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Implications of the Past on the Present: Health Care Access and Ethnicity in Rural Guatemala

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B.A. in International Relations

University of Minnesota – Twin Cities

2009

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Abstract

Implications of the Past on the Present: Health Care Access and Ethnicity in Rural Guatemala

By Christina Renquist

The following literature review and qualitative study discusses the factors, both historic and present contributing to the unequal access to adequate health care experienced by indigenous Guatemalans in comparison to their *ladino* counterparts (Guatemalans of European descent). The principal investigator performed an extensive and systematic review of literature relating to Guatemalan history, human rights, the right to health, and indigenous rights. They then conducted in-depth interviews (IDIs) with key informants in-country in the towns of San Juan La Laguna and San Pablo La Laguna, Sololá, Guatemala in order to gain a more contextual, field-based perspective on the issues. These data were analyzed using the ICESCR General Comment 14's AAAQ Framework for health facilities, goods and services, as well as other international right to health legislation. The investigator found that the main factors contributing to unequal access were systematic and historic discrimination against indigenous Guatemalans, lower socioeconomic status, poor representation in political spheres of their health needs, cultural differences between ethnicities, and the concentration of health services in areas where primarily *ladino* Guatemalans reside. To address these deep-seated issues and improve the unequal burden of disease experienced by these populations, it is necessary to develop and implement a National Plan of Action for Guatemala that upholds the AAAQ Framework as its main objective as well as the right to health for those indigenous communities.

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Finally, the author would like to acknowledge the Organization for the Indigenous Maya (ODIM) for acting as the gatekeeper as well as the interview location for some of the study participants.

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Acronym List

AAAQ = Availability, Accessibility, Acceptability, Quality of Care
ACS = Assembly of Civil Society
AEU = University Student's Associations
CAT = Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment
CEH = Commission for Historical Clarification
CERD = International Covenant on the Elimination of All Forms of Racial Discrimination
CESCR = Committee on Economic, Social, and Cultural Rights
CEDAW = Convention on the Elimination of All Forms of Discrimination against Women
CIA = Central Intelligence Agency (United States Government)
CICIG = UN International Commission against Impunity in Guatemala
CPMW = International Convention on the Protection of the Rights of Migrant Workers and Members of their Families
COPREDEH = Guatemalan President's Commission on Human Rights
CPPCG = Convention on the Prevention and Punishment of the Crime of Genocide
CRC = Convention on the Rights of the Child
CRPD = Convention on the Rights of Persons with Disabilities
IACHR = Inter-American Commission on Human Rights
ICESCR = International Covenant on Economic, Social, and Cultural Rights
ICCPR = International Covenant on Civil and Political Rights
IDI = In-depth Interview
IGSS = Guatemalan Social Security Institute
IRB = Institutional Review Board
MINUGUA = UN Human Rights Verification Mission in Guatemala
MSPAS = Guatemalan Ministry of Public Health and Social Assistance
MOH = Ministry of Health
NGO = Non-government organization
OAS = Organization of American States
ODHAG = Human Rights Office of the Archdiocese of Guatemala
ODIM = Organization for the Indigenous Maya
OHCHR = Office of the High Commissioner for Human Rights (United Nations)
PDH = Human Rights Ombudsman (Procurador de los Derechos Humanos)
PEC = Expansion of Coverage Program
SAA = Secret Anti-Communist Party
UN = United Nations
UNDAF = United Nations Development Assistance Framework
UNDP = United Nations Development Programme
UNDRIP = United Nations Declaration of the Rights of Indigenous Peoples
UNICEF = United Nations Children's Fund
URNG = Guatemalan National Revolutionary Unity party
US = United States
USAID = United States Agency for International Development
USDOS = United States Department of State

Glossary

Encomiendas = "a device whereby privileged Spaniards or their [mixed Spanish-indigenous] offspring received tribute in labor, goods, or cash from [indigenous] entrusted to their charge. *Encomiendas* were not grants of land but, rather, awards to enjoy the fruits of what the land and its people could provide, whether prized items such as gold, silver, salt, or cacao or less spectacular produce like corn and chickens." (Kramer, 1990)

Ladino = individuals born in Guatemala but of mixed indigenous and European descent, particularly Spanish; speak primarily Spanish (Castilian); the Ministry of Education defines this population as follows "The *ladino* population has been characterized as a heterogeneous population which expresses itself in the Spanish language as a maternal language, which possesses specific cultural traits of Hispanic origin mixed with indigenous cultural elements, and dresses in a style commonly considered as western." (MINEDUC, 2008)

Indigenous = individuals native to the land of Guatemala; also referred in other texts as "Mayan", "native", "Indian", "natural" or by their tribe name; the largest indigenous tribes in Guatemala are the K'iche' , Q'eqchi , Kaqchikel, Mam, and Tzutujil, although there are a total of 23 recognized indigenous tribes in Guatemala, each with their own dialect. (CIA World Factbook, 2012)

Gini Coefficient = "Measure of the deviation of the distribution of income among individuals or households within a country from a perfectly equal distribution. A value of 0 represents absolute equality, a value of 100 absolute inequality." (World Bank, 2013)

Introduction

Since the Spanish conquest, the indigenous population of Guatemala has been systematically oppressed and discriminated against from the beginning of the 16th century to present day. Although on paper this marginalized and vulnerable population has equal human rights with Guatemalans of European descent, termed "*ladinos*", in practice this is far from the reality. This paper focuses on the indigenous right to health, particularly in relation to the disparities that exist between indigenous and *ladino* populations in health care access. The principal study question is as follows:

> *What are the factors, both historic and present, contributing to the unequal access to adequate health care experienced by indigenous Guatemalans in comparison to ladino Guatemalans?*

To answer the proposed question, the principal investigator performed an extensive and systematic review of literature relating to Guatemalan history, human rights, the right to health, and indigenous rights. In order to gain a more contextual, field-based perspective on the issues, the principal investigator then conducted in-depth interviews (IDIs) with key informants in-country in the towns of San Juan La Laguna and San Pablo La Laguna, Sololá, Guatemala.

Building off of both the literature review and in-depth interviews, the principal investigator was able to identify the most significant barriers to health care access currently experienced by indigenous Guatemalans as well as the historic contributing factors to that inequity.

Methods for Literature Review

Introduction

In order to guide the systematic literature review, the principal investigator divided the study question into a set of three primary themes: General history and current indicators, health and health care, and human rights (history, treaties) - all incorporated a focus on Guatemala and the race relations between *ladino* and indigenous Guatemalans. For each theme, the principal investigator aimed to review sources that gave information about the history and current situation of the particular topic in Guatemala. Many sources searched using a keyword from one theme gave information about another. For example, sources found under the keyword "Indigenous and *ladino* Guatemalans" may have also provided information about Guatemalan history. However, to aid with analysis, these sources were reported as associated with the keyword under which they were originally searched. The majority of the sources contained brief background information on Guatemala, and were therefore used for that section as well.

Data Collection and Storage

Data were collected by utilizing various online databases of peer-reviewed literature that varied in form from articles published in academic journals, publicly-available government documents and reports, and academic books. Online databases employed included PubMed, Google Scholar, and Web of Science. All data obtained

were either in English or Spanish. Any quotes from Spanish language documents were translated into English by the principal investigator before being included. Documents were searched using the following sets of keywords in English:

- *“Guatemala”, “history”*
- *"health", "human rights", "Guatemala"*
- *“health”, “health care”*
- *“indigenous AND ladino Guatemalans”*
- *"Guatemala" AND "health care" AND "indigenous"*
- *“right to health”, “Guatemala”*
- *“health and human rights”*

Reference lists from literature on Guatemalan human rights, health, and history were also individually searched to access additional peer-reviewed data. Government reports pertinent to the topics were also found through the United Nations (UN) and Organization of American States (OAS) websites. All data were imported from online databases into a bibliographic citation management software program (EndNote X7) and then sorted into groups based on the keywords and database used to obtain the sources.

Inclusion and Exclusion Criteria

For all keywords, sources were included in the review if they were peer-reviewed, from an academic journal or publishing source, a government-approved report or legislation, and if they pertained to Guatemala. The most used reference

types were journal article, book, book section, government document, and encyclopedia. Citations were also only included if they were available online in full text format, either publicly or through the Emory University log-in. For searched keywords that initially produced over 150 results, further exclusion criterion were applied in order to streamline these data. Therefore in all searched databases, sources found under the following sets of keywords were used only if published between January 1, 2000 and December 31, 2014. These were delimited to: *"Guatemala", history; and "Guatemala" AND "health care" AND "indigenous".*

Results

The literature review was conducted between July and December of 2014 and resulted in a total of 721 citations. After 191 duplicates were removed, 585 citations remained to be reviewed by the principal investigator. During the second review of the citations, the principal investigator screened documents that were not related to the study question based on the title, journal, abstract, author and/or keywords listed in the citation. In this manner, 507 were further eliminated, resulting in a total of 68 citations to be used in the systematic literature review. During in-depth article review, a further 27 articles were found, resulting in a total of 95 references to be used in the paper.

Of the 95 references, the majority were found in English, although some government documents and reports did need to be translated from Spanish by the principal investigator.

Conclusion

While database searches were the most straight-forward means of finding articles pertaining to the study question and study aims, richer and more comprehensive articles typically were found through the reference lists of those articles. Both methods were sufficient in developing a clear understanding of the material available and provided adequate background information to answer the proposed study question.

Literature Review

Background Information: Guatemala Past and Present

In order to understand the present-day challenges faced by Guatemala as a whole, it is necessary to have insight into the history of the country and its people. This chapter will cover Guatemalan history beginning with the first known inhabitants, the indigenous people, and concluding with the signing of the Peace Accords following the Civil War. It will begin with an overview of Guatemala prior to the Spanish conquest. Next, the conquest itself as well as its future implications will be discussed. Independence from Spain and the period prior to the outbreak of the Civil War is considered. Then, the 36-year civil conflict will be examined. The chapter will then conclude with the implications of the history discussed.

Introduction

Guatemala is a Central American country bordering Mexico to the north, Costa Rica to the northeast, and Honduras and El Salvador to the south. Coined as the "Land of Eternal Spring," Guatemala is known for its fertile soil and cultural heritage (Encyclopedia Britannica, 2014), both of which hold great significance in the countries complicated history.

With a population of over 14 million, Guatemala is the most populous country in Central America (CIA World Factbook, 2012). It is divided into two general, but distinct, ethnicities: the indigenous and the *ladinos* (see Glossary), making up 49% and

51% of the population, respectively. The indigenous population speaks 23 different dialects (CIA World Factbook, 2012) and women generally wear "traditional" clothing consisting of a long skirt, thick fabric belt, and decorative blouse. Though males don't commonly wear traditional attire, it consists of typically white, linen Capri-type pants and a similar white tunic, each with small stitched designs primarily on hemlines. Each region in Guatemala has its own accompanying language, and typical clothing pattern and color which is worn by the indigenous who are native to that region.

The country is considered one of "Medium Human Development" according to the United Nations Development Program's (UNDP) International Human Development Indicators (HDI) which assess and summarize "average achievement in key dimensions of human development: a long and healthy life, being knowledgeable and [having] a decent standard of living" (UNDP, 2009/2010). Using strictly economic measures, the CIA World Factbook states the country is "predominantly poor" and "struggles in several areas of growth and development" (CIA World Factbook, 2014). This can be seen, at least in part, as a result of the country's history of prolonged conflict and social and political upheaval that impeded the process of advancement apparent in other "developed" countries (Lovell, 1988). Due to their significant impact on social and cultural norms, economic development, and political climate, these years of struggle will be discussed in the following sections.

Pre-Conquest Guatemala

Present-day Guatemala was first inhabited by a number of relatively autonomous indigenous groups, later to be grouped under the name "Maya". There

are a variety of names that have been used to refer to the original occupants of Guatemala including “native”, “indian” (or “*indio*” in Spanish), “Mayan”, and indigenous. However, the most widely accepted of these is “indigenous”, which the principal investigator will use to refer to this population for the remainder of this work. The indigenous’ presence in the area dates back before 300CE, which began a period when most of their cities were built (Encyclopedia Britannica, 2014). From the beginning, the indigenous society developed with a largely agricultural focus (Patch, 2002). The indigenous peoples utilized the products of the fertile land for sustenance, currency, clothing, protection, and as a basis for their religion. Although the foundational characteristics are similar, these indigenous peoples were divided both linguistically and politically in particular sects, and were known to fight amongst each other particularly over land and goods (Patch, 2002). The largest indigenous sects are the K'iche, Kaqchikel, Mam, Q'eqchi, and Tzutujil. According to *Pop Wuj,* the K’iche book of history, there were a number of battles between different sects, the most notable of which was carried out by the K’iche leader, K’iqab, in the areas of Rabanal and Zaculeu (Restall, 2007). Most recognizable as a “collection of powerful city-states”, the indigenous Guatemalans had among their strongest the K’iche and Kaqchikel (Minster).

By the time the Spaniards began to appear, the indigenous were divided into various political entities, the majority (but not all) of which was based on linguistic lines (Patch, 2002). As discussed in more detail in the following section, this division both aided and elongated the Spanish Conquest.

Spanish Conquest

Beginning in 1524 and led by Pedro de Alvarado, the Spanish conquest of Guatemala was met with strong but fragmented resistance by the indigenous of the area (Encyclopedia Britannica, 2014; Lovell, 1988). As previously discussed, these indigenous groups were divided much as they are to this day, in 20 or more different sects with their own dialects, customs, and political loyalties. Without the unification of one leader, the indigenous proved arduous to conquer by forcing the Spanish to defeat one state or group at a time (Lovell, 1988). This process spanned over 20 years, much longer than other conquests of the time, and defeat was not only accomplished by physical overpowering but also when a negotiated compromise could be established. The latter, however, was only sought after physical force was exhausted (Patch, 2002).

While there were obstacles to this invasion, there were also many factors that assisted in the final conquest of Guatemala by Spain, only one of which was the skillfulness and reported inhumanity of the Spanish as conquistadors (Lovell, 1988). The most noteworthy of these elements was the spread of epidemic illness and the contribution of "allied" indigenous peoples on the side of Spain (Matthew, 2012).

In his 1988 article, W. George Lovell defines the "Black Legend" as the "unmitigated slaughter, rapacious exploitation, and abusive treatment on the part of demoniacal Spaniards" towards the indigenous (Lovell, 1988). With swords, firearms, and horses, the Spanish conquistadors used their military training to systematically massacre and enslave the local indigenous population, taking their land and, in turn, their economy (Patch, 2002). Frequently, the Spaniards would burn or destroy

indigenous establishments to send a message, rebuild their own town, or force the indigenous to migrate to *encomiendas* (see Glossary) where they would work the land (Matthew, 2012). *Encomiendas* were a result of the Spanish desire to control both the land and the indigenous by assigning certain conquistadores to villages from which they could collect tax, or "tribute"(Kramer, 1990). This was the beginning of the economic exploitation of the indigenous by the Spanish invaders which came to define the Conquest more than any other outcome (Lovell, 1988). *Encomiendas* began with "forced resettlement...of the Native people into larger, more concentrated settlements, a policy carried out by Spanish priests in order to 'civilize' the Maya and make them easier to indoctrinate" (Patch, 2002). The relocation quickly became akin to slavery and lasted over 200 years. During this time the indigenous populations were forced to work on land that the Spanish had taken from other indigenous peoples and made to pay taxes to their Spanish captors (Patch, 2002). Even after the system was abolished by the crown in the 1720's due to concerns that the colonists were gaining too much power, the indigenous continued to pay taxes that were redirected straight to Spain (Patch, 2002).

Much like other colonial invasions, an onslaught of illnesses brought over by the Spanish including smallpox, measles and mumps greatly reduced the indigenous population prior to (via invasion in other locations), and during the conquest (Matthew, 2012). This significantly reduced the indigenous numbers and weakened the groups as a whole, resulting in a biologic upper hand for the Spanish (Lovell, 1988). This epidemiological fact is thought by many historians to be one of the most if

not the "single most significant factor" contributing to the death of many indigenous and resulting decline of their empire (Lovell, 1988; Matthew, 2012; Patch, 2002).

Another contributing factor to the efficacy of the Spanish conquest was the aid of other indigenous groups who fought alongside the conquistadors, both willingly and as a result of a previous defeat (Matthew, 2012). Laura Matthew argues that the "conquest" seen from another perspective was in fact more of an invasion driven by the Oaxacan and Nahua' warriors from Mexico who were assisted by the Spanish - rather than a Spanish-led conquest (Matthew, 2012). Although this is not a commonly held notion, others do discuss the role of the indigenous groups, such as the Quiche, in fighting with the Spanish (Patch, 2002; Lovell, 1988). As Lovell attests, the Quiche were "initially Spanish allies who rebelled in 1526 after suffering two years of abuse at the hands of their European taskmasters" (Lovell, 1988). However, after they rejected their allegiance with the Spanish, they were also conquered.

Regardless of the reasons behind its success, Spain took control of Guatemala for over 200 years, irrevocably changing the country physically, economically, socially, politically, and demographically. Once the leaders of the land, the indigenous population quickly became 3rd class citizens forced to work the very land that was stolen from them. Lovell states that "[indigenous] life in colonial Guatemala was founded...on the 'dualization of society,' which means that Indians existed in varying degrees of servitude to Spaniards" (Lovell, 1988). This servitude and oppression thus created a pervasive "culture of terror" that has been "endured in Guatemala to scar and disfigure succeeding centuries" (Lovell, 1988). However, during this exploitation, with the Spanish conquistadors pushing them to live in the cities they had created and

provide a labor force for the new elite, the indigenous were constantly attempting to flee to more rural areas where they could enjoy at least a semblance of freedom (Lovell, 1988). This created a concentration in urban areas of individuals of Spanish descent and in rural areas of indigenous communities still seen in Guatemala today (Matthew, 2012).

During this process, the Spanish not only changed the trajectory of the lives of the indigenous they conquered, they also created a new, now prevalent ethnic group of mixed indigenous and Spanish descent that has retained, for the most part, its higher socioeconomic standing in comparison to indigenous groups (Lovell, 1988). *Ladinos*, as they began to be called, spoke (and speak) almost exclusively Spanish and follow their European lineage in dress. When independence was officially declared in 1821, this new ethnic group was well established, as was their subjugation of the indigenous population.

The Spanish Conquest began the systematic oppression and unequal status still experienced by indigenous Guatemalans today. Although Guatemala gained independence from Spain on September 15th, 1821, the country was far from seeing its last battle.

Between Independence and Civil War

Independence from Spain was through majority efforts by the new *ladino* upper-middle class, a generation born of mixed Spanish and indigenous blood, rather than through indigenous leadership (Weaver, 1999). The prevailing political inclinations of the time leant towards a basic continuation of colonial practices,

namely the rule of *ladinos* over their indigenous counterparts and the further incorporation of *ladino* culture into indigenous communities (Lovell, 1988). However, two major visions emerged, both of whom were driven by *ladino* elite and both embraced this continuation but presented a Conservative and Liberal side (Lovell; Weaver, 1999). The Conservatives focused on direct social control with an emphasis on institutions, particularly the Church (an obviously non-indigenous entity) as well as the military, who practiced "a monopoly on education and on birth, marriage, and death rituals and … the possession of considerable economic power" (Weaver, 1999). The Liberals were more interested in following the modern European political trends of the time that re-established the class system and decentralized power to be given to particular levels of civil society (also led primarily by *ladinos*) (Weaver, 1999). Liberal leaders won out, and began a number of projects that established the first public library, national theater, and museum. The government also seized control of the education system and implemented a primarily Spanish language curriculum nationally, primarily excluding the indigenous populations who did not speak the language (Weaver, 1999). Due to their drive to "modernize" Guatemala and abolish all state entities of colonial times, the government was simultaneously launched into a fiscal crisis that has continued, in varying forms, to this day (Lovell, 1988). These reforms, particularly those involving privatizing and distribution of land, continuously exploited the lower levels of society, the majority of whom were indigenous. This resulted in an uprising led by the *ladino* Jose Rafael Carrera (Weaver, 1999). Carrera retracted most of the reforms of his predecessors and, although claiming to have the

indigenous interests in mind, restored the *ladino* institutions of colonial times (Lovell, 1988).

In 1871, President Justo Rufino Barrios took power and began his own infamous reforms which "entailed both an attack on [indigenous] land and an assault on [indigenous] labor" (Lovell, 1988). Indigenous property and subsequently their agricultural livelihood was, again, taken away by their *ladino* counterparts now due to language differences and their inexperience with landholder legislation (Lovell, 1988). This same discrimination will be discussed in later sections in regards to health care access where language and proximity are systematic barriers to attainment of essential needs.

Throughout this era of post-Independence and pre-Civil War, the indigenous populations were dragged through numerous political leaders who frequently campaigned to serve their best interests but when elected, merely continued their exploitation like those that had come before them. This proved to be both arduous and divisive for the indigenous and may have contributed to the animosity felt between *ladino* and indigenous individuals still perceptible in the country today.

Civil War

Spanning 36 years, the Guatemalan Civil War was a brutal and violent affair, known to be "one of the longest and bloodiest war ever in the Central American region (Preti, 2002). The Commission for Historical Clarification (CEH), an organization tasked in the Guatemalan Peace Accords with compiling and reporting on human rights violations carried out by the state during the war, estimated that between the

years of 1960 and 1996 there were a total of 42,275 victims "of human rights violations and acts of violence connected with the armed confrontation" (CEH, 1999). Although many of victims were identified ethnically, of those that were both reported and identified, 83% were indigenous and 17% were *ladino* (CEH, 1999). During this devastating war, there were an estimated "200,000 victims of arbitrary execution and forced disappearance; 200,000 refugees; [and] one million internally displaced people" (CEH, 1999; Preti, 2002).

The origins of the Guatemalan Civil War are debated in academic literature and are divided among those that cite primarily national forces and those that look to international pressures as catalysts to the start of the war. In most accounts, including that of the CEH, the roots of the conflict are stated to be stemming from national and historic pretenses, specifically "the structure and nature of economic, cultural and social relations in Guatemala [which are] marked by profound exclusion, antagonism and conflict - a reflection of its colonial history" (CEH, 1999). The CEH goes on to discuss the constant favoring of the "privileged minority" over the masses, the endemic racism reflected in political, social, and economic decisions, and the concentration of the wealth in the hands of few that created a tumultuous background in which the civil war was born (CEH, 1999). Chamarbagwala et al cites the "chronic status quo of inequality and social exclusion that was inherited from the colonial period" (Chamarbagwala & Morán, 2011). In these accounts the precise start of the war is essentially irrelevant but, keeping in mind its historic precedence, officially cited as November 13, 1960 when junior army officers, dissatisfied with the corruption of President (General) Miguel Ydígoras Fuentes, instigated a *coup d'état*

(Ball, 1999). Although the *coup* was initially unsuccessful in its aim to overthrow Fuentes, the officers fled and became the core of the anti-government rebels leading the civil war (Chamarbagwala & Morán, 2011).

Other perspectives give more weight to both the Cold War global environment, as well as the role of the United States of America (US) in backing the overthrow of the democratic government in 1954 (Ball, 1999). Considered one of the "most democratic and populist governments in the nation's history" (Ball, 1999), the government of Jacobo Arbenz ended the only period of Guatemalan history in which an "effective state social policy" was apparent (CEH, 1999). However, Arbenz's land reforms had threatened the mammoth US-based United Fruit Corporation's land holdings. In order to crush those threats, the US Central Intelligence Agency (CIA) and President Eisenhower initiated a military overthrow replacing the democratic president with military-trained Castillo Armas, without taking into account the potentially disastrous repercussions of their actions in Guatemala (Koonings, 2000). While seen initially as a US triumph in the Cold War geopolitical context of the time, the *coup* is identified by many as a direct precursor to the bloodiest and longest civil war in Central America (Koonings, 2000; Preti, 2002).

Although views on the antecedents to the war are many, there is no debate on its severity to the human, social, and economic capital of Guatemala. The atrocities that occurred in Guatemala, although largely under-reported by global media during that time, affected all levels of Guatemalan society. However, it primarily targeted those of the lower social stratum, especially the indigenous (Chamarbagwala & Morán, 2011). Targets of government military action during the 1960's were primarily armed

rebel militants that were concentrated in urban areas (Ball, 1999). This expanded in the 1970's to those thought to be opposition members or sympathizers including particular community and clerical leaders as well as students (Chamarbagwala & Morán, 2011). This era was home to a rise in the government's use of "death squads" and targeted assassinations and disappearances (Ball, 1999). The government also began sieges throughout urban and rural Guatemala in which elected leaders were forcibly replaced by military constituents that further diminished any potential opposing political representation of the rural poor (Ball, 1999).

With these violent and devastating initiatives by the military came another aspect of the 1970-80's civil war era not frequently reported: the rise of indigenous activism in opposition to these atrocities (Hale, 1997). As a reflection of the social reforms enacted by former President Arbenz, the availability and quality of education for the indigenous populations had increased substantially in spite of the massive upheaval that begun just after his presidency . Due to the increase of globalization as well as general connectivity between persons internationally, rural communities were much more connected to both national and international entities, including church organizations dedicated to capacity building (Konefal, 2003). Though still under state oppression and at high risk to themselves and their families, the indigenous Guatemalans began "a kind of popular insurrection" (Falla, 1994). This movement was also driven by university students, human rights organizations, and church groups and grew into the "National Front Against the Violence" credited with limiting some of the terror activities of the state during the 1970's and 80's (Ball, 1999). Although not widely successful in bringing equality or an end to violence to Guatemala, this

movement did demonstrate the awareness of the indigenous Guatemalans to their own suffering and unequal status, while also showing the modest support they had during this grim time. However, retaliation by the state, using their "government-controlled death squad" (the Secret Anti-Communist Army, SAA) was deadly and public, perpetuating the notion that the state was both cruel and lavished in its impunity (Ball, 1999).

The year of 1979 marked the commencement of the bloodiest and deadliest period of the war in which 91% of all human rights violations were reportedly committed (CEH, 1999). During this period which lasted until about 1984, the state, led by Generals Fernando Romeo Lucas García and José Efraín Ríos Montt, began the practice of desecrating entire rural villages to both show their power and perpetuate the culture of fear already rampant in the country (Ball, 1999). The battles were concentrated in the departments of "Quiche, Huehuetenango, Chimaltenango, Alta and Baja Verapaz, the south coast and the capital, the victims being principally [indigenous] and to a lesser extent *Ladino*" (CEH, 1999). In some records, over 25,000 men, women and children were reported either killed or "disappeared" during this 5-year "'scorched-earth' counterinsurgency plan" (Hale, 1997). Most data collected during this time relates to deaths and disappearances, reflective of the fact that "security forces favored physically eliminating their victims to keeping them illegally detained or torturing them before releasing them" (Ball, 1999). During this period, most indigenous Guatemalans were thought by the state and its army to be guerrilla supporters, thus rationalizing the pointed force used against them (Hale, 1997). Although there was some insurgency among indigenous peoples, the Commission for

Historical Clarification (CEH) has stated that this involvement "was intentionally exaggerated by the State [and was] based on traditional racist prejudices" against indigenous people in general (CEH, 1999). The Government then used that unfounded justification to carry out atrocious acts "to eliminate any present or future possibilities of the people [helping], or joining, an insurgent project" (CEH, 1999). The CEH was the organization tasked in the Guatemalan Peace Accords to report on human rights violations and acts of violence that occurred during the civil war. The organization goes on to state that the actions of the government throughout the civil conflict but particularly during this period can be labeled as genocide (CEH, 1999). The term "genocide" is defined by the United Nations in the General Assembly Resolution 260A (III) Article 2 of the International Convention of the Prevention and Punishment of the Crime of Genocide (CPPCG) as the following: "any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group, as such: (a)killing members of the group; (b)causing serious bodily or mental harm to members of the group; (c)deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part; (d)imposing measures intended to prevent births within the group; [and/or](e)forcibly transferring children of the group to another group" (CPPCG, 1948). Guatemala ratified the Convention in January of 1950. The CEH further concluded that the actions of the State could be seen as an effort to "destroy the cultural values that ensured cohesion and collective action" among the indigenous communities (CEH, 1999).

During the end of the 1980's and the beginning of the 1990's, the outright slaughter and destruction of earlier years was greatly reduced, although still present,

and affected both indigenous and *ladino* Guatemalans in similar capacities (CEH, 1999). This period is distinguished by a new constitution, the election of a non-military president in 1986, and the emergence of new human rights groups (Ball, 1999). Although this period leading up to the final Peace Accords of 1996 was less violent, political and social oppression were still widespread (Jonas, 1991). There were kidnappings and assassinations of individuals leading the call for an end to the war, particularly those in the University Student's Associations (AEU) (Ball, 1999). The 1990's saw a gradual decline in deaths and disappearances while the government, reacting to international, regional, and national pressure to end internal conflict, finally began the process of negotiations with the guerrilla insurgency (Ball, 1999).

In 1996, after 36 years of brutal conflict throughout Guatemala, President Alvaro Arzu Irigoyen and the Guatemalan National Revolutionary Unity (URNG) party, with help from numerous international and national human rights and peace organizations, signed a peace agreement ending the bitter conflict that claimed up to 200,000 lives (Ball, 1999; CEH, 1999). The course of the talks was characterized by small ideological triumphs shrouded by a backdrop of authoritarian predisposition. For example, President and Human Rights Ombudsman Ramiro de Leon Carpio and his party supported civilian participation but with extensive veto power for the military and unwavering autonomy for the President (Jonas, 1991). There was, however, substantial demilitarization across the country, although in practice it has been more of a reduction in observable personnel rather than that of military spending and political presence (Preti, 2002). Some budget records have actually noted an increase in military funding in the early 2000s - which has been of great

concern for international stakeholders (Preti, 2002). There have been many critiques to this peace process, namely that the main actors, the government, the guerillas (URNG), and the United Nations, do not directly represent the group most devastated by the conflict, the indigenous (Preti, 2002). However, as discussed later, individual testimonies did provide the basis of the "truth seeking" projects established during this time (Isaacs, 2010). The Assembly of Civil Society (ACS), a multi-sectorial group established in the Peace Accords, was also instrumental in the movement towards advancing political participation for civil groups and popular sectors as well as acting as a bipartisan voice to aid in negotiations for both sides (Jonas, 1991).

A significant amount of resources has also been spent on responsibility assignment for human rights violations and other acts of violence committed during the conflict (Isaacs, 2010). The military, due to their involvement in the peace process, has been granted amnesty in regards to these acts while they remain a hegemonic power throughout Guatemala (Preti, 2002). Both sides, in fact, have been forgiven legally for atrocities committed during the war, unless those acts included genocide, torture, and forced disappearance - three elements that basically defined the conflict during its most violent period (Isaacs, 2010).

Another major aspect of this peace process has been the seeking of "truth" by various international and national stakeholders, most notably the Guatemalan Catholic Church and the Commission for Historical Clarification (CEH) in an effort to acknowledge the hardship experienced by many during the conflict (Falla, 1994). These projects acknowledged the violent acts that occurred but could not utilize any juridical avenues to adjudicate the perpetrators of those crimes (Isaacs, 2010).

Beginning in 1986, the Human Rights Office of the Archdiocese of Guatemala (ODHAG) began a process of collecting civilian testimonies which totaled to 6500 by the publication of their report in 1998 and cited more than 55,000 human rights abuses (Preti, 2002). As a testament to the continued violence in Guatemala even during the peace process, just two days after that report was published publicly, the director of the ODHAG was assassinated (Jonas). The ODHAG describes their report, a book entitled "Guatemala: Never Again!", as more of a "book of martyrs" and a testament to those who lost their lives, families, land, and sense of well-being to the conflict (ODHAG, 1999). The book documents, through the eyes of the victims, the atrocities committed by the guerilla and state forces as well as the peoples attempts to cope with and act against the daily culture of fear that few survived through during the 1960's, 70's, and 80's (Preti, 2002).

Backed by the United Nations and established in the Peace Accords as the official body investigating human rights abuses and violations of both sides, the CEH compiled more than 9,000 testimonies that implicated a total of 42,000 human rights violations (Preti, 2002). The CEH report, titled "Guatemala: Memory of Silence", includes sections on recommendations and conclusions as well as extensive data on violence stratified by year, time period, political leader, area, and by ethnic group (CEH, 1999). Both reports site historical roots to the civil war and highlight the deep social and cultural implications the war had (and has) primarily on the indigenous populations in Guatemala (Isaacs, 2010). Due to the minimal media given to the Guatemalan civil conflict, the extent of the human rights violations and abuses that

occurred was largely unknown until the ODHA and CEH reports were released (Ball, 1999).

Although tremulous, the peace process itself has been applauded for "its innovative decision to award civil society a formal consultative role, as well as the ambitious and comprehensive nature of the final agreements" (Isaacs, 2010). Politically, moving from a 30-year history of authoritarian and militarized government regimes to a democracy is an ambitious goal that has seen some theoretical progress (Preti, 2002). The Peace Accords assigned a clear framework for that transition and allowed for non-military and non-state actors to play a role in that process (Isaacs, 2010). They were a true negotiation between the stakeholders, rather than a forced concession by the vanquished. Highlights of the Peace Accords were the Human Rights Accord, a document that called for the protection of human rights as well as the establishment of international monitoring and evaluation mechanisms to maintain those rights; as well as the Accord on Strengthening of Civilian Power and Role of the Armed Forces in a Democratic Society in which the army was given a back seat to civilian forces (although in practice this has not been widely recognized) (Isaacs, 2010). While the Accords set the ball in motion for the democratization of Guatemala, skeptics are quick to identify that that movement does not necessarily mean that the country is healed nor that social justice has been achieved (Isaacs, 2010).

Implications and Conclusions

Taking into account the Spanish conquest and the Guatemalan civil conflict, indigenous Guatemalans have had a long history of oppression and systematic

violence. While elections and political demonstration are now common, there remains much to be done by the government and its constituents to heal the deep cultural, social, economic, and health wounds left by that history. Crime rates in some areas have actually increased during “peace”, and criminal violence and social exclusion are known to be the main obstacles to the enjoyment of human rights (Preti, 2002). Poverty and inequality persist, particularly in rural, indigenous locations where the civil war hit hardest (Preti, 2002). The United Nations Development Assistance Framework (UNDAF) reported that “the main obstacle in Guatemala is combating social exclusion … which has three basic roots: the uneven economic model; the weakness of the democratic rule of law; the discriminatory culture, marginalizing indigenous people and women” (UNDAF, 2000). While the peace process resulted in a number of officially-recognized human rights organizations and various legislation defining the human, civil and political rights of all Guatemalans regardless of gender or ethnicity, the actual enjoyment of those rights is still far from universal. There remains a social, political, and psychological hierarchy in Guatemala in which the indigenous remain at the bottom, shrouded by a culture of fear that is not easily diminished (Preti, 2002).

Human Rights in Guatemala

Introduction

While human rights in Guatemala have been part of political and social discourse for over 60 years, human rights abuses and violations continue to be suffered in everyday life for many as they have been for decades. As will be discussed in this section, Guatemala has legislation and institutions in place to uphold the human rights of its citizens but those resources are not being adequately enforced. There are still major barriers to the full enjoyment of human rights particularly for indigenous Guatemalans in relation to health.

In the following section, human rights in Guatemala will first be discussed from a legal standpoint as represented in international, regional and national legislation in the country. After taking into account the legal and institutional framework for human rights present in the country, the human right to health and the human rights of indigenous peoples in Guatemala will be examined. Finally, the right to health specifically for indigenous populations will be explored.

International Legal Framework

Guatemala ratified its first international human rights treaty in 1982, pledging its protection of women against discrimination (Hafner-Burton, 2005). By 1992, it had successfully ratified the six core international human rights treaties including (in order of ratification): the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the International Convention on the

Elimination of All Forms of Racial Discrimination (CERD), the International Covenant on Economic, Social, and Cultural Rights (ICESCR) and Optional Protocol (ICESCR-OP), the Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (CAT), the Convention on the Rights of the Child (CRC), and the International Covenant on Civil and Political Rights (ICCPR), as well as other global treaties (OHCHR, n.d.). All of these treaties ratified by Guatemala incorporate the right to health or health-related rights specifically.

Due to the country's need and request for international assistance during the Peace Accords process in the early 1990's, there are a number of human rights institutions overseen by multi-country alliances, particularly the United Nations (UN). MINUGUA, the UN Human Rights Verification Mission in Guatemala, was created in March of 1994 as a result of the pioneer resolution between the guerilla forces and the Guatemalan government at the end of the civil conflict, facilitated by the United Nations (Amnesty International, 2002). The Mission was tasked with monitoring the country's human rights situation particularly in relation to the following eight human rights: life, liberty, political freedoms, free expression, free movement, free association, due process under the law, and individual integrity and physical security (MINUGUA, 1994).

The right to health is most clearly and explicitly addressed in Article 12 of the ICESCR which recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (CESCR, 1966). This inclusive right provides provisions for health care facilities, goods and services that must be available, accessible and acceptable to everyone as well as of good quality (CESCR,

2000). These four essential standards are known as the AAAQ Framework, and are used as guidelines to evaluate whether a State health entity sufficiently upholds the right to health for its citizens (Potts, 2008). For those health entities to fit the criteria for availability, they must be part of a viable public health system which allows for enough quantity of those health care facilities, goods, and services for all of its citizens. For those health care facilities, goods, and services to be accessible they must be free of discrimination, physically accessible, affordable for all, and provide space for individuals to seek health information, particularly the most vulnerable and marginalized (CESCR, 2000). Medical and cultural acceptability is another important component of health care facilities, goods and services, as well as their proven medical and scientific quality (CESCR, 2000). Cultural acceptability implies that the health care provided takes into account the beliefs and practices surrounding health held by the individuals being treated. As will be discussed further in the following section, indigenous Guatemalans have a different outlook on disease and illness than that of Western medical teachings. A facility, good, or service would be culturally acceptable if it acknowledged that ideological difference and treated the patient within their ethnic or racial context. Under the UN Conventions, the right to health further extends to the social determinants of health including nutrition, housing, potable water and sanitation, and, most importantly, inequality (HRC, 2011).

The UN High Commissioner for Human Rights has held an office in Guatemala since 2005 with the goal to observe, provide advice, and deliver technical assistance to the State on their human rights practices (HRW, 2012).

Serving as an international prosecutor working within the country's judicial system, the UN International Commission against Impunity in Guatemala (CICIG), follows State criminal procedure while being comprised of both national and international members sponsored by the UN (Isaacs, 2010). The group independently investigates groups that propagate State impunity, i.e. underground security groups and structures with ties to State representatives, in order to strengthen Guatemala's public policy framework and effectively litigate against human rights abuses. Identified as one of the major obstacles to the attainment of a transparent, democratic State following the civil conflict, the prevalence of governmental impunity in Guatemala caused widespread distrust in authority by the public and impeded the enjoyment of the people's fundamental human rights.

In Guatemala, vis-à-vis the Constitution, the aforementioned international treaties and protocols become immediately applicable country-wide upon ratification (Republic of Guatemala, 1985a). Therefore, even without the following regional and national legal provisions, the inclusive right to health for indigenous peoples is already actionable throughout the country. However, as discussed in previous chapters, there continue to be substantial disparities between *ladino* and indigenous Guatemalans in all aspects of health and health care access, impeding their fulfillment of these rights.

Regional Legal Framework

The roots of the human rights dialogue among Latin American countries took hold within a foreign policy environment that heralded non-intervention at its core

(Goldman, 2009). Although the Inter-American system dates as far back as 1826 with Simon Bolivar, the First International Conference that brought these countries together was not held until 1889 (OAS, 2015). These meetings of what would later be referred to as the Organization of the American States (OAS), of which Guatemala was an original member, focused heavily on the independent sovereignty of each State as well as the common resistance to any form of interference between States, regardless of the reason (Goldman, 2009). While the acknowledgement and support of human rights was evident early on in their meetings, the topic did not receive much attention internationally until after World War II (Goldman, 2009).

In 1948, the States signed the Charter establishing the OAS in which the "essential rights of man" was a tenet (OAS, 1967). On May 2nd, 1948, in compliance with the preamble, Guatemala and other Latin American States signed the first ever international human rights document entitled the American Declaration of the Rights and Duties of Man (Goldman, 2009). However, it wasn't until 1978 that procedures and political bodies to protect those human rights were established in the American Convention on Human Rights (Goldman, 2009). This Convention pushes for the progressive realization of the rights contained in the Charter of the OAS which upheld particular economic, social, educational, scientific and cultural standards (HRC, 2011). These standards include various references to the right to health and its tenets. The right to health is further set out, with language similar to that of General Comment 14, in the Additional Protocol to the American Convention with regards to economic, social and cultural rights. The Protocol of San Salvador, as this document is called, was signed and ratified by Guatemala in 1988 and 2000, respectively (OAS, 1999).

As part of the OAS, Guatemala is required to have representatives in the Inter-American Commission on Human Rights (IACHR) that aid the country in forming and promoting State human rights policy. The President's Commission on Human Rights (COPREDEH) was established for this purpose, as well as to negotiate human rights cases tried before the Inter-American Court of Human Rights. Due to the increasing threats and intimidation experienced by human rights defenders recently, the COPREDEH has also played a role in protecting those individuals (USDOS, 2011).

Although the Organization for the American States is not recognized quite as formidably as the United Nations, the legislation it has put in place has allowed for greater accountability throughout the Americas to minimize human rights violations and abuses in its member countries. Of particular importance is the overlap of both international and regional treaties which provides layered pressure to countries like Guatemala to re-assess State actions with their citizen's human rights in mind.

National Legal Framework

In addition to the aforementioned international and regional human rights agreements, Guatemala has national provisions for the right to health in its Constitution, as well as special protections for indigenous peoples (Republic of Guatemala, 1985a & 93). The Constitution recognizes the right to health "as a fundamental right of the human being without any discrimination" (Republic of Guatemala, 1985b), thus alluding to indigenous peoples right to health.

The Guatemalan Constitution also prioritizes all international treaties that incorporate the right to health and any human rights obligations over any established

domestic law (HRC, 2011). Furthermore, international and regional human rights treaties ratified by the Government of Guatemala have precedence over legal order and municipal law in the Constitution and take immediate domestic effect when ratified (Guatemala Const., art. 46). The Government of Guatemala has also endorsed the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) which, although not legally binding, reaffirms the rights of individuals of indigenous descent as equal to all others with regard to the right to health, health care access, non-discrimination, as well as many other social, cultural, economic, and political rights (UNDRIP, 2007).

Nationally, Guatemala has numerous government and non-government organizations who focus on human rights advancement, advocacy, public policy, defense, research, and much more. Those under the State include the Human Rights Ombudsman or "Procurador de los Derechos Humanos" (PDH) and the Congressional Committee on Human Rights. The PDH is the government's primary human rights body set forth in the Constitution (Guatemala Const., Chapter V). This entity reports to Congress as well as the international community and monitors all human rights indicated in the Guatemalan Constitution (Guatemala Const., Title II & Chp. V). The Congressional Committee works in drafting and advising on human rights legislation and all congressional political parties are required to have a representative in the group. Although clearly under party influence, it also serves as a public forum to promote and protect human rights (USDOS, 2011).

Human Rights in Practice: The Right to Health

As discussed, Guatemala has numerous international, regional, and national legislative provisions that specifically uphold the right to health as inclusive and universal for all Guatemalans (Hafner-Burton, 2005). However, in practice, this right is not enjoyed equally by all citizens, with a particular disparity occurring among the rural, indigenous sects (Cultural Survival, 2008).

According to the UN Human Rights Council, the Ministry of Public Health and Social Assistance (MSPAS), the primary health care service provider in Guatemala, is responsible for approximately 70% of healthcare delivery (HRC, 2011). However, the majority of that percentage only receive the most basic package of health care services, mostly though subcontracted non-government organizations (NGOs) conducting monthly community visits (HRC, 2011). This availability of services to indigenous Guatemalans is in great need of expansions as most of the health sector, particularly the clinics and hospitals with specialty services and diagnostic capabilities, is highly concentrated in urban areas, while indigenous communities are not. The system is also highly under-resourced, with frequent outages of medicines and proper equipment.

Economic accessibility is also a concern for many indigenous Guatemalans. Although the government has pledged a devotion to improving healthcare in rural areas, in the 2010 budget absolute health care spending in Guatemala actually decreased for the first time in 20 years, while military spending rose (HRC, 2011; MINUGUA, 1994). Historically, total health expenditure makes up a much smaller part of the aggregate percentage, indicating unequal allocation, and therefore accessibility,

of overall healthcare resources for indigenous Guatemalans (HRC, 2011). Physical accessibility is also an issue due to the concentration of health services in urban areas as well as the lack of primary care facilities in rural areas (Cultural Survival, 2008). According to the World Health Organization's World Health Statistics, 53% of the Ministry of Health workforce is based in the department of Guatemala (in which the capital, Guatemala City, is located), and 80% of the Guatemalan Social Security Institute staff are also based in that same metropolitan region (WHO, 2011). As is common for communities in rural areas, there is also limited access to the underlying determinants of health for indigenous populations including adequate food, water and sanitation infrastructure. Lack of access to health as well as the basic public services is tied directly with treatment and health outcome disparities in Guatemala between the urban and rural, and between *ladino* and indigenous communities (HRC, 2011).

Due to the heavy focus on biomedical, Western medicine in the public health system as well as the large number of *ladino* health care providers, medical professionals are not adequately prepared to address rural health and indigenous community needs. Health providers are also typically unwilling to work in locations where indigenous communities are located, and care provided is usually not culturally or geographically acceptable to those populations. Furthermore, the few that do receive some kind of training and are assigned to rural locations are not properly supported by the health system and must work without proper equipment or medicines. This lack of cultural and medical acceptability has had a huge effect on adequate health care access for indigenous communities.

Although a significant element of all human rights doctrine, discrimination against indigenous peoples is still rampant in the health care system and throughout Guatemala. The indigenous population is consistently omitted from health care policy decisions that directly affect their well-being (HRW, 2012). Access to health facilities, goods and services for the most basic health needs are highly inequitable for the most vulnerable and marginalized, i.e. rural, indigenous populations, while rich, urban *ladino*s enjoy the best hospitals and clinics. This inequality has had serious consequences on indigenous health, and therefore has increased the burden on the Guatemalan health care system.

These aforementioned issues have created a healthcare environment in Guatemala that appears oblivious to the international human rights treaties it claims to uphold. Indigenous populations continue to suffer from increased risk of morbidity and mortality from preventable illnesses due to the lack of availability, accessibility, acceptability and quality of health care facilities, goods and services for their communities.

Human Rights in Practice: Indigenous Rights

According to recent data from the United Nations Development Programme (UNDP), Guatemala's Gini coefficient, an internationally accepted measure of internal inequality, is one of the highest in the world at 55.9, also making it the most internally unequal country in Central America (World Bank Development Research Group (WBDRG), 2013). Due to this inequity, indigenous rights continue to be a much debated issue within and outside of Guatemala. While there are numerous domestic

laws in place protecting all indigenous Guatemalans from any kind of discrimination or inequality, pervasive racism and systemic inequality remain rampant throughout the country. In article 66 of the 1985 Guatemalan Constitution, the government "recognizes, respects, and promotes their form of life, customs, traditions, forms of social organization, the wearing of Indian dress by men and women, their languages, and dialects" and acknowledges Guatemala's diverse ethnic makeup (Guatemalan Const., art. 66). Articles 67 and 69 also elicit protections for indigenous communities, including land protection, agricultural cooperatives and of the safety and health of internal migrant workers (Guatemalan Const., art. 67 & 69). Since the signing of the constitution, Guatemala has also signed a number of treaties supporting indigenous rights including the Indigenous and Tribal Peoples Convention of the International Labor Organization (ILO) and the International Convention on the Elimination of All Forms of Racial Discrimination (CERD). In March of 1995, the State further emphasized their support by signing the Agreement on Identity and Rights of Indigenous Peoples, which identifies Guatemala as "multiethnic, multicultural and multilingual in nature" as well as reaffirming the social, cultural, political, and economic rights of the indigenous peoples (MINUGUA, 1994). The Agreement also acknowledged the exploitation, marginalization, and inequality experienced both historically and at present of the indigenous, and its great effect on the well-being of the people as a whole (MINUGUA, 1994). Furthermore, according to the Guatemalan Anti-Discrimination Act, any form of discrimination in relation to race, language, or social status (among other characteristics) is criminal under the law (Cultural Survival, 2008).

There are also government offices devoted to upholding indigenous rights including the Indigenous Affairs Commission in the Supreme Court, the Office for the Defense of Indigenous Peoples in the Office of the PDH, as well as others (Cultural Survival, 2008).

However, even with these provisions, over 75% of Guatemalans, indigenous and non-indigenous, believe their society continues to discriminate against the indigenous population (Isaacs, 2010). Of those receiving any compensation at all, indigenous workers are paid 33% less than non-indigenous Guatemalans, and most earn less than the country's minimum wage (Isaacs, 2010), thus disproportionately impeding the economic accessibility to health care. Language continues to be a barrier to indigenous access to any services due to the highly uncommon use of indigenous dialects in political, educational or informational spheres (Cultural Survival, 2008). Particularly in the political realm, this impediment has led to the widespread lack of indigenous representation in politics resulting in persistent repudiation of indigenous civil and political rights (Isaacs, 2010). Multiple national and international institutions, including the UN Special Rapporteur for indigenous rights, MINUGUA, and the International Labor Organization (ILO), after examining the efforts made by the Guatemalan government to respect indigenous human rights, conclude that indigenous Guatemalans continue to be excluded, marginalized, and oppressed in their own country and the government is not doing enough to address it (CEACR, 2003).

Indigenous Right to Health

Using the standards outlined by the AAAQ framework, Guatemala has consistently fallen short in its efforts in realizing the right to health for its indigenous people (HRC, 2011). As a signatory of the ICESCR, Guatemala has pledged to provide resources so that indigenous peoples can design, deliver and control their own health care services although in reality, they are consistently excluded from public health decisions and public health implementation organizations (CESCR, 2000; HRC, 2011). This exclusion, among other indicators, has resulted in significant disparities between indigenous and non-indigenous health outcomes (HRC, 2011). The ICESCR also directly links collective health outcomes of indigenous communities with individual health outcomes, extending the right to health to include the underlying social determinants of health described in the right to health section of this paper (CESCR, 2000). In Guatemala, however, basic health services are largely absent in rural, indigenous communities and most also suffer from poverty, lack of proper sanitation infrastructure, unemployment, and other necessities (Schooley, Mundt, Wagner, Fullerton, & O'Donnell, 2009). There is also no comprehensive health care plan to improve facilities, good or services for indigenous individuals, particularly those in rural or isolated locations (HRC, 2011). A national public health policy specifically for vulnerable and marginalized groups is one of the core obligations of the right to health (CESCR, 2000). While the Guatemalan government does recognize that indigenous populations fall into this category, they have yet to develop a strategy to specifically address their health care needs (Isaacs, 2010; MINUGUA, 1994).

After much urging from the international community, the government of Guatemala recently established an Indigenous Peoples Unit in the Ministry of Health (MOH) whose aim is to address and remedy State health system inequities. Although the effort is a positive step towards this goal, it is uncertain if this Unit alone can change the entire, culturally-incompetent system (HRC, 2011).

While the Guatemalan government has, on paper, pledged its all-encompassing support towards the right to health, the human rights of indigenous people, as well as the right to health of those people, it has yet to make significant change in the day-to-day health care access reality faced by indigenous Guatemalans country-wide. Racism and discrimination remain rampant throughout the State, and social determinants of health not addressed by the government continue to impede indigenous populations from attaining mental, physical, and emotional health.

Health and Health Care in Guatemala

Introduction

Due to its violent and chaotic past Guatemala has struggled and continues to struggle to establish political, economic, and social stability (Pena, 2013). The country's divided population is both a result of this past, and a hindrance to achieving this desired balance. These factors, among many others, reflect directly onto the current state of health and the health care system in Guatemala. The country continues to fall short in many areas of health and development, including: infant, child, and maternal mortality, malnutrition, literacy, and reproductive and sexual health indicators, with the indigenous population at the forefront of this deficiency (CIA World Factbook, 2014). Although the government of Guatemala has implemented a number of programs to improve health outcomes and strengthen the health care system, a significant health burden still remains country-wide. In this section, principal health and development indicators of Guatemalans, particularly indigenous Guatemalans, will be discussed in detail. These indicators were chosen based on their relationship to right to health necessities, as well as their availability in the literature. Next, the elements of the government health care system will be covered followed by a discussion of the prevalent health beliefs and practices on which that system is based as well as traditional indigenous ideologies. Finally, the socioeconomic factors contributing to the aforementioned topics will be articulated.

Health

Although over the past 10 years Guatemala has experienced substantial positive change in general population health indicators, it continues to have high instance of both chronic and infectious disease which the current healthcare infrastructure struggles to address (See Table 1 below) (WHO, 2011). Highest on health priorities are "communicable diseases, chronic under nutrition and maternal mortality, with an increase in recent years of non-communicable diseases and injuries" (WHO, 2011). The most prevalent infectious diseases in Guatemala are bacterial diarrhea, hepatitis A, typhoid fever, dengue fever, and malaria (CIA World Factbook, 2012). Guatemala has one of the highest fertility rates among Central American countries (CIA World Factbook, 2012), which has been seen as an indicator of a country's development (UNPF, 1994). Higher fertility rates are associated with high maternal mortality, low levels of education and employment opportunity, as well as increased difficulty of rising above poverty (UNPF, 1994). The country also has one of the highest under-five mortality rate of 32 per 1000 live births, while the regional average is 15 per 1000 live births (WHO, 2011). The first and second highest causes of death for children under five in Guatemala are acute respiratory infection (ARI) and diarrheal disease. Life expectancy for Guatemalans is among the regions lowest at 72 for both sexes (Berry, 2014).

Table 1: *Guatemalan Health and Development Indicators disaggregated by gender and urban/rural locations (WHO, 2011; CIA World Factbook, 2014)*

	Total / Both sexes	**Male**	**Female**	**Urban**	**Rural**
Total population in thousands (2012)	15083				
% Population under 15 (2012)	40.8				
% Population over 60 (2012)	6.56				
Life expectancy at birth (2012)	72	68	75		
Neonatal mortality rate per 1000 live births (2012)	15				
Under-5 mortality rate per 1000 live births (2012)	32				
Maternal mortality ratio per 100 000 live births (2 010)	120				
% Births attended by skilled health workers (2009)	51.3				
Density of physicians per 1000 population (2009)	0.932				
Total expenditure on health as % of GDP (2011)	6.7				
General government expenditure on health as % of total government expenditure (2011)	14.7				
Private expenditure on health as % of total expenditure on health (2011)	64.5				
Adult (15+) literacy rate (2010)	75.2				

Population using improved drinking-water sources (%) (2011)	80			99	89
Population using improved sanitation facilities (%) (2011)	80			88	72
Gender-related Development Index rank out of 148 countries (2012)	114				
Human Development Index rank out of 186 countries (2012)	133				
Skilled attendant at birth (%) 2008-2012				77.1	36.6
Underweight prevalence in children under 5 (%) 2008-2012				8.2	15.9
Stunting in children (%) 2008-2012, moderate & severe	38				
Poverty (%)					
Extreme poverty (%)					

Health outcomes in Guatemala are heavily divided along socioeconomic lines with the poorest also having the highest burden of disease (Bhatt, 2012). Economic status and ethnicity are also inextricably tied, with poverty among indigenous groups averaging at 76% and extreme poverty has recently risen to 28% (Bhatt, 2012; CIA World Factbook, 2012). Indigenous communities are also concentrated in rural areas, where health care access is lowest.

Although the historically high maternal mortality rate in Guatemala is decreasing slowly, according to the newest WHO country statistics, "indigenous women still represent 73% of all maternal deaths in Guatemala and are twice as likely

to deliver a baby without assistance of a doctor as non-indigenous women" (Pena, 2013). With stunting a major issue in the country, indigenous children constitute the majority affected (59%) compared with 31% of non-indigenous children (Pena, 2013).

Health Care

Due to the large indigenous population in Guatemala as well as historic influences of globalization, there are two separate health care ideologies prevalent in the country: Western biomedicine and traditional indigenous healing. While ideas about health and illness stem widely from indigenous knowledge and beliefs, these healers are not frequently sought by Guatemalans for treatment (Bhatt, 2012). This may be due to the higher price of consultation (government health posts provide them for free), as well as a desire for a quicker recovery utilizing over-the-counter medications (Bhatt, 2012).

Government-run health facilities most readily available to Guatemalans are local health posts, where medication and services are limited and providers are typically auxiliary nurses or medical students (HRC, 2011). A general mistrust of government health providers leads most Guatemalans to instead consult their neighbors and family, or seek care and medication from local pharmacists, regardless of their licensure or generally low levels of training (Bhatt, 2012). Generally, Guatemalans tend to either treat themselves with herbs or other community/family-recommended supplements, seek over-the-counter medication from pharmacies, or attend local health posts when sick (Bhatt, 2012). As Christine Pena of the World Bank

states in 2011, “while the majority of Guatemalans have some form of access to preventive and curative services, approximately 1 million individuals, most of whom live in rural indigenous areas, still have insufficient or no access to health services” (Pena, 2013). In this case, Pena is directly referring to the lack of accessibility and availability of health care services to the indigenous populations who primarily live in rural, impoverished areas, both of which are imperative criteria for the enjoyment of the right to health.

Western Biomedicine

Western traditions of health care are supported economically, legally, and academically by the Guatemalan government. The Guatemalan health care system is composed of three major entities: government funded and staffed facilities through the Ministry of Public Health and Social Welfare (MSPAS); facilities established by the Guatemalan Social Security Institute (IGSS); and private sector facilities (Bowser & Mahal, 2011). MSPAS facilities provide consultations, medication (when available) and medical testing free of charge, although small donations from patients are also accepted (Bowser & Mahal, 2011). These government facilities have gotten much criticism for their low pharmaceutical stock, long waits, and lack of proper medical equipment (Bowser & Mahal, 2011). These aspects run contrary to the AAAQ framework (discussed in detail in the chapter of Human Rights) as it is applied to health facilities, namely that goods and services must be available, accessible, acceptable, appropriate and of good quality (CESCR, 2000). Unreliability of these health care facilities has led many to seek care and treatment from predominantly

untrained pharmacy staff (Bhatt, 2012). The IGSS is more of a large-scale employer-based system where some services are offered to family and children of the employee (Bowser & Mahal, 2011). Due to low rates of insurance coverage (15% in 2006), the private sector is almost entirely supported by individuals' out-of-pocket spending and is reserved for the small minority able to pay for higher levels of health care (Bowser & Mahal, 2011).

Aside from domestic health care entities focusing on Western medical practices, there is also a substantial international presence in Guatemala, both through non-government organizations (NGOs), global aid organizations, and religious groups, many of whom focus primarily on public health. Although organizations including The Word Bank, US Agency for International Development (USAID), United Nations Children's Fund (UNICEF), and CARE had been working in Guatemala long before the Peace Accords of 1996, with their signing, the country established an expansion of its healthcare reach to officially include these types of organizations (Pena, 2013). In 1997, after years of political, economic, and social upheaval, the Guatemalan government struggled to establish a functional and sustainable health care infrastructure to its citizens (Pena, 2013). Therefore, taking advantage of the eminent NGO presence, the Ministry of Health (MOH) launched the Expansion of Coverage Program (PEC), establishing a wider network of healthcare services for Guatemalans country-wide (Pena, 2013).

Traditional indigenous healing

The indigenous Cosmovision is centered around the idea of balance, both spiritually and physically (McGrew, 2011). For example, the imbalance of hot and cold both inside and outside of the body can frequently cause sickness, according to indigenous belief (Bhatt, 2012; McGrew). There are various foods and drinks considered “hot” or “cold” that may be recommended depending on an individual's present state (too hot or too cold) (McGrew, 2011). After pregnancy, women are considered to be in a “cold” state due to blood loss and treatment for this consists of entrance into a traditional sauna, or *tamascal* (McGrew, 2011). Similarly, indigenous individuals believe that the causes of illness can be internal (relating more to the physical realm) and external to the infirm (a more spiritual cause) as well as both simultaneously. Therefore, one’s illness could be caused by the propensities or “strong blood” of others, especially pregnant women - but usually without ill intention - or due to one's own emotional or physical state (i.e. anger, stress. etc). Children are usually the most susceptible to illness caused by “strong blood” as their blood is considered to be innately “weak”. This type of sickness is sometimes referred to as *mal de ojo*, or “evil eye” (McGrew, 2011).

Much like the indigenous belief in the causal factors leading to illness, traditional remedies for ailments tend to incorporate both physical and spiritual elements (McGrew, 2011). Curative practices may involve herbal treatments, massage, prayer, specific rituals (McGrew, 2011) or a combination of methods. Many of the natural medicines used by indigenous healers, such as specific plants and herbs, are also being studied and validated by modern healthcare providers, suggesting an area

for overlap between the two ideologies (McGrew, 2011). More recently, Western medications are also being incorporated into traditional practice as a result of globalization, and increased access to biomedical or Western health care practices, while medicinal herbs and plants are falling prey to climate change and pollution (McGrew, 2011).

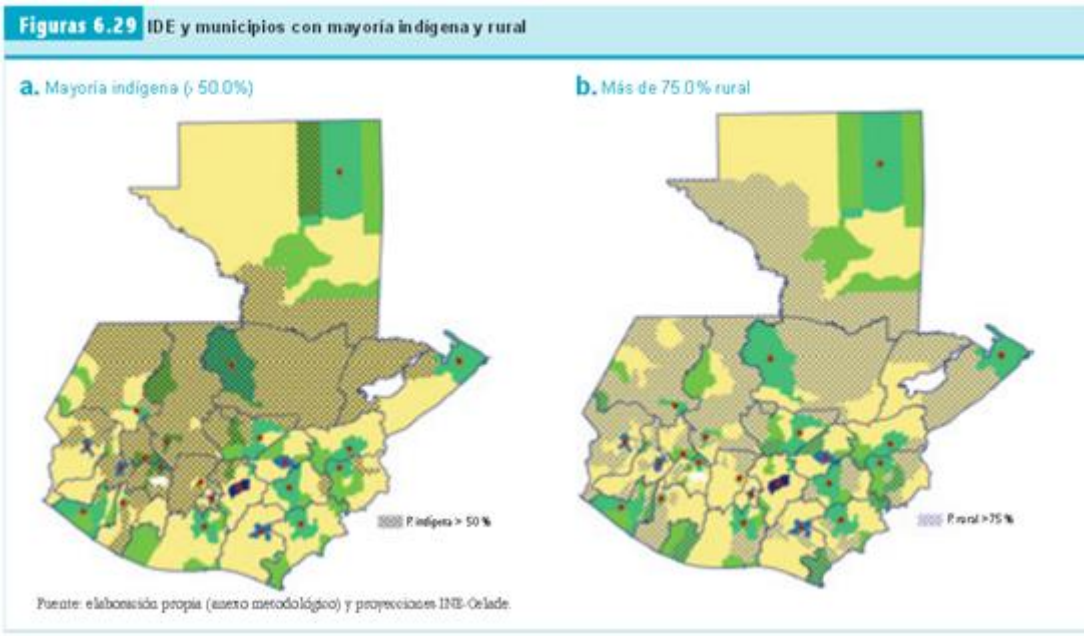
Although health care facilities and international aid organizations typically follow western medical practices and beliefs, approximately half of the Guatemalan population, due to their ethnic heritage, generally ascribe to an indigenous culture of medicine that differs greatly from that of western affiliates. This leads to a culturally unacceptable health care system for indigenous Guatemalans (see AAAQ Framework) adding to access limitations.

Socioeconomic Indicators of Health

The unequal allocation of health care services directly affects the ability of indigenous populations to access health care that is culturally competent (UNDP, 2009/2010). Although the government has implemented programs aimed to address the issue, the majority of health services remain concentrated in the urban centers of the country, making them physically inaccessible to many (Pena, 2013). Meanwhile, the populations who are in most need for proper health care and who have the poorest health outcomes reside in the rural areas of the country, most of whom are indigenous (Bowser & Mahal, 2011). Figure 1 below shows the geographic distribution of both the indigenous populations (shaded area of map a, identified by

municipalities where >50% of individuals identify as Indigenous) and the distribution of the rural populations (shaded area of map b, identified as municipalities that are >75% rural) (UNDP, 2009/2010).

Figure 1: *Geographic distribution of a) indigenous (>50%) and b) rural (>75%) populations by municipality in Guatemala (UNDP, 2009/2010)*

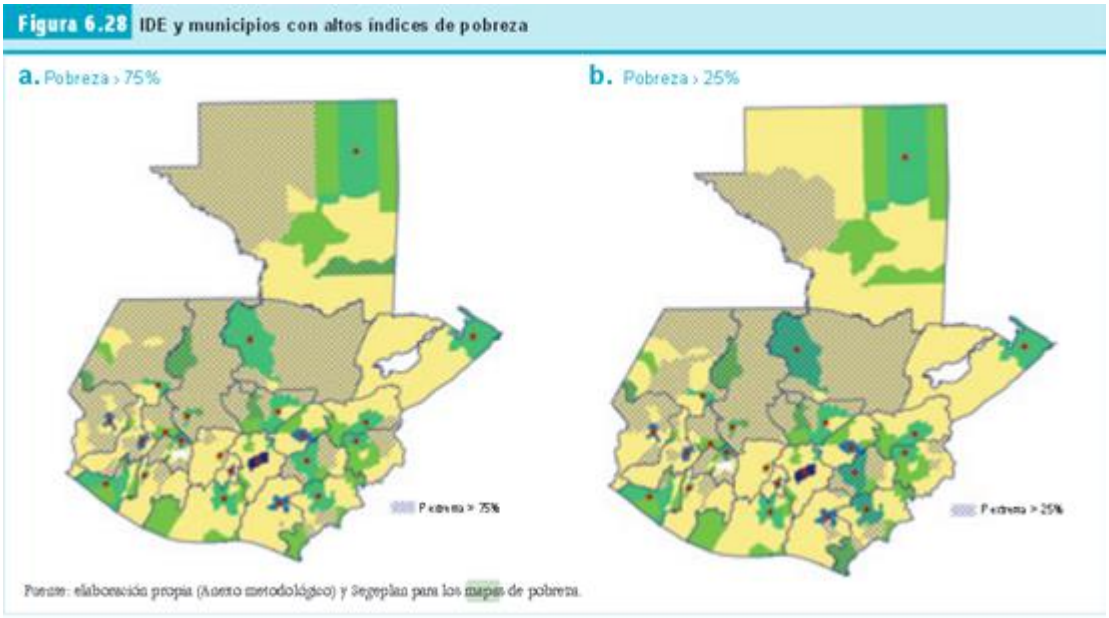


As evidenced in Figure 1, the indigenous population and rurality are intricately linked, providing further insight into the unequal distribution of health care resources in this country (UNDP, 2009/2010). As Christine Pena of the World Bank reported in 2011, "Eighty percent of doctors work in only three departments (Guatemala, Quetzaltenango, and Sacatepequez), the remaining 20 percent are distributed in the other 19 departments". These three departments also house the largest urban and tourism centers of the country, the capital -Guatemala City, Quetzaltenango, and Antigua (CIA World Factbook, 2012). Another significant social factor affecting this concentration of healthcare services, as well as the lack of access to healthcare that Indigenous people face, is that the vast majority of trained health professionals are

ladino, whose populations are generally located in urban areas (HRC, 2011). An example of language inaccessibility, this provides both a social and linguistic barrier to health care access as both doctors and *ladinos* are thought (typically by both parties) to be of higher class than the indigenous Guatemalans, and do not frequently speak local indigenous dialects (Pena, 2013). These two factors contribute heavily to the underutilization of health care services by indigenous populations. The Conclusions of the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health in 2011 stated that there did not appear to be a rigorous effort on the part of the State to provide health services to indigenous peoples in their own languages so that they could understand them (HRC, 2011). This testifies to the lack of health and health care information accessibility for indigenous Guatemalans, a necessary component of the AAAQ Framework. Clearly, not enough effort is being made to combat these historic social indicators in Guatemala, and indigenous health continues to suffer.

Poverty continues to be a country-wide issue in Guatemala with 54% of the population below the poverty line, and 13% in extreme poverty (CIA World Factbook, 2012). However, the indigenous populations remain the most susceptible to impoverishment with 76% under the poverty line, and 28% experiencing extreme poverty (CIA World Factbook, 2012). Figure 2 below demonstrates the distribution of poverty at the municipal level with shading on the left (a) map indicating greater than 75% poverty, and the right (b) map indicating greater than 25% poverty (UNDP, 2009/2010).

Figure 2: *Geographic distribution of a) > 75% poverty and b) >25% poverty by municipality in Guatemala. (UNDP, 2009/2010)*



There is substantial overlap between poverty, rurality, and the indigenous populations (UNDP, 2009/2010). The UNDP Country Human Development Report goes on to state that other than the rurality and impoverishment found in these locations, "these municipalities have the minimum of schools, health centers, police, government workers, funds, [and are] in sharp contrast to the urban municipalities, where the majority is *ladino*" (UNDP, 2009/2010). At the very least, this concentration of indigenous communities in rural areas effects their geographic accessibility to adequate health care services that are typically clustered in urban areas – a component of the AAAQ Framework. However, economic factors greatly effect health care access not only due to their relationship with rurality, but also because of the costs of treatment (health consultations, medications, etc.), transportation to and from facilities, and the lack of general household resources that aid in preventing illness from occurring in the first place (i.e. running water, soap,

sanitary facilities, etc.). Although the local government facilities do not generally charge for consults or medicine, they are consistently understaffed, under-stocked, and lack functional examination and diagnostic medical equipment needed to adequately treat patients, affecting the availability of proper health care services for the indigenous populations (HRC, 2011). The providers must then frequently refer patients to the private sector, whose rates are increasing exponentially (Bowser & Mahal, 2011). A reflection of low quality of care, local health posts, the only government facilities located in more rural locations, are also typically not attended by doctors, but run by nursing assistants, nurses, and (in six-month increments) medical students (Gragnolati, 2003). Bowser goes on to state that "the combination of low access to public services and relatively low ability to bear even small levels of spending by the poor leaves them highly susceptible to catastrophic financial implications of ill health and impoverishment" (Bowser & Mahal, 2011). A reflection of the lack of financial accessibility of health care services, numerous articles have stated that the number one factor contributing to where the indigenous population seeks health care is cost, and many will wait to seek care because of this barrier (Bowser & Mahal, 2011; Giralt, 2012; Pena, 2013). The indigenous population then find themselves in a vicious cycle in which their impoverished status leads to poorer health outcomes, yet they are forced due to lack of resources to wait until their condition is exacerbated to seek care, leading to more out-of-pocket costs they frequently cannot afford (Bowser & Mahal, 2011). Furthermore, the increasing health services privatization and low public expenditure has resulted in a disjointed healthcare system where private primary and secondary level care is largely

unavailable in rural areas where indigenous communities reside (HRC, 2011). Finally, government health care spending is also disproportionately distributed, favoring individuals in the highest percentages of yearly income (mostly *ladino*) who generally seek care in public, urban hospitals (Gragnolati, 2003). Gragnolati further reports that "the proportion of individuals who are treated by doctors varies significantly by consumption quintiles (from 14 percent of the poorest to almost 60 percent of the richest)" (Gragnolati), clearly indicating the inaccessibility of higher level health care providers for the poverty-stricken indigenous population. Even the low percentage of government health care spending as a proportion of GDP that does exist in Guatemala (6.7%) is wielded more by larger pharmaceutical companies, than the needs of the population, whose out of pocket spending on medicine is nearly 63% with the poorest quintiles as high as 70% (CIA World Factbook, 2012).

Conclusion

There are a number of forces, both opposing and collaborative, that define health and health care in Guatemala. Rather than sickness and need, society, politics, and the economy are far more accurate indicators of whether or not an individual can access adequate health care, which in turn are directly tied to an individual's ethnicity. The Guatemalan health care system is not one that reflects an emphasis on the availability, accessibility, acceptability, or quality of care for indigenous Guatemalans. Medicines, for example, are generally not available at all in rural locations where the indigenous reside. Health care tends to not be accessible geographically or economically for their communities. Health care providers are usually unfamiliar with

the indigenous dialects or their traditional health practices, which effects the cultural acceptability of the healthcare they provide. Finally, the quality of care that indigenous Guatemalans receive in rural locations is typically low due to the lack of proper personnel and equipment available. Although the government has made some efforts to remedy the stark disparities between ethnic groups in relation to health care access, those inequities still remain.

Field Work: In-depth Interviews (IDIs)

Methods for Data Collection and Analysis

Introduction

This chapter describes the study design, study participants, as well as data analysis methods used in the data collection portion of the study. First, the choice of qualitative in-depth interviews (IDIs) as well as the location choice for data collection will be explained. Secondly, the methods for purposive and snowball sampling are discussed. The elements of the study instrument are then described and explained. Finally, the analysis process of data obtained using these methods is established.

Study Design

A qualitative study design using three (n=3) in-depth interviews (IDIs) with key informants was chosen for data collection in order to gain more thorough and contextual data on the topic of the human right to health for indigenous individuals in Guatemala. As this topic has not been previously studied through the direct perspective of indigenous Guatemalans, there was an uncertainty to the themes and commonalities that may arise during the IDIs. For these reasons, a qualitative IDI proved to be ideal for obtaining rich, contextual information on the topic. Also, due to the sensitive and highly personal nature of the topic, IDIs, instead of focus groups, were conducted in semi-private locations so as to ensure confidentiality.

Location

Data collection occurred during the months of June and July of 2014 in San Juan La Laguna and San Pablo La Laguna, Sololá, Guatemala. In order to obtain data about the experiences of indigenous Guatemalans currently living in rural Guatemala, it was important to also conduct the study in a rural locale. Two small rural towns located in the Department of Sololá, Guatemala were used as the sampling frame for the study. The towns chosen for the study were selected due to their large indigenous populations - the reported percentage of indigenous was 99% for both villages (INE, 2012).

San Juan La Laguna, although rural, has historically been a site of tourist day trips as well as previous anthropologic research studies that focused on its high number of artisans and artisanal work (Wethey, 2005). In recent years, the town has begun to house a very small expatriate population and is also located only 20 minutes from a much-larger tourist destination, San Pedro La Laguna (Giralt, 2012). These characteristics provided an environment where outsiders (i.e. non-Guatemalans) were fairly common to locals. This allowed for the principal investigator to live and work with the townspeople without her presence coming as a shock or surprise. The second town, San Pablo La Laguna, had very little interaction with outsiders, and was also a much more rural, isolated location. However, the Organization for the Indigenous Maya (ODIM) clinic, which served as a gatekeeper for study participants, had locations in both San Juan and San Pablo, opening both areas up to be studied. In this way, the principal investigator was able to access both communities for study purposes.

Sampling

The selection of study participants was carried out using both purposive and snowball sampling techniques while utilizing community gatekeepers. The participants were chosen based on their self-identified ethnicity (indigenous Guatemalan) and the location in which they were born (either San Juan La Laguna or San Pablo La Laguna). Children were not included in the study due to the mature nature of the study question, as well as Institutional Review Board (IRB) considerations. The ODIM clinic served as a gatekeeper for two of the three participants (n=2) due to its involvement with, access to, and acceptance in the communities, as well as its mostly indigenous staff. Participants were selected based on their standing and involvement in the community, their basic proficiency in spoken Spanish, and their ability to provide highly contextual information in regards to the study questions. Sample size was limited due to time constraints as well as language barriers.

Instrument Design

The study instrument, an in-depth interview guide, was developed by the principal investigator with aid from her study committee. The guide, found in Spanish in Appendix I, included an introduction and description of the study, a basic summary of content to be discussed during the interview, a prompt for verbal authorization of the study participants participation and consent of recording, followed by the interview questions. An introductory section on the participant's self-identified ethnic

identity and demographic information began the in-depth interview. Questions on the participant's family were also used to make the participant feel more comfortable and relaxed in their role as an interviewee since many had never been interviewed in the past. This section was also used to gather further demographic information as well as begin discussion on familial bases to ethnicity. The subsequent section focused on abstracting information about the individual's general experience as an indigenous person living in Guatemala. Experiences that the individuals had with *ladinos* were also discussed in order to bring to light themes of race relations currently being experienced in Guatemala, in the variety of environments in which they may have occurred. Questions included in this section were also aimed at identifying potential links between geography (urban/rural) and ethnicity.

The next section of the in-depth interview guide focused on health norms and services. Of particular focus were potential differences between health services sought and curative practices utilized by *ladinos* or indigenous Guatemalans. Differences in relative access to health care between ethnic groups was also directly asked, as well as where this difference, if any, may have stemmed from. The final question in the interview allowed for any information not directly asked for to be discussed. Finally, the interviewee was thanked for their time and participation.

Ethical Considerations

In May of 2014, the study objectives, design, and justification were submitted to the Emory University IRB and the study was found to be "exempt" from further IRB review. According to the board, the study did not "meet the definition of 'research'

with human subjects as set forth by Emory policies and procedures and federal rules". However, the study protocol set out in the IRB application was still followed requiring verbal consent for participation in interviews, and the use of only first names during the interview process to protect the identity of the respondents. The principal investigator conducted and transcribed all interviews in order to minimize potential breaches of confidentiality.

Data Storage and Analysis

All in-depth interview recordings were stored in the password-protected mobile phone of the principal investigator, and the titles under which the recordings were saved were given a code of one letter and one number rather than the participants' name to ensure confidentiality. All notes made during the IDIs were kept in a personal folder and stored in the principal investigator's personal notebook throughout and after data collection. These data were then transcribed in Spanish by the principal investigator and stored in a password-locked computer, under the same titles as their corresponding recordings. These IDIs were only translated into English as needed for in-text quotations.

In order to assist with reading and abstraction, transcribed data were imported and analyzed using MAXQDA11, a qualitative software package (VERBI software, Berlin, Germany). IDIs were individually analyzed for thematic content, during which codes were chosen to represent those themes.

Limitations

The study design and methods were limited due to a number of factors which should be considered when reviewing the conclusions for this section of the paper. These limitations related to cultural barriers and sample size. First, due to the large indigenous population in both San Juan and San Pablo, the sampling frame was greatly reduced to individuals who felt comfortable being interviewed in their non-native language, Spanish. Similarly, because the principal investigator was not from the location of data collection, other possible respondents may have not felt comfortable talking with someone outside of their culture about this potentially sensitive topic. A final cultural barrier was defined by the traditional gender roles that are prevalent country-wide, particularly in rural areas such as the locations of data collection. As the principal investigator was a woman, when conducting interviews with male respondents, the location and environment of those interviews had to be chosen purposively. Because the communities of San Juan and San Pablo are very close-knit, if a male was seen with another female, regardless of age, it may be assumed that those individuals are romantically involved. Therefore, interviews had to be conducted in public, yet professional locations. These cultural norms may have also been a barrier for other men to assent to interviews with a female interviewer. These cultural ambiances would not have been apparent if the principal investigator did not spend substantial time interacting, working, and living with community members during the time they spent in San Juan and San Pablo.

Another limitation to data collection was time. Knowing the importance of building rapport with study participants and the community at large, the principal

investigator was quite limited in regards to time available for data collection and assimilation. This resulted in a much smaller number of interviews (n=3) than originally planned. However, data obtained were still highly valuable and rich.

Due to these limitations, the conclusions found are somewhat narrow in comparison to a larger study that includes numerous interviews with both *ladino* and indigenous Guatemalans.

In order for the principal investigator to minimize any potential gaps in information due to the limitations of data collection, an extensive literature review of the subject matter is also included in this report (see chapter 5). Although strictly academic works, literature provided a scholarly backdrop to better understand the personal perspectives of the interviewees.

Although many limitations did exist, data collected were instrumental in obtaining an in-depth, personal view of the socioeconomic disparities to access to quality health care currently faced by indigenous individuals in rural Guatemala. In this way, a more in-depth discussion of indigenous access to health care was achieved.

Conclusion

By utilizing a qualitative, in-depth interview study design, the personal perspectives, reflections, and thoughts of indigenous Guatemalans living in rural locations were collected following the use of gatekeepers and snowball sampling for participant recruitment. Throughout data collection and analysis, the interviews remained confidential and were accessed only by the principal investigator for utilization for this study. Data were analyzed based on common themes discussed

during in-depth interviews using a qualitative software package. Although some limitations were acknowledged, data obtained were invaluable to the study objectives.

Results

During analysis of the in-depth interviews (IDIs), codes were selected deductively based on the AAAQ Framework for the right to health described in General Comment 14 of the CESCR (CESCR, 2000; Potts, 2008), as well as on themes that emerged during data induction. A total of 15 original codes were selected, with one code having three subcodes. After all interviews were analyzed, code importance was determined based on number of interviews sharing that theme and amount of segments extracted per code, these results are found in Table 2. The initial analysis resulted in 11 coded/sub-coded themes found in all three interviews, seven found in two interviews. No codes were present in only one interview. The number of segments was used to indicate the extent to which those topics were discussed throughout the interviews, establishing their importance to the participants. A total of 246 segments were coded, with 38 segments overlapping in theme (i.e. different codes for the same segment). The distribution of those segments according to their corresponding codes/sub codes is found in Table 2 below.

Table 2: *Codes and Subcodes, the Number of Interviews in which they Appear and the Justification for their Inclusion in the Analysis*

Code	Subcode	Number of Interviews in which it appears (n=3)	Total number of segments per code/subcode	Justification
Indigenous Rights		3	7	To Establish Background
Politics (general)		2	7	*Emergent Theme
Health and Health Care (general)		3	14	To Establish Background
Racism		3	19	AAAQ Framework
Indigenous-*Ladino* Relations		3	21	To Establish Background
Indigenous Cultural Differences		3	24	To Establish Background
Ladino Cultural Differences		2	11	To Establish Background
Other Noted Differences between groups		3	17	To Establish Background
Accessibility		3	38	AAAQ Framework
	Physical Accessibility	2	10	AAAQ Framework
	Economic Accessibility	3	25	AAAQ Framework
	Language Accessibility	2	3	AAAQ Framework
Availability		3	12	AAAQ Framework
Cultural Acceptability		3	4	AAAQ Framework
Quality of Care		3	15	AAAQ Framework
Politics in Health		3	8	*Emergent Theme

Preference for Provider (traditional or biomedical)		2	5	To Establish Background
Race Identification and Discussion		2	6	To Establish Background

*"Emergent Theme" refers to a theme that became evident during the interviews themselves, as well as during their transcription, which was not based on international human rights documents

In Table 2, the column entitled "justification" provides corroboration for the code's presence in analysis and links the field work with information acquired during the literature review. General discussion and background of the issues (ex. indigenous rights, health and health care, etc.) were included to understand more about what was discussed during the interviews, and were used as context for the thematic coding. "Emergent theme" refers to codes that arose organically during the analysis stage of the study, and were not originally based on review of the literature. The most pertinent of these was that of Politics in Healthcare, which will be discussed in the following section. Finally, while there were eight codes that related directly to the AAAQ Framework, this framework was not discussed prior to or during the interview with the participants but emerged naturally during the discussion. This relates directly to the fundamental and universal nature of human rights, particularly the right to health.

Accessibility

All participants discussed the lack of accessibility to health care services as a barrier for indigenous populations in Guatemala. For general illnesses, the interviewees commented on how most people in their communities, as well as the

poor and indigenous, would typically seek care at the health center in the community center. However, when arriving at the center, they would usually have a consultation with a nurse because no doctors were present. The participants noted intuitively the substantial difference between receiving care from a nurse instead of a doctor, the former being highly inadequate for their health care needs. The nurse would consult with them on their symptoms, and then send them to the pharmacy with a prescription for medication. Because diagnostic equipment and medicine are infrequently available, this would be the extent of the health care service available to a community member.

> *"When one goes to the health center, well, the only thing they do is check you [and give] a prescription...the clinic, the health center neither help because you also have to buy your medicine and the truth is that the medicine is expensive."* (Participant C)

The participants went on to explain that the best clinics and hospitals are in the capital, Guatemala City, which, when buses are available, is an over 4 hour "chicken bus" ride. "Chicken buses" are wildly refurbished US school buses that are typically over-crowded and unsafe, but also the only means of transportation for most Guatemalans. One participant further explained that those that are very rich may even bypass the Guatemalan health system all together and fly to other countries to receive diagnostic and curative health care services, such as the United States, Mexico or even Europe.

Economic accessibility was identified as the most significant determinant for health care access for indigenous Guatemalans by all participants:

> *"The one who pays has the right, and the one who doesn't pay, doesn't have the right to health."* (Participant A)

Linking this theme back to physical accessibility, the participants commented that many times, if the gravely infirm were sent to a hospital for care, they would not receive it unless they paid some amount to the doctor or individual attending them. If one did not have the money to pay, many times, depending on the whim of the doctor, they would just have to wait - regardless of the gravity of their illness. This type of bribing was mentioned by all participants as the primary way one could ensure he or she was cared for. All participants mentioned instances where the infirm would die because they were not attended to in time, even if they arrived via ambulance. These narratives speak to the desperate need for the realization of the right to health in Guatemala where the only way that the indigenous people feel they can receive the health care that they innately deserve is to bribe health care providers.

Also discussed was the inability for indigenous Guatemalans to buy health insurance, due to its high cost. One participant referred to the hospitals as large companies:

> *"Everything is commerce/trade. The best hospitals...manage large capital. Because they have insurance, exactly because of that…. So, since an indigenous [person] can't pay for insurance, well he doesn't get [health care]. [The indigenous] just have to settle for the public services. And if those aren't good enough, well, that's that."* (Participant B)

While participants did not identify race in and of itself as a barrier to access, all participants did talk about the economic disparity experienced by the indigenous in comparison with the resources available to *ladino* populations.

> *"Here in Guatemala, well, unfortunately in all of the countries in Latin America, the people who have money are not the ones that are originally from here, they aren't indigenous. They are people that are European descendants, the majority."* (Participant B)

They noted that while some *ladinos* also suffered from low economic resources, the majority of those that were affected by economic barriers in access to healthcare were indigenous.

> *"Yes, a ladino has the resources to go to a private clinic, but an indigenous [person] can't go to a private clinic because of the high cost that the doctors have there." (Participant, male, age 27)*

While participants did not specifically discuss language as a barrier in health care settings, they did reflect on language as an impediment to receiving services in general as well as a source of racism and misunderstanding. When attending university, one participant described the attitude of some of his *ladino* classmates and teachers as dismissive of those that struggled with the Spanish language, exclaiming:

> *"" It's that I don't understand what you're saying! I don't understand you! It's better to just no longer take you into consideration. I'll do everything, you can just look at me, because I know. Because I know how to express myself. "* (Participant B)

One participant described bullying in schools by *ladino's* as an issue for indigenous children, as well as self-segregation of both ethnic groups in middle and higher education. *Ladino*'s were consistently described as having more job prospects, better treatment and acknowledgement by the government, greater educational opportunities, as well as more economic resources than indigenous Guatemalans.

Availability

The availability of healthcare goods is a major issue in rural Guatemala, according to participants. While community pharmacies and stores at least typically

have very basic medical supplies, specialized medicines and treatments are generally unavailable. Community health centers tend to have an even smaller medical supply than local pharmacies, with a much more unpredictable restocking schedule. One participant expressed considerable exasperation of the inability of the government to provide medicine for its citizens. They instead simply pocket this money or put it towards military or security actions, according to the participant.

As discussed in the following section on quality of care, the viability of the health care system is further threatened by the lack of faith the Guatemalan people have that the doctors and nurses they see have their best interests in mind. Instead, the people are afraid to seek care because they are worried they will be taken advantage of.

Quality of Care

The theme of quality of care arose in all interviews, particularly regarding the low level of care available to indigenous Guatemalans in the participants' communities and throughout Guatemala. This theme related directly to accessibility in so that while higher quality of care exists in Guatemala, it is generally only found in the capital city. Most employees of community health centers are nursing assistants, some professional nurses, and community health educators. Doctors are very seldom present, if at all.

Participants noted that the quality of care given at health centers, as well as the more expensive private clinics and hospitals in the capital, is greatly in need of improvement. Frequently, individuals choose not to go to these facilities because they

are afraid that the doctors will chastise them for their health condition or merely take their money and send them away without proper care. This fear leads rural Guatemalans to simply diagnose and treat themselves with medicine from local pharmacies or stores, avoiding the health care system all together.

Politics in Health Care

Although not found in a review of the literature, the role of politics emerged as a significant obstacle in access to healthcare for indigenous Guatemalans. Each participant spent substantial time explaining how deeply politics is embedded in health care services throughout Guatemala. An example given by the participants was that a municipal mayor's political party affiliation greatly determines the amount of government help that the communities within that municipality receive. If a mayor's party is the same as that of the president when he/she is elected, the community itself has a better chance of receiving funding for public services, including health and education. However, if the mayor is not a member of the same party, the people will get much fewer services, if any at all. Those employed at the health centers and health posts are also there due to their political affiliation, not necessarily their skill or their familiarity with the communities they serve. Each time a new president is elected, almost all of the health care personnel working at a given location are fired and an entirely new staff is brought in. The few indigenous staff employed frequently comes from an area where a different indigenous language is spoken. This further complicates the already inadequate health care system and speaks to the need for

permanent indigenous health care providers in the public sector in locations in which they speak the language.

During political campaigns and throughout their terms, presidents and their constituents continually speak of the importance of health and how much they will or are providing for their citizens. However, according to the participants, this is as far as real healthcare services reach. Communities continue to suffer due to lack of adequate care, and individuals remain sick with preventable illnesses specifically those living in rural, indigenous communities.

Although many of the themes that arose from the interviews were directly applicable to the ICESCR General Comment 14 AAAQ Framework, the participants also discussed themes not related to those criteria that they believed affected indigenous individual's ability to access health care. Much like the literature suggests, the participants described a profound disparity in access to health care between the *ladino* and indigenous populations in Guatemala. Although the AAAQ Framework was not specifically the topic of the interviews, many of its components were discussed by the participants, namely: accessibility (physical, economic, and language), availability, and quality of care. These all proved to be inadequate for the indigenous people.

Interestingly, the cultural and medical acceptability of the health care provided did not appear to be nearly as important for the participants. Although the literature takes note that traditional medical practices are not formally acknowledged in the health care system in Guatemala, the participants, while explaining its importance, did not identify this as a barrier to receiving health care. When asked their preferred form of care (traditional or biomedical), they replied that while they wished they knew

more about the traditional medicines of their forefathers and mothers, they took personal blame for that lack. The participants went on to say that the prescribing of non-natural medicines was just a reflection of the advancement and globalization of society and that most Guatemalans - indigenous and *ladino's* alike - preferred medicines you could buy in the pharmacies and stores.

Another noteworthy divergence from the literature was the lack of discussion on language as a barrier to receiving care for indigenous peoples. While language was acknowledged in daily life and in educational institutions as an obstacle, it was not explicitly discussed in regards to health care access by the participants. Although the participants did state that the majority of the care providers in the health centers were *ladino*, they did not address the fact that this could represent a hindrance to proper healthcare for indigenous people.

Not unlike the literature on access to health care and indigenous rights in Guatemala, the respondents spoke with particular emotion about the consistent failure of the government to provide for the indigenous people. They cited numerous "health programs" initiated by the government for the indigenous people that quickly became obvious were simply a way of channeling more money into the State. While pledging to improve the lives of the rural and impoverished, the government is instead investing in, to quote a participant, "making the rich, more rich; and the poor, poorer" (Participant A).

Conclusion

Although data were slightly limited, participants still created a clear overall picture of the issues in access to health care faced by indigenous Guatemalans today. Through the coding of transcribed interviews, these data could be adequately analyzed. Themes innately followed the all-encompassing criteria described in the right to health AAAQ Framework in their focus on the accessibility, availability, and quality of health care facilities, goods and services. This compliance with that set of standards reflects the highly unanimous nature of the right to health doctrine as well as its applicability to the needs of Guatemala. Participants spoke further on the theme of the role of politics in health care, a subject not adequately addressed by the literature. The topics discussed further emphasized the critical need for the effective realization of the right to health for indigenous communities in Guatemala and the long-standing issues its absence has had on the people.

Discussion

With the historical background provided in the literature review coupled with the data obtained, it is clear that indigenous individuals in Guatemala have very serious and complex barriers to accessing health care services. These barriers stem from the long-standing discrimination and oppression their communities have experienced throughout history. This prejudice extends to the present as they are systematically excluded from adequate health care services as well as decision-making regarding their care. This has directly has affected all aspects of health and healthcare access for indigenous Guatemalans, resulting in long-standing inequalities in health outcomes for the people.

Health care services are not accessible in the locations in which the majority of indigenous groups live, areas where they may have been forced to live during the Spanish Conquest to work on the *encomiendas*. The services are also economically inaccessible because the majority of indigenous individuals live well below the poverty line, and bribing was noted as the only reliable way that one could ensure they received care in both the public and private sectors. Medicines and doctors are also absent from these locations due to the government's failure to provide for its people, as well as the refusal of many *ladino* health care professionals to provide care in rural locations. Indigenous patients are then forced to purchase medicines at local pharmacies, which can also be costly. For low-resource individuals, paying extra money first just to be seen and then for their medicine may be completely impossible and indigenous people will instead wait to receive care until their health issues have

been exasperated. The refusal of the doctors to work in rural locations may stem from nation-wide prejudice against indigenous people, lack of incentives by the government, as well as the providers inability to communicate in the rural dialects spoken in those areas.

The quality of care provided at health care facilities in rural, indigenous communities is restricted by the lack of functional health care equipment as well as by the absence of high-level health care providers. Community members are therefore unable to receive even the most basic health care services and diagnosing their illness is largely unachievable. This lack of proper health care ties directly into the unequally poor health outcomes of indigenous people in Guatemala compared to their *ladino* counterparts.

The first-hand accounts of these disparities obtained through IDIs intuitively follow the AAAQ right to health Framework described in the International Convention on Economic, Social and Cultural Rights, speaking to the fundamental and universal nature of this right. However, even with this obvious ubiquitous nature, the indigenous of Guatemala still have not fully experienced them. Even without the use of the right to health Framework to strengthen their calls, participants cry for their realization, citing countless anecdotes on the severity of the health situation for the indigenous in Guatemala.

Recommendations for Further Research and Action

After an extensive review of the literature and thorough analysis of the data, a number of recommendations have become clear to address the significant disparities experienced by indigenous Guatemalans to accessing adequate health care facilities, services and goods.

Further Research

Due to the limitations of the data, first steps in addressing the issues discussed include expanding the study to include in-depth interviews with both indigenous and *ladino* Guatemalans. This would provide a more comprehensive view of the health access issues faced by all Guatemalans, rather than just the indigenous, as well as a better understanding of the disparities between groups. In the indigenous study population, interpreters could be used to extend the sampling population to individuals not proficient in Spanish as these groups tend to be in the most rural and secluded locations. It would also be necessary to then expand the location of data collection to include indigenous and *ladino* communities in multiple departments in Guatemala and assess the potential differences experienced by Guatemalans closer and farther away from the metropolitan centers.

For a future study, it is recommended that at least 6 interviews be conducted of members of each group to obtain a more well-rounded representation of access to healthcare issues faced by indigenous Guatemalans. To inform the recommendations

section of the research, the scope of all interviews could be expanded to include questions about what the participants see as the most effective way to address health care access disparities from their perspective, and the reasons behind those answers. Examples of these direct questions include: “In what way(s) do you believe the government or Ministry of Health could improve access to healthcare for the indigenous people?”, or “If you were the president or Minister of Health, what would you do to improve access to healthcare for indigenous communities?” Since these themes arose organically in this study’s IDIs, further research could include interview guides with specific AAAQ Framework and right to health theme saturation to obtain a more in-depth view of exactly what the indigenous health care system lacks of these standards.

Due to its emergence as a primary theme in the data, of particular importance is further research on the role of politics in healthcare and its effect on the elements of the AAAQ Framework. If this theme was expounded, interviews would also be needed with health center employees as well as Ministry of Health officials to get an in-depth look at the function and impact of politics on health and healthcare viability.

Action

As the literature has indicated, the government of Guatemala has a plethora of ratified international treaties and conventions, is a part of all possible global and regional human rights organizations, and contains multiple government entities specifically devoted - on paper - to human rights, the right to health, and indigenous

rights. However, even with this enormous amount of documentation, the right to health for indigenous people is far from being realized. Widespread discrimination against the indigenous is a national phenomenon led by the State, and exasperated by a fragmented, urban-centered public healthcare system. The majority of the organizations created to address those issues have little to no State funding and therefore no power to enact the changes that indigenous Guatemalans deserve. Corrupt politics are so deeply ingrained in all State action, that the health of the people continuously suffers.

A national public health policy specifically for vulnerable and marginalized groups is one of the core obligations of the right to health (CESCR, 2000). While the Guatemalan government does recognize that indigenous populations fall into this category, they have yet to develop a strategy to specifically address their health care needs (Isaacs, 2010; MINUGUA, 1994).

Therefore, the government of Guatemala, with aid from the international community, must formulate a National Plan of Action specifically addressing indigenous health care disparities throughout the country. The Plan must be developed by primarily indigenous representatives and all individuals must have little to no political party affiliation. This would ensure that the strategic aims of the plan will not be clouded by corrupt government bodies or favor-giving among constituents. The Plan should directly follow the criteria for health facilities goods and services outlined in the AAAQ Framework and right to health legislation. Each aspect of the Plan will only be included if it a) can be justified using the aforementioned right to

health principles and b) directly seeks to improve indigenous health disparities throughout the country, particularly in rural areas.

A number of nation-wide programs are of particular importance and must be included in this Plan of Action. First, permanent, indigenous, and high-level health care personnel must be employed in all health care facilities, particularly in rural areas. In order to train these individuals, the government must provide scholarships to high-ranking medical universities in Guatemala particularly for rural, indigenous students. These scholarships would need to include all education fees including, but not limited to, tuition, books, transportation, and room and board in the university cities. It would be preferable if a stipend was also given to families of indigenous medical students so that their absence would not negatively affect the households from which they come. In order to address the need for rural health professionals more immediately, non-indigenous providers should be appropriately incentivized by the government to work in rural locations while the indigenous students receive their schooling. In this way, quality of care may be improved while adequate health care is made available to more Guatemalans.

Secondly, health care providers in rural locations will be required to speak the local dialect of the community they serve, as well as have some training in the traditional medical practices of those people. Those employed in these locations will be assigned, not based on political affiliation, but on their ability to provide high-level care to the individuals living there. Political party affiliation, of those employed or of the municipal government, will have nothing to do with health facility employment.

Health care provider terms will not coincide with political elections, but instead be determined based on the individuals performance and treatment of their patients.

Thirdly, the Plan of Action must include a provision for the lack of medicines and medical equipment in rural locations. Both should always be available and up-to-date, regardless of location. In the instance that a particular medicine is not available, the government should subsidize the cost of that treatment for the patient, therefore reducing the economic burden on that individual and encouraging them to seek care. Also, any form of bribing or external payment to health professionals will not be allowed, and providers accepting those will be fined. This would again reduce the economic inaccessibility of health care for the indigenous, and improve trust between provider and patient.

The above three elements are only a small, but imperative, parts of the greater Plan to reduce health care disparities of indigenous Guatemalans. Although this National Plan of Action cannot eliminate the widespread discrimination and decades of oppression experienced by indigenous Guatemalans, it will fight to improve their general well-being and health, therefore increasing indigenous quality of life.

Conclusion

With aid from further research in indigenous health disparities, as well as the development of a concrete Plan of Action to reduce those inequities, the historically low health outcomes for indigenous individuals can be improved. With better health outcomes and strong healthcare support, the indigenous population will be able to rise above prejudice and society as a whole can begin to repair.

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Appendix I: In-Depth Interview Guide

Entrevista Con Miembros de la Comunidad

Titulo de estudio: The Implications of the Past on the Present: Ethnicity and Health Care Access in Rural Guatemala
Investigadora Principal: Christina Renquist, Rollins School of Public Health, Hubert Humphrey Department of Global Health

Fecha:
Lugar:

Preámbulo de la entrevista:

Hola, yo soy Christina Renquist y soy un estudiante de la maestría de salud pública en la Universidad de Emory en Atlanta, Georgia. Estoy aquí con usted para hacer una pequeña entrevista sobre los derechos de salud que tienen las personas indígenas y ladinas en esta área y también hablar sobre la historia de relaciones entre *los ladinos* y las personas indígenas acá en Guatemala por medio de su experiencia. La entrevista es completamente confidencial, así que no vamos a usar nombres ni datos personales y solo voy a usar que usted diga por el uso de mi tesis y mi investigación. ¿Para qué no olvido una cosa que usted dice, está bien para grabar la entrevista con mi celular? Gracias.

Entonces, para tenerlo grabado, ¿puedo contar con su voluntad para hacer esta entrevista?
Gracias.

Por primer, voy a empezar con preguntas demográficas.

¿De dónde es usted?

¿Y dónde vive?

¿Para tenerlo grabado, usted me puede decir tu género?

¿Y cuántos años tiene usted?

¿Está casado? ¿Si si, por cuantos años?

¿Tiene hijos? ¿Cuantos y de que edades?

¿Y dónde viven ellos/ellas?

¿Identifica usted como persona indígena, *ladino*, mezclado, u otro? Explica por favor.

¿Porque identifica en esta forma?

¿Tiene personas del otro grupo que no identifiques en su familia?
Si sí, ¿porque se identifican así?

En su comunidad, ¿dónde vive actualmente, la mayoría de la gente son indígena o *ladino* u otro?

Si ha encontrado personas del otro grupo, ¿cómo eran los encuentros que ha tenido usted con estas personas?

¿Me pueden contar unas historias destacadas con ellos si ha tenido unas?

¿Cómo es la historia de las relaciones entre los personas de ambos grupos en este área?

En Guatemala en general, ¿hay una diferencia económicamente o socialmente entre las personas indígenas y los personas *ladinos*?

Si sí, ¿cómo aparece esta diferencia en la vida diaria de una persona en esta área?

¿Hay lugares en Guatemala donde viven más personas de uno de los grupos específicos?

<u>Servicios y Normas de Salud</u>
Ahora vamos a hablar sobre estos dos grupos, *ladino* e indígena, con relación a los servicios de salud y las normas que hay en relación a este tema.

En cuanto a la salud, cuando usted o un miembro de su familia se queda enfermo, ¿a dónde o a quienes vaya usted primero?
¿Porque?

¿Prefiere usted las medicinas naturales/tradicionales o las medicinas artificiales (los que compra en una farmacia o clínica)? ¿Porque?

¿Son efectivos los métodos que usted utiliza?

¿Que son las ventajas y desventajas de irse a la clínica o consultar con un curandero tradicional?

En general, ¿a dónde vayan las personas indígenas para curarse?

¿A dónde vayan, generalmente, las personas ladinas para curarse?

¿De qué grupo socio-cultural vienen las personas que trabajan en las clínicas públicas (o sea los del gobierno)?

En su experiencia, ¿hay una diferencia al acceso de salud entre las personas indígenas o las personas ladinas?

¿De dónde viene esta diferencia?

Para terminar, ¿hay algo más que usted me quiere contar sobre la diferencia entre las personas indígenas y las personas ladinas que no ha mencionado todavía?

Gracias muchísimo por todo su participación y colaboración en esta entrevista. La Información que usted me proporcionado será muy útil en mi investigación y mis estudios. ¡Que tenga un buen día!