

Healthcare in Guatemala

Rebecca Dunn

Capstone Advisor: Lilian Baeza-Mendoza

General University Honors

Fall 2010

CONTENTS

- 1) Abstract (page 2)**
- 2) Country Overview in Relation to Healthcare (page 2)**
- 3) Overview of Healthcare System (page 5)**
- 4) Significant Problems within the Current System (page 9)**
 - a) Budget Issues**
 - b) Lack of input by healthcare officials**
 - c) Structural problems**
 - d) Exclusive Use of Western Medicine**
- 5) Health Concerns Particular to Guatemala (page 13)**
 - a) Women's Sexual Health**
 - b) Children's Health with a focus on Nutrition**
 - c) Obesity Prevention**
 - d) HIV/AIDS: Prevention and Treatment**
 - e) Counterfeit Medicine**
 - f) Disadvantaged Subpopulations**
- 6) Positive Steps Forward (page 25)**
- 7) Suggestions for the Future (page 25)**
- 8) Bibliography (page 31)**

ABSTRACT

The aim of this paper is to better understand the Guatemalan healthcare system currently in place. This will be done by considering the history of Guatemalan healthcare, the structure of the current system, and the major challenges with which this system has been presented. Detailed focus will be placed on these challenges and the various health issues specific to Guatemala. In regards to this discussion, subpopulations will be considered which have been disproportionately affected by these problems. Finally I will offer my own suggestions as to other possible improvements or initiatives that I believe would benefit the overall health of Guatemalan citizens.¹

COUNTRY OVERVIEW IN RELATION TO HEALTHCARE

Guatemala is located in the heart of Central America, bordered on the north by Mexico, on the east by Belize, and on the south by both Honduras and El Salvador. Guatemala is also bordered by two large bodies of water: the North Pacific Ocean and the Gulf of Honduras (i.e. the Caribbean Sea). The size of the country is rather small (about a hundredth of the size of the United States), but this is in no way representative of its diversity; Guatemala contains jungle, beach, mountains, plains, and forest (CIA, 2010). Although beautiful in scenery, the rugged terrain in some areas renders it difficult to build or maintain infrastructure. Outside of well-populated areas many roads are in extremely bad conditions and can be shut down for days

¹ Although the majority of this paper has been formulated through research, I have also drawn upon my own experiences in Guatemala as well. I lived in the surrounding area of Antigua, Guatemala from May 2010 through August 2010 while volunteering in the area at an HIV/AIDS clinic (Hospicio de San Jose), a hospital (Asociación de Obras Sociales de Santo Hermano Pedro), and a school (Asociación EducArte). It should be assumed that if an assertion is made without citation it is based on my own observations and opinions.

after a natural disaster. This creates a huge obstacle in transporting people to medical facilities or medical equipment and personnel to areas of need.

Many areas of the country have proven to be very fertile, and consequently agriculture makes up a large part of Guatemala's economy (15% of GDP and half of the labor force).

Guatemalan agricultural exports are typical of Central America: including coffee, sugar, and bananas (CIA, 2010). Consequently, much of the population works in rural areas, providing the physical labor necessary for agricultural production. Because this population is also notoriously underpaid they are of specific interest in regards to health concerns.

Although the Guatemalan economy has struggled because of political instability and violence within its borders, it has made great strides in recent years (particularly with the 1996 Peace Accords, which ended the 34 year Guatemalan Civil War). Even more recently (July 2006), the Central American Free Trade Agreement (CAFTA) was created between the majority of Central American countries and the U.S. This agreement's official intent is to increase investment in Central America and diversify the exports from these areas, although this measure is far from unanimously supported by North or Central Americans (Fort and Mercer and Gish, 2004). . Another fundamental element of the national economy is the large amount of foreign aid which Guatemala receives. Perhaps due in part to the large expatriate community in Guatemala, the country receives the most U.S. remittance of all Central American countries. In fact, this funding is equal to almost two-thirds of Guatemala's exports (CIA, 2010). Despite this aid² and forward strides made by the government since the Civil War, much

² Guatemala receives aid from countries other than the U.S. as well.

economic reform and progress will be needed if the state is to create and maintain a health care system that is able to support all Guatemalans.

When discussing Guatemala's economic state it is essential to discuss the overwhelmingly unbalanced distribution of wealth within the country. This imbalance has left the country with a huge percentage living below the poverty line and a very small group controlling essentially the entire wealth of the country³. Many Guatemalans lament this absence of a middle class; although it is an exaggeration to say a middle class does not exist, compared to the middle class presence in more developed countries (such as the United States) the Guatemalan equivalent is rather scarce (CIA, 2010). This imbalance of wealth has long been blamed for the corruption and lack of development within Guatemala. This corruption, in turn, has led to a lack of creation and funding of state-headed health initiatives.

Another important aspect of Guatemalan society is its predominately catholic nature. Guatemala is a constitutional democratic republic, but many religious influences can be seen within the legal structure. This religious influence has affected health within the country in a variety of positive and negative ways. The examples are numerous but include the presence of church-funded and church-run health clinics, the discrimination towards gay and transgendered people, and the illegality of abortion.

As of the 2001 census, the population is primarily composed of mestizo people⁴ (59.4% of the total population) and various Mayans groups⁵. Although there are some who self-identify

³ The actual figures related to wealth distribution are striking: as of 2006 the top wealthiest 10% of Guatemalans control 42.4% of the country's wealth, over half of the population lives below the national poverty line (compared to the U.S. figure of 12%), and 15% of the citizens live in conditions considered to be extreme poverty.

⁴ This is a rather loose term and mainly accounts for all Guatemalans who do not self-identify as indigenous; it implies the mixture of European and indigenous blood.

as indigenous and are in powerful economical positions, poverty does disproportionately affect the indigenous community.⁶ As poverty and access to health care are also correlated, it is important to give special consideration to the indigenous population (Adams and Hawkins, 2007).

Although Spanish is the official language, approximately 40% of the population predominantly uses another Amerindian (indigenous) language. Now the majority of those who speak another language also speak Spanish⁷, but it is often with a distinct accent. Among both the mestizo and indigenous population illiteracy remains a problem⁸ (CIA, 2010). Both the low literacy rate and diversity in languages spoken create an obstacle to typical healthcare initiatives that have been used in the past. Therefore in some areas information needs to be communicated in ways other than written Spanish.

OVERVIEW OF HEALTHCARE SYSTEM

As is the case with many developing countries, Guatemalan's healthcare system leaves much to be desired. Most agree that the Guatemalan healthcare system is in major need of reform; what shape that reform takes, however, is a subject of much debate. Before discussing these various positions let us first take a look at the recent history, involving the healthcare system and its current implementation.

⁵ Mayans account for 40.3% of the total population; major Mayan groups within Guatemala include K'iche, Kaqchikel, Mam, and Q'eqchi.

⁶ Poverty among indigenous individuals averages 76% (compared to slightly above 50% among the general population), and the percentage of indigenous people living in extreme poverty is 28% (compared to slightly 15% among the general population).

⁷ This is specifically the case with younger people; some of the elderly indigenous people do not speak any Spanish.

⁸ In 2002 only 69.1% of the population was literate, with a notable difference among males and females (male: 75.4% literacy rate; female: 63.3% literacy rate).

In discussing the evolution of the healthcare system it seems most logical to use the Civil War (1960-1996) as a point of reference. Directly prior to the war some social reforms were developed and implemented to a very limited degree. This time period, from approximately 1944 to 1954 is often referred to as the “Springtime of Democracy” or the “Ten Years of Spring.” Although some success was seen, it was very short-lived. After the onset of the civil war (specifically in the 1960s and 1970s) social reforms suffered greatly: during this time only 1-2% of the total GDP was spent on the healthcare system. Although never formally privatized, the system became de facto privatized as a result of this government abandonment (CIA, 2010). When the Civil War ended (the signing of the Peace Accords of 1996 formally marked this event) there was initially a great deal of hope among the Guatemalan people. This agreement brought an end to the violence and seemed to be an opportunity to develop and implement greater social reform within the country. Unfortunately this did not occur (at least not to the degree which had been hoped for) within the healthcare sector. Some reforms were made at this time; in 1995 work began to create the SIAS (Sistema Integral de Atencion de Salud), which is a comprehensive healthcare system. Through this system, private organizations already in place within Guatemala were offered government contracts to treat people at a free or reduced price, and the loss in revenue was covered by government funding (Fort and Mercer and Gish, 2004). However, it was not until 1999 that there was a significant increase in overall government spending on healthcare; that year 4.3% of the total GDP went towards healthcare (Encyclopedia of the Nations, 2010). From 1999 to 2003 this percentage ranged from 4.7% to 5.5%: an improvement, but not nearly sufficient to support the health needs of the country (CIA, 2010).

Government spending and aid, although fundamental, does not explain the entirety of this system. Presently the Guatemalan healthcare system is divided into the following divisions: public, private nonprofit, and private for-profit (Encyclopedia of the Nations, 2010). During the initial stages of planning of the Guatemalan healthcare system the World Health Organization (referred to by its acronym, WHO, for the remainder of this paper) played a large role in advising government officials on how to best structure the system. More recently the World Bank and Inter-American Development Bank have had greater influence on the system.⁹ The World Bank favored increasing the private sector, which would receive support from the government (the size of the public sector would then be decreased). The World Bank also promoted a more market oriented system and was in favor of supporting this system, in part, through charging patients. The system would also be subsidized through consumer taxes¹⁰ (Fort and Mercer and Gish, 2004).

The public sector is run by the Ministerio de Salud Publica y Asistencia Social (referred to as the MSPAS for the remainder of this paper)¹¹. This government agency provides public healthcare services through facilities such as the National Hospital in Guatemala City. The mission of the MSPAS is to provide affordable, quality healthcare to all Guatemalan citizens. It also oversees and regulates healthcare provided by the other two private sectors (MSPAS, 2010).

⁹ At this point the World Bank made a noticeable shift and began investing in social services of many developing countries (not just Guatemala); this was an intelligent move on the World Bank's part because they were able to take advantage of government funding and improve the negative image they had acquired.

¹⁰ This method of subsidization has been criticized because consumer taxes do not discriminate between the wealthy and the poor (e.g. sales tax is the same percentage regardless of income), so all socioeconomic groups are contributing to the system equally even though they do not have equal amount of wealth.

¹¹ Other smaller, more specific departments provide care for individuals within the government, such as the armed forces, but the MSPAS is responsible for the public sector serving the general population.

Although monitored by the MSPAS, the private non-profit sector is not under direct control of this group. Health services offered by these facilities are often provided at a free or reduced cost. The hospital at which I volunteered at (Asociación de Obras Sociales de Santo Hermano Pedro) falls under the category of private non-profit. Patients were charged a fee, but this fee was determined based on a sliding scale and was reduced or waived depending on the patient's financial needs (WHO, 2010).

The private for-profit sector is not used by a large percentage of the population because it is financially out of reach for most. As of 2004, this sector consisted of approximately 1,100 organizations, all independent of the government. The private for-profit sector is relatively diverse, providing services through insurance programs, prepaid medical services, medical centers, and hospitals (WHO, 2010).

For the remainder of this paper I will primarily focus on the public sector and briefly the private non-profit sector (because of my volunteer work in such an institution). Obviously all three sectors could be improved (as is the case for the healthcare systems in most of the world), but private institutions are in much less need of reform because of the increased funds (from patient and insurance company payments) which they possess. Private institutions also inherently have more autonomy, as they should if they are operating independent of state funding¹². A case could most certainly be made for further supervision by the MSPAS of all healthcare institutions- including the private sector. If any reform is to come within these private facilities, it will most likely be specific to individual institutions. Reforms to public

¹² It is not always the case in Guatemala that these institutions operate without state funding, which complicates the matter (i.e. how much control or influence the state should have), but when they are funded by the state it is because they are meeting some sort of need that public facilities could not meet (through the contracts with the SIAS, discussed above).

facilities also have the potential to reach a greater number of Guatemalan citizens- specifically citizens of lesser economic ability; in fact, over 40% of the population does not have access to healthcare services (Encyclopedia of the nations, 2010). For all these reasons the public sector will be the area on which the most emphasis is placed.

SIGNIFICANT PROBLEMS WITHIN THE CURRENT STYSTEM

Budget Issues

There are a number of issues with the current healthcare system being implemented in Guatemala today. These can be generally categorized into problems regarding the structure of the system and problems in the exact implementation of the system. The most debilitating issue, as well as the most fundamental, is the lack of resources and funding available within the country. As is the case for any developing country, this is an obstacle for any social reform. Because of this the health needs of the majority of the population (who cannot afford privatized healthcare) have fell to organizations such as NGOs, charities, and churches (WHO, 2010).

In public health facilities there is an extreme lack of personnel, largely because the budget does not exist to pay more people the salaries of more employees. This understaffing already puts the public facilities at a disadvantage. Much of the time the doctors working within the public sector have the best of intentions (if this were not the case they would be working in the private sector and earning a higher salary), but because of the volume of patients and few number of doctors, they are often forced to rush examinations, which often leads to medical

mistakes. In terms of traveling doctors (who visit more rural communities), they essentially work as volunteers because pay only covers their travel costs (Fort and Mercer and Gish, 2004).

Lack of input by healthcare officials

Another major concern with the healthcare system in place is the lack of communication government officials had with healthcare professionals. Productive communication is key in any social service endeavor, and according to many of those working within the healthcare system, this was absent from the planning and execution of the healthcare system. Because those formulating the legal legislation to create the healthcare system are legislators- not doctors- they often have no knowledge of the actual situation and do not adequately incorporate the ideas of officials with that knowledge. This seems to have been the case in the creation of the Guatemalan healthcare system (Fort and Mercer and Gish, 2004).

Structural Problems

The current structure of the Guatemalan healthcare system already puts it at a significant disadvantage. The MSPAS is essentially responsible for the oversight of the system; a large part of their role includes the supervision of a multitude of private organizations. These organizations are very diverse and range from small to large, new to well-established, and offer services of an extremely broad range. Regulation of healthcare system is by nature one of the hardest areas to standardize. One must also ask to what degree it should be standardized anyways. Regardless, the large amount of small, private institutions create a system which is extremely difficult to regulate, which leaves the potential for lesser quality of care. The MSPAS

has also been described as a weak central authority. This isn't necessarily due to the fault of the institution, but rather the power granted to it by the government (Fort and Mercer and Gish, 2004).

Exclusive Use of Western Medicine

Another major reason for the failure of the Guatemalan healthcare system is the exclusive use of Westernized medicine. As mentioned above, poverty in Guatemala disproportionately affects the indigenous population, and those of a lower socioeconomic status are most affected by the public healthcare (those with greater means can afford privatized options). Public health initiatives today exclusively employ Western medicine, rejecting the ancient remedies and practices of curanderismo (traditional Mayan healing). This is unsurprising when looking at past actions against traditional practices of the Mayan people (in health and other realms of society¹³) (Adams and Hawkins, 2007).

Although many medical professions within country seem to be aware of the many benefits to naturalistic healing, they generally refute curanderismo's place in modern medicine. This was best highlighted by an anecdote in the text, *Healthcare in Maya Guatemala: Confronting Medical Pluralism in a Developing Country*, in which a doctor was fully aware of the benefits of a certain herb in relieving the symptoms of food poisoning, but would not advocate its use in a professional setting. Because Guatemala is far from a leader in the modern medical

¹³ Religious groups (such as Catholic Action and other evangelical groups) and other groups have worked to demonize practices of curanderismo and eliminate higher-level Mayan officials who employ these practices. More recently (1980s) the Guatemalan government banned the practice of curanderismo by traditional healers ; soon after they began providing programs which attempted to train traditional health providers (such as midwives) in Westernized medical practices. These programs were met with much resistance and ultimately did not result in success.

world, perhaps doctors feel they must make special effort to become more modern. Also, this concept of curanderismo is most common among Mayan populations, and Guatemala's indigenous population is less likely to have the means to attain a higher education (Adams and Hawkins, 2007).

The differences between typical care practiced by traditional healers and Western doctors are extreme. Western doctors are more likely to quickly diagnose a condition and prescribe a commercial drug. Traditional healers are more likely to talk with the patient extensively before suggesting a remedy. These healers are usually members of the community and thus know the patient better as well. In present-day Guatemala it is very common for an indigenous person (particularly those living in a rural area, where curanderismo is most found) to consult both a Western health professional as well as a traditional healer (Adams and Hawkins, 2007). There is nothing wrong with the mixing of these two forms of medicine; in fact, I feel that both fields could benefit from such a union. However, patients often do not disclose that they have sought help from both health providers. Depending on the prescribed remedies or medications, serious complications and dangerous drug interactions could occur.

The issue of incorporating curanderismo with Westernized medicine in public healthcare is absolutely essential. Without this integration, the confidence of a large portion of the Guatemalan population will be lost (or perhaps more accurately, never gained) and many effective medical measures will remain in obscurity.

HEALTH CONCERNS PARTICULAR TO GUATEMALA

Now that the structural problems have been discussed it seems useful to look at the particular health areas of need within Guatemala¹⁴. Once there exists an understanding of both the structural issues and health areas which require attention, productive suggestions regarding possible reform can be made. Thus the health concern in and of itself will be discussed, along with general strategies that could minimize the negative effects of these issues.

Women's Sexual Health

Despite the fact that the female population is an excellent group through which to convey information, they are often least exposed to health information. Women, as child bearers and often primary caretakers for children and sick adults, could benefit greatly from being exposed to a greater amount (and higher quality) of health-related information. However, because women typically spend a greater amount of time within the home they are often less exposed to information regarding both in-home suggestions (e.g. boiling water before drinking it) and out-of-home resources (e.g. public clinics). Even when women have the opportunity to be exposed to this kind of information the effort can still be thwarted by illiteracy. This is especially true in respect to the female population because in 2002 12.1% more women than men were illiterate (CIA, 2010).

When discussing women's sexual health in another country one must be aware of the general social norms of that country. Common attitudes towards sexual behavior are thus a

¹⁴ Obviously the health needs and specific areas of concerns of an entire nation are immense and could not all be discussed (let alone adequately) within the confines of a single paper. I have therefore chosen to highlight a few health topics which I feel currently afflict a significant percentage of the population. These topics have also been chosen because I feel they would be most beneficial to target and minimize (and hopefully eliminate in time) through future reform.

very important consideration. Therefore the study published in 2005 and conducted by Ali and Cleland helps to give a better understanding of typical sexual behavior of Guatemalan women. I do not wish to claim the results of this study accurately describe every Guatemalan woman, but the general trends seen in this study are useful in understanding the state of women's health in Guatemala.¹⁵ The most striking result was that of the eight Latin American countries studied (Bolivia, Brazil, Colombia, Dominican Republic, Guatemala, Nicaragua, Paraguay, and Peru) Guatemala was among the top three countries in which virginity was most prevalent, and it was the country in which women were least likely to engage in protected sexual activity (of those women who did use contraceptive, the majority use an oral contraceptive or condoms). A finding unique to Guatemala was that in the case of conceptions out of wedlock, over half of the couples quickly married or began cohabitation. This study notes that in countries such as Guatemala the trend of abstinence until marriage is declining, but the use of other forms of contraceptive is not increasing, thus leaving women more exposed to STIs and unwanted pregnancy than in past years¹⁶ (Ali and Cleland, 2004).

Given this lack of contraceptive use it would logically follow that many pregnancies are unwanted and women might be more likely to opt for an abortion (although legally abortion is only permitted if a mother's life is threatened by the pregnancy). This theory is supported in the 2006 research by Susan Singh, Elena Prada and Edgar Kestler which concluded that abortion is

¹⁵ To emphasize that this study is by no means comprehensive of the entire population I feel it necessary to give some background on the women interviewed: all of the women were aged 15 to 24 (54%: 15-19; 46%: 20-24), approximately half had never married, 31% had attended some secondary schooling (the remaining had not), and 21% were living in urban areas at the time thus a significant portion were from rural backgrounds).

¹⁶ It is important to note (and the study mentions this as well) that although the designers of the study were conscience of the bias of self-reported data (which they attempted to combat through the uses of female interviewers among other efforts), there is an increased risk of this bias given the great amount of emphasis on marianismo-like ideology (e.g. idealizing virginity among females) in traditional Latin American culture. It is very likely that the amount of unprotected sex or abortions has been under-reported for these reasons.

very prevalent within Guatemala.¹⁷ Although the data was extensive, the key results were recorded as follows:

Nearly 65,000 induced abortions are performed annually in Guatemala, and about 21,600 women are hospitalized for treatment of complications. Abortions occur at a rate of 24 per 1,000 women aged 15–49, and there is one abortion for every six births. The abortion rate is higher than average in the Southwest (less developed, mainly indigenous population) and Metropolitan (more developed, mainly nonindigenous population) regions (29–30 per 1,000 women). Over a quarter of all births are unplanned; combining unplanned births with abortions yields estimates that 32% of pregnancies in Guatemala are unintended, with an unintended pregnancy rate of 66 per 1,000 women.

These results reinforce the work of Ali and Cleland (that knowledge of contraception is extremely inadequate) and go even further by documenting the grave consequences that result from this (i.e. greatly increased morbidity and mortality of women). From the data Singh and colleagues concluded that unsafe abortion (which many illegal ones are) is an issue of national importance and stress the necessity for an increase in government programming involving women's issues. This particular study also proves to be adept in recognizing the differences among various populations in various regions within Guatemala. Although a relatively small nation, as mentioned above its population is far from homogeneous. The study recommends that when implementing these women's issues programs regional differences (i.e. rural versus urban) are taken into account (Singh and Prada and Kestler, 2006).

Because of the large amount of public attention and debate surrounding the legality and morality of abortion in the United States, it came as a great surprise to me that some people I

¹⁷ These statistics must be approached with some level of caution as the number of abortions performed was necessarily determined in an indirect method (because the majority of abortions performed are illegal and thus unreported). The numbers that do exist are extrapolated from data regarding women who are treated for complications resulting from the procedure.

met in Guatemala were not very knowledgeable on the subject. During my stay I became close to a 26 year old, upper-middle class Guatemalan woman. She was well-educated, worked in a professional setting and was even pursuing a higher degree during the time we met. At one point in conversation the subject of abortion was brought up, and I mentioned its illegality in Guatemala. This well-educated, intelligent woman looked at me questioningly and said she was not sure if abortion was legal in Guatemala or not. She then recalled that a handful of friends who had underwent the procedure. This experience showed the extreme prevalence of illegal abortion as well as the lack of knowledge or even discussion of such an important women's rights issue.

Children's Health with a focus on Nutrition

Much of a child's health is determined during the beginning stages of life. Because of this, prenatal care is absolutely essential for a health birth and subsequently, childhood. Unfortunately, prenatal care, which could be considered a part of women's health, is similarly lacking.

Prenatal care is extremely important, but the health of a newborn is also of the utmost importance. Private obstetricians are available to women with the financial ability to afford this. Those of lesser means living within a travelable distance to a public hospital usually elect to give birth in that hospital, and are thus attended to by trained officials. Although the time of these officials is limited (and the care provided rushed), the child is seen by a professional and obvious, serious ailments can be detected. However, many women from rural areas are unable to reach a hospital, and some simply do not wish to do so. There are many reasons for this, but

one is the difference between tradition birthing procedure and hospital protocol. For example, traditionally speaking, Mayan women give birth in a kneeling procedure, but if a Mayan woman is brought to a hospital she must give birth in the traditional Western position, lying down. Other factors, like language barrier and lack of transportation also contribute to a woman's (or a woman's family's) desire to give birth in the home (Adams and Hawkins, 2007). If serious complications arise it is rare that a woman can be transported to a hospital in time to receive the necessary care for her and her child (PAHEF, 2010).

After the birthing process another difficulty is encountered: overcoming the stigma of breast-feeding. For a large part of the summer I was shadowing a pediatrician, so I often encountered new mothers. First time patients would be asked a series of basic questions to assess the general state of the child's health. One of these question of how long the mother breastfed, if at all. The number of women who reported limited or no breastfeeding was extremely shocking to me. The doctor would sometimes question the women as to why they had not breastfeed and would always stress to them the importance and merits of breastfeeding.¹⁸ The pediatrician explained that there is a stigma against breastfeeding, and formula is often preferred. Formula is often seen as a more modern, high-class alternative, and many women do not realize that most formula is not as beneficial to the child as the mother's natural milk. I recognize that there are valid reasons for not breastfeeding (e.g. a woman must return to work and is not with the child throughout the day), but to choose formula over breastfeeding for no legitimate reasons is a problem. Luckily this problem is fixable- and

¹⁸ I thought that the doctor's advice was very important. This advice needs to be conveyed in a sensitive manner as to not offend or alienate the mother, but it must be communicated. Because most women have more than one child, the advice can be very useful. Whether that advice is followed or not, however, is more difficult to say.

economically fixable as well. Education is the key element here, and although the change will be gradual and require time (as is the case when changing something that has become rooted within a culture).

Nutritional concerns extend beyond the age of breastfeeding. Malnutrition affects the population in general, but children suffer the worst consequences due to this epidemic. Recent data shows that of Guatemalan children under five years old, 43% are chronically malnourished; this is one of the highest rates in the world (CIA, 2010). Malnutrition is a serious issue. It stunts the growth of children, can cause developmental delays, and leaves children more vulnerable to sickness, which in extreme cases can lead to death. (Adams and Hawkins, 2007)

The hospital I worked at also had a nutritional specialist who worked with over- and under- weight children.¹⁹ Although I was initially very impressed that the hospital had such a service, I was quickly discouraged by sitting in on a session. The nutritionist seemed to be reading from a script, and a rather Westernized one at that. For example, the parent was given a food pyramid, like those in the U.S. However a typical healthy Guatemalan diet is not the same as a healthy American diet. Many Guatemalans do not have access to large amounts of meat; but there is a great supply of beans, which are also a source of protein and depending on the method of preparation, healthier than meat. Nutrition education is progress, but it is much less effective if not delivered in a culturally sensitive and accessible way.

Obesity Prevention

¹⁹ Almost all children who were underweight were infants, whereas obesity was a greater problem with adolescents and adults (more commonly among adults than children).

Although not a main concern at the moment, something that should be closely monitored and hopefully prevented is obesity. There has been and continues to be an influx of American culture in Guatemala, and in populated areas McDonalds restaurants abound there as well. Rural populations seem to be at a lower risk for this because of frequent exercise (due to the fact that there is less convenient transportation and physical labor is more common) and less consumption of pre-prepared foods (because it is not as readily available as fresh agricultural products). Like mentioned before, obesity prevention is not a great concern at the moment, but it would be wise to be aware of the possibility and take early preventative steps so that a situation like that of the U.S. does not occur in Guatemala. These steps do not need to be drastic. Public announcements on the merits of fresh produce and the consequences of overindulgence in prepared foods would be sufficient in my opinion. A focus on exercise in schools might also be helpful.

HIV/AIDS: Prevention and Treatment

Although a lack of knowledge about and access to HIV/AIDS resources is most profound among the lower socio-economic class, I soon realized that this ignorance affects all classes. Upon my return to the United States I was discussing my experiences with an acquaintance who is engaged to a woman from (and currently residing in) Guatemala City. When I told him about my volunteer work at an HIV/AIDS hospice, he immediately lit up. Coincidentally a close friend of his fiancée's and his partner were recently diagnosed as HIV positive. The two were attempting to find information about the facilities in the area, but were struggling. They both

came from middle class families, but when an HIV test returns positive many doctors will wipe their hands clean of the situation- regardless of the socio-economic status of the patient.

The subject of HIV/AIDS is to a certain degree taboo in any society today, but this sentiment was greatly intensified in Guatemala. Some of this is because HIV/AIDS is historically thought of as a “gay disease” and many in Latin American society are strongly opposed to homosexuality. This is definitely one component of the issue. However, I feel that an even larger problem is ignorance of the disease itself. Many think that catching HIV is as simple as catching a cold and that one could be infected by simply shaking the hand of an HIV positive person. The deep shame associated with the disease is probably the greatest handicap in preventing infection or death. Many HIV positive pregnant women do not seek treatment because of shame or because they are unaware of the risk to their unborn child. Treatment is essential in reducing the risk of transmitting HIV to the child, but by the time this information is discovered it is often too late.²⁰

I personally witnessed this shame when observing one of the information sessions provided for friends and families of patients of the San Jose Hospicio (an inpatient and outpatient HIV/AIDS clinic located outside Antigua, Guatemala). During these sessions the representatives of the clinics would discuss the facts about HIV/AIDS, answer questions, and pass out some items- including condoms (these sessions were generally during the time in which the patients were receiving their treatment). During the few sessions I was able to observe there was a great amount of embarrassment and discomfort; very few people were willing to accept the condoms, and those who did were almost always men- not women.

²⁰ The majority of the people residing at Hospicio San Jose, the HIV/AIDS clinic at which I volunteered were orphaned or abandoned children who were HIV positive.

Counterfeit Medicine

Even if an individual is able to overcome the obstacles in finding a well-qualified and affordable health professional, that professional accurately diagnoses the patient's condition, and that patient is financially and logistically able to acquire medication; there is still yet *another* obstacle: counterfeit medicine. With the exception of setting up a lab in one's home and testing every medication, there is virtually no defense for the common Guatemalan citizen against counterfeit drugs. Counterfeit drugs are a problem around the world, but are most prevalent in areas in which medical regulatory and enforcement systems are weaker, a category under which Guatemala most certainly falls. Counterfeited drugs can be found under both generic and brand labels, and in place of the correct active ingredients can simply contain inert ingredients (simply rendering them useless) or at times toxic ingredients (which would be harmful to the patient, possibly life-threatening). Sometimes the active ingredient may be present, but in at an insufficient level. Additionally, counterfeit drugs are often cheaper, which puts disadvantaged populations at a higher risk (WHO, 2010).

The WHO is aware of the severity of the issue and has created groups, such as the IMPACT- International Medical Products Anti-Counterfeiting Taskforce (created in 2006), to combat the problem; but the WHO has stressed the importance of support from individual governments, as the governments have more control over regulating the imports and exports within their borders (WHO, 2010).

Recently the international community seems to have heard these requests of the WHO. Ideas behind creating an agreement which would help fight counterfeiting on the international level have been circulating for quite a few years, but it was not until 2008 that world leaders

began official work on the Anti-Counterfeiting Trade Agreement (or ACTA). Officials have not offered much information on the agreement (talks have all been shut off to the public), but some leaks have provided of us with limited information²¹. The agreement's nominal intent is to establish new regulations for international trade under which the sale and receipt of counterfeited drugs²² would become more difficult. With the high prevalence of counterfeited drugs and the potentially extreme consequences of consuming these drugs, this agreement appears to be a step in the right direction. However some believe that the steps being taken towards eliminating counterfeit drugs are actually counterproductive for lesser developed countries, such as Guatemala²³. Although information regarding the agreement is limited, leaks have indicated that the intent behind the agreement may have more to do with intellectual property rights than protecting consumer rights. This viewpoint is expressed by Oxfam²⁴ spokesperson, Rohit Malpani: "ACTA is proposing a new, expanded framework of intellectual property protections on behalf of multinational drug companies which will be combined with border measures to stifle the trade in legitimate generic medicines. This will mean that poor people will be denied legitimate and life-saving generic medicines." Is making reference to the idea that the ACTA may allow countries to seize generic drugs at their borders because those drugs violate the intellectual property rights of these large, multinational drug companies (even if the drugs are not counterfeit, but perfectly safe). If these generic drugs cannot be

²¹ The most recent leak was what many believe to be the final agreement and was leaked on November 15, 2010.

²² The agreement would apply to other items as well, but this is a major focus of the ACTA and the focus of this paper.

²³ It is also significant to note that these behind-closed-doors talks have only included a limited number of countries: United States, the European Community, Switzerland, Japan, Australia, the Republic of Korea, New Zealand, Mexico, Jordan, Morocco, Singapore, the United Arab Emirates, and Canada. However many more countries will most likely feel the effects of this agreement when it comes into effect.

²⁴ Oxfam is an organization of multiple NGO's based in different countries whose mission is to fight poverty and injustice.

transported, they will never reach the lesser-developed countries where less expensive *and* safe alternatives are needed the most. (Hooper, 2010)

Disadvantaged Subpopulations

Some groups within Guatemala are disproportionately affected by the above-mentioned health issues, and many that have not been discussed as well. The female population is certainly one of these groups, as discussed in further detail above. The gay population was briefly mentioned in relation to HIV/AIDS, but it is worth mentioning that people of this population are prejudiced against even if they are not HIV positive. This is at least due in part to the strong presence of machismo²⁵ within Latin American culture. Because of this treatment those who self-identify as gay may be less likely to go to visit a healthcare facility or be honest about their health if they do see a healthcare professional. Another group, also mentioned above, which is at a serious disadvantage in receiving quality healthcare are the indigenous people of Guatemala. This group has been marginalized for years (often time through government policy) and has suffered in many ways, one of which is economically. Thus, this population has less ability to attain healthcare resources. In addition to this problem indigenous people face racism at a personal level to this day. I do not wish to assert that all mestizo Guatemalan people are prejudiced against indigenous Guatemalan people, but prejudice does exist. Spanish is often not the first language of indigenous people, and they therefore speak with an accent. Just in my brief stay I heard countless racist jokes mocking the speech of indigenous people. This accent, their lower literacy rate, and their lower socio-economic status

²⁵ Machismo is the term used to describe the cultural ideology that men should be strong, masculine, heterosexual beings. For obvious reasons this does not mesh well with homosexuality.

all contribute to a negative view of the indigenous population, in general.²⁶ Healthcare officials are not immune to prejudice, so even if an indigenous person has the means to consult a healthcare official (which does occur since a good number of indigenous people live well above the poverty line) they may not be treated as well as a mestizo Guatemalan would be.

Because I spent a significant amount of time working with mentally and physically disabled children I feel it necessary to make note of this disadvantaged population even though the mentally and physically disabled face similar disadvantages in all countries. The slight difference between these countries and Guatemala is that in other countries parents might have the means (especially with the help of social services) to provide for their mentally or physically disabled child in their home. This is rarely the case in Guatemala, so most families are forced to leave their children at facilities which are equipped to take care of them, visiting when they can. In the worst situations, parents do not have the means to take care of the child or the knowledge of where to seek help and simply abandon these children.

One population that is constantly overlooked is the migrants within Guatemala. Because these families are constantly changing location it is very unlikely that they have access to any form of regular healthcare; if they do see a healthcare professional, they are rarely still in the area for any follow-up appointments if necessary (WHO, 2010).

²⁶ About 4 years ago my cousins adopted a baby girl from Guatemala and were assured by the officials of the adoption agency in Guatemala that she was absolutely not indigenous. Firstly, based on her appearance (she is now 5 years old and her features are more distinct) she seems to have a considerable amount of indigenous heritage. Secondly, the fact that the agency would go out of their way to point this fact out to my cousins (who didn't have any preference on the subject one way or the other) is absolutely absurd and is one of many examples of the prejudice against indigenous people.

Positive Steps Forward

Several healthcare initiatives (or at least initiatives involving health) have been put into place and have had varying levels of success. One program of note, instituted by President Colom in April of 2008, is commonly²⁷ referred to as a conditional cash transfer program. The program provides financial help to families who keep their children in school and bring their children to the doctors. At the very least, children are more likely to be properly vaccinated and have some sort of routine physical exam through this program. USAID (the United States Agency of International Development) has also begun some promising programs. One of these programs, Feed the Future (abbreviated FTF), which is being carried out in a number of other countries as well, stands out because of its focus on investing in programs developed and led by Guatemalans, who are typically more aware of the problems and possible solutions for their country. Other USAID programs are currently in place or being put into place, which target areas of concern such as education (through the Centers for Excellence in Teacher Training program), trade (through the Central American Free Trade Agreement, discussed above), AIDS (through the President's Emergency Plan for AIDS Relief) and the sexual exploitation of women and children (through the Trafficking in Persons initiative) (USAID, 2010).

Suggestions for the Future

It seems that reform of the healthcare sector in Guatemala can be generally divided between large, structural changes (which will most likely not occur unless initiated by the government and smaller changes (e.g. how the limited resources are allocated, how medical

²⁷ I use the word commonly because this program has been instituted in other countries as well, such as Mexico.

advice is distributed, etcetera). Let us briefly discuss the former of these two types of changes. More of the national Guatemalan budget needs to be allocated for public healthcare and the overseeing of private healthcare. If the government does not wish to increase the amount of public healthcare provided (which I believe it should do) then it must monitor and restrict the prices of the private healthcare sector. I do not believe any structure in which an innocent child can go without the basic necessities is an adequate one. Any further discussion of these structural or budget issues, however, seems useless because this change cannot occur until much of the corrupt officials are washed out of the government and other positions of power. This is not likely if an uneducated and easily manipulated population continues to elect candidates who refuse to take any significant action. However, the vast majority of the population will remain uneducated because they are living in poverty and receive little to no assistance in attaining an education. Thus the cycle continues, in which the elite few remain in constant wealth and power. This is a heartbreaking and terrible reality, but discussing it further will not have any immediate results, which is what the Guatemalan healthcare system is in need of.

The allocation of money and resources is an equally difficult question. New facilities are needed because many people cannot even reach a healthcare facility without considerable travel (and related expenses). However, existing facilities still do not have the supplies and personnel necessary. On the subject of personnel, those working in the public sector (and to a lesser degree, those working in the private nonprofit sector) are immensely underpaid. Most of the doctors working at the private nonprofit hospital I volunteered at were forced to work in another hospital or teach as well. Thus the point can be made that money should be going

towards increasing the pay of public healthcare personnel in order to attract much-needed employees. Ideally all of the three above-mentioned needs could be met, but this is extremely unrealistic. I would therefore recommend that money be mainly focused on resources (medical supplies, medication, etcetera). Some facilities need to be created, but better infrastructure could solve many travel distance dilemmas as well. I also feel that doctors working in the private for profit sector should be asked to volunteer a certain amount of their time at public facilities. This cannot be too much of a commitment because it would be a huge mistake to deter young Guatemalans from a medical career path, but most doctors are relatively financially stable and could easily afford to volunteer some of their time. There could be some sort of compensation, such as a tax break for this service as well.

Another question is the degree to which preventative care should be focused (compared to the focus on emergency care and other services which occur after an illness or injury). When discussing this matter from a distant, academic position it is very easy to favor more preventative care. After all, preventative care is less expensive (and thus can be provided for a greater number of people) and is generally more successful. From this perspective it seems logical to allot almost all time and money to preventative services. This opinion almost always changes after speaking and interacting with patients who would have benefitted from preventative medicine but are now in need of more extensive care. This is particularly true regarding HIV/AIDS. Preventative measures are the only way to minimize the spread of this horrific disease, and these measures are quite underfunded. However after meeting the innocent, suffering people who have already contracted HIV, this approach does not seem quite as appealing. In almost all situations I do feel that a greater focus should be put on preventative

measures to avoid this perpetual game of catch up, but a balance must be found between the two extremes.

An important factor in any healthcare measures, preventative or not, is the method of delivery. Generalized solutions are not effective. The specific populations within Guatemala must be researched and targeted through respectful, but effective, techniques. Special consideration should be given to the targeting of the indigenous population and how to best incorporate existing health into any new health initiatives. It is important to keep have constant, open communication in any reform. Ideally health officials, personnel, and recipients of the care should work together throughout the development and execution of the program.

Along the same lines, health information must be distributed in the most accessible ways possible. This may mean not using written language. Because of the diversity of languages used within Guatemala (along with the high illiteracy rate), other means of communication will have to be used. A great way to do this is through billboards and pamphlets which convey health information with words and pictures.

Finally, I would like to discuss the issue of foreign aid and programs within Guatemala. When meeting Guatemalans during my stay in the country I was often asked about the purpose of my trip. I would reply that I was there to improve my Spanish language skills and work as a volunteer. Because I was located within close proximity of a relatively touristy area of the country (the town of Antigua), most were not surprised by this response. I also encountered numerous other Americans during my stay- most of whom had spent some time volunteering within the country. What I had not thought about previously was the response of proud Guatemalan citizens to the need for foreign volunteers to keep their healthcare system up and

running. Often times Guatemalans would respond with statements such as, “We need more people *from this country* willing to volunteer their time like that.” When I heard this I could sense their embarrassment or disappointment that they had to rely on another nation for the absolute basics²⁸. This type of comment made me feel uncomfortable because of the obvious discomfort I had caused, but after further thought I began to think about what role foreign aid and volunteer efforts does and should play within other nations. I in no way regret my time spent in Guatemala, nor do I regret the work I did there. However, looking at the development of the Guatemalan healthcare from a broader perspective I have begun to question the effectiveness of this method of help. This notion was better formulated into words in a recent story I heard on National Public Radio. In this segment Carleene Dei, head of the USAID in Haiti who also happens to be a Haitian-American woman, was discussing the disruptive nature of the continuing aid within Haiti. Although aid was absolutely crucial immediately after January’s earthquake, Dei cites the harm that has been caused by some of the foreign aid to Haiti²⁹ (Nnamdi, 2010). I am in no way advocating a halt to foreign aid; if anything, I would be in favor of increasing the amount of money we spend on foreign aid. I believe the more important issue at hand is the manner in which the aid is distributed. In the case of Guatemala, relying on the volunteered time and supplies of foreign medical professionals is not a sustainable or effective measure. Perhaps medical professionals who wish to volunteer would be better put to use by

²⁸ This feeling was intensified by the fact that it was many volunteers (including myself) are United States citizens. There is a reasonable amount of anti-U.S. sentiment within present-day Guatemala. Guatemalans are generally a very kind and warm people, and thus never treated me personally with anything less than the upmost hospitality. However, on a political level there is a great deal of negative feelings towards the U.S. government regarding their part in the onset of the civil war (i.e. the CIA’s support in the coup which overthrew the government of President Arbenz in 1954) as well as numerous more recent U.S. actions.

²⁹ For example, the distribution of free water has run some Haitian companies involved in water distribution out of business, forcing them to layoff a large number of Haitian employees.

training Guatemalan citizens so that someday the need for foreign volunteer is a thing of the past.

When discussing possible solutions one must be realistic, creative, and careful. Realism is necessary because there is only a limited amount of money available. Ideally a better healthcare system would lead to a more developed society, in which more money would be available, however this is not the current situation. Creativity is thus crucial at these developing the most effective solutions possible. In devising these programs much caution and thoughtfulness must be employed because any and all actions- or lack of action- affects a great number of human lives.

Bibliography

Adams, Walter Randolph and John Palmer Hawkins. *Health Care in Maya Guatemala Confronting Medical Pluralism in a Developing Country*. Norman: University of Oklahoma, 2007. Print.

Ali, Mohamed M., and John Cleland. "Sexual and Reproductive Behaviour among Single Women Aged 15–24 in Eight Latin American Countries: a Comparative Analysis." WHO, 1 Sept. 2004. Web. 06 Dec. 2010. <<http://www.sciencedirect.com/science/article/B6VBF-4D75JVD-2/2/5d9e5bd7854ceed056aa8d174895f9d5>>.

CIA. "CIA - The World Factbook." *Central Intelligence Agency*. CIA, 9 Nov. 2010. Web. 20 Nov. 2010. <<https://www.cia.gov/library/publications/the-world-factbook/geos/gt.html>>.

Darabi, Leila. "Guatemalan Health Care System Fails Women." *Guttmacher Institute*. Guttmacher Institute, 31 Oct. 2006. Web. 20 Nov. 2010. <<http://www.guttmacher.org/media/nr/2006/10/31/index.html>>.

Fort, Meredith P., Mary Anne. Mercer, and Oscar Gish. *Sickness and Wealth: the Corporate Assault on Global Health*. Cambridge, MA: South End, 2004. Print.

"Guatemala- Health." *Encyclopedia of the Nations*. Encyclopedia of the Nations, 2010. Web. 28 Nov. 2010. <<http://www.nationsencyclopedia.com/Americas/Guatemala-HEALTH.html>>.

Hooper, Caroline. "Anti-Counterfeiting Trade Agreement Could Endanger Lives of People Needing Affordable Medicines | Oxfam International." *Oxfam International Press Releases*. Oxfam International, 29 June 2010. Web. 20 Nov. 2010. <<http://www.oxfam.org/en/pressroom/pressrelease/2010-06-29/acta-could-endanger-lives-people-needing-affordable-medicines>>.

La Forgia, Gerard M. *Health System Innovations in Central America Lessons and Impact of New Approaches*. Washington, DC: World Bank, 2005. Print.

"Maternity Waiting Homes." *Pan American Health and Education Foundation*. PAHEF, 2010. Web. 20 Nov. 2010. <<http://www.pahef.org/index.php/en/successtories/39/23-maternity-waiting-homes-.html>>.

McManis, Charles. "Essay: The Proposed Anti-Counterfeiting Trade Agreement (ACTA): Two Tales Of A Treaty." *Oxfam International*. Oxfam International, 2009. Web. 20 Nov. 2010. <<http://www.oxfam.org/en/pressroom/pressrelease/2010-06-29/acta-could-endanger-lives-people-needing-affordable-medicines>>.

Ministerio De Salud: Pagina Principal. 2010. Web. 16 Nov. 2010. <<http://portal.mspas.gob.gt/>>.

Nnamdi, Kojo, prod. "The U.S. in Haiti." *The Kojo Nnamdi Show*. WAMU. Washington, DC, 10 Nov. 2010. *Transcript for The U.S. in Haiti*. WAMU, 10 Nov. 2010. Web. 16 Nov. 2010. <<http://thekojonnamdishow.org/shows/2010-11-09/us-haiti/transcript>>. Transcript.

Singh, Susheela, Elena Prada, and Edgar Kestler. "Induced Abortion and Unintended Pregnancy in Guatemala." *Guttmacher Institute*. Sept. 2006. Web. 10 Nov. 2010. <<http://www.guttmacher.org/pubs/journals/3213606.html>>.

Transparency International. *Special Focus: Corruption and Health*. London: Pluto, 2006. Print. *USAID in Guatemala*. 2010. Web. 16 Nov. 2010. <http://www.usaid.gov/locations/latin_america_caribbean/country/guatemala/>.

WHO. "Guatemala." *Pan American Health Organization*. WHO, 2001. Web. 20 Nov. 2010. <<http://www.paho.org/english/sha/prflgut.htm>>.

WHO. "Health Systems Profile of Guatemala." *Pan American Health Organization*. WHO, 2007. Web. 26 Nov. 2010. <http://docs.google.com/viewer?a=v&q=cache:9VXTH1uaksgJ:www.lachealthsys.org/index.php?option=com_docman&task=doc_download&gid=169%20-guatemala+health+care+system&hl=en&gl=us&pid=bl&srcid=ADGEESglLuvfNxWRWGurKs8qdIV2fG9wpfXqV-fcTzaxlN5xiFdpuzaMogOFPS3QjWy8Pta0ixlFSaof7fWY8pkEgmvjnJqvLYWgLK3KZia5JiALMRM7u4_OdB4mWv_QyuzqybDK2x_r&sig=AHIEtbTHOWT5e3lcQbTT3YUt4MBReuUb2Q>.

WHO. "Health in the Americas: Guatemala." *Pan American Health Organization*. WHO, 2007. Web. 25 Nov. 2010. <<http://www.paho.org/hia/archivosvol2/paisesing/Guatemala%20English.pdf>>.

WHO. "Country Profiles: Guatemala." *Pan American Health Organization*. WHO, June 2004. Web. 25 Nov. 2010. <http://www.paho.org/english/dd/ais/be_v25n2-perfil-guatemala.htm>.

WHO. "Medicines: Counterfeit Medicines." *WHO*. WHO, 10 Jan. 2010. Web. 16 Nov. 2010. <<http://www.who.int/mediacentre/factsheets/fs275/en/index.html>>.

World Bank, comp. *Poverty in Guatemala*. Washington, D.C.: World Bank, 2004. Print.