Burning Beds to Boil Water:
The Values that Dictate Reception to Western Health-Related Intervention in rural Guatemala

Abstract

Rural Guatemala is undergoing a major transition in which Western medicine and thought are being introduced. While some health interventions are successfully absorbed into Guatemalan culture, they are more often rejected. In a three week long study centered in Lake Atitlán region of Guatemala, the Western interventions present and the reception to those interventions was studied through interviews and participant observation. It was found that the communities valued economics first and foremost, but that when economics were not in question, practicality of a product or concept was valued above most alternatives, including many health benefits. Western organizations often fail to recognize this as a priority, and for this reason, the projects they fund and implement are abandoned.

Luisa Rodriguez
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Jay Levi
Introduction

After several weeks of trailing a group of International Rotary Club members, known as Rotarians, around in San Antonio Palopó, I was invited to a despedida, or farewell party. The despedida took place at the house of a Rotarian and permanent resident of San Antonio, Evelyn. The house was several stories tall and beautifully decorated, with an elegant garden, a swimming pool and a sizeable terrace. I hid uncomfortably by the wall, and watched the guest dynamics while engaging in light conversation with the Rotarians. There were three, distinct groups. First, there were the Rotarians, a group of twelve elderly Canadians who funded and a number of charitable projects over a period of two and a half weeks. They were dressed in cheaply-made Guatemalan garments designed specifically for tourists and were seated at a beautifully set table. They had also been given glasses of wine, which were periodically refilled by hired waiters, and picked at plates of cut fruit while talking loudly. Second, there were the members of town’s two weaving cooperatives – which served partly as an organization of women seeking fair prices for their loom work and partly as a social club – who had conceived of the projects and had asked the Rotarians into their community to actualize them. This group, which consisted of relatively privileged Guatemalan women, mingled cheerfully while sipping from cups of juice in ornately decorated traje típico, the traditional dress. And thirdly, a group of impoverished women and their children – the beneficiaries of the projects – sat on the low, stone wall of the terrace, wearing faded, out-of-style traje típico, eating nothing and saying little. The Rotarians chatted amongst themselves in English, the weaving cooperatives, in Spanish and the beneficiaries, in Cakchiquel, the local language. None interacted with the members of another group.

The gathering was organized by the members of the weaving cooperative and was a combination of an award ceremony and a party, during which the beneficiaries of the Rotary Club’s projects were invited to thank them for their generosity. The Rotary Club had carried
out several substantial projects, including the distribution of new beds, the donation of high efficiency, low pollution stoves, the reconstruction of several aluminum roofs, and the organization of a free, week-long dental clinic. All of the projects were meant to improve the overall health of the beneficiaries in some way. The stoves were meant to minimize respiratory infections and chronic eye problems caused by indoor smoke pollution. The beds and roofs were intended to reduce illness in general by creating healthier living conditions during the six month rainy season, during which many community members slept on the cold, damp, dirt floor and wore permanently wet clothing. The dental clinic provided dental cleanings, fillings and surgeries for several dozen individuals and offered oral hygiene lessons that were open to the public.

The festivities began with several activities meant to put the groups at ease in which members of the group of beneficiaries were invited to the center of the terrace to have banana eating contests and string sucking races. The beneficiaries competed, the weaving cooperative instructed and the Rotarians laughed, entertained. Following the games, the members of the weaving cooperative began a formal presentation of certificates and gifts, with several thank you speeches which were translated from Spanish to English and vice versa, though never to Cakchiquel. As the presentations progressed, several Rotarians began to cry, perhaps moved by their own good deeds. The beneficiaries were considerably less moved, sitting politely, speaking only to hush their bored and distracted children. Watching silently, I wondered who exactly this gathering was for and which group was truly benefiting. Finally, after the Rotarians and weaving cooperative had both sufficiently expressed their gratitude to one another, large plates of elegantly decorated entrees were brought out and delivered to the Rotary Club and weaving cooperative members.

I took this opportunity to question the beneficiaries, finding three that spoke and understood some Spanish. I asked them how helpful they had found the projects as, based my
observations from the few weeks prior, I had my doubts regarding their efficacy. They immediately responded with enthusiastic affirmation that, yes the projects and gifts had been very well received. However, upon further probing, two admitted that they preferred their old stoves to the new one and all three admitted to have disassembled the wooden bed frames to use as firewood. They maintained that the roofing projects and free dental consultations were both very appreciated. The stove and bed projects, due to the cost of the stoves and the special wood treatment involved in the bed assembly, accounted for roughly 60% of the funds spent by the Rotary club while the roofing and dental clinic constituted only 35% (the other 5% of the Rotary Club’s costs went to travel and accommodations).

After all of the capital and time spent, the gratitude shown by the beneficiaries was underwhelming, which suggests that there was a serious disconnect between the way each group perceived the value of the projects. The Rotarians’ gifts, which in their eyes were incredibly important, seemed only moderately useful to the beneficiaries. During my three weeks of research in the community, my aim was to understand exactly which values and priorities, as highlighted by this scene, accounted for the behavior and perceptions of the beneficiaries.

Originally, I had been interested in studying the interaction of the pre-existing theory of medicine— the pre Columbian theory— with the new medical ideas and products being introduced to rural Guatemalan communities by the Western world. In the past twenty years, the Guatemalan government has implemented quite a few health care reform policies as part of a national health campaign which draw from Western health practice and ideology considerably. It was my goal to understand how the Western ideas and products were being received (Goldman 1994). However, contrary to my expectations, I began finding that the Western health interventions – both governmental and non-governmental – had very mixed
results. While some, a minority, had a lasting impact on the community’s health and health seeking behaviors, a majority seemed to be ineffective or even useless.

After noting these trends, my question became the following: as Western organizations penetrate rural Guatemala, which factors, values and priorities influence the way the new theories of health and health-related products are absorbed or ignored by the indigenous people? Also, as an extension, do Western organizations understand those factors and their interplay? There is a vast body of literature with a number of hypotheses regarding the factors that seem to be influential in communities where there is medical pluralism and where there is an organized Western presence. The factors that have been identified are primarily culture, education, and economics (Gold 2011) (Nnadi 1984). My experiences suggest that decisions are actually made almost entirely by considering urgency first, then economics, then practicality and only occasionally by cultural components (that is, those components that are a result of traditional beliefs and practices). I also explore the observations that led me to believe that these elements, their relationships with each other, and nuances that exist in particular situations are not well understood by most Western institutions.

For the purpose of this argument, I define Western health-related interventions as the introduction of Western medicine and ideas regarding health and disease by both governmental and non-governmental organizations (NGOs). The relevant subdivisions of the general Western health-related interventions are theory of disease, prevention of disease, and treatment of disease. To understand the discrepancy between Western and Guatemalan values, I will explore the pre-existing health seeking behaviors and practices, the newly proposed Western ones, and then describe and analyze the observed behavior of a population facing both.

Methods

During the three weeks of research, I lived in Santa Catarina Palopó, a town on the southern shore of Lake Atitlán with a population of roughly 500 families. My research was
focused on the various facets of the health-related programs and products being produced, offered, or endorsed by Western organizations in the surrounding communities. These were compared with the programs and products offered by local community members and medical professionals, whose strategies and philosophies were derived from the pre-Columbian theory of health.

I began by investigating the programs and services offered by the Guatemalan government whose policies and programs drew strongly from Western methods. I had formal interviews in several government funded clinics, called *puestos de salud*, which offer free consultation and treatment to community members. I visited a number of these clinics, located in nearby towns, including Santa Catarina Palopó, San Antonio Palopó, San Lucas Tolimán, Panajachel, Sololá and Ciudad Vieja. The number and variety gave me the opportunity to note the varying degrees of funding, community use and staff dynamics. Administrators, caregivers, and *educadores*, whose job it is to educate community members about health issues, were interviewed to achieve a more complete depiction of the clinic health professionals. In each interview, several pre-planned questions were asked first. Then impromptu questioning that followed the interview’s natural progression. In addition to paid employees, I approached patients in the waiting areas of the clinics and engaged them in informal conversation regarding their health habits and ideas.

I also studied the pre-Columbian health practices, natural remedies and theories of health that prescribed by traditional health specialists. To accomplish this, a series of informal conversations with community members and Mayan shamans, or *Ajq’ijab*, were conducted. I also employed participant observation in order to learn about daily health seeking behavior from community members and about *aj q’ij* ritual and the philosophy that informs those practices. Because of my extended presence in Santa Catarina Palopó, most of these conversations took place there, with community members with whom I had formed
relationships. Because socioeconomic class, education, and age, seemed to affect in the behavior and responses of the participants, community members from varying economic backgrounds and age groups were questioned and observed.

Finally, a third perspective involved observing and evaluating several Western non-governmental organizations (NGOs) with regards to their health-related education and donation programs. NGOs in Santa Catarina Palopó, San Antonio Palopó, Panajachel, Sololá, San Andres, Aguas Escondidas, San Lucas Tolimán, Santiago, Barrancó, San Juan la Laguna, San Jorge la Laguna and San Pablo la Laguna were selected to maximize diversity and sample size. Formal interviews were conducted, using a specific set of questions, with administrators and staff members belonging to the organizations. In addition to this, informal conversation and participant observation was employed to understand the perspective of the beneficiaries.

Challenges that arose were mostly cultural. Language was sometimes problematic, as many of the subjects of interest spoke Cakchiquel, as opposed to Spanish. In addition to this issue, it was often the case that beneficiaries assumed, based on my nationality, that I was involved with the organizations that were helping them, and therefore were hesitant to express their opinions regarding projects when they were negative. To combat this problem, I emphasized my lack of association with the organizations and lack of investment in their success or failure.

All participants included in the study were given a brief summation of the research investigation before interviews, conversations and observation were initiated. Because explicit permission was not formally requested, all names have been changed in order to protect the identities of the participants.

Theory of Disease

Pre-existing Concepts of Disease and its Causes
The predominating principle of traditional Mayan medicine, which centers on the interaction of hot and cold substances interacting with the body, is known as humoral medicine (Logan 1875: 8). Many substances, including foods, medicinal plants and illnesses, have either hot or cold character – designations that do not actually refer to temperature but rather their perceived essence – and these designations indicate the manner in which the substance should be used or illness dealt with (Logan 1975: 8). It is believed that excessive exposure to either a hot or cold substance is detrimental to health is the primary cause of disease (Logan 1975: 8). Similarly, to cure the ailment, a specific medicinal plant with the opposite quality must be used (Logan 1975: 8).

In addition to the concept of humoral medicine, Guatemalans have traditionally subscribed to the belief that intense, emotional experiences can cause or worsen an illness (Rubel 1964). This phenomena, which is usually described as a response to fear specifically, is named susto, an abbreviation for the Spanish noun meaning fright, asusto (Uzzell 1974: 369-370) (Rubel 1964: 268). It is thought to be brought on by anxiety, fear, anger or grief and results from highly stressful situations such as spousal discord, the death of a family member, or sudden financial problems (Rubel 1964: 268-269). Those suffering from the condition exhibit the following symptoms: fatigue, depression, withdrawnness, fever, nausea, vomiting and diarrhea (Houghton 1988:146-149).

Western Intervention into the Community’s Theory of Disease

Western scientific research has produced a thorough and relatively complete depiction of pathology and immunology and the Guatemalan government has made attempts to incorporate these concepts into government funded programs and curriculums. For example, as mentioned, the educadores are employed to teach local families about sanitation and hygiene. In these talks, which are given privately in homes, simple explanations of disease and transmission are discussed. Privately and publicly funded medical professionals who have been
trained in Western medicine also provide scientifically supported explanations of health and illness to their patients.

The Western theory of health and disease is also part of the curriculum in all public and most private schools. Science is taught with special attention given to pathology and biology, and students begin mandatory sexual and developmental education at the age of ten. In two out of three schools visited (one in Santa Catarina Palopó and the two in San Antonio Palopó), the science books and materials were written and published in the United States and translated into Spanish, illustrating the extent to which Western science has penetrated Guatemalan institutions. Also, educadores make bimonthly visits to the schools in order to give more detailed explanations of disease and transmission.

*Observed Behavior, and Why?*

One might expect the Western theory of disease to have replaced traditional thought, but this is not at all the case. In fact, both exist alongside each other with little interaction or interference. When questioned, most will deny belief in traditional ideas regarding health and disease. However, in daily life, I found that many frequently reference the concepts described by humoral medicine, attributing their diarrhea to having eaten beer and pork (two cold foods) at one meal, or by attributing a fever with to fact that they swam in cold water on too hot of a day. Community members insist that the idea of *susto* no longer exists, but doctors at both *Tierra Prometida* and at *Familias Mayas* described encounters with patients who cited a recent fight with a family member, or other traumatic event, member as the cause of their diabetes, anemia or other affliction.

It seems plausible that the reason these ideas have not disappeared is because these communities’ overall health is relatively unimproved by the addition of Western ideas, while the ideas themselves may be more accurate. They do not preserve their beliefs consciously out of the desire to maintain their traditions. Instead, they have heuristics that, though founded on
superstition, are based on correlations that really exist. For example, though prolonged exposure to hot weather alone does not cause a fever, people often develop a fever in response to prolonged sun exposure because they become dehydrated and their immune system becomes impaired, making them more susceptible to bacterial and viral infections. Therefore, because their heuristics are useful most cases, there is nothing driving them to seek alternatives. Here, the value being displayed is not a cultural one, but simply a basic desire to be healthy, or efficacy, which is met by their preexisting beliefs. Because beliefs and ideology have no financial cost, efficacy is the highest priority in this case. This hypothesis is supported by Douglas Uzzell, who writes that the use of traditional conceptions of illness as guideline may be an effective strategy in disease prevention and it is for this reason that they are preserved, rather than the fact that they are rooted in tradition (1974).

However, many ideas in Western ideology are also often referenced. Several individuals gave detailed, biologically accurate explanations of the transmission and cause of several complicated diseases, including both gastritis and cancer. Not coincidentally, the cases in which the individuals utilize Western conceptions of disease are consistent with a classification system they have developed, which distinguishes between natural diseases and modern diseases. Natural diseases are those that have been recognized described for centuries, while modern diseases are those that have only recently been identified and characterized, like hernias, ovarian cysts and dyslexia. While they are not new diseases, they were not present in the community’s concept of diseases prior to introduction by the West. It seems logical to assume that communities have adopted the Western conceptions of diseases for which they had no alternative in order to fill in the gaps of their preexisting philosophy.

The exception, in which one theory, pre-Columbian or Western, overshadows the other, and in effect showing some cultural bias, seems to be attributed to age. Older generations are consistently more likely to have a better understanding and reliance on traditional theories of
disease than younger ones and younger generations are much more likely to have and correct understanding of and more confidence in Western theory. This disconnect seems to be a result of the differences in exposure, which implies there are cultural values at play to some extent. However, it seems primarily to be the case that community members value their health above allegiances to culture-based traditions and beliefs, and for this reason, their concept of health and disease is a union of ancient tradition and new understanding.

**Preventative Health**

**Pre-existing Concepts of Preventative Health**

Because the traditional theory of health is centered on the idea that the body must be maintained at thermal homeostasis, strict guidelines regarding dietary and bathing habits have been developed and are enforced regularly. In Santa Catarina Palopó, sources gave pork, beer, milk, plantain and soft drinks, among others, as examples of foods with a *cold* essence and ginger, rice, tea, chicken and vegetables as examples of foods with a *hot* essence. Studies conducted in the past confirm the categories identified by the Santa Catarina community members (Matthews 1983: 827-829). Using these categories, community members prepare meals with balanced ingredients, to minimize illnesses that would result from an excess of one quality (Logan 1975: 9). In addition to guidelines regarding diet, bathing and other activities are regulated in order to avoid abrupt changes in actual bodily temperature. For example, bathing in the *temazcal*, the sauna-like room used to bathe, is done in the late afternoon or early evening, when the day is warmest so that the hot steam and water in are not a shock. On particularly hot days, meals are eaten outside of the kitchen, which houses the heat-radiating stove, to minimize heat saturation. With respect to cold, sweaters are always worn in the evening to avoid illness caused by chill. By minimizing inappropriate combinations or shifts between conditions with *hot* and *cold* character, an individual minimizes his risk of infection and disease.
Western Intervention

There was quite significant evidence of Western intervention with regards to preventative health in all of the communities. The government funded health clinics require that all children be immunized against Hepatitis B, BCG, polio, rotavirus, pneumonia, diphtheria, tetanus, influenza and convulsive cough by the age of four years old. Children are also given an anti-parasite medication every six months until they are five years old. Educadores make monthly visits to each of the homes with pregnant women or with children under five years old in order to give short talks describing basic sanitation and personal hygiene, focusing on the importance of washing hands, brushing teeth/hair, wearing clean clothing, washing produce prior to consumption and cooking with clean utensils and ingredients.

NGOs seem to focus especially on preventative health care, offering impoverished community members a number of products with significant health benefits at low or no cost. The secular organization, Familias Mayas, which has centers in Panajachel, San Jorge la Laguna, Barrancó and San Antonio Palopó, has several projects that provided such products. Their longest running project involves the distribution of specially designed stoves, whose purpose is to decrease the amount of smoke that the user is exposed to, thereby reducing serious respiratory and eye conditions. The other notable project proves water filters, whose elegant filtration system supplies a family with potable water.

The International Rotary Club had several members funding a number of short term projects in San Antonio Palopó that were organized by a group of women who were part of the community’s weaving cooperative. Like Familias Mayas, the Rotary Club purchased and distributed a total of twenty-four high efficiency, low emission stoves to families deemed by the weaving cooperative to have “demonstrated” need (Field Notes March 2nd 2014). These stoves have less surface area and therefore require less firewood. They also have a chimney meant to keep excess smoke from filling the interior of the home. In addition to the stoves, the
Rotary Club supplied approximately fifty beds to families with dirt floors in the hopes that being raised off of the ground would decrease the incidence of preventable illness and infection. A roofing project, through which the club funded the distribution of aluminum laminate which was then used by residents to reconstruct roofs which were in serious disrepair, also hoped to improve the unhealthy living conditions. Finally, the Rotary club organized a dental hygiene class for fourteen young women in the community that focused on the basics of tooth brushing and the principles of dental decay.

**Observed Behavior, and Why?**

The majority of Western interventions in this category fail because, while they have legitimate long-term health benefits, either practical concerns or prospective financial burdens are weighed more heavily than the less obvious benefits derived from preventative health measures. The stove and water filter projects that were coordinated by the International Rotary Club and *Familias Mayas*, which both proved unsuccessful, illustrate the trend in which practical concerns trump long term health benefits. The stove programs seemed to be the most problematic. By my estimates, it is likely that less than 25% of the stoves in San Antonio Palopó and Panajachel are in use. In San Antonio, out of the fourteen stoves supplied, only three were being used. In Panajachel, over one hundred stoves were distributed in the town as well as in neighboring community. Out of eighteen recipients questioned or observed, only four were being used. Though the explanations given by the recipients who were not using their stoves varied considerably, their theme was obvious; small practical benefits offered by their original cooking practices were perceived as more valuable than the benefit of improved respiratory and eye health. The reasons given included the following: 1. the smoke from their original stove drives away insects, 2. the new stove is not large enough to cook many tortillas at once, 3. the stove takes considerably longer to heat things, 4. the new stove, built to reduce heat loss and increase efficiency, does not serve as a space heater the way their original stove does,
and 5. The new stoves’ complicated design keeps users from installing it properly. A number of studies critiquing similar stove programs have reported similar responses (Subramaniam 1994: 1176-1177); (Barnes 1993). The water filter was a failure because design requires users to lift fifty-gallon jugs of water more than a meter off the ground. Because Familias Mayas supplies a population that is mostly elderly, many of the recipients were unable and unwilling to use the filters. Program administrators encouraged the recipients to seek assistance from family members or neighbors but this inconvenience was enough to dissuade them from using the filters.

Another pattern of behavior, illustrated by the beds and water filters, offers another interesting case. Instead of using the beds and water filters provided by the International Rotary Club and Familias Mayas, as the products were meant to be used, the beneficiaries of both projects chose to use them for alternative, more valuable (in the eyes of the beneficiaries) purposes. As mentioned, many of the beds were chopped into firewood, suggesting the utility of the bed was less than the utility of the money they would save by not buying firewood for two or three days. And the water filters that were not left in disuse as described above were used, not to filter pollutants from water, but to filter out particles and pollutants alcohol, which many distilled professionally in their homes as a source of income. Again, it is apparent that the economic problems of today are prioritized over health of tomorrow.

The projects that have been effective are those that have tangible benefits. They do not result in issues of practicality, require no financial investment by the recipient, and cannot serve a better purpose. For example, the roofing project organized by the International Rotary Club, which offered immediately obvious improvement was very successful from the perspective of both the Rotarians members as well as the beneficiaries. The San Antonio Palopó community accepted the aluminum laminate and used it as intended without any prolonged inconvenience or cost. The communities have also been been very receptive to the vaccination and anti-
parasite programs, which have an infrastructure in place that makes them accessible and convenient.

**Treatment**

**Pre-existing Concepts of the Treatment of Disease**

The treatment of disease prior to the arrival of Western medicine involved a combination of cultural and natural curative measures, methods known to both *Ajq’ijab* as well as some untrained community members. The most common treatments, known as *cultural cures*, are simple remedies made by brewing special herbal teas. The plants needed to remedy typical, easily treated afflictions are known by most community members. Less common, more tenacious conditions must be treated by an *aj q’ij*, who, in addition to herbal treatment, leads a ceremony that often involves massage, prayer and, as individual illnesses and medicinal plants also have a thermal character, attention is again paid to humoral medicine. Illnesses that are considered *cold* include diarrhea, stomach pain, rheumatism and tuberculosis (Currier 1966: 253-254). Examples of illnesses with *hot* character are dysentery, kidney ailments, sore throats and rashes (Currier 1966: 254). Traditionally, these conditions were treated with medicinal plants which had the opposite thermal essence.

Another traditional medical professional is the *comadrón*, who is the Guatemalan equivalent of a midwife. These women, who also identify as having a spiritual component to their work, believe it is their destiny to work as midwives and use traditional birthing techniques and therapies to assist mothers. These women form relationships with the pregnant women at the beginning of their pregnancy, meeting frequently to discuss and tend its progression, and continue to offer support, both medicinal and moral, after the birth of the child.

**Western Intervention**
The treatment of disease is perhaps the area in which the Western methods are most present. All governmentally funded health facilities subscribe fully to Western thought and professionals at those facilities are quick to discredit the natural or cultural cures prescribed by inherited tradition and shamans. The *puestos de salud* offer medical consultations with nurses or with a doctor (if the clinic has a resident doctor) as well as Guatemalan versions of Western pharmaceuticals free of charge. They also offer extensive pre- and post-natal care in the form of frequent examinations and free nutrient supplements. Pharmacies filled with Western pharmaceuticals, known as chemical medicines, line the streets of cities and towns alike.

The majority of NGOs in the region provide centers where the local population can seek Western medical care at low cost to no cost. Examples of organizations that do this are Mission Guatemala, the International Rotary Club, *Familias Mayas*, and *Tierra Prometida*. Mission Guatemala is a permanent clinic located in San Andres, funded by a group of Presbyterian churches in the United States that is run by two Westerners. The clinic charges ten *quetzales*, roughly equivalent to a $1.25, for a consultation with a doctor, is open six days a week, and is able to accommodate roughly thirty five patients per day. *Tierra Prometida* is another also an permanent clinic funded by Evangelists from the United States and Canada. It services the Evangelical community in San Lucas Tolimán at reduced rates for adults and no charge for children enrolled in the local Evangelical school. More than just offering consultations and medication, the clinic also finances eye exams, eye-glasses, and transportation to medical facilities in cases where a health condition warrants intensive medical attention.

*Familias Mayas* offers frequent medical consultations to members of its health programs at its Panajachel center. The consultations are provided by Western doctors who come to Guatemala (generally for one week) to volunteer their time and service. The visiting International Rotary Club members also organized a temporary dental clinic in San Antonio Palopó lasting a week long, which screened potential patients and selected the most life
threatening cases to be seen by the Rotarian dentist and dental hygienist. They performed eight dental cleanings, filled twenty-four cavities, extracted nine teeth, and performed two surgeries.

**Resulting Behavior, and Why?**

In the area of treatment, financial pressure is the deciding factor. An individual is certain to use any medicine that is free first. For that reason, the *puesto de salud* or NGO funded clinics are the first choice and are used often and without hesitation. When the *puesto de salud* does not have the medication needed to treat a particular illness, which it often does not, or when there is no resource-rich NGO clinic in the area, one will seek out relatively cheap, easily available *cultural cures*. Despite the fact that Guatemalans have relatively less confidence in these cures, they are sought out because they are less financially burdensome.

In cases where both government funded care and cultural cures fail, and more serious treatment is needed, individuals must choose between visiting a private doctor, visiting an *ajq’ij*, and purchasing non-prescribed medicine at a pharmacy. In this case, evidence suggests that individuals continue to make decisions based on economics but, because those three options do not follow a consistent pattern in terms of pricing, this decision is made on a case by case basis. In Santa Catarina, there were several cases where one disease was treated more cheaply by visiting a pharmacy while another was treated most cheaply by meeting with a private physician. This suggests that the communities have roughly equal confidence in the two options as they are chosen primarily based on price. In instances where the cheapest of those more expensive options failed, patients selected the next cheapest, and if that failed, they settled for the most expensive option. Throughout this process, urgency is weighed first to determine whether or not a patient is desperate enough for treatment that they are willing to seek out the next expensive option. Contrary to the prevailing body of thought supported by Baru and Caldwell, which is that decisions regarding disease treatment are affected primarily by culture and education, it appears that, in rural Guatemala where financial instability is universal and
crippling, economics informs an individual’s treatment seeking behavior first and foremost (2005); (2000).

Economic factors play a significant role even when a non-urgent medical intervention is provided at no cost and without solicitation. The eye-glasses and toothbrushes provided by Tierra Prometida and the International Rotary Club, respectively, were sold immediately by the beneficiaries, who prioritized the financial gain above the health benefits derived from oral hygiene and improved eyesight. Both organizations only successfully convinced their recipients to use the items as intended when they decreased the value such that it was essentially worthless and therefore impossible to sell. They did this by purchasing glasses with unique prescriptions and unwrapping the toothbrushes prior to distribution.

There are two notable exceptions. The first appears in cases where a condition is life threatening. In these cases, patients seemed to seek out Western intervention from a private doctor or hospital. This hints at a slight preference for Western medicine, which again supports the assertion that traditional methods are not always conserved simply because they are tradition. A more definitive exception is evident in the case of prenatal care and issues of feminine health. In this specific context, the major deciding factor does seem to be culture as women consistently choose to be assisted by traditional comadronas and aj q’ijab, who are both almost always female, rather than Western midwives. The reason for this, as described by staff of the puestos de salud in both San Antonio Palopó and Sololá, is that, due to the prevalence of machismo that exists in Latin American culture, men refuse to allow their wives to be examined by other men (and doctors and nurses trained in Western medicine are men more often than not), even if it is in a professional setting.

Conclusions

Not surprisingly, the first factor considered when making a health-related decision in rural Guatemala is urgency (health matters that are deemed urgent vary from person to person);
the basic desire to survive and be relatively healthy is compelling and Lake Atitlán is no exception. Whether deciding to seek medical attention, purchase medication, or utilize a donation or gift of some sort, the primary question is: do I need it desperately? If the answer is yes, an individual will sacrifice other values, including money and traditional values, in order to meet the need.

The next factor that is considered, economics, is related to urgency. Due to the economic circumstances of the members of the communities surrounding Lake Atitlán, it seems the way they receive Western health interventions is almost always decided by the intervention’s ability to satisfy an immediate need. If the monetary value of a product -- a medical visit or physical product, for example -- can be spent on a need that is immediate, like food, it is. This sense of desperation leads residents to undervalue health investments that offer long-term gratification, which suggests economics influence decision making significantly. Products that meet an immediate need with tangible gains, like food, shelter and in some cases medicine, are valued so highly, that all other products are much less valuable by comparison.

When economics are not a factor, either because options are equally priced or the item is free, practicality is considered. The mistake of assuming a community will tolerate inconveniences seems to be common. The evidence indicates strongly that potential health benefits that provide only long-term gratification are not worth short term inconveniences. This may seem illogical, but the reason for the amount of emphasis placed on practicality is likely inextricably linked to the economic factors that are so important. When there is such a sense of desperation, it is crucial that neither time nor energy be wasted on activities that are not an immediate concern. When one is struggling to survive through tomorrow, it seems impossible to waste resources on concerns that several years in the future.

The importance of practicality as a factor in health seeking behavior seems to be the one that continues to elude Western organizations. They seem to underestimate the need for basic
essentials, often offering what may be extremely valuable in the future, but which is of no use now. The reason for the inaccurate predictions regarding the way theory of health will evolve with the introduction of Western ideology, and the number of unsuccessful projects described can be explained by their fundamental misconception of this value. Unfortunately, they continue to be oblivious to this fact, focusing on the same projects, which only treat symptoms instead of the underlying illness. In fact, rather than recognizing the true needs of the communities, they attribute the fruitlessness of their projects to cultural rigidness. In fact, it is seems to be their own inability to understand the values of the communities that hinder their own success. Understanding the enormous economic desperation, and in effect, their need for efficient, effective habits and products, is key to supplying useful aid to the communities.

At one point, while investigating the stove project, I asked a young Californian representative from Familias Mayas why she felt the program had been unsuccessful. She laughed and rolled her eyes.

“Oh, they’re very protective of their culture. They’re beautiful people and it’s a beautiful culture, but they’re all going to get lung cancer because they feel like that have to do everything the way their parents did it. It breaks my heart.”

I asked, “so you definitely think it’s about keeping tradition?”

“Oh, absolutely,” she responded. “Look at their outfits. Look at their hair. They think they’ll get a cold just by walking in the rain. They just aren’t very open to change. We thought that if we showed them that they could still cook their same tortillas on this new stove top, they’d be open to it. But the stoves are just sitting in the corner rusting. We should have known, really. We could have saved a lot of money if we’d just realized they’d never let go of the open fire thing. But you learn from these things, you know? We won’t make the mistake again.”

(Field Notes March 3rd, 2014)
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