Jesus Is Free:

Religious Influence on Health and the Plausibility of Changing Traditions

Dan Bollinger
SoAn 295
Jerome Levi
March 11, 2014
Abstract

Many researchers have studied religious differences in Guatemala. Others have studied specific aspects of health that might deal with religious factors. I examine the leadership of the three largest religious denominations in the towns of San Antonio Palopó and Santa Catarina Palopó, Catholicism, Charismatic Catholicism, and Evangelicalism, and what they perceive to be the biggest threat to the health of their members. They all stress the importance of dealing with problems that cloud spiritual or mental health, i.e. alcoholism, adultery...etc. However, certain traditions concerning physical health permeate through the whole community, regardless of religious identification. I attempt to make sense of why some of these traditions change and others do not. Similarly, I look at the churches’ involvement in these areas and offer an analysis of the circumstances surrounding the health of these people.

“Identity is based on the narcissism of small difference”

-Sigmund Freud

“People here don’t care about their teeth. They don’t care about their health. They have no conception of hygiene; simple things like washing their hands before eating. They don’t take care of themselves.”

-Dr. David Smith DDS., dental volunteer

Wine is a mocker, strong drink a brawler, and whoever is led astray by it is not wise.

-Proverbs 20:1

Introduction

Guatemala consistently ranks as one of the poorest countries in Latin America. The World Food Programme reports that “fifty-three percent of the population lives in poverty, and 13 percent in extreme poverty. The most vulnerable groups are indigenous women, girls and boys living in the highlands”(World Food Programme 2014). In addition, the average rate of chronic under nutrition for children under five is 49.8% (World Food Programme 2014). To exacerbate the problem, the Guatemalan government does not prioritize health or sanitation spending. According to the World Bank, 6.7% of the national budget is appropriated for health (World Bank 2011b), and only 35.5% of that is public expenditure (World Bank 2011a). The rest is spent on private hospitals and clinics; hospitals that are better equipped and better staffed, but which
people must pay for.¹

When I arrived at San Antonio Palopó, I learned that religious divisions split the town, each with very different ideologies. I found that many people possessed a feeling of “otherness” toward members of different faiths. It appeared as if people belonging to one group would categorize other people in town as almost foreign, separate in their religious spheres. I determined that these religious differences might correlate to differences in how each group deals with the lack of public health services and the lack of personal resources that compound the problem.

Does religious affiliation affect what people see as the first priority in staying healthy, and what are the religious leaders doing about it? What do they see as the biggest problem to a healthy lifestyle in their towns? Finally, are the churches’ solutions working in an area lacking in government sponsored preventative and curative care? Before I discuss my research into those areas, I first must give a brief history of how the religious factions developed around Lake Atitlán.

Background

Because there was no real competition from other religions after the conquest, the Catholic Church did not actively attempt to convert the masses (Stark, Rodney and Buster Smith 2012). As a result, the majority of people did not actively participate in the Church activities. With the active rejection of the Church by the Guatemalan government starting in the 1950s, Protestant groups began to move into the void, resulting in an explosive rise in Protestant groups, primarily Pentecostals (Stark, Rodney and Buster Smith 2012).

The Protestants gained a following because they stressed personal connections with the

¹ The government-run institutions offer free health care. These include both local clinics and larger regional hospitals.
Holy Spirit rather than allegiance to a church hierarchy (Bastian 1993, Chestnut 2003, Stark 2012, Steigenga 2001). Jean-Pierre Bastian writes that while Protestant groups reflecting more progressive and liberal aspects of society existed in Latin America almost as long as Catholicism, they never existed under an international branch of Protestantism. Following the introduction of the international Protestant groups, these two groups merged, the result being a wide range of ideologies within the heading of “Protestantism” (Bastian 1993). In pluralistic terms, Protestant groups catered to the religious marketplace better than Catholicism (Chestnut 2003). Because they reject a central hierarchy, modern Latin American Protestant groups reflect the historical absence of ordained priests and prevalence of lay leadership during the Catholic influence. (Bastian 1993, Steigenga 2001).

The Catholic Church responded by endorsing first liberation theology, then the Catholic Charismatic Renewal after that failed to convert many people (Stark, Rodney and Butler Smith 2012). The CCR takes most of the aspects of popular religion seen most in Pentecostal groups and frames it within the Catholic Church. It is also primarily a lay movement, and many argue has more in common with the Pentecostals than the main Catholic Church (Chestnut 2003, Stark, Rodney and Buster Smith 2012). In fact, the only real difference lies in the CCR’s emphasis on the Virgin Mary and adherence to the pope. It has proved enormously popular among Latin American populations to the point that now most Catholics in Guatemala say that they participate in CCR meetings (Chestnut 2003).

Thus, Guatemala presents a complicated web of religious preference and competition, but no one has studied health from both a religious leadership and general public perspective; instead, scholars have studied certain aspects of health relating to each religion. For instance, Shiffman and Garcés de Valle show that in countries with strong conservative religious influences, the people do not have full access to contraceptives, family planning, or possible life-saving
resources during pregnancy complications (Shiffman, Jeremy and Ana Lucía Garcés del Valle 2006). Similarly, some studies show how Charismatic Catholicism and Pentecostalism tend to stress gifts of the holy spirit and personal religious experiences as forms of medicine (Chestnut 2003, Steigenga 2012). Steigenga writes that Pentecostalism took hold in poor areas of Guatemala because “for many converts, faith healing provided the hope of low-cost alternatives to formal medicine” (Steigenga 2001: 24).

My ethnographic study offers a look into the lives of people living in San Antonio, Santa Catarina, San Lucas and other similar lake towns, as well as their struggle for basic medical care. I will show how religious leaders of each of the major religious factions in the area, Catholicism, Charismatic Catholicism, and Evangelicalism, offer solutions to what they perceive as the biggest threat to healthy living. Then, I will compare those conceptions with those of the general public and study their effectiveness in changing long held traditions or behaviors.

**Methods**

During my three weeks of research from February 12 until March 6, I utilized formal interviews, informal interviews, and participant observation, depending on the type of information I was trying to gather. I first talked to the leaders of the various religious factions in town. In San Antonio Palopó, I interviewed the vice-president of Catholic Action, the pastors of two Evangelical churches, the president of the Charismatic Catholic church, and an Evangelical pastor visiting from Chimaltenango. In Santa Catarina, I interviewed the pastor of an Evangelical church, and I talked to the secretary of the Catholic Parochial in Panajachel. I am leaving the names of the people and places anonymous for reasons I will go into later.

When I first tried to talk to the religious leaders, I asked townspeople who was in charge of the respective church. I continued this process until I tracked down the person I wanted to talk to; usually someone either led me to the person personally or went to go find them while I
waited. I utilized formal interviews with most of the religious leaders that I talked to, although they were all, for the exception of the pastor in Santa Catarina, spontaneous\textsuperscript{2}. I usually introduced myself as a student interested in studying religion and health in town. Fortunately all of my informants spoke Spanish; so I was able to interview them without a Kaqchikel translator.

I began with questions about how they ran the churches or about their job positions in order to build some rapport. I asked, “What is the most important aspect of health to you?” or something similar, but I found this to be too broad. So, I usually had to provide examples of what I was looking for, citing physical, spiritual, mental, emotional…etc. I wanted to leave it open-ended in order to see what aspect of health my question would bring to mind.

I began to feel however, that I was missing out on how people beyond the religious authority felt about health in their communities. For this reason, I visited San Lucas and talked to a doctor of the Catholic hospital and two medical professionals in an Evangelical-run clinic. I used both formal and informal interviews on separate occasions here. Then, I spent several days interviewing personnel and observing at the Puesto de Salud in San Antonio. It was at this point that I began to primarily utilize informal interviews as my primary source of information. I found that this approach allowed for a much more intimate conversation that made people more comfortable talking about health in their communities. As a result, much of my information comes from informal interviews with people that I met in various towns around the lake.

I regularly utilized connections that other members of my program had made in order to save time in trying to build a relationship from scratch. On various occasions, I interviewed people together with another group member with a similar project focus. This allowed me to observe how an informant reacted to certain questions, and I was able to gather information from

\textsuperscript{2} I am using “spontaneous” here meaning that I had not scheduled a time to interview most of my informants. Luckily, they all had time to speak to me when I first found them.
questions I did not think of asking. I also participant observed alone on several occasions: traditional Catholic masses, a Charismatic Catholic mass, an Evangelical wedding, and two Evangelical cultos. Due to the time constraints and the fact that I had to deal with personal issues towards the end of my time, I was not able to attend a Charismatic culto. I did, however, gain secondhand information about that subject through several informal interviews.

Because many people spoke a mixture of Kaqchikel and Spanish in my areas of focus, I sometimes had to rely on translations by a Kaqchikel teacher in order to fill in some gaps. I conducted all of my interviews in Spanish, which I found the most challenging part of my research. I am confident in my understanding, but while I was in general able to express my point, it should be said that some misunderstanding of my questions and responses might have caused some error in information. I am, however, very confident in the accuracy of my information as I confirmed it with several sources. The quotes that I use in my paper I either wrote down immediately or memorized and wrote down later. Usually, I had already translated it in my mind, since I had understood it in English. As specified above, I understand Spanish very well, and I trust that while some slight variations might have arisen in translation, the words still retain their original intention.

I also spent several days working with an NGO that works in several towns around Lake Atitlán. There, I participant observed one of their food trips to several towns and informally interviewed several of their health coordinators. I also talked to several health volunteers on Rotary Club missions to San Antonio. I was interested in getting an outside perspective on the relationship between health and religion there. As outsiders, they offered a much different look at how religion operates as a powerful force in people’s health. They also helped bring to my attention the need to study how people act in areas of health that do not seem immediately connected to religion.
Because I never explicitly said that I was going to use any information in a paper, I have chosen to use pseudonyms for my informants. I have also decided not to name the Evangelical churches because their pastors’ do not change, and this would undermine their anonymity. Due to the sensitive nature of the information and the fact that all of my informants placed some degree of trust in my discretion, I do not want to betray that confidence, nor do I want to instigate conflict among their communities. They welcomed me into their communities, and while this will not alter my findings, I do want to respect that by not disclosing sensitive information to people to whom my informants would not wish it known.

Results

Under the larger subject of the nature of the relationship between religion and health, I studied two related themes: what religious leaders thought of as the largest obstacle to living healthily and whether or not their solutions are effective, and what people do in areas of health not directly under church influence. In order to display my results, I am going to first compare the three religious groups followed by a discussion of my findings on how the townspeople deal with everyday illness and other health problems.

Catholicism

The Catholic Church in the Parochial of Panajachel works through a series of organizations of the laity. A number of these organizations work for the purpose of education the Catholic youth. *EPI* for example, teaches kids before their First Communion, and *Jóvenes* continues the education until Confirmation. After that, they join either the boy’s organization, *Juventud Catolica*, or the girl’s organization, *Hijas de Maria*. The Catholic Church utilizes both the education and involvement of the youth as a way to maintain control over them. During every

---

3 Both the presidents of Catholic Action and the Charismatic church rotate every year, which protects their anonymity.

4 See Appendix for total list of organizations in the Parochial of Panajachel.
mass that I attended, the priest, a catechist, or both would mention the need to control the wayward nature of the youth. One lay person spoke before mass saying, “we must watch the youth; watch your children. They might say that they are going to the church, but in reality, they are going to the streets” (Field notes Feb 16th 2014). Therefore, the Catholic Church stresses educating the youth and keeping them involved as a way to keep them off the streets, i.e. drinking.

This concern with the youth and spiritual purity suggests that the Catholic leadership perceives the biggest threat to be from the streets, the material world. Alberto, the doorman for the church in Santa Catarina, said that alcoholism is the biggest health problem in town, closely followed by domestic abuse: “They are connected. A man is drinking too much and he comes back and hits his wife” (Field notes February 27th 2014). He said that he thinks it starts by children growing up with parents who drink as well. This was echoed by a Juan Luis, a Catholic educador for the Puesto de Salud in San Antonio. He lamented the fact that he did not have enough resources to properly educate the kids about changing their habits when they get married. But he added that “education comes from the house,” so he wanted to educate parents about the effect their habits have on their kids (Field notes February 24th 2014). This suggests that even lay people use similar techniques, or have similar ideas, about when problems relating to wayward behavior start and what to do about them.

However, the Catholic leadership proves a bit more complicated than it appears. There are over 15 communities without priests of their own in the Parochial of Panajachel, the more rural of which might only have mass once a month, as the only three priests in the Parochial live in Panajachel. This means that the members of the community, or Catholic Action, have more decision-making power in how their churches operate than the central church hierarchy. This allows them to be slightly more flexible with fitting Church doctrine into the needs of their
communities. Juan Luis told me that the Catholic Church supports having small families but not the use of *planificación de familias*, a term that includes all forms of birth control. He said they want parents to have fewer children, so they can keep a closer eye on the ones they have. However, he distinguished that while the priests do not support it, the Catholic Action allows them, the *educadores*, to come to meetings with people there to discuss its uses. This suggests that the lay leadership recognizes the health needs of their communities and is willing to allow minor doctrinal changes in order to educate their congregation.

However, the Catholic Church seemed more interested in making sure people came to mass rather than trying to actually alter their behavior. People who commit sinful acts such as drinking or adultery cannot participate in mass until they go to confession. The town is so small that people know and talk, so there is immense social pressure to go to confession and rejoin the community. I asked how the Church combats alcoholism and he replied that they just keep their door open when people need it. Confession, therefore, serves as an institution for absolving people of their transgressions and allowing them to rejoin the community, not for changing their behavior. Further, the *Convite de Concepción* now brings into the church the already existing parades and *fiestas* by dedicating them to the conception of Mary. The Catholic Church appears more interested in bringing people under its influence rather than addressing the problem: although, the existence of *Esperanza Viva GEV* shows that the leaders at least recognize that substance addiction is a serious problem.

What, if anything, does the Church do about physical health in the communities? I learned that they do not do much in the way of social works. I asked Maria, the secretary for the Parochial of Panajachel, why they do not open medical clinics or similar health services when they are so obviously lacking. She responded that “there is not a place to put it and there is no space either. People can go to the *Puesto de Salud* if they need medicine” (Field notes February
18\textsuperscript{th} 2014). I discovered from personal experience that this was not true. While at the \textit{Puesto de Salud} in San Antonio looking for a rabies vaccine, I was unimpressed by both the lack of the rabies vaccine on site, and the quality of the medical professionals. I saw that they had enough supplies to clean minor wounds, but were not equipped to deal with anything more serious. In addition, they seemed unconcerned that a dog and broken skin on my arm, and told me I could wait three weeks to begin treatment for rabies\textsuperscript{5}. Because of this, there is an obvious need for better and more medical care and I got the impression from Maria that they simply do not have the resources to fill that void.

\textit{Evangelicalism}

The Bible provides the basis for how the Evangelicals organize themselves and how they conduct themselves in life outside their churches. One Evangelical pastor in San Antonio displayed how we can learn how to act from the Bible. He told me that the parable of the \textit{gran cena} shows how not everyone is ready to receive the word of God and we must prepare ourselves before we can: “God does not let everyone into the kingdom of heaven” (Field notes February 16\textsuperscript{th} 2014). They believe that everything they do must be for the service of God and according to his laws. I found a large difference in the way the churches are run compared to the Catholics. In the words of Pedro, a member of one church, “the Bible is our teacher and only authority” (Field notes February 16\textsuperscript{th} 2014). They stress having a personal and direct connection to God, without the need for priests. You must ask God to forgive your sins, not a priest.

Some see physical health as necessary only so that you can be healthy enough to continue praying and participating in the church. Crying and wailing pervade Evangelical \textit{cultos} as participants feel overwhelmed by the Holy Spirit and gratitude toward Jesus’ sacrifice. This form of prayer occurs while one person sings along with a marimba band, and everyone else claps and

\textsuperscript{5} The effectiveness of the rabies vaccine actually decreases significantly after 24 hours.
lets their emotion build. They do this to ask God’s help with sickness or forgiveness for some transgression. Many people use this faith healing as their primary care, before getting physical medicine. While certainly there is a spiritual aspect to this, it is free to pray to Jesus. A belief in the power of prayer also yields a self-fulfilling prophesy. If you get better, it is because God helped you, and if you do not, you must not have prayed hard enough. This pervades their conceptions so thoroughly that most Evangelicals use “cry” to mean “pray.”

Members of Evangelical churches are expected to follow extremely strict rules of conduct. In fact one of the biggest differences between them and the Catholics is that “they have a different way of conducting themselves [than we do]” (Field notes March 4 2014). Catholics are perceived as more loose and immoral because they only go to mass on Sunday and whatever they want the rest of the time, while the Evangelicals hold cultos nearly every night of the week. The strictest rules involve restrictions on alcohol and smoking.

The following information I received from an interview with Diego, an Evangelical pastor in Santa Catarina. There are a series of steps to correct infractions by members of their community. First, the leaders hear about someone’s falta, or mistake, usually through other members of the town that saw or heard about it. Then, 7 investigators gather witnesses and evidence to verify that it actually happened, and they make a verdict. The final step involves disciplining, the severity of which depends on the falta. Members being punished cannot participate in parts of the culto, eat the santa cena (communion), or be a part of the church for a period of some months. The person should reflect on their error during this time so they are ready to come back when the time comes. The most common falta is drinking, and the worst are adultery and repeated offenses. I heard from a number of sources that many Evangelicals drink, they just do so in their homes. Because alcohol consumption is so common even in Evangelical churches, the severity of the rules appears not to exorcise drinking from members’ lives. It is
especially common with young people, despite the religious classes that all members under 14 receive every week.

However, while the rules do not eliminate drinking altogether, the stricter sanctions discourage that sort of behavior, at least in public. Other regulations do not yield the same benefits. In an Evangelical ceremony, the pastor used the Bible to describe each person’s role in the marriage. “The woman must respect her spouse” because we are all subject to God and must respect him and the man “should love his woman like God loves his church” (Field notes February 22nd 2014). He went on to describe how God fashioned Eve out of Adam’s rib, and now the woman is returning again. In marriage problems arise when there are differences in opinion: so, the woman must be subservient to the man so that there is one voice and peace. He did stress that they must find peaceful resolutions to problems, but obviously the man held the power in the relationship. Therefore, like the aversion to sexual education in the Catholic Church, aspects of the Evangelical doctrine act contrary to healthy relationships and in some cases perpetuate the prevalence of domestic abuse. I want to note that this machismo pervades the whole society, not just the Evangelical portion: my Catholic Kaqchikel translator told me that they ask people the same questions at their weddings for instance.

Charismatic Catholicism

The Charismatic movement arose as a Catholic response to the explosive rise in Evangelicalism. As a result, it more closely resembles Evangelicalism than traditional Catholicism. Very few of the Charismatics attend mass at the Catholic church on Sundays. Instead, they attend cultos in their separate church several times a week. The activities at these meetings almost exactly replicate Evangelical meetings; however, despite these similarities, Charismatics adamantly claimed that they are a sanctioned part of the Catholic Church because they still worshiped the Virgin Mary. In fact, I attended one of their rare masses and found it
almost exactly the same as a regular Catholic mass, except that the people acted more engaged in the service and seemed more reverent of the host (exclaiming their love and awe for Jesus) when the priest began that part of the service.

The severity of the rules of conduct displayed the biggest split from the regular Catholic Church. Much like the Evangelicals, Charismatics cannot drink alcohol or smoke. In fact, one catechist told me that he became first interested in the Charismatic church because he used to be the head of the youth group at the Catholic Church but the kids did not listen. After church, they would go back to the street and do whatever they wanted. The Charismatics, however, actually lived according to the Jesus’s example. Alcoholism and the need to protect the children from its influence were at the forefront of their minds. I discovered that they incorporated the Catholic stress on keeping children active within the church with the Evangelical rigid social mandates. In fact, the process of disciplining rule breakers was almost exactly the same as the Evangelicals’.

Again, other members of the community bring up charges against people and they are sanctioned from participating according to the severity of the *falta*. They also utilize faith healing for the same purpose as the Evangelicals, although they pray to Mary for protection and help as well. Groups of people go to members’ houses to “cry” when someone is sick, leaving to work abroad, or needs something else.

In addition, the second most common *falta* is adultery. People find out about this when a woman gets pregnant. Either the man pays for the child or she has to go to the leadership and explain, hoping that they can help her convince the man to recognize the child. If the man is not Catholic, she goes to the municipality building to accomplish the same thing. Women go through this same process in both the Charismatic and Catholic communities. The Catholic leadership seems to accept the Charismatic movement as long as they abide by the Catholic doctrine. For this reason, catechists receive lessons in Church doctrine from the priests once a year. Therefore,
while the Charismatic conceptions on how to live a healthy life show more in common with the Evangelicals’, they remain a part of the Catholic church inasmuch as they obey doctrine not necessarily organization. The Catholic hierarchy again appears willing to stress nominal association rather than direct involvement in its diverse lay organizations.

*Changing Traditions and Religious Influence*

While the vast majority of the people in San Antonio and Santa Catarina are Catholic, few actually attend mass every Sunday and take part in church functions. So, most people in the towns are nominally religious but do not devote significant parts of their lives to the Church. So while religion certainly plays a large part in people’s lives, many people live more in the secular world. In addition, while the three main religions take different approaches to combating immoral or unsafe behavior, they also show remarkable similarities in other areas. For example, all three do not support the use of birth control or general sexual education. The Charismatics and Evangelicals are admittedly somewhat more averse to it, but all three look at it as sinful. Women are however overwhelmingly in support of using it but cannot due to a number of factors. If their husbands catch them using it, they will assume the wives are cheating, men are pressured to have as many children as possible by their *machismo* culture, and men want more kids to help work. As a result, it is *machismo* that pervades through religions, not the other way around. It is seen in Evangelicalism, Catholicism, Charismatic Catholicism, and the non-religious.

So what role does religion play in physical health? I have already discussed how ill-equipped the government run *Puestos de Salud* are, and there is only one public hospital in the town of Sololá for upwards of 50,000 people in the Lake Atitlán area. In San Lucas Tolimán, Fr. Gregory Schaffer built a hospital to serve the town and its surrounding communities. He, an American priest stationed there, received funds from people back in the United States to run and expand the hospital as necessary. He passed away some years ago, and now the hospital is run
separately from the church. Donations from “Amigos de San Lucas” flow directly to the public works projects that he started, bypassing the church. Nearby, an Evangelical pediatric clinic built to offer free consults to the children of an Evangelical school outside of town, provides consults to children who do not attend the school for a small fee. Both of these institutions serve the wider community, and both survive on donations from North America, usually in conjunction with churches there. However, they function separate from direct connection with their parent religious institutions.

Therefore, religion plays a large role in serving whole communities, but only when they can rely on money coming from the north. To do this, they need connections: Fr. Greg already knew people there and was able to serve as an intermediary, and the international Evangelical network allows for money to come from North American Protestant churches. Both of these services do not come free however; people must still pay a small fee for medical care that they cannot receive elsewhere at the public health posts.

Economics drive a similar prioritization process in people who needs health care. Almost everyone uses homemade natural medicines, called *remedios caseros*, when someone gets sick first. These are teas or other remedies that one can make using plants readily available around the house. Then, as the situation demands, they will purchase either chemical or natural medicine from an *ak’o manel*, or “one who cures.” They use this word for both a doctor and a specialist in natural medicine, showing the duality of the two. People chose one or the other; they do not see one or the other as less effective unless they try one and it does not work. Then, if extremely necessary, they will go to a specialist, but only if they can afford it.6

Evangelicals and Charismatics, however, also subscribe to faith healing as a viable alternative. “Talking to Jesus is free,” one Evangelical woman told me (Field notes March 4

---

6 See Appendix for exceptions to this process.
2014), and she believes wholeheartedly in the power of her prayer because it had worked once before when both natural and modern medicine failed her. God answered her prayer by sending her financial aid from a friend in the United States to see specialists for her illness and begin moving around again. She now almost solely depends on prayer and *remedios caseros* when she or a member of her family gets sick. She goes to the hospital for very dire situations. I presuppose that people are therefore willing to accept religious alternatives to medicine when it makes economic sense and they can see the results, either in themselves or in others.

Much like in the United States, economic factors affect when people chose to go to the doctor and their condition when they arrive. They do not want to go to the hospital because it costs money so they wait and rely on cheap *remedios caseros*. When they eventually cannot wait any longer, they visit the doctor, and treating the illness costs much more than it would have earlier. One doctor told me a story of a woman who worked in Sololá and came into the hospital at San Lucas ten and a half months pregnant. She had not wanted to leave her job and go to the doctor; her baby had died a month earlier while still inside her. He did not have the resources to treat her there, so he had to send her on and never saw her again. The reality of life in Guatemala shows the lack of resources for people and the structural societal flaws that prevent them from being able to pay for better care.

Furthermore, I learned that the three most common illnesses that doctors see in the area are related to skin disease, respiratory problems, and bowel issues. All of these could be prevented with better living conditions and better hygiene. Many NGOs and religious public work projects try to accomplish just this in the area. Most projects include building better stoves to prevent respiratory problems, teaching better hygiene and cooking methods to prevent bowel and skin issues, and nutritional programs. Many volunteers from outside the country lamented the fact that the people do not know how to take care of themselves. They must rely on aid from
North America to survive since they cannot help themselves. Much of the time these projects do not work; people do not change their behavior. But why not?

I argue that economics, in part, contribute to when people change their tradition. For instance, one of the main criticisms of the stoves is that they are too small if someone wants to sell tortillas, and they make them taste different. Furthermore, older people have been cooking the same way for decades and do not want to change, so there are significant cultural reasons as well. It comes down to practicality. Is it worth it to change? Can they see the benefit of changing, and is it feasible to change? People from San Antonio, or Tonecos, used to all use temescals, or steam baths, to bathe, and they used dried corn cobs both as toilet paper and fuel for the temescal. This completely changed in a generation. Showers, or baths in the lake, are much quicker and take less effort, and toilet paper is much more comfortable than a corn cob. The extra time allowed people to find other things to do and they could also use corn cobs in the stoves instead. However, machismo, for example, has ingrained itself so much into the culture that to change it would require massive social reforms.

So if the biggest problems to people’s health result from societal and structural issues, why do the religious leaders focus so much on alcoholism? Materially, if people do not spend their money on alcohol, they have more to spend on food and other necessities. Therefore, tighter restrictions would in theory allow for a higher standard of living as people spend their money more wisely. However, religious sanctions are not powerful enough or pervasive enough to drastically alter people’s behavior. In addition, they are not equipped to offer support to alcoholics, people who cannot rid themselves of the addiction just by coming to culto. Churches appear structurally similar to NGOs; they have a vested interest in maintaining themselves. They are more concerned with making sure that the maximum number of people is involved than treating ingrained societal problems.
Much of the money from collection goes to support the churches rather than towards social projects. Every single church that I talked to had plans to expand in the future and was asking their congregations for donations. I saw recent purchases included matching polo shirts for the Juventud Catolica, or the new glass podium for the Evangelical church, rather than social programs. While their motives might be more pure, the fact remains that the church leadership of all three denominations seem more interested in treating spiritual ills and extending that on down to the ground rather than starting from the ground up.

**Conclusion**

Many studies have investigated the religious progression in Guatemala; others have explored certain aspects of health. By looking at health in how the religious leaders define it, I was able to distinguish what they see as the most important aspect for their respective churches. All three church leaderships showed remarkable similarities in what they perceived as the worst *yabil*, or sickness, in their communities; however, they all displayed slightly different approaches in how to treat it. Furthermore, each one stressed the need to combat alcoholism and other deviant behavior, such as adultery, but did not hold physical health itself at the forefront of its mind. I argue that this results partly because churches are first and foremost a religious institution. They are concerned with “saving” their communities from sin and correcting moral deviancy. The religious leaders do not have the resources to fill that gap left by the limited efficiency of the *Puestos de Salud*.

The few religious public work projects all promised to be available to the entire community, and exist therefore separate from direct control by the churches. The hospital in San Lucas Tolimán for example offers medical aid to that entire side of the lake. Sometimes in order

---

7 The people consider alcoholism a sickness. Future research should examine their conceptions of what it means to have an *ahop’* (cough) or *k’atan rij* (to have a fever) compared to other less obvious illnesses.
to consolidate resources, there results working relationships between the public health centers and their religious counterparts. In their tuberculosis prevention program, the San Lucas hospital works in conjunction with the Puesto de Salud. The Puesto can order medicine for free but does not have the resources to find patients; so, the hospital promotores go out into the community to find people suffering from tuberculosis and send them to the Puesto for treatment. In addition, sometimes the Puesto de Salud goes to the churches to distribute information about vaccines and other programs because they can reach more people. Thus, both the religious and public health institutions work together to some extent in order to help distribute information. They stand at odds however when health education contradicts church doctrine or traditional beliefs.

Therefore, in order to change issues related to spiritual health, the churches themselves must change, as that their greatest sphere of influence. Traditional beliefs that pervade the entire community require much more than the churches themselves can attempt in order to change. However, as with the story of the temescals, people are willing to change in part if they can see the cost effectiveness and general success of new information. For instance, people embrace faith healing because they can contact the Holy Spirit, they have “seen” its success, and costs nothing. In general, one church is not powerful enough to alter an entire community’s consciousness. The plurality of religions in Guatemala in conjunction with the fact the majority of people in my area of study did not participate wholeheartedly in any one religion result in the general ineffectiveness of any one church’s efforts to combat socially pervasive behavior. For example, people still drink alcohol regardless of religious preference and despite Church efforts. I argue that some behaviors permeate through the spiritual realm, and require a change in society rather than more Bible study. People will chose from the religious marketplace⁸ to fit their current

---

⁸ The term, “religious marketplace,” I coin because many people described the churches as different tiendas from which you chose what to buy in a matter of speaking.
lifestyle. Their choice to join the Catholic, Evangelical, or Charismatic church depends on what they feel most suited to in their pluralistic society. \(^9\) Future research should focus on which traditions change and which ones do not, as this needs much more analysis. In addition, more study of the power of religion in changing behavior could better our understanding of the forces behind changing unsafe behavior. For now, religious institutions trying to fill the void left by the absence of medical care must rely on international aid, and the people will continue to use whatever options they can afford.

References Cited

Bastian, Jean-Pierre.


\(^9\) If someone does not agree with one religion’s rules, they will find one that fits their lifestyle. For this reason, many recovering alcoholics turn to Evangelicalism: they are seeking a rigid environment free from temptation.
Chestnut, Andrew


Shiffman, Jeremy and Ana Lucía Garcés del Valle.


Stark, Rodney and Buster Smith


Steigenga, Timothy J.


The World Bank

2011a   Health Expenditure, Public (% of Total Health Expenditure).

http://data.worldbank.org/indicator/SH.XPD.PUBL/countries/GT?display=graph,

accessed March 6, 2014.

2011b   Health Expenditure, Total (% of GDP).

http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS/countries/GT?display=graph,

accessed March 6, 2014.

World Food Programme


accessed March 6, 2014.
Appendix

1. The poster below shows these branches as seen in the office of Maria, a Panajachel church secretary.

Two branches have since been added from the time the poster was made. *Esperanza Viva GEV* provides support networks for people, mostly teenagers, struggling with substance abuse, and *Convite de Concepción* takes existing festivals and dedicates them to the conception of Mary.

2. If the situation appears dire enough, people will bypass economics and find immediate care. For example, one Evangelical woman told me that her daughter got very sick and they had to rush her to the hospital. She was having problems with her pregnancy, and while she lived, she lost her baby. Therefore, in order counter serious illnesses, people will go find immediate medical attention, even if it is not economically practical.