levels of chronic and acute malnutrition. According to the 1996 *Encuesta Nacional de Salud Materno Infantil* (National Survey of Maternal and Child Health), this happened because the majority of health services were concentrated in urban areas – especially around the capital, Guatemala City (INE 1996). Urban concentration was particularly worrisome since the same document also stated that 67 percent of Guatemalans lived in rural areas. In addition, the 1996 survey demonstrated that rural communities also had limited access to basic services such as electricity and potable water. Nationally, about 45 percent of households had access to potable water and about 60 percent had access to electricity; these numbers, however, were significantly lower in rural areas.

Also through the 1990s, the World Bank became the single largest financer for health programs in the developing world; as a major funding institution, it had a significant impact on health policy-making around the globe (de Beyer, et al. 2000). According to the World Bank website (2012), between 2002 and 2009, total official development assistance of about $3.5

billion was given to Guatemala, of which over $375 million were destined specifically for health commitments. Just like other international organizations, the bank wanted to make sure that the aid they were about to offer Guatemala would not fall in the hands of a corrupt, brutal government. As an institution, the World Bank subscribes to the neoliberal economic ideology, which, simply stated, argues that the private sector is more efficient than the public sector, and therefore the role of governments should be reduced (Homedes and Ugalde 2005). In Guatemala, neoliberalism translated into cutting governmental investment in health and an over-reliance on international aid: between 2002 and 2009, the government was only responsible, on average, for about 36.2 percent of the total health expenditure in the country (World Bank 2012). In addition, these scarce governmental funds did not derive from income taxes. Guatemala has some of the lowest income taxes in the hemisphere, and a comparatively high sales tax. Increasing sales tax is a common neoliberal solution to increase public revenues, alleviate budget deficits, and finance loan repayments; public protests in Guatemala failed to prevent the government from raising the national sales taxes from 10 to 12 percent in 2001 (Almeida and Walker 2006). Both of these neoliberal policies – reducing governmental investments in social services and increasing sales taxes – are particularly harsh on the poor, who can afford less of their material needs and who usually depend on welfare services.

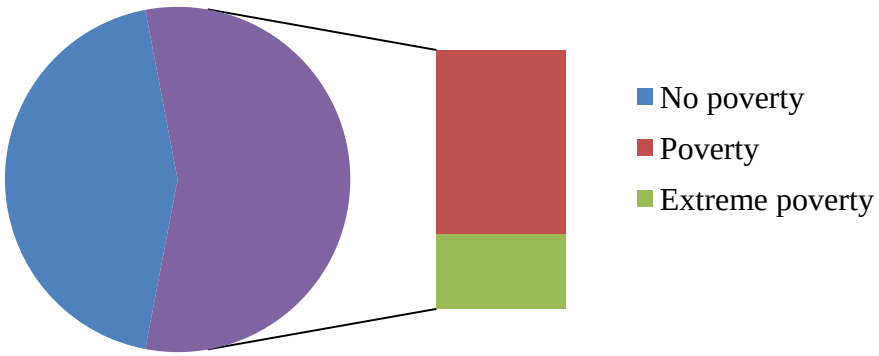
The World Bank, the International Monetary Fund (IMF), and the Inter-American Development Bank (IDB) used their economic power as leverage and urged the Guatemalan government to focus on three efforts in order to diminish health disparities. First, the government should increase legitimacy, transparency, and efficiency of public institutions. Then, it should invest in human capital by providing basic social services. Finally, it must promote trade and the growth of the private sector (WorldBank 2006). International organizations, through their

influence in the Guatemalan Peace Accords, demanded that the government take concrete measures to improve the health conditions of indigenous, rural, poor communities. Leaders of these organizations often said that lessening inequalities, including those in health, would allow for an intense social and economic transformation that would lead to the development of a more inclusive nation. Coburn (2000), however, contends that inequality was never a true concern to neoliberal proponents, and that many of them perceived inequality as positive, inevitable, or necessary; inequality is the unavoidable by-product of the unregulated economy.

Indeed, almost a decade after the Peace Accords were signed, the economic situation of most of Guatemala's population had not improved significantly: 56 percent of the Guatemalans still lived in poverty, and 16 percent lived in extreme poverty (WorldBank 2004). Poverty level, as a quantifiable measurement, is often used as a proxy for poor health; in fact, recent studies confirmed the relationship between lack of access to economic resources and poor health in Guatemala (Jensen, et al. 2009) and elsewhere (Farmer 2001; Farmer 2005). Poverty, however, is a narrow concept and does not account for all the less quantifiable aspects that cause poor health; poverty alone does not explain why some individuals are more likely to suffer of poor health than others who share their economic circumstances.

Prevalence of Poverty in Guatemala (2004)

Source: World Bank



Leatherman (2005) argued that while the poor are often the ones more vulnerable to illness, conventional measures of poverty – such as income – are but one of the factor contributing to their poor health. Vulnerability, he says, is a consequence of one's risk of being exposed to a certain kind of stress (i.e.: illness), one's risk of not being able to cope with such stress (i.e.: lack of access to health care), and one's risk of severe consequences due to the stressor (i.e.: death). Vulnerability is a better indicator of risk for poor health because it goes beyond just one's gross income, but rather connects the health of individuals to their positioning in a complex, hierarchical social order that is permeated by power relationships and structural violence (Farmer 2004; Farmer, et al. 2006; Leatherman 2005; Watts and Bohle 1993). In addition, vulnerability makes it more obvious that there are a series of structural inequalities that underlie poverty and not only make individuals more likely to experience illness but also less able to cope with it and suffer extreme consequences due to it. Structural violence has also become a popular concept among anthropologists who are concerned with issues of poverty; it is a kind of violence that subtly, indirectly kills people by preventing them from accessing needed resources:

> Structural violence […] constricts the agency of its victims. It tightens a physical noose around their necks, and this garroting determines the way in which resources—food, medicine, even affection—are allocated and experienced. Socialization for scarcity is informed by a complex web of events and processes stretching far back in time and across continents. (Farmer 2004:315)

To exemplify vulnerability and structural violence in rural Guatemala, the most recent World Bank report on Guatemala, published in 2004, evidenced that poverty in the country was not only chronic, but also predominantly rural: 79 percent of the poor were chronically poor, with 81 percent of the poor and 93 percent of the extreme poor residing in rural areas. Community health studies also provided evidence that villages in rural, isolated areas are more

likely than urban areas to be excluded from economic development and lack infrastructure and basic services (Jensen, et al. 2009; Loewenberg 2009). Rural residency, therefore, makes some Guatemalans significantly more vulnerable to poverty and its detrimental health effects, and less able to cope with poor health due to the lack of needed infrastructure for services such as potable water, the sparse presence of health care providers, and the lack of needed equipment and medication near to their communities. This connection is relevant because, according to data from the United Nations country profile on Guatemala, over 50 percent of Guatemalans still lived in rural areas in 2010.

Indigenous identity also makes Guatemalans more vulnerable to poverty and poor health. Estimates on the proportion of the indigenous population in Guatemala vary widely, the most conservative source being the Guatemalan Census, which has historically undercounted indigenous individuals; still, the 2001 census shows that at least 40 percent of the population is ethnically indigenous. World Bank (2004) data demonstrates their high vulnerability: poverty rates were found to be significantly higher among indigenous groups – 76 percent of those who identified as indigenous were poor as compared to 41 percent of the non-indigenous (WorldBank 2004). A recent published study demonstrates that conditions such as chronic malnutrition are still significantly more prevalent in rural, indigenous communities than in urban, non-indigenous ones (Loewenberg 2009). In addition, there is evidence that ethnic disparities in health persist because of social and economic inequalities (Gravlee 2009). It seems valid to argue that since vulnerability is connected to the social hierarchy, it is often reinforced by official and unofficial racism that structures society (Holmes 2011; Quesada, et al. 2011). The fact that health outcomes in Guatemala are still worse among poor, indigenous, rural residents suggests that – in spite of

reform attempts in the Guatemalan health care system – significant factors continued to exclude a large number of Guatemalans from accessing health services.

The current state of health care in Guatemala is clearly the product of several historical, social, and political forces. This echoes what Foley (2009) identified in Senegal, and I have found in Guatemala and will demonstrate in the next chapters: that issues of public health often emerge from the clash between market-based health policies and socio-political systems which have been, and still are, permeated by inequalities. In both Senegal and Guatemala, recent health care reforms failed to improve health care access, aggravated existing social inequalities, and had important consequences for the vulnerability to disease of the most disadvantaged communities.

Decentralization and Privatization: Fragmenting Guatemalan Health Care

Recent anthropological studies criticize global health efforts based on the premise that international funding institutions (such as the World Bank, the IDB, and the IMF) use their economic power to promote what medical anthropologists Pfeiffer and Chapman call "market fundamentalism." Market fundamentalism is an over-reliance on the invisible hand of the market and faith that supply and demand meet people's needs better than governments do – two ideas that are at the core of modern neoliberalism (Pfeiffer and Chapman 2010:150). Harvey explains how neoliberalism presumes that "human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade" (Harvey 2007:2). Therefore, as an economic and political paradigm, neoliberalism supports private enterprises instead of public institutions.

In the mid-1990s, World Bank experts argued that the best way to solve Guatemala's health problems was to employ neoliberal economic principles. Meanwhile, the IDB mandated health care reforms in Guatemala that emphasized cost-effectiveness: the government was to provide basic primary care, while insurance and private providers would supply other services (IDB 2005; Janes 2004). Proponents of neoliberal reforms in Guatemala strongly advocated for two lines of action: decentralization and privatization. First, the government should decentralize state health care and delegate roles to local authorities in order to secure services at the community level. For decades, advocates of reform in developing countries have viewed decentralization as an administrative move that improves efficiency and quality of services while promoting democracy and accountability (Bossert 1998). The government should also allow private enterprises, both for profit and non-profit, to provide care that was not covered by decentralized state facilities. This allows local governments to establish service agreements with the private sector, including NGOs experienced in health service delivery (Cardelle 2003). While neither of these practices is in essence negative, their success depends on the context in which they are implemented.

In their analysis of neoliberal reforms in several Latin American countries, Homedes and Ugalde explain that "the underlying principle to promote the decentralization of health services was to transfer fiscal responsibilities to the provinces in order to free central government funds to pay national debts" (2005:86). They describe the logic of decentralization as follows: 1) local decision-makers understand community needs and are less prone to errors; 2) community involvement in local services promotes democracy; and 3) local control allows for a more efficient use of resources and greater user satisfaction. As well intentioned as this strategy

sounds, Homedes and Ugalde, however, concluded that decentralization efforts in Latin America rarely met these expectations.

The practice of decentralization in itself is not necessarily the problem; under the proper design and socio-historical conditions, decentralization can be beneficial to governments and citizens. A World Bank scholar argues that decentralization, in theory, does not imply a reduced role for the central government but rather a reorientation of its role, "away from one of direct supervision and toward one of environment setting and general oversight" (Khaleghian 2004:179). In practice, however, reducing the responsibilities of the central government can have detrimental effects on health services (Birn, et al. 2000; Khaleghian 2004). One of the most striking issues that arise from decentralization in Latin America and Africa is that it is used as a means for the central government to allocate its budget to things other than health care. Central governments delegate the responsibility of health provision to local authorities regardless of the fact that local authorities, particularly in rural areas, lack the necessary resources and infrastructure to support these services. Because local authorities are now the ones funding health services, decentralization often widens inequities between urban and rural areas; urban dwellers not only benefit from more per capita resources, but they also hold more political power to pressure local authorities and can often secure a disproportional amount of health resources regardless of their actual need (Homedes and Ugalde 2005). Briggs and Mantini-Briggs (2003) demonstrate how, under the emergency conditions of the Venezuelan cholera epidemic, national and regional governments alike chose to focus prevention and care on middle- and upper-class voters as opposed to the indigenous communities most in need. In the absence of an emergency, the pattern also holds.

Van der Geest et al (1990) have argued that decentralization should be understood as a multi-level process where all actors are connected. International agencies promote decentralization policies, which are adopted by national governments, implemented by local agencies, and dealt with by health care providers and their patients. Because none of these entities exists independently from the others, actions taken at one level have intended and unintended consequences at others. A study conducted by Kyaddondo and Whyte (2003) in Uganda demonstrates that policy-makers advocating for decentralization often fail to account for the perspectives of health workers, and fail to anticipate some of the undesirable practices that emerge due to reforms. According to them, "decentralization means one thing at the Ministry of Health and quite another to people working at front line health units and trying to manage a life as well as a job" (Kyaddondo and Whyte 2003:341). I have found that in Guatemala, as well, the perspectives of health policy-makers do not align with those of health care providers working in rural areas, and I will demonstrate that in chapters three and four through the statements of several different health care providers.

Several studies identified issues that emerged with the political decentralization of health services in Africa (Kyaddondo and Whyte 2003; Pfeiffer, et al. 2008); this literature is relevant because several African countries underwent health care reforms prior to Latin American countries, including Guatemala. In addition, the health care reforms implemented on developing African nations also followed the recommendations of international funding agencies. Several consequences ensued: first, the decentralizing reforms undermined health care providers' professional identity by lowering their salaries and their statuses in communities. This caused a "brain drain" through which many professionals quit working in public institutions and joined the private sector because it would pay them more (Pfeiffer, et al. 2008). Besides, health care

providers developed “survival strategies” both outside and inside health establishments to supplement their income and social status in communities (Kyaddondo and Whyte 2003). In Uganda, these strategies included misappropriation of drug supply, informal charging of patients, and mismanagement of health unit funds. Health care providers admitted that these practices could be detrimental to the standards of care provided by these facilities. In sum, integrating the perspectives of all the agents involved in the reform effort could be beneficial to health care (Van der Geest, et al. 1990); there is, however, little evidence that such integration existed in Guatemala, where problems were similar to the ones experienced by African nations.

Finally, decentralization and privatization efforts are intimately connected. Homedes and Ugalde (2005) propose that decentralization is ultimately a means to justify the privatization of health services. According to them, decentralizing public health facilities forces them to eventually behave like private health facilities; many start charging fees or raise previously existing ones to increase their cost recovery. Through her research in Senegal, Foley (2009) found that user fees in newly decentralized (de facto privatized) health posts generated mistrust on the part of patients about the quality of care. She found that patients considered the biomedical care provided at the post too expensive to pay for, or of such low quality that it was not worth paying for. This stems in part from the fact that patients were constantly referred to more expensive facilities because the services provided by local posts were very limited. Overall, because services were decentralized but resources were not, patients questioned the motivations of health care providers who were seemingly more interested in charging fees than in providing good care.

The efforts toward privatization of health services also took advantage of the strong presence of grassroots organizations in Latin America. Grassroots organizations have played an

important role in Latin America since the 1980s, when most of the region faced military regimes and economic crisis. Ewig (1999) established how many of these movements later turned into non-governmental organizations (from here on, NGOs). Historically, both grassroots organizations and NGOs have traditionally defined themselves in opposition to the state; indeed, the Guatemalan government actively marginalized both of these social organizations until the mid-1990s (Cardelle 2003; Ewig 1999). Neoliberal reforms in health care, however, have changed this pattern by encouraging their participation. As previously mentioned, neoliberalism values private agencies, often to the detriment of public institutions. One of the main mechanisms through which the Guatemalan government used NGOs in health care provision was through contracting with them to provide health services, particularly to communities that were previously out of reach of governmental facilities. This preference for NGOs stems from the neoliberal logic according to which NGOs are better prepared to develop marginal communities than are state institutions (Ewig 1999; Maupin 2009). As well intentioned as this sounds, scholarly research has demonstrated that NGOs are not a panacea for the development of disadvantaged communities, and that this partnership may actually benefit the state more than it benefits NGOs and the communities with which they work (Arellano-López and Petras 1994; Cardelle 2003; Maupin 2009; Pfeiffer 2003; Rohloff, et al. 2011).

There are several reasons why NGOs sometimes fail at promoting health in the communities where they work. The first has to do with organization. It is true that some Guatemalan NGOs emerged from the egalitarian, grassroots, social movements of the 1980s. Since then, however, many NGOs have been structured like businesses: they have paid professionals, specialize in certain services, and display hierarchical structures and have increasingly been charging for their services (Ewig 1999). In other words, most NGOs function

more like private businesses, and only a few are still voluntary, grassroots organizations that represent the interests of a community (Arellano-López and Petras 1994; Ewig 1999). Thus, Janes found that NGO action is not standardized: “They may or may not attempt to be responsive to local needs, and they are as likely to represent the local articulation of global interests… At best these local organizations are nonbureaucratic, nonhierarchical, and nonhegemonic. This, however, is not always the case" (2004:467). The professionalization of NGOs, their workers, and their mission statements have also changed NGO allegiance: their professional structure and funding (including the common dependence on external grants and private funders) often make them accountable to outside agencies rather than the target population. As if these were not enough, internal power struggles and divisions within and between NGOs further undermine their effectiveness as actors of social change.

Internal factors, however, are not the only ones limiting NGO action; more often than not, external pressures also weaken their efficacy. In spite of the fact that neoliberal policies are aimed at strengthening the private sector, the Guatemalan government still retains decision-making power because it controls which NGOs it contracts with for the provision of health services. Research shows that the contracting of NGOs by the Guatemalan state has created three segments: one segment of NGOs collaborates with the state; another is subordinated to it; and a third is autonomous (Cardelle 2003). In addition, Jonathan Maupin (2009) argues that NGOs contracted by the Guatemalan government are primarily assigned an administrative role which can severely limit their autonomy and their potential to actively improve health services. In this context, even NGOs that originally promoted social change risk becoming mere service administrators, disconnected from community development. It is clear that, in Guatemala, NGOs not only have limited influence over state policy-making, but also are often limited to providing

services that are ignored by the contracting state. Their attempts to fill in the gap left by major cuts in social services, however, justify the abrogation by the state of its obligation to provide health care to its citizens.

In sum, the promotion of decentralization and privatization has not solved the problems previously identified with Guatemalan health care. In fact, as Wilson (2008) points out in his focus on neoliberal policies towards Ecuadorian indigenous groups, neoliberalism is, in a sense, a continuation of the agendas of previous regimes. Wilson described two kinds of neoliberal policies: "roll-back" policies, such as decentralization, which cause the state to retract and reduce its investment in social services, and "roll-out" policies, which also promote economic austerity by privatizing social services. He concludes that both kinds of policies exacerbate the precariousness under which the most marginalized groups in a society live, and are consistent with historical agendas of indigenous market integration or "modernization" (Wilson 2008). Ewig (2010) agrees with him, and describes this "second-wave neoliberalism" as a softer version of the "one-size-fits-all" structural adjustment policies of the 1970s and 1980s. While the language may have changed, the objectives of cost-effectiveness and withdrawal of state funds remain. While decentralization and privatization do have the theoretical potential to work, policy-makers working on health care reform often fail to account for all the complex factors influencing the efficacy of such policies, including how they will impact the decision-making of poor, rural, indigenous people, and how they will influence the ability of health care providers to work effectively. Ultimately, they can be used as an excuse for cuts in funding that simply cannot be recovered by purported greater efficiency.

The Research Setting: Rural Suchitepéquez, Guatemala

Suchitepéquez is located in the Boca Costa region of southwestern Guatemala, an area that has appeared in medical literature since the late 1800s. It was the setting for one of the earliest attempts by international institutions at promoting global health when, in the early 1900s, the Rockefeller Foundation's International Health Commission attempted to eradicate hookworm disease there.

Map of Suchitepéquez

Hookworm exemplifies how, historically, the socio-economic conditions of Suchitepéquez's residents made them vulnerable to a myriad of diseases and general poor health. The disease was endemic in the region's plantations, and Palmer describes it as a "sickness of ecological, economic, and cultural displacement and recombination" (2009:679). According to him, hookworm's prevalence originated from:

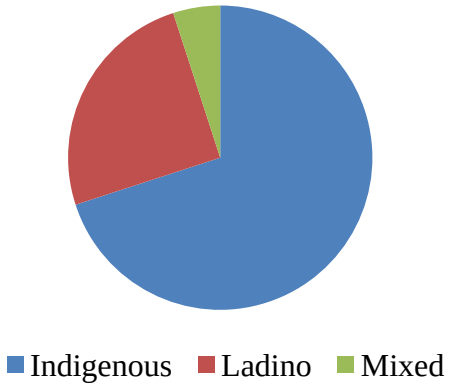
> A combination of violence, vagrancy laws, land concentration, and debt peonage—one of the most spectacular and extreme examples of coercive Latin American labor mobilization in this era—[which] succeeded in pushing the indigenous peoples of highland Guatemala into annual labor pilgrimages to the coffee and cotton plantations fresh cut from the Pacific piedmont. (2009:693)

Physicians from early 1900s cited in Palmer's historical analysis attest that hookworm disproportionally affected indigenous plantation laborers, often infecting thousands and killing hundreds in a single year. Palmer's account includes some of the earliest recorded evidence of how low socio-economic status made certain Guatemalans more vulnerable to succumb to

preventable diseases. Recent anthropological and public health studies demonstrate that socio-economic status continues to affect health in Suchitepéquez (Adams and Hawkins 2007; Berry 2008; Jensen, et al. 2009). These scholars argue that being indigenous and living in poverty has historically made Guatemalans vulnerable to poor health and limited health care access.

The relationship between poor Mayans and the predominantly Ladino Guatemalan state has been historically marked by the systematic, centuries-old exclusion of the Maya, such that deficiencies in the Guatemalan health care system are not random (Berry 2008). Largely a rural state, Suchitepéquez has a mixed population of Ladino and indigenous individuals, the latter being predominantly speakers of K'iche' and Kaqchikel, two of the most widely spoken Mayan languages in Guatemala. Prior to the civil war, the 1950 census revealed that approximately 67 percent of the population in Suchitepéquez was identified as indigenous, ranking it eighth among Guatemala's twenty-two states in proportion of indigenous to Ladinos (Handy 1994). Similar results were found in 1995 by the *Encuesta Guatemalteca de Salud Familiar* (Guatemalan Survey of Family Health), in which over two thirds of respondents in Suchitepéquez identified themselves as indigenous, a quarter identified as Ladino, and almost five percent claimed to be of mixed descent (Beckett and Pebley 2003; INE 1995; Pebley, et al. 2005). The 1995 governmental survey demonstrated the heterogeneity of Suchitepéquez, especially when compared to the neighboring states of Chimaltenango and Totonicapán, where 99 and 90 percent

Population in Suchitepéquez by Ethnicity in 2005
Source: *Encuesta Guatemalteca de Salud Familiar*



of the rural population identified as indigenous, respectively. Many scholars argue that Suchitepéquez owes its diverse nature to the historical economic need for laborers to work in the agro-export plantations. The steady arrival of displaced indigenous workers from the western highlands has, since the late 1880s, intensified social interactions between indigenous peoples and Ladinos living in the Boca Costa region (Palmer 2009; Pebley, et al. 2005). This means that while Suchitepéquez is among the Guatemalan states with the highest proportions of indigenous communities, the indigenous population is in constant contact with their Ladino counterparts.

Adams and Hawkins have argued that the national medical system in Guatemala failed to reach into the poor, indigenous communities because its physical presence in rural areas is very limited: "biomedical clinics… are neither physically nor economically accessible" (2007:215-216). This assertion is significant for the case of Suchitepéquez because this state is located in one of the poorest regions of Guatemala. According to a study funded by the World Bank, over 30 percent of Guatemala's poor live in the southwestern region where Suchitepéquez is located (Marini and Gragnolati 2003). The high level of poverty has direct effects in the population's health and its usage of the limited health care services. Two studies have found a correlation between poverty and poor health in the Guatemalan southwest: over 50 percent of the children in the region are severely malnourished, the second highest rate in the country (Gragnolati and Marini 2003; Marini and Gragnolati 2003); most of these children go untreated. Issues of poverty and its detrimental consequences for health are blatant in the southwest of Guatemala. The region should have benefitted from the promises of the Peace Accords, yet, few studies analyze the effects of health care reforms in southwestern Guatemala.

As a researcher in the field and a worker for Raxnaqil, I observed first-hand the health care system in a small section of rural Suchitepéquez. Through my work as an intern for

Raxnaqil, I gained access to communities, informants, and data that were previously unknown and inaccessible to me. Raxnaqil's previous experience in this region and the fact that they gained the trust of people in these communities over several years allowed me (even as a newcomer) to network with a variety of health care providers, and to observe interactions which may have been otherwise unavailable to me. I was directed to some of the health professionals that contributed to this study by Raxnaqil's staff, and these professionals later referred me to others in their community. I interviewed individuals working on four interrelated but very different communities: a commercial town (San Aurelio) inhabited by roughly 40,000 people, two bedroom communities (San Tadeo and Calixto) with populations of 18,000 and 13,000 respectively, and a small roadside hamlet (Tinamit) inhabited by approximately 500 people. I decided to include these four communities in my study because they epitomized different levels of access to health care even after the efforts toward decentralization and privatization established with the health care reforms. These four communities are also geographically close to each other. Because of this, health services available on one of them may be accessed by people living on the others. In addition, my partnership with Raxnaqil allowed me access into Tinamit, the poorest and most isolated of the three communities, and also the one that suffered the most from health disparities. The interviews I conducted with 26 health care providers in these communities offered sharp insight into the challenges faced by individuals working in a fragmented system that lacks an adequate distribution of resources.

My observations over the course of my fieldwork allow me to describe parts of the health service landscape on these communities. Currently, the health care system in rural Suchitepéquez is organized hierarchically. Hospitals, which are at the top of the hierarchy, have the most advanced equipment and the most qualified and specialized staff, as well as the capability of

running a variety of exams and executing complex medical procedures. However, they are not immediately accessible to the rural population because they tend to be located in large urban areas. None of the towns in my study had a hospital, and the closest one was located in the state capital, Mazatenango, about two hours away by bus from the four communities here analyzed. In some instances (such as in the case of Nina, illustrated in the introduction) Raxnaqil's patients had to be redirected to that hospital because they would not otherwise find treatment for their illnesses.

Front desk at the San Tadeo Centro

Below hospitals in the chain of Guatemalan health care are the *centros de salud* (health centers), which are located in medium-sized commercial towns. While there are physicians among the staff, they can only perform simple exams; the most complicated procedures executed by such doctors are related to childbirth. Health centers are fairly limited, as mentioned by Adams and Hawkins (2007), because few professionally trained physicians choose to work in remote rural towns and virtually none in the hamlets. Even if they would, diagnostic equipment and other specialists are only found in larger urban areas which possess full-fledged hospitals. Only two out of the four communities in this study have health centers (see Appendix for further information on these). San Aurelio has a medium-sized health center and San Tadeo has a small one, both of which serve not only their urban population but also the large number of rural communities surrounding them. Added

together, their staff includes nine doctors and twenty-six nurses who are responsible for a population of over 70.000 people. These numbers illustrate what Adams and Hawkins (2007) point out: health centers primarily reach out to isolated, rural hamlets through *promotores de salud* (health promoters) and through their smaller counterparts, the *puestos de salud* (health posts). The towns included in this research had a total of three *puestos de salud*, one of which was located in the bedroom community of Calixto and two of which were located in the outskirts of San Aurelio. Only a few nurses work in each of them, and their capabilities as well as available equipment are very limited. This is exemplified by the fact that the only equipment available at the *centro* in Calixto was some scales, first aid supplies, needles, and a fridge used to refrigerate vaccines (see Appendix).

To the left, some of the medical equipment available at the *puesto de salud* in Calixto. The puesto was staffed by three nurses and lacked medication and laboratory equipment.

My observations indicate that, while there are governmental services available to some of these communities, they lack the resources necessary to provide adequate treatment. A recent public health study conducted in Northeastern Brazil demonstrates that the greater the difficulty in obtaining treatment, the bigger the likelihood that people will turn to private services, such as non-profits and pharmacies, for treatment (Araújo, et al. 2009). The shortcomings of the

governmental health facilities in these towns are supplemented by the emergence of several private health care providers. An assortment of private pharmacies and practices are available, if a patient can afford them. However, while medicine purchased at pharmacies is affordable to middle-class professionals, more often than not they come at great sacrifice for poor families.

Pharmacies (*Farmacias*) in San Aurelio and Calixto

In one instance, while conducting interviews, my partner and I were also seeking medication for a woman from Tinamit who had ulcers. We inquired about that specific medication on the three pharmacies that we visited that day. Prices ranged from 40 quetzales (5 dollars) to 210 quetzales (26 dollars); even the cheapest version would take up all of that woman's income for a day of labor in a coffee plantation. In addition, private pharmacies and

practices also tend to be located in urbanized, commercial centers (as is evident in the pictures above), making them less accessible to poor, rural families, who not only have to purchase the medication but also pay for transportation there and back. Of all the pharmacies visited for this research, the overwhelming majority was located around the central plaza of San Aurelio, and a few were located on the main streets of Calixto (see Appendix). People residing in one of the several rural hamlets that resemble Tinamit are forced to visit one of these urban centers in order to gain access any kind of medication.

Because of this, non-profit organizations like Raxnaqil often attempt to "make up" for deficiencies in rural health care. Non-profits often operate at the fringes, and many of the services they offer are fragmented and limited to specific communities. While Raxnaqil does operate in other regions of Guatemala, in Suchitepéquez its actions are primarily concentrated in Calixto and the roadside hamlet of Tinamit, which represent the two most underserved communities in my study (see Appendix). It is important to mention that no other health care provider works directly in Tinamit with the exception of Raxnaqil; therefore, most of their health care comes either from the non-profit or from one of the facilities in the neighboring town of San Aurelio or San Tadeo.

Volunteer nutritionist and two Guatemalan social workers measuring a child during one of Raxnaqil's community health clinics in Tinamit

This is a problematic arrangement because the majority of the people in Tinamit rely on public transportation via buses and vans to access either town, and public transportation costs money and time, two resources that are crucial in an impoverished community where people are paid very low wages by the hour.

To the right, the site where the community health clinics were held in Tinamit due to lack of a community health post

It is clear to me that the four communities analyzed in this study display a very uneven concentration of health care providers and health resources. The concentration of resources in specific areas (namely, urban and commercial centers) poses challenges for the residents as well as for the few health care providers active in the region. Economic analyses such as the ones developed by the World Bank, the IDB, and the public health experts working within the Guatemalan government presuppose that nearly all of these resources should be economically, culturally, and spatially accessible to all individuals. However, despite the promises of improvement made by the Peace Accords, my research indicates that health care access has not improved enough. My evidence indicates that the governmental facilities exist, but lack supplies, staff, and funds. I also indicate that new health care providers are emerging. Pharmacies and non-profit organizations are among the most prominent of these. However, while they do offer alternate sites for health provision, it is unclear to me whether they can promote the significant improvement that was promised in the

mid-1990s or whether they are more likely to act as palliatives. I will continue this discussion on chapters three and four.

Methodology

Prior to arriving in the field, I had already chosen to study issues of health in Guatemala because the socio-economic inequality and health disparities in this country are blatant. Guatemala also provides an example of a country that only recently attempted to improve the quality of life of disadvantaged communities. With that being said, however, the idea for this project did not follow the traditional steps: instead, this inquiry emerged from my experiences in the field. What I learned through my interviews and observations opened my eyes to the issues of health care access in Guatemala. It was through my interactions with health care providers in rural Suchitepéquez that my research questions were developed. My experiences showed me that understanding how neoliberal reforms affect health care access in Guatemala is important because neoliberalism, espoused by international funding agencies, now defines much of the global health development. This is particularly true of developing countries that depend on external funding to support their economies.

For this thesis, I collected data through bibliographical research, participant observation, and informal semi-structured interviews, all of which will be further explained later in this section. This work is also informed by my experience with the non-profit Raxnaqil where I volunteered for six weeks in the summer of 2010. As an intern, I had administrative responsibilities. I assisted with the organization and management of two community health clinics in Tinamit. Clinics lasted for almost an entire day during which volunteer doctors and medical students monitored children and pregnant women for anemia and malnutrition. Other

community members also received medical assistance for a variety of ailments, ranging from parasitical infections to diabetes. The health clinics were a fertile ground for social interactions between health care providers and their patients, which provided me with plenty of opportunity for collecting data; I relied heavily on participant observation to collect data during these events. In addition, as a health care provider myself, I experienced first hand some of the constraints that my informants mentioned during their interviews. Finally, interactions and conversations with other volunteers who had previous experience with these communities not only allowed me to learn my way around places and people fast, but also contributed to my understanding of health issues in this region and enriched my data analysis. Scholarly research is never an individual endeavor, but rather builds on the work done previously by others. I believe that my interactions with Raxnaqil's staff had a positive influence in my research, sometimes challenging my assumptions and exposing additional viewpoints.

If the community health clinics allowed me a glimpse into the myriad interactions between health care providers and patients, my interviews with health care professionals allowed me to document and analyze how these professionals perceive their work, responsibilities, and challenges. My methodology and interactions with informants were approved by both the institutional review board at the University of Kansas and by Raxnaqil's internal board. In addition, Raxnaqil's staff collaborated with me in the development of the research instrument used to collect the data. The interviews (one for doctors/nurses and another for pharmacy employees/owners, as demonstrated in the Appendix) contained some questions relevant to my personal research and others relevant to Raxnaqil as an organization. This collaborative endeavor allowed both parties to benefit from this project: the data used on this research was also shared with Raxnaqil as a way for them to learn more about other providers in the region.

A medical student and I were the ones responsible for conducting the semi-structured interviews that support this research. We conducted 26 interviews, in Spanish, with men and women between the ages of twenty and fifty, who identified primarily as being middle-class and Ladino (non-indigenous or mixed ancestry). The use of audio recorders was discouraged by Raxnaqil's staff based on previous experiences with this population and what they knew about their reactions to such equipment. For the sake and comfort of our interviewees, we avoided using an audio-recorder. Instead, Raxnaqil's staff members suggested a team approach to conduct interviews: working as a team allows one person to focus on documenting the answers as thoroughly as possible while the other engages with the interviewee. We chose the semi-structured format for the interviews not only because it is among the most common for qualitative research, but also because it allows interviewees to answer relevant questions while engaging in a dialogue that flows naturally, giving them a chance to discuss what they perceive as important. We took extensive notes as we spoke with them, which we elaborated shortly after the interview.

We selected health care providers for interviews using a convenience and snowball sample; often interviewees would indicate another health care provider that we should contact. Interviews were relatively informal: while we did request from our informants their permission for an interview, our interactions with them often happened as they worked, in small bursts between tending to patients or selling medication. In addition, while we had a list of specific questions (see Appendix) that we asked every single provider, with some of them the conversation allowed for additional inquiries which only occurred to us at that moment. Interviews lasted between half an hour and two hours and took place at health care facilities. This setting allowed us to observe additional interactions between health care providers and

patients or clients, as well as gauge the level of equipment, staff, and services present at the particular location.

To analyze the data collected through interviews and participant observation, I have followed these steps: 1) field note translation and development, 2) coding, 3) initial analysis to locate broad, major themes, and 4) comparison of my findings with current scholarly literature. I have identified three major themes, which were present in virtually all interviews with health care providers: 1) shortcomings of the health care system in Guatemala, 2) prescriptive behavior of health care providers and self-prescriptive behavior of their clients, and 3) pharmacies as a business. I extracted a fourth theme from field notes taken during the interviews regarding interactions among health care providers themselves, as well as between them and their patients/clients. The analysis of these themes allowed me to answer, inductively, my research questions: What challenges do Guatemalan health care providers face as they try to mediate between policies made at the national (and global) level and the needs of vulnerable people living in rural areas? What significant barriers remain which prevent poor, indigenous, and rural Guatemalans from accessing adequate health care? How do local health care providers understand and negotiate their patients' life circumstances and the limitations in their available medical treatment? How do health care providers enhance or subvert trust, both from their patients and their colleagues? I attempted to answer these questions in order to understand how health care providers working in rural Guatemala make sense of their experiences and manage daily challenges posed by the government, their work environment, and the socio-economic status of their patients.

Data Presentation

My partner and I interviewed a variety of health professionals acting in San Aurelio, San Tadeo, Calixto, and Tinamit. Among the sample used for this research, there are eighteen pharmacists, two nurses, one physician, one *promotora de salud* (health promoter), one receptionist, one sanitary inspector, and one assistant director of a non-profit clinic. These professionals hold positions in governmental, private, and non-profit health facilities. Only the assistant director works for a non-profit entity; in addition, some of the data regarding non-profit action came from participant observation in community clinics. The nurses, the *promotora de salud*, the sanitary inspector, and the receptionist work for governmental entities, such as *puestos* and *centros de salud.* All of the pharmacists and the physician belong to the private sector. In addition, an interesting finding regarded two professionals who owned pharmacies in addition to working in the health care field, one as a governmental nurse and one as a physician. A list of all the interviewees, interview settings (facility and location), gender, position held, and years of training is available in the Appendix; the names of informants and communities were changed to reflect the pseudonyms used in this thesis. Some of the limitations of this sample size and distribution will be discussed in the following section.

A variety of health care facilities was also visited over the course of this research. In addition to a total of seventeen different pharmacies, we visited two health centers (one in San Aurelio, one in San Tadeo), one health post (located in Calixto), one non-profit clinic (located in San Tadeo), and a private practice (located in Calixto). During our interviews, we recorded the number and training of professionals working in such facilities (see Appendix). We counted thirteen physicians, nine of which were employed by the Guatemalan government. In addition, we found 24 nurses, 21 of which were state-employed. Finally, 35 “other” professionals were

present, in both governmental and non-profit facilities. This category includes receptionists, technicians, inspectors, health promoters, and other professionals who are somehow involved in health provision and employed by a health care facility. These facilities ranged in their ability to serve patients (from 15 a day to 150 a day), in cost (from free to 40 quetzales per appointment), and length of appointment (15 to 30 minutes). The availability of laboratory equipment and medication also ranged. In addition, we found that whenever these facilities could not provide patients with a certain exam – a sonogram, as an example – they would refer patients primarily to laboratories in Mazatenango (the state capital) or to the Missionary clinic in San Tadeo. On the other hand, when they lacked medication (which happened very often in the *centros* and *puestos*), they chose to not recommend any specific pharmacy. For more information on these details, please refer to the Appendix as well as chapter three and four.

Methodological Challenges and Ethical Implications

While I believe that this research accounts for many of the challenges faced by health care providers working in rural Guatemala, the results of this thesis are not comprehensive and do not attempt to make sense of the state of Guatemalan health care as a whole; instead, I will draw conclusions about rural health care in Suchitepéquez. In addition, due to the limited size of my sample, some of the insights in the present research may be also true for other places, but the conclusions of this work will not necessarily translate into solutions for health care access issues faced at other regions. The present discussion solely aims at shedding light over some of the shortcomings and unanticipated consequences of a particular attempt to improve the health of rural Guatemalans, as perceived by the professionals who are primarily responsible for providing these communities with health care.

The questions posed in this research concern as much health care providers as they concern policy-makers and patients. This particular study, however, will focus on health care providers not only because they are underrepresented in scholarly research but also because, for the most part, they were readily available and willing to talk about their work, their challenges, and their opinions about health care in Guatemala. In only three instances did a health care provider refuse to be interviewed. Most of them gave oral consent right away and willfully shared an hour or more of their day. With that being said, it was much easier to interview pharmacy owners and clerks than doctors and nurses, in part because the large number of pharmacies allowed for plenty of access to workers, and in part because, as business-people, some of them saw in the interview an opportunity to gain more clients. The interests of pharmacists as businesspeople should be considered when analyzing their responses. On the other hand, access to nurses and doctors was restricted because of their much smaller presence in these rural communities. Only a small number of them were available for interviews. The additional insight of other health professionals, such as project directors from local NGOs, a sales representative from a pharmaceutical company, and a *promotora de salud* (health promoter) added to the quality and depth of my observations regarding decentralization and privatization of health care in rural Suchitepéquez. Each of these professionals offers different viewpoint and adds to the depth of my analysis.

Another challenge in the production of this research involved preserving the anonymity of my informants. My ties with Raxnaqil from the beginning implied that the anonymity of the organization, its staff, and patients would be necessary. Raxnaqil requested full anonymity as a way to preserve their work which extends to other communities in Guatemala. Raxnaqil is proud of the trust afforded to them by partner communities, and their humanitarian and research efforts

depend primarily on the maintenance of these trusting relationships. Preserving such relationships was a significant factor in my decision to maintain the anonymity of all of my informants (even those not associated with the NGO) and of the communities that they lived and worked in. In communities as small as these, even non-public figures are easily identifiable. I have changed all the names of people, organizations, and communities involved in this research. Instead of their real names, I provide professional descriptions of my informants and their organizations. I believe that this will suffice in painting a clear picture of the issues at hand. Finally, I use the real name of one location: the state of Suchitepéquez. This is necessary because the history and socio-economic situation of Guatemalan states varies considerably, and removing the name of the state would remove the analysis from its context. After all, it is impossible to understand the significance of health care reforms to rural Guatemala without referring to the context in which such rural communities are embedded.

CHAPTER 3

The Current State of Public Health Care in Rural Guatemala

In the previous chapter, I offered a detailed explanation of the institutional changes that took place in Guatemala during the 1990s. New political and economic ideologies endorsed by international development organizations promoted decentralization and privatization as paths toward more equitable access to rural health care. In reality, however, these policies had the adverse effect of fragmenting Guatemalan health care. I also demonstrated through several recent studies how neoliberal reforms have affected health care provision. Neoliberal policy-makers at best have failed to account for all factors influencing the efficacy of their policies, including how these changes impact the ability of health care providers to work effectively. At worst, they may be more concerned about cutting taxes and assistance and opening new markets than the health of communities. Previously cited studies identified several issues that have developed around the globe in the aftermath of neoliberal reforms, among which are the ways through which health care providers have adapted in order to maintain their status and their ability to work.

In this chapter, I look specifically at how health care providers working in four communities located in rural Suchitepéquez understand their work and what issues have concerned them recently. Through interviews with two state-employed nurses, a private physician, a sanitary inspector, a health promoter, a receptionist, and the assistant director of a non-profit clinic, I analyze how decentralization and privatization of health care in rural Suchitepéquez have concretely affected health organizations, governmental facilities, and the labor of health professionals. In rural Suchitepéquez, these professionals indicate that challenges are exacerbated by low budgets, derived from little governmental investment in health, and

corruption among local level providers. In addition, while the presence of NGOs in the region provides benefits to the population, it also poses challenges to the long-term improvement of health care access.

Decentralization and the Work of Health Providers in Rural Suchitepéquez

Juana used to be a nurse assistant, and is now a pharmacy clerk in San Aurelio. At the end of her interview, she posed a very pertinent question: what is the purpose of my study? I explained that it was an attempt to learn about health care in rural Guatemala, and she suggested that we should investigate how to expand services at the *centros* and *puestos de salud* because they lack medication, staff, and equipment. Juana explained that the services at the governmental facilities "are not good" and that many "people in need who visit them are not given adequate treatment." As will be demonstrated in this section, her assertions resonated with my observations and with opinions expressed by several other health care providers that I interviewed. By describing and analyzing the challenges faced by health care providers working in governmental health care in rural Suchitepéquez, I demonstrate some of the ways in which neoliberal decentralization has failed to significantly improve health care access for one of the most disadvantaged populations in Guatemala. I also reveal the role of rural health care providers in either exacerbating problems of health care or compensating for them.

As detailed in chapter two, scholarly research points to several historical challenges to rural health care in Guatemala. Adams and Hawkins (2007) argued that the Guatemalan national medical system has historically failed to reach the Maya communities because of its limited physical presence in rural areas. In addition to lacking medication, *centros* and *puestos de salud* have also historically lacked trained specialists and diagnostic equipment, which were only

found in major urban areas located several hours away, by bus, from rural hamlets. The majority of health care providers who contributed to this research agreed that the very same problems cited by Adams and Hawkins still pose challenges to their work as health care professionals, even after the implementation of decentralization policies. A recent analysis of the Guatemalan health care "system" by Rohloff, Kraemer Diaz, and Dasgupta (2011) found that deficiencies in public health care tend to be understood as problems of coverage, as if the solution is simply to increase the number of facilities available. While the Ministry of Health claims that it has improved the percentage of the population with access to health care since the signing of the Peace Accords, this was done primarily through privatization of health care, while decentralization played a smaller role. Rohloff et al. also indicate that "rather than an absolute lack of services and facilities, patients and families complain consistently about the apparent unintelligibility and poor quality of biomedical care" (2011:429), which derives both from the confusing nature of "the health care landscape" and a series of disappointing experiences with health care providers.

In this section, I explain the issues that the health care providers I interviewed have recognized as factors constraining their ability to work, and possible causes of the perceived "unintelligibility" described by Rohloff et al (2011). Several health care providers agreed that budget constraints represent a significant challenge to governmental health care in rural Guatemala. As demonstrated in chapter two, the neoliberal reforms of the 1990s – much like a continuation of the structural adjustment policies of the 1970s and 1980s – called for states to dramatically reduce investments in social services (Arellano-López and Petras 1994). Decreasing public investment in health care causes a series of logistical issues: it limits the number of facilities and trained professionals, and restrains access to necessary equipment and treatment. In

addition, because they negatively affect the salaries of workers, budget cuts weaken staff motivation, facilitate corruption, and push workers to seek alternative sources of income.

One of the consequences of the tight budget for governmental health care is that a small number of facilities have to serve large geographical areas. Enrique, the sanitary inspector of the *centro* in San Aurelio, attested that this particular *centro* serves not only all urban San Aurelio, but also a myriad of neighboring smaller towns and villages, many of which are located long distances away. While waiting for an opportunity to interview him (Enrique was the only staff member who had the time to be interviewed that day) we observed long lines and lengthy waits, and several patients had brought food over and were eating as they waited for their turn. Elisa, the receptionist at the San Tadeo *centro de salud*, said that although this facility is much smaller and more limited in scope than the San Aurelio *centro*, it also serves its town and an additional ten neighboring communities. According to Carmen, one of the nurses in the same *centro*, people often travel long distances to seek care in this facility because rural villages lack both doctors and pharmacies, and the *centro*, albeit limited, is their closest option. We spent an entire morning in the San Tadeo centro, moving from staff member to staff member, stopping the interview each time a patient walked in. Nurse Carmen attended to over two dozen patients, mostly mothers seeking vaccination for their children. Overall, both facilities and their staff seemed overworked, overused, and underprepared.

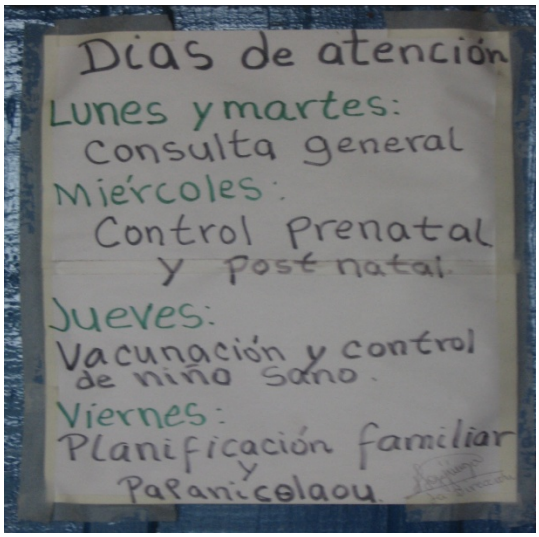
The current state of local health facilities is worrisome for several reasons. The Guatemalan governmental health care facilities are currently arranged in a way which presumes that the smallest ones will deal with simple, non-threatening health issues and progressively refer patients to bigger facilities as needed, based on the gravity of their condition. This way, the Ministry of Health would be able to concentrate its limited national resources in district

hospitals, which should manage the critical referrals from regional *centros* and local *puestos*. Anthropological research in Guatemala, however, indicates that the referral system has flaws. For starters, the number of hospitals is very limited in rural areas. There is only one governmental hospital on the region I studied, which is located on the capital city of Suchitepéquez, Mazatenango. Pedro, an experienced pharmacy clerk, proposed that there is only one governmental hospital because the state cannot afford to fund additional ones. In addition, Berry (2006) uses ethnographic data from Sololá, Guatemala, to demonstrate why rural, poor women may delay visiting hospitals when pregnancy-related problems arise. According to her, the fact that traditional midwives are often reluctant about referring a client to the hospital is not due to their lack of biomedical knowledge. Berry demonstrates that among experienced midwives, decisions about birthing emergencies are not solely made based on cultural beliefs or biomedical knowledge; rather, the decision-making process is complex, interactive, and constantly negotiated between midwives and families in an attempt to "maximize benefits and minimize costs to all the parties involved" (Berry 2006:1968). In this context, the expectation of the Ministry of Health that a midwife will automatically refer women with risky pregnancies to a local hospital fails to materialize because midwives are negotiating their interests and the interests of their patients, and not solely following the protocol designed by the state. Therefore, either because of the limited availability of hospitals or because patients fail to get referred to them, local facilities such as *centros* and *puestos* end up dealing with a much larger number of critical, serious conditions than they were originally intended to.

The same economic constraints that cause rural health facilities to serve large populations spread over broad geographical areas also limit the number of health care providers employed by these governmental facilities. The four communities analyzed in this research have an added total

population of over 70,000 people. Among the health care providers employed by the government, there are nine doctors (seven in San Aurelio, two in San Tadeo). There are also twenty-six nurses (fourteen employed by San Aurelio's *centro* and five by two of its *puestos*, four employed by the San Tadeo *centro*, and three in the Calixto *puesto*). These units also employ eighteen others professionals, primarily lab technicians, inspectors, and administrators (five in San Aurelio's *centro*, thirteen in San Tadeo's *centro*). A recent study by Mainthia et al. confirmed the low ratio of doctors in Guatemala: "the lack of healthcare spending is reflected in the fact that Guatemala only has [on average] 93.3 physicians per 100,000 people" (2009:6). However, the information I collected with governmental health care providers in these four communities indicates that the ratio of state-employed doctors in these communities is only around 13 doctors per 100,000 residents; the ratio of both doctors and nurses employed by these state facilities is also very low, ranging around 50 professionals per 100,000 residents. These ratios present a challenge considering that state-employed doctors and nurses are the only ones who, by law, are supposed to offer free care. When paired with the high poverty level in these communities, the low number of governmental health care professionals affects their ability to serve large numbers of impoverished families.

Through my research, I also found evidence of what Berry has described in her studies: on a material level, *puestos de salud* lack space, equipment, and personnel. "A single auxiliary nurse staffs each post and is responsible for both tending patients from 8:30 to 4:30 M-F, and attending weekly meetings, in-service training and spending 2–3 days a month vaccinating" (Berry 2006:1960). All the nurses interviewed for my research complained that they are assigned duties that would be more proper of physicians because few physicians work at the



The shortage of nurses in Calixto means that certain services are only offered once a week: general appointments on Mondays and Tuesdays prenatal care on Wednesdays, vaccination on Thursdays, and women's care on Fridays.

governmental health facilities, and those who do are not always present. In fact, during the morning that we spent in the *puesto* in San Tadeo, one of the doctors was absent – attending a meeting in Mazatenango – and the other one spent most of the morning locked in her office. She was a doctor from Cuba who had recently arrived on the region, and she refused to be interviewed on the basis that she did not know these towns. Meanwhile, as we waited for a chance to talk to someone, nurse Carmen attended to dozens of women and their children, most of which were seeking vaccines. During several of her very short breaks, Carmen spoke to us. One of her major complaints was that both *centros* and *puestos* should be able to diagnose and treat common illnesses in order to allow only the most serious health issues to be referred to hospitals. However, Carmen and several other nurses that we interviewed questioned their ability of doing so. Norma, one of the nurses at the much smaller *puesto* in Calixto, was very disillusioned:

> I do everything here: consultations, injections, emergency care... I always see patients when the doctor is not around. Here we cannot do exams that require laboratory tests because we do not have the necessary equipment. When people come in sick, we offer them medication when we have it, and if we do not have it, we have to prescribe. But most of the times there are no drugs. I do not know what is going on with the economic situation of the country. The government sends us very little, and few kinds of medication, and here there is a lot of demand. Whatever they send us for a whole month is over in eight days sometimes! The situation is very delicate here… This *puesto* was built over seventeen years ago, through collaboration between a European mission, and it was very good then but now we lack furniture, fixtures, a decent bathroom… Of course, we also lack a lab where we can run tests, because there is much demand

> here. Here we attend to people that come from San Pedro, San Tadeo, many villages... I think that sometimes the health authorities in Guatemala do not analyze the situation carefully, they send a lot of help where there is little need, and little help where there is a lot of need.

Norma is disappointed at what she perceives as the inability of governmental *puestos* to provide adequate care. One way in which both Carmen and Norma adapt to these circumstances is by suggesting affordable (yet less biomedical) treatment options when asked about how to treat common illnesses. For diarrhea, they prescribe a rehydration treatment. To stimulate lactation on nursing women, they mentioned a tea of a native herb called *ixmut*. Anemia can be treated by ingesting iron-rich foods (such as black beans) accompanied by orange or lime juice to improve iron absorption; it can also be treated by regularly eating *hierba mora*, a common herb used in several local dishes. The common cold can be ameliorated with over-the-counter painkillers and vitamin C, as well as rest and plenty of liquids. However, when asked about chronic, serious illnesses such as diabetes and high blood pressure, both nurses gave the same answer: the lack of laboratory equipment and adequate biomedical medication at their posts severely impairs their ability to diagnose and treat these conditions. Whenever a patient has symptoms of chronic illnesses such

Health education posters at the San Tadeo *centro de salud* provide information on what nurses have been increasingly using as medical treatment

Some of the equipment available to nurse Norma at the Calixto *puesto de salud*

as these, all they can do is diagnose their external symptoms, prescribe medicine, and hope they will follow up with treatment.

In their analysis of motivation in the work context, Franco et al. (2002) found that performance of workers depends on service quality, efficiency, equity, and worker motivation; the latter, however, is a consequence of individual workers' degrees of willingness to uphold the goals of the organization. They found that the organizational structures and availability of essential resources provide health workers with the ability to carry out their tasks, but the internal hierarchies, differential levels of autonomy, responsibility, and authority, as well as the relative status of different workers, determine how work is done. "Motivational processes in the work context operate at the level of the individual, and are composed of two parallel components: the extent to which workers adopt organizational goals ('will do') and the extent to which workers effectively mobilize their personal resources to achieve joint goals ('can do')" (Franco, et al. 2002:1256). The testimonies of nurses such as Carmen and Norma demonstrate that, in the context of rural Suchitepéquez, the personal motivation of these health care providers (what they will do) is significantly affected by their disbelief in the organizational structure and by the limited availability of essential resources (what they can do).

The limited investment in rural health services is also particularly problematic when paired with corruption. Mayra, who is a private physician and a pharmacy owner working in Calixto, believes that the biggest problem with the Guatemalan health system is that "the money does not go where it needs to go." According to her, the government initially allots money into different areas, such as national defense, education, health care, and infrastructure. Funds, however, are not secure; later, bureaucrats take money away from health care and education to support projects in other, more privileged areas, she says. Mayra also claims that the government

does not adequately remunerate physicians and often fails to do so in a timely manner. Mayra's testimony sheds some light on the reasons why trained physicians such as herself may avoid jobs in isolated, underfunded, rural facilities.

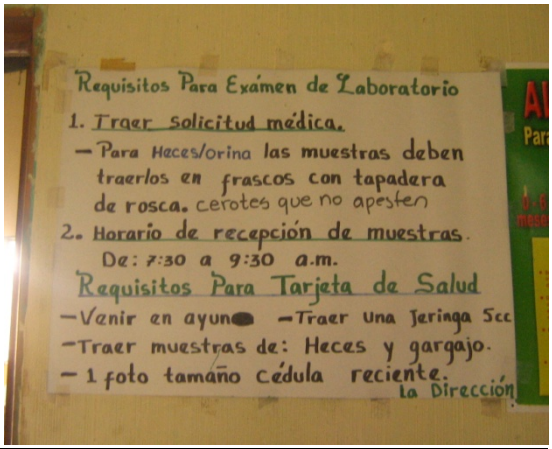
In their analysis of the effect of decentralization on the lives of Ugandan health professionals, Kyaddondo and Whyte (2003) note that decentralization policies worsened pre-existing issues with the remuneration of health care providers, exacerbating the occurrence of low salaries, delayed payment, and total nonpayment. Kyaddondo and Whyte recognize that health care professionals – particularly trained physicians – expect their professional abilities to provide them with the living standards and status of members of the middle class, including the ability to educate their children, to dress reasonably, to not be constantly in debt, and to assist their relatives. According to Franco et al. (2002), there is evidence that health care professionals are likely to seek alternative means to access income when their salaries are low or are not paid in a timely manner. One such alternative involves illegally appropriating medication from public and private hospitals and selling it directly to patients (McCoy, et al. 2008). Mayra justifies, "Physicians sell medicine from the hospital because they also have families to feed." In Guatemala, just as in Uganda, evidence suggests that underpaid health care professionals rely on a mixture of formal and informal economic activities in order to support their families and achieve their desired economic status.

It is not uncommon for governmental health staff in Guatemala and other countries to resort to "survival strategies." As Kyaddondo and Whyte (2003) state, these survival strategies can be found inside or outside governmental health facilities, and providers often combine resources from both spheres. As previously mentioned, one illegal means through which health care providers boost their income involves misappropriation of drugs, as well as informal

charging of patients and mismanagement of public funds (McCoy, et al. 2008). During one of the volunteer community clinics held by Raxnaqil in Tinamit, one of the veteran volunteer doctors attested to this problem: according to him, on several instances, he noticed the governmental seal used to identify the free medication distributed to hospitals, *centros,* and *puestos* in the boxes of pills that he purchased at private pharmacies.

In addition, as previously mentioned, many physicians and nurses resort to legal means to increase their earnings. Mayra herself provides an example since she is a private physician who also owns a pharmacy; ownership of private clinics and pharmacies is a common survival strategy for health workers in both Guatemala and Uganda, as pointed by Kyaddondo and Whyte (2003) and as evidenced by my research. This indicates an interesting relationships between primary health care providers (both public and private) and private pharmacies as a business. Given the current limitations of the governmental health facilities, several health care providers operating in *centros* and *puestos* choose to or are forced to refer patients to private facilities,

Private laboratory in San Tadeo offers exams unavailable at the *centro*



At the San Tadeo *centro,* the poster with the "Requirements for Laboratory Exams" and "Requirements for the Health Certificate" require that patients collect their own feces and urine, provide them in their own containers, and bring their own needles

such as private laboratories for diagnostic exams and private pharmacies for treatment. These referrals happen frequently, and may include the laboratories and pharmacies owned by themselves. This is also an indication of the symbiotic relationship that has been developing between public and private health organizations in several places around the world. While to a certain extent they complement each other, it is not clear whether the effect of this state of affairs is completely beneficial to communities (Birungi, et al. 2001; Goel, et al. 2007).

Research in Uganda indicates additional problems with the decentralization and privatization of health care. According to Birungi et al. (2001), Uganda has moved from having a state-centric health care system where over 90 percent of the care was provided by the state, to a model in which almost 80 percent of services are now provided by the private sector. They argue that because of decentralization, Ugandan governmental health facilities have been increasingly operating as de facto private institutions, where economic inputs from the government serve as a mere subsidy and not as the main economic support (Birungi, et al. 2001). The evidence presented in this section indicates that a very similar process is taking place in rural Guatemala. The lack of sufficient governmental investment, exacerbated by neoliberal decentralization policies, has a negative impact in the staffing, equipping, and general availability of essential services in rural facilities. In this context, the so-called survival strategies adopted by health care providers represent an attempt to supplement the inadequate economic support that comes from "governmental subsidies" with additional resources acquired in the private sector. Aside from being detrimental to the work of the health care providers in rural areas, decentralization policies also affect rural patients who, in Guatemala, are less likely to visit the urban facilities and have their access to treatment limited by what is available in the neighboring communities.

Private and Non-Governmental Provision of Health Care

Josefa, a pharmacy clerk, asked during the interview whether we belonged to the "clinic of the *gringos* in Iximulew." Josefa mentioned that she knows of some non-profit doctors that try to help low-income patients, including an ophthalmologist that charges 25 quetzales (about $3) per consultation and a general medicine physician that charges 20 quetzales. In addition, she said, one of the churches in San Aurelio pays a doctor and a dentist to offer consultations for 25 quetzales. Josefa admires the local priest, who according to her gives money so that "really poor people" can buy the medication prescribed by the church's doctor. Josefa was not alone in her admiration of local non-profits; several other health care providers referred us to local NGOs when asked about where patients could find economically accessible health care.

In the previous section, I discussed the effects of decentralization for the governmental health facilities in rural Guatemala. Decentralization and privatization are closely related: to the same degree that decentralization has undermined the ability of governmental health care providers, privatization has allowed for the emergence of new players in health care provision. Particularly, the scarcity of governmental investments in health has allowed private enterprises to increasingly perform the role of health care providers. In this section, I will focus primarily on the role of non-governmental organizations (NGOs) in health provision. I will focus on other private providers such as pharmacy clerks, pharmacy owners, and private physicians in the next chapter.

As detailed in chapter two, recent institutional changes in Guatemala – and in Latin America at large – turned NGOs into prominent alternatives to the state, particularly in developing impoverished communities. In their analysis of neoliberal reforms implemented in Bolivia, Arellano-López and Petras (1994) argue that the political authoritarianism characteristic

of Latin America in the 1970s and the emergence of democratic governments in the 1980s have both contributed to the expansion of NGOs. This expansion was further encouraged by economic policies, including structural adjustment (which required cuts in social spending) and neoliberalism (which has an ideological preference for private institutions), both of which were sponsored by the International Monetary Fund and the World Bank. It is clear that the democratization of Latin American states brought about ideological shifts in politics and economic policy which became increasingly private-sector-oriented instead of state-oriented.

Ewig's (1999) analysis of the women's movement in Nicaragua shows that early Latin American social movements defined themselves in opposition to authoritarian states. The democratization of the 1980s, however, prompted many social movements to institutionalize themselves as NGOs. In addition, NGOs were increasingly perceived by funding agencies as more efficient than states. Arellano-López and Petra (1994) demonstrate that Bolivian NGOs, during the 1970s, acted primarily as channels for political participation of groups that opposed authoritarian governments; the democratic opening of Bolivia fundamentally changed the political alignment of several NGOs which moved from supporting grassroots organizations to collaborating with the government and international agencies. In addition, the influx of international development funds has directly led to the emergence of many new NGOs created to make use of these financial resources. Through the 1980s and 1990s, the number of Bolivian NGOs grew exponentially and their roles have significantly changed.

A recent study by Rohloff et al. (2011) analyzes the explosion in growth of NGOs in Guatemala; current estimates suggest that over 10,000 of these organizations now operate in the country. Historically, the emergence of NGOs in Guatemala happened due to two events that took place in the 1960s. The first was the Kennedy administration's Alliance for Progress, a

major initiative to support modernization projects in Latin America. The second was Catholic Action, a movement led by foreign priests brought over after the Guatemalan coup of 1954. Both of these promoted a style of NGO action where small organizations competed among themselves for international funds. As previously explained, the end of the four-decade long civil war and the signing of the Peace Accords in 1996 exacerbated this trend by weakening the state and allowing international institutions to strongly influence domestic policies, creating what Rohloff et al (2011) have described as a "proliferating patchwork" of NGOs working on development. In Guatemala, this patchwork include internationally-funded organizations, local grassroots organizations, recent professional NGOs created as a consequence of health reforms, charity organizations, churches and other religious groups, etc. These non-profits are of all sizes; have a wide range of budgets and funding sources; employ national and foreign professionals; and work with a wide range of health issues. They lack, however, coordination: resources concentrate around certain issues (i.e.: malnutrition) and certain geographical regions (i.e.: Lake Atitlan, a popular touristic destination). It is also common for different non-profits to focus on the same health issues (i.e.: maternal and childcare), while other problem go unattended (i.e.: men's health).

Neoliberal reforms prompt NGOs to assume functions which previously belonged to state agencies. In this way, NGOs can and do allow states to defer responsibility for the welfare of populations (Arellano-López and Petras 1994; Ewig 1999; Rohloff, et al. 2011). Neoliberal health care reforms in rural Guatemala use NGOs as collaborators in the "depoliticization" of health disparities, or a process that reduces state responsibility for the social welfare of its people (Ferguson 1990). This is evidenced by the fact that, since 1997, the Guatemalan Ministry of Health has successfully outsourced many of its activities, increasingly "marketizing" health

services and utilizing NGOs to “fill the gaps” in rural areas (Rohloff, et al. 2011). Advocates of neoliberal reforms refer to this effort as a success in expanding health coverage in rural areas: they argue that between 1997 and 2002, over 3 million rural inhabitants have received new services because of outsourcing (Danel and La Forgia 2005).

Indeed, a comparative global analysis of NGO contracting conducted by Loevinsohn and Harding (2005) found that contracting could have positive results. Their analysis, however, ignores several of the restrictions faced by NGOs in Guatemala, including limited power in defining national policy; dependence on specific funding sources; power struggles within the organizations themselves; and hierarchical structures which require accountability to outside actors rather than to the people they work with (Ewig 1999). Maupin, who is very critical of neoliberal reforms, has noted that the Ministry of Health often reduces NGOs to the role of mere administrators, limits community-based efforts, and undermines the authority of community health workers (Maupin 2008; Maupin 2009). In addition, there is evidence that outsourcing caused the recent boom in NGOs, and that many were created specifically to compete for contracts despite having no prior experience in healthcare (Cardelle 2003).

Pfeiffer (2004), in his study of development actors in Mozambique, has found that both NGOs and Pentecostal churches have proliferated in the eras of structural adjustment and neoliberalism; these two kinds of organizations, however, understand development and engage communities in different ways. Pfeiffer is very critical of NGOs that operate on a top-down model: they hire foreign, middle-class professionals who run projects that compete for international funding in an uncoordinated manner. Buse and Walt (1997) also criticize the “unruly mélange” that characterizes international aid to NGOs: its lack of proper coordination produces duplicated or unrealistic health projects. This structure produces development projects

that are fundamentally disconnected from the communities they intend to help. Churches, on the other hand, have succeeded in "providing a respite for the poor from the insecurities of the free market and new arenas for mutual aid for those who appear alienated from the world of commerce, foreign aid, and the high costs of basic services" (Pfeiffer 2004). Pfeiffer cites examples of several churches whose continued commitment to the well-being of their communities has endured for years, despite the lack of foreign aid to support their projects.

Outside of the Missionary clinic, located in San Tadeo (above). The reception area of the same facility, which is clean and decorated, includes free filtered water (to the right).

This research identified one example in rural Suchitepéquez that parallels what Pfeiffer observed in Mozambique. I came across the Missionary clinic through the indications of several informants who spoke highly of the clinic as a place where poor people could be seen by a doctor, do exams, and buy affordable medication. The Missionary clinic has been active in the region for the last four decades, and operates several projects that receive support from varied donor agencies. When my partner and I arrived, we were struck by the good condition of the building, particularly when compared to the governmental facilities that were falling apart. The walls were newly painted, the garden was tended, the waiting areas had benches and chairs,

flowers and plants, and paintings on the walls. Upon arrival, a woman greeted us; she was in her fifties, and identified herself as an American nurse and one of the directors of the Missionary clinic. The woman greeted both of us in fluent Spanish, and did not default to English even after we introduced ourselves as US-based researchers. She directed us to Guillermo, the assistant director, who received us in a simple but nice office where we spoke for almost two hours.

Guillermo had worked there for over 36 years at the time of his interview. He was very proud of the Missionary clinic, which was the place where he held his first health-related job:

> I started in a very simple job, down the hierarchy. I was initially hired as a secretary for the vaccination campaigns, because 30 years ago the state used to delegate vaccination to the parishes, because they had a much more extensive presence in rural areas. Parishes knew where people lived, who needed services, and they were the only ones that could get by foot to the most isolated communities. We used to go and stay a week in a community, then another week in another one, doing this several weeks each year.

He then became an accountant despite his lack of formal training and held that position for the next seventeen years. His continued attention to the clinic and constant attempts to improve its services led to his promotion to assistant director, the administrative position he now holds.

The paradigm developed by Franco et al. (2002), which was previously applied to the governmental health care, also offers some insight here; according to it, motivation in the work context is a consequence of the worker's degree of willingness to promote organizational goals. Franco et al. (2002) acknowledge several internal influences on worker motivation, among which personal values and expectations about the consequences of their actions are paramount. Guillermo's lifelong commitment to the Missionary clinic and his devotion to the organization and to the communities it serves demonstrate his strong adherence to the clinic's mission and his willingness to perform his role appropriately. It is also in stark contrast to most of the

governmental health care providers, who lacked belief in and loyalty to their employers, and felt disappointment with the conditions of their work and their ability to be effective.

Twenty-two people in total, including two doctors, one professional nurse, and two nurse assistants staff the Missionary clinic. Guillermo believes that the gender, ethnic, and linguistic variety of their staff is one of their strongest assets:

> We have hired both men and women to work here. Here, we value diversity. It is important to have all sorts of people working with us. Sometimes women would rather tell their issues to other women, and so do men. We also require that people who work here speak both K'iche' and Spanish. Many of our staff members also work dressed in traditional *trajes.*

The language requirement was very strict, particularly with volunteer foreign doctors, and I suddenly understood why the missionary that greeted us spoke in Spanish despite the fact that we could speak English. The need for culturally and linguistically appropriate health care has been demonstrated by several studies (Kleinman and Benson 2006). Ngo-Metzger et al. (2003), in a study among underserved Asian communities in the United States, demonstrate that foreign-born, non-native English speakers valued sensitive, same-sex health professionals. Linguistic difficulties are particularly problematic in rural Guatemala because many indigenous individuals have limited Spanish fluency and few physicians can (or choose to) speak indigenous languages in their practices. Even providers who were raised speaking indigenous languages avoid these languages in the professional environment (Hinojosa 2004). The strong preference of the Missionary clinic for professionals who can identify culturally and linguistically with their patients is remarkable, especially considering that among the governmental health providers interviewed, only one nurse claimed to be fluent in an indigenous language and willing to use it during health care provision.

In addition to cultural and linguistic competency, the Missionary clinic also offers technical advantages to its patients when compared to *centros* and *puestos.* One of the most noticeable ones is its well-equipped laboratory. Guillermo is adamant about the lab being essential to diagnostics and a great aid for doctors in determining the appropriate treatment: “If a patient has a fever, the doctor can test his urine to know if he has a kidney infection, or draw blood to know whether it is *dengue* or typhoid fever. This way, we treat the cause and not just the symptoms.” Several state-employed nurses interviewed for this research have previously cited the lack of laboratories as a major constraint on their ability to diagnose patients appropriately. In the absence of labs, nurses working on *puestos de salud* often find themselves referring patients to private laboratories despite the fact that they know the costs may be prohibitive to some patients. In several instances, they mentioned the Missionary clinics as a place where the poorest patients could go to obtain the necessary exams (see Appendix). Guatemalan *puestos* and *centros de salud* have developed a symbiotic relation with organizations such as the Missionary clinic, which can provide their patients with the services that scarce governmental funds cannot support.

Guillermo is particularly proud of the Missionary clinic’s natural medicine program. He believes that “the natural medicine is a patrimony of the community and the culture.” The natural medicine program is effective and affordable to low-income patients with consultations that cost only five quetzales. When approached by a patient, one of its three staff members will identify the health issues of the patient, then search through over 100 available local herbs to find the ones that provide the best treatment. The most important component of their job is educational. They interact directly with patients, explain how the herbs work, where they can be found (either in nature or commercially), and how the natural medicine should be used.

The careful treatment provided by programs such as the natural medicine project at the Missionary clinic is a factor in what patients perceive as the “friendliness” among NGO staff. Friendliness promotes satisfaction with services and is an important factor in the effectiveness of health care (Danel and La Forgia 2005). In addition, the study by Ngo-Metzger (2003) with underserved Asian patients in the United States found that the majority of patients value being treated with respect and dignity by their health care providers, which often translates as being treated "as an equal" in the patient’s narratives. Health care staff who provided what patients perceived as a respectful treatment were the ones with whom patients could establish trusting relationships (Ngo-Metzger, et al. 2003). Berry (2008) has identified a similar phenomenon in Guatemala: while cost, distance, and perceived need affect people’s decision to seek care, perceptions of the quality of care and trust in providers are two of the most robust predictors of service use. She argues that most of the health services – governmental or non-governmental – emphasize biomedical treatments, which are often expensive and seldom explained to patients. Biomedical protocols can be incompatible with local understanding of health issues and health needs; more often than not, biomedical protocols are also assigned more value than local understandings, and health care providers are treated as experts while patients are supposed to be passive, disempowered recipients. During interviews with the state-employed nurses, we noticed that, when questioned about culturally defined illnesses (such as *mal de ojo* and *empacho*), they did not offer treatment. “Some people believe in that, but we cannot do anything… These illnesses are just people’s beliefs,” Norma said. Carmen added, “People have their *creencias*, their beliefs, but it almost never gets here… We do not treat that here.” Berry argues that relying on effective, biomedical protocols to improve a patient’s health is important, but acknowledging a patient’s agency in decisions about their care, understanding their beliefs and limitations, and

recognizing their need to understand their conditions, have their concerns recognized, and receive adequate treatments is equally important.

Though the Missionary clinic clearly offers several advantages to its rural, mostly poor patients, it is far from a solution to all of the region's health issues. Similar to governmental health facilities, the clinic serves a very large geographical area; it provides care primarily to the communities under the influence of the parish of San Tadeo, which spreads over 250 square kilometers and includes over 65,000 people who live in about 90 communities. In addition, people from other municipalities also visit the clinic seeking health services. Guillermo said:

> Here we do not deny care to people from other places when they visit our establishment. Our philosophy is to help people from places where there is a deficit in public health. Here the government fails a lot the poor, those who do not speak Spanish. These people are the ones most in need, they do not know the cities very well because they live in rural areas, they do not speak Spanish or speak very limited Spanish, they are afraid of the people that they do not know. They are the most affected and the ones who receive less help.

Despite the good intentions of the staff and the donors, I found that there is only so much that the Missionary clinic can do for this large population. The bilingual, culturally appropriate staff and the well-equipped lab cannot account for the immense imbalance between what these communities need and what the Missionary clinic feasibly can provide. As an example, I noticed that unless a patient with a serious emergency arrives, the clinic provides consultations to no more than 50 patients a day in order to maintain the quality of care. In addition, though the natural medicine program can be helpful in some instances, there are conditions for which a patient needs access to biomedical medication. While I found that the Missionary clinic has a traditional pharmacy on the premises, and while they sell medicine at discounted prices, they still cannot solve the underlying issue of poverty that prevents patients from purchasing these treatments. Finally, there are conditions for which the expertise available at the clinic is not

enough; if a patient needs a complex procedure or surgery, he or she will go back to the problematic referral system previously described.

I conclude that the Missionary clinic, like many other NGOs, is also constrained by external factors. Gow would argue that advocates for rural development face the same dilemma as the communities they represent: "how to make their voices heard and how to make society respond" (Gow 2002). Ewig (1999) says that the Nicaraguan feminist NGOs never intended to replace the state health system in that country. Rather, they attempted to improve health care in three ways: 1) developing models for the state to emulate, 2) coordinating with state institutions to improve health care, and 3) gaining a foothold in health policy-making at the national level. The Nicaraguan NGOs, however, developed a strong presence in the traditional political sphere (Ewig 1999), which is not true of most Guatemalan NGOs. Though the Missionary clinic has been extremely active in Suchitepéquez for many decades, it has little political leverage to affect policy making; therefore, it can neither fill the gap left by the state nor force the state to fill it.

Raxnaqil, the NGO with which I collaborated during my summer in Guatemala, is a much younger organization; similar to the Missionary clinic, it has little political leverage to affect policy making and it can neither fill the gap left by the state nor force the state to fill it. However, according to one of its directors, they are placing efforts on networking:

> I will argue that in the last two years we have grown tremendously and are now working with some of the largest Guatemalan nonprofit agencies. Through academic, medical, and political networks, we are working to bring together all actors in development.

Though there is only so much they and other NGOs can do, I contend that some aspects of Raxnaqil as an organization make it more likely than other NGOs to succeed: it hopes to work with communities on long-term projects and focuses on collaborative research and participatory decision-making. I echo the arguments of many other medical anthropologists: community

participation (not markets and enterprises) is what is essential to ensure equitable and responsible health systems (Barrett 1997; Janes 2004; Torri 2011). Community participation requires a degree of activism and advocacy from NGOs: instead of merely ameliorating the health issues of local communities, they need to advocate on the national and international levels to challenge the economic neoliberal policies that now define much of the global health development.

Conclusion

Marion Carter (2002) has noted that Guatemala has long been characterized by the coexistence of biomedical treatment and traditional approaches to health care. Currently, rural Guatemalans who need or want biomedical care have to decide whether to seek governmental services of low cost and varying quality, to look for help in the growing sector of NGOs, or to access health care at the popular private pharmacies. In this chapter, I examined the decentralization and privatization of state health care in rural Suchitepéquez. While these reforms may not have worsened health care access, I argue that they have failed to significantly improve rural health care as it was promised by the Peace Accords of 1996. Instead, these reforms seem to have fragmented health care in rural Suchitepéquez. I demonstrated how decentralization has created problems for the governmental facilities: while this policy was intended to transfer decision-making to local authorities, what it did in reality was exacerbate the economic constraints faced by governmental organizations. I also indicated how the privatization of health care has, to a certain extent, transferred the responsibility for providing health from the financially challenged public institutions to private organizations such as NGOs. I argued that these neoliberal policies fail to address the issues faced by health care providers in rural regions

and add to the already challenging nature of their work as they try to serve a very disadvantaged population.

CHAPTER 4

Commercializing Health: Pharmacies as Primary Care Providers

In chapter three, I analyzed some of the challenges encountered by rural health care providers in Suchitepéquez, Guatemala. I showed how decentralization and privatization policies have directly affected the work of health care organizations, governmental and non-governmental facilities, and the daily labor of health professionals working on these fields. Through my research, I found that the cuts in the national budget for health aggravate challenges faced by rural health care providers, who have to rely solely on local authorities; because rural populations are more dispersed and generally poorer than their urban counterparts, their communities are less able to fund health services, increasing their vulnerability. I also noted how decentralization policies have allowed for the continuation of corruption in health services instead of increasing their accountability and transparency. Finally, while the presence of NGOs has benefitted part of the population, it undermines the long-term improvement of rural health care because the reliance on services provided by NGOs allows the state to distance itself from its responsibility to provide all citizens with health.

Here, I further develop my analysis of the privatization of health services through an examination of pharmacies as primary health care providers. I look specifically at how pharmacy employees and owners understand the ambiguous nature of their businesses, which oscillates between a commercial activity and a needed health service. The role of pharmacy employees in

Guatemala has a very "elastic" nature, and these individuals are often conflicted between the need to make a profit and the need to help, maintain the loyalty, and recruit their clients. I explain the impacts of the scarce regulation concerning who has the authority to operate pharmacies and prescribe medication, as well as the issues of mistrust between patients and providers, and providers themselves.

Neoliberal Privatization and Mistrust of State Health Care

In her book about privatization of health services in Africa, Turshen (1999) proposes that decentralization brought dramatic changes to the "social contract" between states and citizens regarding health care: as explained previously, decentralization charges local authorities with full responsibility for health provision but offers them limited resources to do so. As a result, cost recovery measures require that patients pay fees for services and treatments if they are to access basic health services (Turshen 1999). This effectively means that the responsibility for financing health care moves from the government to the citizens themselves who become less like patients seeking a rightful service and more like consumers paying for a desired service.

Coburn (2000) argues that neoliberalism, income inequality, social fragmentation, and lower health status are deeply connected. He contends that privatization policies are antithetical to social cohesion and trust because they promote individual ownership of services that were once the responsibility of states. While the state has not completely disappeared due to neoliberalism, it has fundamentally changed: neoliberal states do not execute actions themselves but rather facilitate private agencies to do so (Coburn 2000). In the case of Guatemala, the state has decentralized and (de facto) privatized its health services, but I contend that it moreover fails to properly regulate the new private players. In their book about the global pharmaceutical

industry, Petryna et al. (2006) explain that the inconsistent regulation of medications, which are produced and commercialized globally, can create economic and political inconsistencies as well as dangers at the national level. While in places such as the United States pharmacies are part of the formal, regulated economy of health, the lack of standardization in places such as Guatemala means they often fall between the cracks of regulation and formal health care policy.

The Guatemalan state indeed plays little regulatory role; it exerts minimal control over who can run pharmacies, who has the authority to prescribe, and how medication is sold. Historically, Guatemalan pharmacies have been attractive as health care providers because they provide biomedical drugs while sharing local understandings of illness. Prior to the implementation of neoliberal reforms, Cosminski (1994) found that Guatemalan pharmacists mediated between international drug companies, national level health policy, and community needs; they also acted as "cultural brokers" between biomedicine, Ladino popular medicine, and indigenous medicine. Because decentralization and privatization have undermined other health care providers, such as local *centros* and *puestos de salud*, the role of pharmacies as primary health care providers has only grown. Scarce regulation and coordination force individuals seeking health care to be exposed to often incongruous logics and practices of various private, governmental, and non-profit organizations, each with its own medical standards, accountability practices, and funding mechanisms. Rohloff et al (2011) have demonstrated how this chaotic, "unintelligible" health care landscape leaves people without a reliable "therapeutic home" that they can trust. In this section, I explore how this collective mistrust is not only fomented between patients and providers, but also permeates relationships among health care providers.

Giddens (1991) has developed a framework to understand trust in institutions: he states that trust stems from an accepted "expert system of knowledge" and from its "symbolic tokens,"

or the things that hold value and can be exchanged between experts and non-experts. Thus, confidence in state health care providers is eroded and their symbolic tokens lose credibility when the state retracts maintenance and investment in the health care system and leaves much of it to the whims of the free market. Birungi (1998) identified an example of this process in Uganda, whose excellent state health care system crumbled due to economic crisis, political disruption, structural adjustment policies, and cuts in the governmental budget for health. Until the 1960s, governmental health services were free, private care was relatively cheap, and professionals were well trained, respected, and satisfied with their jobs. When the government stopped investing in health, many professionals left and those that remained worked in nearly non-functional health facilities. Private health care proliferated, including unlicensed private clinics, pharmacies, and home providers (Whyte 1991). These changes fundamentally undermined confidence in health facilities and medical practitioners in Uganda.

In the case of Guatemala, health workers' trust in state health care has decreased because, as evidenced in chapter three, its nurses and doctors feel that they cannot provide patients with laboratory exams essential for diagnosis, free medication essential for treatment, or complex medical procedures. Berry (2008) demonstrated that Guatemalan patients' trust in state health care has also decreased: she says that state health care in Guatemala is supposed to be free, but the financial limitations of rural authorities cause the public and the private systems to effectively restrict themselves to a triage type of care, whose earnings often derive from the sale of medicine. "Private doctors either do not charge patients or only charge a nominal fee, making their money instead by selling the drugs patients need… From the perspective of the patients, this seems to be precisely what the hospital is doing" (Berry 2008:177). For-profit, private providers benefit from the shortcomings of state facilities because doctors frequently have to

request that families pay for procedures or treatments, which can cost as much as half a week's wages for some of the poorest rural families.

While many patients and health professionals no longer trust the expert knowledge of state health care, they still trust pharmaceutical medications as "symbolic tokens" of health. This is best exemplified by the answers that the majority of health professionals interviewed for this project gave to the question "Do you prescribe or recommend natural remedies?" Of the seventeen pharmacies visited, eleven had in their stock some natural remedies and six did not have any; only two, however, consistently *recommended* that patients used natural remedies. Mariela, manager at a chain pharmacy in San Antonio, argues that they do not sell more remedies that are natural because there is no demand: "Only the more educated people come and ask for natural medications because they know that they are better to them… The others, the majority of people who come, the do not really know and do not really want it." Enrique, the sanitary inspector for the San Aurelio *centro,* adds that at this facility they usually do not focus on natural medicine because "People here are young, they almost do not seek it, do not believe in it… They only believe in real medication." In addition, as demonstrated in chapter three, the nurses themselves are disillusioned about having to prescribe foods, herbs, and vitamins to their clients; they do so because they lack free medication to offer them and they know that their clients cannot afford to purchase it on their own.

This phenomenon could be a consequence of the "pharmaceuticalization of public health" that Biehl (2007) has identified in Brazil's national AIDS program: in a context in which the state is institutionally absent, people's trust is then placed on drugs. Hence, people may visit the pharmacy from the start; this way, they can by-pass doctors and nurses in order to avoid the prohibitive costs of diagnostic exams and yet still purchase the desired medication. Several

scholars studying health care in Latin America have found that, historically, people prefer pharmacists to doctors when seeking health advice, for a variety of reasons (Cosminski 1994; Ferguson 1988; Logan 1988; Van der Geest and Whyte 1988): clients seek pharmacies for health advice because, unlike doctors, it is free. In addition, it is fast; a visit to the pharmacy does not require forms, waiting rooms, or time-consuming procedures. Finally, pharmacies allow their clients a higher degree of decision-making than a doctor would.

Many of my interviewees, however, contested and questioned this trust in pharmacies. In rural Suchitepéquez, I have found that mistrust has pervaded the relationships between different health professionals. Guillermo, assistant director of the Missionary clinic, displayed intense mistrust of pharmacies and their employees whom he accused of greed: “Here, in Guatemala, health is a business for everyone and it is not a right to anyone; there are lots of illnesses here and that is why owning a pharmacy is a great business. Money is worth more than people. It is very sad.” The Missionary clinic, where he works, runs its own pharmacy and sells medication at recovery cost; only when they lack a specific medication do doctors and nurses resort to prescriptions. Guillermo, however, says that the staff is instructed to not direct patients to any specific pharmacy because, as he says, they have no way of knowing how each establishment works and cannot guarantee the quality of the product they sell. Quality of medication is a serious concern because, according to Guillermo and others, several falsified medications are often sold in Guatemala. Several health care providers shared his opinion about pharmacists, just as pharmacists shared negative feelings about doctors and nurses. I found that this mistrust emerged, in part, because of the way pharmacies function as private businesses, which will be detailed in the next section. I also found it was very uncommon for providers in any setting to hold their peers in high esteem.

Pharmacies as Businesses

Upon arriving in San Aurelio, my partner and I were astonished by the large number of pharmacies surrounding the central plaza. Finding pharmacy employees and owners to interview proved to be simple because there were at least two or three pharmacies per block. In addition, there was a wide range of pharmacy "styles:" large pharmacy chains with a dozen of uniformed employees, medium-sized pharmacies attached to convenience stores, small family-owned pharmacies staffed by couples, etc. Each time, we questioned employees about why there are so many pharmacies in San Aurelio, and their answers were consistent: pharmacies are a great business in Guatemala because they are easy to open and maintain; they require little training for licensing; there is a great demand for their products; and they are very profitable. In this section, I will explore how pharmacy employees understand the nature of their business.

Assortment of pharmacies (*Farmacias*) in Calixto (above) and San Aurelio (to the right)

Many of the employees and owners interviewed have extended experience working with pharmacies in rural Guatemala, which allows them to explain how these businesses have evolved over the last decades. Javier claimed to know the business very well because he had worked as a pharmacy clerk in four different pharmacies located in different cities for over sixteen years. According to him, pharmacies have traditionally been family businesses in Guatemala, but this has been changing: family-owned pharmacies often close when the original owners die or retire, most of the time because their children refuse to continue running the business. Instead, I found that many of the pharmacies visited during this research belonged to national or regional chains.

One of the few family-run pharmacies that we found in San Aurelio is owned by a couple, Jorge and Elena. We visited their pharmacy as we sought medication for a Tinamit woman who had an ulcer; Raxnaqil's staff recommended Jorge and Elena's pharmacy to us. Their pharmacy was medium-sized and it was located right off one of the main streets in San Aurelio. It was very loud inside the pharmacy, in part because of the cars driving by and in part because American dance music was playing (relatively loud) on the store. Medications at this establishment seemed cheaper than in other places, but there also seemed to be less medicine than in other pharmacies because this store did not seem to have storage space on the back. Jorge, one of the owners, has worked in pharmacies for over two decades. He got his first job as a clerk when he was fourteen years old and learned through apprenticeship. He moved to the United States when he was twenty-five years old and worked for two years to save enough money to buy that very same pharmacy that he and his wife have now owned and operated for over a decade. According to Jorge, the expansion of pharmacies into communities such as San Aurelio is a recent phenomenon, one he attributes to how unregulated they are in Guatemala:

> Before, every pharmacy needed to have a chemical pharmacist in charge in order to exist, but now the owner only needs to be licensed by the government. The

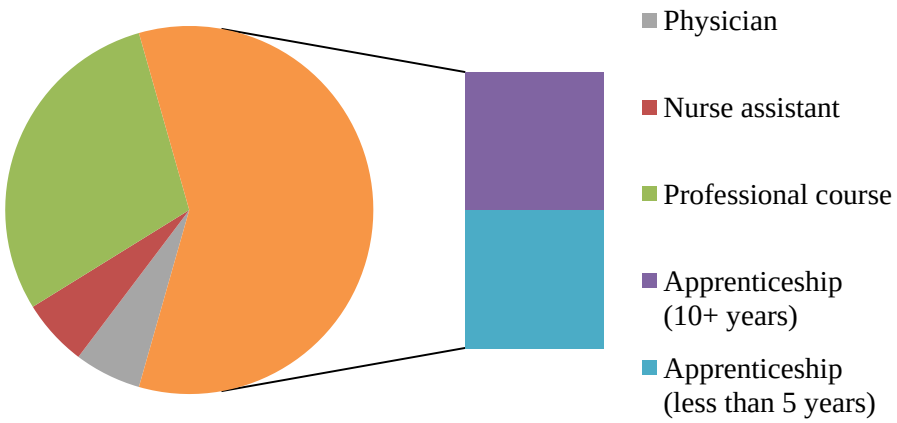
> license only costs about 3000, maybe 4000 quetzales (375 to 500 dollars) and then a monthly payment of 600 quetzales (about 75 dollars) for however long you run the business. Anyone with a little money can have a pharmacy nowadays.

Jorge, Elena, and others have indicated that the lack of regulation in the pharmacy business makes it easy for anyone to own and operate a pharmacy in rural Suchitepéquez.

Mariela, manager of a chain pharmacy in San Aurelio, added that the fact that medication is easily sold without prescription also explains the boom in pharmacies. She managed a medium-sized pharmacy that belonged to a national chain. The store was narrow but extended deeply into the building where it was located, and as we interviewed her we could see shelves extending toward the back of the room filled with various kinds of medication. She managed four uniformed clerks who were prompt to attend to us when they thought that we were there to purchase medication, and just as prompt to leave the conversation once we indicated our intentions. During our interview, we noticed several clients walking in and purchasing medication; Mariela, then, mentioned that they had never gotten in trouble for selling medication without a prescription from a doctor.

The fact that pharmacists are very comfortable prescribing medication, however, can create problems. Out of the seventeen pharmacies visited during this research, ten were owned, managed, and staffed by people who learned only through apprenticeship, while among the remaining seven, one was run by a physician, one by a nurse assistant, and five by people with some professional training, usually obtained through courses or private companies (see Appendix). Among those who learned by apprenticeship, five had been working in pharmacies for over ten years – like Jorge, Elena, and Javier (see Appendix). There were others, however, like Cesar: he had been working alone and unsupervised for over two weeks in the pharmacy

Pharmacy owners and clerks according to their training



where his main experience was as a cashier. The extreme variation in the level of experience of pharmacy employees creates challenges for clients who often trust the pharmacist when purchasing medication, as will be explained in the next section. Unfortunately, this phenomenon seems to resonate throughout the region. Logan (1988) found in Mexico that rural areas in particular tend not to have professional pharmacists operating pharmacies, and in El Salvador Ferguson (1988) found that it is common for pharmacists to learn on the job rather than be trained formally.

Little regulation is not the only factor promoting the expansion of pharmacies in rural Guatemala. Several pharmacy employees also mentioned the high demand for medication in the region. Miranda, a pharmacy clerk, says that there are always sick people in the small villages around San Aurelio. The pharmacy where she worked attested to this fact: it seemed small but extended deep into the building, and was located in close proximity to the city market, which made it very crowded and noisy. The first time we attempted to interview her, there were about ten people waiting in line for service; we decided to take a walk and come back later. Even after

we finally started the interview, it was constantly interrupted as a never-ending stream of clients walked in and out of the establishment.

Cesar, the cashier acting as clerk, added that the high demand for medication is due to the fact that many of the conditions that afflict the rural population are chronic, and often one condition will cause others. These observations reflect how poverty affects rural health. As explained in chapter two, the department of Suchitepéquez is located in one of the poorest regions of Guatemala, and the high level of poverty has direct effects on the health of people, particularly in the rural areas where limited health care services are available. Two studies have found a strong correlation between poverty and malnutrition in the region in and around Suchitepéquez, which has the second highest rate of infant malnutrition in the country (Gragnolati and Marini 2003; Marini and Gragnolati 2003). Malnutrition increases the susceptibility of both infants and adults to develop other conditions, both infectious and chronic. A recent study by Müller and Krawinkel (2005) has confirmed that, globally, malnutrition is the most important risk factor for illness and death, particularly in rural communities, where its high prevalence pairs with infectious diseases and the lack of efficient treatment in a vicious circle. They argue that for health interventions to be effective, the issue of poverty must be addressed.

Several health professionals working with the government have highlighted how poverty affects the health of rural patients. Nurse Norma, who works in Calixto, says that many of the illnesses that she treats are due to contaminted water: “The water there is not clean. Most people, when they can, buy jugs of purified water. Those that cannot afford to buy jugs have to at least boil their water. We always tell them to do that.” Enrique, who works in San Aurelio, also said:

> We always tell people here about better hygiene and better housing. It is a vicious cycle, what we have here: people get sick, come to the *centro,* get cured but do not change their hygiene habits, and then they get sick again. The health services and medication are worthless if people refuse to change their habits. But the

> socioeconomic level of people here is too low, and we cannot improve their housing, so I guess they will keep getting sick.

Pharmacists also noted these issues on their interviews. Sebastian, who worked in a small yet very popular pharmacy, pointed that poor patients tend to seek pharmacies because they cannot afford to visit a hospital:

> When people have a simple illness, they come here and save themselves the money they would pay to a doctor... Often, people work a lot, and when they get paid, they only have enough to buy food. However, sometimes the money is not even enough for that and their body suffer a lot… They are overworked and still do not enough money to buy medication for sick people. Hospitals and *centros* also are also part of the problem because they only give prescriptions and not the actual medication, and sometimes people have no way to pay for the drugs… It is a very hard situation.

While most health professionals recognized that poverty caused illness and that it prevented people from accessing treatment, their statements also indicate a level of powerlessness, or a belief that there was not much more that could be done to improve the health of poor, rural individuals.

Much like decentralization, privatization and the locations of pharmacies have also exacerbated inequities between urban and rural areas. The health needs of rural communities are equal, if not bigger, than those of their urban counterparts, but urban dwellers can exert more political pressure and constitute a denser market for sales, thus securing a disproportional amount of public and private health resources (Homedes and Ugalde 2005). Most pharmacy owners agreed that commercial towns such as San Aurelio are particularly good locations for their businesses. Sebastian and Dalila, owners of two different pharmacies, argued that the larger population in San Aurelio creates a greater market for pharmacies that serve both the town and surrounding rural communities. Miranda mentioned that many neighboring villages do not have pharmacies of their own, and therefore their residents come to San Aurelio to purchase

medication when they visit the town for work, shopping, or transit. In addition, because most people in rural areas do not own cars, dozens of pharmacies are concentrated at the commercial center of San Aurelio, just blocks away from major bus stops. Of the seventeen pharmacies visited for this research, fifteen were located around the central plaza of San Aurelio, and only two were located in the main road of one of its neighboring bedroom communities, Calixto. Tinamit, one of the roadside communities located between Calixto and San Aurelio, had none.

The high concentration of pharmacies in commercial centers means that they compete fiercely for clients. Whyte et al. (2002) explain that private pharmacies operate primarily as businesses: to keep afloat in a very competitive market, such as the one in rural Guatemala, private pharmacies must attract clients and keep their loyalty. Sometimes, pharmacies attract clients by offering cheaper medication. Mariela manages a chain pharmacy and said, "If the other pharmacy offers some drug at a certain price, we can lower our price and have their clients come to us." Other times, pharmacies attract clients by selling what they want to buy (Whyte, et al. 2002). In several instances, I observed clients request very specific medications contradicting the advice of the doctor or the pharmacist, and every time they got what they wanted. This is evident in the answers of some of the pharmacists. Mayra, a pharmacist who is also a doctor, said that many of her clients prefer injections, and will sometimes only purchase a medication if it can be injected: "It is something about the culture here; it is different from the cities. Here people think that if you inject them with something, it will cure them faster, and if they drink a syrup or ingest a pill it will not be as effective." Dalila, a pharmacy manager whose brother is a physician, sometimes tries to advise her patients otherwise: "People here think that injecting a medication makes it work better and faster. But my brother, who is a doctor, says that on the long run pills are better. What you inject comes out in the urine fast, and pills are absorbed slowly and over a

longer period of time." She added, however, that not everybody listens to her advice. Her observation is congruent with our participant observantion. In several instances, while we interviewed, pharmacists administered injections on the patient's request.

Several pharmacy employees believe that people benefit from the large number of pharmacies because it provides them with access to more options and a larger range of prices. While competition between pharmacies may allow some clients a higher degree of choice, it is only beneficial to those who can afford to make choices. The pharmaceutical industry in Guatemala also benefits from the population's fear of falsified medications. This fear allows some pharmacies to charge more for their product by guaranteeing that it is legitimate. They can also instill fear in clients who may be inclined to purchasing cheaper drugs at competing pharmacies by insinuating that those may be falsified. Chloe explained that medication at the chain pharmacy where she works is expensive because they sell high quality, imported drugs: "There are cheaper drugs in the market, out there, but they are fake and do not really work." Pharmaceutical labs also have big stakes in what medications are sold and, through their influence on pharmacies, also compete for clients. Our interview with Chloe was interrupted briefly while she attended to a client; in the meantime, a sales representative from a major pharmaceutical laboratory approached us. She was promoting products for her lab, which were not only on sale but also displayed prominently in a glass case. "I am here to make sure people buy my products," she said, laughing, later assuring us that medications from her lab were expensive because they could be trusted to work.

This leads us to the final and most obvious complicating factor in pharmacies' provision of health care in rural Guatemala: their profitability. At one end of a continuum, pharmacists are interested first and foremost in profits. Young Chloe, for example, who was interviewed during

her shift as a clerk for a chain pharmacy in San Aurelio, mentioned that she owns her own small, but very profitable pharmacy. She affirmed that pharmacies are very lucrative: they can purchase medication from suppliers and sell it to their clients for up to three times as much. At the other end of the continuum are those who emphasize the responsibility and satisfaction of helping clients. Sebastian has been a pharmacy owner for over 20 years and thinks one should consider the needs of the clients:

> One has to offer good prices; one cannot sell aspirin for a 100 quetzales because the people here do not even have 50 cents to buy aspirin. If I sell it for 50 cents (granted I bought aspirin at a lower price), then I can help the client and myself: the client because he is feeling better, and myself because I am selling medicine.

Jorge and Elena subscribe to this ideal as well. Elena said right away that their business was about helping people: “Some people in this business do it because it is lucrative, they do it solely to earn money, but we do not. It is not about earning money but about helping people.” Nonetheless, if a pharmacy is to stay in business in such a competitive market, it must both make a profit and satisfy its clientele.

Mayra is a physician who owns a pharmacy in Calixto. She argued that the profitability of the pharmaceutical business is actually a detriment to clients: “One person opens a pharmacy and starts making money, and then their neighbors get the same idea. They think it is like selling candy and they do not realize how much they can harm people.” Javier, who is not a physician, agrees that many pharmacies in this region are ill prepared to meet the needs of clients who purchase medication without prescription. “Just having a lot of money is not enough to open a business. First one needs the knowledge.” He has been a clerk for over sixteen years, and made the analogy that one should not open a boutique without knowing about fabrics, just as one should not open a pharmacy without knowing about medicine. Josefa, who has been a clerk for over eighteen years and currently works at a *Farmacia de la Comunidad*, thinks that pharmacists

who focus on profit take advantage of people's low health indicators, low educational level, high levels of poverty, and of the fact that the governmental facilities are less than desirable.

In recent years, an alternative business model for pharmacies emerged in Guatemala in regards to issues of accessibility and affordability. *Farmacias de la Comunidad* (Community Pharmacies) offer a broad array of generic medications at affordable prices. The chain is owned by a non-profit association and has over 450 establishments through the country. Dalila described the process she and her husband had to go through to manage one of these pharmacies. First, the potential managers have to find a good location for the pharmacy. Then, they must contact the regional representative of the chain, who after a thorough background check on prospective managers, will allow them to get trained. Dalila showed us some of the ten booklets that she received during training, which contained extensive, educational, and simple-to-understand information on common illnesses and their treatments. Josefa, who works for another pharmacy in the chain, remembers attending classes and being tested very strictly: "we have to study like doctors do." Finally, future managers have to observe other managers for a certain period to learn from them. Once training is complete, managers can open their own pharmacy. In addition to affordable medication, both of the managers interviewed said that the *Farmacias de la Comunidad* hire doctors who receive a monthly stipend to visit each pharmacy in their region once or twice a month. The pharmacy's clients can consult the doctor for free if they need. This is significant because, as evidenced in the previous chapter, access to trained nurses and physicians is severely limited in rural Guatemala, a shortage that increases the rates of patients self-prescribing, seeking help in their social networks, or seeking pharmacy clerks for their health needs.

While the *Farmacias de la Comunidad* offer an affordable alternative to private pharmacies, they cannot supply, on their own, all the health needs of these communities. On one hand, they remedy issues such as the scarcity of trained health professionals and the high costs of medication; on the other, they are also constrained by the same business model followed by their private counterparts: they are scarcely regulated, tend to be located in urban commercial centers, and need to make at least some profit in order to stay afloat. Overall, while these pharmacies do attempt to address the issue of poverty, they lack the means to effectively solve it – a necessary change in order for health interventions to be truly efficient (Müller and Krawinkel 2005).

In sum, I have found evidence that neoliberal reforms that push for little regulation of private businesses have made the nature of the pharmaceutical business in Rural Suchitepéquez more ambiguous and profitable. As explained in chapter three, decentralization and privatization policies exacerbated problems with the governmental health care system due to the lack of public investment in local hospitals, *centros,* and *puestos de salud,* which lack the staff, equipment, and treatments needed by communities. Since state health facilities routinely lack medication and are not easily accessed, patients use pharmacies as primary health care providers. I have noted that the business nature of pharmacies strategically shapes the quality and availability of pharmacy staff and their attitudes towards patients: pharmacies must please their clients if they want to survive in the market, but they also seek to make as much money as possible from a destitute population. I confirmed the reversion of a state health system into a market-driven one riddled with holes and inadequacies, as seen in the fact that several doctors and nurses now own pharmacies as a way to secure additional income. Whyte (1991) uncovered a similar result in Uganda, where the public health care sector became more subsidiary to the private one after neoliberal reforms. My interviews indicate that Guatemalan health workers in pharmacies,

governmental facilities, and non-profit organizations are often ambivalent about this state of affairs, recognizing issues with the current health system while feeling disempowered to improve it. They recognize that standards of care are compromised in rural Suchitepéquez and that the current situation is particularly detrimental to poor, rural communities. Yet, as I will demonstrate in the next sections, health workers continue to help reproduce the system and often blame their competitors, not the policy-makers, for substandard health care.

Pharmacy Use in Practice

As mentioned in the previous section, the role of pharmacies as primary health care providers is very ambiguous: not only are pharmacies primarily businesses, but also there is a wide range in how experienced and knowledgeable pharmacy employees are (see Appendix). In countries like the United States, the ability to prescribe medication is awarded to those professionals who, by virtue of their training, understand the biological and chemical interactions that can heal people. The commercialization of most medications is thoroughly regulated as a way of preventing patients from accessing drugs that are not sanctioned by these trained professionals. The measure is understood as a way to protect patients from harming themselves. As an example, most antibiotics in the United States can only be purchased with a doctor's prescription. This prevents patients from using antibiotics to treat viral infections, against which these medications are useless. It also prevents patients from using antibiotics indiscriminately, making harmful bacteria less likely to develop resistance to these medications. On the long run, the regulation of antibiotic use protects the larger community by preventing the emergence of antibiotic-resistant microorganisms that could potentially kill many people. In Guatemala, however, pharmacies face a very different situation. As mentioned in the previous section, the

Guatemalan state exerts very little regulation on this business: while there are rules (i.e.: prescriptions should be requested prior to selling medication), they are not always enforced (i.e.: pharmacists seldom are punished for selling medication without requesting a prescription). Privatization and the resulting utilization of pharmacies as primary health care providers had a strong effect on health service delivery in Suchitepéquez. In this section, I analyze how privatization of health care in Guatemala affects prescriptive behavior among pharmacy workers and their clients.

In the case of health care in Guatemala, the formal sphere where medications are supposed to be distributed includes governmental hospitals, *centros*, and *puestos de salud*, as well as private pharmacies, clinics, and hospitals. In these establishments, medication is supposedly provided under the supervision of trained professionals and through the means of prescriptions. However, because of the lack of funding or institutionalized corruption, I found that most public hospitals, *centros*, and *puestos de salud* lack even basic medications. No governmental facility visited for this research had supplies of medication in them at the time of our visit; some had received them, but stocks had already ran out and new supplies would only arrive in the next month. Pharmacies benefit from this because the demand for medicine continues after the governmental supplies ends. In addition, as mentioned in the previous section, prescription medications are not strictly regulated in Guatemala and patients can bypass doctors because pharmacies will sell medication regardless of prescription. Ultimately, the purchase of medications by Guatemalan patients may not even be informed by a professional, but instead by friends and family, previous experiences with illnesses, and the pharmacy clerks themselves.

The role of pharmacists in Latin America has been described as being an “elastic” one (Whyte, et al. 2002). Kleinman (1980) argued that pharmacists operate between the professional,

folk, and popular sectors of the health care. In countries such as the United States, where regulations are enforced, formality, and distance characterize how pharmacists interact with clients and their professionalism enhances social distance. The case of Guatemala is different. Clients usually perceive pharmacists as trained professionals, but I found evidence that many of them are trained on the job through apprenticeship. As demonstrated earlier in this chapter, ten out of the seventeen pharmacy owners and employees here interviewed learned to work in pharmacies through apprenticeship. Guatemalan pharmacy clerks and owners are, therefore, less constrained by bureaucratic and regulatory concerns. Moreover, it seems that clients are not as interested in the professional qualifications of pharmacy employees and are more concerned with the range of services offered at the pharmacy. During our interviews, we never observed a patient questioning a pharmacist about their training or source of their knowledge; rather, they were concerned with the kinds of medicine available, their prices, available discounts, the possibility of receiving an injection, etc. In addition, pharmacy clerks and owners are less distanced from their clients in rural Guatemala because of their informal training. This enhances their "social embeddedness," which has been described by Franco et al. (2002) as having very direct effects on health workers' motivation to provide good service. According to them, when there is a closer social relationship between patient and health provider, the latter may provide more empathetic treatment or focus on the treatment that the client values. On the other hand, their lack of professionalism can also undermine their authority and symbolic tokens.

As demonstrated in chapter three, access to trained nurses and physicians is severely limited in rural Guatemala. In addition, accessing nurses and doctors at local state facilities does not imply access to medication. Hence, it is not uncommon for people to bypass doctors and go straight to the pharmacy when sick. From the seventeen pharmacy owners and employees

interviewed for this research, five said that clients usually bring prescriptions, five said that they almost never do, and seven interviewees affirmed that about half of their clients bring prescriptions while the other half does not. Mariela, the manager of a large chain pharmacy located in San Aurelio, said that clients who come without prescriptions usually do so because they cannot afford to go to a doctor. Often times, according to her, these clients also believe they have a "simple enough" illness. Magdalena, a clerk at another small pharmacy in the same town, concurs: "When people have a cold or a headache, or something else that is simple, they come to the pharmacy and not to a doctor," she says. This behavior, however, tends to be prevalent even with serious illnesses, such as an infection. Jorge, who owns and manages pharmacy jointly with his wife, says:

> Say a customer needs ten pills of a certain antibiotic, or twenty if he has a very severe infection. If he cannot afford to buy all of them right away, we can sell him the first five, and that will give him five days to get the rest of the money. That way, when he gets to the middle of the treatment and runs out of pills, he might have enough money to come back and buy the rest of his medication.

As it was previously mentioned, indiscriminate or inappropriate use of antibiotics is harmful, on the long run, for the health of individuals and communities. In addition, unlike other medications, antibiotics must be used for the full course of the treatment in order to eliminate the cause of the illness. Stopping the treatment halfway allows the strongest of the microorganisms to survive and reproduce again, creating antibiotic-resistant strains of bacteria. This demonstrates how the common practice of "splitting the treatment," while well intentioned, can have very harmful effects.

Berry (2008) argues that patients' negative perceptions about the quality of governmental health care emerges because doctors and nurses sometimes act as if they were the sole experts in what is best for the patient who feels disempowered in this relationship. She concludes that while

relying on biomedical protocols to help patients is important, so is allowing patients some degree of agency. While the doctor tends to prescribe treatments unilaterally, pharmacists more often engage in a discussion with the client that allows people to decide what treatment to pursue. I argue that there is a fundamental difference in the relationship of doctors and patients, and pharmacists and clients. Among doctors and patients, power and decision-making flows unilaterally: one side has the knowledge due to training, and hence the ability to prescribe; the other side, by virtue of the its of authority, only follows. With pharmacists, passive patients become active clients: they ask questions, get guidance, and ultimately are in control. Javier, a very experienced pharmacist, contrasts the attitudes of doctors with those of pharmacists such as himself by saying that doctors often fail to explain to their patients what condition they have, the importance of treatment, and why a specific treatment was prescribed. Because patients do not understand the doctors, and doctors do not understand patients, they do not trust each other. In comparison, his clients come to him because they trust that he will treat them and will explain how he will do so in understandable terms.

Individuals who avoid doctors and nurses often rely on their social networks in order to decide what treatment to pursue. This kind of popular health care involves non-specialists whose relationships to the sick individual go beyond the mere provision of health care (Kleinman 1980). Berry (2008) demonstrates that patients tend to judge the quality of the care they receive based on their ability to obtain the specific treatment that was recommended by a more trusted provider, be it a local midwife, family member, or trusted pharmacist. Mayra, a physician who owns a pharmacy in Calixto, says that patients routinely consult family members, friends, and neighbors who fell ill with similar symptoms and inquire about their treatment. As a physician, Mayra is skeptical about the practice. According to her, “People think that if someone presented

their same symptoms, it must be because they have the same illness." Mayra is also very skeptical of the ability of most people, including pharmacy clerks, to prescribe medication:

> If someone has not worked in a pharmacy or hospital in a long time, they are doing damage to the patient, because they tend to give strong or new antibiotics for everything, even things like colds and sore throats. This creates resistance to that particular antibiotic. As a result, when people get truly sick, they cannot take that medication anymore, which causes patients to waste more money on expensive medication for something that otherwise could have been treated with a simple antibiotic. In addition, patients may buy other medications that they do not really need, and as a result, they waste money.

While Mayra does not discount the knowledge learned on the job in the pharmacy business, she argues that pharmacy owners and their employees should have more formal training in positions such as nurse assistants. She, Guillermo, and other doctors, nurses, and NGOs staff have criticized pharmacy staff for selling of medication irresponsibly and unethically.

Both pharmacy employees and their clients employ strategies to provide and seek desired treatments in an affordable manner. Miranda, a clerk at her mother's pharmacy, said, "Here in our pharmacy, we can give people medical samples if people do not have enough money to purchase the treatment." She said that this is only possible because they receive free medical samples from distributors. Her mother's pharmacy was located near the main market in San Aurelio. It had been recommended to us by several people and it had a large clientele. Ana, a clerk at another pharmacy, said that in her pharmacy they try to help people mostly through discounts ranging from 30 to 50 percent. Another common practice among pharmacy employees in Guatemala is to sell a similar, often cheaper, version of the prescribed (or desired) medication. Six pharmacy employees specifically mentioned that clients ask them to find affordable versions of certain medications. Many others reiterated the practice when asked about it.

Another strategy to which pharmacy employees and patients adhere on a regular basis is "splitting the treatment" into affordable portions, which was mentioned above. Dalila, who

manages a *Farmacia de la Comunidad* in the edge of San Aurelio's commercial center, says that she usually sells medication by the pill even though it is against regulations. She does it because she recognizes that many people cannot afford to buy the whole box. This way, they can purchase part of the treatment and come back when they can afford to purchase the rest. Dalila keeps the money for individual pills sold inside their respective boxes, and only registers it when the whole box is gone – that way, it seems as if she sold the whole box at once instead of a couple of pills at a time. Jorge, who has worked with pharmacies for over twenty-five years, thinks that some kinds of medication, such as painkillers, are better purchased in small amounts because clients can evaluate the effectiveness of the medication and its side effects before committing to buying a larger amount. This practice seems particularly widespread among pharmacy employees in spite of their level of experience working in pharmacies or their level of professional training. While pharmacy clerks and owners do recommend that the client returns and completes the treatment, many admitted that patients return less often than they should.

Most of the health care providers interviewed acknowledged the financial challenge represented by treatment, particularly for chronic diseases. Pharmacy employees and owners usually justify their commercial strategies (such as substituting prescriptions and splitting the treatment) based on two widespread perceptions: 1) many of their clients are too poor to afford treatment any other way, and 2) doctors and nurses do not care for or do not understand their patients' economic realities. According to Ana, a pharmacy clerk at a small pharmacy in San Aurelio, many of her clients complain about the *centros de salud*:

> People have to beg doctors to pay attention to them, and even then, the doctors do not take good care of them, plus there are the long lines; they say that only important people are seen promptly in the *centros*, everybody else has to wait.

According to another pharmacy manager, Mariela, doctors tend to be careless and "only care about prescribing medication, never thinking if people can afford to buy it."

Through this research, I found, based on participant observation, evidence of the widespread mistrust between doctors and other health care providers, which has been previously documented by other scholars (Berry 2006; Berry 2008; Birungi 1998; Goldman and Heuveline 2000; Rohloff, et al. 2011). I have also found, however, indications that other health care providers themselves do not trust each other. As indicated in the previous sections, doctors, nurses, and NGO staff perceive pharmacy employees as largely untrained, profit-seeking, and careless people who only try to please and keep their clients. Pharmacy employees have similar opinions of governmental doctors and nurses, whom they imagine as disconnected, careless, and uninterested in the well-being of their patients. These perceptions are aggravated by the state of poverty in rural Guatemala, as well as by the fragmentation of the health care services available, which undermines the ability of every single provider to be effective. In a fragmented, underfunded, and uncoordinated health care landscape, health care providers and patients/clients are all left to fend for themselves.

Conclusion

Privatization of health care in rural Suchitepéquez caused an expansion in the number of private pharmacies, but a large number of pharmacies does not imply improved health care. In fact, competition between these pharmacies may or may not benefit the population: it pushes pharmacies to offer more affordable medication but also stimulates alternate commercial schemes such as selling alternate drugs to the ones prescribed or splitting the treatment in smaller portions. Hence, some scholars have argued that pharmacies "do not quite fit" as health care

providers because the extreme variation between establishments and workers creates ambiguities in their roles (Whyte, et al. 2002). In rural Suchitepéquez, I found that the lack of regulation caused the pharmaceutical business to lack standardization, and depending on which pharmacy people visit, they may be accessing a completely different level and quality of health care that may do themselves more harm than good.

During our interview with Elena and Jorge, they mentioned that earlier that day a very poor woman seeking help for her 11-year-old daughter visited their pharmacy. Elena described the girl's condition as an "inflammation of the lungs and chest," and I was unsure as to what she was referring. The woman was so poor that her daughter had been suffering like that for four months and had never seen a doctor in the meantime. According to Elena, she sold her some painkillers and gave her a bottle of expectorant as well as some antibiotics for free. Elena noted that the pharmacy did not lose any money because both of those medications were given to them as free samples from the supplier. This anecdote clearly demonstrates how, because of neoliberal decentralization and the de facto privatization of state health services, pharmacies may be used by the poorest in rural areas as their primary health care provider. While we will never know whether Elena's diagnostic was effective and whether her pills truly aided the girl, it is a fact that her mother avoided seeking health care anywhere else because she could not afford it. Her story exemplifies how neoliberal policies have not improved, and have potentially further undermined health care provision in rural Guatemala. In its current state, local health services are fragmented and underfunded; pharmacists are sought for health advice; and the neoliberal state is freed of its responsibility to provide disadvantaged citizens with even basic health care.

CHAPTER 5

Conclusion

Over two years after I recorded Nina's story in rural Suchitepéquez, my understanding of the interactions between her family and her health care provider is much clearer. The findings of my research help explain, tangentially, the reluctance of rural, poor, and indigenous Guatemalans in seeking health care. This thesis, however, is primarily concerned with the frustration and the challenges that are part rural health care providers' daily lives, and their effects on health care providers' ability to offer better services. The neoliberal policies of decentralization and privatization have directly affected the work of health care providers in rural Suchitepéquez, Guatemala, regardless of their job or where they work. I conclude that neoliberal restructuring actually equates to cuts in state services, poorer regulation efforts, gains for private providers and the pharmaceutical industry, and inferior health care for the most vulnerable communities.

Through my research, I have confirmed the conclusions reached by studies of decentralization of health care in Africa (Ferguson 1990; Foley 2009; Kyaddondo and Whyte 2003); their findings also hold true in rural Guatemala. Decentralization is defended by neoliberal policy-makers as a move that should increase the accountability, transparency, and efficiency of local health care; by transferring the responsibility for health provision to local authorities, they claim that the most disadvantaged communities will be better served (Bossert 1998). Instead, however, I noted in rural Guatemala what others have identified elsewhere: decentralization policies actually undermine the budget, the infrastructure, and the supplies of state health care, posing fundamental challenges to the work of state health care providers. Neoliberal decentralization policies in Guatemala have exacerbated the inferior condition of rural

health care: scarce investment from the national government paired with the limited resources available to local authorities negatively affect the staffing, equipping, and general availability of essential services in rural facilities.

I agree with Birungi et al. (2001) when they assert that decentralization forces state health care facilities to operate as de facto private institutions, where economic inputs from the government serve as a mere subsidy and not as the main economic support. In this context, cost recovery policies (Turshen 1999) as well as informal "survival strategies" adopted by health care providers (Birungi 1998; Kyaddondo and Whyte 2003) represent an attempt to supplement the inadequate governmental support. I have found doctors and nurses who are employed by the state and who also own pharmacies as a way to supplement their income. I have also noted the tendency of state health care providers to rely on non-profit organizations or private providers to complement state health care by providing patients with needed exams or medications (Birungi, et al. 2001; Maupin 2009). My research confirms that neoliberal health care reforms in Guatemala have effectively transferred the responsibility for providing health from public institutions to private organizations.

Privatization, on the other hand, is promoted by neoliberal policy-makers based on the assumption that the "free market" will efficiently regulate the allocation of health services. What I observed in rural Guatemala, instead, was a boom in private pharmacies and the growing ambivalence of their roles, as they oscillate between primary health care providers and business enterprises. The expansion in the number of private pharmacies in rural Guatemala does not imply improved health care; in fact, I found evidence that alternate commercial schemes (such as selling inferior drugs or splitting the treatment) have emerged because of decentralization and privatization. I understand that, on one hand, these schemes may represent an attempt on the part

of pharmacy owners and employees to help their clients and their communities. However, they also represent a business strategy to survive in an environment where several pharmacies compete for clients, and that sometimes (as in the case of antibiotics) these schemes can be harmful to clients and their communities. In addition, I conclude that decentralization and privatization de-emphasize governmental regulation, which frees the pharmaceutical business in rural Guatemala from standardization. Rural pharmacies "do not quite fit" as primary health care providers, as evidenced by Whyte et al. (2002): depending on which pharmacy people visit they may be accessing a completely different level and quality of health care and even doing themselves more harm than good. However, the current state of rural health care means that because local health services are increasingly fragmented and underfunded (Janes 2006), pharmacists will continue being sought for health advice (Cosminski 1994; Goldman and Heuveline 2000; Van der Stuyft, et al. 1996), and the neoliberal state will remain freed of its responsibility to provide all citizens with basic health care.

The Suchitepéquez case provides further evidence that leaving health care to the market likely means that poor, rural dwellers will receive substandard, inadequate, and inferior care compared to their less vulnerable, urban counterparts. Less government and more business control does not erase marginalization; it exacerbates it. This has been described by several scholars as the promotion of "poor health care for poor people," or the idea that that the limited resources in the global south (or lesser developed areas within the global south) make it unrealistic to expect its inhabitants to receive the same quality of health care afforded to those in the global north (or in the more affluent areas of the global south itself) (Farmer 2001; Farmer 2005; Janes 2006).

Finally, my research demonstrates how decentralization weakened the motivation of governmental health workers, their confidence as professionals, and their belief in the organizational mission of their employers, as described by Franco et al. (2002). Privatization also fueled mistrust between different health care providers because it affects the cohesion of health service provision (Coburn 2000), promotes inconsistencies in service delivery (Petryna, et al. 2006), and generates an "unintelligible" health care landscape (Rohloff, et al. 2011). I conclude that mistrust among health care providers, their lack of confidence in each other, the state of poverty in rural Guatemala, and the fragmentation of the available health care services all undermine the ability of every single provider to be effective. Ultimately, I argue that health provision in rural Guatemala is fragmented, underfunded, and uncoordinated, leaving health care providers dispirited, working in a triage type of environment, disrespecting each other, and torn between profiteering and attracting "clients" and serving "patients."

Implications for Future Research

The conclusions of this investigation are limited by the exploratory nature of this research project. My study would certainly be more complete had I included a broader variety of professionals involved in health care provision and health policy-making, such as higher-level administrators. My conclusions would also be more valid if my sample was bigger, and if I had had the chance to interview a wide range of physicians and nurses. This study would also have benefitted had I been able to spend a longer period of time in the field. Also, while I was able to identify nuances of mistrust between health care providers through participant observation and other interactions, the interview instrument itself lacked questions on how providers perceived each other. The interviews also lacked direct, longitudinal questions that explored the evolution

of health care provision before and after the Peace Accords. Most of my conclusions on this aspect resulted from informal conversations with health care providers and bibliographical research.

As I have previously mentioned, several studies have analyzed the consequences of structural adjustment and neoliberal policies for health care provision; most of them, however, were conducted in Africa during the 1980s and 1990s. Future research on this topic might update their conclusions, as well as further evaluate decentralization and privatization in Latin America, as these countries offer a different setting for the application and interpretation of neoliberalism, both historically and culturally. Comparative research is also necessary: are there places in which neoliberal reforms achieved desired results? If so, why were they efficient, and can they be replicated in struggling countries such as Guatemala?

In addition, while analyzing issues of health care access and the commercialization of services, future research could explore the ideal of health as a human right along with its ethical, economic, and political dimensions. Potential researchers should analyze how the neoliberal discourse is incompatible with the idea of health care as an unalienable human right. What are the implications for states of classifying health as a human right? How does it affect the state's responsibility for its citizens? What implications would it have in the Guatemala, where neoliberal reforms emerged because of the violation of the human rights of indigenous peoples?

Finally, this thesis focused on a topic that has been largely ignored by academia: the direct consequences of decentralization and privatization for the work of health care providers in rural Suchitepéquez. The effects of such policies obviously extend beyond health care providers themselves. Future research should attempt to close the gap and provide a better understanding of Guatemalan health after the civil war. Anthropologists and other scholars must acknowledge

that very little is known about the real outcomes of the Guatemalan Peace Accords and its demands. Only by understanding what is happening in rural Guatemala can we truly work to improve the quality of life in these communities.

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APPENDIX

Interview for Health Centers, Posts, Doctors, and Nurses (ENGLISH VERSION)

Introduction:

Good morning! We are students from the United States and we want to learn more about the health system here in Guatemala. We would like to learn more about the common illnesses that people suffer from here and the medications and treatments used in Guatemala. We also would like to learn about your work here at this facility and what do you think about health in this region. Do you have a little time to talk to us? (Continue if yes)

Everything that you tell us will be kept anonymous and we will not write down your name. We will ask some questions, and write down your answers.

Quick Questions:

1. What are the hours and days when this centro/puesto/private practice/hospital operates?
   ___ Monday ___ Tuesday ___ Wednesday ___ Thursday ___ Friday
   ___ Saturday ___ Sunday
   ___ Mornings ___ Afternoon ___ Evenings
   ___ All day and night ___ All week
2. How many people work in this centro/puesto/private practice/hospital?
   ___ Doctors ___ Nurses ___ Others
3. Which communities and hamlets does this facility serve?
4. What kinds of people come here more often?
   ___ Women ___ Men ___ Adults ___ Children ___ Elderly
5. How many people (on average) do you serve in this facility per day?
6. How much (on average) does it cost to have an appointment at this facility?
7. How long (on average) lasts an appointment in this facility?
8. Does everybody schedule appointments? ___ Yes ___ No
9. If someone does not have an appointment, how long does he or she wait to see the doctor/nurse?
10. How many people without appointments can you serve in one day?
11. What kinds of exams can be done at this facility?

12. Where do patients go when they need exams that you cannot perform? Do you recommend a specific lab?
13. When people come to this facility, do you offer them:
    ___ Prescriptions ___ Free medication
14. When you cannot offer medication, do you recommend a particular pharmacy? Which one?
15. Do you keep records on all of your patients? ___ Yes ___ No
16. Do you offer (for free):
    a. Birth control? ___ Yes ___No
    b. Vaccination? ___ Yes ___ No

Other Questions:

17. What is your position in this centro/puesto/private practice/hospital?
18. For how long have you been working in this facility? Have you worked in other centros, hospitals, labs, or pharmacies as well?
19. How did you learn to work in this centro/puesto/private practice/hospital? Did you attend a college or university? What was your major?
20. What do you like about your job?
21. Do people from other towns come to this facility? Why?
22. How do people decide which clients can see the doctor or nurse?
23. What are the most common illnesses here? Why do people come to this centro/puesto/hospital?
24. Usually, what do you prescribe for (ask which illnesses are more common):
    a. Diarrhea
    b. Nervios
    c. Cough
    d. Fever
    e. Headaches/Body aches
    f. Nausea/Vomit
    g. Birth control
    h. Cansancio
    i. So women can lactate

j. Anemia
k. Pregnant women
l. Mal de ojo
m. Malnourished children
n. Children who refuse to eat
o. Estreñimiento
p. Empacho
q. Cold/Flu
r. Diabetes
s. High blood pressure
t. Kidney problems
u. Mal de orina
v. Hernia
w. Fungus
x. Burns
y. Worms

25. Do you prescribe or recommend:
    a. Natural medication?
    b. Changes in eating habits?
    c. Physical exercise?
    d. Drink and cook with clean water?
    e. Keep personal hygiene?
26. Is it common that people come back several times because of the same illness?
27. If someone has a chronic illness (diabetes or high blood pressure, for an example), do you recommend that they come back to this facility regularly? Do they usually come back?
28. When a woman is pregnant, is it common for her to seek prenatal care here? Does she come starting in the first month or only closer to the due date of the baby?
29. Is it common for women to use birth control?
30. If a woman wants to use birth control, what kind of medication or method do you recommend?
31. Do you recommend that women come back regularly to this facility? Do they come back?

32. We have heard that you vaccination program is very efficient. How does it work?
33. Which vaccines do you offer? When do you offer them?
34. Do most people come here to vaccinate their children? What happens when someone does not seek vaccination for their baby?
35. Do people understand the importance of vaccination? Does this facility works with schools or other institutions?
36. What do you think about the quality of the services offered here? Is there something that you would like to change or improve?
37. What are the challenges that you face in your work?

Participant Observation:

1. Interview:
    a. Date/day of the week:
    b. Time/duration:
    c. Interviewer:
2. Interviewed person:
    a. ____ male ____ female
    b. ____ 20-30yrs old ____ 30-40 yrs old ____ 40-50 yrs old ____ 50+ yrs old
    c. ____ ladino ____ indigenous ____ other:
    d. ____ friendly/open ____ closed/difficult ____ other:
3. Centro de salud:
    a. Size:
    b. Equipment:
    c. Staff:
    d. Patients:
4. Other comments :

Encuestas con Centros, Puestos, Doctores, y Enfermeras (VERSION EN ESPANOL)

Introducción:

Buenos días! Somos estudiantes de los Estados Unidos y queremos aprender más del sistema de salud aquí en Guatemala. Nos gustaría aprender más de las enfermedades comunes que tiene la gente y los medicamentos que se usa en Guatemala. Tambien nos gustaría aprender acerca de su trabajo aqui en ese sitio y que piensa usted sobre la salud en ese pueblo. Tiene usted tiempo para platicar un poquito? (continue if yes)

Todo lo que usted dice es anónimo y no vamos a apuntar su nombre. Tenemos algunas preguntas, y vamos a apuntar las respuestas.

Preguntas Rapidas:

1. Cuales son las horas y dias de funcionamiento de este centro/puesto/consultorio/hospital?
   ____ Lunes ____ Martes ____ Miercoles ____ Jueves ____ Viernes
   ____ Sabado ____Domingo
   ____ Mananas ____ Tardes ____ Noches
   ____ Todo el dia y noche ____ Toda la semana
2. Cuantas personas trabajan en ese centro/puesto/consultorio/hospital:
   ____ Medicos ____ Enfermeros(as) ____ Otros
3. A cuales comunidades y aldeas ofrecen sus servicios?
4. Que tipo de personas viene más al centro de salud?
   ____ Mujeres ____ Hombres ____ Adultos ____ Niños ____ Ancianos
5. Cuantas personas (promedio) se atiende en ese centro por dia?
6. Cuanto cuesta (promedio) una consulta en el centro de salud?
7. Cuanto tiempo (promedio) dura una consulta en el centro de salud?
8. Llegan todos con citas? ____ Si ____ No
9. Si alguien no tiene cita, cuanto tiempo espera para pasar con el doctor/enfermera?
10. Cuantas personas sin cita se acepta en un dia?
11. Que tipos de examenes se puede hacer en ese centro de salud?
12. A donde van los pacientes cuando necesitan examenes que ustedes no pueden hacer? Recomiendan un laboratorio?
13. Cuando viene la gente al centro de salud, se les ofrece:
    ____ Receta _____ Medicamentos gratis

14. Cuando no ofrecen medicamientos, ustedes recomiendan alguna farmacia en particular? Cual?
15. Tienen archivos de todos los pacientes que atenden? ____ Si ____ No
16. Se ofrecen (gratis):
    a. Anticonceptivos ? ____ Si ____ No
    b. Vacunas? ____ Si ____ No

Otras preguntas:

17. Cual es su trabajo en el centro/puesto/consultorio/hospital?
18. Por cuánto tiempo ha trabajado aquí? Ha trabajado en otros centros de salud, hospitales, laboratorios, o farmácias tambíen?
19. Cómo aprendió trabajar en ese centro/puesto/consultorio/hospital? Usted fue a diversificado o la universidad? En que carrera?
20. Qué le gusta de su trabajo?
21. Viene gente de otros pueblos hasta este centro de salud? Por que?
22. Como deciden quien puede pasar con el doctor o con la enfermera?
23. Cuales son las enfermedades más comunes de la gente? Para qué viene la gente al centro/puesto/hospital?
24. Normalmente qué le receta para (marcar las enfermedades mas comunes):
    a. Los asientos/diarrea
    b. Nervios
    c. Tos
    d. Fiebre
    e. Dolor de cabeza/Dolor de cuerpo
    f. Nausea/Vómitos
    g. Para controlarse/planificar
    h. Cansancio
    i. Para que baje la leche
    j. Anemia
    k. Mujeres embarazadas
    l. Mal de ojo
    m. Niños desnutridos

n. Niños que no quieren comer
o. Estreñimiento
p. Empacho
q. Gripe
r. Diabetes
s. Alta presión
t. Problemas de los riñones
u. Mal de orina
v. Hernia
w. Hongos
x. Quemaduras
y. Lombrizes

25. Se receta o se recomienda:
    a. Remédios naturales?
    b. Cambios en la alimentación?
    c. Ejercício físico?
    d. Tomar y cocinar con agua pura?
    e. Mantener higiene personal?
26. Es comun que la gente vuelva varias veces por la misma enfermedad?
27. Si alguien tiene una enfermedad cronica (diabetes o alta presión, por ejemplo), se recomienda que la gente vuelva al centro/puesto/hospital regularmente? Y la gente generalmente vuelve?
28. Cuando una mujer está embarazada, es comun que venga aqui por cuidados prenatales? Viene desde el primer mes o solo cerca del nacimiento del nene/nena?
29. Es comun que las mujeres quieran planificar?
30. Si una mujer quiere planificar, que tipo de prevencion, medicamientos, o metodos ustedes recomiendan?
31. Ustedes recomiendan que ellas vuelvan regularmente? Y ellas generalmente vuelven?
32. Hemos oido que su programa de vacunas es muy eficaz. Como funciona?
33. Cuales vacunas ofrecen ustedes? Cuando?

34. Llega la mayoria de la gente para vacunar a sus hijos? Que se hace cuando alguien no viene para vacunar a su bebe?
35. Entiende la gente la importancia de las vacunas? Trabajan ustedes con las escuelas u otras instituciones?
36. Que piensa usted de la calidad de los servicios que se ofrecen aqui? Hay algo que le gustaria cambiar o mejorar?
37. Cuales son las dificultades que ustedes encuentran en su trabajo?

Participant observation:

1. Interview:
    a. Date/day of the week:
    b. Time/duration:
    c. Interviewer:
2. Interviewed person:
    a. ____ male ____ female
    b. ____ 20-30yrs old ____ 30-40 yrs old ____ 40-50 yrs old ____ 50+ yrs old
    c. ____ ladino ____ indigenous ____ other:
    d. ____ friendly/open ____ closed/difficult ____ other:
3. Centro de salud:
    a. Size:
    b. Equipment:
    c. Staff:
    d. Patients:
4. Other comments:

Interview for Pharmacists (ENGLISH VERSION)

Introduction:

Good morning! We are students from the United States and we want to learn more about the health system here in Guatemala. We would like to learn more about the common illnesses that people suffer from here and the medications and treatments used in Guatemala. We also would like to learn about your work here at this facility and what do you think about health in this region. Do you have a little time to talk to us? (Continue if yes)

Everything that you tell us will be kept anonymous and we will not write down your name. We will ask some questions, and write down your answers.

Questions:

38. For how long have you been working in this pharmacy? Have you worked in other pharmacies as well?
39. How did you learn to work in pharmacies?
40. What do you like about your job in the pharmacy?
41. What are the most common illnesses here? Why do people come to the pharmacy?
42. Do people come with prescriptions for specific medications? On the other hand, do people come with an illness but have not seen a doctor about it?
43. Who usually comes to the pharmacy? The person who is sick or a family member or someone else?
44. Usually, what do you prescribe for:
    a. Diarrhea
    b. Nervios
    c. Cough
    d. Fever
    e. Headaches
    f. Body aches
    g. Nausea
    h. Vomit
    i. Birth control
    j. Cansancio

k. So women can lactate
l. Anemia
m. Pregnant women
n. Mal de ojo
o. Malnourished children
p. Children who refuse to eat
q. Estreñimiento
r. Empacho
s. Cold/Flu
t. Diabetes
u. High blood pressure
v. Kidney problems
w. Mal de orina
x. Hernia
y. Acne/skin problems
z. Fungus
aa. Burns

45. Where do these medications come from? Are they from Guatemala or other countries?
46. Where do you buy your medication from? Do you buy them all from one single company or from many companies?
47. Do you sell natural medication?
48. Why are there so many pharmacies?
49. What do people do when they cannot afford to buy medication?

Participant Observation:

1) **Description of the pharmacy (store, location, etc)**
2) **Description of the pharmacist(s)**
3) **What did they sell at the pharmacy?**

Encuesta para Farmacéuticos (VERSION EN ESPANOL)

Introducción:

Buenos días! Somos estudiantes de los Estados Unidos y queremos aprender más del sistema de salud aquí en Guatemala. Nos gustaría aprender más de las enfermedades comunes que tiene la gente y los medicamentos que se usa en Guatemala. También nos gustaría aprender acerca su trabajo aquí en esa farmacia y acerca de lo que usted piensa del sistema de salud en ese pueblo. Tiene usted tiempo para platicar un poquito? (continue if yes)

Todo lo que usted dice es anónimo y no vamos a apuntar su nombre. Tenemos algunas preguntas, y vamos a apuntar las respuestas.

Preguntas:

1. Por cuánto tiempo ha trabajado aquí en la farmacia? Ha trabajado en otras farmacias tambíen?
2. Cómo aprendió trabajar en una farmacia?
3. Qué le gusta de su trabajo en la farmacia?
4. Cuales son las enfermedades más comunes de la gente? Para qué viene la gente a la farmacia?
5. Viene la gente con recetas para medicinas específicas? O viene la gente con una enfermedad pero sin haber ido al doctor?
6. Quien viene a la farmacia? Normalmente viene la persona que está enferma o un familiar u otra persona?
7. Normalmente qué le da para:
    a. Los asientos/diarrea
    b. Nervios
    c. Tos
    d. Fiebre
    e. Dolor de cabeza
    f. Dolor de cuerpo
    g. Nausea
    h. Vómitos
    i. Para controlarse/planificar
    j. Cansancio

k. Para que baje la leche
l. Anemia
m. Mujeres embarazadas
n. Mal de ojo
o. Niños desnutridos
p. Niños que no quieren comer
q. Estreñimiento
r. Empacho
s. Gripe
t. Diabetes
u. Alta presión
v. Problemas de los riñones
w. Mal de orina
x. Hernia
y. Manchas/Granos
z. Hongos
aa. Quemadas

8. De dónde vienen las medicinas? Son de Guatemala o de otros países?
9. Dónde compran las medicinas? Compran todos los medicamentos de una sola empresa o de varias empresas?
10. Se vende remedios naturales?
11. Por qué hay tantas farmacias?
12. Qué hace la gente cuando no tiene suficiente dinero para comprar la medicina?

Participant Observation:

1) **Description of the pharmacy (store, location, etc)**
2) **Description of the pharmacist(s)**
3) **What did they sell at the pharmacy?**

Interviews

(Names of informants/locations were changed for the pseudonyms used in the thesis)

Informant	Setting	Location	Gender	Position	Experience
01 - Chloe	Pharmacy	San Aurelio	F	Clerk and Owner	10 years (apprentice)
02 – Jorge+	Pharmacy	San Aurelio	M	Clerk and Owner	25 years (apprentice)
03 – Elena+	Pharmacy	San Aurelio	F	Clerk and Owner	20 years (apprentice)
04 - Mariela	Pharmacy	San Aurelio	F	Manager	3 years (apprentice)
05 - Magdalena	Pharmacy	Calixto	F	Clerk	3 months (apprentice)
06 – Mayra*	Pharmacy	Calixto	F	Owner and Physician	2 years (physician)
07 - Josefa	Pharmacy	San Aurelio	F	Clerk	18 years (*capacitacion*)
08 - Javier	Pharmacy	San Aurelio	M	Clerk	16 years (apprentice)
09 - Claudia	Pharmacy	San Aurelio	F	Clerk	11 years (*capacitacion*)
10 - Juan	Pharmacy	San Aurelio	M	Clerk	1.5 years (*capacitacion*)
11 - Pedro	Pharmacy	San Aurelio	M	Clerk	10 years (apprentice)
12 - Juana	Pharmacy	San Aurelio	F	Clerk	1.5 years (nurse assistant)
13 - Ana	Pharmacy	San Aurelio	F	Clerk	5 years (apprentice)
14 - Sebastian	Pharmacy	San Aurelio	M	Clerk and Owner	20 years (*capacitacion*)
15 - Dalila	Pharmacy	San Aurelio	F	Clerk and Owner	5 years (*capacitacion*)
16 - Miranda	Pharmacy	San Aurelio	F	Clerk	14 years (apprentice)
17 - Jennifer	Pharmacy	San Aurelio	F	Clerk	2 years (apprentice)
18 - Cesar	Pharmacy	San Aurelio	M	Clerk	15 days (apprentice)
19 - Enrique	Centro	San Aurelio	M	Sanitary Inspector	17 years (college)
21 - Elisa	Centro	San Tadeo	F	Receptionist	N/A
22 - Carmen	Centro	San Tadeo	F	Nurse	25 years (nursing school)
23 - Esperanza	Centro	San Tadeo	F	Health promoter	N/A
24 - Norma	Puesto	Calixto	F	Nurse	24 years (nursing school)
25 - Guillermo	Non-profit	San Tadeo	M	Assistant Director	36 years (apprentice)
26 – Mayra*	Private clinic	Calixto	F	Physician	2 years (physician)

+ Individuals were interviewed separately but worked for the same pharmacy.
***** Individual was interviewed twice, in two different settings: once as a pharmacist and once as a private physician.

Health Care Facilities (Centros, Puestos, Non-profit, Private Practice)

(Names of locations were changed for the pseudonyms used in the thesis)

Facility and Location	Doctor	Nurse	Other	Clients/ day (average)	Cost	Length appt.	Exam available	Recommend laboratory?	Recommend pharmacy?
Centro S. Aurelio	7	14	5	150	Free	15 min	Urine, blood, fecal, pregnancy, infectious diseases	Yes – Capital (offer discount)	No
Centro S. Tadeo	2	4	13	60	Free	20 min	Urine, blood, fecal, pregnancy.	Yes - Capital	No
Puesto Calixto	0	3	0	50	Free	20 min	Only physical exams	San Tadeo and Missionary Clinic	No
Non-profit Miss. Clinic	2	3	17	100 (50 appts.)	15Q	20 min	Urine, blood, fecal, TB, infectious diseases, HIV	Yes - Capital	No
Private Practice Calixto	2	0	0	15-20	40Q	30 min	No	Missionary Clinic or others in San Aurelio	No